REPORT OF THE COMMITTEE

ON SERVICES FOR HOMELESS PEOPLE

WITH MENTAL HEALTH PROBLEMS

MAY, 1997.

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INTRODUCTION

The Committee was established in September 1995, to formulate draft policy for service delivery to "homeless/non-district" persons with mental health problems, who become detached from their local catchment area services and drift thereafter between service areas. The aim was to improve the overall health status of this group and to provide for better continuity of care.

The Committee in its deliberations was also requested to review the issue of specialised central services for the homeless mentally ill. In this context, the Committee was requested to examine (a) whether the specialist psychiatric programme at St. Brendan's Hospital should deal with all the service needs of the homeless mentally ill or (b) whether it would be more appropriate for that programme, to operate as a "catch and filtering" service, providing assessment and intervention in a specialised day setting, with links to each catchment area for in-patient needs and, in the longer term, (c) the transfer-back of individuals to their catchment area service.

TERMS OF REFERENCE

The Committee adopted the following as it's terms of reference:

> *To establish policies and procedures for the delivery of a comprehensive psychiatric service to adult homeless/non-district persons with mental health problems.*

The Committee reviewed current service provision, policies and practices in relation to homeless/non-district persons operating:

(a) in the specialist psychiatric programme based at St. Brendan's Hospital;
(b) at catchment area level and

The Committee also reviewed a number of specific cases, which highlighted the problems and difficulties associated with the provision of a comprehensive service to this particular client group.

In formulating policy for service provision, the Committee was concerned that overall, services should be delivered in a flexible manner, responding in as far as is practical,

to individual need. The Committee was also concerned that freedom of choice, should not be taken from homeless/non-district persons, in trying to keep these individuals attached to services. It was recognised that this particular client-group have their own culture; and service provision should ideally reflect this.

Whilst freedom to move across service-areas creates problems for service providers who are understandably concerned about 'continuity-of-care', it was felt that restriction of this freedom could result in some individuals opting out of service provision.

The Committee was also concerned that resource allocations for services, [catchment area/specialist programme], should acknowledge the fact that areas with higher concentrations of homeless/non-district persons, need to be resourced accordingly.

Accommodation

In assessing current service provision, the Committee was aware of the limited availability of accommodation for the homeless in general and for the homeless mentally ill in particular. The emergency and long-term accommodation needs of homeless females were felt to be especially acute and this issue needs to be addressed as a matter of urgency.

The committee welcomes the developments currently taking place in relation to housing and services for the homeless and in particular the initiative taken by Minister Liz McManus which has resulted in the establishment of formal working arrangements between Dublin Corporation and the Health Board in provision of services and the strengthening of the role of local authorities in respect of accommodation provision. A number of housing development projects for homeless persons are currently being undertaken by the voluntary, non-profit housing sector under the scheme of capital assistance for the provision of housing accommodation, provided for in section 6 of the Housing (Miscellaneous Provisions) Act 1992 and section 15 of "The Housing Act, 1988" (see Appendix A).

The joint appointment, in September 1996, of a co-ordinator of services for homeless persons, between Dublin Corporation and the Eastern Health Board is a very welcome development as is the appointment of a fourth Programme Manager within the EHB whose brief includes responsibility for Homeless Services.

The Committee consider that these developments will facilitate greater co-ordination of services for the homeless between the statutory and voluntary sector and bring about an overall improvement in service.

Information Needs

The Committee found that there was an information deficit with respect to the number and needs of the homeless/non-district mentally ill. This was felt to create difficulties, not only in assessing the nature and extent of current problems but in making projections regarding service delivery. This is another issue which needs to be addressed as a matter of urgency.

The proposal to develop a register of homeless/non-district mentally ill under the auspices of the specialist psychiatric programme at St. Brendan's Hospital, is welcomed as a first step in addressing the information deficit. The Committee recommends that the management of each catchment area establish a similar register of non-district persons living in its area and that those registers be cross-referenced throughout the Board's area.

SECTION I

DEFINITION OF HOMELESS/NON-DISTRICT CLIENT GROUP

Current operational policies within the Eastern Health Board vary having regard to client status i.e. homeless or non-district. The term "non-district" has in the past been applied to persons who have no lasting attachment to any given catchment area service. These individuals are known to drift between and across catchment area services in their attempt to secure their physical, mental and social well-being.

For the purpose of this report, the Committee has decided to retain the term "non-district" as it is generally understood by service providers in the Eastern Health Board's psychiatric services. The Committee found that in practice, there was neither uniform definition nor acceptance of policy for "homeless/non-district" client groups throughout the catchment area psychiatric services; other than the operation of a "three month criterion" in respect of access to services: (a) at catchment area level and (b) in the specialist psychiatric programme based at St. Brendan's Hospital. This "three month criterion" has generally operated as follows:

a) if a person is known to be homeless (i) for a period of three months or longer and is known to reside in conventional accommodation facilities for the homeless*, or (ii) is known to be sleeping rough for any length of time prior to referral, he/she is referred to the specialist psychiatric programme operated at St. Brendan's Hospital.

The specialist programme does not however accept referrals who have been placed in conventional accommodation facilities for the homeless* by the catchment area services, or substance abusers whose acute treatment needs include detoxification in dedicated facilities.

b) When a person who has resided in a catchment area is known to be homeless for a period of less than three months, it is the responsibility of the catchment area he/she is known to have resided in, to provide the psychiatric intervention/service required by that person.

c) Individuals who drift into catchment areas and reside therein either intermittently or continuously for a period of less than three months, are referred to their previous catchment area service, unless there has been a formal hand-over of care, coinciding with their move to their new area of domicile.

** These facilities include: direct-access hostels, night-shelters, refuges, flats/bedsitters, other sheltered accommodation and Bed and Breakfast (B&B) accommodation.*

Since 1st July, 1995 the Homeless Programme at St. Brendan's has taken on responsibility for female homeless persons. Prior to this development, homeless females were dealt with by the general psychiatric services at St. Brendan's Hospital.

The Committee found variation in the way the "three month criterion" operated at catchment area level and also in terms of the client groups to which it applied, with subsequent impact on the comprehensiveness of service delivery resulting in persons falling between services.

Whilst in the past there were some disadvantages in using the three-month criteria, the Committee consider it to be a reasonable and practical criteria if there is universal agreement on the client groups it should apply to and it is implemented in a uniform manner throughout catchment areas. This criteria provides a reasonable time frame for existing services to hand over patient care and for the new service to take on responsibility for that patient. It can facilitate the transfer of patient care from one service to another in a seamless fashion. It was the Committee's view that the variation in interpretation of the three-month criteria was in part contributory to the difficulty of persons "falling" between services.

Classification - Homeless/Non-Distrct Client Groups

For the purpose of its deliberations, the Committee identified a number of client groups as coming within the overall definition of homeless/non-district (See Appendix B).

The Committee agree that the first two groups identified should continue to be the responsibility of the Specialist Homeless Programme and the Committee's deliberations in relation to this service are outlined in Section II of this report.

With regard to persons placed in conventional accommodation for the homeless by catchment area services, it is the Committee's view that transfer of responsibility for such persons, if necessary, to the Homeless Programme should only be by formal agreement between both services.

The Committee consider that the needs of individuals in the remaining groups identified are those mainly in the non-district category and need to be specifically addressed, because of the lack of clear and standardised policy throughout the Eastern Health Board region. Section III of this Report deals with the Committee's deliberations in this regard.

SECTION II

SPECIALIST SERVICES FOR THE HOMELESS MENTALLY ILL

The Committee as part of its brief, was asked to review the issue of specialised central services for the homeless mentally ill and in particular, to consider whether the psychiatric in-patient needs of the homeless mentally ill could be provided in acute units at catchment area level or whether a specialist in-patient facility was required.

The Committee reviewed the service being provided by the specialist homeless programme based at St. Brendan's Hospital. This programme, which has been in operation since 1979, caters for the in-patient needs of homeless males and has a day care programme which in a limited way, caters for the physical, mental and social needs of this group. Since 1st July, 1995 this service has been extended to accept referrals of homeless females, with the exception of those who have been placed in conventional accommodation facilities for the homeless* by the catchment area services.

Currently this programme has three hospital based and three community based components. The former include (a) an Admission Unit with 16 beds, most of which are occupied by new-long-stay-patients awaiting placement elsewhere, (b) a Day Centre initially designed to cater for 36 attenders, which now has over 90 attenders and (c) an Assessment Unit with 8 beds for the acute treatment needs of homeless referrals.

The Assessment Unit caters for the assessment and residential needs of the homeless programme including a 24 hour intervention service and respite service. It serves as a point of referral for homeless and non-district individuals who present with a plethora of medical, psychiatric and social needs, with approximately 3,000 contacts annually.

The community-based component comprises (i) a high-support hostel with 24 hour nursing cover for 10 residents and 8 day attenders, (ii) a rehabilitation programme which caters for 22 residents and 10 day attenders and (iii) a supervised group home for 5 residents.

* Refer to footnote on page 8.

This programme is currently undergoing considerable development to enable the homeless to access health, housing and welfare services, commensurate with their needs and entitlements. It is intended to (a) transfer the Day Centre located at St. Brendan's Hospital together with the services provided therein, to a city-centre location within walking distance of most direct access hostels, (b) develop the following services from this Day Centre: outreach, rehabilitation/resettlement, social welfare, and a range of primary-care services e.g. general practitioner, public-health nursing and chiropody and to (c) provide clinical outreach services through the assignment of care co-ordinators/outreach staff working from this dedicated Day Centre.

It is the view of the Committee that this developing specialist psychiatric service for the homeless is the most appropriate to deal with the service needs overall - acute in-patient, day care, rehabilitation and residential - of the homeless mentally ill, male and female, and therefore should be resourced accordingly.

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. The Committee accept that this will present difficulties for the specialist psychiatric programme, given the known and projected demand for acute in-patient beds for this group, the increasing demand for beds for females and the lack of accommodation to facilitate the long-term care and/or resettlement of suitable patients.

The Committee recognises that resources to the Homeless Programme will be finite and therefore in order to provide a comprehensive service, a corporate approach must be adopted facilitating effective interface between the specialist service and catchment area services. The Committee's deliberations in this regard are discussed further in Section IV of this report.

SECTION III

PROVISION OF PSYCHIATRIC SERVICES FOR NON-DISTRICT PERSONS

The Committee feel that uniform policies and procedures are required to cater for the many sub-groups subsumed under the title "non-district" [Appendix A; (iii) - (xi)] to:-

(a) ensure that they have equal access to a comprehensive range of psychiatric services appropriate to their need

and to

(b) prevent, in so far as is practical, individuals from becoming detached from local services or indeed services overall.

The Committee, having reviewed current service provision to these client groups, recommend the following approaches which are considered to be the most practical in terms of service delivery on a catchment area basis.

Homeless persons living in conventional accommodation for the homeless for a period of less than three months.

The policy currently operating in respect of the above group is such that the catchment area in which the person was living prior to taking up residence in such accommodation, would retain responsibility for the client until they had been established for a period of three months and then refer the client to the specialist service at St. Brendan's Hospital as appropriate. This policy in general has operated uniformly in respect of clients who had a previous service contact within their catchment area. Difficulties have arisen when such persons have had no previous contact with their catchment area service prior to moving into accommodation for the homeless, or where a long period of time has elapsed since the last contact with the service.

The Committee recommends that in the case of persons who have had a previous contact with their catchment area service, the policy currently in operation should continue.

In the event of a person becoming a long-term resident in accommodation for the homeless, there should be a formal handover of care, by agreement, to the specialist homeless programme. However until such time as there has been formal acceptance of a client by the homeless programme, the client should remain the responsibility of the catchment area service. Some clients have been referred to the homeless programme in the past by catchment area services in an informal manner and without agreement, thus creating difficulties and unsatisfactory service provision for the individual client.

The Committee further recommends that prior to a client becoming established in homeless services, every effort should be made by the catchment area service to re-establish the person within their own catchment area.

With regard to clients who have had no previous contact with their catchment area service, the Committee recommends that such clients should initially be catered for by the specialist homeless programme who will work closely with the catchment area service with the aim of re-establishing the person within their own catchment area. Recomendations in respect of the interface between the specialist service and catchment area services are discussed in Section IV.

Persons sleeping rough, drifting through various catchment areas, presenting at casualty departments, moving outside Eastern Health Board region and outside the Country from time to time.

The Committee was requested to review this group specifically because of their transient nature and their high tendency to become detached from service. The Committee consider this group to be the most difficult and challenging in terms of service provision overall, particularly in the context of keeping such persons continually attached to services.

The Committee recommends that in the case of this group, in the first instance, the service where the client presents should provide immediate assessment and appropriate psychiatric intervention until the last known catchment area service has been identified. Once the last known catchment area service has been identified arrangements should be made to transfer as appropriate to that catchment area service. Every effort should be made to provide services at local level and keep the client attached to their particular catchment/sector team. Where this is not feasible,

arrangements should be made to formally transfer the person, by agreement, to the most appropriate service.

Given the characteristics of this particular client group and their propensity to drift to centre-city services, the Committee consider that the specialist homeless programme would tend to be the best option in terms of keeping this group attached to services. However, again the Committee recommend that the transfer of clients between local catchment area services should and the specialist programme be carried out in a planned way and by agreement.

Persons moving from child and adolescent services to adult psychiatric services.

Where children have come of age in the child psychiatric service and require residential placement within adult services, it should be the responsibility of the parent catchment area to provide such placement. A mechanism exists at present between the Child and Adult psychiatric services whereby the transition from child to adult services can take place in a planned and agreed manner.

However, there is a further group of young adolescents who are being cared for in hostel accommodation operated by community care and other agencies, for whom placement in community residential accommodation presents difficulty when they reach the age of 18, in particular those who present with challenging behaviour. In the past many graduates from such hostels/orphanages/remand centres have failed to settle in the community and drifted to the formal psychiatric services leading to long-term care and support.

The Special Hospital Care Programme recognises and welcomes the development work being undertaken by the Community Care in the provision of hostel places for children and adolescents presenting with challenging behaviour. In this context, the Committee recommend that a Liaison Service be established between Special Hospital Care and Community Care to plan services for the small number of graduates from Community Care Services who may need to be provided with ongoing care and support by the adult psychiatric services.

The Committee recommend that data be compiled to identify (a) the number of vulnerable children needing supportive residential services over any given year and (b) the projected need for residential places over the next decade. This data would be invaluable in terms of future service planning.

There has been some difficulty in the past, regarding service responsibility for homeless persons aged 65 years and over. Many such persons continue to be referred to St. Brendan's Hospital, irrespective of their catchment area.

It is the view of the Committee that homeless persons aged 65 years and over with a history of previous psychiatric contact and requiring ongoing psychiatric intervention, should be the responsibility of the catchment area service in which they reside.

Any homeless person aged 65 years and over with no previous contact with the psychiatric services and requiring psychiatric intervention, should be the responsibility of the specialist old age psychiatry service and that service should be resourced accordingly to meet this particular need.

HOMELESS PERSONS IN PRISON/FORENSIC SERVICES & IN INSTITUTIONAL CARE

Homeless persons released from the Prison Service

An increasing number of homeless persons released from the Prison Service, present themselves at out-patient clinics seeking medication. These clients usually present without any referral note from a doctor and with no indication of their need by the Probation and Welfare Service. The Committee feel that recommendations made in Department of Health Circular No. 5/87 (Appendix C) should be extended to include those homeless mentally ill who are released from Prison to such after-care as is offered by the Probation and Welfare Service. This should minimise the abuse of psycho tropic medication while ensuring that relevant individuals who need to be helped, do not slip through the network of care which is now being established.

Homeless persons in the Forensic Service

The Committee reviewed the position of persons who become homeless whilst in the prison/forensic services and consider that this group can also be difficult to accommodate in an appropriate service on a continual basis as such persons may not engage with the local service until there is a crises/emergency.

The Committee recommends that serious consideration should be given to the development of non-residential forensic services for this particular client group under

the auspices of the Forensic Service. The Forensic Service is a specialist service and should provide aftercare and support to meet the needs of persons who come within the remit of that service.

It is the view of the Committee that such aftercare and support should be provided until the individual has been settled for a reasonable period of time in a particular catchment area. This service could develop formal links with catchment area services to facilitate hand-over of care, by agreement, thereby ensuring that clients have continuity of care and access to local services as appropriate. The Committee consider that six months is a reasonable time in which to develop a joint management and appropriate hand-over.

The Committee endorses in principle the current policy which operates within the Eastern Health Board area whereby long-stay patients from the Central Mental Hospital are discharged to catchment area services with transfer of care agreed between the respective Clinical Directors of the Central Mental Hospital and the area services involved.

However, an increasing number of these patients are being repatriated to the Eastern Health Board area although their original domicile is outside our Board's region.

Every effort should be made to redress this practice in future arrangements and ensure that individuals are repatriated to their own Health Board area as appropriate.

Homeless persons in institutional care

Persons who become homeless whilst in institutional care are the responsibility of the parent catchment area service. If any such person is rehoused or placed in another catchment area, arrangements should be made by the institution or hospital to transfer the care of this person to the appropriate catchment area service. All transfers should be by mutual agreement between the services involved and with due regard for the wishes of the person and/or surviving relatives - if any. In this context, where it has been established that a person will settle in the new catchment area, transfer of care can take place as soon as possible following a period of resettlement.

MENTAL HANDICAP AND PERSONALITY DISORDER

Mental handicap

Traditionally, individuals with mild mental handicap who suffer from mental illness, have been the responsibility of the psychiatric service, while those with moderate to severe mental handicap have been the responsibility of the Services for the Mentally Handicapped.

In recent times, the presence of a small though increasing number of mentally handicapped individuals with additional disabilities, has been reported in the homeless circuit in Dublin. The latter include: organic brain damage, epilepsy, personality disorder and the effects of substance abuse.

The Committee feel that the needs of this group would be more appropriately met by the Mental Handicap Service rather than by generic psychiatric services. The need for in-patient and/or crisis-intervention beds for this group must be addressed.

In this context, the Committee welcomes the development between the Eastern Health Board's Mental Handicap Service and Focus Housing of a community residential unit in Community Care Area 7 which will cater for 5 individuals with a mild mental handicap who are currently homeless. The Unit will be staffed and co-ordinated by the Board's Mental Handicap Service and the ethos and structures will reflect the particular needs of this homeless group.

Personality disorder

The "New Mental Health Act"* explicitly excludes "personality disorder" from the definition of mental disorder. This group are currently catered for to some extent by the general and homeless psychiatric services.

However, in the absence of a primary psychiatric illness as defined by this impending legislation, individuals with personality disorder will no longer be admitted to psychiatric hospitals voluntarily or involuntarily. It is the view of the Committee that in the future, provision must be made for the management of homeless individuals with significant personality disorder, with support from the specialist psychiatric and other services as appropriate.

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* *"A New Mental Health Act". White Paper (1995). Dublin: Department of Health.*

OTHER NON-DISTRICT GROUPS

Persons placed in residential accommodation (Nursing Homes or supervised accommodation for short, medium or long-stay care)

Current policy/practice operating in relation to this group is such that the parent service continues to provide follow-up and intervention as required, irrespective of whether the accommodation is located outside the catchment area. This policy presents practical problems in terms of follow-up but evolved at a time when certain catchment areas had a higher concentration of nursing homes than others.

The Committee recommends that where persons are being placed in nursing homes for long-stay care or other supported accommodation, every effort should be made to secure placement in a facility within the parent catchment area. Where this is not feasible and placement in a facility outside the catchment area is effected, arrangements should be made to transfer the care of the patient, by agreement, to the service local to the facility once the person has settled for a reasonable period of time. The Committee considers that 6 months is a reasonable period to effect these arrangements.

The Committee recognises that this arrangement may present problems for certain catchment areas which have a high number of nursing homes particularly, in their area and given the service needs of those patients. The Committee therefore recommends that special consideration be given to such area services, with respect to resource allocation where this factor presents.

Nationals and non-nationals 'in-transit' through Dublin

The current arrangement in relation to members of this group who become ill while in transit through Dublin, is as follows: Individuals who present at Dublin Airport are referred to St. Ita's Hospital while all other individuals are referred to St. Brendan's Hospital. This practice is an inequitable one, discriminating against this client group in terms of access to services.

The Committee recommends that the service where an individual presents should provide assessment and emergency treatment until the home/origin of the individual can be established and arrangements made with the appropriate local service to deal with the person. The transfer of individuals should be effected as soon as possible.

If the person has been brought initially to the Casualty Department in a General Hospital by the Gardai and thereafter requires acute psychiatric in-patient care, it should be the responsibility of the local acute unit to provide such care or to make alternative arrangements with a special care facility should same be necessary.

Members of the travelling community

Members of the travelling community who take up permanent residence within a catchment area become the responsibility of that catchment area service.

The Committee feel that unhoused travellers who move between known catchment areas and beyond, should be the responsibility of the catchment area service in which they present. Following assessment and treatment, members of this group should be referred to a named professional in the area service they expect to travel to. A voluntary patient-held record could help alleviate problems associated with continuity of care. However, this is left to the discretion of the Consultant responsible for the care of all such patients.

SECTION IV

RECOMMENDATIONS FOR THE SPECIALIST AND CATCHMENT AREA SERVICES

The current status and future directions of the specialist psychiatric service for the homeless have been discussed in section II. The Committee reiterate the view that (a) this specialist service is the most appropriate central service to cater for the needs of the homeless mentally ill and (b) that it should be resourced accordingly, to broaden and strengthen it's services to cater for emerging needs.

INTERFACE BETWEEN THE SPECIALIST SERVICE AND CATCHMENT AREA SERVICES

The Committee recommend that formal links be established between the specialist psychiatric service for the homeless and the catchment area services, to facilitate by agreement the cross-referral and formal transfer of patients across boundaries of care. Every effort should be made by catchment area services to re-establish patients within their own catchment area before referring them to the specialist service for the homeless. Transfers when effected should suit the long-term clinical and social needs of patients and should be made with due regard to their expressed choice. It is the Committee's view that until such time as there has been formal acceptance of any given patient by the receiving service, the patient will remain the responsibility of the referring or parent service.

It is recognised that the referral of patients requiring supported residential accommodation across boundaries of care, has resource implications for all services involved in reciprocal exchanges, given the lack of community residential accommodation to meet the needs of long-stay populations. The Committee consider that this should be a matter for negotiation between the specialist psychiatric service for the homeless and the relevant catchment area services.

The Committee recommend that each Clinical Director should nominate one Consultant to accept responsibility for homeless non-district persons in his/her service. This Consultant would be expected to: (a) help shape policy for the homeless/non-district patients in his/her catchment area service, rather than have personal responsibility for the clinical management of this group, (b) establish a working relationship with the Consultant in the specialist psychiatric service for the homeless

and (c) serve on a cross-catchment area committee, which should be established to review and monitor the interface between the specialist psychiatric service for the homeless and the catchment area services. Where possible, the nominated person should be involved at catchment area level in rehabilitation services.

The Committee also recommends that each catchment area team should, through a nominated Community Psychiatric Nurse (C.P.N.), maintain a register of all homeless/non-district patients in their service as discussed in the introduction of this report. This register could also include a list of non-compliant patients who are known to be repeatedly lost to follow-up.

The Committee further recommends that a system of networking be established between C.P.Ns. in each relevant service, to ensure that patients who drift into direct access hostels/night shelters and are often lost to follow-up thereafter, are picked-up by the outreach arm of the specialist psychiatric service for the homeless and referred to appropriate care-agents thereafter.

The Committee feel that the interface between the specialist psychiatric service and other catchment area services would be strengthened by the development of an appropriate, modern information system for the handling of medical information and all other pertinent data regarding the homeless mentally ill. This should ensure that relevant information is transferred smoothly and expeditiously between all services involved in caring for this group.

SECTION V

GENERAL RECOMMENDATIONS

Discharge Procedures

The Committee recommended that the discharge of all homeless/non-district patients from hospital be preceded by adherence to the 'Discharge Procedures' identified in Circular 5/87 issued by the Department of Health (Appendix C). Thus, when the discharge of any given homeless patient is being effected, the Committee recommend that a copy of the completed documentation identified in Circular No. 5/87 be sent to both (a) the appropriate Director of Community Care and to (b) the specialist psychiatric service for the homeless. This should enable the outreach arm of the latter service to locate patients who are repeatedly lost to follow-up and to monitor their progress thereafter in conjunction with other relevant care-agents from the catchment area services.

The discharge and placement of homeless patients in any given residential facility in the community by the specialist psychiatric service for the homeless, or catchment area service should routinely be preceded by contact from a CPN attached to that service to provide appropriate information and advice in relation to the client.

Day Care

The provision of day care facilities for the homeless, is a prerequisite which ensures that many of their clinical and social needs are met, while averting or reducing the frequency and duration of hospitalisation. All patients discharged from the specialist psychiatric service for the homeless, are encouraged to attend at the programme's Day Centre.

It is appreciated that (a) patterns of mobility customarily displayed by homeless patients, (b) their tendency to gravitate to city-centre accommodation, (c) their personal preferences and (d) circumstances which may have contributed to their leaving their original catchment area, may not be conducive to their continuing contact with these catchment area services following their discharge from hospital.

In the latter event, the Committee recommend that cross-referral for day-care and/or follow-up should be negotiated either (a) between catchment area services or (b) between catchment area services and the specialist psychiatric service for the homeless. Individuals accepted into the latter programme for day-care would remain the responsibility of the referring service should hospitalisation be necessary at a later stage, except in particular circumstances where it would be more appropriate that the provision of in-patient services be provided by the specialist psychiatric service for the homeless and same was by agreement between the appropriate consultants.

Emergency presentations

It is the view of the Committee that any homeless person who presents as emergency andi s deemed to require in-patient care be admitted to facilities in the catchment area in which they present.

Should the individual be referred back to catchment area services appropriate to the individual's customary domicile, or to the catchment area service which previously attended to their needs, as appropriate.

User friendly services

The provision of services on a catchment area basis tends to be based on the assumption that service-users have a stable residence and supportive social networks in the community. This model has limitations when dealing with the needs of the homeless. It is the view of the Committee that all service agents dealing with homeless persons should be flexible in this approach to service delivery; and that catchment area services would adopt a flexible approach when catering for individuals whose presence is likely to be transient and/or whose behaviour does not conform with that of the generality of individuals for whom services are provided at local level.

Homeless and barred

The Committee noted that some patients on the homeless circuit with a history of intractable violent behaviour, were barred from access to services in certain catchment areas and therefore responsibility for their care was placed on other services. This gave rise to medico-legal concerns and the Committee were of the view that legal opinion should be sought to clarify this issue.

Medical Needs

A common finding in homeless populations is the problem of co-morbidity, namely the presence of dual psychiatric diagnoses and concomitant physical disabilities in a substantial proportion of individuals, leading to morbidity and mortality rates which are two or three times higher than those for domiciled individuals. Homeless individuals are rarely registered with General Practitioners and even if registered, a sub-group appears to be incapable or unwilling to access this service. As a result, many homeless tend to be dependent on casualty services in General Hospitals for their health needs. The committee welcome the developments proposed in relation to the provision of primary care services for the homeless referred to in Section II of this report. In this context the Committee recommend that Medical Cards be routinely applied-for, when homeless patients are discharged and placed in community settings, to ensure that their primary health-care needs and access to general medical services are guaranteed, following their discharge from any given psychiatric service.

Screening For Tuberculosis

High prevalence rates for Tuberculosis and the emergence of multiple drug resistant strains have been reported the world over, among homeless populations. A linear relationship exists between the prevalence of tuberculosis and the length of homelessness, with substance abusers including alcoholics emerging as both the most vulnerable and the most difficult to treat because of their non-compliance. There is a high prevalence rate of tuberculosis among the homeless in the specialist psychiatric service and the Committee recommended that appropriate screening and treatment measures are put in place to reduce infectivity among this group.

CONCLUSION

The Committee feel that the specialist psychiatric service for the homeless currently based at St. Brendan's Hospital is the most appropriate to deal with the service needs overall of the homeless mentally ill and should ideally provide for the in-patient needs of that group to ensure that there is no fragmentation of service delivery.

Service for the homeless mentally ill and in particular for persons falling into the category of "non-district", a corporate approach must be adopted, facilitating effective interface between the specialist service and catchment area services as outlined in Sections III and IV of the report.

Psychiatric services for the homeless mentally ill are a component of overall service needs for this group. It is therefore essential that the homeless mentally ill have equal access to the full range of health and welfare services available to improve their health status overall and ensure that their totality of needs are met.

The Committee feel that the provision of specialist psychiatric services for the homeless in the Eastern Health Board area with complementary support from the catchment area services, should ideally be supported by related provisions in other areas around the country. Otherwise the demand for services for the homeless in Dublin will continue to grow given the migratory behaviour of young able-bodied homeless individuals with peripatetic lifestyles who gravitate to the capital in search for anonymity and support.

Appendix A

HOUSING PROJECTS FOR HOMELESS PERSONS COMPLETED/IN PROGRESS UNDER CAPITAL ASSISTANCE SCHEME/RENTAL SUBSIDIARY SCHEME, DUBLIN CORPORATION.

LOCATION	VOLUNTARY BODY	NO. OF UNITS	POSITION
Green Street	Green Street Housing Trust	10	(completed)
George's Hill, Dublin 7.	Focus Housing Association	29	(completed)
Basin Street/St James's Avenue	N.A.B.Co.	45	(completed)
South Earl Street/Meath Street	N.A.B.Co.	20	(nearing completion)
Newstreet, Dublin 8.	N.A.B.Co.	42	(in progress)
Townsend Street, Dublin 2.	N.A.B.Co.	16	(in progress)
Back Lane, Nicholas Street, Dublin 8.	St. Vincent De Paul	70	(completed)
Inveagh Trust, Kevin Street, Dublin 8.	Inveagh Trust	?	(in progress)
Woodville House, Kilmore Road, Dublin 5.	Aoibhneas Ltd.	11	(completed)
Clonmore Villas, Ballybough, Dublin 3.	Focus Housing	6 (homeless Mentally Handicapped)	(nearing completion)

Appendix B

Homeless/Non-District Client Groups

Homless Group

(i) Homeless persons who have been living in conventional accommodation for the homeless e.g. city centre hostels, beds & breakfast accommodation, emergency shelters etc. for a period of three months or more.

(ii) Homeless persons with no current address, hostel or otherwise, for a period greater than three months.

Non-District Group

(iii) Homeless persons living in conventional accommodation for the homeless for a period of less than three months.

(iv) Persons with a current address in a catchment area for a period less than three months with/without a previous service contact.

(v) Persons with no current address, be it hostel or otherwise for a period of less than three months.

(vi) Persons sleeping rough, drifting through various catchment areas, presenting at casualty departments, moving outside the Eastern Health Board region and outside the Country from time to time.

(vii) Persons graduating to adult psychiatric services from child and adolescent services.

(viii) Homeless persons aged 65 and over.

(ix) Persons who have become homeless whilst in institutional care i.e. hospital, forensic service, prison etc.

(x) Persons placed in nursing homes for long-stay care, where the nursing home is outside the person's catchment area of origin.

(xi) Non Eastern Health Board persons presenting as emergency cases and not established within catchment area for three months or more.

Appendix 1

Department of Health
Custom House, Dublin 1

An Roinn Sláinte
Teach an Chustaim, Baile Átha Cliath 1

TEL. (01) 735777 EXTN.
TELEX 24894
REF.

CIRCULAR NO. 5/87 11th March, 1987

Chief Executive Officer
Each Health Board

Secretary Manager
Each Voluntary Hospital

ARRANGEMENTS FOR DISCHARGE FROM HOSPITAL AND AFTERCARE OF HOMELESS PERSONS

I am directed by the Minister for Health to refer to previous correspondence and discussions regarding the procedures to be adopted by hospitals in the identification and discharge of homeless persons, so that they can be provided with the appropriate aftercare services.

The views and recommendations submitted to the Department in response to the draft circular of Meitheamh, 1986, have been carefully considered. The difficulties posed for hospitals and for those providing community based services are acknowledged. Despite the problems which have been identified, the Minister considers that every effort must be made to improve the services available to homeless people who become ill, and is now making a special appeal to you and the staff directly concerned to implement the procedures which are being recommended in this letter.

It is the Minister's intention to carry out a review of your experience and those of relevant voluntary organisations in the operation of the revised procedures in March, 1988, so that any problems identified during the coming year can be identified and steps taken to further improve arrangements for the care of homeless people. Consideration will be given to having a special meeting of key people involved at that time. In order to

..../..

CONFIDENTIAL

Discharge of Homeless Person.

Patients Name Age _____

Address (if any) Marital Status

Address of nearest relative
(or organisation the patient
is in contact with)

Date of Discharge

Patient has residential accommodation available

Yes ☐ at

No ☐

Clinical condition treated in hospital.

Condition is stable Yes ☐ No ☐

If No, details are

Perscribed medication

Patient has medical card Yes ☐ No ☐ *

Letter to Employment Exchange provided Yes ☐ No ☐

Discharge letter sent to G.P. Yes ☐ No ☐

Name and address of G.P.
(if known)

*(If the person does not have a medical card the Director of Community Care should, if possible, be alerted by telephone immediately this comes to notice)

..../..

Next outpatient appointment on

Other arrangements made for further hospital treatment are as follows:

The patient has voluntarily provided the following additional information regarding his/her financial position and has authorised the hospital to convey this information to you, on a confidential basis:-

Normal source of income:

Point of delivery:

Amount:

Amount of cash in hand:

Rent commitments:

Other relevant details:
(e.g. availability of clothing footwear etc.)

General Comments (if any).

CONFIDENTIAL

_____ Hospital

Discharge of Homeless Person

Director of Community Care
Area

Dear Director,

In accordance with the recommendations of the Department's Circular No. 5/87 of 11th March, 1987, I have set out beneath information on _____ who is being discharged on _____ from this hospital. We believe that this person is homeless, and needs support from the community based services in order to cope with his/her condition. I would be glad if you could make arrangements to provide such support as you consider appropriate.

Yours sincerely

_____
On behalf of Hospital

..../..