Disability Federation of Ireland

Mentally Ill and Homeless in Ireland: Facing the Reality Finding the Solutions

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Executive Summary

People who are mentally ill and homeless in Ireland are triply handicapped and stigmatised by virtue of: (1) being disabled and therefore handicapped within society generally (2) being marginalised within the disability sector and (3) being homeless. There are about 1,500 people in Ireland who are both mentally ill and homeless.

People who are mentally ill and homeless should be regarded first and foremost as people with a disability since it is their mental illness - and particularly society’s response to that disability - which is the primary influence on their lives. This group of people face two main problems: (1) they do not receive treatment or rehabilitation services for their mental illness and (2) they live in accommodation such as emergency hostels or sleeping rough which is not appropriate to their needs and may even exacerbate their illness. Any strategy to address their needs must tackle these two problems.

In proposing a strategy for people who are mentally ill and homeless, it needs to be acknowledged that the present system does not work for them and is fundamentally at odds with the objectives of equity, quality of service and accountability which are at the core of health care policy in Ireland. It is also failing to achieve the twin objectives which have been set for the mental health services: to promote mental health and to restore the mentally ill to as independent and normal a life as possible.

Services for this group of people need to be more flexible, to be free from catchment area constraints, and to be better resourced in terms of community-based facilities such as supported accommodation, day centres for treatment and rehabilitation, training and sheltered work spaces as well as an adequate supply of in-patient facilities. These services need an input from all the key agencies involved - both statutory and voluntary - and be delivered by a multi-disciplinary, community-based team.
Given that most of those who are mentally ill and homeless tend to live in Ireland’s major urban areas, a Mental Health and Housing Task Force needs to be established in each of these areas to draw up and implement a plan of action. The voluntary sector has a crucial role in this process but it too must face the challenges of greater specialisation which this work requires.
1 Introduction

“As long as mental illness is out of sight and out of mind we do not need to consider those aspects of our society that might exacerbate our normal human tendency to mental ill-health.”
(Clarke, 1991, p.14)

“Some former patients slip through the net altogether to join the wandering homeless who constitute a growing group in most large cities in the Western world.” (Smith, 1991, p.115)

People who are mentally ill and homeless are among the most destitute and neglected people in our society. They are mainly invisible except to those offering services to homeless people. Their existence is largely unknown by the various study groups, strategy groups and commissions which have examined disability and mental illness over the past 15 years or so. In this period, six major government-sponsored reports have looked at the service needs of people who are disabled and mentally ill (see Table 1).

| Table 1 Government-Sponsored Reports on Mental Health and Related Services, 1984-1998 |
|---------------------------------------------|--------------------------|
| **Name of Report**                        | **Date of Publication** |
| The Psychiatric Services: Planning for the Future | Dec 1984               |
| Green Paper on Mental Health               | Jun 1992                |
| White Paper: A New Mental Health Act       | Jul 1995                |
| Guidelines on Good practice and Quality Assurance in Mental Health Services | Apr 1998 |

With one exception, none of these reports makes any reference to the existence of people who are mentally ill and homeless. The one exception is the Commission on the Status of People
with Disabilities which acknowledged that: “A number of submissions also drew attention to the risks of homelessness faced by people with psychiatric disabilities who often face serious accommodation problems after being discharged from hospitals” (1996, p.189). However the Commission made no recommendations to address the specific needs of people who are mentally ill and homeless. Similarly, it is rare to find any mention of homelessness in the reports of the Inspector of Mental Hospitals (1998b and 1998b) or in more academic papers on mental illness in Ireland (see for example, Walsh, 1988; 1990; 1997; O’Hare and O’Connor, 1987; Cleary, 1997).

The purpose of this paper therefore is to draw attention to the existence of a hidden group of mentally ill homeless people and to invite consideration of their needs by those who make up the broader disability family in Ireland as well as by Irish society in general. The paper begins with a statement of the problem as experienced by people who are mentally ill and homeless (section 2). The size of this group - including its relative size vis à vis other forms of disability - is estimated by drawing upon a number of studies which have examined the homeless population (section 3). One of the difficulties which has helped to thwart the development of services for mentally ill homeless people in Ireland is that their needs have been seen from a “homeless perspective” rather than from a “disability perspective”. In section 4, it is argued that we need to see disability as their primary condition and homelessness as their secondary condition since this has the potential of improving their right and their claim to a better service. The present system of care for people who are mentally ill has been exhaustively analysed and criticised and a brief synopsis of the main defects of the present system, particularly as it affects homeless people, is presented in section 5. The desired direction of change in policy and services has also been well documented and is summarised in section 6. Finally, in section 7, the main themes of the paper are summarised and the need for action is highlighted.

2 Statement of the Problem

“People with disabilities are the neglected citizens of Ireland. On the eve of the 21st century, many of them suffer intolerable conditions because of outdated social and economic policies and unthinking public attitudes.”
We begin by stating the essential parameters of the problem. All people with disabilities face problems in trying to participate fully in the economic, social and cultural life of this country. This is not just because of their disabilities but because of how society reacts to their disabilities. As pointed out by the Commission on the Status of People with Disabilities (1996, p.9): “A given level of impairment or degree of restriction does not necessarily lead to disadvantage: it is the societal response (in terms of attitudes and expectations as well as the services and facilities made available) which has an important impact on the extent to which impairment or disability leads to disadvantage”.

Each of the three broad categories of disability - physical disability, mental handicap and mental illness - face common challenges to participation as well as unique difficulties peculiar to their condition. In the case of people with mental illness, there are two sets of difficulties which make their disability decidedly worse.

First, there is a pervasive stigma and shame associated with mental illness which has led to its concealment within institutions and families and an unwillingness to publicly acknowledge the scale of the problem much less respond to it various dimensions. As a result of this stigma, writes Anthony Clare, “the mentally ill are marked and branded as fearsome, evil, inferior, weak, dangerous, unpredictable, unreliable and, by the particularly ignorant, contagious” (Clare, 1991, p.12; see also Dinan, 1999). Indeed the case of mental illness confirms the limitations of a purely medical model of disability since society’s reaction to people with mental illness - including the inaction of services providers - can have an even more disabling effect than the original illness.

The powerful stigma of mental illness has meant that mobilisation of people and resources in this sector is decidedly weaker than in the physical disability sector or mental handicap sector. Even
within the disability family, mental illness is sometimes seen as the unwanted child. Thus stigma is not just a psychological reality; it is also a political and policy reality which has financial and service implications for people who are mentally ill. The delay in publishing the Mental Health Bill - to replace the outdated Mental Treatment Act of 1945 - is but one example of this; another is the failure of the 1998 Eastern Regional Health Authority Bill to provide for the appointment of a representative of the mental health sector to the new authority. Both examples call out for remedy while also confirming the observation made ten years age by the Inspector of Mental Hospitals that there is “a discriminatory attitude towards psychiatric services compared to the rest of medical social services. This is ubiquitous and basically springs from public attitudes which are anti-pathetic towards the mentally ill. It is reflected in central and local politics and there is an old saying that there are no votes in lunacy. There is therefore a danger that in a time of financial recession and reduction in expenditure on health services, psychiatric services may suffer” (Walsh, 1988, p.157)

Second, there has been massive State neglect of people who are mentally ill and homeless. We discuss later the scale of this problem but we know that no more than 10% of the population suffer mental illness and yet between a quarter and a half of the homeless population are known to have mental illness or to have an addiction to alcohol or drugs. Some of the mentally ill end up in prison rather than homeless. According to a recent survey of Mountjoy Prison, one quarter of all inmates there have been in either a psychiatric hospital or the Central Mental Hospital; a similar proportion have attempted suicide while two thirds have used heroin (O’Mahony, 1997, pp.112-113). This confirms the worries of one psychiatrist about the risk that “uncared for illness may end up very inappropriately in a prison setting. Illness abandoned is illness at risk” (Smith, 1991, p.117). From a disability perspective, we know that persons with mental illness make up a much higher proportion of those who are homeless or in prison compared to people with a physical disability or a mental handicap. Indeed it is doubtful if society would tolerate a situation where, for example, a large proportion of the homeless and prisoners were made of those with physical disabilities or mental handicap.
In focusing on people who are mentally ill and homeless we are dealing with a group who might be described as triply handicapped and stigmatised by virtue of (1) being disabled and therefore handicapped within society generally (2) being marginalised within the disability sector and (3) being homeless. In order to make some progress, we need to understand better the parameters of the problems facing this group. We begin to do this by considering the number of people affected by disability in general and then proceed to estimate the number of people who are mentally ill and homeless.

3 Size of Mentally Ill and Homeless Population

Almost every Irish family has had some first-hand experience of mental illness.” (Keane, 1991, p.1).

Table 1 summarises the estimated number of persons in each category of disability in Ireland, drawing upon data contained in the report of the Commission on the Status of People with Disabilities (1996, Appendix A, pp.284-289). It is worth emphasising that these are estimates since there are numerous difficulties in measuring disability due partly to definitional problems - given that psychiatric disability has both a medical as well as a social dimension - and due partly to uncertainty as to where to draw the cut-off point between minor and major disability. Bearing this in mind, Table 2 reveals that physical disability comprises about two thirds (65%) of all disabilities; mental handicap (about 15%) and mental illness (about 10%) comprise the remainder. The overall rate of disability in Ireland, according to the Commission on the Status of People with Disabilities, is about “10% of the population” (1996, p.7 and p.288). This compares with an EU average of 12%. Based on the Commission’s figures, it would appear that about 1% of the population in Ireland - equivalent to around 40,000 people - are estimated to have mental illness. This however seems to be inconsistent with earlier estimates which suggested that the prevalence of mental illness in Ireland may be of the order of 10% (Study Group on the Development of the Psychiatric Services, 1984, p.7 and p.153). As suggested above, these differences are due to differences in definition and methods of measurement.
If estimating the number of persons with a disability is difficult, then estimating the number of persons who are mentally ill and homeless is even more difficult, again because of the definitional and measurement problems involved. Homelessness is defined in the 1988 Housing Act as follows: “A person shall be regarded by a housing authority as being homeless for the purpose of this Act if (a) there is no accommodation available which, in the opinion of the authority, he, together with any other person who normally resides with him or who might reasonably be expected to reside with him, can occupy or remain in occupation of, or (b) he is living in a hospital, county home, night shelter or other such institution, and is so living because he has no accommodation of the kind referred to in paragraph (a)”.

In this paper, the term homeless refers to people who are sleeping rough or living in emergency accommodation such as hostels.

**Table 2 Estimated Number of Persons in each Category of Disability in Ireland, 1990s**

<table>
<thead>
<tr>
<th>Category of Disability</th>
<th>Estimated Range</th>
<th>Mid-Point in Range</th>
<th>Estimated N</th>
<th>Rate in Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Disability</td>
<td>50-80%</td>
<td>65%</td>
<td>234,000</td>
<td>6.5%</td>
</tr>
<tr>
<td>Mental Handicap</td>
<td>10-18%</td>
<td>15%</td>
<td>54,000</td>
<td>1.5%</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>5-15%</td>
<td>10%</td>
<td>36,000</td>
<td>1.0%</td>
</tr>
<tr>
<td>Margin of Error</td>
<td>-</td>
<td>10%</td>
<td>36,000</td>
<td>1.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-</td>
<td>100%</td>
<td>360,000</td>
<td>10%</td>
</tr>
</tbody>
</table>


In the course of the 1990s, estimates of the number of homeless persons in Ireland have varied from around 2,500 (Department of Environment and Local Government, 1993; 1996) to 5,000 (Daly, 1994; Irish Division of the Royal College of Psychiatrists, 1998, Appendix XIV) to 10,000 (MacRiocard, 1997). In Dublin alone, it has been estimated that the number of persons availing of homeless services is “in excess of 4,000 persons / families” (Dublin Corporation and Eastern Health Board, 1995, p.7). It is difficult to know where the truth lies in these estimates.
and all of them seem to reflect the highly politicised nature of statistics in this area. As one study has pointed out, “the political nature of the debate on homelessness tends to result in much higher estimates cited by advocates for the homeless than by authorities with responsibility for housing them. Advocates campaigning for funding to address the problem of homelessness appear to feel the need to report very large numbers of homeless persons. Local housing officials, on the other hand, may have an incentive to downplay the problem” (Fahey and Watson, 1995, p.100).

Statistics on the prevalence of mental illness among homeless persons are also subject to fluctuation. One study based on a survey of 153 homeless persons known to the Simon Community in 1991 estimated that 40% of them had a psychiatric problem (Collins and McKeown, 1992). A smaller Dublin-based study carried out in 1998 based on a survey of 50 people using the Fáiltú drop-in centre found “a 40% prevalence of psychiatric illness” (Cleary and Prizeman, 1999, p.35). In both of these studies, about 90% of the respondents were men. A more comprehensive study, based on a survey of 502 homeless people living in emergency accommodation in Dublin in March 1997 found that nearly four in ten (39%) had chronic psychiatric problems such as depression or anxiety; these respondents had been told this by a doctor (Holohan, 1997, p.14; see also Eastern Health Board, 1998, p.73). A lower rate of mental illness was found during an audit of all services for homeless people in the Eastern Health Board region in 1997 and may be accounted for by the fact that the audit covered transitional as well as emergency housing and included the counties of Kildare and Wicklow as well as Dublin (Haase and McKeown, 1999). The audit found that that there were about 1,500 people using homeless services each day of that year comprising 58% men and 42% women; of these, about a quarter (27%) - divided equally between men and women - were deemed by the service providers to have mental health problems; an additional four out of ten (39%) were deemed to have an alcohol or drug dependence problem (Ibid, p.6). From these various studies, it is probably safe to say that at least one third of all homeless people in Ireland are probably mentally ill. If one assumes that the number of homeless persons in Ireland is around 5,000, this yields a rough estimate of about 1,500 people who are mentally ill and homeless; correspondingly, the number of homeless who are alcohol or drug dependent is probably around 2,000.
Ireland is not unique in having a high proportion of homeless people who are mentally ill. Similar patterns are to be found in Northern Ireland (Gilloway and Donnelly, 1996), Britain (Craig, et al, 1995; Leff, 1993) and the rest of Europe (Bhugra, 1996). Data collected by the European Observatory on Homelessness report rates of mental illness at 30-50% in England and Wales, 15% in Belgium and 53% in Portugal (see Harvey, 1999; Cleary and Prizeman, 1999). It is not clear how much the deinstitutionalisation of psychiatric services - a trend found throughout Europe - has contributed to the high rates of mental illness among homeless people but there are few who would deny that it has played a role. In Ireland, as elsewhere, community care services for people who are mentally ill tend to be poor and it is relatively easy for people with mental illness to become homeless. At the same time, services also tend to be uneven in different parts of the country: for example a study of 162 persons discharged from long-stay psychiatric care in Ennis, County Clare between 1987 and 1994 found that none ended up homeless (Finnerty, Guckian and Lough, 1999) which is very different to the experiences reported by the Simon Community in Ireland’s larger urban centres (Simon Community, 1992). It is also important to recognise that homelessness itself can both induce and exacerbate mental illness.

4 **A Disability versus a Homeless Perspective**

“Mental illness is as genuine and real as, and perhaps more damaging than, physical illness. Our health strategy documents have emphasised equity as a cardinal principle of health care delivery. This means equal and just treatment for the mentally ill with the physically ill and between the social classes.”

(Walsh, 1997, p.141)

Having estimated the approximate number of persons who are mentally ill and homeless in Ireland, it is now necessary to clarify the perspective to be adopted in analysing the service needs of this group. This is a crucial issue for policy, planning and service delivery but one that has been largely ignored in most discussions of the topic. At its simplest, it is necessary to decide if people who are mentally ill and homeless are to be seen as: (1) people who mentally ill but happen to be homeless or (2) people who are homeless but happen to be mentally ill.
Answering these questions involves more than simply choosing one label over another. It involves choosing the perspective to be taken in assessing the needs of this group of people and the service implications which follow from this. From a service point of view, designating a person as primarily mentally ill is fundamentally different from designating a person as primarily homeless. If one adopts a disability perspective then this points towards a service response which gives centre-place to addressing mental illness and maximising the person’s capacity to participate fully in society; clearly, housing is only one aspect of the service response. By contrast, if one adopts a homeless perspective this points towards a service response which gives centre-place to housing requirements; in this perspective, mental illness is only one of many factors which may need to be taken into account in helping people settle into appropriate accommodation.

In reality, both mental health needs and housing needs are not clear-cut categories. Mental illness is a continuum from those who have a minor illness to those who have a major illness. Similarly, housing need varies from those who require little or no ancillary support services to those who require high support services. This inevitably creates ambiguities. Nevertheless, on grounds of principle and practice, we would argue that people who are mentally ill and homeless should, for the purpose of service provision, have their mental illness treated as their primary condition and their homelessness treated as their secondary condition.

The principle which informs this argument is that persons with mental illness - like persons with a physical disability and mental handicap - have a disability which creates an impairment in all aspects of their lives. In other words, it is the disability - and particularly society’s response to that disability - which is the primary influence on their lives. However a disability perspective does not imply a narrow health perspective. As the Commission on the Status of People with Disabilities has pointed out, we need to move from “a medical and caring model of services towards one based on meeting the social needs of people with disabilities” (1996, p.84). At the same time, the disability perspective does determine the overall service orientation to be adopted in meeting the needs of people who are mentally ill and homeless. In short, the disability
perspective represents a way of including this group of people in a service framework that can meet their needs in a holistic manner.

The practice which informs this argument is that designating a person as homeless - who also happens to be mentally ill - creates virtually no service response for that person, particularly from the statutory sector. In the statutory sector, the response to homelessness falls within the remit of the Department of the Environment and Local Government and their local agents, the local authorities. However it is well known that local authorities prioritise the housing needs of families and elderly to the virtual exclusion of single individuals, particularly those who are mentally ill and homeless. This is primarily an issue of resources but it is also an issue of housing management since local authorities typically see people who are mentally ill and homeless as potentially problem tenants. It is also an issue of competence since local authorities have no competence in dealing with the complex needs of the mentally ill. As one study has shown: “the traditional role of the local authorities is that they have not been in a position to provide the support needed by those homeless households with psychiatric or addiction problems. In addition, concern for the welfare of other tenants probably leads to reluctance to house potentially ‘problem’ households in existing or new housing schemes. Part of the problem here lies in the difficulty in distinguishing those homeless households who do need additional support or services from those who could manage quite well once they are housed” (Fahey and Watson, 1995, p.118).

Having decided on the appropriate service orientation to the needs of people who are mentally ill and homeless, we now look at some of the acknowledged defects of the present system from their point of view.

5 **Acknowledged Defects in the Present System**

“There is very, very real concern coming from New York, London, Melbourne ... about mental illness on the streets. I am not saying we have reached that stage in Dublin, but I do say that we could arrive there.” (Smith, 1991, p.116)
At its simplest, the problems facing people who are mentally ill and homeless are twofold. First, they tend to go without treatment or rehabilitation services for their mental illness. Second, they tend to live in accommodation - such as emergency hostels or sleeping rough - which is not appropriate to their needs and may even exacerbate their illness. Let us explore each in turn.

5.1 Inadequate Treatment Services

“Community care does not mean putting people onto the streets”
(Simon Community Newsletter, 1992, p.3).

There are four main reasons why people who are mentally ill and homeless do not receive psychiatric services. First - and this applies particularly in the Eastern Health Board region - a person’s access to psychiatric services is based on where they come from rather than where they are now living. Since many homeless people gravitate to city centres such as Dublin - where most of the hostels are concentrated - many of those who are mentally ill would have to go back to where they came from in order to access a psychiatric service. This is clearly unrealistic but is nevertheless a very effective way of excluding mentally ill homeless people from services, as indeed the Eastern Health Board have acknowledged (1996). The problem is due to the “sectorisation” of psychiatric services into catchment areas which was first introduced in 1984 as a result of the report, Psychiatric Services: Planning for the Future (Study Group on the Development of the Psychiatric Services, 1984). It is still seen as an appropriate model for service delivery for the settled population but is wholly appropriate to the needs of homeless people. It leaves many homeless people without a service due to the unwillingness or inability of service providers to resolve their catchment area differences. The problem, as seen by one professional grouping of service providers, is summarised in a report prepared by the Irish Division of the Royal College of Psychiatrists as follows: “A major source of discontent in the Eastern region is the problem posed by homeless individuals who repeatedly cross or are pushed across catchment area boundaries to St. Brendan’s Hospital, or to direct-access hostels and night shelters in this hospital’s catchment area, leaving the services there over-stretched and under-resourced” (1998, Appendix XIII). The practical consequence of this is that most of those who
are mentally ill and living in emergency accommodation in the centre of Dublin cannot get a psychiatric service because they do not come from there originally.

A second reason is that many people who are mentally ill and homeless do not present for services. The community psychiatric system, as presently organised, essentially caters for compliant clients; non-compliant clients are largely ignored. Compliant clients are typically those who fit into the service, do not present behaviour problems and conform to the demands of service staff; non-compliant clients, by definition, are those who do not fit easily into the service, they often have behaviour problems and rarely conform to what staff suggest. Although rarely spoken of in official reports and studies, the distinction between compliant and non-compliant clients is crucial in determining which category of person with mental illness receives a service and which category ends up homeless. Moreover it is a distinction which will continue to be hugely important as psychiatric services become more community-based and less hospital-based. Beyond the compliant / non-compliant distinction, there many people on the homeless circuit who have become mentally ill as a result of their homelessness. Some of these are drug and alcohol dependent while others may have fallen through the system following discharge from residential care and have no experience of living independently as an adult. These people will never receive a service unless the psychiatric services are prepared to do out-reach work to find them and help them.

The third reason - and this is perhaps the most important one - is that often there is no service available. Some of the key components in a comprehensive community-based psychiatric service, according to the report, The Psychiatric Services: Planning for the Future (1984, Chapter Two) include: day care, mental health consultations, crisis intervention, specialist out-patient clinics, rehabilitation and training services as well as residential facilities such as houses, hostels and boarding out. These services should be provided by the a psychiatric team (to comprise a psychiatrist, psychiatric nurses, clinical psychologists, social workers, occupational therapists and a health administrator) and should liaise with primary health care workers such as GPs and community care workers (1984). In the main, these services are not available to people who are mentally ill and homeless.
The fourth reason is that there is often no follow-up of patients after discharge from in-patient care. The ideal presented in the report, The Psychiatric Services: Planning for the Future (1984, Chapter Two, p.9) states that: “There should be, as far as practicable, continuity of professional responsibility running through the different treatment services provided by the psychiatric team. For example, a patient who is discharged from hospital may need to attend at an out-patient clinic or day facility for some time but he or she should remain under the general care and supervision of the medical and nursing staff who provided treatment in hospital”. The reality as experienced by the Simon Community is that there is no follow-up of some patients by the psychiatric services: “If the person fails to turn up at the clinic, no follow-up action is taken” (Simon Community, 1992, p.38). In order to address this problem, the Guidelines on Good Practices and Quality Assurance in Mental Health Services (1998, p.12) specify that: “A mechanism should be in place to review patients who have been lost to follow up and everything possible done to find out what has happened to the patient and to take appropriate action”.

5.2 Inappropriate Accommodation

“Many long-term homeless mentally ill are forced to resort to emergency social accommodation for their permanent abode. ... Remaining homeless is a decision mediated not by ‘personal choices’ but by a lack of statutory responses to their need.”

(Fernandez, 1996, p.215)

There are three main reasons why mentally ill people live in inappropriate accommodation. The first is that health boards do not seem to see it as part of their remit to provide accommodation to mentally ill people who are homeless. This is a little ironic in view of their traditional obsession for housing people in psychiatric institutions. It is surely taking de-institutionalisation to an unacceptable extreme to imply that people who are mentally ill can be cared for even if they have not been properly housed first. Health boards provide some supported accommodation for people who are mentally ill in the community - particularly for its compliant clients - but they seem to apply a cut-off point for those who are homeless, perhaps because they are non-compliant? None of the blueprints for the care of mentally ill people - such as The Psychiatric
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Second, mentally ill people become homeless because local authorities provide housing almost exclusively for families and elderly people. Their limited resources and expertise has meant that they do not house single people, especially if they need any form of additional support. Local authorities, not unlike aloof private landlords, have tended to adopt a minimalist approach to housing provision - involving the basic house or flat - with few extras apart from rent collection, cleaning and maintenance. This approach works well in many housing estates but, where families and communities have serious problems, it is wholly inappropriate and has resulted in serious mismanagement of estates (see Fahey, 1998). Most people who are mentally ill and homeless, perhaps because they know all this, do not apply to local authorities for housing because they see no point in it.

The third reason concerns the absence of organisations in the voluntary sector who have developed a specialisation in the care and accommodation of people who are mentally ill. In Ireland, about 90% of services to homeless people are provided by the voluntary sector, compared to about 66% in other European countries (Harvey, 1999, p.9). The audit of services to homeless people in the Eastern Health Board region in 1997 identified 71 different services (accommodation, food, drop-in, medical and income support) but only one service in the voluntary sector - the Salvation Army’s Granby Centre in the north inner city of Dublin - specialises in the care of mentally ill homeless; three other accommodation services for mentally ill homeless are run by the Eastern Health Board (Haase and McKeown, 1999). From a disability perspective, the lack of specialisation by voluntary organisations in providing accommodation for people who are mentally ill and homeless is remarkable when seen in the context of the involvement of this sector in housing people with physical disability and mental handicap. In some ways, it is not unlike the contrast found within the homeless sector where voluntary organisations have become involved in the development of housing provision for a variety of vulnerable groups but none have become involved in the development of halting sites for
Travellers where the need is just as great (see McKeown and McGrath, 1996). Perhaps Travelling People and people with mental illness have something in common?

The lack of appropriate accommodation for people who are mentally ill and homeless is increasingly seen as a given and unalterable fact of life, to such an extent that patients are routinely discharged from psychiatric hospitals to emergency shelters for homeless people. The Simon Community, which runs four shelters for homeless people in Ireland, has documented its experience of this (Simon Community, 1992, p.36). Its experience is not unique however since discharges of homeless people from psychiatric hospitals are also made to other emergency hostels. The core difficulty with this procedure is that emergency hostels are not suitable for people who are mentally ill as the Simon Community has pointed out: “Emergency hostels for people who are homeless are simply not equipped to cater for the needs of people who have mental health problems; often they are understaffed, under pressure and cannot offer the level of care and support needed by people who are mentally ill. Emergency hostels and shelters do not provide ‘therapeutic communities’ and with their large transitory populations, they are simply unsuitable for people with psychiatric problems. Yet such hostels run by voluntary organisations appear to be a major accommodation referral option for the psychiatric services” (Simon Community, 1992, p.35).

In was in recognition of the problems being experienced by mentally ill homeless people that the Minister and Department of Health issued a circular in 1985 (Circular Number 6/85), and again in 1987 (Circular Number 5/87), specifying arrangements for the discharge of homeless persons from hospitals. The main purpose of these discharge procedures was to record information on the patient and send a letter of notification to the GP and the Employment Exchange. However this procedure did nothing to stop the practice of mentally ill people being discharged into emergency hostels for homeless people as the documented experience of the Simon Community has shown (1992, p.36). Indeed the more recently published Guidelines on Good Practices and Quality Assurance in Mental Health Services (Department of Health and Children, 1998a) makes no reference to the accommodation circumstances of persons being discharged from hospital and the problem seems set to continue.
6 Strategy for the Future

“Every person who needs it should have access to a comprehensive psychiatric service. A comprehensive service is one which caters for the varying needs of people with psychiatric illness.”  
(The Psychiatric Services: Planning for the Future, 1984, p.xi)

“The objectives of the mental health services are: to promote mental health; to restore the mentally ill to as independent and normal a life as possible.”  
(Department of Health, 1994, p.68)

In many respects, the way forward has already been well documented; it is only a matter of looking back to read what has been written in the many government-sponsored reports and been adopted as public policy. To begin with, it is essential to acknowledge that the present treatment of people who are mentally ill and homeless is fundamentally at odds with the three core principles that underlie all health care in Ireland: equity, quality of service and accountability (Shaping a Healthier Future: A Strategy for Effective Healthcare in the 1990s 1994, p.10). People who are mentally ill and homeless receive no “health gain” or “social gain” from the present system.

6.1 Strategic Vision

It is also essential to acknowledge that the present system does not work in the best interests of people who are mentally ill and homeless. As such it is not achieving the twin objectives of the mental health services which are: (1) to promote mental health and (2) to restore the mentally ill to as independent and normal a life as possible (Shaping a Healthier Future: A Strategy for Effective Healthcare in the 1990s 1994, p.68).

The present system of services for people who are mentally ill and homeless needs to change. It needs to become more flexible, to be free from catchment area considerations, and to be better resourced in terms of community-based supported accommodation, day centres for treatment and rehabilitation, facilities for training and sheltered work, as well as an adequate supply of in-
mentally ill and homeless in Ireland: facing the reality, finding the solutions

patient facilities. These services need an input from all the key agencies involved - both statutory and voluntary - and be delivered by a multi-disciplinary, community-based team. This team should include nurses, personal assistants, psychiatrists, psychologists and social workers. The team needs to be led by a person who understands the needs of people who are mentally ill and homeless and is skilled in working in a multi-disciplinary manner. There should be no presumption that leadership of this multi-disciplinary team will fall by automatic tradition to a consultant psychiatrist; psychiatrists themselves recognise that this presumption is no longer sustainable as mental illness is increasingly seen as having social as well as medical dimensions (see for example Smith, 1991, pp.118-119; Walsh, 1988, p.3).

It is worth emphasising here that the service needs of people who are mentally ill and homeless are not very different from other categories of disability. This is clear from reading the report of the Review Group on Health and Personal Social Services for People with Physical and Sensory Disabilities (1996) - Towards an Independent Future - many of whose recommendations apply equally to people who are mentally ill and homeless. According to the Chairperson of the Review Group: “The main thrust of our Report is the development of services to enable people with a physical or sensory disability to live as independently as possible in the community. We recommend that priority be given to the provision of more day care, respite care, nursing and therapy services, personal assistants and residential accommodation to achieve this goal. The Review Group attaches great importance to integrating services for people with disabilities with mainstream services wherever possible” (1996, Chairperson’s Foreword).

6.2 Centralised rather than Catchment Area Services

It is encouraging to note that the Eastern Health Board (1996) has acknowledged the weaknesses of the present catchment area system for meeting the needs of mentally ill homeless people. The recommendation of its Committee on Services for Homeless People with Mental Health Problems - if carefully implemented and generously resourced - could do much to improve the present situation: “The Committee consider that the in-patient treatment needs of the homeless mentally ill should ideally be provided by a centralised service, rather than devolved to catchment area services, to ensure that there is no fragmentation of service delivery” (Ibid, p.9).
6.3 Mental Health and Housing Task Force

Given that most of those who are mentally ill and homeless tend to live in Ireland’s major urban areas - particularly Dublin, Cork, Galway, though not confined to these areas - a team should be set up in each of these areas. This team might be called the a Mental Health and Housing Task Force and would be similar in function and composition to the Health Board Co-ordinating Committees which have been set up for physical and sensory disability services. The first task of this team should be to formulate a plan of action, similar to the Community Action Plan envisaged by the Commission on the Status of People with Disabilities calls a (1996, p.87). This plan would be drawn up by a local group comprising health boards, local authorities, relevant government departments, voluntary sector bodies and user groups, as well as other organisations who may have a role to play. In a manner similar to the Integrated Services Project (1998-2000) for disadvantaged areas, the Community Action Plan would set goals and targets and would require a commitment of resources by the organisations involved.

6.4 Statement of Needs

Implementation of the plan would require that the needs of each mentally ill homeless person are fully assessed and addressed. Again, the Commission on the Status of People with Disabilities, provides a useful blueprint of how this might be done through the concept of a “Statement of Needs” (1996, p.97). This is similar to the idea of a customised care plan for each individual and would identify the full spectrum of services required by that person from a range of agencies as well as their financial needs.

In the area of housing the Statement of Needs would require a distinction to be made between those who require “residential care” involving constant supervision and support and those who require “residential accommodation” involving a much lower level of care. The range of accommodation options has also been spelt out by the Commission on the Status of People with Disabilities as follows: “Housing options for people with disabilities should include a mix of different arrangements. Single houses, houses capable of accommodating four or five people; bungalow units clustered together; a groups of three or four town houses with a communal
garden - all of these options must be included. They should be situated close to amenities and retail outlets in order to maximise independence and they must have the appropriate support staff” (1996, p.44).

6.5 Build Services Around the Person

A crucial feature of this initiative must involve building the service around the person and doing whatever is needed to facilitate their treatment and rehabilitation. This will involve outreach and street work as well as constant follow-up. As one group of experts have pointed out: “This group needs an assertive, outreach approach which demands a specialised team approach” (Irish Division of the Royal College of Psychiatrists, 1998, p.26). The solution will also involve the construction or adaptation of housing within city centre areas and the creation of day centres and sheltered workshops. The service will help the person to settle in a place which they can call home and integrate them in a network of social contacts.

6.6 Key Role for Voluntary Sector

Another feature of this initiative must be a key role for the voluntary sector in view of their experience and expertise in this area. At the same time, the capacity of organisations in the voluntary sector to deal with the needs of mentally ill homeless people will need to be developed to a much greater degree than is evident at present. It will be essential for voluntary organisations to specialise in this type of work rather than act as generalists for all categories of homeless persons, as at present. Otherwise there is a danger of the present situation continuing which is clearly not in the best interests of people who are mentally ill and homeless. This will require organisational development and training but it will also require increased funding. In particular, it will mean reform of the Capital Assistance and Rental Subsidies Schemes so that they cover the full costs involved in providing supported housing for people who are mentally ill and homeless. This reform is already urgent for other groups of homeless people and would be the most effective way of ensuring a speedy increase in the supply of appropriate housing for mentally ill homeless people.
6.7 Service as a Right

The strategy outlined in this section should not be regarded as optional. It should be seen as a right for people who are mentally ill and homeless. Moreover, in the context of legislation to replace the 1945 Mental Treatment Act, there are strong arguments in favour of enshrining this right to service in legislation. One legal expert has argued that this right would be based on “the principle of reciprocity” since the state’s right to detain a person for psychiatric treatment - a right unique to mentally ill persons - should be counterbalanced by the state’s obligation to provide appropriate treatment to all persons deemed mentally ill (Keys, 1998). Conversely, a social policy expert has argued that legislative protection for people who are involuntarily admitted to psychiatric hospital - estimated to be around 11% of all admissions - should be matched by a corresponding protection for “those who acknowledge their need for treatment - the remaining 89 per cent of admissions” (Prior, 1997, p.11)

7 Conclusion

“The particular needs of people with mental health problems and psychiatric illness who find themselves homeless are not being effectively met.”

(Lennon, 1998, p.16)

This paper has highlighted the plight of a hidden and neglected group of mentally ill homeless people. The paper argues that this group is triply handicapped and stigmatised by virtue of (1) being disabled and therefore handicapped within society generally (2) being marginalised within the disability sector and (3) being homeless. It is estimated that there are about 1,500 people who are mentally ill and homeless in Ireland; although their needs are great, this is a relatively small problem in a national context.

A central argument of the paper is that people who are mentally ill and homeless should be regarded first and foremost as people with a disability since it is their mental illness - and particularly society’s response to that disability - which is the primary influence on their lives.
The danger of labelling this group as homeless is that people who are single, homeless and mentally ill have no effective claim to a service within our present system of services.

At its simplest, people who are mentally ill and homeless face two problems: (1) they do not receive treatment or rehabilitation services for their mental illness and (2) they live in accommodation such as emergency hostels or sleeping rough which is not appropriate to their needs and may even exacerbate their illness. Any strategy to address their needs must tackle these two problems.

In proposing a strategy for meeting the needs of people who are mentally ill and homeless, it needs to be acknowledged that the present system does not work and is fundamentally at odds with equity, quality of service and accountability which are at the core of health care policy in Ireland. Moreover the present system is also failing to achieve the twin objectives which have been set the mental health services to promote mental health and to restore the mentally ill to as independent and normal a life as possible.

Our argument is that services for this group of people needs to become more flexible, to be free from catchment area considerations, and to be better resourced in terms of community-based facilities such as supported accommodation, day centres for treatment and rehabilitation, training and sheltered work spaces as well as an adequate supply of in-patient facilities. These services need an input from all the key agencies involved - both statutory and voluntary - and be delivered by a multi-disciplinary, community-based team. Given that most of those who are mentally ill and homeless tend to live in Ireland’s major urban areas, a team which is both inter-agency and inter-disciplinary needs to be put together to draw up and implement a plan of action. The voluntary sector must have a crucial role in this process but they too must face the challenges of greater specialisation which this work requires.

Our conclusion brings us back to where we began. We need to acknowledge that the stigma of mental illness is carried deep within each of us. Once we acknowledge it we can start to remove it. There can be little doubt that this stigma is part of the reason why mentally ill homeless
people are such a hidden, almost untouchable group within our society. Our hope that this paper will help to dismantle the stigma and start a process which will bring this group of people into the disability family and into the larger family of Irish society generally.
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