DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE

JOINT COMMITTEE ON HEALTH

Dé Céadaoin, 5 Iúil 2017

Wednesday, 5 July 2017

Tháinig an Comhchoiste le chéile ag 9 a.m.

The Joint Committee met at 9 a.m.

Comhaltaí a bhí i láthair / Members present:

Teachtaí Dála / Deputies	Seanadóirí / Senators
Bernard J. Durkan,	Colm Burke,
Billy Kelleher,	John Dolan,
Alan Kelly,	Keith Swanick.
Margaret Murphy O'Mahony,	
Kate O'Connell,	
Louise O'Reilly.	

Teachta / Deputy Michael Harty sa Chathaoir / in the Chair.

Business of Joint Committee

Chairman: I propose that we deal with a number of housekeeping matters in private session. Is that agreed? Agreed.

The joint committee went into private session at 9.10 a.m. and resumed in public session at 9.30 a.m.

Link between Homelessness and Health: Discussion

Chairman: The purpose of this meeting is to engage with the Simon Communities of Ireland and Safetynet Primary Care on the link between homelessness and ill health. I welcome Ms Niamh Randall, head of policy and communication at the Simon Communities of Ireland, Mr. Aaron O'Connell, Cork Simon, Ms Majella Darcy, Dublin Simon, and Ms Emma Dolan, Galway Simon. I also welcome Dr. Fiona O'Reilly and Dr. Austin O'Carroll from Safetynet Primary Care.

I draw the attention of witnesses to the fact that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to a qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him or her identifiable. Any submission or opening statement that has been submitted to the joint committee may be published on the committee's website after this meeting. Members are reminded of the longstanding parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the House or an official either by name or in such a way as to make him or her identifiable.

I invite Ms Randall to make an opening statement on behalf of the Simon Communities of Ireland.

Ms Niamh Randall: I thank the joint committee for inviting us to today's meeting. The Simon Communities of Ireland is a network of communities that provide local responses to local needs and issues. They are based throughout the country in Cork, Dublin, Dundalk, Galway, the midlands, the mid-west, the north west and the south east. They provide local responses to local issues. As members of the committee will be aware, the complexity of homelessness is touching every aspect of Irish life. The greatest impact is being felt by the most vulnerable people in society. We have provided our full submission to the committee. I will not go into the detail of the figures in the appendix to the submission because the Chairman has asked us to keep our presentation brief, but members will see that 7,699 people are currently in emergency accommodation. This is the highest such figure we have ever known. Among those who are

in emergency accommodation are 1,312 families, 2,777 children and 3,150 adults who do not have dependants in their care. I intend to highlight some of the key aspects of our opening statement. As officials from Safetynet who have undertaken some of the key research in this area are present at this morning's meeting, I will ask them to set out some of the statistics and details in that regard.

There is a complex relationship between homelessness and health. Multiple health issues and needs can cause homelessness in the first place, but can also be a consequence of being homeless. We know from our experience throughout the country that the longer people remain homeless, the greater the impact on their overall health and well-being. The lack of a stable home can cause physical health issues. People who are homeless are at a much greater risk of developing illnesses than the general population. A recent study, which my colleagues will talk about, found that 67.8% of participants in a study of the health of homeless people had a chronic physical health diagnosis, such as diabetes, high blood pressure, arthritis, heart disease, epilepsy, tuberculosis, chronic respiratory problems and stomach problems.

The existence of mental health issues can be a reason for people becoming homeless. Such issues can have a significant impact on people's experiences while they are homeless. A homeless person's mental health can really deteriorate over the period of time for which he or she is homeless. Some 58% of those who participated in the study to which I have already referred had at least one mental health condition.

There are high levels of problematic drug and alcohol use among the homeless population. Drug and alcohol use can put people at risk of homelessness and can be caused or exacerbated by traumatic experiences, including homelessness. We know there is a significant correlation between risky behaviour and housing stability. The poorer someone's housing type is, the greater the chance that he or she will engage in risky or harmful behaviour. People who are sleeping rough and those who are in emergency accommodation are more likely to use alcohol and drugs in unsafe ways and to use them in greater quantities. A health snapshot study that was conducted by the Simon Communities in 2011 found that 50% of homeless people who participated in the study were alcohol users and 31% of them were problematic drug users.

We know that people who are homeless can have multiple needs or complex needs. This means that a couple of issues can happen at the same time. Physical health issues, mental health issues and problematic drug and alcohol use can exist at the same time. This can lead to difficulties in accessing services and can make it difficult for people to have their needs met. We find that people can fall between two stools. It is often argued that if someone has a mental health issue, it should be dealt with in a mental health setting. If that person also has a drug and alcohol issue, however, that needs to be dealt with in a drug and alcohol facility. This means that people's needs are not necessarily met. As a result, problems can arise when efforts are made to respond effectively to people's needs. We would certainly recommend that people's needs should all be dealt with at the same time. Such needs should not be isolated so that they are dealt with individually.

People who are homeless encounter many barriers when they try to access health care. It can be difficult to access services. As a result of the cutbacks in services we saw during the period of austerity, there are greater waiting lists and longer waiting times. Some services have been closed, particularly in rural areas. This means people can have to travel great distances to access services which used to be readily available in their local communities. We know that people who are homeless often contact health services at a time of crisis. We need to intervene before a crisis hits. We need to look at prevention and early intervention. Other barriers to ac-

cessing health services include stigma, restrictive catchment areas, inflexible services, lack of discharge protocols, lack of specialisation in services, lack of case management teams and the dearth of services in rural settings.

I would like to speak about possible solutions. Housing First is critical if we are to address homelessness. Housing First programmes are internationally recognised as representing best practice in housing people who have experienced long-term homelessness and have complex and multiple needs. People with mental or physical health issues, including those with dual diagnosis, have complex needs. There are two key aspects to the Housing First approach - the immediate provision of housing without preconditions, including a requirement for housing readiness, and the provision of open-ended ongoing housing support for as long as is necessary.

I will comment specifically on health services. It is essential to increase access to general practitioner and primary health care services so that the health care needs of people who are homeless can be met and early intervention can be provided to prevent further chronic illness. The ongoing resourcing of primary care services is critical if we are to ensure interventions in homeless services are provided nationwide where they are required. Some really good examples of such initiatives are operating in the Simon Communities around the country. It is also important to look at the resourcing and delivery of step-up and step-down beds for homeless people who are being treated for chronic illness. We can discuss this further during the question and answer session.

It is essential to fill the posts in mental health services to ensure there is nationwide coverage of community mental health teams and, in particular, to ensure there is responsibility and accountability for people who are homeless within catchment areas. We also need to look at the development of specialist adult teams, as recommended in A Vision for Change and in the national clinical programme for the assessment and management of patients presenting to emergency departments following self-harm. We need to look at increasing funding for mental health services to 8.24% of the national health budget, as recommended in A Vision for Change. Trauma-informed practices and counselling services are needed to deal with the traumatic experiences that have led to people becoming homeless and to support people's recovery from homelessness. Such work should be resourced in social work settings, community and family services and homeless services. We need to ensure HSE-funded services are upskilled to manage and deal with dual diagnosis.

Harm reduction is absolutely essential and must be at the heart of homeless and drug service provision. The success of harm reduction approaches is vital because there is no conditionality attached to Housing First. It is really critical that we align harm reduction with the Housing First approach. The key to doing this is to look at expanding current harm reduction programmes and at what works best in other jurisdictions. The recent passing of the Bill establishing the State's first medically supervised injecting centre is really welcome. Immediate implementation is critical so that this legislation can have the greatest impact really quickly. This will save lives and keep people much healthier for much longer. We need to ensure there is greater expansion of, and access to, needle exchange programmes across static, outreach and pharmacy exchange models.

Drug treatment and rehabilitation is about ensuring national alcohol and drug services target the specific needs of homeless people who have alcohol-related or drug-related problems, or both, in line with the four-tier model. Access to aftercare housing is particularly important when people leave treatment. When people engage in drug treatment, it is a really difficult and challenging programme for them and it is expensive for the State. If they do not have anywhere

to go to follow up on that, it does not make any sense. We need to ensure aftercare housing with support is provided for people. Rapid access to treatment is really important. People often have to wait in homeless services while they are on treatment waiting lists. Again, this does not make a huge amount of sense.

We also need to look at rehabilitation. There are actions in the Rebuilding Ireland action plan, but there is not enough detail about what this looks like. How are we going to support homeless people with drug and alcohol issues in the longer term? On the specific commitments, we need some of the vagueness to be clarified.

We also need to look at developing, resourcing and implementing discharge programmes and in-reach services in general hospitals, mental health services and drug treatment services. Nobody should be discharged back into homelessness, yet that still happens. We also need to ensure that ring-fenced emergency accommodation options are in place for drug users experiencing homelessness who are detoxing or working towards methadone maintenance where they are trying to abstain from drug and alcohol use. It does not make sense, when people are dealing with this hugely challenging issue, that they may be in an environment where other people are actively using around them.

We greatly support the report of the Oireachtas Joint Committee on the Future of Healthcare. It makes many very important recommendations including the expansion of counselling services in primary care settings, which is significant and could have a huge impact in terms of dealing with some of the trauma associated with the experiences of homelessness. The proposal to introduce universal access to primary care must continue to be a key priority**.**

We look forward to the publication of the new national drugs strategy, which we expect in the coming weeks. We made a submission to that process and we are happy to share that with the committee if there is any interest in it.

I thank the members for listening to us. They have received our full submission. We will be happy to take any questions they may wish to ask.

Chairman: I thank Ms Randall. I call on the representatives of Safetynet Primary Care to make their opening statement.

Dr. Fiona O'Reilly: I am Fiona O'Reilly. I am joined by Dr. Austin O'Carroll and we are here from Safetynet Primary Care.

Safetynet Primary Care is a medical charity that aims to deliver the highest possible standards of health care to homeless people and other marginalised groups. Our network of services includes 20 clinic sites in Dublin, Limerick and Cork providing services to thousands of homeless and vulnerable people each year. Our direct services delivered in collaboration with the Health Service Executive, HSE, social inclusion and partner organisations, such as our colleagues here from Dublin Simon, include a primary care in-reach team in homeless hostels, a mobile health unit for rough sleepers, clinics for vulnerable migrants and a health and screening unit for vulnerable populations, including the recently relocated asylum seekers from Syria.

The link between homelessness and poor health is well established. Ms. Randall pointed out that homeless people have far worse physical and mental health conditions than the housed population. She pointed out also that poor health can lead to homelessness and that homelessness can lead to poor health.

I will draw on two examples from patients Dr. O'Carroll saw earlier this week. He saw Mary on Monday. She is a single parent in her 20s. She has been depressed recently and is not coping with managing household expenses. She failed one rent payment and is to be evicted this week. Peter is a young man whose drug addiction has gone out of control in the past three months since he went into a hostel. He had three overdoses in one week recently and needed to be revived with naloxone each time.

Dr. O'Carroll and myself conducted and-or analysed significant health surveys of homeless populations from 1997, which were conducted by Tony Holohan, and one we conducted in 2005. The one in 2013, which I made available to the members, was conducted with the Partnership for Health Equity. As a result of that significant research, we conclude that over time, through economic bust and boom, homelessness remains an unhealthy state. Of the 601 homeless people interviewed in Dublin and Limerick in the most recent survey, we found that almost the entire sample had either a diagnosed mental or physical health problem.

Ms Randall highlighted some of the important findings, but others are that over half reported a diagnosis of depression and half a sample had both a mental health problem and an addiction problem. I find it alarming that one third of respondents had self-harmed, three fifths have had suicidal thoughts and one in three reported having attempted suicide. Compared with the previous studies in 1997 and 2005, the recent study showed that the homeless population had more diagnosed ill health, more were treated with prescribed medication and more reported mental health diagnoses and treatment in 2013. We believe that is as a result of more services diagnosing disease rather than an actual increase in disease. Ill health is a constant feature of homelessness.

Services have improved. Medical card coverage has improved. The level of primary care and emergency department use has increased. We thought that increasing primary care access would decrease hospital admissions and presentations in hospitals but because there is such a high burden of disease, putting in place more services will just pick up that ill health. That has resulted in a higher number of onward referrals.

Ms Randall outlined the findings about addiction. It, too, has risen steadily over the 17 years to now become polydrug use. Rates of dangerous drinking have also increased, particularly among women. Drug and alcohol addiction associated with secondary health problems such as liver disease, dental problems and hepatitis C were also found to be elevated among those populations.

Recommendations are included, and we concur with the recommendations Ms Randall pointed out, namely, expansion of specialised primary care services; expansion of easy access to methadone treatment in primary care; improved access to appropriate mental health supports, including psychiatry; and the urgent establishment of interventions for homeless people in crisis in line with national suicide prevention guidelines, including a crisis house. Overall, we found that the health needs of the homeless are great and although much is being done, much more needs to be done, particularly in the area of mental health and addiction.

Safetynet Primary Care aims to provide health care for the most vulnerable in our society and to employ the most effective treatment. For homelessness, the most effective treatment is a move away from the homeless condition. Our services, therefore, seek to remove ill health, addiction and poor mental health as a barrier to exiting homelessness. However, that is not simply primary care as usual. For many very good reasons, typical primary care services are simply inappropriate or inaccessible for many homeless people and other vulnerable groups. Again, I

point to a patient Dr. O'Carroll saw yesterday to demonstrate that homeless people with serious health problems often fail to attend the mainstream services for treatment. Dr. O'Carroll saw Julie, whose right leg was completely swollen from her foot to her groin for the past six weeks. She has experienced a deep venous clot in the past. It is highly likely that she has another. She knows that could fire off, block an artery and cause instant death. She has been referred to an accident and emergency department twice in the past six weeks but has not gone.

Services have to meet people where they are located. They need to be innovative, appropriate, accessible and, importantly, patient centred and delivered in a coherent and collaborative way aimed at moving the person out of homelessness. A heath strategy in isolation of housing will not succeed. One quick fix that would succeed in removing one of the barriers to homeless people's access to care and medication would be to remove prescription charges for homeless people.

Chairman: I thank Dr. O'Reilly. I will open the meeting to members for their observations and questions. I will call members in groups of three, so the witnesses might make a note of the points they make and they can refer to them as time allows. Our first three contributors are Senator John Dolan, Senator Colm Burke and Deputy Louise O'Reilly.

Senator John Dolan: I will focus on two areas on which I am interested to hear the responses from both organisations. While two organisations are before the committee, they are *ad idem* about the multi-faceted nature of the problem in terms of mental health, the physical aspect, drugs and so on. I should not say that is impressive but it is important to hold those three things together. Nearly all the population is caught up in one way or another.

I should apologise before I ask my two questions because I am going to have to leave later on. I should be here for the answers but forgive me if I have to leave before the meeting closes.

Ms Randall referenced the causal and consequential aspects. I am interested in the responses from both. What is the ratio or impact of causal things? What are the consequential things that come on the back of sheer homelessness?

Dr. O'Reilly commented on how a health strategy in isolation from housing will not do it. That is a hint to me to talk about the things that are beyond health. Clearly, housing is one of them. What other things help or hinder? That is the main question.

Within the health area, we have to go back to the physical, mental health, drugs and other aspects of the problem. How will I frame the question? How well or efficient or co-ordinated or timely are responses within the health area and across public services generally? How does the system, in the round, come to the aid of people when it is most needed? When can it be most effective?

Senator Colm Burke: I thank the deputations for their comprehensive presentations. The reports are comprehensive as well. I want to raise one or two issues. In many cases, there is a housing problem and a health problem.

I want to deal with housing briefly. We brought in regulations to try to improve rented accommodation. They were welcome at the time. The purpose of one of the regulations we brought in was to get rid of bedsits. Did that change in the regulations contribute to more people ending up living on the street? If the deputations were in charge now, is there anything they would do to change it in any way? Many of the people who were in bedsits are people who want to live on their own. The regulations came in and more or less prescribed the minimum

space for living accommodation. The regulations were brought in because there were some appalling bedsits that needed to be sorted out. Is there any half-way house between both that would in any way contribute to improving the situation?

The second issue relates to the management of people who have mental health problems. I came across a case recently involving a person who had perfectly good support from family but the person had health issues. Basically, it had got to the point where a single carer could not be assigned to the person at any one time. Two people had to be there all the time. Carers had been assaulted by the individual and a package was put together by one of the agencies involved. The cost of the package was €134,000 per annum for that individual. How do the deputations deal with a difficult situation like that when there are health issues? This particular person could be in the southern part of the country one day but might turn up in Donegal two days later and end up in hospital. That is a difficult situation. How do we manage that?

Long ago, mental hospitals were used to deal with these problems. In many cases, they were used inappropriately. I came across one particularly difficult case. In 1956, the Army wrote to the parents of a person and said that if they did not collect their son, the Army would admit him to a mental hospital. Some 50 years later, the man was still in a mental hospital. That is one of the saddest cases I have come across. In fact, he did not really have a mental health problem, although he may have had a depression problem at the time. I do not want to go back down that road. The question is how we deal with that difficult situation.

We need to consider the whole approach in respect of people who are sleeping on the street. I remember being outside the Simon Community in Cork one night. I found eight or ten people trying to get in. It was 11 p.m. The hostel has rules and regulations and it was full. How do we deal with those people when there is an alcohol problem - it is a serious problem - to ensure they are not living on the street at night? I know many things were done. It is about the management of all of that. No matter how much assistance is given, it changes from day to day. They will change from day to day. How do we deal with that situation?

The homeless issue is one of the major problems we have. It comes back again to the whole issue of accommodation. Cork City Council had more than 1,800 single people looking for accommodation. Do the witnesses find any change by local authorities in the provision of accommodation for single people? The priority seems to have been that we build accommodation for families but we are not building enough appropriate accommodation for single people. Do the witnesses believe that we need to fast-track that whole issue to deal with this particular problem?

Deputy Louise O'Reilly: I thank the witnesses for their attendance, for the evidence they have given thus far and for the work they are doing. I imagine it is not easy to find the time to come in.

This is something I often think about and it is heart-breaking really. It relates to children who are sleeping in emergency accommodation, bed-and-breakfast accommodation, hotels or even hubs - wherever they happen to be. Is there any support available? Those children are probably the most in need of mental health support but are possibly among the least likely to receive it. I am keen to hear from the witnesses on this.

It must be soul-destroying to live in a hotel but to never be able to bring friends over and so on. Are there any specific supports available for children? I do not suggest it is a bed of roses for the parents either, but I am thinking of the children in particular in this situation. When my

daughter was younger, there was a constant stream of her friends in and out of the house and she was in and out of their houses too. We would regard that as a normal upbringing – although she might disagree with that. Anyway, is there anything specifically targeted at children? We learned recently that the HSE child and adult mental health services units are running at approximately 50% or 53% of what they should be in terms of the staff recommended in A Vision for Change. Are there any targeted resources for that group?

The next question is probably for both groups. It relates to the best place. Dr. O'Reilly made the point that the services need to meet people where they are. I know there are small groups working in this way, but what is the national picture? Let us consider that statement from Dr. O'Reilly. She said the services need to meet people where they are. Are the services meeting people where they are? In the case of people who are homeless at the moment, are the services not meeting them where they are? Is there a national policy in this regard? Are staff members designated to ensure that the services meet them? Are we talking about a number of specific pilot programmes in urban areas? Ms Randall referenced the urban-rural split in services. Is the picture uniform throughout the country? Related to that, there are people who are not necessarily presenting as homeless and who are living in cars or even tents along the canals in Dublin. They may not necessarily be engaging with the homeless services. Is there that level of outreach for people who are not using homeless services but who are providing such accommodation for themselves, even though it might involve sleeping in a tent or a car?

During the debate about supervised injecting centres, we got distracted into thinking that it was only about the centres. While the provision of these centres is important, it is a small part of a much bigger picture. What are the witnesses' views on the bigger picture and what supports should be in place? These centres will be fighting a losing battle if there are no support services for people. What is the national picture on this and the urban-rural split on this?

Senator Colm Burke raised the issue of bedsits. There were good reasons that regulations for bedsits were introduced, namely, substandard communal facilities such as shared bathrooms. I would not necessarily agree the introduction of these regulations was a massive contributing factor to homelessness, but it was a factor. There is talk now about perhaps revisiting those regulations. For me, that sets off alarm bells because many bedsits were closed because they were unsuitable. Would the witnesses see the return of bedsits and accommodation of that sort as a retrograde or progressive step? There is obviously a need for single people to have accommodation. However, having been in many bedsits as a student, I am not necessarily convinced that living in a single self-contained room is ideal for a person with mental health issues or someone who has experienced homelessness. What are the witnesses' views on that?

Ms Niamh Randall: Senator Dolan asked what are the issues beyond health. We need to ensure that there is an effective cross-departmental response to homelessness and housing issues. That means the Department of Social Protection taking action on income adequacy and rent supplement. It means education, training and employment opportunities. Once people move out of homelessness, it is important that they have meaningful occupations and an opportunity to engage in further training and employment. Housing is key because the link between health and housing is important. Ensuring that people have a stable housing environment is critical. If they have a stable environment, people, without prompting, will start looking at their drug and alcohol issues, reducing their levels of use and their mental health issues can become much more stable. We must ensure there is that support in housing because sometimes people might have a trigger, such as a trauma, and we might need to intensify that support in housing. It is critical that we have an open-ended, flexible response to support people. Income adequacy,

a sense of tenancy security and stability, and ensuring that people have opportunities, such as those relating to education, training and employment, are key.

On the query about the ratio of cause and consequence, I have not come across anything that can definitively argue that. We often see people coming to our services after several things have happened to them. People do not become homeless and then end up in the Simon Community's services. People often rely on friends and family for support. There is hidden homelessness whereby people are sleeping on floors and move around. When it comes to using services, it is difficult to work out what was the precipitating factor. The key point is prevention and early intervention. If we can intervene when people have health, drug and alcohol, or housing issues, we can intervene to stop this spiralling out of control.

Senator Colm Burke raised the issue of bedsits. We really welcomed the decision to look at this regulation. People were living in really awful circumstances, with poor quality accommodation and grown adults sharing facilities. There were also significant issues with health and safety, as well as a range of other matters. At this point, the real issue is the provision of social housing. The reason we are in this situation is because the State stopped building and providing social housing. We need to be clear that social housing provision is the solution. The quick fix to this is looking at vacant property throughout the country. There are approximately 200,000 vacant homes in Ireland and there should be mechanisms to ensure that they can be brought up to speed. We are awaiting the publication of the vacant homes strategy. It was due to be published before the recent Fine Gael leadership contest. We are now waiting for the new Minister, Deputy Eoghan Murphy, to publish it. It would be a really quick fix because these are low-hanging fruit due to the length of time it takes to build housing units. We need to be clear that this is the solution. My understanding is that there are approximately 1,000 bedsits remaining. Of those, between 50% and 60% would have fire and health and safety issues in any event. They would not be appropriate settings. We also need to look at quality of life for people. The last thing we need is people with mental health issues and ongoing pressures in their life living in tiny isolated places with poor light and space. It is not the way to go from our point of view.

We must look at diversity in housing provision. Up to 44% of those on the social housing waiting list are single people. Building three-bedroomed semi-detached houses around the country is not the way to go. We need to look at building a range of different types of accommodation and housing estates which can provide for people at different stages of their lives. Perhaps what we need to encourage is more residential mobility than we have. Often what happens is that people buy a home and it is a home for life. Maybe we need to look at opportunities for mobility. People often want to stay in their communities. If one had the opportunity to move into a smaller accommodation type within one's community, more people might take up those particular options. We must look at diversifying what we are providing. We need to do it quickly.

Deputy Louise O'Reilly referred to children's experience of homelessness. We know from research that children who experience housing instability and homelessness have a greater chance of experiencing homelessness in adulthood. We know this damage is being done. We are very much on the back foot on this issue. Additional supports have been provided in some of the bed and breakfast and hotel accommodation settings. One of the key issues is actually keeping children in school. Schools and teachers play an important role in this regard. One of the important developments was supports around transport to ensure that children could actually get to school. Some families were taking two or three buses to get their children to school because the setting they were in was so far away from the school. Having continuity and routine

in school attendance is important. Again, the solution is moving people out of emergency accommodation quickly. It is about housing supply and, in particular, affordable housing supply.

Hidden homelessness is a really challenging issue. We know the number of people who are currently in emergency accommodation. We do not know the number of people who are struggling but we can guess. Figures from the CSO on overcrowding show that the number of people sharing housing has grown when the family size has actually reduced. We know there are increased amounts of overcrowding with people doubling and tripling up. Again, prevention is the key. If we can support people when we know they are at risk and vulnerable, that is important. Ensuring that there is enough information, advice and awareness in order that we can intervene quickly is key. Medically supervised injecting centres are only one piece. They are a really significant and important development from a harm reduction and health promotion point of view. They are part of a suite of measures to respond effectively to drug and alcohol issues. We need a plethora of harm reduction services. We need naloxone and we need to look more progressively at heroin and opiate prescription and a range of other things. We need to look at criminalisation. We need to look at how we approach these issues, particularly at a time when people are making such changes internationally. We can learn from international experience but we need to be increasing beds. We need residential and detox beds. We need to ensure there are clear supports and referral pathways within the medically supervised injecting centres in order that if people make contact, especially people who are homeless, there is a real opportunity to make contact with people in a particular setting like that and link people in with further services and support. I will invite some of my colleagues in on some of those more practical issues and also the regional issues.

Ms Majella Darcy: I work with Dublin Simon Community. For the past 15 years I have worked with homeless clients, first with the HSE and then with Dublin Simon Community for the past ten years. Senator Dolan asked about causes and consequences. While I do not have empirical evidence to support this, over the past 15 years, 90% to 95% of adults I have seen come from a background of severe social deprivation, such as poverty, not having access to education or not having access to health care. I have seen people who became homeless at the age of 13. There are many social causes, such as poverty and social exclusion. If a person enters homelessness at 13 years of age, by the time the person reaches 18, he or she already has lots of other consequences that add trauma to the original reason for becoming homeless. Looking at the social dimensions of health for the homeless population is key.

The issue of bedsits was raised. One's environment is extremely important in terms of one's physical, mental and social health. I lived in a bedsit when I moved to Dublin first and it was appalling. I could afford to live in a very expensive bedsit but it was appalling. I did not want to live there so I do not expect that homeless people should have to live there either. That adds to the social exclusion. I do not think returning to bedsits is appropriate at all. Homeless people are entitled to the same as the rest of us in terms of the type of accommodation we have.

Senator Dolan asked about health services and how the system works. Dublin Simon at Usher's Island has 64 beds. Those 64 beds are there as a consequence of trying to plug the gaps that have existed in addiction and health services for the homeless population. In 2004, we started off with eight detox beds and we had 12 recovery or rehab beds. Since then we have expanded to meet need and we could expand even further. We have plans in for a 100-bed unit on that site. It is a medical facility for detox and recovery. We have a HIV unit for homeless people who are living with blood borne viruses such as HIV or hepatitis C. We only exist because we take 64 people off the street every night. If those 64 people did not have access to that

service, they would be on the street or they would be dead. That is the reality of the situation.

Phase one of our plans for Usher's Island is planning permission for 70 beds. Phase two will be an additional 30 beds. We will expand what we currently do and work with other colleagues in the sector such as SafetyNet and St. James's Hospital to look at facilities such as a step-up, step-down unit. We are working with Merchant's Quay to set up a rapid access detox unit. It is something that has not happened in Ireland to date. There are examples of variations of it in Scotland in Turning Point and in City Roads in London. It is to address the issue that has been raised already of people who are not able to access methadone or addiction treatment centres because their lives are quite chaotic on the street. They are not even able to get to a methadone clinic. The idea is to initiate the methadone on the site or stabilise the person. It comes back to the question of how we meet people where they are at. It is something that Deputy O'Reilly mentioned. With rapid access as an example, we meet people where they are. We do not know what will come through the door. We have to see the person and their myriad issues, whether those are physical health, mental health, addiction issues or other social issues. We have to take them as they come through the door and try to deal with it. It takes a lot of innovation and flexibility. That is what is probably not in the mainstream - the level of flexibility to adapt to what homeless people need. There are other groups who would also experience that exclusion or lack of access to services. There is not an equality of access to health services for people who are marginalised or socially excluded.

Senator John Dolan: I would like some clarification. Am I right in concluding the Simon Community plans to expand are because there are not timely integrated services?

Ms Majella Darcy: Yes.

Senator John Dolan: That is very important. I am delighted to see Senator Lynn Ruane was involved in this. She has moved to other accommodation since she wrote it.

Ms Majella Darcy: We are a homeless organisation so why are we in this sphere of health and addiction? It is in response to the need that has arisen. I started ten years ago when it was mainly alcohol detoxing we were doing, but we have had to adapt to the situation that faces us. There is now polydrug use, people are living more chaotic lives and they are more excluded from services. It is the only reason we exist in terms of providing addiction and health care. I also mentioned the bedsits.

Senator Burke mentioned a health package of €134,000 for one person, but if one looks at the amount of funding NGOs get, probably five times that would put 71 people through a detox programme for three weeks. The NGOs are running services at a pittance. It needs to be acknowledged. I do not think NGOs should be supplementing what the State should be doing.

Senator Colm Burke: Nor do I. I am not saying that but to deal with this particular person, this is what an organisation came up with. It was the cost of carers and providing the care in order that the person would not end up back in a hospital situation. That was the cost just for one person. There are very difficult cases that have to be handled and the question is what is the best management of those cases, which is always very difficult.

Ms Majella Darcy: In terms of the injection centres, Deputy O'Reilly mentioned that while it is important, it is also a small portion of the response. Rapid access is another aspect that responds to the needs of people who need more immediate access to a service when they say it. We only have a small window of opportunity when people say they want to do something.

People may not know what they want to do but they are fed up with the life they are living and want to do something. We have that small window of opportunity and we need to act rapidly. The idea of the rapid access is to pick them up immediately and provide the service. It is a huge challenge. It has not been done in Ireland before but we should not shy away from it because it has not been done. The idea of working with Merchants Quay on that project is to pilot it. One of our key requirements in that regard is for a pharmacist. If we do not have a pharmacist, we will not be able to unblock the system in terms of how long it takes someone to access a methadone programme.

Deputy Louise O'Reilly: Ms Darcy mentioned that this had not been done in Ireland before, which I assume means it has been done elsewhere. Are there examples of international best practice to which she could point us?

Ms Majella Darcy: Scotland has Turning Point, which has a variant of our proposal. Cranstoun City Roads in London also has a variant. They are slightly different from each other and from what we are proposing. We are trying to adapt to the Dublin situation.

Deputy Louise O'Reilly: They have been proven to work.

Ms Majella Darcy: Yes. They have been running for a long time.

Chairman: I invite Dr. O'Carroll and Dr. O'Reilly to comment.

Dr. Austin O'Carroll: We are going to share the questions. Senator Dolan raised the issue of cause and consequence. I agree with Ms Darcy. To clarify, I work as a GP in inner city Dublin, but I have also worked in many homeless hostels since 2002. I see some of my patients in my surgery, in homeless services a few months later and back in my surgery a few months on again. As Ms Darcy stated, this is because poverty is the key cause of homelessness.

The majority of people who end up homeless do so because of poverty, but the mechanisms of how they end up there are complex. When I first started, there were two main mechanisms. Drug addiction played a large part. It is endemic in poverty and intrinsically associated with it. Mr. Alastair Storey refers to how there is a cliff at the edge of poverty, namely, homelessness. Many people end up in homelessness because of drug addiction. The dilemma then is that their addictions get worse. The same is the case with alcoholism, which was the classic stereotype of a homeless person in the 1990s. It is the same mechanism. It was probably more spread throughout society than just in poverty, but it was more concentrated in the latter.

Since the recession, drug addiction has worsened in the inner city, which is affecting the homelessness figures, and alcoholism is re-emerging. We see many people involved in poly-substance abuse - drink and drugs. It is a major problem because it is very difficult to treat such people. While it is not easy to treat either on its own, having the two together makes it incredibly complex.

Everyone agrees that the main issue in recent times has been economic homelessness. It is worsening. I saw two people this week, one on Monday and one yesterday, who had become homeless. In recent weeks, I have seen more and more patients who have become homeless because of poverty. I referred to "economic". As with the person whom I saw on Monday, people can become stressed out because of, for example, the pressure of being a single parent or managing in the social welfare system. They might miss one rental payment. Landlords now have no sympathy and, because the market is so intense, people are out if they miss a rental payment. The situation is complex, but the real issue is poverty.

Another issue is a self-created one, namely, the lack of social housing, which Ms Darcy discussed. Ireland has 7% social housing. In the Netherlands, the figure is 33%. That is a significant difference. As we all know, our social housing stock has shot down since the 1980s. I will revert to the question of social housing when we discuss the bedsit issue, but Dr. O'Reilly will answer some of the other queries.

Dr. Fiona O'Reilly: Senator Dolan referred to the housing issue. Housing and health are linked, but he asked what else was linked. The whole gamut of social determinants of poor health - education, employment and networks - are linked. As such, it is important that there be cross-sectoral collaboration to tackle health issues. It cannot be done through health policy alone.

The Senator also asked about how good co-ordinated responses were. They are improving. One of our main reasons for being is to co-ordinate responses among health organisations that are working with homeless people in order that there is a joint medical record and web-based database that those organisations can access to see whether, for example, Johnny in Merchants Quay can be seen today and whether Dr. O'Carroll can see him in the Granby Centre tomorrow. That is good co-ordination, but there is not enough overall and it could be improved, particularly in mainstream services.

Deputy O'Reilly rightly stated that services should be delivered at the point of contact with homeless people. Were that a major national policy, it would be helpful. There are good examples and Dr. O'Carroll might address shared care and trying to get the new hepatitis C treatments out to people who would not otherwise receive them because they are not a hospital-going population. Hepatitis C treatment has to be initiated by consultants. Our population will not be able to access those treatments unless we think creatively. To that end, we are working on a shared care model with Dr. Jack Lambert. Running outpatient departments, OPDs, for homeless people is a waste of money because so many do not attend. Maybe we should stop expecting them to attend and bring the outpatient services to where they are. That would be a mind shift for mainstream services, but it is required and we should highlight it in policy.

Dr. Austin O'Carroll: I will clarify the example. I have 40 patients with hepatitis C. There are new life-saving treatments with a 95% cure rate. I have had many people who died of hepatitis C in recent years. In the past four months, I have referred my 40 patients for treatment and told them that it was life saving. Twenty-six did not turn up for their appointments.

We have set up an initiative with Dr. Lambert in the Mater hospital whereby we use a GP trainee to bring the hospital outpatient service to our service in the hostel. People are getting their hospital outpatient appointments in the hostel. We have 20 people lined up for treatment. Two started last week and two are starting this week, with a further four set up for next week. All 20 will have started within the next month and we are chasing down the other six. We have been referred ten more from other services who have dropped out of hospitals. That is the importance of bringing the hospital to the patient.

Dr. Fiona O'Reilly: Senator Burke raised a case. Obviously, we would have to hold a case conference to examine a case and determine the appropriate treatment, but I believe that the Senator might be alluding to a certain matter. The fearful backlash from what we learned about what we did wrong with asylums has sent us to the other extreme. Sometimes, this means not providing protected care in institution-like, but appropriate, facilities that can look after people who do not have the capacity to look after themselves.

A proposal that has been on the table from both of our groups for a decade is that of an intermediate care centre, something that is between a hostel and a hospital and would look after the needs of people who do not necessarily have a home but for whom a hospital is not appropriate either. Being terrified of past mistakes involving institutions, we sometimes shy away from handling situations in which people do not have the capacity to look after themselves.

Dr. Austin O'Carroll: I might speak on that point. This is a common problem with homelessness. For example, there is a service in Dublin called a wet hostel. The issue of people staying out all day drinking alcohol only to return to their hostel too late was mentioned. A wet hostel is where people are allowed to drink on the premises to counter that problem. The Dublin wet hostel was set up seven or eight years ago and has been successful. It caters for chronic alcoholics who would otherwise be out on the streets.

I will provide an example of the complexity involved. In a recent survey, Dr. Cliona Ní Cheallaigh found that the wet hostel's 32 residents accounted for 2% of admissions at St. James's Hospital. We reckon that if they were not in the wet hostel, they would account for a significantly higher percentage of admissions. If one does not manage certain groups of complex people, they will cause mayhem and huge costs. We must have flexibility in our responses to them. We need institutions such as the wet hostels which are very good, or the intermediate care centres to respond to these needs.

Senator Colm Burke: There is one of them in Cork also and it has worked very well.

Ms Niamh Randall: My colleagues from Cork and Galway probably have useful regional examples to contribute. I should note for the committee that a member of our delegation, Majella Darcy, must leave because she has an urgent appointment.

Mr. Aaron O'Connell: On the point about co-ordinated responses, one of the key things is the admission from all of us that, owing to the complex nature of the issues we are dealing with, nobody can do it by himself or herself. It is a complex issue which requires a co-ordinated response. In some respects, there has been much innovation, much of which has come from within the sector through Safetynet Primary Care and the adult homeless team in Cork. We have examples and templates that work, but we just do not have enough of them. For example, the adult homeless integrated team is part of the HSE's adult homeless support network within the main hostels in Cork. There is a link with the adult addiction services through working with the Cork local drugs and alcohol task force. The key point is that there are many people in the same area around the same table, which means that they are communicating and working together. One is adapting to circumstances as people present.

We have found that accessibility is key, particularly in achieving positive health impacts. The reason we set up in the first place around these services was people were not going to the emergency services until it was too late. Sometimes they went *in extremis* and sometimes they were not in a position to wait and created problems in emergency departments and so forth. Obviously, the services are under enough pressure as it is. The idea, therefore, was to bring the services to them and make them easily accessible. That is what works. Dr. O'Carroll referred to hepatitis C screening and so forth. It is about that adaptability in the wider health service to become more of a part of supporting such initiatives because they work. It is more cost effective in the longer run. We also operate these systems in Cork in managing people. One knows that they are not going to give up drink, but one tries to manage their drinking and keep them and everybody else safe. The key to doing that is understanding the nature of the issues and then finding a response that will meet the particular needs identified. In many cases, we are

not dealing with homogenous groups. People are individuals and their needs are individual; therefore, the system must be able to adapt to circumstances. It is about people; one cannot separate their mental health, polydrug use and so forth. Dealing with these issues has become far more complex.

There is another issue which is related to harm reduction. There is no point in telling somebody not to do something if one does not offer an alternative. Part of that alternative is activity programmes, for example, where somebody expresses an interest. If we can intervene with two hours or a full day of activity without somebody drinking or using, that is a positive step and opens up opportunities for the future. A similar example is moving people along a continuum of access to education, training and work. As I said, this is a complex issue and everybody has a role to play. We have direct links with employers to get people into employment, work programmes, work placements and so forth, all of which work.

There is also the provision of aftercare services and supports. The difficulty we find is that we are providing many of these services and supports, but we are not getting any support for them. As they are not funded, we must fundraise to provide these essential services in the continuum of care provision and support for people with mental health issues, addictions and so forth. As we know that they work, there is an opportunity to deal with these issues. It is important when considering these matters that we look at what works effectively and then adapt the programmes to suit these needs.

Senator John Dolan: Mr. O'Connell says he is fundraising to connect with and move people on. Are they things that are a key responsibility of other public bodies?

Mr. Aaron O'Connell: I believe they are everybody's responsibility, but, to be honest, they are. The difficulty is that when one is dealing with people who have particularly challenging issues, not everybody wants to move into that space. That is a problem. However, we have found ways to deal with it and make it work. They are what must be supported.

Senator John Dolan: I understand the halfway house concept, if one can call it that, where services have to be brought to people. Are public bodies responsive enough to come half way or deliver services in a different way? Mr. O'Connell gave the example of the Mater hospital bringing the hepatitis C screening service to where folk were. That is somebody figuring out a cultural change.

Mr. Aaron O'Connell: There is no doubt that there is more like that to be done. Everybody has a responsibility, be it the Department of Social Protection, local employment services and so forth. The difficulty is that the people we are discussing are falling out of those systems.

Senator John Dolan: Is that because of the way services are provided?

Mr. Aaron O'Connell: Yes; therefore, we have to fill the gap. One must look at this issue in terms of being able to solve the problem. If we want to support people to move out of homelessness, one of the key factors is financial stability and people being able to support themselves, as Dr. O'Carroll mentioned. Getting people back to work is part of it. As some are nowhere near that stage, one must work at the different stages where the people are and respond accordingly. If we can do that and support the transition programmes mentioned, we will be giving people the capacity to support themselves in the long run. These things work.

Senator Colm Burke mentioned the issue of over-capacity in Cork. When there are not enough beds and too many people with complex issues looking for beds, one ends up with

people on the streets. That is the reality. The answer is the prioritisation of people who are in homeless services for move-on accommodation. However, there is a dearth of accommodation. There has been some movement, but demand is outstripping supply and, in the case of move-on accommodation, we are running to stand still, effectively. The only way we can deal with this is through the provision of social housing. We talk about bedsits and the like, but we are reacting to events. We already had those problems and decided to move away from them. We must plan our response, as these things take time. Ms Randall mentioned the low hanging fruit. If we can bring what is out there back into play quickly, that is one way of dealing with it, but in the long run we must deal with this issue comprehensively.

With regard to lifelong adaptable housing, if people are living in their own areas, those communities are strong. If somebody moves in terms of life changes, he or she should be able to move within these areas. New builds must incorporate lifelong adaptable housing in order that people can move up and down, depending on their life cycle. We must think this through comprehensively. As Dr. O'Carroll mentioned, many of the people with whom we work are single and the vast majority come from areas of high social deprivation. We must deal with the issues of poverty, income and housing. Some 7% of housing is social housing. We need at least 20% to make the system work. That would help immeasurably to recalibrate spiralling rents and so forth. As one has a huge impact on the other, we must connect the dots.

Chairman: I thank Mr. O'Connell. Perhaps Ms Dolan from the Simon Communities of Ireland in Galway might comment.

Ms Emma Dolan: A great deal has been said. I echo what Ms Darcy and Dr. O'Carroll said about poverty being the main cause of homelessness. In rural areas outside the urban centres the big issue is access to services. Dr. O'Carroll spoke about people experiencing drug or alcohol addiction and it being a cause of homelessness. That is a great deal more manageable if someone has means. If he or she is outside an urban centre, he or she might not have access to services. There might be nothing in the local area and the person concerned might not be able to afford to use public transport. He or she probably does not have access to a car. How is he or she to get to a GP, a hospital, the emergency department or psychiatric services unless he or she calls an ambulance? It quickly turns into a revolving door.

The other piece that continues to arise is the idea of fundraising for services that should be available in the mainstream. Homeless services are available because there are gaps in the mainstream. In an ideal society homeless services should not be available, yet we have seen them expand exponentially in recent years to meet demand. They are viewed as a legitimate response to people's health and housing needs. We are seeing an increase in the provision of emergency accommodation as opposed to the building of social housing. I echo the point made by previous speakers that the State needs to build social housing.

The people who engage with homeless services have complex needs and are dealing with multiple issues at the same time. Not only are they physically or mentally unwell they also do not have a home or access to paperwork, do not know where their belongings are and do not feel safe. All of these factors compound the problem and make it more difficult for them to visit a general practitioner.

In terms of inter-agency working, there is no cohesive strategy between the health and housing areas. They are entirely separate, as is clear from the way in which services are commissioned and procured. Even if we wanted to offer a solution that integrated health, housing and homelessness responses, the problem is that one speaks to the Health Service Executive one day

and the local authority the next. Clearer mechanisms are needed to get everyone into the same room to find a way to navigate the issue. While there is certainly a will to do this and everybody is trying very hard, mechanisms are required to achieve this outcome. This filters down to the delivery of front-line services. People with multiple needs engage with multiple services. For example, a person will have a general practitioner and may have one consultant for a physical health need and another for a mental health need. He or she will also work with someone in homelessness services. Trying to bring all of these people together to establish good and effective case management systems to identify a cohesive strategy that will work for the homeless person and get him or her out of homeless services quickly can be complicated and difficult.

If services apply certain criteria and allocate specific resources using these criteria, one finds, for example, that if Ms Darcy has different criteria, there is a gap between the services provided and Ms Darcy's needs. Everyone involved can leave the room believing he or she has done his or her job because he or she has found he or she could not do anything for Ms Darcy within his or her remit. As a result, Ms Darcy does not get a response when the response must always be built around the homeless person.

As Mr. O'Connell stated, there are many solutions available and a great deal of good work is being done. The issue is one of capturing this good work, pulling it together and commissioning services in a way that one can respond rapidly. Housing First is an example of how to get homeless and health services working together and directed at the individual. The services also stay with individuals, which means that they do not have one case worker one day and another the following day because they are moved between one service and another. Instead, they have one case worker who knows them, knows their plan, works for them and co-ordinates the work of the health professionals with whom they are also engaged. It would be fantastic if this approach were used more widely alongside social care.

The rural issue must also be acknowledged. There is a dearth of services in rural areas. People refer to the large amount of vacant housing in rural areas. These areas do not have services and public transport and are not, therefore, an appropriate solution for many people who have been in homeless services for a long time and need a significant input from mainstream and voluntary organisations.

Deputy Margaret Murphy O'Mahony: I thank the delegates for appearing before the committee. I extend a particular welcome to Mr. O'Connell from Cork Simon. I am very parochial and it is great to see someone from Cork in the Big Smoke. I also acknowledge the work done by the Simon Communities which are very much the unsung heroes in this area.

Many of the issues I intended to raise have been covered. Thankfully, homelessness is not a major issue in Cork South-West, the constituency I represent. However, the problem is hidden to some extent because if it were not for the large number of households in which three or four generations of one family are living, many more people would be homeless. This overcrowding creates problems of its own, including significant mental health issues. While the number of homeless persons in some areas, particularly rural areas, may not be high, that does not mean that these areas do not have significant housing problems.

What is the relationship between the Simon Communities of Ireland and organisations such as Aware and Pieta House? Do the Simon Communities of Ireland work with such organisations or refer clients to them? Do they work together and are they singing from the same hymn sheet, as it were?

Deputy Bernard J. Durkan: I compliment our guests on the work they do individually and collectively throughout society in very difficult and challenging circumstances. Unfortunately, the position has become more challenging and difficult with the passage of time. We all encounter at the coalface the social issues that emerge daily, record the extent to which we are capable of addressing them and ask whether we are winning or losing the battle. Unfortunately, as we come under more and more pressure, we are sliding and I believe losing the battle, but that is not a reflection on the services provided by the Simon Communities of Ireland.

Housing is the kernel of many of our current problems which date back to a change in housing policy introduced approximately 20 years ago. I do not know the reason for this change or where the wisdom for it came from because it was not a wise decision. I made myself very unpopular at local level by slating this change in policy and at the time I predicted what has since come to pass. I refer to the decision to shift responsibility for providing houses from local authorities to what are known as approved housing bodies. These bodies were supposed to be the answer to everything, but they could not and never will be the answer to everything. The answer is for local authorities to start building quality houses again.

We also started to build duplex houses, which involves building homes on top of each other. I remember having an argument one night about this practice. In some cases, four houses are built on top of each other and the front door of some houses is located under an outside stairwell. Everybody likes to have a hall door because it gives people dignity and self-respect and also shows respect for them. Parity of esteem comes with what is around a person. I could not believe the architecture of some of the housing schemes built. People who were suffering from social deprivation were placed in this type of setting which made matters even worse. The position is appalling. I could go on a rant for at least two hours about it, but I promise the Chairman that I will not do so.

A large number of people are affected by the issues we are discussing, whereas previously only a small number fell off the edge. I cite the example of a young girl living in a socially deprived area in a household in which other members of the family may be engaged in substance abuse. If she becomes pregnant at 15 or 16 years, the cycle will start all over again, without her ever having had a chance to be a child, in the first instance, or to raise a family because she has no experience, no one to advise her and no support in the household. The family unit is absent from this scenario which causes multiple problems.

Sheltered housing is needed for people who are at the bottom of this scale because the alternatives are sleeping rough and night shelters. Sheltered housing will work, but we have a long way to go before we will have even provided general housing. Sheltered housing is the answer because it involves supervision and medical services can be laid on. There is also someone available who will inform a person about what will be done for him or her.

In recent times I have seen a considerable number of reformed alcohol and drug addicts, many more than one would have seen years ago. This is a great achievement and I compliment those who have been involved in this area. The cycle continues when depression occurs and leads to substance abuse and homelessness.

Local authorities must take much more seriously their responsibility to provide quality housing and in respect of what goes on in some houses. There is no sense in having some poor family eventually being allocated a local authority house only to find they are living next door to a dysfunctional family who trade in drugs and have people coming and going at all hours of the night. How can we expect a family who are already under pressure to survive in that envi-

ronment? Everyone tends to be dragged down in such circumstances.

I am not afraid to criticise the Government and have done so from the inside and outside for many years.

Unless we deal with the housing situation in a serious manner, in the shortest possible time, we will have further problems. In three, four or five years' time it will be worse. We can throw our hands up and ask what is the cause. The cause is simple. There is no accommodation. We have a bigger population than we had; it is almost double what it was in the 1950s. We cannot presume that we can manage in the same old way, in particular in off-loading responsibilities to other bodies and agencies when the State should deal with those requirements itself. Mine is a commentary, I am not asking questions. I have been dealing with this issue for so many years that I get depressed myself from time to time. I am sure the Chairman would not want me to get depressed.

Chairman: Certainly not.

Deputy Bernard J. Durkan: Thank you.

Deputy Kate O'Connell: At least the Deputy's depression is not affecting his tongue. I am sorry that I have been in and out of this meeting but I had other things on this morning. I know the witnesses were looking for a pharmacist and I might send in my CV. A number of us very much supported the injection centres. I worked in drug addition in the midlands 12 years ago. I see the need for a bespoke, tailored approach to deal with people who have addiction issues. As Deputy Durkan said, this all starts in a person's home and the circumstances in which he or she is brought up. One of my big concerns is the effect of living in hotel rooms on small children. This would be grand if they were there for three or six months. If they were four years of age, they might think they were on holidays, although I know that being in a hotel room with children for more than 24 hours proves it is a very restricted environment. There is an idea that children do not know. Children know well what is happening. They are fully aware that their classmate is living in a house with a door while they are in a hotel and this is because mammy, daddy or whoever has fallen on hard circumstances. I am not a psychologist, but I can imagine that has a detrimental effect on their psyche and how they see society and their aspirations for their own lives.

It should not be like a school report card where if someone makes the right choices in life, there is a prize at the end. People can make the wrong choice that leads them down the wrong path of alcohol abuse or violence in the home or another form of abuse, but then sometimes these things are thrown up at people. As Deputy Durkan pointed out, it could be that the wrong lad moved in next door or someone just happened to kick a ball with the wrong lad in the park. One cannot control who one's children are friendly with when they are six or seven years of age. It is not always bad choices. It is not about punishments. It is necessary to provide bespoke supports for each individual case. There is not a one-size fits all model here.

We need to move away from the idea of drug dependence and it being a bad thing. It is a health issue. We need to educate children about what happens if one goes down this route and to try to tackle it before it gets out of hand. I cannot imagine what it would be like for children and teenagers living in substandard accommodation and growing up in that environment. Whatever it would be like in a hotel room with a four year old or a six year old, I cannot imagine what it would be like with a 12 year old nor can I imagine what it would be like to explain it to a 12 year old or for the parent to stop this 12 year old hating him or her, even though the situation

is probably not his or her fault.

I commend the Simon Communities on their work. The witnesses will see many of us are on the same page. I recognise it is not as simple as putting everyone on a bus and sending them to a ghost estate, doing it up for them and giving them a bus pass to get to wherever. Removing people from Dublin city and putting them in towns outside the city where they have to travel to the city for their drug treatment is totally unacceptable. One cannot have that as it does not work. I know from my role as a community pharmacist, there is no quantitative value that can be put on the connection between a community pharmacist and the person suffering from addition. In my husband's case, if someone does not turn up for their methadone, he drives to their house that evening on the way home to see that they are alive. Pharmacists do not go on about this but we make the call, we go down and check to see the children are all right, did the individual get their methadone. One cannot replicate that on a mass basis. It is good value. I have spoken about this before. I think it is one-eighth of the cost to provide methadone services in the community within the group setting. It does not have to be a pharmacist, it can be a GP, but that connection between people suffering in these ways and a health care professional who understands them and respects them as a human being, who understands that this is something that has just happened in their lives and tries to support them and their families to get out of it. It has to be very targeted towards the individual. If one looks at the economics of it, and one wanted to be so cold as to look at it as a money saving exercise, the State will get its money back in spades and will end up with a better society. I thank the witnesses for their work.

Chairman: Before we return to the witnesses for their answers, I have many questions. Some are specific and some are general. Some months ago, when Professor Gerard Bury appeared before the committee to deal with the injecting sites issue, he spoke of people being condemned to remain on methadone for life. It seemed there was no system for trying to get people off methadone and that they would be condemned to a methadone life. Will the witnesses comment on that?

Ms Darcy spoke of the barriers to health care specifically regarding the prescription charge. Safetynet is developing services to provide care for those with street health problems but my impression is that the health service is generally very fragmented and there is no co-ordination between services. The witnesses mentioned that if someone has a mental health problem, it is a mental health issue and if one has an addiction problem, it is an addiction issue, and there is very little co-ordination between the two. There must also be a lack of co-ordination in general GP health services. Can the witnesses comment on whether there is a need for a dedicated health service for people who are homeless and have dual or even triple diagnoses? Is there enough support or co-ordination between the Departments of Housing, Planning, Community and Local Government and Health? Senator Dolan referred to the social determinants of health which span the Departments of Education and Skills, Transport, Tourism and Sport and Communications, Climate Action and Environment. Is a co-ordinated, dedicated unit necessary within the Department of Health which would go across multiple Departments?

If one can cut the number of people entering homelessness, one can start solving the problems. On previous occasions, this committee has heard evidence from people coming out of direct provision, or prison into homelessness or being discharged from hospital and going back into homelessness. There do not seem to be supports available to help them stay off the streets.

Housing First gives a person a house first and wraps the services around them whereas in Usher's Island, the strategy is one of detoxing and rehabilitating and supplying services without supplying the home. Is there a contradiction or competition in that area?

Are Irish cities different in terms of homelessness from other European ones? The witnesses might say this is because we have such a small percentage of social housing. Is it different from other countries? One could walk up Grafton Street on a summer or winter's evening and pass 14 or 15 people within 200 yd. who are sleeping on the street. That is my first tranche of questions. I am sure I will think of others.

Dr. Fiona O'Reilly: I will respond to some of those questions and Dr. O'Carroll might wish to comment then. Deputy O'Connell raised the issue of methadone. I totally agree with what she said about the community pharmacist being that connection or human relationship with people who have an addiction and the fact that it is a very cost-effective treatment. The phrase "condemned to a life on methadone" was used. I am condemned to a life on Eltroxin because I am slightly hypothyroid. That means I have to take a tablet every day for the rest of my life. Is it a problem? No, because the manner in which it is handled is not one that is treated with stigma and mistrust. I do not have to go to a centre where I meet people who would increase my likelihood, if I had an addiction, of falling back into the habit. It is very user-friendly. It does not stop me going on holidays or anything like that. People may not feel they are condemned to a life on methadone if the manner in which treatment services provide methadone were a lot more user-friendly. Obviously, that is suitable and works very effectively in primary care. Diabetics are treated in primary care. Approximately 10% of GPs overall can and do provide methadone as level one GPs. That is a consequence of some illnesses being stigmatised in our community and being criminalised rather than being treated as a health condition. That is something that can be done by the Department of Health. A new GP contract is coming up. One could ask why methadone is not one of the basic services GPs offer to their patients. Why does a patient have to go to his or her GP for a sore throat and then go to an addiction centre for methadone? Level one treatment for methadone is based on a three-hour, free online course that provides certification. In terms of homelessness, people on waiting lists have died waiting for methadone. That is just unacceptable in this day and age.

Deputy Kate O'Connell: I completely agree with the point about someone being condemned to a life on methadone. It is an umbrella term that suggests dirty, bad people. I have seen people for years that have functioning lives who are down to 10 ml to 15 ml of methadone maintenance. One could probably argue that they might not need it at all but it is a crutch and support. I totally agree there is no reason to channel people and stigmatise them by allocating them to a particular GP in a particular area where perhaps they may meet people from their past or, statistically, they are more likely to meet somebody involved in that habit. It is really important people do not feel they are stigmatised or that they are different. It is almost as if there is nearly no acknowledgement that they have come so far from the needle in their arm to the 10 ml of methadone and that they are in the same category. I do not say that the person using the needle in the arm is in a different category but I fully agree that we must move away from calling people addicts and saying they have to go down a certain channel, and if they are not, they go down a different channel. We must deal with addiction in the same way as we deal with hypothyroidism or whatever else one might have. It is due to ignorance.

That said, we have come a long way. We came a long way in this committee with the injection centres and with people's views on housing. With the help of the Department, we can remove some of the stigma from people. That is very important for recovery, that for a person to be on methadone is not considered dirty. Methadone is cheap and clean.

Dr. Austin O'Carroll: First, to go back to the idea of bad choice, I do not see it that way because when one is living in poverty, in particular if one comes from a dysfunctional family,

we see drug addiction as the way to treat the actual trauma. In a way, it is not a choice at all when all one's friends are on drugs, one does the same. In a way we need to get away from the idea of bad choice because the addiction is created by poverty. That is the causation.

I agree we have come a long way, but I wish to address two issues, one is methadone and the other is the provision of primary care services to the homeless. There is still a problem down the country. We have many people coming to us who become homeless specifically to get onto methadone. We have started over 500 people in the last four years on methadone through our homeless services, where we treat them in the community. A significant proportion of them have come up from the country. It relates to Ms Dolan's point about the lack of services down the country. I see that all the time.

I will outline two stories. One story turned out really well. It is about one of those people on the canal who was in a tent. The person had been homeless for over a year. We started them on methadone and within six weeks they had stopped living in the tent, moved into accommodation and stopped using heroin. That was fantastic. The other story is about a young girl who came up from the midlands. She was a mother who came up to us to get onto methadone because she could not get it in her local area. She went to stay in a hostel, got onto methadone with us and did very well. She moved back to her home but came up to us for her prescription, which was crazy. When she came up she had to stay in a hostel and one night she was violently assaulted there and ended up back on the streets because of the depression relating to the assault and died three weeks later from an overdose. If she had got treated down the country she would not be dead.

We have had two people die on our waiting list for methadone in the past six months. People do not realise it but more people die from drug-related deaths than from suicide or car accidents combined. It is the biggest killer of young people and is much more dangerous than diabetes, as Dr. O'Reilly indicated. The huge gaps in drug services down the country are a significant issue.

The other issue relates to what has been said about rural areas. The Chairman referred to a team for homelessness. To be fair to the HSE, it has funded a number of our services and we reach over 50% of the homeless population with primary care services. The HSE is funding many services that are getting out there to the people. The problem is that when there are so many chaotic people, it is very hard to adapt a general practice service to respond to their needs. It is a case of achieving a fine balance. One does not want people to get dependent on our services because that might capture them and keep them in homelessness, so one wants to capture them and hold them, like a safety net while they are in homelessness but as soon as they get into accommodation they would get back into the mainstream services. We need to maintain those flexible services while still allowing the route back into homelessness. Our problem is - this comes back to the query about getting a primary care team for homeless people - that we still have to use other primary care services, for example, physiotherapy, counselling and occupational therapy in the mainstream and they give out appointments. Homeless people do not keep appointments. They do not have home addresses to send the appointment notices to; they have chaotic lives; they do not have diaries; they do not have time or transport and they do not keep appointments. It would be extremely useful to get into homelessness services those primary care health professionals that we cannot access. It is the Safetynet Primary Care team that captures people and it could be hugely expanded.

There is a gap in particular in the area of mental health, as we have indicated several times. There are psychiatrists who work in homelessness but they deal only with pure schizophrenia or manic depression, the pure psychoses, which comprises one in five or one in six homeless

people. They will not deal with people who have drug addiction. They say that is the role of psychiatrists who deal with drug addiction, but the problem with the psychiatrists who deal with drug addiction is they deal with people who attend the addiction centres. Only yesterday Dr. O'Reilly and I had a meeting about this with doctors and nurses who are frustrated because they cannot get mental health services for people on the ground. There needs to be a dedicated mental health team which works with homeless people whether they have a drug addiction or not. That needs to be urgently addressed. I know the HSE is trying to do that because it recognises the problem but it has been trying to do it for several years. It needs to get the funding resources in place to address the issue.

In response to the question of bedsits - I know the issue has been repeated over and over - I do not know anywhere that the private sector has addressed the issue of homelessness. The Deputy asked about comparisons across other countries. I am sad to say I am in a thriving business. It is terrible to say, but the reason it is thriving is because of the lack of responsibility being taken for social housing by Government. I agree that it is not about providing vast estates of social housing. In the Netherlands, 33% of housing provided is social housing but it is much more integrated amongst the community. It is not set up in vast housing estates which concentrate many social problems into one area. It is really important to get that point across. It would be great if really nice, wonderful apartments which have a bed and a living space could be provided but I fear that the reality is that once bedsits are allowed the previous terrible situation of having horrific bedsits will return. When I used to do house calls I would see people living in appalling states. It is not the private sector but the public sector that needs to get moving.

Ms Niamh Randall: I will just fly through some of the comments and queries. I absolutely concur with Deputy Murphy O'Mahony in respect of overcrowding and hidden homelessness. CSO figures will support that. We know there is a huge underbelly there. People often make temporary arrangements, which can break down. It is very stressful and a huge strain and these people may end up trickling into homelessness. If they do not, there is still a huge group of people living together, possibly in overcrowded conditions, in a setting which is not necessarily appropriate. As yet we do not have any measure of that problem. In other countries, such as Canada, there is a mechanism which attempts to count cases of hidden homelessness. We will be linking in with the CSO on that issue at the time of the next census to see if it might be possible to get some sense of the scale of that issue. It is a bit of a challenge, absolutely.

Deputy Durkan, who is not present, is absolutely correct that the response is housing, but it is housing and support. We do not emphasise the support element enough. It is about responding effectively to the issues people have to ensure they can maintain their tenancies and their housing. It is really important to include the support element. On the query about youth homelessness and the response to it, we recently published a report authored by Dr. Paula Mayock of Trinity College with a number of other homeless organisations. It is titled "Living in Limbo" and looks at youth homelessness. I am very happy to share that report and some of its recommendations with the committee if that would be considered useful.

On Deputy O'Connell's comments on the bespoke, tailored response to dealing with drug-related issues, we absolutely must have that tailored response to each individual. It is the only way we can deal with it effectively. In terms of responding effectively, prevention is the key element. It is prevention and early intervention and then it has to be rapid rehousing using a Housing First model. That is the only way we are going to effectively deal with this particular issue.

We spoke about children and the damage being done. The real danger is not only that we are

working with people who are experiencing poverty but that there will be a poverty of expectation and aspiration for the future and a sense of fatalism among those who are growing up in such a challenging and limited situation. We really need to intervene as quickly as we can.

In terms of responding to rural homelessness, this issue is really complex to deal with in an urban setting where there is a greater range of services. Once we move out of an urban setting, it is really challenging. Either the services do not exist or they are really spread out and people have to travel great distances to access them. Again, we have published a paper on rural homelessness which we can share with the committee. It outlines some of the challenges and some of our recommendations for dealing with the issue. In terms of a response, it is about building houses or renovating vacant homes. Vacant homes being renovated need to be those which are near services, supports and infrastructure because, critically, people need to be able to access those particular services.

In terms of the query about whether Ireland is unique and about similar experiences in other countries, we are quite similar to other countries in western Europe. Growing levels of homelessness are seen across most other European countries, including the UK, at this point in time. Regarding how things are done differently, quite progressive harm reduction and drug services responses are seen, particularly in Copenhagen where there is a very successful approach to naloxone treatment, a number of drug consumption rooms and a range of other things. There has been quite a successful approach using a housing-led model in Finland. There has been very strong local and national political and financial commitment to that model. It has been the most effective country in Europe in respect of addressing homelessness to this point in time. It is currently highlighted as quite a successful model of intervention on that issue.

There was a query about service fragmentation. There is a challenge in terms of intersectoral, inter-agency and interdepartmental working. It seems to be an ongoing challenge. Sometimes it depends on relationships to a great degree and if someone changes job or role, that relationship can then break down. We certainly need to have a stronger push in terms of guidelines and commitments to ensure that actually happens to ensure that we address people's issues effectively.

There was query in respect of Housing First in Usher's Island. I will refer that query to Ms Darcy for a response.

Ms Majella Darcy: To answer Deputy Murphy O'Mahony's question, we do refer to other agencies such as Pieta House or Aware. It goes back to a point which Dr. O'Carroll made, which was that appointment-based systems do not always necessarily work. The Dublin Simon Community set up the Sure Steps counselling service over four years ago. Last year that service had 1,750 hours available specifically to homeless clients It is an adaptive model of counselling where attempts are made to meet people literally where they are at. It might initially be crisis intervention to get people engaged, because counselling is not traditionally a type of service which homeless people would access, so we adapted the model and it has worked very successfully. This year we have 2,250 hours available for homeless clients and all of those hours are taken up. They are not just available, they are used.

To answer the Deputy's question on Usher's Island, tonight we have 64 people in our Usher's Island facility. They are in treatment, in recovery and in the blood-borne virus unit. Out of those 64 people, 25 are in accommodation in Blessington Street and in Tallaght. Those 25 people are ready to move onto accommodation. We provide some accommodation. We have 300 units of accommodation, which we have already provided for homeless people generally

and not just for clients of the Dublin Simon Community. These 25 people are ready to live independently but the accommodation is not there. The longer we leave them in that holding pattern in terms of their recovery, the more likely it is that all the investment they have personally put into their recovery and the challenges they have overcome to get to that point will unravel. The amount of work they have had to put in has been horrendous. For it to unravel because we do not have that final piece of the jigsaw, that is, the accommodation, would be the biggest crime we could commit. The Dublin Simon Community, as well as other approved housing bodies, are providing accommodation but much more accommodation is needed, as we are all aware. In Usher's Island we provide a percentage of the accommodation for people to move on. That could be the high, medium or low-support accommodation that we have in the organisation or it could be referring clients to other organisations.

We run an addiction inreach-specific service through which we provide services to the HSE and to two other organisations. The sole remit of that addiction homeless action team is to avoid people exiting treatment into homelessness. We only have two people to do that and they have a case load of 25. They have had some really successful outcomes and it is an example of good co-ordination in terms of swapping clients. If one organisation feels that the client is not suitable to its criteria it refers the client to us and *vice versa*. It is an attempt to move people out of homelessness into suitable accommodation.

To return to the issue of methadone, I agree that people may feel that they are condemned to methadone but the service we run in Usher's Island is unique in that we take people in for an alcohol detox on any dose of methadone. We do not have an upper limit because, unfortunately, the upper limit serves to further exclude people. People might come in on anything up to 120 ml of methadone or more. We do not currently detox them from methadone but they can move into our recovery unit. Dr. O'Reilly was part of a project which we did a few years ago with regard to lowering our threshold. We had a rehabilitation unit but we have now changed it to be a recovery unit because we felt that we were losing many people who had completed an alcohol detox successfully but could not move into a rehabilitation unit because such units did not traditionally allow a person to be on benzodiazepines or methadone. Now people can come into the recovery unit on prescribed benzodiazepines or prescribed methadone. Once they are on a prescribed dose, many of those people exit our treatment and recovery and manage to live very successful lives afterwards. While I may not agree that people should be on methadone for the rest of their lives, a conversation needs to happen around whether we want to reduce to a level that is acceptable. We cannot talk about health without talking about accommodation as it would be pointless. It would be worth having cross-departmental work in this regard but there is no point unless it trickles down to the HSE, local authorities and NGOs working in real partnership. NGOs have to be an equal partner at that level. We have the cumulative experience over the years and we know how things work. We have adapted and have had to be very flexible and innovative and this should be taken into account when trying to come up with solutions for the cohort with which we work.

Dr. Fiona O'Reilly: There is an old story about coming upon a river and seeing a load of people drowning. One puts the emergency project in place and starts to pull people out of the river. That is what we are doing. We and our colleagues are working very innovatively to get drowning people out of the river. The problem is that more and more people are falling into the river and a social housing bridge or some such thing needs to be built. We cannot really do that because we are too busy dragging people out of the river. Perhaps people from mainstream public agencies including social protection, primary care or local authorities should be invited before the committee to be asked what they are doing for health and homelessness. How are

they preventing people from falling into the river? Are they adapting flexibly to people in their community who are at risk of homelessness? How are they preventing it? We all have good ideas but we are just pulling people out of the river.

I saw an excellent movie recently, "I, Daniel Blake", which should be mandatory for anybody in public services or medicine because it shows how the State helps people into homelessness.

Mr. Aaron O'Connell: Deputy O'Connell asked about the impact on people living in hotel accommodation. One of the dangers in the provision of temporary accommodation is that it can be seen as a long-term solution. We need to be really clear that it can never be that. There are not just huge difficulties for children, it puts stresses and strains on relationships and this doubles back onto children, causing trauma and stigmatisation. The housing crisis is driving the crisis in homelessness and the related health issues. We need to plan for a long-term solution to this problem.

Senator Colm Burke referred to the situation in Cork. We have tried to focus on pushing for long-term stable accommodation where people have their own front door. Deputy Durkan mentioned sheltered housing. There is a place for everything and a one-size-fits-all approach does not necessarily work. The more independence we can create, the better people's health and well-being will be and consequently, we need a range of options. Some people are transient and we had such a case in Cork. The GP with the adult homeless team made a decision and the person was involuntarily admitted for treatment. Such cases are exceptional but they also require responses. There may be additional costs but if the services do not provide for such people we need to ask why they are falling into that scenario. What preventative measures can be taken? Everybody is different and we deal with individual scenarios as they arise. We should not lose anybody simply because of putting a cost per head on a particular provision. Everybody needs to be valued equally and the best way to provide for these people is to have a spread of services and access to them, wherever they live. Community services in such areas need to be flexible and aware of the complexity of the issues with which people present, particularly those with issues related to addiction and mental health. All front-line services need to be versed in these issues and to upskill as necessary. Everybody needs to understand at what stage people are in the continuum of provision. The services need to support each other and while we can be critical of the HSE in many ways, the adult homeless team in Cork is working very well. It is a classic case of partnership working and people adapting to work together. The difficulty is that there is not enough of this and there are gaps in nursing hours, occupational therapy etc. We need to resource them and make them more effective. The work is collaborative and innovative, and is exemplified by Dr. Austin O'Carroll in Safetynet Primary Care. Such things show the way and it is really important that the upper echelons of the HSE understand that they are effective and need more support.

Ms Emma Dolan: On the co-ordination of services, there was a question on whether there was competition between the Usher's Island and Housing First services. We can sometimes have either-or responses to difficult or complex issues, and Ms Darcy explained what works in this regard. These things should be seen as part of a package and when somebody in a Housing First team needs treatment, somewhere like Usher's Island could work alongside that Housing First team to enable the person concerned to have his or her period of stability before coming back out into his or her home.

We were asked whether there should be a co-ordinating body to pull together the various agencies and elements of Government but I would find such a thing depressing because it

would acknowledge that the mainstream was not working. There is a need for the mainstream to become more flexible and to adapt. If there was a need for a co-ordinating body it would need to have access to its own funding. I have worked with individuals with a disability or a mental health issue or who suffered from depression or came from a Traveller background and required a lot of social work input from many different Departments, and such people needed a package to be developed for them. We would have to go to social inclusion, disability or mental health services or primary care. Given the length of time it takes to negotiate these things, one has to ask where the funding would come from. All the time the individual's circumstances are getting worse and there is an even bigger job to do by the time one finally gets it all. There is a similar structure for dealing with vulnerable adults and any time one wants to put a package together, one has to go back and negotiate with the various departments in the HSE to do so. Any such body would need to be able to commission its own services. The risk is that it would operate separately from the mainstream, which would bring its own headaches.

Ms Niamh Randall: With regard to housing, I would just like to make it very clear that Housing First does not preclude access to residential drug treatment. The crucial thing here is choice. Housing First has no preconditions and does not require anyone to access drug treatment. If an individual chooses to do so, however, this can then be made part of the overall picture and individuals can move seamlessly from one part of the service to another. That should work.

I want to pick up on Dr. O'Reilly's comment about addressing the issues at the very top of the stream and why people are homeless. It is very clear that the reasons people experience homelessness, problematic drug and alcohol use and housing insecurity come down to poverty and inequality, lack of housing affordability, poor supply, and the lack of tenancy security and income adequacy. The committee's advocacy on these issues could really help us. If tackled, these are the issues that could prevent these problems happening in the first place. Very strong advocacy at a policy level is really important when it comes to preventing these issues.

Other key messages include the importance of requiring, ensuring and supporting intersectoral, cross-departmental work. This needs to be done in a co-ordinated way. Another is the importance of bringing services to where people themselves are and ensuring that those services are flexible, appropriate, affordable and adaptable. We need to be able to adapt services to meet people's needs. As Deputy O'Connell commented, we need to provide tailored responses because it is not the case that one size fits all. These are are central messages.

As Ms Darcy mentioned, it is really important that NGOs and organisations like Safetynet and the Simon Communities are seen as equal partners. We are very happy to play our role. We all want the same thing: to prevent homelessness and prevent problematic drug and alcohol use and the range of health issues that come with it. We are very happy to support the idea of working together in a stronger, more collaborative way. It is very important that we are seen as equal partners in this process.

Dr. Fiona O'Reilly: With regard to children, Safetynet goes where there is a gap and where there is a need. We have not to date expanded our primary care services to families with children in hotels. It would not be a good sign if we had to do that. Just as people should be kept out of homelessness, they should be kept out of homeless-specific services. This would indicate a failure on the part of our mainstream primary care services. Additional supports will be required to keep families in these mainstream services, additional liasion and transport provision, for example. This needs to be done because we will have failed again if another cohort comes into homeless services.

In response the co-ordination mentioned by Ms Dolan, I agree that homeless individuals should not be taken out of mainstream services and put into a separate system. It should not be a question of entering a separate system. We need co-ordination to prevent this from happening and to have enough clout within the mainstream services to say that cases are not appropriate for homeless services and should be under the local authority or the HSE, for example. Services need to be more flexible and the level of co-ordination mentioned would be of benefit.

Deputy Kate O'Connell: Let us move away from the drug addiction issue and look for a moment at childhood immunisation programmes, particularly for children living in hotels. Is the necessary information reaching these families? Do they know where they have to go and what immunisations their children have to get and when? Is that working? Are the services already in place to address this issue or are children temporarily falling off the radar? Do the witnesses know?

Dr. Austin O'Carroll: We know that becoming homeless affects an individual's future in the long term. We now have a very specific issue that we have never seen before. Children came into homelessness in the past but usually because their parents were chaotic due to drug or alcohol addiction or because of family breakdown. Many of the parents now coming into homelessness remain very connected to their communities and to their GPs. They are still going to their GPs, and this is critical. We do not want to intervene because we want that connection to be maintained.

The question was asked as to how many additional services we need around children. I do not think that there is any service we can give to a child experiencing homelessness. What these children need are play areas and a stable life. Counselling is not going to do anything for children whose lives are chaotic. What they need is to get back into a home in the community where they started. That is the central issue. I do not think that putting more services in place helps. Many of the parents in question are quite stable and are keeping things together. It is the parents, not the children, who need support in this chaotic situation. As was already mentioned by Ms Randall, there is a need to maintain transport to and from the family GP so that the connection can be maintained. The main thing is get them out of homelessness as soon as possible.

Deputy Kate O'Connell: There needs to be support for parents to keep things as normal as possible.

Dr. Fiona O'Reilly: Yes. Things like public health nursing are important, as are measures to stop families falling away from their GPs and communities. If a hotel opens up on a public health nurse's patch then all of sudden it is that nurse's responsibility to remind families of their immunisation appointments and so forth. There is a new draw on the mainstream services then and they in turn are overburdened. Wherever there are new family hubs or people living in hotels these services will need to be supported. If these services are not supported a gap will arise and we in Safetynet will be asked to intervene. It is not that our failing to intervene solves the problem either, of course, but it is better that this gap be prevented in the first place. Our having to intervene marks another failure in the mainstream service.

Chairman: On behalf of the committee I thank Ms Randall, head of policy and communications for the Simon Communities, along with Mr. O'Connell, Ms.D'Arcy and Ms. Dolan, from the Cork, Dublin and Galway Simon Communities. I also thank Dr. O'Reilly and Dr. O'Carroll from Safetynet.

This concludes our business for today and we will now adjourn. Is that agreed? Agreed.

The joint committee adjourned at 11.37 a.m. until 9 a.m. on Wednesday, 12 July 2017.