Homelessness in the Eastern Health Board

Recommendations of a Multidisciplinary Group

March 1999

Acknowledgements

On behalf of the group, I would like to acknowledge the commitment of the CEO of the Eastern Health Board, Mr. McLoughlin, to this client group. I would also like to thank each member of the group for their wonderful contribution and application to the task.

Further thanks are also due to the voluntary service providers who participated in the focus group work and to Mary Higgins of the Homeless Initiative for her submissions in relation to accommodation and legislation. Submissions were also made by Dr John Latham, Dr Anthony Clarke and Professor William Shannon and were gratefully received.

During the course of the work carried out, consultations were held by members of the group and I thank those who contributed to these consultations including Dr Noel O'Gorman, Dr Kevin O'Doherty and Dr Kieran Harkin of the Eastern Health Board GP Unit and Ms Alice Leahy of Trust.

A final word of thanks is due to Philomena Canning for her work with the voluntary service providers.

Hugh Kane,
General Manager
Chairman of Group

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Chapter 1 Introduction

The Chief Executive Officer of the Eastern Health Board Mr Pat McLoughlin convened this group in February 1999 to look at the gaps in service provision to homeless people. Given the on-going difficulties experienced by homeless people and the current positive economic climate it is appropriate to examine how all members of society may benefit at this time. There are many services provided by many different service providers yet some people are still slipping through the net. The group had to focus on an integrated model of service provision as the most appropriate way of dealing with the complex combination of difficulties facing this very vulnerable group.

The committee was cognisant of the fact that a number of groups are working in this area, particularly the Homeless Initiative, who have been working in the broader frame towards a more integrated approach to service delivery. The group would, therefore, see the recommendations that it makes in this broader context.

1.1 Composition of Group

The group which was established was multidisciplinary and consisted of the following members

Ms. Pauline Bryan, GP Unit Administrator, Dr. Steevens' Hospital
Dr. Joe Fernandez, Consultant Psychiatrist, St. Brendan's Hospital
Ms. Margaret Fitzpatrick, Superintendent Public Health Nurse, Community Care Area 2
Mr. Paul Harrison, Director of Services, Child and Families
Dr. Tony Holohan, Department of Public Health, Dr. Steevens' Hospital
Ms. Breda Lawless, Director of Services, Mental Health
Mr. Hugh Kane, General Manager, CCA/3 - Chairperson
Mr. Gerry Kenny, Superintendent Community Welfare Officer, Homeless Persons Unit
Ms. Rosaleen Quinn, A/CNO, Psychiatric Services, St. Brendan's Hospital
Dr. Brion Sweeney, Consultant Psychiatrist, Addition Services

1.2 Terms of Reference

The terms of reference for the group were as follows

1. To identify and describe the current services provision for adults and homeless families (the Homeless Forum is currently examining young people out of home under the auspices of the Homeless Initiative)
2. To analyse the gaps in current services provided both by the voluntary and statutory sectors
3. To prioritise needs in terms of an immediate or long-term response and also in terms of who should receive what service and when they should receive it
4. To examine how existing services meet the identified need and the current relevance of these services and providers suppliers in meeting such need
5. To examine alternative models of service delivery
6. To determine how services can be targeted for users and specifically to examine the use of case management
7. To identify barriers to access
8. To identify needs in terms of education, information, prevention, care of special needs groups, drugs services, alcohol services etc.
9. To provide an adequate definition of homelessness

This report constitutes a brief overview of the issues in relation to homelessness and must be seen in this context.

1.3 Work of the Group

The group met on nine occasions in plenary session. The group divided into three working groups to address the following issues/service areas.

- Primary health care
- Day care services
- Accommodation and legislation

The group also commissioned a survey of day care service provision which was carried out by means of a focus group of voluntary service providers.

Chapter 2 Definition of Homelessness

Definitions of homelessness can be conceptual or operational and it can be difficult to reconcile them. The term "literal homeless" has been used as an operational definition of homelessness in some situations. A person would be considered literally homeless if he or she was resident in a shelter for homeless persons, was found living on the streets or other unsuitable accommodation and found not to own or rent a conventional housing unit and did not belong to a household owning or renting conventional accommodation.

Definitions of homelessness usually encompass duration and location of homelessness. Homelessness can be located at some point along a spectrum of housing need with those without any formal shelter at one end and those who live in shared accommodation but have a preference to live separately at the other.

In the UK, the legally defined homeless are often called the "official homeless". In Ireland, the Housing Act sets out the legal definition of the homeless to include those for whom no accommodation exists which they could be reasonably expected to use or those who could not be expected to remain in existing accommodation and are incapable of providing suitable accommodation for themselves. The judgements concerning these matters are made by the local authority.

A definition which reflects the legislative framework in Ireland and which shows homelessness as a point along a continuum rather than a simple black or white homeless/non-homeless existence is shown in figure 2.1. This definition agrees with the definition which is to be used in the forthcoming census of homelessness being carried out by the Homeless Initiative and the Economic and Social Research Institute. Consideration should be given to adopting a definition of homelessness along the lines outlined here so that similar definitions might be used in the planning of services to meet the health and social needs of homeless adults.

Figure 2.1. Recommended working definition of homelessness

Shelterless	Sleeping on the street or in other places not intended for night-time accommodation or not providing safe protection from the elements.
Homeless in shelters and B&B	Usual night-time residence is a public or private shelter, emergency lodging, B&B or such, providing protection from the elements but lacking the other characteristics of a home and/ or intended only for a short stay.

R 2.1 We recommend the following definition of homelessness

Those who are sleeping on the street or in other places not intended for nighMime accommodation or not providing safe protection from the elements or those whose usual nighMime residence is a public or private shelter, emergency lodging, B&B or such, providing protection from the elements but lacking the other characteristics of a home an& or intended only for a short stay,

R 2.2 It is recommended that the above definition, which is consistent with that of the Homeless Initiative Census, be agreed by all agencies so that agreed estimates of numbers of people who are homeless are used for planning purposes

Chapter 3 Health and Social Services

3.1 Introduction

Health care provision for the homeless population of Dublin presents difficulties and challenges for providers. The available evidence suggests that most of the physical and mental health problems which arise for homeless people are common acute self-limiting or chronic diseases. The general population receives and expects to receive management in respect of these problems primarily from primary care. The evidence further suggests, however, that the homeless population experiences significant barriers in accessing such care which limits their access to appropriate services and ensures that they either inappropriately use accident and emergency departments and other services or simply do not present to health services.

Furthermore, the health problems faced by homeless people do not relate solely to difficulties in accessing appropriate health services. Homeless people have greater prevalences of many common chronic diseases particularly mental health problems. The also have poor lifestyles in respect of high levels of illegal drug taking, alcohol consumption, tobacco consumption and poor diet and exercise. Health service solutions to the health problems faced by homeless people must attempt to address such barriers. The needs of children, while not examined in this research must also be considered in the wider context of service provision for the homeless.

3.2 The Health Problems of the Adult Homeless in Dublin

A recent study of over five hundred homeless adults in the Dublin area provided some baseline information about the health status of homeless people and about their use of health and related services. The needs of children, while not examined in this research, must also be considered in the wider context of service provision for the homeless.

The population was loosely divisible into, firstly, older Irish males living in hostels who have been homeless for long time periods; secondly, younger females, often with young children, who live in bed and breakfast accommodation; thirdly, refugees, who also live in bed and breakfast accommodation and, fourthly, young Irish males who sleep rough on the streets. The reasons for homelessness, the health problems, the health risks and the utilisation of services all varied between these groups.

The population had many behavioural risk factors. Most spent much of their time outdoors irrespective of their health status or the fact that they might have young children. Almost 80% of them were smokers, 30% drank alcohol beyond recommended limits and a further 30% of them said that they had used illegal drugs.

Almost half of the respondents perceived themselves to be in poor health. Approximately one quarter of them felt that they were limited by their physical health in the previous month while a similar proportion said that they were limited by their mental health during the same time period. Almost 30% felt that their health had disimproved in the previous year.

Sixty six per cent of people had at least one physical or psychiatric problem. At least one of a number of specific chronic diseases was reported by 41% of people. The reporting of individual health problems was found to vary with age, sex, duration of homelessness and the existence of behavioural risk factors such as cigarette, alcohol and drug consumption.

Close to half (45%) of all respondents did not have a personal medical card. Some sub-groups, such rough sleepers had particularly low medical card ownership (19%). The possession of such a card was not influenced by the existence of chronic disease. The utilisation of services varied according to age, sex and other demographic factors. There was evidence that some of the

services were not used appropriately in that those with various chronic diseases were more likely to attend accident and emergency departments. Some groups, such as rough sleepers, used all services at low levels. Ancillary services, such as social work and community welfare, were mostly used by young women, often with children.

Many barriers to service utilisation, such as the lack of a medical card, language difficulties, cultural differences, information barriers and the unacceptability of many of the existing services to homeless people were identified in the study.

3.3 Current Special Provision of Health Services by the Eastern Health Board

While mainstream services have provided for some of the health needs of the homeless, the services which are provided are not being adequately and appropriately accessed by the homeless. As a result of this, health care needs are not being met by existing mainstream services. There are a small number of GP practices that have provided services on a "special type consultation" (STC) basis or any other *ad hoc* basis for homeless people in certain hostels in the inner city. One community care area, which has a particularly high number of homeless patients, has a named public health nurse with responsibility for the homeless within the area.

3.4 Health Care for the Homeless in the United Kingdom

During the course of the work of this group we have consulted widely with providers of services in the UK. A summary of these consultations is provided below.

3.4.1 Manchester

The service that is provided in Manchester has been set up in recent years. The services are provided by one practice mainly from a branch surgery in the offices if the "Big Issue" but also from the main practice base. The principal in the practice remains involved in the provision of services according to his NHS contract. The health authority funds a major component of the salary of an additional doctor who works from the branch surgery also.

3.4.2 Leeds

In contrast to the system in Manchester, the providers in Leeds health authority took the view that existing mainstream general practice had not met the needs of homeless people to an appropriate degree and concluded that the best way to improve this was to provide a separatist service for these people. In 1984, a salaried GP post was established to provide such services. The service now operates 9 sessions per week from a purpose built premises in the centre of Leeds and is operated by one GP. The contract that this GP has is outside of the NHS contract structure of independent GPs and the practices caters solely, therefore, for homeless people. The breakdown of consultation type is

- 42% Drug related (include methadone dispensing)
- 15% Alcohol related
- 13% Mental Illness
- 20% General medical
- 2-3% Social

The practice is supported by a number of staff including a drugs worker who screens people for referral to drug treatment services.

3.4.3 Edinburgh

Whereas a system existed in Edinburgh in the past which provided separatist services, the current service is provided by three city centre practices which also operate a drop-in centre.

3.5 A Multidisciplinarv Integrated Team Approach

Many of the health problems encountered by the homeless are the result of sub-optimal access to the health services and although shelter and food are increasingly provided for them, health care programmes are largely unavailable.

A number of different models and systems for provision of health care for homeless adults were considered. Three models of service delivery can be identified from international experience and literature and each was considered in terms of its appropriateness for the Eastern Health Board region. There has been, and will continue to be, considerable debate about the appropriateness of each of these models of service delivery for homeless people.

3.5.1 Integrated Health Care

In this model, the health service of homeless people are met by existing services (i.e. their health care is integrated with general population heath care). Integrated service provision starts with the assumption that comprehensive coverage is the goal and that the services should reach out to meet unmet need. The homeless person, however, is faced with the difficulty of access and the lack of flexibility of the mainstream services

Integration of homeless people into mainstream general practice would be a more appropriate and acceptable form of delivery of primary care services. This could help to promote the reintegration of homeless people into the community. The work carried out in this area suggests that mainstream existing primary care services are not meeting the needs of homeless adults.

3.5.2 Separate Services

Separate services arise from the notion that exiting mainstream primary and other health care services have failed to meet the needs of homeless people and that a special dedicated service needs to be set up. Some feel that unless these special services dedicated to the homeless exist, then each separate service component of the mainstream health services can withdraw on locally plausible grounds.

In spite of their advantages, however, the protection that they provide for the homeless in the long-term may lead to perpetuated segregation. They are also more likely to cater for those who are long-term homeless and in use of facilities and institutions for the homeless and consequently less likely to be comprehensive and appropriate to all sub-groups of the homeless population. In addition, other health care service providers may feel no obligation to provide services for the homeless, on the assumption that the separate services are comprehensive.

3.5.3 Special Schemes

Special schemes, which are some where between the two extremes described above, have been established in recognition of the fact that the health services are biased against homeless people and that this is not acceptable. They focus on assessing peoples' needs and advocating on their behalf for access to mainstream service provision. They tend to advocate across the broad range of problems relating to homelessness and, therefore, tend to be made up of multidisciplinary teams. They have a dual objective: gaining access to general services on an integrated basis and providing direct transitional primary health and social care services on the other. Some primary health care service schemes have succeeded in increasing registration rates with GPs and increasing the use of some services.

3.6 Primary Care Teams for the Homeless in the Eastern Health Board

R 3.1 We recommend the introduction of two multidisciplinary primary care teams in the inner city with one team in the North inner city and one in the South inner city. The teams should be small, multidisciplinary and integrated with the other primary care services provided within the city centre. The teams aim to improve the health and social gain of the homeless through the provision of integrated care which links people into mainstream service.

3.6.1 Objectives of The Primary Care Teams

1. To meet primary health care needs for homeless people who do not have adequate access to primary health care services
2. To refer users of the services back to mainstream services after an appropriate time period
3. To support mainstream primary care in its efforts to provide registration and services for homeless people
4. To link homeless people into secondary and other services where appropriate
5. To liase closely with other professionals (e.g. GPs, Addiction Consultants, Voluntary bodies, A&E Consultants) in the inner city in relation to provision of health services

3.6.2 The Composition of The Primary Care Teams

The structure and function of the team are described according to a number of headings below. The precise composition of the team and the respective roles of each of the members of the team should be considered in some detail prior to their establishment. The team should be small and multidisciplinary as indicated below.

Co-ordinator

One of the professionals described below who make up the team should act as co-ordinator for the team in all of its functions. This person would be the named contact for the team for the purpose of referrals and would direct the delivery of appropriate services for those in need. The person should also be responsible for the production of an annual service plan and annual report as well as contributing significantly to the evaluation of the service after an appropriate time period.

R.3.2 It is recommended that the teams should be co-ordinated and managed by a named member. They should have the input of nurses, doctors, social workers, community welfare officers, care attendants, community psychiatric nurses, outreach drugs workers and administrators.

Nurse

A nurse should be employed full-time on each multidisciplinary team with qualifications in primary care/public health nursing. The person should have experience appropriate to primary care nursing which would include running clinics, providing outreach services such as TB control and treatment and general nursing care. The nurse would work closely with the GP and would be the lead person in terms of running hostel-based clinics, which would provide screening, diagnostic, and treatment services as appropriate. Referral from these clinics would be to the team doctor or specific GPs in the case of registered patients. This would be an essential component of the functioning of the team in terms of meeting the objective to re-assimilate homeless people back into mainstream services.

Doctor

Each team should have medical input to the equivalent of a half-time post. It is important, given the nature of the health problems experienced by the homeless, that any medical input

into the teams should come from a person who is vocationally trained in general practice and possesses an MICGP or equivalent membership or qualification and has experience appropriate to the work of the team. The principle of integration with existing mainstream general practice in the inner city should be paramount. The post should require the provision of clinics in the proposed inner city primary care centres primarily as well as appropriate domiciliary services in hostels. This could be done in the context of a regular planned short clinic in each major hostel.

Social Worker

A social worker should be employed full-time on each multidisciplinary team. The experience of this person should be appropriate to the work of the primary care team. This person should be assigned to work full-time with each team from the but should also act as the key link person between the team and mainstream social work services.

Community Welfare Officer

A community welfare officer should be employed full-time on each multidisciplinary team. It would be important that this person ensures that the services provided by the team would be fully integrated with the work of the Homeless Persons Unit.

Outreach Drugs Worker

An outreach drugs worker should be employed full-time in both multidisciplinary teams. The qualifications and experience of this person should be appropriate to the work of the primary care team. This person should be assigned to work full-time with each team. He/she should also act as a link person between the team and mainstream drug services to ensure that the work carried out in this regard within the team is in keeping with the work and policies of mainstream drugs services in the Eastern Health Board.

Community Psychiatric Nurse

A community psychiatric nurse should be employed full-time in both multidisciplinary teams. This person would assist in the basic assessment, treatment and ongoing support of those with mental health needs. This specialised input into the team would support mainstream primary care and would also help to closely link the work of the team with the work of the mainstream mental health services generally. This person would also be a key support for those who are in need of support housing in order to facilitate their discharge from hospital or to ensure their maintenance in the community.

Care Attendant

The team should also include a care attendant who is capable of providing for basic care and hygiene needs of homeless on a domiciliary basis.

Administrator

An administrator should be employed full-time between both multidisciplinary teams with the following qualifications and job specifications

- Grade IV
- Practice organisation/management
- General administrative duties
- Computer literate
- Secretarial/receptionist duties

Other staff

Other professionals should be available to the teams for ease of consultation/ referral/ access. Referral pathways should be set out which include referral guidelines to these services. Ideally such services would be accessed wherever the regular nurse/doctor clinics are conducted. Such services include dental services, chiropody services etc.

R 3.3 It is recommended that the team should arrange for other professional services such as dental and chiropody services.

3.6.3 Locations of The Primary Care Teams

The teams should work in close consultation with and in support of existing and inner city primary care groups on both sides of the city. The physical location of the team should maximise links with the inner city primary care groups and it should operate all services from one base. Further services such as outreach clinics in hostels and outreach services on the streets should be conducted from this base. This would allow the team to be fully integrated into primary care services in the inner city and to have similar access to services and referrals pathways available to primary care generally within the inner city. It would also allow the team to meet its primary objectives of addressing the health needs of the homeless and linking them back into mainstream primary care services. As well as having these clear and strong links with primary care in the inner city, the team should also have clear links with the structures described below in relation to mental health services and primary care teams at community care area level.

R 3.4 It is recommended that the teams should operate all services from one base on either side of the city and should link closely with existing inner city primary care services

3.6.4 Steering Committee

While the day to day operation of the service as well as its health service strategy will be determined as appropriate by the members of the team, it is recognised that a forum should exist where other professional and health board staff who are not members of the team could have an input into the strategy of the service in the context of the overall delivery of health services to the homeless population of inner city Dublin.

A suggested composition of the steering committee is set out below

- Team co-ordinator
- Representatives of inner city GPs
- General Manager for the homeless
- Programme manager or delegate
- GP unit administrator or delegate

R 3.5 It is recommended that the strategy of the team should be set and overseen by a steering committee which consists of appropriately appointed members

3.7 Additional Work of the Team

The main responsibilities are set out above in the composition and objectives of the team. The health issues of priority that should be met by the team can be set out according to a number of areas

- Acute medical services
- Screening, diagnosis and treatment of hypertension, alcoholism, diabetes and other chronic diseases as appropriate etc.
- Methadone maintenance
- Dental services
- Chiropody services
- Other paramedical services including hostel based diagnostic an treatment facilities

Other areas of work for the team in addition to that already described includes out of hours and on-call services, street outreach services and the support of medical beds in hostels.

3.7.1 Out of Hours Services

It is recognised that access for homeless patients is limited after hours. Ideally medical services should be available at primary care level. Arrangements to deal with this difficulty should be considered.

R 3.6 We recommend that arrangements are put in place to provide the homeless with access to twenty four hour GP services which could be accessed via the freephone helpline currently in operation. The latter service should be extended to provide continuous twenty four hour coverage.

R 3.7 We recommend the provision of skeleton team services on an out of hours basis (e.g. 9am-6pm at weekends and public holidays) to ensure that problems are appropriately managed when they arise. This service should be accessible via the freephone helpline currently in use or directly from the service base of the relevant primary care team.

3.7.2 Street Outreach Services

It is envisaged that the nurse on each of the teams would provide outreach health, social and welfare services for those sleeping rough with the support of the wider team on a regular basis. These outreach services could be linked into existing outreach services such as the "Soup Run" provided by the Simon Community.

3.7.3 Medical Beds in Hostels

Some hostels should be funded to provide health care to hostels for the provision of sick bay beds. This would help to ensure that people did not get admitted to hospital or kept in hospital simply because they are homeless. These beds could cater for people who might be more appropriately located in them such as

- Those requiring step down care from hospital
- Those who are intoxicated
- Those who are terminally ill
- Those who are aged and infirm and in need of more intense nursing support

3.8 Referral to the Team

The team would be in a position to accept referral for those in need of primary care services from whatever sources they are likely to come such as

- Inner city A&E departments
- Gardai
- Other health professionals
- Other health board staff
- Voluntary bodies

3.9 Teams in Community Care Areas

In each community care area in the Eastern Health Board there should a person who is given responsibility for co-ordinating health services for homeless people at local level. The purpose of having such a person is to ensure that, when someone becomes homeless, appropriate health and social services can be mobilised to ensure that they are available and accessible to that person at local level. This will help to ensure that people do not drift towards city centre based services

simply to access services that could be provided locally. This would therefore provide a local solution to a local problem.

There should also be identified professionals (a local GP, public health nurse, community psychiatric nurse, community welfare officer, social worker, drugs worker) who act as *named contacts* responsible for meeting, and with the appropriate skills to meet, health and social needs at local level. This size of this responsibility would depend on the community care area and would be a matter for local prioritisation and management. The community welfare officer would be a key person in local efforts to deal with homelessness. He/she should have strong local links with the local authorities in order to ensure that homelessness can be prevented.

These professionals would act as a designated team which would have planned meetings to discuss and plan the local response to homelessness at regular intervals. The team co-ordinator would be the point of contact for all other agencies at local level.

R 3.8 It is recommended that a named individual from each of the professional groups comprising the inner city primary teams should be given responsibility for the homeless in each community care area. The appropriate time commitment for the members of this designated team should reflect local need but would be a matter for each community care general manager. The individuals in each community care area should meet on a regular planned basis. The work carried out by these individuals would help to support homeless people in their own communities.

3.10 Mental Health Services for Homeless People

The homeless mentally ill have problems and needs some of which similar to those of other homeless people. They have particular needs for treatment, rehabilitation and support. In 1979 the Eastern Health Board psychiatric service established a specific programme for homeless males at St. Brendan's Hospital. This was to cater for mentally ill males of no-fixed-abode, who lived in direct access hostels and night shelters in the city centre catchment area.

The above programme currently has the following components some of which are based at St Brendan's and some of which are based in the community.

Assessment Unit

It is expected that the assessment facility currently provided at the Assessment Unit in St. Brendan's Hospital will be transferred to the Day Centre described below, consonant with plans to down-size facilities at St. Brendan's Hospital.

16 bed Admission Unit

This unit provides admission and access to ancillary hospital based facilities as necessary. Since 1995, additional hospital beds have been made available to cater for homeless males and females.

Day Centre

This facility has now been transferred to a city-centre location at Usher's Island. It provides out-patient and medico-social support services. Over one hundred and thirty former mental health service patients are registered with the day centre and up to seventy six individuals attend daily for medication, meals and out-patient contact.

High Support Hostel

This unit provides accommodation for ten residents and further facilities for five day attenders.

Rehabilitation Programme

This programme provides services for up to twenty two residents and further facilities for five day attenders.

Supervised Group Home

The supervised group home provides accommodation for five residents.

Care Management Team

The movement of patients between hospital and community is facilitated by the care management team which is involved in the after-care and follow-up of ex-patients, screening new referrals and the provision of support to hostel staff in the voluntary sector.

3.10.1 Mental Health Service Strategies

Mental health needs of homeless persons may be provided through the establishment of special programmes or by making existing mainstream programmes more responsive to their special needs. Whichever approach is taken, there are certain requirements of a service to ensure its responsiveness. A high level of clinical expertise is required in view of the complexity of the clinical problems presented. Some form of outreach is also needed, because many patients will not readily seek treatment. Furthermore, close integration with social services is essential to help persons deal with their social needs. The provision of adequate treatment to a person who is sleeping rough is extremely difficult. It is, therefore, important that accommodation needs are met and for this purpose to have access to a variety of housing options. As outlined in chapter 3, close collaboration with primary health-care is essential so that needs can be met at the appropriate level and in the most appropriate setting. Close integration with mainstream mental health and substance abuse services are needed, so that as soon as possible people may be facilitated to move back into the general mental health services.

3.10.2 Developing Mental Health Services for the Homeless in the Eastern Health Board

In order to ensure that mental health services for the homeless in the Eastern Health Board are developed in the most appropriate fashion, It is recommended that consultation takes place with all clinical directors and consultants responsible for sector and specialist services. These consultations should take place with a view to the implementation of the recommendations set out in report entitled "Report of the Committee on Services for Homeless People with Mental Health Problems".

R 3.9 We recommend the implementation of the recommendations contained in the report entitled "Report of the Committee on Services for Homeless People with Mental Health Problems". H H H H H I

3.11 Addiction Services

There is a requirement for special arrangements to be made for homeless people in respect of addiction services in view of the high prevalence of such problems in this group. This should consist of a special waiting list initiative for homeless people both centrally and at catchment area level. Furthermore, special links with the primary care teams, through the outreach drugs worker, should be fostered.

R 3.10 It is recommended that the drug services provide a special waiting list initiative in respect of people who are homeless.

R 3.11 It is recommended that the methadone mobile clinic should be made available to all hostels and day care centres on a systematic basis.

3.12 The Views of Voluntary Organisations

The survey of voluntary service providers which was referred to in chapter one was conducted primarily to examine the issue of provision of day care services in the Eastern Health Board.

However, the survey revealed many important issues concerning the provision of health and social services and some of these are summarised below.

- Creative solutions to the existing geographical base of health and welfare service delivery which mitigates against the accessibility of services to the mobile homeless population must be sought as a matter of priority. Restricted access imposed on the basis of a lack of permanent address must be addressed.
- The extent of health and welfare problems associated with homelessness requires commensurate statutory funding with a long-term commitment for sustainable health development. Funding for the maintenance and upkeep of facilities should also be made available. Collaboration between donor and recipient agencies in the review and evaluation of services in relation to funding should also be strengthened.
- Hostel barring policies on drug and alcohol abuse must be reviewed in order to increase access to this high-risk group and to integrate them as much as possible into hostel services. Increased staffing levels and training as well as outreach drugs workers is widely viewed as a necessary precondition to changing existing barring policies.
- Increased access to drug treatment and rehabilitation for the homeless must be facilitated as a matter of priority.
- While respecting the rights of the individual to a doctor of their own choice, a GP service should be made available to each hostel on a formal basis for emergencies, on-going monitoring of ill health, and increased efficiency in the management and co-ordination of health care between the secondary and primary levels of care.
- Outreach public health nurse services should be made available to all hostels according to need. In collaboration with the GP, the role of the public health nurse should include referral for geriatric and incontinence assessment, chiropody, dentist and ophthalmic services as well as the supervision of medications, skin care and assistance with bathing.

R 3.12 It is recommended that the views of voluntary service providers be considered in the formulation and implementation of health and social service strategy in the Eastern Health Board.

Chapter 4 Housing, Shelter and Accommodation

4 A Introduction

People who are in need of emergency accommodation are placed by the Eastern Health Board homeless persons unit in various forms of emergency accommodation for varying periods of time. Emergency accommodation by its nature can cause disintegration of family units and compound existing difficulties.

R 4.1 It is recommended that persons should not remain in emergency accommodation other than in the very short-term. The Eastern Health Board should advise each Local Authority of the persons in need of accommodation only and request that each Local Authority provide for this need from their own housing stock or from the private rented sector

R 4.2 It is recommended that additional accommodation be set aside for emergency accommodation needs and that this be earmarked for specific homeless groups

Concerns exist about the quality of some accommodation which is used and about some of the private rented accommodation which is accessible to homeless persons in the Board's area.

R 4.3 It is recommended that the Eastern Health Board should request that the Local Authorities monitor these residences closely in accordance with the appropriate pieces of legislation.

R 4.4 It is recommended that the Eastern Health Board should establish quality standards for all accommodation and its uses and should subsequently use only accommodation which meets these standards.

4.2 Hostel Accommodation

Seven hundred and thirty hostel accommodation beds for homeless persons were identified in the Board's area. Almost three quarters of these are provided by the voluntary sector, over one in five by Dublin Corporation and the remainder by the Eastern Health Board (Table 4.1).

Table 4.1 Hostel Accommodation in the Eastern Health Board

Provider	Number of Beds
Voluntary sector	514
Dublin corporation	157
E.H.B.	59
Total	730

Of the 514 beds in the voluntary sector many are filled by long term residents. Effectively many of these units run as social housing in that for many of the residents, their tenure has been so long that the institution is home to them. These numbers create the impression that a large number of emergency hostel places are available for homeless people in need of immediate crisis intervention which do not, however, exist. In reality, there is a severe shortage of emergency beds.

In order to deal with this situation, two options should be examined. Firstly, the creation of new hostel beds in addition to existing ones could be considered while secondly, active long term re-settlement work in the hostels in an attempt to appropriately re-locate as many as possible in other forms of accommodation. This type of resettlement requires ongoing support. It has already

been identified that hostel dwellers have similar health needs and health care access problems to other homeless persons.

4.3 Bed and Breakfast Accommodation

The use of bed and breakfast (B&B) accommodation is appropriate for certain categories of homeless persons for specific short-term placements. However, many clients need a more suitable placement and service and such accommodation is not appropriate.

Currently, there are 249 cases in emergency accommodation using B&B's. Some of these cases have accommodation needs only whereas others require service supports in addition to accommodation due to some level of dysfunctionality.

A brief analysis of those currently in B&B accommodation, in order to ascertain the relevant local authority and those whose needs were for accommodation only, was carried out and showed the following numbers in each local authority as follows:

Table 4.2 B&B residents and their local authority of origin

Local Authority	Male	Female
Dublin Corporation	**177**	***66***
Sth. Dublin Co. Council	**25**	15
Fingal Co. Council	**8**	5
Dun Laoghaire/Rathdown	**30**	15
Unknown	**9**	
Total	249	101

In order to free up B&B accommodation and place persons in more suitable long-term accommodation, It is recommended that the Eastern Health Board advise each Local Authority of the persons requiring accommodation only and ask each Local Authority to source housing either from their own hosing stock or from the private rented sector. If this cannot be achieved in the short term, we should provide targeted resettlement services through the HPU to move the people concerned into private rented accommodation.

R 4.5 We recommend that the local authorities attempt to reduce the backlog of homelessness by increasing their housing stock and by agreeing to reserve a number of units specifically for the homeless which are spread throughout their housing stock rather than solely taken from their low demand areas.

4.4 The Legislation

Section 54 of the Health Act, 1953 is a clear and strong section requiring Health Boards to provide shelter whereas Section 10 of the Housing Act, 1988 places the obligation to provide housing on the Local Authority. Section 10 needs to be strengthened to ensure legal responsibility. Supplementary Welfare Allowance payments under the Social Welfare Consolidation Act, 1993 are used to secure and maintain persons in accommodation.

R 4.6 It is recommended that the Local Authority take legal responsibility for the provision of housing.

During the transition period the Homeless Persons Unit should continue to provide emergency accommodation. This service should remain in place until the Local Authorities have developed their services to take on the added responsibility.

4.5 Anti-Social Legislation

The group was concerned that this legislation was leading to homelessness. The legislation needs to be amended to provide protection for vulnerable clients. Two categories of clients were identified:

1. Persons removed by the courts
2. Persons who leave before formal procedures begin, due to harassment from local residents or pressure from Local Authorities.

The legislation also needs to be amended to allow the relevant evidence to be provided and examined by the courts in forming their judgements. The current legislative situation is creating a serious homelessness problem and is potentially ghettoising drug users in B&B's and hostels. Each Local Authority must be obliged to discuss potential evictions with Health Board staff at an early stage. This would allow the Board to assess the situation and intervene where appropriate. Department of Health Circular 5/87 needs to be re-activated and a designated person in each area identified to receive and act on these notifications.

R 4.7 It is recommended that the anti-social legislation and its interpretation by the local authorities be re-considered and that the local authorities be required to discuss all potential evictions with health board staff at an early enough stage to allow for appropriate intervention to take place.

R 4.8 It is recommended that Department of Health Circular 5/87 be re-activated and a person should be designated in each area identified to receive and act on these notifications

4.6 Emergency Accommodation Needs

The interface and overlap between Health Board and Local Authority responsibilities causes some confusion when attempting to define precisely the role of the Eastern Health Board. Particular housing needs and gaps in suitable accommodation to meet those needs can be identified which arise as a result of this lack of clarity.

R 4.9 We recommend the provision of twenty beds for alcohol abusers and twenty beds for drug abusers (i.e. those who are not currently being admitted to existing facilities) as a matter of accommodation priority

We also recommend the following provision of accommodation to meet the needs of certain groups of the homeless

1. Family type accommodation (own sleeping accommodation with shared living space). This must be provided with supports to prepare and support people to move on to more appropriate accommodation types.
   10 units
2. *A* transitory and supported hostel for stable drug users. Existing hostels need to facilitate these people in appropriate consultation with the Drug services.
   30 places
3. A halfway house for stable drug abusing homeless people to follow on from the accommodation type specified in the previous point. It should be transitory and consist of self-contained units.
   20 units
4. A specialised unit for adolescents including those who may be abusing drugs.

5. A hostel well supported with shared catering for single women and women and children transitory with
   Include 10 units of social housing
6. More sheltered accommodation for Homeless people with HIV infection because of their increasing survival times with the disease

4.7 Institutional Discharge Policies

R 4.10 It is recommended that where people enter institutions that their existing accommodation should be actively secured in order to prevent homelessness on discharge.

R 4.11 It is recommended that the Eastern Health Board enter into dialogue with appropriate institutions such as prisons and hospitals so that their discharge policies can be altered to ensure that people are not discharged without proper planning and placement.

4.7.1 Prison

There are on-going problems with persons being discharged form prison into emergency accommodation. We need to enter into discussions with these institutions to prevent these inappropriate placements. Persons leaving prison require appropriate responses and supports which are not available in emergency situations. No one should be allowed to leave prison without proper planning and placement.

4.7.2 Acute General Hospital

Many beds are currently blocked by the lack of suitable post discharge accommodation and by inappropriate social admissions. In a recent Eastern Health Board report (Department of Public Health, 1998) 16% of admissions are in this category. The provision of suitable accommodation could impact favourable on expenditure in hospitals and also help to shorten waiting lists. There is a need for a change in current hospital practice in order to properly plan for discharge back into the community.

4.7.3 Psychiatric Hospitals

The lack of next stage-supported accommodation is also limiting access to beds in psychiatric hospitals. Sixteen beds in the assessment unit at St. Brendan's Hospital and 60 other psychiatric beds were identified as being blocked in this way. If more appropriate accommodation were available for these patients then the needs of all users of in-patient psychiatric services would be more readily met.

Some discharges from hospitals would be more appropriately made to nursing and convalescent homes rather than to emergency accommodation.

Chapter 5 Day Care Services

5.*1* *The Views of Day Care Service Providers*

5.1.1 General Issues

As a means of gathering the views of key service providers in this area a focus group was established, chaired by an independent facilitator. The outcomes of this focus group was reported back to the main working group for discussion. What follows represents the issues that emerged from this process.

Consistency of contact on a daily basis with the homeless was widely viewed as a key strategy to successful resettlement which existing day care service provision is ill-equipped to achieve. There was broad agreement about the need for two parallel strands in the development of day care services. The first of these was the strengthening of existing hostel services to provide a comprehensive service that meets the physical, mental, social, emotional and educational needs of the homeless. The second was the development of additional day care centres to meet the same needs of those who are currently excluded from hostel accommodation. Day care centres have the potential to act as an important anchor independent of housing status.

Multiple factors impinge on the health status of the homeless at the physical, mental social, economic, environmental and political levels which requires a cohesive approach both within sectors and across sectors in order to make progress in addressing their needs. The establishment of the Homeless Initiative represents a multi-sectoral approach to the problem of homelessness and was welcomed as an important step in this regard. The investment of support and resources in the Homeless Initiative was considered an important way to foster and maintain holistic and strategic service development.

In order to develop a cohesive approach to meeting the needs of the homeless within the health sector, a strategic approach to homelessness by the Eastern Health Board was suggested so that an integrated, efficient and appropriate response could be made by all services on coming in contact with homeless people. The existing geographical base of service delivery was currently identified as the most important barrier to all health care services for the homeless. Access to convalescent and rehabilitation units for drug addiction was regarded as severely restricted and particularly problematic because of the prevalence of drug addiction among the homeless population. An Eastern Health Board policy on homelessness should have as its overall aim the strategic and broad development of services for the homeless in all community care areas.

R 5.1 It is recommended that homeless people should not be denied health or social services on the basis that they do not have a permanent address.

R 5.2 It is recommended that individuals or families, who are already known to the service, should be followed up by their key worker (e.g. public health nurse, community psychiatric nurse and social worker) if they are rendered homeless until such time as they have another permanent address. At such time the case can be passed on.

Since much of the work with homeless people was said to be qualitative in nature requiring the investment of time for befriending as well as fostering acceptance and trusting relationships, the focus on turn-over of numbers and quantitative measures of success by donor agencies was considered inappropriate in isolation of qualitative measures so that a balance between both methods of evaluation was called for. Closer collaboration between donor and recipient agencies in the on-going review and evaluation of services in relation to available resources was also considered important.

A perceived gap in existing services was the need for a dedicated day care service for women with long term psychiatric difficulties who are also homeless. A similar service currently exists at Ushers Island for men. .

R 5.3 It is recommended that the service at Ushers Island should be expanded to provide comprehensive day care for women

R 5.4 It is recommended that the new homeless persons unit at Parkgate Street should include a creche facility to provide support to homeless women and families with children

It was also noted that some suburban areas, Dun Laoghaire for example, have concentrations of homeless families.

R 5.5 It is recommended that local day care services are provided to people outside the city centre to ensure that they can be supported in close proximity to where they are in temporary accommodation.

5.1.2 Issues Relating to Women and Children

Women, particularly those with children, were said to be mostly accommodated in B&B accommodation and the widely observed increase in homelessness among women was thought to be reflected in the growth of B&B use by the homeless from 50 to 250 cases within the past 2 years. There were widespread concerns expressed about women and children walking the streets during the day while their B&B is closed. The only form of day time shelter currently available to women and children from B&B accommodation was the drop-in day centre with creche and nursery provided by Focus Ireland and the drop-in day centre provided by Failtiu. The prevalence of drug and alcohol abuse as well as psychiatric illness was said to contribute to anti-social, aggressive and often violent behaviour among the homeless. The day care centre provided by Failtiu was said to be used mostly by men and this was thought to deter women, particularly those with children, from using the service.

The separation of the sexes in hostel accommodation and the limited availability of family units as shown in table 5.1 supports the widely held view that existing services for the homeless undermines the family unit and that a dedicated day care centre for women and children should also make facilities available for families. The development of such a centre would meet the play and education needs of children as well as those of women and families. Women were currently said to rely on food centres to meet the needs of their children such as changing nappies, making up feeds and heating feeding bottles so that where possible, food centres as well as all service outlets should adapt to the needs of children by providing changing areas and mats. Funds should also be made available for the provision of nappies which women were said to often not have. All food centres should also promote the nutrition of infants and children and the existing limited availability of creche facilities to be expanded in health board and drop-in centres. B&B accommodation for women and children is inappropriate and hostel accommodation needs to be made available so that they have access to shelter on a 24 hour basis and a structured, consistent day care services.

R 5.6 We recommend the development of a full day care facility for homeless women with children, particularly for those in B& B.

R 5.7 It is recommended that a review of existing food centres take place with a view to maximising co-ordination and minimising duplication.

Table 5.1. Type of voluntary day care services provided

Type of service	Frequency
Drop-in information and advice centres	3
Drop-in day centres	3
Hostels open during the day	13
Women's refuges	2
Residential resettlement programmes	5
On-site education and training programmes	5
Off-site VEC education and training	3
Structured arts, crafts and recreation	4
Outreach services	2
Creche	2
Food centres	11

Chapter 6 Survey of Voluntary Service Providers

6.1 Introduction

The following points provide a summary of the views and recommendations of the voluntary providers of services to the homeless. The survey was carried out by means of a focus group as well as six unstructured in-depth interviews with the providers. The focus group interview was conducted with ten key representatives from Trust, Crosscare, Dublin Simon, Focus Ireland, St Vincent de Paul, Centrecare, Capuchin Day Centre and Failtiu.

6.2 General Issues

The complex and multi-faceted needs of the homeless demand a cohesive multi-faceted response for the promotion of health and wellbeing. The investment of support and resources in the multi-sectoral Homeless Initiative must be continued to foster and maintain holistic and strategic day care service development.

The homeless population is a heterogeneous group with varying and wide-ranging needs so that flexibility and choice of service provision is essential for an appropriate response to needs. A policy and procedure on homelessness should be drawn up by the Eastern Health Board to be implemented by all staff on coming in contact with homeless persons for a cohesive, efficient and appropriate response to their needs.

Creative solutions to the existing geographical base of health and welfare service delivery which mitigates against the accessibility of services to the mobile homeless population must be sought as a matter of priority. Restricted access imposed by all services on the basis of a lack of permanent address must be lifted.

Information services should be provided in appealing surroundings to increase acceptability and with sensitivity to the reduced capacity of the chaotic homeless to read, comprehend, absorb, and act on the information given.

R 6.1 It is recommended that information services should be designed to meet information needs in the pre-homeless, homeless and post-homeless phase and be made available at all service outlets for the homeless. The Eastern Health Board website should be developed to increase public awareness of the problems and solutions to homelessness and the actions currently being taken to address their needs.

Competitive salaries and wages were considered essential for increased recruitment and maintenance of staff with the expertise to meet the specialist needs of the homeless. Education and in-service training to promote the development and maintenance of specialist skills to meet the needs of the homeless must be made available for all staff. Health and safety, behaviour management, drug and alcohol awareness, physical and mental health care, first-aid, counseling and information updates must be included at minimum. The incorporation of the implications of homelessness to health and welfare in undergraduate training in the health and social sciences was also considered an important strategy.

Education and training programmes for the homeless should be linked with FAS, the education sector, the corporate sector, local business, as well as settlement and post-settlement programmes in order to break the cyclical links between homelessness and unemployment. Social welfare benefits in relation to education and training should be reviewed in order to provide realistic incentives for people to participate. Collaboration with the education sector to promote the education of children is also imperative to break the cycle of homelessness between generations.

Staff resources of food centres should be increased to enable a proactive approach to be taken to the promotion of health and welfare at this point of access. While some degree of duplication in food service provision prevailed, the number of food centres can only be reduced when increased hostel accommodation and day care centres are made available to accommodate those people who currently move between food centres for the purpose of shelter during the day.

6.3 Day Care Services

Consistency of contact on a daily basis with the homeless is widely viewed as the key to successful resettlement. The establishment of additional day care centres which act as an important anchor independent of housing status is considered imperative for those groups currently excluded from hostel residents. Day care centres must be developed to meet the physical, mental, social, emotional and educational needs of the homeless. A dedicated day care centre for women and children should be established as a matter of priority, to provide an environment that is free from fears of male anti-social and violent behaviour. The provision of laundry and washing facilities should also be incorporated.

Day care services for the homeless should be strategically developed in all community care areas in the Eastern Health Board region. The need for expanded structural development throughout the region to meet the needs of the homeless should be reflected in the management and disposal of assets by the Eastern Health Board and local authority.

All service outlets must adapt to the needs of children through the provision of changing areas, mats and nappies. Food centres should also engage in the promotion of infant and child nutrition and provide sterilisation equipment for making up feeds. Creche facilities need to be made available at the Charles Street Homeless Unit, health board and drop-in centres in order to promote child development and learning and to enable women the freedom to tend to their own needs and to avail of education and training.

6.4 Health and Social Services

The extent of health and welfare problems associated with homelessness requires commensurate statutory funding with a long-term commitment for sustainable health development. Funding for the maintenance and upkeep of facilities should also be made available. Collaboration between donor and recipient agencies in the review and evaluation of services in relation to funding should also be strengthened.

Whilst respecting the rights of the individual to a doctor of their own choice, a GP service should be made available to each hostel on a formal basis for emergencies, on-going monitoring of ill health, and increased efficiency in the management and co-ordination of health care between the secondary and primary levels of care.

Outreach public health nurse services should be made available to all hostels according to need. In collaboration with the GP, the role of the public health nurse should include referral for geriatric and incontinence assessment, chiropody, dentist and ophthalmic services as well as the supervision of medications, skin care and assistance with bathing.

Increased access to drug treatment and rehabilitation for the homeless must be facilitated as a matter of priority and the admission criteria of a permanent addressed to be removed. The methadone bus should be made available to all hostels and day care centres on a systematic basis. All service outlets should provide the option of drug and alcohol counseling and safer drug use promoted through needle exchange programmes, the availability of sharps bins and health promotion literature. Formal structures for collaboration with youth organisations should also be established to comprehensively address the issue of drug and alcohol abuse in youth.

Increased resources are needed to recruit the necessary expertise to meet the complex needs of the homeless. The existing secondment by the Eastern Health Board of a community welfare officer to Back Lane should be extended to all hostels and day care centres. The position of community welfare officer is widely considered to be ideally placed to fulfil the additional role of on-site settlement and post settlement support.

The existing limited focus of community welfare service provision on payments and booking-in procedures must be broadened to include information, advice, liaison with and referral to medical, social and local authority services as well as medical cards. Travel expenses should also be provided to the homeless to increase social contact with family and friends.

The lack of privacy and facilities for children as well as the adverse state of repair of the Homeless Unit at Castle Street must be addressed in order to render this important facility acceptable and to increase its uptake by the homeless in general and women and children in particular.

While the strategic development of psychiatric services in all community care areas of the Eastern Health Board region is considered essential for the long-term effective and sustainable management of mental illness, the outreach service consisting of one nurse from Usher's Island should be expanded in the meantime.

6.5 Accommodation and Legislation

Hostels for the homeless are widely viewed as an invaluable existing resource that must be developed for the provision of a comprehensive day care service that addresses the physical, mental, social, emotional and educational needs of the homeless. Additional hostels are required in response to the escalation in homelessness over the recent past. Increased staffing levels and skills together with the expansion of outreach services are necessary for the development of day care services at hostel level.

A dedicated hostel for women and children including facilities for the accommodation of families should be established as a priority in order to provide them with 24 hour shelter and the opportunity to avail of a comprehensive, structured and consistent day care service. The accommodation of homeless women and children in B&Bs that close during the day should be simultaneously phased out.

Women and children, the under 25 age group and drug and alcohol abusers are largely excluded from hostel residences so that these groups who are most at risk, together with those sleeping rough on the streets, have least access to shelter and basic facilities for living during the day. A dedicated hostel for chronic drug and alcohol abusers should also be established in order to honour their basic rights to shelter and warmth.

Hostel barring policies on drug and alcohol abuse must be reviewed in order to increase access to this high-risk group and to integrate them as much as possible into hostel services. Increased staffing levels and training as well as outreach drugs workers is widely viewed as a necessary precondition to changing existing barring policies.

The need for the under 18 age group to contact the Gardai in order to gain access to a social worker out of hours acts as a formidable barrier that must be reviewed. Increased access to legal representation for the homeless, particularly for men answering to barring orders, is required in order to address homelessness which is being perpetuated by the existing nine months waiting list.

Chapter 7 Conclusions

The Department of Health and Children produced a strategy document entitled "Shaping a Healthier Future- A Strategy for Effective Health Care in the 1990s" in response to the civil service strategic management initiative. This report identified the health of disadvantaged groups as one of the important issues and recommended that health boards, in the pursuit of equity, give special attention to the health of such groups. The homeless provide an example of such a group.

The homeless population of the Eastern Health Board region has grown considerably in recent decades. The likelihood is that this growth will continue into the future given the current legislative and societal context. Certain sub-groups of homelessness such as women and children are growing in numbers at even greater rates. This increase presents a challenge to the statutory providers such as the Eastern Health Board and the local authorities as well as the voluntary agencies in the Board's region. The considerable needs of homeless people for basic services such as the provision of accommodation and shelter, access to health care, access to day care services and provision of social and welfare supports require planned responses from these agencies.

In order to improve the health and social gain of this group, a multidisciplinary response will be required which incorporates all of the services and their providers that the Eastern Health Board provides. However, many of the needs of the homeless can only be met by provision of supports or changes in society that are outside of the control of a singe agency such as the Eastern Health Board. It is for this reason that the Eastern Health Board must work in partnership with all of the other agencies that provide for the homeless. Only through such a multidisciplinary partnership approach can the many varied needs of the homeless be met to ensure their continued health and social gain.

Chapter 8 Recommendations

8.1 Definition

R 2.1 We recommend the following definition of homelessness

Those who are sleeping on the street or in other places not intended for night-time accommodation or not providing safe protection from the elements or those whose usual night-time residence is a public or private shelter, emergency lodging, B&B or such, providing protection from the elements but lacking the other characteristics of a home and/ or intended only for a short stay.

R 2.2 It is recommended that the above definition, which is consistent with that of the Homeless Initiative Census, be agreed by all agencies so that agreed estimates of numbers of people who are homeless are used for planning purposes

8.2 Health and Social Services

R 3.1 We recommend the introduction of two multidisciplinary primary care teams in the inner city with one team on the North inner city and one on the South inner city. The teams should be small, multidisciplinary and integrated with the other primary care services provided within the city centre. The teams aim to improve the health and social gain of the homeless through the provision of integrated care which links people into mainstream service.

R.3.2 It is recommended that the teams should be co-ordinated and managed by a named member. They should have the input of nurses, doctors, social workers, community welfare officers, care attendants, community psychiatric nurses outreach drugs workers and administrators.

R 3.3 It is recommended that the team should contract for other professional services such as dental and chiropody services.

R 3.4 It is recommended that the team should operate all services from one base on either side of the city and should link closely with existing inner city primary care services

R 3.5 It is recommended that the strategy of the team should be set and overseen by a steering committee which consists of appropriately appointed members

R 3.6 We recommend that arrangements are put in place to provide the homeless with access to twenty four hour GP services which could be accessed via the freephone helpline currently in operation. The latter service should be extended to provide continuous twenty four hour coverage.

R 3.7 We recommend the provision of skeleton team services on an out of hours basis (e.g. 9am-6pm at weekends and public holidays) to ensure that problems are appropriately managed when they arise. This service should be accessible via the freephone helpline currently in use or directly from the service base of the relevant primary care team.

R3.8 It is recommended that a named individual from each of the professional groups comprising the inner city primary teams should be given responsibility for the homeless in each community care area. The appropriate time commitment for the members of this "dormant team" should reflect local need but would be a matter for each community care general manager. The individuals in each community care area should meet on a regular

planned basis. The work carried out by these individuals would help to support homeless people in their own communities.

R3.9 We recommend the implementation of the recommendations contained in the report entitled "Report of the Committee on Services for Homeless People with Mental Health Problems".

R 3.10 It is recommended that the drug services provide a special waiting list initiative in respect of people who are homeless.

R3.11 It is recommended that the methadone mobile clinic should be made available to all hostels and day care centres on a systematic basis.

R 3.12 It is recommended that the views of voluntary service providers be considered in the formulation and implementation of health and social service strategy in the Eastern Health Board.

8.3 Accommodation and Legislation

R4.1 It is recommended that persons should not remain in emergency accommodation other than in the very short-term. The Eastern Health Board should advise each Local Authority of the persons in need of accommodation only and request that each Local Authority provide for this need from their own housing stock or from the private rented sector

R4.2 It is recommended that additional accommodation be set aside for emergency accommodation needs and that this be earmarked for specific homeless groups

R 4.3 It is recommended that the Eastern Health Board should request that the Local Authorities monitor these residences closely in accordance with the appropriate pieces of legislation.

R 4.4 It is recommended that the Eastern Health Board should establish quality standards for all accommodation and its uses and should subsequently use only accommodation which meets these standards.

R 4.5 We recommend that the local authorities attempt to reduce the backlog of homelessness by increasing their housing stock and by agreeing to reserve a number of units specifically for the homeless which are spread throughout their housing stock rather than solely taken from their low demand areas.

R 4.6 It is recommended that the Local Authority take legal responsibility for the provision of housing.

R4.7 It is recommended that the anti-social legislation and its interpretation by the local authorities be re-considered and that the local authorities be required to discuss all potential evictions with health board staff at an early enough stage to allow for appropriate intervention to take place.

R 4.8 It is recommended that Department of Health Circular 5/87 be re-activated and a person should be designated in each area identified to receive and act on these notifications

R4.9 We recommend that the local authorities provide twenty beds for alcohol abusers and twenty beds for drug abusers (i.e. those who are not currently being admitted to existing facilities) as a matter of accommodation priority

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R 5.2 It is recommended that individuals or families, who are already known to the service, should be followed up by their key worker (e.g. public health nurse, community psychiatric nurse and social worker) if they are rendered homeless until such time as they have another permanent address. At such time the case can be passed on.

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R 5.4 It is recommended that the new homeless persons unit at Parkgate Street should include a creche facility to provide support to homeless women and families with children.

R 5.5 It is recommended that local day care services are provided to people outside the city centre to ensure that they can be supported in their own communities.

R 5.6 We recommend the development of a full day care facility for homeless women with children, particularly for those in B& B.

R 5.7 It is recommended that a review of existing food centres take place with a view to maximising co-ordination and minimising duplication.

8.5 Views of Voluntary Service Providers

R 6.1 It is recommended that information services should be designed to meet information needs in the pre-homeless, homeless and post-homeless phase and be made available at all service outlets for the homeless. The Eastern Health Board website should be developed to increase public awareness of the problems and solutions to homelessness and the actions currently being taken to address their needs.