Cork Simon Community

Dark End of the Street

Dealing with Mental Health and Homelessness in Cork

Funded by St. Stephen’s Green Trust

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<th>Description</th>
</tr>
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<tbody>
<tr>
<td>AA</td>
<td>Alcoholics Anonymous</td>
</tr>
<tr>
<td>ACCES</td>
<td>Assertive Community Care Evaluation Service</td>
</tr>
<tr>
<td>AHMDT</td>
<td>Adult Homeless Multi-Disciplinary Team</td>
</tr>
<tr>
<td>AMHS</td>
<td>Adult Mental Health Services</td>
</tr>
<tr>
<td>B&amp;B</td>
<td>Bed and Breakfast</td>
</tr>
<tr>
<td>BPRS</td>
<td>Brief Psychiatric Rating Scale</td>
</tr>
<tr>
<td>CSES</td>
<td>Cork Simon Emergency Shelter</td>
</tr>
<tr>
<td>CUH</td>
<td>Cork University Hospital</td>
</tr>
<tr>
<td>ESRI</td>
<td>Economic and Social Research Institute</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner (Doctor)</td>
</tr>
<tr>
<td>HEART</td>
<td>Homeless Empowerment Action Research Team</td>
</tr>
<tr>
<td>HSE</td>
<td>Health Service Executive</td>
</tr>
<tr>
<td>HUD</td>
<td>Housing and Urban Development</td>
</tr>
<tr>
<td>ICESCR</td>
<td>International Covenant on Economic, Social and Cultural Rights</td>
</tr>
<tr>
<td>MQI</td>
<td>Merchant’s Quay Ireland</td>
</tr>
<tr>
<td>MUH</td>
<td>Mater Misericordiae Hospitals</td>
</tr>
<tr>
<td>NACD</td>
<td>National Advisory Committee on Drugs</td>
</tr>
<tr>
<td>NCH</td>
<td>National Coalition for the Homeless</td>
</tr>
<tr>
<td>NDA</td>
<td>National Disability Authority</td>
</tr>
<tr>
<td>NESC</td>
<td>National Economic and Social Council</td>
</tr>
<tr>
<td>ODPM</td>
<td>Office of the Deputy Prime Minister</td>
</tr>
<tr>
<td>PHAI</td>
<td>Public Health Alliance Ireland</td>
</tr>
<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration (USA)</td>
</tr>
<tr>
<td>UNEP</td>
<td>United Nations Environment Programme</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>

**Homeless**

1. A man or woman who is accessing Cork Simon Emergency Services;
2. A man or woman who is 18 years or over. (The length of time a person is deemed homeless is not relevant for the sample, only that they are accessing homeless services at the time of the sample.)

**Mental Health**

a) A man or woman who has been diagnosed as having (or had) a mental health problem or mental health illness; or
b) A man or woman who has indicated that they have (or had) a mental health problem or mental health illness; or
c) A man or woman who has been referred to the HSE Adult Homeless Multi Disciplinary Team on the basis of displaying behaviour that suggests that care or intervention might be required: or
d) A man or woman who has met the criteria above and is willing to participate in the project.

**Dual Diagnosis**

The simultaneous presence of both an addiction and mental health disorder.
Executive Summary
1.1 Introduction

The purpose of this study is to capture a sense of the real life experiences of people who were both homeless and mentally ill. It offers a glimpse of their experiences of accessing and using mental health services, and the impact those experiences have had on their lives.

The study also assesses the perceived adequacy of existing services in meeting their needs. This was achieved by conducting structured face-to-face interviews with a sample of people who are homeless, at risk of becoming homeless, or who have experienced homelessness. Care was taken to capture the views expressed by the people who agreed to be interviewed. The life experiences captured act as a foundation for creating a better understanding of the issues surrounding mental ill health and homelessness in Cork.

It was important to add context to the views and lived experiences that were gathered. The perspectives of key stakeholder agencies supporting people with a mental illness facing homelessness were gathered through consultation. A literature review was conducted to explore the experience of appropriate data collection tools, and methods of sampling and analysis, that would respect the people and organisations that took part in the research. This also helped ensure that the data collected would reflect the current situation of all contributors.

1.2 Findings

1.2.1 Survey Interviews

Twenty-one people who were homeless agreed to participate in the survey. Their contributions helped identify barriers that they encountered. In particular, the case studies highlighted the challenges they face. Their contributions highlight the acute nature of those barriers for people who have both an addiction and are mentally ill – otherwise know as having a dual diagnosis.

Participants in this study are doing their best to move out of homelessness. Many find it extremely difficult to succeed with the current range of supports and housing that are available to them.

Summary Profile

- 86% were men;
- 28% were aged 45-54 years and 24% were aged 35-44;
- 43% used Cork Simon Emergency Shelter;
Exploring Homelessness and Mental Health

Eleven participants went on to provide further information. They had a range of different mental health difficulties, which have affected their lives in various ways. Participants mentioned their feelings of isolation and how they described homelessness as being either; a loner when they were growing up, or had feelings of isolation due to their condition.

Stigma in society still exists when talking about mental health, and this was very clearly reflected in a number of the interviews. Many of the participants also acknowledged a sense of shame about homelessness.

The GP was the first access point to mental health services for most people who participated in the research. The GP was almost universally identified as the service provider for medication and for medical certification, necessary for access to social welfare disability payments.

Many of the participants did not equate medication with mental health care. For example, one person saw mental health care as accessing rehabilitation units or psychiatric hospitals. Of the eleven participants in the main sample group, six had accessed a psychiatric hospital as part of their mental health care. There were very different views of the services they experienced. Being sectioned\(^1\) - or the fear of being sectioned, acted as a deterrent or barrier for continuing care for some participants.

Six of the eleven participants that were interviewed mentioned that they took either alcohol or drugs, or both. Three of the six were taking medication for their mental health conditions; two of the other three admitted to taking themselves off medication.

The Adult Homeless Multi Disciplinary Team has opened access to mental health care for the users of Cork Simon and St. Vincent’s. All participants spoke very favorably of the service provided. The participants also commended Cork Simon staff.

\(^1\) The term “being sectioned” refers to the use of a part of the Mental Health Act to gain legal permission to give someone compulsory assessment or treatment for a mental health problem. Under Ireland’s Mental Health Act, 2001 “A person may be involuntarily admitted to an approved centre pursuant to an application under section 9 or 12 and detained there on the grounds that he or she is suffering from a mental disorder.” (Mental Health Act, 2001, Part 2 Section 8)
1.2.2 Support Organisations

Twenty-two key agencies and organisations were interviewed. Not all have a statutory remit with regard to people who are homeless, however all provide a specific service for people who are homeless.

A number of agencies and service providers stated self-referral as being the main way in which people find their services. Word-of-mouth from friends, family and peers is another important way in which people become aware of the services available to them. Other referrals come from hostels, hospitals, doctors, psychiatric services, Cork Mental Health, social workers, primary treatment centres, the Gardaí, prisons, Probation Services, Community Welfare Officers, Child Protection Services, the Adult Homeless Multi Disciplinary Team and the Homeless Person’s Unit.

The key agencies revealed that the majority of people presenting themselves to their organisations are male, and that the majority of men who are homeless are single. The lower incidence of women is believed to be because:

- Women are more likely to get themselves out of homelessness more easily;
- Impact of the Rent Supplement barrier.

In 2008 Cork Simon statistics showed that 18% of all people supported were aged 26 years or younger. The majority of people were aged between 27 and 44 years. The majority of key agencies stated that people were typically aged between 30 and 55 years, however this varies depending on the service being provided. Two shelters noted that the majority of women availing of their services are between 20 and 35. A new trend emerged recently where more elderly women experiencing abuse from sons and daughters are availing of their services, leading to an increase in the number of women over 60 years. The main driving factors that led to homelessness, as identified by the key agencies, were as follows:

- Family disputes and breakdown;
- Barring Orders;
- Social factors;
- Care history;
- Sexual or physical abuse in childhood or adolescence;
- Offending behaviour or experience of prison;
- Previous history in the armed services;
- Lack of social support networks;
- Anti-social behaviour;
- Financial Debt;
- Drug or alcohol misuse;
- School exclusion or lack of qualifications;
- Mental health problems; and
- Poor physical health.
It was found that measuring homelessness is difficult because of the fluidity of the homeless population. Most organisations support between 25 and 400 people, depending on the service and size of the organisation. September and October are often busy months as families obtain cheap student accommodation during the summer months, but subsequently find themselves homeless when the students return. January, February, and March are busy times for most organisations.

1.2.3 Mental Health

There is no coordinated approach for dual diagnosis\(^2\). People often have no access to addiction counsellors after hospital. There is a need for primary care service that interlinks with addiction services, as these are currently being managed separately.

Access criteria mean that a person must be drug or alcohol free before they can access mental health services, and this poses a serious problem for people with a dual diagnosis. A number of people with drug or alcohol addiction, or those who are in withdrawal, show symptoms of mental health problems, but it is difficult to assess whether the symptoms are as a result of the addiction or not.

The majority of the key agencies estimated that between 25-30% of people presenting to them are considered to have a mental health issue. Five organisations stated that they estimate between 60-80% of people presenting to them for support have some type of mental ill health.

About 80% of people in the prison system have addiction problems and this is often correlated with mental health problems\(^3\). In most cases, when people are released from prison they are not referred to mental health services. Mental health problems are detected through assessments on entry and through interactions. Also, a number of people presenting themselves to organisations or hostels have been referred from psychiatric wards or other organisations where it is known that the individual is currently taking medication for a mental health issue.

Some organisations stated that some people are quite open about their mental health issues and treatments.

Of the key agencies consulted the following profile of the main mental health problems were identified:

<table>
<thead>
<tr>
<th>Incidence</th>
<th>Mental Health Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 No.</td>
<td>Depression</td>
</tr>
<tr>
<td>10 No.</td>
<td>Drug and alcohol addiction</td>
</tr>
<tr>
<td>9 No.</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>4 No.</td>
<td>Anxiety</td>
</tr>
<tr>
<td>4 No.</td>
<td>Behavioural problems</td>
</tr>
<tr>
<td>4 No.</td>
<td>Self-Harm behaviour</td>
</tr>
</tbody>
</table>

\(^2\) Dual diagnosis is the simultaneous presence of both an addiction and mental health disorder.

\(^3\) Dermot O’Connell, Probation Services.
Dark End of the Street - Dealing with Mental Health and Homelessness in Cork

Other mental health issues noted were bipolar disorders, obsessive-compulsive disorders, coping problems, suicidal tendencies, psychotic episodes, and psychosis.

The Adult Homeless Multi Disciplinary Team is seen as a very effective resource by many of the organisations and stakeholders consulted. However, a number of stakeholders were unaware of the existence of the Team, or had little or no communication with the Team directly.

Almost all of the organisations consulted highlighted the issue of the 'revolving door' and identified it as a key issue that needs to be tackled. A number of the people who are presenting themselves to the organisations are known not to be medicating properly. There is a lack of monitoring of people to ensure that they are not returning back into the system. This leads to a 'revolving door' type of effect, where people are in and out of the system.

A significant number of organisations would like to see specific drug and alcohol treatment programmes put in place and targeted programmes for people with coping problems and undiagnosed mental health issues. There are people who do not have the ability to sustain their tenancy. They avail of the services of shelters and then move into private rented accommodation, but are unable to cope independently and soon find themselves homeless once more.

People who have been hospitalised through alcoholism and are in recovery have no intermediary service between discharge from hospital and homeless shelters. When they leave the shelters they often find themselves reverting back to drugs and alcohol. If people are intoxicated they will not be allowed to enter emergency shelters and so find themselves sleeping rough.

There is an acute shortage of appropriate housing for people who are homeless or at risk of becoming homeless. One organisation believes that there is a need to monitor activity on accommodation availability. The reason people do not access the available services could be for any number of reasons, including emotional or societal factors, untreated mental state, drugs or alcohol issues, or they feel discouraged by the system. There is also a lack of visible routes for people seeking more permanent forms of accommodation.

There is a need for an intermediary service or a halfway house for people who are abstinent. There is also an identified need for more in-patient ring-fenced beds for people who are homeless. The lack of detoxification beds available causes some concern.

There is a problem of drug-related brain damage and a need to look to the future to the numbers of people with alcohol and drug induced dementia, which will increase the numbers of older people who are homeless with a mental health issue.

The mental health service does not have respite beds and do not have access to the nursing home service.

From the point of view of prisons, it is felt that there needs to be a supported hostel situation that acts as a halfway house for people leaving the prison system who have nowhere to go.
There is a need for a seamless transition from prison back into the community. This should include education, housing, psychology services, psychiatric services and training programmes.

1.3 Recommendations

1.3.1 Adult Homeless Multi Disciplinary Team (AHMDT)

The success of the AHMDT based at Anderson’s Quay is unquestionable. The Team clearly has a positive impact on the mental health of people who are homeless in terms of their access to mental health services and experiences of those services. For the majority of people who are homeless, the AHMDT is their only effective means of accessing mental health services.

1. It is recommended that adequate administrative supports be put in place for the AHMDT. The availability of top-line information on the number of people availing of the AHMDT and the nature and severity of their health is crucial in organizing and planning homelessness services in the short, medium and long–term. Information is key in helping to identify people’s needs and trends in gaps in services.

2. It is recommended that an Addiction Counselor, access to trained counseling, Social Worker and Occupational Therapist are added to the AHMDT. While this research indicates that it is generally easy for people to get medication on prescription, many do not have any access to ‘talking therapies’ or alternative treatments. This is particularly the case for people for whom medication doesn’t work or has other severe side effects. Since the research project was commissioned, Cork Simon now provides access to trained counseling on a walk-in basis.

1.3.2 Addiction Services

Whilst there is a range of addiction services in Cork, access to those services can be problematic. Of particular concern is the lack of after-care supports for people accessing addiction services, creating the ‘revolving door’ effect whereby people are continuously in and out of services.

3. It is recommended that existing addiction treatment services need to be expanded to cater for existing need, including increasing the number of dedicated detoxification beds. People need a place where they can stabilise, receive a full medical assessment and supervised withdrawal as part of an overall care plan. The Dublin Simon Detox Model is one that may be appropriate for Cork.

4. It is recommended that a ‘Step Down Dry House’ with associated supports be established to support people after they access addiction treatment services.
1.3.3 Dual Diagnosis

People with addictions and co-morbid psychiatric conditions, sometimes referred to as dual diagnosis, often require more intensive treatment. The National Advisory Committee on Drugs (NACD) advocate much closer collaboration between addiction programmes and general mental health services to improve outcomes for individuals with dual diagnosis.

5. It is recommended that there be closer collaboration between detoxification services, addiction services and the AHMDT for people who are homeless with dual diagnosis.

1.3.4 Accommodation

Accommodation issues featured prominently throughout this research – from issues about the quality of accommodation to a shortage of appropriate accommodation. Access to appropriate accommodation with the right levels of care and support is a major obstacle for people to move out of homelessness. This is especially the case for people with poor mental health. A mixture of low-support, medium support and high support housing is crucial in enabling people to build normal lives.

6. It is recommended that supports are developed and existing projects expanded to provide routes to more permanent forms of accommodation:
   - More High-Support Residential accommodation places
   - More places in sheltered housing for people requiring medium levels of support
   - More permanent and sustainable housing units for people requiring low levels of support
   - Increasing the capacity of the Housing Plus team to support more people in securing and maintaining their tenancies

7. It is recommended that the quality of accommodation, especially for at-risk groups, needs to be monitored on an ongoing basis. The quality of housing for some participants in this research, particularly in the private rented sector, served to exacerbate people’s mental ill-health and contributed to their pathway into homelessness.

1.3.5 Supports for Personal Issues

Supports for the personal issues that affect people as a result of being homeless often receive scant attention. It is important to recognise and respond to the impact of homelessness as it bears down on the person. In addition to improving access to trained counsellors and underpinning the work of the AHMDT as already outlined, it is also important to provide for the employment and recreational needs of people.

8. It is recommended that existing access to training and employment is maintained and expanded; that access to arts, creative and sports opportunities are increased.
1.3.6 Research

Homelessness is a complex issue, all the more so when people have complex needs – mental and physical health conditions, addictions, disability, poverty, education needs, and more. We need a better understanding of the links between mental health and homelessness – especially in Cork, if we are to put in place effective responses. We need a better understanding of people’s ‘pathways’ into homelessness, their experiences while being homeless and the obstacles they face in trying to leave homelessness behind them. The scope of this research project was limited, yet it gives us an insight into the lives of people with complex needs and the challenges that they face.

It is recommended that further research be conducted in Cork with a particular emphasis on mental health, on ‘pathways’ into homelessness, and on the experiences of people using existing services for people who are homeless. More in-depth research should include an analysis of initiatives that work, clearly identify the ones that are failing and explore innovative solutions so that people with complex needs can get the care, support and accommodation they need for as long as it’s needed.
Through the narratives of those living on the streets their ‘life stories’ are told, and a deeper understanding is gained of what it means to live with mental health difficulties and homelessness. The following ‘life stories’ were developed based on one-to-one interviews with three individuals who are homeless. The names of the individuals and some wording of their quotes were changed to protect their identities.

Nora

When participants were asked to talk about their lives before they were homeless or before they started using Simon Services, they often spoke about their past and their home. It was in that question that people gave an indication whether ‘life’ had been difficult from the beginning or if things had only started to get difficult when they became homeless. In the case of Nora, life had always involved stress, anxiety and depression.

Nora was in and out of counselling and had dealt with a lot of issues throughout her life. She had been prescribed medication for anxiety and depression. She had not seen a psychiatrist or counsellor in three and a half years, but wanted to see a counsellor again in an effort to reunite with her family.

Nora believed that her mental health deteriorated since she became homeless and this had directly influenced her lifestyle, which included street drinking, taking hard drugs and living in dangerous situations. Her living situations changed regularly, moving between different squats and derelict buildings.

Nora feared street life on her own. Nora either invited people back to her squat or people had found out were she lived and arrived at her squat. It was a paradox of not wanting to mix with people who may have a deviant lifestyle and yet needing social relationships to survive on the streets. This fear added to her anxiety and affected her mental health.

She had spent 12 days clean (without drugs or alcohol) with family, but on her own, needed a place to stay or she would be back on streets. Nora desperately wanted to stop the cycle of homelessness and drug and alcohol abuse from starting again. She wanted to move away from the people who she associated with drugs, but did not believe she had a choice when she was living on the street. She moved from one dreadful situation into another.

Nora’s memory was also affected by her drug and alcohol use, and this contributed to her either failing to access services or stopped her from accessing them because she was using
substances at the time. Her lack of memory, her movement between one place and another, and her sense of desperation as she thinks about being back on the street, were evident.

Nora acknowledged the link between being homeless or being out of home and her mental health: ‘…I was doing fine… I was ok, my mental health was ok… until I became homeless, I even started using drugs and I never used before…It's been the worst 6 years of my life…’

Nora was recorded as being homeless for eighteen months, but her mental health and life had been in crisis for the last six years.

The day of the interview she was looking for help, but the counsellor was not available. She made an appointment for the next day and asked would there be a room in the shelter. It was a case of first come, first served. Nora turned up the next day, but did not stay in the shelter. She went somewhere else...

Peter

When Peter was younger he was different to his friends and he did not know what it was. His parents suspected behavioural problems, but it was a local GP that suggested that Peter had depression and that he should be admitted to hospital. Although this started to get to the root of the problem, it was also the instigator that ended Peter’s connection with home.

Peter was a teenager when he entered a psychiatric house, and although he was afraid, he knew that at least someone noticed that things weren’t right.

Due to medication, Peter felt more confident and wanted to leave the hospital, for fear of ending up like some of the people there: ‘…who were there for years upon years upon years… I wanted to move out to more… what they call, more normal society’. So he left the psychiatric house and went into Cork City, not back home.

It is not clear how or where he lived during that time, but Peter said that he lived on the streets for about four months before he went to Cork Simon. ‘I actually met someone on the streets and he told me that if I was ever stuck, that there’s always a Simon’s up the road and I said… maybe one day and then I decided one day that was it…’

The structure and process of striving towards getting his own flat provided by Cork Simon was the start of normal life for Peter in Cork City. Peter availed of Cork Simon on and off for several years and during that time he had to deal with his mental health and found a GP to give him his medication.

It then came the time when he got his first flat. ‘I had a flat and the first flat I couldn't cope because I was on my own and there was no support… and I had to pay this bill and that bill…’

He subsequently had a few more flats but each one he left for one reason or another.
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He finally decided he wanted something different and decided to move abroad for several years, for a better life and to move further away from home. Peter ended up in hospital a number of times, due to mental health issues on several occasions, and once for alcoholism. He stated things had changed for him and can recognise when he needs help and knows when to talk to a doctor.

Since Peter’s return to Cork Simon he availed of the service of the Adult Homeless Multi Disciplinary Team, which offers medical and mental health services to people using the service. Having been in and out of different mental health facilities, he really did not know how to access or avail of any health services. There was something about the life he lived in the Cork Simon Emergency Shelter that worked for Peter. Homelessness had become part of his life:

‘It’s like a way of life for me now… I might have a drink… I might get barred for a week or two weeks and then get back in again… it’s normal for me… if you get barred for whatever reason for one or two weeks… I miss this place… it’s my home…’

Peter felt he did not have to go through life by himself; there was someone there for him.

Peter has started counselling, which is offered as part of the AHMDT service and is getting his medication regularly, as it is distributed through a central distribution point in Cork Simon offices. Peter explained that the counselling helped, as well as the connection he has with the Cork Simon staff who watch out for him.

‘Most of my life… up till now, I was homeless. But as long as I live here I guess… I feel that it is a safe haven for me here because they know my moods so at least I don’t have to deal with it on my own…’

Alice

Alice was very aware of her bipolar condition, and her story showed how diagnosis and different care services have worked in her case. Her medication journey over the last decade alone told a story.

In the after effects of a traumatic family event, Alice was working, partying and depriving herself of sleep even though she knew something was not right: ‘I used to brainwash my brain… (to stay awake)’

Alice went to her GP because of feelings of anxiety and depression. The first time she was put on Prozac and after a while she threw these tablets away. She had mixed feelings about medication, in some ways she believed it helped her and in other ways, she was afraid of the side effects, but mostly she debated that it might be the ‘easy way out’.

The GP was Alice’s only access to mental health care and she only went to her GP when she felt she could not cope or was on a ‘downer’. She had three changes to her medication before
an incident in the GP’s surgery; an anxiety attack prompted the GP to arrange an assessment in a city hospital. Alice suggested that if it were not for this, she would have continued to receive GP care only.

Alice was assessed and was told she had Manic Depression/Bipolar Disorder. She was subsequently weaned off of the medication she was taking in preference to a mood stabiliser. She was then sent to see another psychologist in her area with whom she was not impressed. She decided that she would return to her doctor and asked to be returned to the hospital to continue her care.

Homelessness was also a factor that Alice had to deal with during this time. She spent several years periodically sleeping rough. It was through acquaintances that she got to know Cork Simon. Alice found living that type of life difficult and often met people and got into situations that were not conducive to her overall health.

‘Not having my own place is depressing, my wellbeing… I’ve got no where I can go and lie down, I have to be up all day walking around and what I really want to do is sit down and I don’t want to be hanging around the streets all day… then of course you’re drinking and taking drugs, which there is no getting away from…’

Drug use was also part of Alice’s life but she never mentioned receiving any care or assistance with addressing this part of her lifestyle. She was aware of the potential risks she took. Alice did not take her medication when she took ecstasy or other drugs. This contributed to her on-off approach to her medication.
1 - Views from the Street

Homelessness and Mental Illness in Cork
1.1 Gathering Real Experiences

This research attempts to record the personal, real-world experiences of people who were accessing homeless services, and who also had a mental health difficulty. To achieve this objective a process of recording primary experiential data\(^4\) from three points of perspective was adopted:

- **Non-random short questionnaire** of people who attended the emergency services of Cork Simon during a three-week period.

- **Semi-structured qualitative interviews** undertaken with eleven people. This comprised of open-ended questions for a small sample of people who are experiencing homelessness and using Cork Simon Emergency Services to document their experiences of dealing with/accessing mental health services.

- **Life Stories**: Three ‘life stories’ were chosen to give a broad perspective of the current situation of people who took part in the semi-structured interviews.

1.2 Diversity of Experience

Short duration interviews based on a questionnaire were used to establish a ‘snap shot’ of the diversity of people who were accessing the Simon Emergency Shelter during the time period of the research. This approach served to verify the degree to which the ‘sample’ reflected similar data to that found in literature review, and also facilitated a rapport between the participants and the researcher. This helped later with the longer format, qualitative interview.

Twenty-one short duration interviews using the developed questionnaire were conducted. These interviews took place in either the Cork Simon Community Day Service or the Cork Simon Emergency Shelter. By agreement, the staff of Cork Simon acted as ‘gatekeepers’ and put up posters in the Emergency Shelter entrance hall and in the Day Service, to advise people that the survey was being conducted on the premises.

The main focus of the initial questioning was on the experience of each person in accessing mental health services. An overall picture of the demographics of the sample group was established so that comparative analysis could take place with relevant research; therefore, age, place of birth, cohabitation, present living arrangements and source of income were included.

\(^4\) A full description of the tools used to engage individuals in the research is contained in the appendices.
It is important to note that the short questionnaire was not intended to be a comprehensive research tool, but was used as an introductory mechanism to inform the participants about the study, and to establish basic information. In turn, this allowed the identification of the main sample group for the longer format interview.

1.2.1 Findings

Taking into account that the sample of twenty-one was relatively small, it is, nonetheless, noticeable that some of the results were quite similar to other studies. The demographic information provides a snapshot profile of the diversity of users of the Cork Simon Emergency Services.

Gender and Age Profiles

The gender profile of people using Cork Simon Emergency Services in 2008 was estimated to be 88% male. This was similar to Holohan’s (1997) study, which showed 85% of the 506 people participating were male. At present it is difficult to quantify exactly how many men have a mental health problem. A recent survey on the issue of mental health in St. Vincent’s hostel by a UCC student, estimated that 80% of the men attending were considered to have a mental health problem. Edel House sees between 12 and 16 women every month who are considered to have a mental health problem.

This research was not designed to seek a predetermined gender balance. The gender profile achieved in the survey was found to correspond with the feedback from the Adult Homeless Multi Disciplinary Team, which stated that between 80% and 90% of those presenting for care were male.

The majority (66%) of participants who took part in the short questionnaire were between 27 and 55 years-of-age, with the highest percentage profile (28%) being in the 45 to 54 years-of-age category.

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6 Tim Savage, St Vincent’s Hostel.
Dark End of the Street - Dealing with Mental Health and Homelessness in Cork

The average age of respondents was 42.3 years, which is higher than the mean age recorded in the National Advisory Committee on Drugs Report (2005). While this does not indicate that the age profile of those who are experiencing homelessness is increasing, it suggests that mental health may have been a factor for those participating in the questionnaire.

It also corresponds with the Key Stakeholders observations, which suggested that the typical age of those presenting, was likely to be between 30 and 55 years of age.

Figure 2 – Participant by Age

Place of Birth

The Central Statistics Office has recorded a significant change in the demographic profile of Irish society over the past 20 years. It is reasonable to assume that some of the relevant changes will be reflected in the profile of those who are experiencing homelessness.

Figure 3 – Participant by Place of Birth

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Cohabitation

Of those who took part in the short interviews, both male and female, all but one said they lived alone. This corresponded to the literature and the information from agencies to the effect that most men who experience homelessness are single. The Government Review of Homelessness: an Integrated Strategy and Homelessness Preventive Strategy (2005)\(^8\) showed that single people accounted for 80% of households who were homeless.

Bines (1994) study\(^9\) showed that one in four single people who are homeless, and have mental health problems, have been in a psychiatric hospital at some point in the past. All participants in this current study that have spent time in psychiatric facilities were, at the time of the study, living alone. However, a number of the men interviewed had been married previously. Two of the three women had children who were taken into care by either family members or the State. Therefore, the statistical definition of single or living alone does not provide the full picture of the social networks that the individual experiences.

Accommodation

The National Advisory Committee on Drugs Report (2005) stated that the most common type of accommodation for people who are homeless was hostels, accounting for 64%, with 19% stating that they were rough sleepers.

When participants in this research were asked what their present living situation was, nine stated that they were living in Cork Simon Emergency Shelter (CSES), three were living on the street and three were living with friends or family. One person was living in a bed-sit, another was living in a squat and three people said they were living in an apartment.

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Further analysis identified that of the three people who said they were living on the streets, all had been diagnosed with mental health difficulties. Two of these stated that they suffered from depression, with the other suffering from schizophrenia and self-harming tendencies. Additionally, of the four individuals who said that they were living with family and friends, three acknowledged they had mental difficulties (two of these being women). The other two noted that they suffered with bipolar disorder, and depression and anxiety, respectively. One individual did not volunteer to name his mental condition.

**Income**

Disability Allowance was found to be one of the main sources of identified income for a majority of the participants. Other sources of income included: Disability Benefit, Jobseeker Support, and Supplementary Welfare Supports.

Three of the twenty-one participants had no recognisable source of income. Of those who had no source of income, all were from Poland, Slovakia or South America. Two reported that they did odd jobs to provide a part-income.
The participant who was receiving Supplementary Welfare had an injured leg. This participant also stated that they were in the middle of separation proceedings and attending Gamblers Anonymous.

Two participants were on Jobseeker Schemes, and one participant reported that they were receiving training support from FÁS.

The National Disability Authority (NDA) has noted that approximately 40% of men who are homeless have mental health problems. Cork Foyer estimate that typically 40% of their residents are claiming Disability Allowance, but not all of these may be for mental health reasons.

Ten of the thirteen survey participants (77%) who stated that they were receiving Disability Allowance or Disability Benefit also identified that they had a mental health difficulty.

**Medical Cards**

Seventeen of the twenty-one participants stated that they were holding a medical card. Two of these individual also noted that they had lost their cards, along with other personal documents.

Of the four participants that did not have a medical card, two were from Poland, and one each from Slovakia and South America. Only three individuals had a European Insurance card: the participants from Slovakia, South America (who got it when in Spain) and one Irish National.
Dark End of the Street - Dealing with Mental Health and Homelessness in Cork

Out of the twenty-one participants, two individuals had no medical cover\textsuperscript{10}. One of these had a mental health difficulty.

**Mental Health**

Figure 7 – Participant by Mental Health

Eleven participants reported that they had been diagnosed with a mental health difficulty. Six of these stated that they were ‘seeing someone’ regarding their mental health. Seven individuals said that they were on medication for mental health difficulties, whilst four had admitted to taking themselves off medication.

Of the eleven who have been diagnosed with a mental health problem, two people did not appear to be receiving any support; one was a Polish National and the other an Irish National. Both requested the name of someone to talk to regarding their mental health.

It is understood that the Garda Síochána and the Community Welfare Office detect mental health issues through interactions with people who are homeless. Consultation with other key stakeholders indicates that mental health problems are detected through assessments on entry into the organisations, and also through subsequent interactions.

The Adult Homeless Multi Disciplinary Team carries out a comprehensive assessment of all patients. For those presenting to the Addiction Counsellor, this involves a social assessment that looks at family issues, and a chemical assessment that looks at alcohol, drugs, and gambling problems. Additionally, each person’s history is considered: everyone is asked to identify their GP, who is subsequently contacted. Each person is also asked if they are currently

\textsuperscript{10} It was noted that Cork Simon Staff ensure that those gaining access to the Shelter apply for a Medical Card, if eligible. This could explain the relatively high rate of Medical Card ownership by the participating sample.
on any medication and whether or not they have ever experienced depression or had attempted suicide.

**Diagnosis**

It is recognised that it can be particularly difficult for individuals to judge their own mental state.

**Figure 8 – Participants by Conditions Noted**

Studies have identified that alcoholism and/or substance abuse can be particularly difficult to categorise as it can be understood as a mental health difficulty by some, but not necessarily so by the person concerned.

When analysing the data in this section it was noted that some participants had more than one mental health difficulty, and in some cases only mentioned those that had been diagnosed. The figure above refers only to the incidence of different conditions identified by the participants, and not to the numbers of people who claimed to have them.

According to the Adult Homeless Multi Disciplinary Team, the vast majority of people referred demonstrate a personality disorder, organic brain disorders or a mental illness. Generally, about 60% of people presenting themselves to the team have a mental health issue.

Recent studies have indicated that homelessness is most frequently associated with people who were diagnosed with organic mental disorders, schizophrenia, bipolar disorder and other related psychotic disorders, mood disorders (especially depression), anxiety disorders, substance use disorders, and personality disorders that cause interference with functions [(Robinson 2001), (Munoz et al 2004), (Mater Hospital)].

Consultations with the key stakeholders confirmed these findings. Of the twenty-two agencies consulted regarding the main mental health problems observed, thirteen identified depression, ten agencies identified drug and alcohol addiction, nine organisations said schizophrenia, four noted anxiety, four identified behavioural problems, and four reported self-harming behaviour.
Other mental health issues noted were bipolar disorders, obsessive-compulsive disorders, coping problems, suicidal ideations, psychotic episodes, and psychosis.

**Perceptions**

Participants were encouraged to consider what would be of assistance to them, with respect to their mental health needs. On being asked if they were currently consulting anyone about their mental health, each participant denoted a different significance to ‘seeing anyone’. For example, one participant answered NO to this question, yet he was seeing a counsellor. This participant had a history of psychiatric support, yet did not associate the counsellor with mental health services. Another participant, who stated that she had been diagnosed with depression and anxiety and was receiving medication, responded NO when asked was she seeing anyone regarding her mental health. This indicated that, even though she was receiving medication for her depression and anxiety, she did not relate her GP as someone she was accessing for her mental health support. She only saw this point of contact as a means for medication, not mental health treatment.

On being asked if they have contact with anyone who talks to them about their mental health, 13 of the 21 participants said that they had someone. Those identified included: two general practitioners working with the Adult Homeless Multi-Disciplinary Team in Cork; Psychiatric Nurse; Counsellor; their own GP; Nurse; Staff in the Cork Simon Emergency Shelter; Key Workers; a Nun; Social Worker; and Friends. Other services were also identified, including: St. Michael’s, Gamblers Anonymous, and the Christian Church.

### 1.3 Detailed Interviews

Eleven participants volunteered to proceed to the longer duration interview: Peter, Mathew, Nora, Mark, Luke, David, Alan, Richard, Alice, Oliver and Steven. Of these, Nora, Peter and Alice also provided more detailed narratives of their life experiences.

#### 1.3.1 Pathways into Homelessness

Each participant had a different story of their ‘pathway’ into homelessness and yet they also had some similarities: -

- Three participants began their experiences of homelessness when they were in their childhood to late teens;
- Four were either evicted or asked to leave their home;

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11 A key worker provides support and advice to people, often advocating for them, and acting as a bridge between voluntary and statutory organisations. Key workers often have information about the needs of their residents, their history, and knowledge of services in the area.
Dark End of the Street - Dealing with Mental Health and Homelessness in Cork

- Two became homeless following the breakdown of a personal relationship;
- Two migrated to homelessness following personal relationships they had with people who were homeless already, or whose lifestyle included living on the street at the time.

For some, the reasons given for becoming homeless did not capture earlier incidents in their lives that would have contributed to people's homelessness. Nora said that she was evicted from her flat just three months after taking up her tenancy there, and that this began her pathway into homelessness. It is only by listening to her life story that it became clear that Nora had lived through a number of seemingly crucial events that may have contributed significantly to this crisis, such as child abuse, suffering from anxiety, depression, and drug and alcohol abuse.

Mark was very clear as to when he started to get the ‘taste’ for homeless life due to his experiences of domestic violence as a child. He was only 8 years of age when he would return from school to see his father beating his mother. ‘I mightn’t go home for days… and I’d go to where my mother was working and she’d feed me… and I still wouldn’t go home… I use to sleep somewhere else for safety, away from my father when I was a child… That’s when I first got the taste…’.

Mathew had experiences of homelessness a few times when barred from the family home. During that time he stayed with family, friends, and sometimes with Cork Simon. It was only when he was barred for life that the facts of his situation became a reality: ‘…even today, it never leaves you…When she gave me the last barring order I had nothing coordinated properly…I said…I have no where to go…’.

Alan had early life experiences that indicated that he was at risk of homelessness, however, it wasn’t until he came to be with his family that he entered into a cycle of drinking and homelessness; a cycle that has only changed in the last six months after many years. He was taken into care at a young age. As a young adult his family contacted him, and he decided to move back home: ‘I felt very lonely in the world because I wanted contact with my family… little did I know they were chronic alcoholics, and I knew nothing about chronic alcoholics, so I ended up being homeless… that was more than twenty years ago…’.

1.3.2 Episodic or Chronic Homeless

Each person interviewed was availing of Cork Simon Services, and some found that moving beyond homelessness was easier said than done, particularly for those who had been episodically or chronically homeless.
As Alan explained, having never experienced a better quality of life, he has ‘...no taste of a better life... and you don’t even know what you’re able for because you’ve never tasted it... you have to have a taste of it before you actually you say... I really want it...’.

Living on the street and availing of the homeless services, particularly those provided by Cork Simon, may have become the norm for some. This is particularly the case if they have accessed the service over a long period of time. Peter noted: ‘...it’s my way of life... it’s normal for me... for instance. If you get barred (from Cork Simon), for whatever reason, for one or two weeks... I miss this place... it’s my home, this is my home... there are some that don’t agree with that, but this is what I’m always saying ... home kind of thing...’.

1.3.3 Cycle of Homelessness

Despite the social restrictions experienced through homelessness, one participant seemed to indicate that there was a level of freedom embedded in the lifestyle they were accustomed to, compared to the available alternatives, ‘I feel if I go around there (homeless services) and get nice clothes, I’m going to get fed up. What do I need nice clothes for?... I’ll be locked in... I can’t stick it... I have to be back here at 12 o’clock... I can’t stick that...’.

There are those who appear to be doing their best to ‘break the cycle’ of homelessness and shake off the homeless identity, but find it impossible to deal with the system that is currently in place. On being asked if there was anything that helped him through the whole experience of homelessness, Richard explained that there were no interventions to help him get on his feet, and it’s been up to him to ‘snap out of it’. He explained that at the moment he has a chance of getting a flat, but rent allowance will only cover a portion of the cost and he is not permitted to make up the difference from his pension book, because of concerns that he will not have enough money for food as well. Due to these restrictions, Richard has no choice but to look for a smaller place – a ‘box room’.

When asked how this would suit him mental health-wise, Richard replied: ‘It’s just another cell... Didn’t you see them when we were walking by?... (The bedrooms in the shelter)...That’s the same as prison...’.
Dark End of the Street - Dealing with Mental Health and Homelessness in Cork

Richard's example demonstrated that even though he experienced homelessness from an early age, he attempted to get back on his feet. It has been two years since he's last had a flat or a house. He has a long history of being in and out of prison and of being in a psychiatric hospital when he was still young. Richard also has a history of heroin and alcohol use, but in the last few months he has successfully completed his Safe Pass\textsuperscript{12}. He is attending the counsellor once a week, which is part of the services offered by the Adult Homeless Multi Disciplinary Team in Cork Simon. Yet other policies, such as rent supplement, do not take into account that Richard would find living in a box room detrimental to his mental health because it reminds him of prison.

Other participants stated that they have tried other ways of finding accommodation. Alice is seeking a letter from her doctor to assist her in applying for council housing. She has been diagnosed as having a mental health difficulty and receives Disability Allowance. She is presently living with her mother in inappropriate housing conditions. She feels she 'might as well be homeless'. Matthew has a Bipolar Disorder and has lived in the Cork Simon Shelter on and off for a number of years. Cork Simon has been very influential in Matthew's life, both as a place to live and introducing him to the Adult Homeless Multi Disciplinary Team to help him manage his mental health. They have helped him apply to the Council for his own flat.

1.3.4 Self Doubt

Fear

One participant explained that their mental health has deteriorated since they became homeless and that it has directly influenced their lifestyle, which includes street drinking, taking hard drugs and living in dangerous situations. Their living situations seem to change regularly, moving between different squats and derelict buildings, sometimes on their own.

The street life for a woman can be frightening, and it was observed that to overcome this, one participant invited people back to her squat. This resulted in hanging around with people who 'party', which lead inevitably to the squat being vandalised and inhabitable. It is the paradox of wanting not to mix with people who may have a deviant lifestyle, and yet needing social relationships to survive on the streets. This fear can only add to anxiety and have an affect on mental health, especially when trying to change things.

\textsuperscript{12} The Safe Pass Health and Safety Awareness Training Programme is a one-day programme run by FÁS. It aims to ensure that all construction workers in Ireland have a basic knowledge of health and safety. This is to enable them to work on construction sites without being a risk to themselves or others who might be affected by their actions.
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Peer Pressure

Social relationships developed on the streets seem to lead to peer pressure or bullying, which then perpetuates a cycle of behaviour. As Nora explained, she left Cork for a few weeks to get away from some people that she did not want to be around. However, she ended up in a worse situation outside of Cork, and had to return to Cork into the same peer circle: ‘whenever I see them, I’m being bullied… I have to go with them…’.

Homelessness was a factor that Alice had to deal with during a time when she was seeing a psychiatrist in relation to her mental health condition. In total, she spent about three years periodically sleeping rough. It was through her association with the people on the street that she got to know Cork Simon. Alice found living that type of life difficult and often met people and got into situations that were not conducive to her overall health.

Isolation

It is well reported that when a person with a mental health difficulty takes alcohol or drugs, they may experience different responses to the initial affects. After a while, however, these affects can often intensify the feelings of powerlessness and confusion. Isolation is reinforced and a cycle of behaviour seems to continue. As Alan explained: ‘You’re totally lost… how did I get here? Why am I here? How come I’m staying here? How come people are getting on with their lives, how come I can’t do it?… you don’t even know why you’re in such a hole… you can’t get out of it… What is wrong with me?’.

Stigma

Stigma still appears to exist when talking about mental health, and was very clear in a number of the interviews. One participant felt people treated him differently when they heard he was being treated for a mental health difficulty. He was upset that strangers knew about it.

There still appears to be a shame or label attached to ‘seeing’ a psychiatrist or attending a psychiatric facility. Some people would prefer to deal with their GP as ‘there is a stigma attached to the other (psychiatrist)’. It may be that the old image of the person who has been ‘taken away’ plays in the back of some people’s minds.

Stigma is not only associated with mental health, but also homelessness. As one participant observed, he would often hear people say they wouldn’t ‘be seen dead down in the Simon’ and often do not want people to know that they have stayed in Simon Community’s Shelter.
1.3.5 Lack of Direction

Suicide

Of the eleven qualitative interviews conducted, six participants mentioned suicide. The reason for the mention of suicide differed in all cases, from the feeling of losing direction in life, to depression.

For others it was a cry for help, and for another it was a way of justifying asking for help. When asked how she thought her mental health was now, one participant explained that she had very strong thoughts of killing herself because of being on the streets. She does not know how she will feel from day to day and seems to recognise that she needs help: ‘I asked…… two weeks ago, could (I be signed-in) somewhere to dry out, and (I was told), that they only sign people in if they have a mental health problem, and I pointed to the scar (from a suicide attempt) and said… “is that not good enough of a mental health problem?”… and (I didn’t hear) any more after that…’

Other views were volunteered on suicide because of fear or desperation. It is accepted that suicide is the most acute manifestation of mental illness. Ireland experiences higher rates of suicide than most of our European neighbours. It is the second most common cause of death in young men. There is a clear social class gradient in suicide for men and women of all ages with higher prevalence among people from lower socio-economic groups.¹³

1.3.6 Stress, Anxiety and Depression

When participants were asked to talk about their lives before they were homeless or before they started using Simon Services, they often spoke about their past and their home. It was in that question that people gave an indication whether ‘life’ had been difficult from the beginning or if things had only started to get difficult when they became homeless. In the case of one participant, life had always involved stress, anxiety and depression, and although recorded as being homeless for eighteen months, it was revealed that her mental health and life has been in crisis for a number of years. Although on medication for anxiety and depression, she was not seeing a psychiatrist or counsellor.

Alice described how not having her own place as depressing, which greatly affected her wellbeing: ‘when I hang around the streets I’m drinking cans… I shouldn’t even be drinking because a drink is a depressant anyway… and I shouldn’t be out taking drugs, but when you’re on the streets, hanging around and you have no where to live …and you want to lie down, put your head down and all you want to do is go to sleep, and then of course you’re drinking and taking drugs, which, there is no getting away from it…’

Identifying the Problem

When Peter, was younger he was different to his friends: ‘I always knew that things weren’t right even before I was sixteen. All the lads would be happy, laughing and joking and I would be too, some of the time, but then most of the time I’d stay in my room…not wanting to come out…’. His parents also thought there was something wrong, but thought it was behaviour problems. It was a local doctor (GP) that suggested that Peter had depression and suggested that he go into hospital. That started to get to the root of the problem. It was also the end of Peter’s connection with home.

Peter was a teenager when he entered a psychiatric house and was a resident there until he was about 18 years. Due to medication, Peter started to feel more confident and decided he wanted to leave the psychiatric house. He did not want to end up like some of the people there: ‘… people who were there for years upon years upon years… I wanted to move out to more kind of… what they call it, more normal society’. So he left the psychiatric house and went into Cork city, not back home. ‘That’s really what got me on the streets really because I didn’t go home after that really…’ Peter said that he lived on the streets for about four months before he went to Cork Simon.

1.3.6 Access to Mental Health Services

General Practitioner (GP)

The GP was named as the first point of call for mental health care for most of those who participated in the research. The only other access point that was named was through the prison service or homeless services.
Research has shown that people who are experiencing homelessness often use Emergency Rooms, but in the case of this research, most participants appeared to associate the GP, particularly, with access to mental health care. When one participant was asked if he was attending any clinics, doctors, and mental health services, he said he was not, but mentioned that he was still seeing his GP: ‘...to get medical certificates and things like that to get my (social welfare)...money’. Another participant described how she was going to her doctor because she was evicted from her house and believed she could get Council accommodation quickly, given her mental health history ‘if I go to my doctor and get a letter... when you are on disability... you get sent to the top of the list... now that I am homeless...’.

From the discussions, it appears that in some cases the GP referred the participants to the psychiatric services, but the GP continued to be the main point of contact for many. The GP was Alice’s only access to mental health care and she only went to her GP when she felt she could not cope or was on a ‘downer’. She had three changes to her medication before an anxiety attack in the GP’s surgery caused the GP to arrange an assessment in a city hospital, and Alice suggested that if it were not for this, she would have continued to receive only GP care.

One difficulty that emerged with the GP acting as the bridgehead to mental health services was that in instances where the individual did not have a Medical Card, was not attending a GP, or had been in care institutions from a young age, they did not necessarily know how to get help, unless they went back looking for assistance. One participant explained that due to his circumstances and age at the time, he did not know how to go about things: ‘I had to become an adult fast and actually got someone that (a hospital) mentioned...’.

From a positive perspective it was noted that the relative anonymity of attending a GP’s clinic means that no one knows why a person goes to the doctor. The individual attending the clinic could be there for any number of health reasons. Therefore, the GP does not hold the same ‘stigma’ as going to a psychiatrist.

‘...I go back to my doctor and get a note from him and he’d sign you in ...You couldn’t just walk up to the hospital and say you want admittance...’
Mathew

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14 The term ‘mental health care’ is being used as a GP can not be termed as a mental health service: ‘mental health services’ means services which provide care and treatment to persons suffering from a mental illness or a mental disorder under the clinical direction of a consultant psychiatrist” (Mental Health Act 2001: No. 25:8).
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Medication

Using these examples and taking the ‘social model’ and ‘medical models’ of disability into account, both these individuals clearly had childhood experiences that affected their mental health and contributed to their life path.

One intervention to deal with mental health difficulty has been to prescribe medication. Another has been to offer services; such as a social worker. A social worker was assigned to one participant, and even though she believed the anti-depressants prescribed to her were making her feel worse, she was told that she had to take them. She attempted to go off the anti-depressants twice, which resulted in two mental breakdowns that she did not seek help for: ‘I got through it myself and the third attempt to get off them, I got off them and I got back to my normal self and I felt great and I managed to stay off them for two years…’

Nora did not mention that she had received any social programme or other supports at that time, other than her Public Nurse. This is not to say that supports may not have been offered to Nora, but that she felt she did not get any help.

Steven’s path took him to different jobs and he spent a number of years abroad. It was only when he became homeless abroad that he came in contact with mental health services. He found these services by talking to people on the streets: ‘….I didn’t even realise that depression was a disease… That is when I realised I could actually get sickness benefit…’

Steven mentioned that he had been on medication for twenty years and has been homeless, on and off, for ten years. He too did not equate medication with mental health care. It was only when he accessed rehab units or psychiatric hospitals that he thought he was receiving mental health care and when he was identified as having a ‘disease’.

A dual diagnosis approach is lacking in favour of a medical model of care, which focuses on medication of the condition alone. There is a lack of co-ordination with other services such as Addiction Counsellors, psychotherapists or other occupational options, which would represent a more ‘social model’ of care. This is not to say that participants were not offered these services, only that they did not mention them in the course of interview.
Non-Compliance in Taking Medication

Those suffering from mental ill health are often the most vulnerable in society, and it may be argued that, as such, are often coerced into accepting treatment. Those who refuse treatment appear to be frequently labelled as non-conformist.

A person’s option to refuse treatment should be based upon informed consent. By eliciting information, shared negotiation, planning and improved communication, health professionals may improve compliance behaviours based upon each person’s needs and wishes.

Non-compliance in taking medication was cited in many of the interviews. The most common reason that participants stopped taking medication was that they felt it did not suit them. This was the case with Alice: each time she felt the stopped. She also stopped when she felt the medication was keeping her in a depressed state. Alice had mixed feelings about medication, in some ways she believed it helped her, and in other ways, she was afraid of the side effects, but mostly she debated that it might be the ‘easy way out’.

Although drug use is also part of Alice’s life, she never mentioned receiving any care or assistance with addressing this part of her lifestyle. Although aware of the potential risks she is taking Alice, does not take her medication when she takes ecstasy or other drugs. This contributes to her on-off approach to her medication.

Alice was aware of her mental health condition. Her story shows how diagnosis and different care services have worked in her case. Her medical journey is summarised below, and demonstrates her pathway through homelessness.

Richard stopped taking medication because he felt it made him aggressive. When asked what the purpose of the medication was, he said it was: ‘Just supposed to get me out of their hair…’. Richard did not seem to gain any perceived benefits from the medication or understand why the medication was being prescribed to him. When asked if the GPs explained why they were prescribing him the medication, he said it was ‘To deal with the past and to deal with this, that and the other…’.
Figure 9 – Alice’s Pathway

Alice's mental health illness triggered by:
- Parent’s Death
- Relationship with Boyfriend ends
- Passing a ‘milestone’ birthday
- Millennium and new coinage milestone

She feels it is getting worse
Stops taking medication
Goes back to GP for different medication and gets information on medication and drug use and a new prescription.
She has an anxiety attack in the GP surgery and she is referred to Hospital for re-evaluation

She then went on a ‘downer’ and couldn’t get out of ‘it’ and stops taking medication
Zyprexa from 10mils to 12 and half mls.
Now she is going back to GP to ask for letter to apply for Council accommodation and also to ask for a different medication in case she goes into a ‘downer’ again.

On her second visit she saw a different doctor who, after discussion with her, changed her dosage as she felt she was still manic.

Zyprexa and weaned her off Lexapro
She felt the doctor ‘psycho-analysed’ her and listened to her. He gave her new medication,

Psychiatric Services diagnoses
- Manic Episodes
- Bipolar Disorder

Referred to local Psychiatric Services
She did not feel the psychiatrist listened to her and she refused to go back. She was referred back to Hospital

10 year timespan

Alice's mental health illness triggered by:
- Parent’s Death
- Relationship with Boyfriend ends
- Passing a ‘milestone’ birthday
- Millennium and new coinage milestone
In Mathew’s case, he developed a relationship with his psychiatrist and seemed to try different medications until ‘they’ found the right one. Up until that time he had different experiences with different doctors around medication and often ended up leaving them. He described the experience of one of the medications prescribed to him in the past: ‘from the neck up it made you numb and it took out your vocabulary and you didn’t know half the time what you were talking about because the tongue and the brain wouldn’t coincide with one another…’. The key to the success with his psychiatrist was that he felt he was listened to, respected and treated like a human being.

Psychiatric Hospitals

The Mental Health Act 2001, which replaced the Mental Treatment Acts 1945-61, has started to impact on people’s attitudes towards psychiatric services. The Act enabled the establishment of the Mental Health Commission, which has created more transparency and information around mental health services and patient’s rights. The Act was ratified in November 2006, and still has a long way to go, but it is regarded as a very important step in legislation regarding mental health service provision.

Of the eleven participants in the main sample group, six have accessed a psychiatric hospital as part of their mental health care. There were very different views of the services they experienced, which varied from ‘mental agony’ to ‘it helped’.

Peter’s experience of psychiatric hospitals started when he was a teenager. Under the previous Act, Peter was deemed to be an adult. Today, anyone under-18 years is considered to be a child. Individuals below this age require the HSE to make an application (under Section 25 of the Act 2001) for an order authorising the admission and detention for treatment of the child in an approved centre. Current figures show that: “Four children were admitted under section 25 between November 2006 and February 2007, out of a total of 49 child admissions to approved centres. Of the 49 children admitted to approved centres, over 80% were aged 16 or 17” (Review of the Operation of the Mental Health Act 2001, 2007:20).

Along with Peter, Mark stated that he was admitted into psychiatric hospitals in his teenage years. Mark reported that when he was eighteen years of age he suffered a ‘mental breakdown’. Other experiences were more graphically told, particularly around electric shock treatment, treatment for depression and medication to help detoxification.
Peter explained that having been in and out of different mental health facilities, he really did not know how to access or avail of any health services: ‘I’d find myself going to a psychiatric hospital for an assessment, I didn’t even know anything about that… since sixteen it was always someone else that actually spotted the problem…’. Somewhere along the line he never learned how to recognise the signs and ask for help, until now.

There seems to be something about the life he lives in the Cork Simon Emergency Shelter that is working for Peter. There is something about homelessness that has become part of his life.

**Fear of Being ‘Sectioned’**

When talking to the participants about their experiences of psychiatric hospitals the subject of being ‘sectioned’ entered the conversation. Two participants mentioned the fear of being sectioned, and noted it as a deterrent or barrier against engaging in continuing care. One participant explained that she would go back to the psychiatric hospital if she knew they would give her a prescription for her medication and send her on her way again. However, her fear is that she will have to stay there: ‘I’d go back, but only I’m half afraid to go back in the sense that I think they might want to section me for not taking the drug…’.

**Dual Diagnosis**

Based on the interviews it appears that there is little being undertaken by way of dual diagnosis. This view is evidenced by the manner in which the participants spoke about either their admittance to hospital or to other services. One participant explained that while he was living abroad he was in the hospital a few times due to depression and self harm, but since returning to Ireland: ‘…there was nothing like that… I mean the self-harming, I snapped out of it… and when I came back, I ended up in (hospital)… once for mental health, the other for alcoholism…’.

Six of the eleven participants that were interviewed mentioned that they took either alcohol, or drugs, or both. Three of the six are on psychiatric medication, and two of the other three admitted to taking themselves off medication. Non-compliance in medication was also recorded during interviews.

### 1.3.7 Access to Services

**Cork Simon Staff**

When analysing the short questionnaire concerning the access to services, particularly in respect of referral, Cork Simon Staff were mentioned most frequently. The role of on-the-ground staff and the expertise they have in dealing with people who experience homelessness and mental health difficulties cannot be under estimated.
One participant’s testimony revealed that the support received from Cork Simon relieved his feelings of isolation, because he knew there was someone there for him and he was not alone. As he explained, it was challenging previously when he was living on his own and was going through depression, but knowing that Cork Simon has someone he can talk to has eased the pressure. As he explained, ‘we all have an image of home… something we have learnt to strive for… We often think the ideal thing is for someone to live ‘on their own’, to have their own place… on their own… if I’m living on my own and I do start to get depression it’s more or less like… what do I do? It’s harder… while here I can actually go to somebody, one of the staff members or even the counsellors here… once a week… then something’s done…’.

The interpersonal skills that the staff members use to connect with people were also described as helpful. As one participant explained, he felt that people care about him, accept him, and even if he goes out drinking and gets barred, that somehow, people still have a connection with him and still watch out for him.

**Adult Homeless Multi Disciplinary Team**

The Adult Homeless Multi Disciplinary Team was set up as a pilot programme\(^{15}\) and has opened access to mental health care for the users of Cork Simon and St. Vincent’s. Five of the participants of this research were either seeing a psychiatrist on a regular basis, or the Counsellor. The psychiatric nurse was also mentioned.

When asked whether he was attending any clinics or doctor at the moment, Mathew expressed his satisfaction with an AHMDT team member who he sees regularly.

David has found that he needs help to deal with the different people in Cork Simon Shelter that he feels have a mental health difficulty. He talks with an AHMDT team member who helps him deal with any issues he would find difficult to deal with on his own.

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\(^{15}\) The Health Service Executive’s overall objectives for the provision of health and welfare services provided the focus for a comprehensive response to the needs of homeless persons which led to the development of the Adult Homeless Multi-Disciplinary team comprising of a General Practitioner, a Public Health Nurse, an Addiction Counsellor, a Consultant Psychiatrist, Community Mental Health Nurses, a Health Promotion Officer and an increase in the number of Community Welfare Officers. These services are being delivered on site at the hostels. (*Homelessness – An Integrated Strategy for Cork 2005-2007, Cork City Council*)
Prison

Of the eleven people interviewed, five people mentioned that they were in prison at some time or other. This was not a direct question and, therefore, does not give accurate data but it is interesting for those who volunteered the information, in particular what was it that:

a) Got them to mention it; and
b) Did they receive any mental health service while in prison?

Nora mentioned she was on remand for three months during the eighteen months she was homeless. When she was calculating the amount of time she had been homeless, she subtracted the time she spent in prison. This indicates that being in prison changed her perception of her state of homelessness. As she described: ‘…I had a Council house and I lost it… and that was about 18 months ago, so I’m actually homeless 18 months – and I was living in a trailer for 6 months, and I went to jail… I was 3 months on remand and I got off with it in the end so 12 months basically I’m on the streets in Cork…’.

Mark mentioned the Probation Service, and even though he said that they did not give him support, as he tells his story it becomes clear that the attention the Probation Officer gave him made a difference in his behaviour. When asked if the probation officer gave him any support, Mark explained that the Probation Officer visited him regularly, and he would go see the probation officer twice a week. The support from the Probation Officer also seemed to keep Mark’s mind focused, as he explained: ‘… I wasn’t using drink, I wasn’t using drugs … I got away from bad company. I started to get into new company… it kept me away from serious crime.’

Alan found Alcoholics Anonymous through the prison services. Even though AA is widely available, it was within the prison system that he found this support. Due to his behaviour in prison, Alan felt he had no other choice but to start the AA programme. As he explained, he ‘cracked up’ one night while in prison and assaulted several guards: ‘… it’s just that I was at the end of my tether, I couldn’t take it any more, and I was in the ‘station’ for 3 years so it was either AA or …’.

Richard served the longest time in prison. He said that at one of his hearings it was advised that he be seen by a psychiatrist when he started his sentence and he said this never happened. If this was the case, then the ruling was not carried out, and Richard did not get the care he was ordered to get.

The Importance of Talking and Listening

One of the clear ways to access information, services or mental health care cited by many participants throughout this research was through talking and listening. Throughout the observations offered, there are clear indications that talking to someone helped individuals find

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16 Slang for prison.
what they were looking for: from finding the Cork Simon Community by talking to people on the street, to talking to the AHMDT team member and finding the right medication.

One of the clearest illustrations was with participants who talked to someone who listened. This included Simon Staff, a counsellor or their own GP. This began the process of gaining access to appropriate mental health care. When asked what he thought the difference for him was between medication and counselling, Oliver explained: ‘... I don’t know what’s going to happen in counselling but I know what’s going to happen in medication’. Oliver also explained that having someone to talk to helped his mental health. ‘...It is being around people and chatting to people that helps… if something is bothering you, you can have a chat with someone’. Nora observed that counselling helped her with her confidence and self esteem.

Drug Addiction

While acknowledging the link between being homeless or being out of home and mental health, one participant explained that her mental health was fine until she became homeless. The deterioration of her mental health seems to have been compounded by drug use. As she declared: ‘It’s been the worst 6 years of my life…’.

It appears that breaking free from the cycle of drug use can be difficult when homeless because of existing social networks and a feeling of helplessness to change. The experience of one participant reveals that, when her stay with family was over she needed a place to live, or she would be back on streets. She desperately wanted to stop the cycle of homelessness and drug and alcohol abuse from starting again. She wanted to move away from the people who she associated with drugs, but believed she often did not have a choice when living on the street.

Nora described how her memory has been affected by drug and alcohol use, and how this has resulted in her either failing to access services because she forgets, or it stops her from accessing the homeless service because she is using substances at the time: ‘I did contact (drug treatment centres)… and my memory was so bad, if I had an appointment, because in two hours time I wouldn’t remember it… I ask the staff here (Cork Simon) the day before, please remind me tomorrow, it would completely float out of my head …’.

Heroin in Cork City

Throughout their interviews, participants named heroin as the biggest contributing factor to homelessness. Richard explained: ‘The heroin is hitting here at the moment…and when that hits… it just destroys your life … you’d do anything to get it…Before, you’d have to go to Dublin on the train to get it – but now you can get it around the corner here…’.
A number of participants interviewed stated that heroin was changing the environment in the City. For them, the City was becoming even more dangerous as they would meet people and would not know what they were going to do or how they were going to react.

Steven, reported that violence on the streets of Cork had increased: ‘…I see more violence being homeless in Cork…’. It was reported to the researcher that for the past year, a particular gang had been targeting people in the vicinity of the shelter and stealing and intimidating them. As Richard explained, ‘Any time of the day… if they have no money and they see you walking around they’ll take money off you, whether you like it or not… – if you want to get stitches they’ll take it off you, otherwise you just have to give them…’. He went on to describe how these thefts are resulting in people getting stabbed and getting their throats cut, but nothing can be done about it because if anyone complained, it would put them in even more danger.

Mathew was asked about the streets of Cork and the changes that he has witnessed. He described how people high on something treated him: ‘…you’ve got to be wary of the people who’s on it… they can turn like that… these three people were out of their (heads)… and they pulled knives for me to empty my pockets, and I know if I gave one false move, I would have been dead…’.

**Relationships**

Relationships with others were important for some participants, and became a running topic throughout the interviews, especially relationships with other people who were homeless or living or drinking on the street. These relationships had a ‘black or white’ dimension to them as they were reported to be either very good or very bad.

Alice noted: ‘…I only have one friend that doesn’t take drugs… she use to – now she does them occasionally, she’s the only one person I know, out of everyone I know…’.

Another relationship that was very strong for some, and non-existent for others, was that with immediate family. Nora made reference to her mother when she was saying why she would not drink alcohol. Her contact with her children and family can at times be instrumental in her decision-making. Nora described a recent event where she was being peer pressure into drinking alcohol ‘…I was there for an hour saying NO, I said, please don’t offer me it to me again, I don’t want it and I didn’t touch it and I was proud of myself… I also knew if I did touch one, I was on the streets. Because if I did, when I would go home… my mother would have me straight back out the door… all I was thinking at the time was I did not want it…’

‘…I see my friends out there and they might want me to go for a drink and I prefer to go for a drink because they’re the people I know…’: Mark
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Others get letters or telephone calls from family members. The connection to family can be powerful for some and detrimental for others. During the interviews personal questions on family were not asked unless the person volunteered the information. Of the eleven people interviewed, five said that they had contact with family. Generally, the women spoke most about their attachment to either mothers or children, while men spoke about their mothers who had passed away, separated spouses, and children.

**Everyday Life on the Street**

For people who experience homelessness the day starts at 6:00 or so, and ends about 3:00 or 4:00 a.m., if all is well. As Richard explained: ‘...when you’re outside on the streets… you wake up about 6 o’clock, and you can’t go (back) to bed, and you can’t go to sleep…until 3 or 4 o’clock in the morning, or (have a lie in) because everyone else is running around, so what are you going to do… until 3 at night…’

‘...Being on the streets actually makes my mental health worse…somebody might come to attack me… I am lucky because I have friends in houses and high places… and I know I’m mentally ill and that, but I know there are others ten times worse…’.

When asked if the Mental Health Services were meeting his needs, Oliver replied ‘They are really, yes… I know a lot of people who are not getting services…’. For Mark it is a reality, and he can already foresee what his future might hold: ‘I’m going to be honest with you, I can’t see myself reaching 47, if I have to go through like this…through the winter’. At the same time, Oliver remains optimistic. He explained how he got up in the morning and started walking: ‘It got my blood circulating again, moving and I felt better and I got down there and I went to the bus station… I got into the heat and then I got a smoke and so that was my day started alright…’ (August 2007).
2 - Stakeholder Consultation
2.1 Key Findings from Stakeholder Consultation

A total of twenty-two key stakeholders were consulted to get the service providers’ perspective on the incidence of mental ill health among people in Cork who are homeless. These consultations took the form of semi-structured informal interviews. The key stakeholders included those involved with hostels, supported housing, advice and support services, the Adult Homeless Multi Disciplinary Team, and the Health Service Executive. The majority of services and organisations focus on the Cork city area. The City Council also covers parts of the southern hinterland. Some organisations receive referrals from Cork county and other organisations outside of Cork. The main areas outside of the city include Waterford, Limerick, Galway and Kerry.

2.1.1 Role of Organisations

A number of the agencies and organisations interviewed do not have a statutory remit to support people who are homeless, however, each organisation and agency interviewed provides a specific service. The National Housing Organisation in Ireland, Threshold, mainly deals with the prevention of homelessness by supporting both people who are homeless and those on the brink of homelessness.

2.1.2 Hostels and Shelters

There are a number of hostels and shelters operating in Cork City including Cuan Lee Refuge, Edel House, St Vincent’s, Cork Foyer and O’Connell Court. Each of these organisations provides a specific service to a particular target group, mainly identified by age and gender.

2.1.3 Supporting Agencies

Supporting agencies in Cork City, such as Cork Simon, the Adult Homeless Multi Disciplinary Team, Cork Local Drugs Task Force, Community Welfare Office, Liberty Street House and Probation Service operate integral services, often with linkages to a variety of stakeholders.

2.1.4 Referral

A number of agencies and service providers stated that self-referral was the main way in which people find their services. Word-of-mouth from friends, family, and peers is another

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17 See Appendix A7 for details about services.

18 Including those who have accessed the services on a prior occasion.
important way in which people become aware of the services available to them. Other referrals come from hostels, hospitals, doctors, psychiatric services, Cork Mental Health, social workers, primary treatment centres, the Gardaí, prisons, Probation Services, Community Welfare Officers, Child Protection Services, the Adult Homeless Multi Disciplinary Team, and the Homeless Person’s Unit.

2.2 Profile of People Presenting

It is difficult to get an accurate profile of people presenting themselves to organisations, as the profile can often be quite general. There are, however, a number of trends that were identified from the literature and consultations with agency and organisation representatives.

2.2.1 Gender

The majority of studies conducted in the area of homelessness, show a higher proportion of males than females, with figures ranging from 70% to 85%. The 1999 assessment in Ireland showed that 76.7% of the total population who are homeless were male. Holohan’s (1997) Study showed 85% of the 502 people who participated, were male. Cork Simon figures for 2008 indicated that 88% of those supported were male.

Consultations with key stakeholders confirmed that the majority of people presenting themselves to the organisations are male, which is in accordance with the studies reviewed above.

The lower percentage of females is believed to be caused by an ability of women to get themselves out of homelessness more easily. Another reason offered relates to the rent supplement barrier. This has the effect of increasing the number of single males that find themselves homeless.

The Adult Homeless Multi Disciplinary Team respondents stated that between 80% and 90% of people who present to the team are male. This figure is slightly higher than literature would suggest, and a possible reasoning for this may be because the surgery is based in a male hostel two days a week.

Cork Foyer tries to keep a gender balance among its residents. Liberty Street House also states a gender balance in the organisation. Fellowship House deals only with males and data for 2006 shows that 86% of the men were single.

The majority of the agencies consulted stated that the majority of men who are homeless are single.
2.2.2 Age

Studies from the Department of Environment and Local Government revealed that in 1999, 26% of the total homeless population were aged between 26 and 35 years. This is similar to the study by Holohan (1997), which estimated that 42% of the sample was aged between 18 and 35 years. Feeney et al (2000) found that over half of the respondents were in the 35-54 year age group. Counted In 2005 showed that 42% of those experiencing homelessness reported their age to be between 26 and 39 years and 30% were between 40-64 years. The average age reported was 37 years.

In 2008, Cork Simon statistics\(^{19}\) showed that 18% of all people supported were aged 26 years or younger. The majority of people were aged between 27 and 44 years.

The Adult Homeless Multi Disciplinary Team has noted that the people the support are typically men aged over thirty. They believe this to be mainly because older men are more likely to engage in the services they offer. The surgery typically sees people aged between 22 and 60, with most people in the 40 – 60 age bracket.

The majority of consultations stated that people were typically aged between 20 and 55 years-of-age, however, this varies depending on the service being provided. Threshold states that the majority of people presenting to the organisation are between 30 and 55 years of age.

Cuan Lee and Edel House note that the majority of women availing of their services are between 20 and 35, but that there is a new trend beginning, which sees more elderly women experiencing abuse from sons and daughters, leading to an increase in the number of women over sixty using the services. A smaller group can be found in the 45 to 59 year age bracket in Edel House.

In 2006 Fellowship House recorded that 77% of people were aged between 18 and 34 years. Arbour House notes that the majority of people that present themselves to the Addiction Counsellor are males in their mid- to late-thirties.

St Vincent’s Hostel states that typically the men in the hostel are over twenty years of age.

Those presenting to the Community Welfare Office are all over eighteen years of age. The Garda Síochána noted that the majority of people who are homeless that come to their attention are older males. The Probation Office has recorded that the age profile of those that are homeless is getting younger. Liberty Street House and Cork YMCA deal with younger people, therefore, the age profile of people availing of their services is naturally lower.

2.2.3 Background Factors

Consultations with stakeholders cited the following as the main risk factors for homelessness, which were generally in accordance with the factors stated in Mayock and Carr (2007):

- Family disputes and breakdown;
- Barring orders;
- Social Factors;
- Care History;
- Sexual or Physical Abuse in childhood or adolescence;
- Offending Behaviour or experience of prison;
- Previous history in the Armed Services;
- Lack of Social Support Networks;
- Anti-Social Behaviour;
- Debts;
- Drug or Alcohol Misuse;
- School Exclusion or Lack of Qualifications;
- Mental Health Problems; and
- Poor Physical Health.

Mayock and Carr also mentioned that while a range of factors increases the risk of becoming homeless, there was often a specific event that precipitates homelessness.

It is acknowledged that not all people who are homeless come from challenging socio-economic backgrounds. A number of cases cited by the Adult Homeless Multi Disciplinary Team showed people who once described themselves as ‘having everything’ ultimately find themselves as being homeless. In these cases, it is often mental health issues that are observed to have led to homelessness.

From the Probation Services perspective, the majority of people that they deal with come from a challenging background and have often been assigned juvenile officers or social workers in the past. By the time they reach the Probation Service they are considered to be ‘well down the line’.

The majority of organisations consulted stated that high levels of drug and alcohol misuse were commonly exhibited among clients. Mental health problems were stated as being often masked by alcohol and drug problems.

According to the Probation Services, a significant percentage of people that they deal with would have an alcohol or drug addiction. Most people who present themselves to the organisation are unable to cope for themselves and need supports of some kind.

Arbour House states that the people who they support are very likely to have experienced a lot of trauma, legal issues, suicidal thoughts, and have been institutionalised in some way. Many young people are reported to have severe drug problems. Cork Local Drugs Task Force report that it is often younger people that their members deal with. In appropriate circumstances a counsellor may advise the individual not to return home where it is clearly a fractious or
addictive environment. This advice is offered to encourage the individual to make a fresh start in life.

**Unemployment**

The vast majority of people presenting to the agencies are unemployed, with a number of agencies working with FÁS to provide training programmes to help introduce or reintroduce people to a working environment.

All people presenting to the City Council are reported to be unemployed, and the City Council works with FÁS and Cork Simon to facilitate a pathway to employment for as many as possible.

The Adult Homeless Multi Disciplinary Team indicated that in their experience there was an equal number who are unemployed to those who are on employment-related support schemes. The Team also noted that in a few cases, they have identified multi-generational homelessness within the family unit.

**Educational Factors**

In Fellowship House in 2006, 93% of those supported were unemployed, with an average level of the completion of full-time education being at either Junior Certificate or Leaving Certificate level.

It was reported that in Edel House the young girls that avail of the services may have behaviour problems, are likely to be experiencing difficulty at home, or are early school-leavers. The individuals are quite often known to Social Services. In general, 16% of women move on to private rented accommodation, whilst approximately 30% of the women will return home.

### 2.2.4 Numbers of People Supported

A noted problem in estimating the levels of homelessness is that people who are homeless are transitory, and do not generally stay anywhere long enough to be counted. Furthermore, the phenomenon of hidden homelessness, where people stay on the floors and couches of friends, is effectively impossible to quantify.

Literature reveals that some researchers have attempted to count all the people who are literally homeless on a given day or during a given week\(^{20}\). Critics note that this method is likely to overestimate the number of chronically homeless and underestimate the number of people who experience temporary homelessness. A second method of counting people who are homeless examines the number of people who are homeless over a given period of time\(^{21}\). Critics of this method point to the difficulty of standardising measurements. Other factors in measuring rates of homelessness include the duration of counting and time of year of counting.

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\(^{20}\) Referred to as a ‘point-in-time’ count.

\(^{21}\) Referred to as a ‘period prevalence’ count.
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It is difficult to quantify the numbers of people who are homeless supported by the various organisations in a given time period. Cuan Lee Refuge estimate they are supporting around forty or fifty families a month. The length of stay can range from one night to four months, depending on circumstances. In an average year it is reported that around 700 people avail of the services at Edel House and around 400 avail of the after care service. St. Vincent’s accommodate and assist around 500 men a year. Liberty Street House supports on average 100-120 young people in a given year.

For the first six months of 2007, Threshold had in excess of 5,000 people having some interaction with the organisation. Of this figure, 10.4% availed of the placement services. The organisation receives around seven calls per day, averaging around 50 people per day. However, a number of these may be repeat callers.

In 2006, the Multi Disciplinary Team saw thirty-one new referrals from Cork Simon, on top of the current workload. About half of these were referred to community health nurses.

The surgery has had 7,500 consultations in the past five years, but it is unknown how many of these were repeat patients. In 2006, the Team had 668 appointments, with an attendance rate of 57% (281).

In 2006, Fellowship House supported fifty-nine clients. Of this figure, 75% completed the Programme. In the same year, the Dion Project supported fifty young people.

O’Connell Court provides twenty-five beds for people who are homeless out of a total of sixty-six.

The Community Welfare Office typically deals with around 400 people per month. The Outreach Worker at the Cork City Council supports around 450 people a year. Of this figure about 6-8 people are rough sleepers.

The Probation Office estimates that only around 5% of ex-prisoners are homeless.
2.3 Identified Issues

The key issues identified from the stakeholder consultations are:

2.3.1 The ‘Revolving Door’

It was reported that a number of people who are homeless that present themselves to organisations are not medicating properly. There is no systematic monitoring of people to ensure that they are not returning back into the system. This leads to a classic ‘revolving door’ effect, where people cyclically move in and out of support structures.

A number of organisations would like to see specific drug and alcohol treatment programmes put in place, with targeted interventions for people with coping problems and undiagnosed mental health issues.

2.3.2 Accommodation and Services Availability

All organisations consulted identified an acute shortage of appropriate housing for people who are homeless or at risk of becoming homeless, including pathways to more permanent forms of housing.

A need for the provision of more specialised and youth-friendly services and more progressive interventions that will allow young people a chance to work-through their past was identified.

2.3.3 Drug and Alcohol Issues

A need for an intermediary service or a halfway house for people who are abstinent has been identified.

Arbour House considers that there is a need for more in-patient, ring-fenced beds for people who are homeless. There is a limit in the number of hospital beds and this is more evident among people who are homeless. When there are no beds in the hospitals, the people are sent back to hostels, or else remain on the streets.

The lack of detoxification beds available causes some concern.

There is a recognised problem of the increasing numbers of people with alcohol and drug induced dementia, which, according to O’Connell Court, will increase the numbers of older people who are homeless with a mental health issue. The mental health service does not have respite beds and do not have access to the nursing home service. There is generally a lack of resource allocations to the mental health service.
2.3.4 Assessment of Clients

The key stakeholder consultations generally concurred with the view that a standardised level of assessment needs to be undertaken for everyone presenting to Emergency Shelters. Logically, this needs to be followed up with an agreed care plan for each person.

The Homeless Forum should be used as a medium to agree standardised level of assessment and care-planning. Several stakeholders described the Homeless Forum as being very grounded and aware of what is happening. It is seen as a good vehicle for agencies and organisations to network. Fellowship House have identified an opportunity for a representative in addiction services to sit on the Homeless Forum. It is expected that this representation would significantly aid consideration of dual diagnosis within the Forum.

2.3.5 Prisons

With regard to people leaving prison services, there needs to be a supported hostel provision that acts as a halfway-house for people leaving the prison system yet have nowhere to go.

In prison, people tend to become institutionalised, making adjustments to living independently in the community very difficult for many ex-prisoners. The added problem of the potential for exposure to drugs whilst in prison affects the majority in the system and is difficult to avoid. This can exacerbate mental health problems.

2.3.6 Information

It is difficult to verify the situation of people who are homeless who have been diagnosed with having a mental illness, due to the fact that there is a clear difficulty with access to services. There is a lack of systematic published baseline data on the numbers of individuals facing homelessness, which can be interpreted as being symptomatic of a fractionated support service. Without a clear understanding of numbers, trends and classifications, it is difficult to understand how service quality standards, trends and targets can be established.
3 - Conclusions
3.1 **Prioritising a Response**

The synthesis of the findings of the participant survey, and the key stakeholder consultation identifies a series of challenges that will require a systematic resolve to effectively address.

### 3.1.1 Cyclical Nature of Homelessness

It is accepted that there are considerable difficulties in tracking people who may or may not be visible to the support agencies at any one time, but it was discovered that there is effectively no authoritative database available in Cork City that even records the numbers of people who are homeless at any one time. It was found that this basic measurement has to be drawn from the aggregation of figures across all agencies. Given that the level of inter-agency records were found to be slight, it is easier to understand that some of the work being undertaken with people who are homeless tends to be reactive to their situation. This leaves the opportunity for innovative work to be undertaken at an individual case-study level. The objective of such work must be the creation of a multi-agency progression pathway to enable a seamless movement across supports towards independence for the individual.

### 3.1.2 Access to Mental Health Services

The Adult Homeless Multi-Disciplinary Team was initially established as a one-year pilot to address some of the cycle of homelessness issues identified above. The team of healthcare professionals that operate within the AHMDT are clearly capable of providing an excellent referral resource for agencies in the field. However, key specialists were absent from the team at the time of survey, and there were very obvious resourcing problems within the structure.

Of the 21 participants consulted through the short questionnaire, eleven participants (24%) reported that they had been diagnosed with a mental health difficulty, yet two people did not appear to be receiving any support at that time and did not seem to know how to access suitable services. Although there are people with mental health problems attending homeless services, access to mental health services is poor. Both the survey participants and the key stakeholders have acknowledged the difficulties that exist for people in accessing mental health services. Also of concern is the level of access to counselling services for all people who are homeless.

### 3.1.3 Dual Diagnosis

The views expressed by the survey consultants confirms the findings of the consultations with the key stakeholders that there is generally no coordinated approach for dual diagnosis that deals with the simultaneous presence of both an addiction and mental health disorder. Each diagnosis is seen as separate.
There is a need for primary care service that interlinks with addiction services as these are currently being managed separately. Thus, people who are homeless with a dual diagnosis are often subject to a defensive service provision where it is easier to assume care is someone else’s responsibility. Access criteria mean that a person must be drug or alcohol free before they can access mental health services, and this poses a serious problem for people with a dual diagnosis.

One main problem of the treatment options available for substance abuse is that they are not accessible for people who are homeless. There is a need for sufficient and flexible services to be made available. A number of the studies considered identified drug or alcohol abuse as one of the key risk factors in unstable housing. It is important to note that not all of the organisations dealing with people who are homeless can provide sufficient supports to meet the needs of people with mental illness and drug or alcohol abuse. The government and state services need to monitor the gaps in supports and care to ensure that the complex needs of these people are met.

During the course of the consultation it was noted that individuals presenting themselves to organisations are likely to have difficulty remembering the names of their key worker, and may have dealt with a number of different individuals within organisations.

3.1.4 Accommodation

The support organisations generally identified an acute shortage of appropriate housing in Cork City for people who are homeless, or who may be at risk of becoming homeless. It has been identified that there is a critical shortage of necessary supported housing and community supports for people with mental ill health. An increase in the range of ‘move on’ options and avenues to more permanent types of accommodation can help reduce the numbers of people who are homeless or who may be at risk of becoming homeless. The European Observatory on Homelessness\(^\text{22}\) found that Ireland has one of the lowest levels of supported housing for people who are homeless.

There is no single agency with a remit to monitor the availability of accommodation on a day-by-day basis in Cork City. Additionally, it was reported that there is no effective service to enable people to transition between levels of support, from emergency shelter to residential support accommodation and onwards to independent living. This view may be interpreted as further reinforcing the view that there is an opportunity to improve coordination and integration across the service providers.

The lack of supported half-way houses for those exiting the prison service was seen to be a barrier that would tend prevent the individual from making a positive transition to independent living.

\(^{22}\) FEANTSA European Observatory on Homelessness [www.feantsa.org](http://www.feantsa.org).
Both the agencies and survey participants commented that poor housing standards experienced by some – most notably the small size of bed-sits and flats – is negatively affecting their mental and physical wellbeing.

The Rent Allowance, payable to many otherwise homeless individuals, is considered to be significantly below market prices, compounding difficulties.

3.1.5 Detoxification

Some agencies identified the lack of detoxification beds available as being a cause of some concern. The importance of appropriate accommodation, including transitional housing, after treatment and/or detoxification has been identified as an initial requirement in relapse prevention.

It was identified that there are significant barriers to services, with people being required to travel to Dublin to attend detoxification programmes that last a number of weeks.

3.2 Recommendations

The following recommendations arise from the analysis of the information provided by the survey participants and the key stakeholder consultations.

3.2.1 Adult Homeless Multi Disciplinary Team (AHMDT)

The success of the AHMDT based at Anderson’s Quay is unquestionable. The Team clearly has a positive impact on the mental health of people who are homeless in terms of their access to mental health services and experiences of those services. For the majority of people who are homeless, the AHMDT is their only effective means of accessing mental health services.

1. It is recommended that adequate administrative supports be put in place for the AHMDT. The availability of top-line information on the number of people availing of the AHMDT and the nature and severity of their health is crucial in organizing and planning homelessness services in the short, medium and long –term. Information is key in helping to identify people’s needs and trends in gaps in services.

2. It is recommended that an Addiction Counselor, access to trained counseling, Social Worker and Occupational Therapist are added to the AHMDT. While this research indicates that it is generally easy for people to get medication on prescription, many do not have any access to ‘talking therapies’ or alternative treatments. This is particularly the case for people for whom medication doesn’t work or has other severe side effects. Since the research project was commissioned, Cork Simon now provides access to trained counseling on a walk-in basis.
3.2.2 Addiction Services

Whilst there is a range of addiction services in Cork, access to those services can be problematic. Of particular concern is the lack of after-care supports for people accessing addiction services, creating the ‘revolving door’ effect whereby people are continuously in and out of services.

3. It is recommended that existing addiction treatment services need to be expanded to cater for existing need, including increasing the number of dedicated detoxification beds. People need a place where they can stabilise, receive a full medical assessment and supervised withdrawal as part of an overall care plan. The Dublin Simon Detox Model is one that may be appropriate for Cork.

4. It is recommended that a ‘Step Down Dry House’ with associated supports be established to support people after they access addiction treatment services.

3.2.3 Dual Diagnosis

People with addictions and co-morbid psychiatric conditions, sometimes referred to as dual diagnosis, often require more intensive treatment. The National Advisory Committee on Drugs (NACD) advocate much closer collaboration between addiction programmes and general mental health services to improve outcomes for individuals with dual diagnosis.

5. It is recommended that there be closer collaboration between detoxification services, addiction services and the AHMDT for people who are homeless with dual diagnosis.

3.2.4 Accommodation

Accommodation issues featured prominently throughout this research – from issues about the quality of accommodation to a shortage of appropriate accommodation. Access to appropriate accommodation with the right levels of care and support is a major obstacle for people to move out of homelessness. This is especially the case for people with poor mental health. A mixture of low-support, medium support and high support housing is crucial in enabling people to build normal lives.

6. It is recommended that supports are developed and existing projects expanded to provide routes to more permanent forms of accommodation:

- More High-Support Residential accommodation places
- More places in sheltered housing for people requiring medium levels of support
- More permanent and sustainable housing units for people requiring low levels of support
- Increasing the capacity of the Housing Plus team to support more people in securing and maintaining their tenancies
7. It is recommended that the quality of accommodation, especially for at-risk groups, needs to be monitored on an ongoing basis. The quality of housing for some participants in this research, particularly in the private rented sector, served to exacerbate people’s mental ill-health and contributed to their pathway into homelessness.

3.2.5 Supports for Personal Issues

Supports for the personal issues that affect people as a result of being homeless often receive scant attention. It is important to recognise and respond to the impact of homelessness as it bears down on the person. In addition to improving access to trained counsellors and underpinning the work of the AHMDT as already outlined, it is also important to provide for the employment and recreational needs of people.

8. It is recommended that existing access to training and employment is maintained and expanded; that access to arts, creative and sports opportunities are increased.

3.2.6 Research

Homelessness is a complex issue, all the more so when people have complex needs – mental and physical health conditions, addictions, disability, poverty, education needs, and more. We need a better understanding of the links between mental health and homelessness – especially in Cork, if we are to put in place effective responses. We need a better understanding of people’s ‘pathways’ into homelessness, their experiences while being homeless and the obstacles they face in trying to leave homelessness behind them. The scope of this research project was limited, yet it gives us an insight into the lives of people with complex needs and the challenges that they face.

9. It is recommended that further research be conducted in Cork with a particular emphasis on mental health, on ‘pathways’ into homelessness, and on the experiences of people using existing services for people who are homeless. More in-depth research should include an analysis of initiatives that work, clearly identify the ones that are failing and explore innovative solutions so that people with complex needs can get the care, support and accommodation they need for as long as it’s needed.
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Appendices
A1 Collection of Data

A1.1 Establishing the Criteria

A working group of professionals within Cork Simon assisted in defining the criteria and methods to be employed in choosing the sample group. From this process it was agreed that the qualitative interviews should focus on men and women who were currently accessing Cork Simon Emergency Services and who had mental health issues. It was further agreed that a short questionnaire would engage anyone else who was willing to take part in the research. This approach provides a ‘snapshot’ of the story of those accessing in Cork Simon services during August 2007.

The decision to focus on the clients of Cork Simon Emergency Services was intentional. This approach provided one ‘gate keeper’ and enabled a consistent approach and perspective to be adopted.

A1.2 Design of Data Collection Tools

A number of steps were systematically applied to manage the data collection and ensure continuity of method. The process was designed to establish a representative sample, and to compile a picture that would reasonably reflect the ‘lived experiences’ of the target group.

It was discovered in the process of undertaking the key stakeholder review that there is no reliable record of the number of people that are homeless and experiencing mental health issues in Cork City. In this situation a purposive sample group was chosen to ensure that a reasonable and appropriate sample of individuals were included in the research.

The eligibility criteria adopted for an individual to be included in the sample group was defined as follows: -

**Homeless**

- a) A man or woman who is accessing Cork Simon Emergency Services;
- b) A man or woman who is 18 years or over. (The length of time a person is deemed homeless is not relevant for the sample, only that they are accessing homeless services at the time of the sample.)

**Mental Health**

- a) A man or woman who has been diagnosed as having (or had) a mental health problem or mental health illness; or
- b) A man or woman who has indicated that they have (or had) a mental health problem or mental health illness; or
- c) A man or woman who has been referred to the HSE Adult Homeless Multi Disciplinary Team on the basis of displaying behaviour that suggests that care or intervention might be required; or
- d) A man or woman who has met the criteria above and is willing to participate in the project.

A1.3 Identifying Participants

**Step 1**

The sample group identification process commenced with Cork Simon placing posters around the Cork Simon Day Centre and the Emergency Shelter to inform service users that a research project was taking place and that a researcher(s) would be spending time at the Day Centre over a three-week period conducting short surveys to gather profile data of those attending the
service. Individuals were invited to take part in the qualitative interviews, once they conformed to the sample group criteria.

Step 2

A draft questionnaire was piloted with one participant who was homeless and dealing with a mental health issue. Following feedback, revisions were made to the questionnaire, and the final version was created.

Step 3

Semi-structured, qualitative interviews were conducted on the premises of Cork Simon Day Centre in a private room, and in the Day Centre in a room to the side of the main room.

The qualitative interviews lasted from seventeen minutes, to over an hour in one case, and were digitally audio-recorded.

Before the interview began participants were read the permission letter and asked were they happy to proceed with the interview. They were offered the opportunity of withdrawing at any time during the interview process, if they so wished.

A1.4 Short Duration Interviews

When someone talks about their own mental health they do so under pre-conditions. They have either been asked or encouraged to talk about it, or they choose to talk about it because they have the need to tell someone. The short duration survey had a dual purpose: -

- To gather relevant basic data from the services users accessing Cork Simon Emergency Services; and
- To introduce the research project and assess if they met the criteria for the sample group.

Within the short duration interview process research participants were asked to talk about their mental health. This created the atmosphere in which the person shared their personal experiences. The interviews were conducted as a question and answer session within the context of a listener and talker relationship. During the interviews some of the participants were very open and spoke quite freely about their mental health and experiences of homelessness. They spoke in a narrative, with the questions only being used to keep the story focused. Others found it more difficult and only answered the questions that were put to them. In these cases the flow was more staggered and less fluid in style and content.

Twenty-one short duration interviews using the developed questionnaires were undertaken between the 17th August and 28th August 2007. These interviews took place in either the Cork Simon Community Day Centre or the Cork Simon Emergency Shelter. Most of these took place between the hours of 9 a.m. and 1 p.m., as these were the best times to gain access to people in the Day Centre. By agreement, the staff of Cork Simon acted as ‘gatekeepers’ and put up posters in the Emergency Shelter entrance hall and in the Day Centre to advise people that the survey was being conducted on the premises.

Relationship with Participants

The relationship with the participant began with the introduction by the ‘gate keeper’ to the researcher. It was then the responsibility of the researcher to ensure the welfare of the research participants by explaining as fully as possible, and in terms meaningful to the participants: what the research was about; who was undertaking it; why it was taking place; who would read the report; who would hold the raw data; and where it would be stored.

A level of trust was needed so that the participant would talk and share during the interview process. In the situation in the Day Centre and Cork Simon Emergency Shelter, the researcher was very conscious of being viewed as an ‘outsider’ and needed to be respectful of the people present and participants, which included staff as well as people who used the service. This was achieved by the researcher presenting to the staff at point of entry and taking time to be visible before approaching any potential participant. Cork Simon Staff were particularly mindful and supportive to the researcher and respectful in their approach to any potential participant. This helped develop the ‘trust relationship’, which was essential to the interview process.
A set room was allocated in the Day Centre but this was not used all the time and some interviews took place in other offices throughout the Centre and the shelter. Each participant was consulted before their interview if they were happy with the room and all found it satisfactory.

Individuals who were under the influence of either alcohol or other drugs were not interviewed.

Out of the twenty-one short questionnaires conducted, eleven met the criteria and agreed to take part in the longer qualitative interview. The remaining ten either did not meet the criteria or decided not to take part in the longer interview.

### A1.5 Longer Duration Interviews

When participants finished the shorter interview they were asked if they would like to partake in the longer qualitative interview. In most cases, the participants were prepared to continue. These interviews involved more in-depth analysis and information and, in all cases, the participants gave permission and signed the consent form.

The longer interview repeated a number of the questions that were contained in the short questionnaire, and this was considered advantageous as participants had time to think about the questions and had a second opportunity to expand on the information they had given previously. The interviews varied in length depending on the participant’s willingness to talk about the topics, and varied from 17 minutes to more than 1 hour.

Participants were not offered any payment for their participation and were very giving in their time and thought.

### Ethics and Informed Consent

The adopted process adhered to the values of Cork Simon, and to the standards of the Ethical Guidelines of the Sociological Association of Ireland. The four main pillars of the approach being:

- Professional Competence;
- Integrity;
- Respect for Human Rights, Diversity and Equality; and
- Social Responsibility

**Anonymity, Privacy and Confidentiality**

The anonymity and privacy of those who participated in this research was respected. To ensure understanding, the consent form was read out to the participant before any notes or recordings took place. Also, a separate question was asked seeking permission to use digital recording equipment. The participant was also required to give permission before documenting any medical information relating to medication or treatment.

### Process and Indicators

Verbatim transcripts of all eleven interviews were prepared. The analysis process was designed to enable emerging patterns of experience and behaviours to be identified and coded. This was achieved by reference to the following key indicators, after the work of Sigurdsson and Schweitzer (1994): -

- Frequency and nature of events;
- Experiences;
- Feelings;
- Thoughts;
- Images;
- Strategies;
- Relationships;
- Attitudes;
- Psychological conditions; and
- Socio-political images
Dark End of the Street - Dealing with Mental Health and Homelessness in Cork

These key indicators helped identify categories within the two main themes; Homelessness and Mental Health. The analysis moved back and forth between deduction and induction (Kane, Eileen & O'Reilly – De Brún 2001) by:

- Reading and re-reading the data;
- Reduction of the data;
- Grouping and finding relationships; and
- Creating visual displays of the data.

Narratives were used to construct and present the analysis to ensure the voice of the participant was centre to the process. Quotes and stories are used extensively throughout the analysis to illustrate the main categories and themes that emerged. A table was constructed to readily establish the clustering of the main categories that emerged in the data. This table also introduces the participants and how their ‘stories’ interlink with the categories. In some cases participants either did not answer some of the questions or they told their story in a different way. This did have an affect on the data as some people shared information more than others. This opened up new categories that others did not mention. To accommodate this feature the qualitative analysis, while mentioning numbers and frequency, concentrates more on the ‘experiences’ of the participants and their story.

The relationships between categories and themes added to the analysis particularly using the social model of disability. This assisted in the identification of relationships in the data, or the negative instances of the same. ‘Thought experiments’ and ‘what if’ scenarios were also used to develop other perspectives (abid: 297).

Social and Medical Models of Disability

Using a model of disability in the analysis allowed for relationships between cause and effect to be identified. The ‘ideological’ framework of the analysis holds a rights-based viewpoint of health. This reinforces the medical model, which focuses on the individual and their disability, and compares it with the social model where disability is viewed within the structure of society and has its responsibility for the behaviour and attitude of society in relation to disability.

“Two theoretical models that represent these approaches are the medical model of disability and the social model of disability. In the medical model the disability is seen as the primary focus with a particular ‘pathology’ – a scientific approach to the cause and treatment of the ‘disease’. The social model of disability considers disability in the context of society, in particular the impact of society’s values and attitudes in relation to disability and the physical and social barriers faced by people with the disability” (Crawford, Karin & Walker, Janet 2003:55).

The approach taken recognises the participant’s mental health difficulties where appropriate, and also explores the experiences of participants in living in a society whose attitudes and values may have consistently created barriers to adequate mental health care, particularly when they are homeless.

A1.6 Life Stories

Three ‘life stories’ were chosen to provide a first hand perspective from key research participants willing to share their experience of living with mental health difficulties and homelessness.
# A2 Survey Questionnaire

## A2.1 Short Survey Questionnaire

<table>
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<tr>
<th>Code:</th>
<th>Place</th>
<th>Date</th>
<th>Time</th>
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</thead>
</table>

### Short Questionnaire

1. **Sex:**
   - Male
   - Female
   - Other (__________)

2. **Age:**
   - ________

3. **Date of Birth:**
   - ________

4. **Population Group:**
   - Where were you born? (__________)
   - Ireland / 2. UK / 3. N. Ireland / 4. EU 12 / 5. EU 15 / 6. Other (please specify)

5. **Cohabitation:**
   - 1. Are you currently living alone? [ ]
   - 2. Living with a partner [ ]

6. **Present living arrangements:**
   - Where are you living at the moment?
     - 1. Cork Simon Emergency Shelter
     - 2. Other: (__________)

7. **Income:**
   - What is your main source of income? (__________)
   - Do you collect/receive any Social Welfare payments? YES [ ] NO [ ]
     - a) Invalidity Pension
     - b) Occupational Injury Benefit
     - c) Illness Benefit
     - d) Disability Allowance
     - e) Disablement Benefit
     - f) State Pension (Transition) (Contributory) (Non Contributory)

8. **If NO have you ever applied for a payment? YES [ ] NO [ ]

9. **If NO What do you live on? (__________)
8. Mental Health:

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</thead>
<tbody>
<tr>
<td>1. Do you have a medical card?</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2. Do you have European Health Insurance card?</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. If not have you ever applied for one?</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
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<tr>
<td>4. Are you currently seeing anyone about your mental health?</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Have you ever been diagnosed with any mental health difficulty?</td>
<td>YES</td>
<td>NO</td>
<td></td>
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</tbody>
</table>

5. If yes to you remember what it was...
   - a) Schizophrenia
   - b) Major depression
   - c) Bipolar disorder (also known as manic depression)
   - d) Borderline personality disorder
   - e) Obsessive-compulsive disorder
   - f) Eating disorder
   - g) Panic disorder
   - h) Post-traumatic stress
   - i) Other (please specify) ________________________________

7. May I ask are you presently taking any medication? YES NO

8. If YES, what is your medication for and what is it called? ________________________________

9. Are you receiving any other mental health treatment?
   - Counseling/Psychotherapy/Other (please specify) ________________________________

9. Services:

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</thead>
<tbody>
<tr>
<td>1. Do you have contact with anyone who talks to you about your Mental Health? YES/NO</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2. If NO, would you like to have contact with someone to talk about your Mental Health?</td>
<td>YES/NO</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 3. If YES, who are they? ________________________________
| 4. Did you contact them or did someone refer you? ________________________________
| 5. If referred... who referred you? ________________________________

5. How often would you be in contact with this/these services?
   - Once/ A few times/ Often/ All the time

Would you like to talk to me further and do a longer interview about your experiences of living out of home and your mental health? YES/NO

IF YES: Can we make an arrangement now to suit you? ________________________________

How will I contact you? ________________________________
## A2.2 Long Interview Questionnaire

<table>
<thead>
<tr>
<th>Qualitative Long Interview</th>
<th>Work Stage – 2</th>
<th>Consultation with People who are Homeless</th>
</tr>
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<tbody>
<tr>
<td><strong>Set:</strong></td>
<td><strong>Theme:</strong></td>
<td><strong>Indicators:</strong></td>
</tr>
<tr>
<td><strong>1.</strong> Present living and health status</td>
<td><strong>1.1</strong> I would like to start off with a few straightforward questions about your present living situation and health. May I ask where you are presently living? How often? Present homeless status</td>
<td></td>
</tr>
<tr>
<td><strong>1.2</strong> Are you attending any clinics, doctors or mental health services at the moment? Present Access to Services</td>
<td></td>
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<tr>
<td><strong>1.3</strong> May I ask, are you presently on any medication for anything? Present status of mental health/physical health</td>
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<tr>
<td><strong>2.</strong> Past Experiences</td>
<td><strong>2.1</strong> Could you tell me a little bit about your health history before you started using Simon’s services? Present past health history</td>
<td></td>
</tr>
<tr>
<td><strong>2.2</strong> Were you ever in contact with any mental health services at that time? Where/when/why/what/how Focus on mental health history and access</td>
<td></td>
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</tbody>
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**Cork Simon Community**

Page 69

Dark End of the Street - Final
# Dark End of the Street - Dealing with Mental Health and Homelessness in Cork

## First Homeless Experience and was there any contact with Mental Health Services

<table>
<thead>
<tr>
<th>3.1</th>
<th>When did you first start using Simon's services? Why? How? What?</th>
<th>Tracking access to homeless services</th>
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<table>
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<tr>
<th>3.2</th>
<th>Did you come into contact with any mental health services at that time? Who/what/why/how?</th>
<th>Tracking access to mental health services</th>
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## Homelessness and mental health

<table>
<thead>
<tr>
<th>4.1</th>
<th>How would you say your mental health is now?</th>
<th>Perceived mental health status</th>
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<tr>
<th>4.2</th>
<th>How has being homeless affected your mental health</th>
<th>Links</th>
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<tr>
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<tr>
<td>4.3</td>
<td>Are you in contact with any mental health services now? When/where/who/why/how</td>
<td>Follow-up from previous contact? Any new contact?</td>
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<td>4.4</td>
<td>Are the mental health services meeting your needs?</td>
<td>Needs analysis</td>
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<tr>
<td>5</td>
<td>What has made a difference to your mental health?</td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td>Is there anything that has made a difference to your mental health during your experience of being homeless?</td>
<td>Pointing something significant</td>
</tr>
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<tr>
<td>5.2</td>
<td>Is there anything else you would like to say before we finish this interview?</td>
<td>Closing the interview</td>
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</tbody>
</table>
A2.3 Consent Form

Cork Simon Community

Name of Researcher and contact details:
Dr. Aoife Sheehan, E: aoife.sheehan@sussex.ac.uk, T: +353 (0)1 310 2859, H: 4 Florey

Title of the Project:
Researching Mental Health among people in Cork who are homeless

Funded by:
St. Stephen’s Green Trust

The Purpose of the project:
This project aims to take part in the current mental health among people in Cork who are homeless. The project was commissioned by Cork Simon and conducted by EUSPESS-ESCAPE Consultancy Ltd, who are an independent body. We plan to do research on the mental health of as many homeless people as possible and then participants who need the research carried out are part of a larger interview. The reason for this is that we have several Cork Simon's primary services and have indicated that they have a mental health difficulty.

What will you be asked to do?:
1. If you agree to do a short questionnaire that will help us better understand the present situation of people who may have their own service and mental health. This can provide local information that will help us to create a model of the present situation. If we will only ask a few simple yes or no questions about what people think or feel about their own mental health.
2. If you agree to do a longer interview. This will help us to create a model of the present situation of people who may have their own service and mental health. This interview will take about half an hour of your time and will be conducted over the phone. This will mean that the information you give will be treated with the utmost respect.

Your privacy will be respected and your comments will be kept confidential.

Signed: [Signature]
Date: [Date]

Parental Consent Form

Parent’s Name: [Name]
Parent’s Signature: [Signature]
Date: [Date]

Guardian’s Name: [Name]
Guardian’s Signature: [Signature]
Date: [Date]
A3 An Overview of Homelessness

The following appendix records the primary elements of background research relating to homelessness that was undertaken to inform the gathering of the real-world experiences. The process of literature review was used to identify a variety of viewpoints ranging from an international through to local perspective.

A3.1 Defining Homelessness

The Simon Community views homelessness in experiential terms as the lack of accommodation, shelter, security, belonging and safety.

FEANTSA states that ‘Homelessness is probably the most serious manifestation of social exclusion. To be homeless means to have no access to decent and secure housing.’ (FEANTSA Policy Statement, 2002)

Section Two of the Irish Housing Act 1988 defines homelessness as including people sleeping rough and those accommodated in direct access hostels, emergency shelters or in Bed and Breakfast accommodation, but excludes those involuntarily sharing with friends or family, in insecure accommodation, or living in inadequate or sub-standard accommodation. It also excludes those currently housed but who are likely to become homeless due to economic difficulties or health problems. The Act marked a major development in responding to homelessness in Ireland. While the 1988 Act does not impose a duty on housing authorities to provide housing to people who are homeless, it does clearly give responsibility to the local authorities to consider the needs of people who are homeless and expands their powers to respond to those needs. Specifically authorities may house people who are homeless from their own housing stock or through arrangement with a voluntary body.

The 1988 Act also enables the local authority to provide a person who is homeless with money to source accommodation in the private sector. Section 10 of the Act states that the local authority has the power to respond to homelessness by directly arranging and funding emergency accommodation or making arrangements with a health board or voluntary body for the provision of emergency accommodation. The Department of the Environment was empowered to recoup local authorities in respect of their expenditure. This level was originally set at 80%, however this was increased to 90% in 1993. The Simon Community estimates that nationally there are currently at least 4,176 adults experiencing homelessness, according to statutory definition. However, they estimate that the real totals of Irish people who are homeless could be over 10,000.

The United Kingdom Housing Act 1996 Part VII looks at the definition of homelessness but was amended by the Homelessness Act 2002. The 1996 Act defines a person as homeless if there is nowhere where they can reasonably be expected to live and includes those threatened with homelessness. The 2002 Act broadens this definition to include those people leaving state institutions. UK local authorities are required under both of these Acts to provide temporary accommodation to homeless households who have a priority need.

Homelessness is generally agreed to be one of the most pressing of all social issues. There are several structural factors that contribute to homelessness. Poverty and lack of affordable housing are the main factors common around the world. People with disabilities who are unable to work and must rely on entitlements can find it virtually impossible to find affordable housing. There are also several individual factors that may increase a person’s risk for becoming homeless.

US studies by SAMHSA National Mental Health Information Centre have shown that untreated mental illness can make it difficult for individuals to maintain employment. Substance abuse can drain financial resources and make exiting from homelessness extremely difficult. According to SAMHSA, individuals with co-occurring mental health and substance use disorders are among the most difficult groups to put in stable housing. This is due to the limited availability of integrated mental health and substance abuse treatment in most locations.
A3.2 International Homelessness Overview

The United Nations Environment Programme (UNEP) has estimated that the global homeless population figure, plus those living in poor housing, is currently close to one billion people. The world population figure totalled 6.6 billion for the first six months of 2007, highlighting the growing level of homelessness as a percentage of total population. In Canada's largest city, Toronto, emergency shelters for the homeless took in an average of 6,500 persons each night in 1997. For the same year, the EU estimated the extent of Europe's homeless population as being between three and five million people. The level of people who are homeless in Western Europe was considered to be three million in 2003, showing the highest homelessness levels since the end of World War II. According to the European Commission, there are 2.7 million people who are homeless in the EU dependent on emergency solutions and 1.8 million people relying on hostels.

In 1996, it was estimated that 250,000 people under 25 years experienced homelessness in the UK. 26,000 young people were believed to be living in the inner London area. In 1994 in Portsmouth it was noted that two thirds of the people approaching the Single Homeless Project were under the age of 18 years. It is believed that upwards of a third of young people who are homeless in the UK are care leavers, leaving institutional or foster care settings. Aggleton et al (2000) notes that these young people may see street life as a community and a stepping-stone into adulthood. Young people who are homeless often fall through the gaps in services, as there is often a lack of appropriate services available for them. They believe that homelessness is usually a symptom of underlying difficulties. While it can contribute to certain mental health problems, many of these have their origins in the cluster of variables that led the young people become homeless in the first place.

In the United States there are currently 3.5 million people who are homeless, reflecting 1% of the entire U.S. population, and about 842,000 people in any given week. However the real numbers of people who are homeless may be much higher than the official statistics suggest. In 2005, 71% of the 24 cities surveyed by the U.S. Conference of Mayors Hunger and Homelessness Survey reported a 6% increase in requests for emergency shelter. An average of 16% of overall emergency shelter requests went unmet, according to the report. Research conducted in 1996 in the US showed that 49% of people who are homeless were in their first episode of homelessness and that 34% had been homeless three or more times. Single people were more likely to have been homeless three times or more. For 28% of people who are homeless, their current episode has lasted three months or less, but for 30% it has lasted more than two years. Families were more than twice as likely as single people to have been homeless for three months or less.

A3.3 National Homelessness Overview

It is only recently that homelessness in Ireland has been recognised as a social problem. Until the 1980’s people who were homeless were largely regarded as a marginal concern to the Irish political system. The Health Act 1954 outlined the provision of services and assistance to people who are homeless. In the last decade, numerous intense housing problems have emerged in the Irish economy, resulting in a housing crisis. Most of the information relating to the extent of homelessness in Ireland comes from studies carried out in the Dublin area as this has the highest concentration of people who are homeless.

Homelessness is generally seen as a problem primarily affecting Dublin. However, the fact that outreach services for people who are homeless do not exist in rural areas leads them to move to areas where those services can be found. The Simon Community’s shelter in Dundalk receives clients from as far as Cavan, Meath, Monaghan and Northern Ireland, as well as those from the Louth area.

Since the 1988 Housing Act was introduced, local authorities have carried out four assessments on the levels of homelessness in Ireland. The 1996 assessment indicated that there were approximately 2,501 people who were homeless in the country. The 1999 assessment saw this figure double to 5,234 people. The majority of these people were in cities with Dublin accounting for 69.5% of the total according to the Department of Environment and Local Government. Counted In 2005 looked at the duration of homelessness in the preceding five years and found that 29% were homeless less than six months, 22% between six and twelve months, 25%
between one and three years, 9% between three and five years, and 14% for five years or more. Figures in 2002 show the total homeless population to be 5,581 for Ireland as a whole. Of this total, 70.88% were in the Dublin area and 16.45% in other city council areas.

Following EU Accession, only Ireland, Britain and Sweden gave nationals of these new EU states full residence rights, including the right to work. In order to prevent the abuse of the social welfare system in Ireland, the habitual residence requirement, also known as the two-year rule, was introduced. This condition requires any claimant for social assistance to be habitually resident in the State or the rest of the Common Travel Area for a continuous period of two years. This condition affects everyone who comes to or returns to Ireland, even Irish nationals returning from abroad. Between May 2004 and February 2005, 68,868 nationals of new EU States were allocated PPS numbers and between 1%-2% attempted to access social welfare payments. Service providers in the homeless and migration sectors report that many new EU nationals are arriving in Ireland with few or no supports in place in advance. Consequently, the homeless sector has seen an increase in new EU nationals attempting to access its emergency services and supports.

Holohan’s study on the Health Status, Health Service Utilisation and Barriers to Health Service Utilisation among the Adult Homeless Population of Dublin in 1997 demonstrated the extent of health problems among people who are homeless. The study sampled 502 people who are homeless aged over 18 years of age. 77% of the sample was resident in hostels with the remainder in Bed & Breakfast accommodation (17%) and 6% sleeping rough.

Feeney et al’s study (2000) focused in detail on the health status and health care needs of 171 men who were homeless in three south inner city hostels. He found that 25-50% of people who are homeless experience mental health problems. The study also found that 85% of men said that they wanted GP, nursing, and dental care provided within their hostels. Condon’s study (2001) provided clinical data about the health of people who are homeless. The study covered 234 people who are homeless, 92% of whom were located in hostels in the city. The mean age of leaving school was 14.9 years. 38% of the sample reported to have taken illicit drugs at some point in their lives.

Homelessness – An Integrated Strategy was produced in May 2000 and was developed in response to the many issues that cause and impact upon levels of homelessness in Ireland. The Integrated Strategy provided clarification for the first time on the division of responsibility between local authorities and health boards. It explicitly stated that local authorities were responsible for the funding of accommodation-related costs while health boards were responsible for care related costs. The main elements of the Strategy were that local authorities and HSE Areas are obliged to draw up action plans to provide a coherent response to homelessness, homeless forums were to be set up in each county and supported by the Housing Strategic Policy Committees, local authorities are to be responsible for providing emergency accommodation and HSE Areas are to be responsible for the provision of care, and settlement and outreach programmes are to be set up to help people who are homeless back into independent living.

The formulation of actions targeted at those leaving state care was considered one of the primary objectives of the Integrated Strategy and Homelessness – A Preventative Strategy 2002. A homeless forum was established in every city and county council area, however their operation has been inconsistent between the areas and further development needs to be conducted here. Under the Strategy, each local authority was to prepare an action plan to provide accommodation to address the homeless situation within three years. Significant progress has been made with regard to these action plans, however there is still a need to base the planning of accommodation provision on a more rational and consistent basis.

A Key to the Door is the latest Action Plan to be published by the Homeless Agency on homelessness in Dublin for 2007-2010. One of the strategic aims of the plan is the prevention of homelessness. One of the core actions of this aim is to identify people and households at risk of becoming homeless and to intervene appropriately with a coordinated multi-agency approach. A second core action is to ensure access to mainstream health services and other services for people at risk of homelessness. The HSE and the Homeless Agency are to conduct an audit of a range of services that people who are homeless may access in 2007 and 2009. From this audit a plan is to be put in place to address any barriers and deficits in service provision. The third core action is the implementation of an information and awareness strategy to inform the government, the public and target groups. People who are homeless are entitled to a rent supplement from the State towards the cost of renting private accommodation. However, this
stands at €130 per week in Dublin for a single person and less in some other parts of the country. Single men, who constitute the majority of the people who are homeless, are bottom of the social housing list, as priority is given to families.

In 2002 Focus Ireland, Simon Communities of Ireland, Society of St Vincent de Paul and Threshold came together to conduct research analysis into the Homeless Action Plans and Housing Strategies. The research findings highlighted a number of important trends and weaknesses in the current housing system. The projected levels of social need were alarming and increasing unsustainable residential patterns were emerging in all regions. In April 2005 the Government Review of Homelessness An Integrated Strategy and Homelessness Preventative Strategy was launched. This review showed that single people accounted for 80% of households who are homeless. Social housing is generally geared towards the needs of families and so there is an insufficient supply to meet the needs of single individuals who are homeless.

A3.4 Local Homelessness Overview

According to the Cork City Social and Affordable Housing Action Plans, there were a total of 3,727 households whose housing needs went unmet in 2004. Around 47% were single person households. The local authority waiting list in Cork city in 2006 was 4,810, marking an increase of 369% on 1999 figures. According to the Cork Social Housing Forum, the largest age category was the 31-40 year age group. Over 20% of households on the 2006 waiting list for Cork city have been there for over four years.

Kearns et al (2000) conducted a study in Cork and estimated that 300 people in the city were homeless. The NACD report 2005 found that 58% of the sample of people who were homeless in Cork was male. 44% were over the age of 35 years. The mean age was 34.28 years. The most common type of current accommodation was a hostel, with 64% of the sample reporting this type. 19% stated that they were rough sleepers. 75% of the respondents were from Ireland. 71% of the sample population in Cork were homeless for twelve months or less.

The Integrated Strategy on Homelessness in Cork 2005-2007 set out a long term vision for ending homelessness in Cork, by identifying gaps which exist and ensuring that every person who is homeless will have access to services which address all their needs in an integrated manner. Before this the Integrated Strategy 2001-2003 was produced as an approach to combating homelessness in Cork. Many of the targets set out in the Strategy have been achieved. This included the employment of an Outreach worker by the Cork City Council, the provision of additional housing units, a day care centre provided by the Cork Simon Community, and the establishment of a Cold Weather Shelter. The 2005 Strategy looks to ensure that relevant services will be accessible to people who are homeless in the city, encourage the advancement of people who are homeless towards independent living through the provision of adequate support, develop health and welfare services for people who are homeless, facilitate the reintegration of people who are homeless into the community, and to develop pro-active strategies to work towards the elimination of homelessness. The Strategy was devised to stimulate action and provide a framework to build on previous successes.

The Cork Simon Community supported 1,347 people who were homeless in 2006. Of this figure, 52% of all people supported were from Ireland. 89% of all people supported accessed two or more Cork Simon projects and services. 75.3%, 1,015 people, accessed the Day Centre in 2006 and 63.1% of these did so for seven days or less. A total of 492 people accessed the Emergency Shelter in the same year. The focus of Cork Simon is on containment and in some months they have 108% occupancy. Around 80 people out of 500 are returnees. There is no mechanism as such currently for tracking people once they leave the hostel. At present, Cork Simon are working on a mechanism that will record who people are, where they went to, where they are now, and how to stop them from returning into the system again.

For the first quarter of 2007, Cork Simon Community supported 687 people, representing 51% of the 2006 total. There was a slight increase in the number of men availing of Cork Simon projects and services to 87%. 64% of all people using the Day Centre did so for a period of seven days or less. The occupancy rate for those using the Emergency Shelter was up 7.7% from the same period in 2006. 60% of all people supported during the first quarter of 2007 used just one service or project provided by Cork Simon. This is comparable with 11% for all of the previous year. Seven people were supported by the Housing Plus team in their transition to independent living in City Council housing, private rented accommodation, and Cork Simon flats, in the first quarter of 2007.
Mayock and Carr’s study (2007) looked at 38 young people aged 16-25. The birthplace of twenty-four participants was Cork city. Eleven people were living in supported housing, nine in adult emergency hostels, five in private rented accommodation, and four in the Under 18 ‘Out of Home Provision’. Twenty people reported a history of state care. 21 of the participants were currently unemployed. 17 of the participants reported leaving school before the age of sixteen.
A4 An Overview of Mental Health

The following appendix records the primary elements of background research relating to mental health that was undertaken to inform the gathering of the real-world experiences. The process of literature review was used to identify a variety of viewpoints ranging from an international through to local perspective, and may be seen as complimentary to the information contained in appendix 3.

A4.1 Defining Mental Health

Mental Health was defined by the World Health Organisation (WHO) as ‘a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.’ The WHO has calculated that one in four people will be affected by mental or neurological disorders at some point in their lives. It is estimated that one in 100 people worldwide has schizophrenia. This means that in Ireland alone, there are approximately 39,000 people with schizophrenia. 45% of those with a mental disorder meet the criteria for two or more disorders.

The Mental Health Services Department of the Irish Health Service Executive (HSE) aims to promote optimal mental health and enhance mental wellbeing, by minimizing the effects of mental illness. The 2002 Census of Population indicated that there were 2,904,172 adults in the Irish population aged over 18 years. Between 20% and 25% of the population, approximately 494,000 and 617,000 adults will be affected by a mental health problem according to the Mental Health Commission Annual Report 2002. In 1999, there were 25,062 people aged 16 years and over admitted to Irish psychiatric hospitals, according to the Public Health Alliance Ireland (PHAI) report, Health in Ireland An Unequal State.

The Commission of the European Communities issued a Green Paper on improving mental health in Europe in June 1992. The Green Paper on Mental Health set out the context of mental ill health, the challenges the EU faces in relation to this topic, and the policy initiatives required. This included the promotion and prevention of mental ill health in the general population, protecting the fundamental rights of the mentally ill and those with disabilities, and promoting their fundamental rights. The creation of a EU strategy was highlighted by Schizophrenia Ireland as being important in increasing the attention on the issue of mental health. They welcomed the Green Paper produced by the European Commission in 2006, as a way of promoting best practice across member states and monitoring the establishment of best practice across member states. They believe it would open a platform for positive exchange of information and cooperation at all levels.

The Inspector of Mental Hospitals looked at the need for a greater co-operation between the Gardaí and local mental health services in his report in 2003. Some progress has been made in this area with the introduction of a mental health awareness module in the Garda Training College. The Inspector also questioned the quality of the supported accommodation offered by Health Boards.

Collaborative mental health care is seen as an important component of mental health care reform in many countries. Collaborative mental health care describes models of practice in which patients and health providers work together to provide better-coordinated and more effective services for individuals with mental health needs (Craven 2006). It can offer the opportunity for comprehensive coordinated care and clinical resource management. Different models of collaborative mental health care have been described in the literature (Craven 2006). Fusion of Care, developed at Seaton House, one of Canada's largest shelters for men who are homeless, involves a partnership with St Michael's Hospital, an inner-city hospital. It refers to an integrated continuum-of-care model, with on-site medical support of shelter staff and clients, and a flexible referral process. Shelter staff and St Michael's Hospital physicians work as a single team and share a common client record. This best practices model was introduced in the San Francisco Bay Area and a study into its effectiveness by the University of California,
Berkeley, found that there was a 58% drop in emergency room usage after the model’s implementation (Proscio 2000).

The goal of Assertive Community Treatment is to help people stay out of the hospital and to develop skills for living in the community, so that their mental illness is not the driving force in their lives. Assertive community treatment offers services that are customised to the individual needs of the consumer, delivered by a team of practitioners, and available 24 hours a day. At the heart of the treatment is a trans disciplinary team of ten to twelve practitioners who provide services to one hundred people. Services are delivered directly by the team as opposed to being brokered from other agencies or providers. To ensure that services are highly integrated, team members are cross-trained in each other’s areas of expertise to the maximum extent possible. Team members collaborate on assessments, treatment planning, and daily interventions. Instead of practitioners having individual caseloads, team members are jointly responsible for making sure each person receives the services he or she needs to support his or her recovery from mental illness. Research from Canada has shown that this model costs around $16,000 a year per client, and is expensive when compared with other approaches. However, they estimate that the annual cost of dealing with a person who is homeless with a mental illness is $24,000 (Lavoie, 2007).
A5 Mental Health and Homelessness

The following appendix records information gathered in the process of literature review that was used as a foundation to the consultative elements of this report.

A5.1 World Health Organisation

The WHO 2001 Annual Report stated, "individuals may be predisposed to mental disorder because of their social situation and those who develop disorders may face further deprivation as a result of being ill. Such deprivations lower levels of educational attainment, unemployment and, in extreme cases, homelessness".

The WHO Regional Office for Europe 2005 report stated that mental illness commonly presents in the form of schizophrenia, depression and other affective disorders, psychoses, anxiety states or personality disorder. The report included a Danish study of people who are homeless with mental health problems, of which 90% were male. The study found that 90% of participants were aged 20-59 years and 98% were unmarried or separated. Only 2% were in employment at the time the study was completed. Bines (1994) stated that less than one-third of people who are homeless with mental illness actually receive treatment. For some elderly people who are homeless, mental illness is the entry into homelessness.

A5.2 UK Studies

UK studies have consistently shown for many years that people from lower socio-economic groups have higher levels of common mental health problems than people from higher socio-economic groups. The European Survey of Surveys 2002 compared studies from different European countries and found that none of these contradicted the observed link between social disadvantage and higher levels of mental health problems.

The majority of people with serious mental illnesses who are homeless have had prior contact with the mental health system. These experiences were not always positive; they may have been hospitalised involuntarily or given treatment services or medications that did not benefit them. The symptoms of mental illness, combined with the hygiene problems associated with homelessness result in many untreated physical health problems. A study by Hourigan and Evans (2003) found that the health of people who are homeless is extremely poor when compared to the health of the general population. 47% of the sample reported that they did not avail of services because of negative feelings or previous negative experiences at that service.

The Addressing the Health Needs of Homeless People Policy Brief stated that many people who are homeless find it difficult to register with a GP and so fall outside the system and get no help. The brief states that people who are homeless are 40 times more likely to not be registered with a GP than the general population.

According to Gill et al (1996) mental health problems are four times as common among people who are homeless than in the general population. North et al (1998) found that dysfunctional family background and maternal psychiatric illness can play an important role. Caton (1995) stated poor family social support as being a key factor. Craig and Hodson (1998) discussed low educational achievement as influencing the level of vulnerability and found that psychiatric disorder was identified in 55% of the sample.

Bines (1994) study showed that one in four single people who are homeless with mental health problems had been in a psychiatric hospital at some point in the past. One in eight people in hostels and B&Bs, one in five people at day centres and one in six people at soup runs had been in a psychiatric hospital at some time in the past. Most people said that they had not been directly placed in a hostel or B&B accommodation after being discharged from hospital. Almost two-thirds of the survey population with mental health problems was not receiving treatment. Those who had previously been in a psychiatric hospital were more likely to be receiving treatment. Bines found that mental health problems were eight times as high among hostel and
Bed & Breakfast residents compared to the general population. 10% of residents said that mental health problems had contributed to difficulties in finding or keeping accommodation.

Dean and Craig’s (1999) study looks at whether mental illness is the cause or the effect of homelessness. They believe that the signs of mental illness among people who are homeless precede the loss of accommodation. However they acknowledge that people who are homeless with mental illness are more likely to remain without permanent housing for longer. Their study shows that one in five people believe that mental health problems were one of the reasons for becoming homeless. North et al (1998) estimated that 94% of men who are homeless and 90% of women who are homeless developed mental health problems before the onset of homelessness.

A5.3 USA and Canadian Studies

The National Coalition for the Homeless (NCH) has estimated that approximately 20-25% of single adult people who are homeless suffer from persistent mental illness. According to a Human Rights Watch study (2003), people with serious mental illnesses are over-represented among the homeless population, and experts estimate than anywhere from 20% to 33% of people who are homeless have serious mental illnesses. The Arizona Department of Education has stated that only 5-7% of people who are homeless with a mental illness need to be institutionalised.

The University of California, San Diego, in 2005 announced that the prevalence of homelessness in people with serious mental illness was 15%, while one-fourth to one-third of people who are homeless are estimated to have a serious mental illness. This is one of the first studies that show the level of homelessness among the mentally ill. A study of mental health issues and the educational attainment of young people who are homeless in hostels in Los Angeles showed that 47% had receptive vocabulary delay, 39% had delayed reading, 37% had depressive symptoms and 28% had significant behavioural problems. These difficulties were seen in children aged between six and twelve years of age. This highlights the need for serious intervention at an early stage.

A study by the University of Pennsylvania (2001) calculated the cost of 5,000 people with mental illness who were homeless in seven publicly funded shelters, jails, and hospitals for two years. They evaluated that the average annual cost for each person was around $40,500. They also tracked this sample after they were housed and found that providing them with supportive housing would cost the same amount while also providing them with comprehensive health support and employment services. This study shows the importance of providing safe and affordable housing to people with mental ill health that is linked to voluntary health, social and employment services.

It is estimated that as many as one in five of the 2.1 million Americans in jail and prison are seriously mentally ill, far outnumbering the number of mentally ill who are in mental hospitals, according to Human Rights Watch (2003). Hwang (2000) stated that the prevalence rate of schizophrenia is at 6% in the homeless population in Toronto and refers to a US study by Fischer, which shows a rate of 10-13% in the US. Acorn (1993) found that shelter users in Vancouver were predominantly a young, male, single, mobile population. About half reported a current physical health problem, 44% reported use of non-prescribed drugs, and 69% reported use of alcohol. 19% reported a current mental or emotional problem, with schizophrenia and bipolar disorder the most common diagnoses reported. Mental health status was assessed using the Brief Psychiatric Rating Scale (BPRS) and these scores indicated that depression, anxiety, and tension were common problems.

A5.4 Australian Studies

Robinson (2001) stated that people with a mental illness experience cycles of homelessness, where they continuously move through various forms of temporary or sub-standard housing and periods of living on the streets. A number of the participants commenced or resumed this cycle of homelessness after a period of imprisonment or hospitalisation. Robinson noted that almost 75% of the homeless population in Australia demonstrates a mental health issue. 46% of the survey had been in prison or juvenile detention in the past. Only 50% of this figure reported that they had received treatment or help for their mental health issues while in prison. A high
proportion stated that they did not receive information from the prison staff regarding their post-release housing options. As a result, 20% lived on the streets in city centres after being released. 65% of all participants in the survey stated that they had been admitted to hospital at some point because of their mental illness. After discharge, 13% reported that they returned to living on the streets.

Kadmos and Prendergast (2001) acknowledge that not all people who are homeless have a mental health problem and that the majority of people with a mental health issue are not homeless. They note that people who are homeless are more likely to be affected by a mental health problem than the general population, but estimate that the incidence of mental health issues among people who are homeless can range from 25% to 75%.

The Australian Department of Health and Ageing 2005 report suggests that when researchers define serious or severe mental illness, they generally refer to psychotic disorders, such as schizophrenia and bipolar disorder. Other research has added depression, anxiety, and substance abuse disorders to the definition. The report refers to research by Herrman and Neil (1996), which states that a person with a pre-existing illness is more vulnerable to becoming homeless by the nature of their illness, but also notes that severe mental health issues are a risk factor rather than a consequence of homelessness. The report states that homelessness can occur as a direct consequence of an established mental health issue, or as a result of problems with coping and social withdrawal because of the early stages of schizophrenia.

The report cited a study by Cohen (1994), which determined that people with no prior psychiatric hospitalisations and those who were hospitalised for short stays, were more likely to become homeless than long-term patients. A number of researchers have shown that alternative and flexible accommodation services are required for people with severe mental illness. Supported housing can reduce hospitalisation. Herrman et al (2004) noted that the main treatment for people who are homeless included psychotropic prescribed medication for psychotic symptoms. A minor part of the treatment was attendance at a rehabilitation or day programme.

A5.5 Studies from Denmark and Spain

Pre-lapse Magazine in September 1995 referred to research by Brandt on schizophrenia and homelessness. Brandt found that many people who are homeless and suffering from schizophrenia would, in reality, like to undergo treatment but are not immediately able to make the decision. The prerequisite is for a strong bond of trust to be created between patient and doctor and for long-term stable contact to be maintained. Medicinal therapy and admission to hospital are important elements in the treatment.

Munoz et al (2004) published Qualitative Studies of the Homeless Population in Spain. A high proportion of participants in the study experienced institutionalisation at some point in their history, the majority of experiences being before the age of sixteen. The majority of participants in the study reported histories of separation and abandonment. More than 50% of participants had failed academically and most people reported a long history of unemployment. The study showed that 90% had been homeless for more than a year, with 45% reporting homeless durations of more than five years. The main barriers to overcoming homelessness were stated as being economic factors, the lack of adequate training, mental health problems, and family rejection.

A5.6 Studies from Ireland

Mental Illness: The Neglected Quarter (2003) found that homelessness and mental illness are casually linked. It was estimated that 75% of people who are homeless in Dublin have mental health problems. The report includes research by Holohan (2000) who found that 66% of people suffered from one physical or psychiatric problem. He stated that people who are homeless have increased risks for illness and suffer similar but more prevalent health problems to the general population for which they do not receive adequate and appropriate care. The report also referred to McKeown (1999), which estimated that there were 1,500 people who are homeless with mental illness for that year. In 2002 the Simon Communities of Ireland conducted a survey on the public’s attitudes to homelessness. Results showed that 15% of those surveyed believed that individuals were homeless as a result of mental health.
The Inspector of Mental Hospitals 2003 report has drawn attention to the deficiencies in the availability of services for people who are homeless. The report stated that homelessness is a major problem for many mentally ill people and often results in neglect and premature mortality and the problem is most prevalent in the Dublin city area. The report stated that the issue of people who are homeless with mental health difficulties should be tackled by providing appropriate housing and outreach services. The report also found that a large number of current psychiatric inpatients that are homeless are accommodated in acute or long-stay hospital wards despite being suitable for a community residential placement.

McKeown and Clarke (2004) state that the prison population represents a particularly vulnerable group of men in terms of their social backgrounds and mental health problems. They found that there is a high incidence of mental ill health among prisoners and inadequate services to address them. A study of prisoners published in 2005 by the Department of Justice found that one quarter of the prison sample were homeless on committal to prison. Of this figure, over one-third had previously been diagnosed with a mental illness, and two-thirds of these had been hospitalised in a mental health facility.

McKeown and Clarke also highlight the lack of supported accommodation for when these prisoners return to the community. They call for early interventions for young men who are homeless who may be at risk of developing mental health problems. There are a substantial number of young men, who as a result of family problems and other difficulties are homeless and showing signs of mental health problems. They believe that such interventions should include training programmes such as Fás courses, the provision of opportunities for mixing with other people and for engaging in various activities, and the provision of transitional and on-going supports for young people who leave institutional care. Focus Ireland is at present trying to reduce the gaps in the provision of these supports and services for young people.

A Vision for Change (2006) details a comprehensive model of mental health service provision for Ireland. It proposes a holistic view of mental illness and recommends an integrated multidisciplinary approach to addressing the factors that contribute to mental health problems. It proposes a person-centred treatment approach through an integrated care plan, and community mental health teams should provide specialist expertise. The closure of many mental institutions saw the opening of community residences throughout the country providing housing to people who had previously lived in hospitals. One of the major concerns discussed in the report was the problem of stigma. This was highlighted also in the Amnesty International report. Stigma can result in people avoiding working or socialising with people with a mental illness.

The Irish Mental Health Coalition, in their paper published on the third anniversary of A Vision for Change entitled Late for a Very Important Date, commented that the reform process has been painfully slow. Despite statements of support for mental health reform from Government and the HSE, basic systems to promote reform are not in place, targets for service delivery have not been met, and development funding has all but ceased.

The Department of Psychology in Queen's University conducted research into the health and social care among people who are homeless with mental ill health in Belfast. The main aim was to assess the prevalence and nature of mental health problems among adults who are homeless in Belfast. They found that 37% of residents in hostels and B&Bs surveyed were reported to have a mental health problem. 86% were single, unemployed males in their late thirties. These residents were mainly homeless due to substance or alcohol abuse and family disputes. Half of the residents had levels of disability comparable to those of a long-stay psychiatric hospital population. 44% were judged to require supportive forms of shared accommodation and 61% reported high levels of psychological distress. 39% of single homeless residents were judged by hostel staff to need highly supportive forms of permanent accommodation. Only 44% were receiving mental health services.

MQI (2005) found that 42% of the sample had undergone psychiatric assessment, 30% had been admitted to a psychiatric hospital, and 30% had been diagnosed with a psychiatric illness. Almost 50% of the study participants reported concerns about their psychiatric health. 9% of these were based in Cork.

The Mater Hospital produced The Homeless Mentally Ill – An Audit from an Inner City Hospital, and found that 13.8% were homeless. This group represented 34.8% of all Emergency Department referrals to psychiatry. The most common living arrangement was hostel accommodation accounting for 48.2%. The mean age for this group was 39.37 years. 34.8% recorded homelessness for 6-12 months. 72.4% of people who were homeless were male. 50% were self-referred to the hospital. 25% had affective and anxiety symptoms, 26.6% suicidal.
crisis, and 21.9% presented with substance abuse. The typical patient attending the hospital is male, under fifty, single, homeless for at least one year, and likely to be living in a hostel. The patient will typically present themselves to the hospital without GP referral, with a history of psychiatric illness and a criminal history.

The Homeless Empowerment Action Research Team (HEART) (2005) found that 70% of those interviewed stated that homelessness had affected their mental health. 64% said that they had sought help for mental health problems. Those that sought help availed of a range of services. Psychiatric wards accounted for 38% and private counselling services totalled 26%. 18% visited a GP and 8% day hospitals. 18% used casualty psychiatric services. 20% of people interviewed had a negative experience of the psychiatric unit and 41% rated services for mental health problems as poor.

The Mayock and Carr (2007) report showed a significant number of those reporting depression wanted to conceal their depression from others. There was evidence to suggest that many of them had few trusted adults or peers in whom to confide. The study noted that feelings of inadequacy were the main causes of self-harming behaviour. Nine of the study’s young people reported lifetime use of heroin. They also found that young people who accessed the adolescent ‘Out of Home’ services in Cork city told a more encouraging story.

Pilinger (2004) showed that mental health services in Ireland receive a declining share of overall health expenditure. The report finds that services continue to be provided within a medical model. Despite an increasing emphasis given to the social model of disability and the development of community-based services, services remain medically oriented. As a proportion of overall health funding, mental health services have received a declining share of resources from 10.6% of total health expenditure in 1990 to 6.8% in 2003.
A6 Dual Diagnosis

It is clear from the literature review process that the issue of dual diagnosis is universally considered to be one of great importance in dealing with mental ill health and homelessness. Susser et al (1993) stress the link between psychiatrics and substance abuse disorders and homelessness. Courtney (2005) in a review of temporary accommodation services for people who are homeless noted an increase in referrals of those with multiple needs, usually involving substance abuse and physical or mental health problems. The National Advisory Committee on Drugs (2004) cited Crome (1999) who stated that substance abuse may alter the course of the primary psychiatric disorder or, vice versa. Studies reviewed by the NACD supported the stress vulnerability model, which was proposed by Zubin and Spring (1977). It proposes that an individual has unique biological, psychological and social elements. These elements include strengths and vulnerabilities for dealing with stress. It hypotheses that drug use may cause schizophrenia or increase the likelihood of its expression.

A6.1 Influence of Self-Medicating

The high prevalence rates of substance abuse in mentally ill patients are often the result of self-medicating (Kasten, 1999). Dual diagnosis patients are more difficult to treat according to the NACD because of higher levels of physical, social, and psychological impairment. For a patient with dual diagnosis, each disorder will impact on the prognosis of the other. The NACD report also states that 93% of respondents from mental health services said that they treat substance abuse, but 77% reported that they do not offer specific services for dual diagnosis. The Comprehensive Integrated System of Care Model was developed as a best practice model for system design for integrated services. It is a framework for behavioural health system development. The goal of the model is to design an accessible and integrated system of care that can support individuals with psychiatric and substance disorders. The model states that when psychiatric and substance disorders coexist, they should both be considered primary. For each individual, interventions must be individualised according to diagnoses, level of functioning, external constraints or supports, phase of recovery, and an assessment of the level of care requirements.

A6.2 Integrated Treatment

Integrated Dual Diagnosis Treatment differs from traditional approaches in several ways. The most important is the integration of mental health and substance abuse treatments. One practitioner or one team in one agency provides both mental health and substance abuse treatments so that the consumer does not have to use two different programmes. Other features of the model include assessment, stage-wise treatment where different services are provided at the different stages of recovery, motivational treatments, and substance abuse counselling. The integrated model is commonly used in the US, however not all healthcare models are conducive to the model. Another option is parallel treatment, where two separate services provide treatment concurrently.

A6.3 Mental Illness and Homelessness

The Arizona Department of Education argue that at least one half of mentally ill people who are homeless are estimated to have a co-occurring substance abuse problem, increasing the likelihood that they will be chronically homeless. SAMHSA has estimated that 72% of mentally ill individuals entering the jail system have a drug-abuse or alcohol problem. North et al's (1998) study found that twenty per cent of people who are homeless with mental ill-health are dually diagnosed with substance dependence. The Pathways Project in Canada found that around 86% of people who are homeless suffer from both a mental illness and a substance abuse problem. This is 2.7 times the rate of the general population. 17.7% of people who are homeless...
stated that substance abuse was the reason for becoming homeless the first time. 3.7% stated that mental illness was the main reason. A study by Nordentoft (2003) showed 70% of participants were seen to have a mental illness and were misusing alcohol or drugs.
A7 Key Stakeholders

A7.1 Hostels and Shelters

Cuan Lee Refuge

The Cuan Lee Refuge supports single women and women with children experiencing domestic violence. When the individuals and family units are ready to move on they are placed in private accommodation or else return home. The organisation provides a physical shelter, psychological support, an outreach programme, and training programmes.

Edel House

Edel House supports women with children who are homeless, and single girls and women who are homeless. The organisation can provide emergency accommodation for twenty-four people and there is a residential unit for girls under the age of fourteen, and an after-care service is also in operation.

In 2005 there was an increase in the number of single women presenting to Edel House. The Annual Report of Good Shepherd Services for 2005 showed that there is limited supported accommodation for those with special needs or those with mental health problems. The report highlighted a number of difficulties that arise when admitting women with mental health problems, including problems with room sharing, difficulties in trying to find alternative accommodation, and problems with managing their medication.

St Vincent’s

St. Vincent’s provides a hostel for men who are homeless. The welfare of the resident is the main priority at the hostel, which includes health, food, clothing, and cleanliness. Where required, men are referred to services such as medical and social welfare. Fellowship House provides a twelve-week residential programme for men in recovery and ensures that nobody leaves the organisation without accommodation set up.

Cork Foyer

Cork Foyer accommodates and supports eighteen young adults aged between 18 and 25, entitled to rent allowance, that are homeless or at risk of becoming homeless in Cork. It is managed and owned by the Cork City Council, and was opened in 2006. The Foyer exclude people with acute mental health problems. Of 28 successful applicants in 2006, the Foyer reported that 7.1% of residents had mental health issues. Young people can stay for up to two years and then move on to independent living, usually in the private rented sector.

O’Connell Court

O’Connell Court provides accommodation and support services to people over the age of fifty with mental illness. They make sure that people keep their OPD appointments, are aware of their social welfare entitlements, and stay away from alcohol. The organisation advocates for the client to get back into hospital when they need it. They supervise medication and focus on nutrition.

A7.2 Supporting Agencies

Adult Homeless Multi Disciplinary Team

The Adult Homeless Multi Disciplinary Team is seen as an effective resource by many of the organisations and stakeholder consultees, however, a significant number of stakeholders were unaware of their existence, or had little or no direct communication with them.
Both Cuan Lee and the Probation Office were unaware of the Adult Homeless Multi Disciplinary Team at the time of consultations. The Garda Síochána, Cork YMCA, Liberty Street House, and the Local Drugs Task Force stated that they do not deal with the team directly.

The Community Welfare Office refers people to the Team when needed. Cork Foyer link in with the Team through the City Council, but generally stated that they have little contact with them due to the nature of the service that they provide.

O’Connell Court does have the right to refer to the Team and this is reciprocated, but the organisation is not covered directly by the Team services. In this instance it is understood that if the Team refers people to the organisation, they will continue to visit and support those people in the shelter.

Edel House stated that women demonstrating mental health problems are referred to the Team’s surgery in St. Vincent’s Hostel. In the first ten months of 2006, 33 out of 84 women in the house were given appointments to see the Team. Of these 33 people, only 18 women kept their appointments.

As it was initially established as a pilot study, the Team were only based in the two mainstream hostels. Some of the consultee service providers serve the needs of young people and children, and so the nature of the service that the Team provides is not appropriate for them. Also it was identified that a number of people presenting to the service providers have their own GPs, or the organisation has a GP who they refer to on a regular basis. In these cases it is from these GPs that the client is referred for further treatment.

It is widely considered that if the Team were centrally based then they would be more effective. Team members observed that the only time when they all meet is during a pre-arranged meeting. It was considered that if all members were based in the same office it would make communication and task completion easier.

The Team has stressed the importance of the addition of a social worker and while funding has been allocated for this position, the position remains unfilled. An occupational therapist is also called for in the Team.

It was also noted that the surgeries do not have computers and so very little information is stored on the numbers of clients that attend.

The Team does not have a database for statistics and all statistic collation is done manually and is usually only referred to for the compilation of annual reports and presentations.

**Cork Simon Community**

Cork Simon works with men and women who are homeless, offering housing and support towards independent or supported living. Over 100 beds per night are provided for people in Cork who are homeless. Other services include: a Day Centre for people sleeping rough, offering access to doctors, nurses and counsellors; an Emergency Shelter with 44 beds; 32 beds in four high-support houses, providing homes to men and women with physical and mental health needs; 25 Independent-living apartments at four separate locations throughout the city. Cork Simon Community also offers a range of training, education, life skills and back-to-work programmes.

**Cork Local Drugs Task Force**

The Cork Local Drugs Taskforce has twenty members comprising of key stakeholders in the arena of addressing illicit drug use at City level. The members consist of an HSE representative, representatives from the Department of Education, the Department of Social and Family Affairs, Ógra Chorcaí, Gardaí, Cork Prison, FÁS, and VEC. One initiative that is directly linked with Cork Simon is the Street Outreach Project.

**Community Welfare Office**

The Cork City Council Community Welfare Office acquires emergency accommodation on behalf of City Hall, and deals with income maintenance and medical cards. The Outreach Worker provides two street services and assists people into hostels or transitional accommodation. Cork City Council contribute to the provision of emergency accommodation. The Outreach Worker monitors the transference of people between hostels. There is a frequent linkage with the Cork Simon Day Centre. The Office provides a linking service to local authority housing for those people who are ready to leave the hostels.
Liberty Street House

Liberty Street House ‘Young People Out of Home’ operates under the HSE and deals with young people between the ages of fifteen and eighteen who are out of home or those who are at risk of being out of home. Their aim is to try and keep young people at home. They look at supported lodging, emergency accommodation, independent living, and semi-independent living. The team is made up of approximately fifteen people, and all members are based in Liberty Street.

Probation Service

The Probation Office refers people to St Vincent de Paul, or to the Cork Simon Community, as appropriate. The Garda Síochána has a Liaison Guard to all service providers, and has specific protocols for dealing with people who are homeless. The Garda Síochána visit Day Centres on a regular basis and check-in with members of the community, and they arrange community initiatives for people who are homeless, which include fishing courses, photography classes, and soccer tournaments.

A7.3 Referral

A number of agencies and service providers stated that self-referral\(^{23}\) was the main way in which people find their services. In Edel House, approximately 45% of cases are self-referrals. Word-of-mouth from friends, family, and peers is another important way in which people become aware of the services available to them. Other referrals come from hostels, hospitals, doctors, psychiatric services, Cork Mental Health, social workers, primary treatment centres, the Gardaí, prisons, Probation Services, Community Welfare Officers, Child Protection Services, the Adult Homeless Multi Disciplinary Team, and the Homeless Unit. 98% of referrals in Fellowship House come from agencies.

Cork City Council publishes an information leaflet on Emergency Accommodation, entitled ‘Homeless in Cork’? The Cork Homeless Forum also has a homeless directory for the Cork area.

Threshold works together with local services such hostels, Cork Foyer, Sofia Housing, and the Citizen’s Centre. It is also noted that Cork Foyer and Fellowship House receive a large proportion of referrals from the National Learning Network.

\(^{23}\) Including those who have accessed the services on a prior occasion.