Questionnaire for the FEANTSA Annual Theme

The Right to Health is a Human Right:
Ensuring Access to Health for Homeless People

AC members are asked to draft a national report for their country, based on responses to the questions outlined in this questionnaire. The reports should be 10 – 15 pages in length, written in either English or French and they should be submitted to the office by June 15th 2006. AC members are asked to consult with all FEANTSA member organisations in their country in the preparation of the reports; a copy of the questionnaire will be circulated to all FEANTSA members. The European report on Delivering Healthcare to Homeless People will be prepared over the course of the summer, on the basis of the responses received, and will be presented at FEANTSA's annual conference in Wroclaw on the 13th of October 2006.

For all questions, please contact Dearbhal Murphy
Email: dearbhal.murphy@feantsa.org
Tel: 0032 (0)2 534 49 30

Preamble: health and homelessness:

When considering homelessness and the best ways to tackle it, one cannot fail to be aware of the close links between health and homelessness. Looking at health and how it relates to homelessness offers a view of homelessness in health terms that is very useful. A definition of health is set out in the preamble to the World Health Organisation Constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Given that being homeless will certainly affect at least one of these spheres of health, homelessness may, by its very nature, be considered as a state of ill-health.

There is a range of factors, which may lead to a person eventually becoming homeless and often health issues are among them. Health and homelessness have a relationship of both cause and effect: illness (such as mental illness, substance-abuse or illness leading to loss of employment) may be among the trigger factors that lead to homelessness. Once in a situation of homelessness, a variety of health problems may result, such as exposure to infectious illness, mental health problems, development or aggravation of substance-abuse and addiction, or health problems resulting from an unsanitary or overcrowded environment. These health problems may make it harder to break out of a cycle of homelessness. What is more, accessing healthcare is often very problematic for homeless people.

This health perspective offers many people a better grasp of homelessness and can serve to counteract stereotyped visions. Health is one of the elements that has been used to define homelessness in Australia for example: in Australian legislation, homelessness is defined in the Supported Accommodation Assistance Program Act 1994. This act defines a 'homeless' person as follows:
"For the purposes of this Act, a person is homeless if, and only if, he or she has inadequate access to safe and secure housing. "(Section 4) The Act goes on to define 'inadequate access to safe and secure housing' and the very first criteria that is used is that of health: "For the purposes of this Act, a person is taken to have inadequate access to safe and secure housing if the only housing to which the person has access: damages, or is likely to damage, the person's health; or threatens the person's safety…" This offers a concrete understanding of homelessness in terms of a threat to health and well-being that policy-makers are likely to be able to identify with and which is concrete enough to mobilise political will.

Health is a vital factor for social inclusion. Good health is a prerequisite to reintegration and is a vital factor in being able to access and maintain employment and housing. Conversely, having a home and a job are important to good state of mental and physical well-being. Thus the right to health underpins and reinforces the right to employment and to housing. What is more, the right of a person to enjoy the highest attainable standard of health has a strong place in international human rights law and is enshrined in international conventions and charters such as the International Convenant on Economic, Social and Cultural Rights and the European Social Charter. This right has been clarified in the General Comments of the UN Committee on Economic, Social and Cultural rights, where it is set down that "the right to health is closely related to and dependent upon the realisation of other human rights, including the right to food, housing, work, education, participation…" So it is clear that health is a good way of framing and approaching these other needs, which are particularly acute in the case of homeless people.

Thus it is clear that health has a role to play in understanding homelessness and in communicating about homelessness. It is also true that health policy is a useful avenue for tackling homelessness in a preventative and also a holistic manner. Health services have a vital role in the fight against homelessness, as meeting health needs is an important step towards tackling homelessness and health services should be a gateway to other services. It is for all of these reasons that FEANTSA has dedicated 2006 to exploring the theme of health and homelessness. This questionnaire will try to establish a broad overview of the issues relating to health and homelessness across Europe. It will look at health profiles of homeless people, access to healthcare, training of health professionals, inter-agency working, data collection on health and the right to health.

Q1: Health profiles of homeless people:

This section aims to establish an overview of the main mental and physical health needs of homeless people in Europe; the public health issues that arise from them; as well as common treatment problems. When answering the questionnaire, it may be useful to refer to the ETHOS (European Typology of homelessness and housing exclusion) categories in order to ensure clarity and comprehensiveness. You will find the ETHOS typology in Annexe 1. It is also useful to bear in mind that many homeless people will present with more than one health problem and that these multiple problems across a range of areas may interact with each other and add up to a high aggregate of vulnerability. Please take multiple needs into account when answering these questions.

For reference, here is a definition of multiple needs:

"A typical homeless or ex homeless person with multiple needs will often present with three or more of the following, and will not be in effective contact with services:

- mental health problems
- misuses various substances
- personality disorders
- offending behaviour
- borderline learning difficulties
- disability
- physical health problems
- challenging behaviours
- vulnerability because of age.

If one were to be resolved, the others would still give cause for concern."
(Definition from Homeless Link Good Practice Briefing "Multiple Needs" August 2002)

It should be noted that these multiple needs may also be complicated by previous bad experience of health or social services and a mistrust of health and social workers.

1.1: Please outline the common mental, physical and substance abuse related health problems of the homeless people bearing in mind the conceptual ETHOS categories. Some of the health problems will reoccur in several categories.

A study undertaken in 2002 and 2003[1] assessed the health needs of seventy-two homeless people in Dublin. Out of the seventy-two respondents only 15 rated their general health as excellent or very good. Just over 20 respondents were satisfied or very satisfied with their general health and 38 respondents rated their health as poor or very poor.

The study also found that forty out of the seventy-two respondents had at least one medical condition or illness while a further nine reported suffering from anxiety. Reported illnesses included angina (3), high blood pressure (11), diabetes (1), depression (28), heart attack (1) and stroke (1). 31 respondents reported taking prescribed medications at the time of the survey. The use of prescribed medicines was most common among 26-45 year old respondents; 77 percent of all women and 30 percent of all men in this group were regularly taking prescribed medications. A further forty-four out of the seventy respondents reported having used illegal drugs within the previous thirty days. The main drugs reported included heroin, cocaine, ecstasy, amphetamines and cannabis.

Conceptual Category		**Health Issues**
ROOFLESS While a number of studies have been carried out, there is not one definitive national study, or one which clearly disaggregates those sleeping rough from those using emergency accommodation. The opposite are the prevalent health issues for both groups of people		Higher than national population experience of: Depression Psychiatric Disorders Respiratory tract problems Hypertension Alcoholism Illicit drug dependency Hepatitis

[1] (Hickey C & Downey D 'Hungry for Change: Social Exclusion, Food Poverty and Homelessness in Dublin', Focus Ireland, 2003)

		Dental health problems Chiropractor needs and skin disorders In addition they have a lower life expectancy than those of comparable age in the general population
HOUSELESS		As above
INSECURE Among the Travelling Community the health issues opposite have been identified:		Double the national rate of still births More than double the national fertility rate Infant mortality 3 times higher than national rate Traveller women live on average 12 years less than their settled peers, Traveller men live 10 years less Travellers have higher rates of morbidity for all main diseases
INADEQUATE		Researchers have found that many expectant mothers in direct provision suffer malnutrition, babies in these communities suffer ill-health because of diet, many adults experience hunger. Research on families using B and B facilities has shown that families may endure inadequate cooking and laundry facilities, inadequate space leading to increased stress and lack of privacy for older children. Older people living in poor quality homes are more likely to experience ill heath and to seek the use of health services (Stratten 2003) Children living in damp accommodation are likely to suffer from asthma and other respiratory illnesses. Poor quality accommodation increases risks of accidents and injuries (Laffoy, 1997)

1.2: Certain diseases, which are widespread among the homeless population, carry a clear public health risk. This is the case, for example, with tuberculosis. Tuberculosis incidence is much higher among homeless people than among the general population and there is a risk of the spread of this infectious disease and the development of multi-drug resistant strains. For this reason, some countries have put in place specific programmes or strategies to combat tuberculosis among homeless people. Please outline any public health risks associated with the health of homeless people and actions taken to alleviate these risks.

Research in the Dublin area (Condon 2001), suggests that TB among hostel dwellers is not as common as in homeless populations in other countries; this may be due to the combination of climate and the efficacy of cold weather strategies.
Both Hepatitis B and C are recognised as prevalent among those accessing emergency services. In the Dublin area the General Practitioner services (see question 3.1 below) offers an influenza vaccine as well as a Hepatitis C vaccine.

1.3: Certain health conditions experienced by homeless people pose significant problems of treatment. (For example: tuberculosis treatment can be rendered difficult by a mobile and chaotic lifestyle and overcrowded conditions; there may be availability problems for mental health treatment and drug and alcohol treatment etc…) Treatment of mental health problems is evolving and deinstitutionalisation has taken/ is taking place in many countries, but this too has given rise to new challenges and problems. Multiple needs are another factor that can make treatment problematic. Please outline treatment problems encountered when trying to ensure access to health for homeless people.

The barriers to accessing health care services for people who are homeless can be summarised as:

- Many people are unlikely to present to a GP as they place greater emphasis on basic requirements of food and shelter[2].
- Homeless adults face significant difficulties in sourcing, funding, storing and preparing nourishing foods[3].
- There is an inadequacy of specialist alcohol and drug addiction services.
- Many people experience dual diagnosis (in particular addiction and mental ill health) and there are not adequate services to meet their needs.
- In relation to mental health services, they are already stretched throughout the country.
- Mainstream psychiatric services are considered to be inflexible and to harbour negative attitudes towards people who are homeless, particularly those with forensic histories or with addiction issues.
- 'Sectoralisation' in the health services to date has meant that many health practitioners have not received any training in meeting the specific needs of people who are homeless.
- The operation of a 'catchments' area system, whereby people are referred back to area from which they originated in order to access services has proved to be particularly problematic for people who are homeless.
- The organisational systems of mental health service delivery are based on a single level medical/illness model and limited by funding
- The path to recovery can be life-long for some individuals and this has implications for the capacity of mental health services to maintain a long-term service.
- Existing discriminatory practices make access to mental health services difficult, and in some instances impossible for people homeless, including those residing in hostel and voluntary housing accommodation.
- The lack of appropriate housing options means that many people who are homeless are accommodated in acute or long stay hospital wards despite being suitable for community residential placement..
- People can find it hard to access services in different geographical locations.
- People may have little or no knowledge of what health services are available to them.
- Research on difficulties accessing services indicates the main difficulties in accessing services are: being passed from one service to another (48%); feeling that a service did not meet ones needs (48%); not knowing where to go to get a service (46%). One third of those interviewed felt they had been discriminated against when trying to access a service.
- 47% had missed a service or not attended one when advised to. Reasons for non attendance included: negative feelings (fear, shyness), feeling that a service would not be helpful often due to past experiences and difficulties in relation to time and notification of appointments.[4]

---

[2] (Holohan T & Holohan W 'Health and Homelessness in Dublin', Irish Medical Journal, 2000.

[3] (Hickey C & Downey D 'Hungry for Change: Social Exclusion, Food Poverty and Homelessness in Dublin', Focus Ireland, 2003)

[4] A Picture of Health, 2004, Western Health Board

- There is a lack of clarity as to where the responsibility lies for meeting the needs of people who are active drug users and also homeless, there is a lack of integration of services for this group and a lack of appropriate, targeted services.

Q2: Social Protection: Healthcare entitlements of Homeless People

The healthcare entitlements of homeless people vary from country to country according to the social protection system in place. It may also relate to their administrative status (whether they have registered). It may also vary according to whether the homeless people are nationals or non-nationals. This question seeks to examine the impact on access to healthcare and quality of care available to homeless people.

2.1: What are the healthcare entitlements of homeless people in your country (for nationals; for non-nationals, including asylum seekers and undocumented migrants)? What are the registration requirements etc.?

In Ireland, entitlement to publicly funded health services is determined by income. All Irish residents are classified in either Category I or Category II eligibility. Those in Category I are entitled to a "medical card". The vast majority of people who are homeless are, by virtue of their very low income, in Category I. Thirty per cent of the general population are entitled to a medical card, and since 2001 all those aged 70 years or over are also entitled regardless of income.
Medical card holders are entitled to free general practitioner service, prescribed medicines and drugs, free dental, ophthalmic and aural services and appliances. Quin 2005, writing of the general population notes that the latter three services 'actual provision' is 'in reality very limited'. Medical card holders are also entitled to receive all public hospital out patient and in patient services in a public ward, including consultant's fees.
65% of hostel dwellers surveyed in the Dublin area were medical card holders.
Since the introduction of the *Integrated Strategy* progress has been made on 'fast –tracking' medical card applications and approvals for people who are homeless.
The issue now is not so much access to the card itself as access to GPs who will actually include people who are homeless on their register of clients.

If a person is taking up residence in Ireland or returning here to live, they would be regarded as ordinarily resident in Ireland if they satisfy thier Health Service Executive (HSE) Area that it is their intention to remain in Ireland for "a minimum of one year".

To establish that a person is ordinarily resident a Health Service Executive (HSE) Area may require:

- Proof of property purchase or rental, including evidence that the property in question is the person's principal residence.
- Evidence of transfer of funds, bank accounts, pensions etc.
- A residence permit or visa.
- A work permit or visa, statements from employers etc.
- In some instances, the signing of an affidavit (a sworn written statement) by the applicant.

(The fact that a non-EU National has established his/her eligibility for health services does not automatically mean that their dependants are also eligible. Dependants of non-EU Nationals may also have to satisfy the above requirements.)

Under EU Rules if you are living in Ireland and getting a Social Security Pension from another EU State you may be entitled to a Medical Card here without having to satisfy the usual means test **provided** you are not getting an Irish Social Welfare Pension and are not employed or self-employed in Ireland.

Nationals of another EU Member State who is not covered for health services under EU Rules should have his/her status as "ordinarily resident" sorted out by the Health Service Executive (HSE) Area (formerly known as '*health board*') in order to be eligible for health services here.

All applications are handled through the Community Welfare Officer system of each Health Services Executive area. There is some discretion in this process, and there is an appeals process.
Given the criteria for proof of residency above, it is likely that many EU 10 nationals and those in Ireland illegally would find it very difficult to prove their eligibility.

2.2: Has the health system evolved in such away that it is getting harder for homeless people to access their entitlements?

It is widely acknowledged in Ireland that we have a crisis in the health service. This is most evident in Accident and Emergency units where patients regularly wait on hospital trolleys for extended periods before being admitted to a ward.
People relying on emergency accommodation services also rely heavily on Accident and Emergency units for health services.

2.3: What do you consider to be the main barriers facing homeless people in your country when they try to access healthcare (stigma, financial barriers, administrative barriers, etc.)?

See question 1.3

2.4: Have attempts been made to overcome these barriers? Have they been successful?

See question 3.1 for specific actions.

Q3: Ensuring Access to quality healthcare

This question will explore why homeless people across Europe have difficulty accessing the good quality healthcare that they need. There is a range of services that homeless people should access in order to enjoy good health: these include medical treatment; but also preventative services (screening, check-ups etc.); specialised services such as dental services; and health promotion services.

3.1: Are you aware of specialist and/or outreach healthcare centres that have been put in place specifically for homeless people? Do you consider that this is a good way to meet the health needs of homeless people? What are the costs and benefits of targeting homeless people in healthcare provision?

Funding for specific healthcare initiatives under the Homeless Agency arrangements in Dublin, has increased from €8.5m in 2003 to €19.3m in 2006 and the following specialist services are now in place:

- **Two Multi-disciplinary Primary Care Teams** for north and south of the city were established in mid-2000. The teams have a provision for nine posts and each links people with mainstream health services. They also provided feedback on gaps and barriers in services and fast tracks medical cards. The staff compliment remains the same and the key challenge for this service as with any other is to ensure that vacancies are filled. Posts include a team leader, welfare officer, occupational therapist, drugs worker, outreach worker and a new temporary consultant in Ushers Island.
- **Outreach psychiatric teams** have been operating in Dublin 2003 in the east coast, south western and northern areas. They operate on an outreach basis and work with people with dual diagnosis and behavioural problems. Training and support to staff working in homeless services is also provided.
- **A Detox programme** for people with alcohol addictions was established in partnership with Dublin Simon and the Salvation Army. The Dublin Simon Detox Unit was established in 2003 and provides a three-week residential alcohol programme for homeless clients. The service is for men and women. A full assessment and detoxification from alcohol as part of an overall care package is also provided if a client cannot make use of a community service. This service also operates a rehabilitation and aftercare programme.
- **Primary healthcare in homeless services** – All emergency shelters receive funding to employ a nurse and for the services of a GP. In some access is also available to a chiropodist and counsellor.

- **A Dedicated Dental Surgery** has been established and people homeless do not require a medical card to use this service. The aim is to provide equitable and accessible dental healthcare for any person registered as homeless and to improve individual and the population's oral health and access to services. Its functions include direct dental treatment, health promotion, improving access to regular dental services, multidisciplinary cooperation and research and training.
- **A five-day health promotion programme in 2003** targeted at staff in homeless services was delivered and Influenza and Hepatitis B vaccinations were provided to homeless people and staff in services – the latter is always available to staff.
- **A protocol** was developed for people being discharged from acute and psychiatric hospitals and a detailed assessment of the needs of children leaving care completed.
- **The Merchants Quay Ireland** project is involved in harm reduction and includes a needle exchange and methadone clinic.
- **The Drug Treatment Centre Board, Trinity Court** also provides services for people who experience homelessness including a dental surgery and methadone clinic.

- The Health Service Executive has also funded a nurse, who is available to treat and advise **young people** around drug treatment, harm reduction and general health. This nurse is shared between a hostel for young people in Dublin run by Focus Ireland and the Young Person's Programme at Trinity Court Drug Treatment Centre.

- A step down programme has also been newly developed for homeless single adults coming out of addiction treatment; this programme is for both males and females and runs for 3 to 6 months.

- Three mental health teams operate in the greater Dublin area, consultant psychiatrists with multi disciplinary teams lead two, and one consists of a social worker, .5 psychiatrist and one outreach worker.

An example of an initiative outside of Dublin:
In Cork the Health Services Executive employ an Adult Homeless Medical Team, who are based in Cork Simon Community's Day Centre. The service currently employs a Clinical Psychologist a GP, Nurse, Community Psychiatric Nurse and Addiction Counsellors.

A cost benefit analysis of these initiatives has not been undertaken.

Two additional health proposals are currently being progressed in the Dublin areas. The first is the provision of crisis beds for people with mental health needs who have not being assessed as having a psychiatric disorder. Where this situation occurs it increases pressure on Accident and Emergency services and people may be discharged back into hostel settings or onto the street despite pressing need for more intervention. The maximum length of stay in this unit will be two weeks, by which time alternative accommodation will be sourced.
In addition, a step down service for people discharged from hospital that have physical health needs and require convalescent care is also being planned.

While transparent access to quality mainstream health services is the ideal goal of public policy, it is recognized that specialist services are in some cases necessary. The priority should be to follow the primary care model and ensure, particularly as people move out of homeless services, that people are linked into the network of services available in their geographical area and receive good quality, joined up services.

3.2: Are you aware of any health promotion/ preventative health initiatives that are accessible to homeless people? Do you think that these impact positively on access to employment?

Eat Well Be Well initiative was developed by Focus Ireland in response to research into food poverty[5] which highlighted the poor diets and inadequate nutrition of people who are homeless. Eat Well Be Well is a healthy eating campaign is designed to promote health awareness with an emphasis on nutrition, diet, information and advice on eating well for positive health among people who are homeless and is run annually.

3.2: How do homeless people in rural areas access health care?

There is no specific data or research in this area.

3.3: Do you consider the healthcare received by homeless people in your country to be comparable, in terms of quality of care, to that received by the general public? In what health areas is there the greatest lack of access to care and why?

The quality of care available to all those who rely on the public health service is widely acknowledged to be poorer than that available to those who have health insurance. This is due to overcrowding in services, lack of bed and treatment space, and waiting times for procedures.
The area where people who are homeless receive disproportionately worse care is in the area of mental health services, for the reasons outlined in question 1.3

3.4: In some countries, a specific policy framework and action plan around health and homelessness has been put in place in order to ensure that homeless people can get full access to quality care. Has such an approach been tried in your country?

The 'National Health Promotion Strategy' (2000) specifically referred to the need for a health promotion programme for homeless people delivered through community and primary care settings.

'Homelessness – An Integrated Strategy' (2000) clarified the responsibility of the Health Boards (now the Health Services Executive) for the health and in house care needs of people who are homeless (with the Local Authorities being responsible for people's housing needs). Local homeless action plans with an integrated approach delivered by statutory and voluntary agencies were to be devised which would meet the health and housing needs of people who are homeless.

In addition, the recommendations made by the then Eastern Regional Health Authority (Greater Dublin area), listed below, were to be implemented, and used as a model in other regions by health authorities throughout the country.

Two Multidisciplinary Primary Care Teams be established in the Dublin Inner City area. The Teams will be small and integrated with the other primary care services provided within the city centre and their aim will be to provide integrated care linking homeless people into the mainstream service and thus improving homeless people's health. The teams should be co- ordinated and managed by a named member with input of nurses, doctors, social workers, community welfare officers, care attendants, community psychiatric nurses, outreach drug workers and administrators and will be overseen by an appropriate steering committee.
The introduction of arrangements to provide homeless people with access to 24 Hour General Practitioner services e.g. via the current freephone helpline which will be extended to 24 hour coverage.
The provision of an after-hours skeleton team service.
Nominated individuals from each of the professional groups to be given responsibility for the homeless in each community care area.
The recommendations in the Report of the Committee on Services for Homeless People with Mental Health Problems to be implemented.
The drug services to provide a special waiting list initiative for homeless people.

[5] (Hickey C & Downey D 'Hungry for Change: Social Exclusion, Food Poverty and Homelessness in Dublin', Focus Ireland, 2003)

The methadone mobile clinic to be made available to all hostels and day care services on a systematic basis. The views of the voluntary service providers to be considered in the formulation and implementation of health and social service strategy by the Eastern Regional Health
Authority.

The 'Review of Implementation of Homeless Strategies', 2006 suggests that the recommendations on health services cited above were 'significantly progressed' in the greater Dublin area, and the recommendation that each other health authority to consider it's range of responses and adopt strategies from the model above was 'partly progressed.'

Q4: Training of health professionals

Homeless people sometimes encounter a lack of understanding and reluctance to engage with them from healthcare professionals that might be overcome through training for health workers on how to work with homeless people, as well as on their specific health issues. The problem of homeless people presenting with multiple needs can also be professionally challenging for healthcare workers. This is another area where training would be useful.

4.1: Do you know of any such training courses (in all areas of healthcare – nurses and doctors, but also mental health workers, dentists, podiatrists etc.) or plans to put them in place, as part of medical training or as follow-up training?

Focus Ireland has developed a series of ten modules to be used as part of the national Nursing Degree Programmes. (Copies of the material can be made available to FEANSA if of interst)

Q5: Interagency working

Ideally, accessing healthcare should provide a route into other care and integration services, through referral and transfer practices between homeless services, social services and health services.

5.1 Are you aware of instances of this kind of networking in your country?

'Primary Care- A New Direction', 2001 Department of Health and Children formalised primary care and the accessing of additional health services through primary health care professionals as the overarching policy in health services.

Initiatives which are based on increasing the access of people who are homeless to appropriate GP services which are then networked into multi- disciplinary teams replicate this overall policy shift.

5.2: Are health and social services supportive of this type of working? Have administrative procedures or agreements been put in place to facilitate transfer and sharing of information and cooperation between different services? What are the discharge practices from hospitals in your country?

The Homeless Agency in Dublin set up a computerised client database in order to facilitate transfer and sharing of information and cooperation between different services. Information collected includes services such as assistance in applying for medical cards or referral to medical services/detoxification facilities.

There has been no formal national review of health interventions for people who are homeless, see q3.4 above.

The 'Homeless Preventative Strategies' 2002, set out the following in relation to discharge policies:

- All psychiatric hospitals to have formal & written Discharge Policy, communicated to all staff involved in the discharge of patients and will be provided to patients and next-of-kin.
- Psychiatric teams will have a nominated professional to act as Discharge Officer and

ensure that discharge policy is followed.

- All hospitals to have formal admission & discharge policies in place to identify homeless persons on admission to hospital & ensure arrangements made to ensure that accommodation is provided for the homeless person after their discharge.
- These policies will be communicated to all staff involved in the admission and discharge of patients and all patients and next-of-kin will be provided with a copy of the policies..
- Every hospital will have a nominated officer to act as Discharge Officer and ensure that the discharge policy is followed.

The 'Review of Implementation of Homeless Strategies',2006 noted that the above had been 'partly progressed'.

In addition, the preventative strategy set out that:

- Records will be kept of the number of patients being discharged and the type of accommodation into which they are being discharged.
- The relevant Departments will put monitoring systems in place to ensure that the measures in this strategy that are relevant to them are implemented and that they contribute to the overall aim of preventing homelessness & report regularly

The 'Review of Implementation of Homeless Strategies',2006 noted that 'little progress' had been made on the above.

'Preventing Homelessness: A Comprehensive Preventative Strategy to Prevent Homelessness in Dublin, 2005-2010' recommended that health boards:

- Improve discharge planning processes and develop training and tools to implement existing joint protocols as established in the Homeless Prevention Strategy.
- Agree integrated care policies for people discharged from hospitals, care homes and prisons. This includes a) the full implementation and monitoring of the Leaving Care Policy currently being progressed by the National Children's Office and the HSE; b) improved prison discharge planning with supported or transitional housing, particularly for young single men.
- Implement and further develop joint protocols as established in the Homeless Prevention Strategy.

5.3: Have you encountered instances where there is an obvious breakdown in this kind of networking? (eg: homeless people being retained in hospital because no other option has been found for them to move on to other services).

Despite six years of national policy specifically advising close interagency working Local Authorities and Health Authorities in some parts of the country continue to dispute who's responsibility it is to meet people's needs. In addition health authorities sometimes fail to take responsibility for people who should be in mainstream statutory services and they are left to rely on voluntary agencies. The recent case studies complied by Simon illustrate these points:

A man who suffers from mental ill health was discharged from hospital without a secure address; the HSE advised him to approach the Local Authority. The Local Authority advise him that they will only accommodate him for three nights in a B&B and he will have to make his own arrangements after that. Through the lobbying of two voluntary agencies the Local Authority increased the number of nights accommodation they will pay for, but only for two or three nights at a time, leaving the client very distressed and vulnerable. Midlands Simon found suitable private rented accommodation for the man.

Midlands Simon Community have experienced a number of cases where people are being discharged from hospital with no appropriate accommodation. In each case a 'turf war' has arisen between the local authorities and H.S.E., with either agency accusing the other of not taking up their responsibilities. In one case the L.A refused to refer people that came directly from hospital to the Midlands Simon Community settlement team; thus denying people access to voluntary, as well as statutory services. The local authority in question refused to meet with Simon for over three months to discuss the issue. A partial resolution has so far been reached.

A long-term resident of one of Cork Simon's high-support residential houses was recently admitted to the hospital with chest complaints. He was also experiencing secondary health problems, including double incontinence. After a short stay he was discharged into Cork Simon care even though his secondary health issues had not been addressed or resolved. Cork Simon, as his named next of kin, had advocated on his behalf that he not be discharged until fully recovered. The man is still suffering because of his secondary health issues, attempts are being made to have him referred back into hospital by a GP, but so far the hospital is not accepting him. He is now displaying symptoms of the 'winter vomiting bug', giving much rise for concern at the residential house in question.

A long-term resident of the Cork Simon's Emergency Shelter suffers from mental health problems and is unable to access appropriate support from the HSE. Cork Simon has convened countless meetings with the HSE in an effort to convince the authority that they should take responsibility for the man. On each occasion the HSE has refused to take that responsibility, saying the man's mental health problems are no more severe than most people they encounter. At each meeting, Cork Simon has agreed to offer accommodation and support to the man at different Cork Simon Community high-support residential projects. On each occasion the arrangement has failed and the man ended up returning to the Emergency Shelter. On each occasion the HSE has refused to take responsibility for the man's well-being, saying they cannot find a suitable place for him. The only suggestion they have made is that the man be moved to the private rented sector with standard community mental health supports. Cork Simon has continuously advocated that the man will not be able to cope in the private rented centre and that the Emergency Shelter is most inappropriate accommodation for the man, which only serves to compound his mental health problems.

Q6: Health indicators, data collection and research

It is not always easy to access information on the health situation of homeless people. Yet such information can be crucial to making the case for political investment in healthcare for homeless people. This question seeks to establish possible effective ways of accessing reliable data on the health situation of homeless people.

6.1: Is data collected on any area related to the health of homeless people in your country? (such as the different illnesses suffered by homeless people, number of homeless people using specialist health services, number of people using general services, causes of death, life expectancy, etc.) If so, who collects it? (hospitals, homeless service providers, Accident & Emergency, youth care centres, psychiatric services, etc).

See answer to q 1.1 and 5.2

The Homeless Agency in Dublin has commenced this process but much more work needs to be done to understand the impact of the specialist initiatives underway and of the interventions which have been made.

6.2: Do you know of any research undertaken on the health of homeless people by academic or other bodies? (eg: Government reports, NGO reports, scientific reports, etc.)

A number of research reports on the health needs of people who are homeless have been undertaken in recent years by both statutory and voluntary agencies.
The overarching findings are that the health of homeless people is extremely poor particularly in comparison with the general population. (Hourigan & Evans 2005).

Among the most relevant recent reports are:

A Qualitative Study of Homelessness and Social Support, HSE Western Area, 2005

A Picture of Health – A study of the Health Status and Health Promotion Needs of Homeless people in the West, Western Health Board, 2003
The Health and Dental Health needs of homeless people in Dublin, Northern Area Health Board, 2001
Drug use among the homeless population in Ireland, *NACD*, 2005
Pieces of the Jigsaw - Six reports addressing homelessness and drug use in Ireland, *Merchants Quay Ireland*, 2003
Hungry for change; social exclusion food poverty and homelessness in Dublin, *Claire Hickey and Daithi Downey*, *Focus Ireland* 2003
Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland, *L. MacGhabann*, *NACD*, 2004
Mental Health: The Neglected Quarter Homelessness, *Amnesty*, 2004
The Mental and Physical Health and Well-being of Homeless Families in Dublin: A Pilot Study (2000), *Focus Ireland, 2000*

6.3: Do you know of data collection in the following areas that might be relevant in relation to the health of homeless people?
- Health determinants including lifestyle factors, drug and alcohol abuse and smoking
- Environment and health
- Access to health
- Mental Health

"Health in Ireland - An Unequal State" brings together information and evidence from a wide variety of sources to highlight health inequalities in Ireland, it was published by the Public Health Alliance Ireland in 2004, and among the key findings were:

- Between 1989 and 1998 the death rates for all causes of death were over three times higher in the lowest occupational class than in the highest.

- The death rates for all cancers among the lowest occupational class is over twice as high for the highest class, it is nearly three times higher for strokes, four times higher for lung cancer, and six times higher for accidents.

- Perinatal mortality is three times higher in poorer families than in richer families.

- Women in the unemployed socio-economic group are more than twice as likely to give birth to low birth weight children as women in the higher professional group.

- The incidence of chronic physical illness has been found to be two and a half times higher for poor people than for the wealthy.

- Men in unskilled jobs were four times more likely to be admitted to hospital for schizophrenia than higher professional workers.

- The rate of hospitalisation for mental illness is more than 6 times higher for people in the lower socio-economic groups as compared with those in the higher groups.

- The incidence of male suicide is far higher in the lower socio-economic groups as compared with the higher groups.

- On average 39% of people surveyed in 2003 identified financial problems as the greatest factor in preventing them from improving their health.

- Members of the Traveller community live between 10 and 12 years less than the population as a whole – the 2002 census found that only 3 per cent of all Travellers were aged over 65, as compared with 11 per cent for the population generally.

- The rate of sudden infant deaths among travellers is 12 times higher than for the general population.

- Researchers have found that many expectant mothers in direct provision suffer malnutrition, babies in these communities suffer ill-health because of diet, many adults experience hunger.

- The incidence of injecting drug abuse use is almost entirely confined to people from the lower socio-economic groups.

6.4: Do you know of any indicators used to measure the effectiveness policies/services in the following areas that might be used to get information on the health and well being of homeless people?
- Health determinants including lifestyle factors, drug and alcohol abuse and smoking
- Environment and health
- Access to health
- Mental Health

Health Determinants:

Study	Condon et al, 2000	SLAN survey 1998/1999
Sample	**Male and female adult homeless**	**Male and female general population**
Smoking prevalence	85 %	31%
Prevalence of unsafe drinking	54 (men)%	27%
Prevalence of hazardous drinking	28.9 (men)%	N/A
Lifetime prevalence of drug misuse	38%	N/A

Sometimes "self-perceived health status" is used as an indicator to collect health data - do you think this is useful in relation to homeless people?

"Self-perceived health status" was found to be a useful indicator of the health of the homeless population and was deployed as such in 'Hungry for Change: Social Exclusion, Food Poverty and Homelessness in Dublin'[6]

Condon 2001 notes that a 'striking finding' of their study was the disparity between self reported illness and the findings following physical examination, laboratory investigations and mental health assessments, and that 'this disparity suggests that there is a large burden of undiagnosed physical and mental health problems among the homeless population'.

[6] Hickey C & Downey D 'Hungry for Change: Social Exclusion, Food Poverty and Homelessness in Dublin', Focus Ireland, 2003)

6.5: In relation to housing, are you aware of any comparisons undertaken between the health of the well and poorly housed populations? In relation to employment, do you know if comparisons between the health and well being of homeless or formerly homeless people who have access too employment and those who don't?

Very little specific research on the impact of bad housing on the health of inhabitants has been undertaken. The research findings in relation to families in B&B accommodation is cited in the opening grid.
There is no research that we are aware of correlating access to employment, health and formerly homeless status.

Q7: The Right to Health

The right to health is enshrined in several international human rights texts. You can find the articles on health brought together in FEANTSA's brief on the right to health. It is further strengthened by the right to non-discrimination in the area of access to health. Tackling health inequalities is an ongoing priority at European level. For this reason, expressing homelessness in terms of health has the potential to be a powerful political tool. The right to housing, the right to employment and to access to the services you need are all underpinned by the right to be healthy and to enjoy a state of well-being.

7.1: Do you know of any examples where a rights-based approach has been adopted in relation to health for homeless people or other vulnerable groups, whether in the form of court cases or campaigns?

A number of Irish NGO's have used the shadow reporting system of the UN to draw attention to health issues for example the Children's Rights Alliance (Convention on the rights of the Child), the National Women's Council (CEDAW) and the Irish Traveller Movement (CERD). In the 2002 report on Ireland's compliance with the ICESCR the UN criticised Ireland for the lack of rights based approaches to both our national health strategy and our national anti poverty strategy, mainly as a result of the work done by Ngos through the shadow reports on this convention. When Ireland reports on ICESCR in 2007 a larger number of NGOs will be involved in the shadow reporting system.

Much work is being progressed by NGOs on advocating for economic, social and cultural rights. The right to health for people who are homeless has not specifically been addressed as yet in any campaigns or activities. However, the three examples below are very relevant and homelessness ngos have been very active in these campaigns:

Amnesty Campaign for the highest attainable standards of mental health
Amnesty International's Irish section launched a domestic campaign on the right to the highest attainable standard of mental health in 2003. In advance, it consulted extensively with stakeholder organisations on what value it could add to the national advocacy movement. It published four reports assessing Ireland's compliance with mental health–related standards, including one focusing on the interrelationship between mental health problems and homelessness. The campaign's objective was to raise public and political awareness of the link between respect for international human rights, mental health and Ireland's mental health system, and to promote human rights based approaches to mental health promotion, prevention and treatment. It also added its support to the disability movement strengthening in Ireland lobbying for rights-based legislation.

The campaign was endorsed by the main stakeholder NGOs, and Amnesty has lobbied jointly with other NGOs on specific initiatives. It continues to lobby the Irish Government for human rights based approaches to mental health policy, law and funding, and is currently planning to deliver advocacy training and support to service users to promote self-advocacy. In June 2006, it was one of five NGOs that launched the lobby group, the Irish Mental Health Coalition, which has a human rights focus.
See: www.amnesty.ie and www.bodywhys.ie/news/MentalHealthCoalition_Web.doc

The Public Health Alliance

The membership of a Public Health Alliance aims to be broad based and to reflect the breadth of sectors and

disciplines that impact on public health. This includes statutory, voluntary and community organisations from sectors including health, education, environment and sports. It's core messages are : People's health is determined by their social, economic, environmental and political context. Poorer people and people experiencing exclusion, get sick more often and have shorter lives. A Fairer society is a healthier society. Among it's core values is the promotion of health as a human right.
See www.publichealthallianceireland.org

The Disability Legislation

For many years the Disability movement in Ireland lobbied for rights based disability legislation. The campaign successfully defeated the Governments first attempt at legislation in this area. Unfortunately the Bill that was eventually passed falls far short of a right to health services. The Act gives all persons with a disability the right to an assessment of need, and the right to appeal that assessment. However, it does not give people a guarantee that they will receive the services they require, and it does not allow people to appeal against the non-delivery of services.

In addition

Challenging homeless services on rights

The Simon Communities of Ireland and Amnesty International Irish Section have created a training course 'Delivering Homeless Services in a Human Rights Context' and delivered it throughout Simon. This work challenges homeless service providers to examine their own service provision from the perspective of promoting and protecting the human rights – including the right to health – of the people who use their services. It is hoped that this work will eventually be mainstreamed throughout homeless services in the country.

7.2: Is the health of homeless people a political issue in your country? Could it be a useful campaigning point? Why? Why not?

Currently the health of people who are homeless is not a political issue in Ireland.
The health service per se is one of the top political issues in the country and many people have been directly affected by the crisis in Accident and Emergency services. The general public are very vocal on this topic and it is likely to be a key election issue (elections within the next 12 months).
There is a possibility that people who are homeless may actually become 'scapegoats' in this area; one political party has proposed the operation of 'drunk tanks' for people who are intoxicated and using emergency services.

A national campaign with a primary focus on putting ending homelessness on the agenda for the general election will be launched in September by four national NGOs. The focus of the campaign will include 'humanising' people who are homeless, engaging the empathy of the general public and telling the real life stories of individuals who are homeless.

New housing legislation is expected in the Autumn, one area which has been flagged by Government is needs assessment. This will hopefully create the opportunity to raise and get action on the issue of health needs assessment.

Please return your completed questionnaires to dearbhal.Murphy@feantsa.org before June 15th 2006.

Annexe 1: ETHOS TYPOLOGY

ETHOS
European Typology of Homelessness and housing exclusion

Homelessness is one of the main societal problems dealt with under the EU Social Inclusion Strategy. The prevention of homelessness or the re-housing of homeless people requires an understanding of the pathways and processes that lead there and hence a broad perception of the meaning of homelessness.

FEANTSA (European Federation of organisations working with the people who are homeless) has developed a typology of homelessness called ETHOS.

*The ETHOS typology begins with the conceptual understanding that there are three domains which constitute a "home", the absence of which can be taken to delineate homelessness. Having a home can be understood as: having an adequate dwelling (or space) over which a person and his/her family can exercise exclusive possession (*physical domain*); being able to maintain privacy and enjoy relations (*social domain*) and having a legal title to occupation (*legal domain*). This leads to the 4 main concepts of Rooflessness, Houselessness, Insecure Housing and Inadequate Housing all of which can be taken to indicate the* absence of a home. *ETHOS therefore classifies people who are homeless according to their living or "home" situation. These conceptual categories are divided into 13 operational categories that can be used for different policy purposes such as mapping of the problem of homelessness, developing, monitoring and evaluating policies.*

ETHOS European Typology on Homelessness and Housing Exclusion

Conceptual Category		**Operational Category**		**Generic Definition**
ROOFLESS	1	People Living Rough	1.1	Rough Sleeping (no access to 24-hour accommodation) / No abode
	2	People staying in a night shelter	2.1	Overnight shelter
HOUSELESS	3	People in accommodation for the homeless	3.1 3.2	Homeless hostel Temporary Accommodation
	4	People in Women's Shelter	4.1	Women's shelter accommodation
	5	People in accommodation for immigrants	5.1 5.2	Temporary accommodation / reception centres (asylum) Migrant workers accommodation
	6	People due to be released from institutions	6.1 6.2	Penal institutions Medical institutions

	7	People receiving support (due to homelessness)	7.1 7.2 7.3 7.4	Residential care for homeless people Supported accommodation Transitional accommodation with support Accommodation with support
INSECURE	8	People living in insecure accommodation	8.1 8.2 8.3 8.4	Temporarily with family/friends No legal (sub)tenancy Illegal occupation of building Illegal occupation of land
	9	People living under threat of eviction	9.1 9.2	Legal orders enforced (rented) Re-possession orders (owned)
	10	People living under threat of violence	10.1	Police recorded incidents of domestic violence
INADEQUATE	11	People living in temporary / non-standard structures	11.1 11.2 11.3	Mobile home / caravan Non-standard building Temporary structure
	12	People living in unfit housing	12.1	Unfit for habitation (under national legislation; occupied)
	13	People living in extreme overcrowding	13.1	Highest national norm of overcrowding

For more information please see FEANTSA's *2005 Review of Homeless Statistics in Europe* (Edgar et al.) at www.feantsa.org

FEANTSA is supported financially by the European Commission. The views expressed herein are those of the author(s) and the Commission is not responsible for any use that may be made of the information contained herein.