DÁIL ÉIREANN

AN COMHCHOISTE UM THITHÍOCHT, RIALTAS ÁITIÚIL AGUS OIDHREACHT

JOINT COMMITTEE ON HOUSING, LOCAL GOVERNMENT AND HERITAGE

Déardaoin, 24 Meitheamh 2021

Thursday, 24 June 2021

Tháinig an Comhchoiste le chéile ag 10 a.m.

The Joint Committee met at 10 a.m.

Comhaltaí a bhí i láthair / Members present:

Teachtaí Dála / Deputies	Seanadóirí / Senators
Francis Noel Duffy,	Victor Boyhan,
Thomas Gould,	Mary Fitzpatrick,
Emer Higgins,	Mary Seery Kearney.
Steven Matthews,	
Cian O'Callaghan,	
Richard O'Donoghue,	
Eoin Ó Broin.	

Teachta / Deputy Paul McAuliffe sa Chathaoir / in the Chair.

Interim Report on Mortality in Single Homeless Population 2020: Engagement with HSE

Deputy Paul McAuliffe took the Chair.

Vice Chairman: Apologies have been received from the Chair, Deputy Steven Matthews, who has been selected for oral parliamentary questions with the Minister for Housing, Local Government and Heritage this morning in the convention centre, and therefore cannot be here.

Today, we are joined by Dr. Austin O'Carroll, HSE clinical lead for the Dublin Covid-19 homeless response, who was commissioned by the Dublin Regional Homeless Executive, DRHE, on behalf of the four Dublin local authorities, to review the mortality of persons experiencing homelessness during 2020.

Members have been provided with a copy of Dr. O'Carroll's report. I thank him for joining us today. I invite Dr. O'Carroll to make his opening statement, following which, members will be invited to ask questions. Members should limit their questioning to five minutes initially. We may be able to have a second round of questioning at the end. I remind members that this is a 90-minute session. We will get through as many contributors on the rota as possible.

I will make a quick comment on privilege. Members attending remotely within the Leinster House complex are protected by absolute privilege in respect of the presentations they make to the committee. This means they have an absolute defence against any defamation action for anything they say at the meeting. However, they are expected not to abuse this privilege. It is my duty as Chair to ensure that privilege is not abused. Therefore, if their statements are potentially defamatory in relation to an identifiable person or entity, they will be directed to discontinue their remarks and it is imperative that they comply with any such direction. I remind members of the constitutional requirement that they must be within the confines of the place where the Parliament has chosen to sit, namely, Leinster House or the convention centre, in order to participate in this meeting.

For witnesses attending remotely, there are some limitations to parliamentary privilege and, as such, they may not benefit from the same level of immunity from legal proceedings as a person who is physically present in the building.

Members are reminded of the long-standing parliamentary practice to the effect that they shall not comment on, criticise or make charges against a person outside of the Houses or an official either by name or in such a way as to make him or her identifiable.

The opening statement submitted by Dr. O'Carroll to the committee will be published on the committee website after the meeting.

I welcome Dr. O'Carroll to the meeting, particularly in light of the committee's work on the forthcoming launch of our report on homelessness. I invite him to make his opening statement.

Dr. Austin O'Carroll: Can I use a PowerPoint presentation as part of my opening statement?

Vice Chairman: That is fine.

Dr. Austin O'Carroll: I will share the slides with members and speak quickly so that I can get through them. I thank the committee for the invitation to speak today. I will summarise the report to outline the main findings and highlight what I think are the main issues.

First, the report is an interim report because I could not get access to all the data. The data from the coroner and the CSO will not be available until next year. There should be a complete report next year.

It is important to highlight what we already know from the literature on homelessness. Internationally, we know that people who experience homelessness die younger than they should. The reason for this is that among people experiencing homelessness, there are high rates of physical and mental illness, suicidality, substance misuse and accidental and violent death. There is also the influence of poverty. Poverty is associated with a lower life expectancy, as is childhood adversity. We know that people who are experiencing homelessness tend to come from poverty and have high rates of childhood adversity, as well as being affected by all the other issues.

We already know that there are interventions that can reduce mortality such as providing a multiagency response and improved access to primary care. The two big preventable causes of death in homelessness are suicidality and overdose deaths. There are interventions that help reduce those two particular causes of death.

I was asked to review 2020, specifically. There were 79 deaths in 2020. However, we reduced that figure down. I need to explain why, because it is important for people to understand. First, of the 79 deaths, four were not known to the DRHE, so those people had not accessed their services and were not technically DRHE service users so were excluded. Second, the DRHE reports on deaths that occur in tenancies that it funds. People in tenancies are not homeless people, so we excluded the deaths of people in tenancies such as Housing First tenancies or supported tenancies. Third, long-term accommodation tends to house people who are older and very unwell. These people are not counted by the census as being in homeless accommodation because, in a sense, they are almost in the nursing homes of the homeless sector. As they are not counted by the census as homeless, we excluded the number of deaths in that group from the figures. I have reported on those deaths separately, because they do come under the DRHE. Lastly, in 2020 only one death occurred in family homelessness. Looking over the past five years, very few deaths have occurred in family homelessness. By including the deaths in family homelessness and the numbers, and the numbers of homeless families are very high, you are artificially deflating the mortality rate. The mortality rate among those in family homelessness is very low. We excluded that figure because it was diverting attention away from where the real issue is, which is among single homeless people. In the end, we were left with 47 deaths in 2020 among people who were experiencing homelessness, of whom 44 were in emergency and three were rough sleepers.

Looking at the deaths, there does seem to have been an apparent significant increase in deaths in 2020.

Sorry, did the slide disappear?

Vice Chairman: We are currently experiencing some technical difficulties. I ask Dr. O'Carroll to bear with us.

Dr. Austin O'Carroll: No problem.

Vice Chairman: We are having difficulties sharing the slides. I ask Dr. O'Carroll to continue with his presentation to allow us to keep within the time limits. The technician will share the slides with members.

Dr. Austin O'Carroll: The number of deaths seemed to rise significantly from 26 in 2019 to 47 in 2020. However, the number of homeless people has been increasing steadily since 2016. Looking at crude mortality rates, while the crude mortality rate had gone up since 2018 and 2019, in 2020 the crude mortality rate was actually lower than in 2016 and 2017. That means that the actual crude mortality rate was not significantly higher, taking into account rates over the last five years. The most likely explanation is that it is just simple statistical variation. However, looking at the crude mortality rate for long-term homelessness, it is clear that mortality rates really shoot up for people who have been homeless for more than 18 months. The mortality rate among people who have been homeless for more than 18 months is very high compared to that of other homeless people.

I also looked at the crude mortality rate of homeless people in private emergency accommodation versus those in supported temporary accommodation. The mortality rate of those in supported temporary accommodation is higher. That would be expected because the DRHE tends to put people who are sicker into supported temporary accommodation because there are better medical and social supports in supported temporary accommodation. However, we can see the mortality rate of those in private emergency accommodation is coming closer to that of supported temporary accommodation. That is important in terms of recommendations. It is also important because the population of people in private emergency accommodation has been rising significantly and is coming closer to the number of people in supported temporary accommodation. That is important in terms of recommendations because private emergency accommodation has less health and social supports.

The crude mortality rate in log-term accommodation is much higher, as you would expect, because the people such accommodation are older and sicker. Long-term accommodation is like nursing homes, and the mortality rate is significantly higher.

There were three rough sleeper deaths in 2020, one in 2019, one in 2018, zero in 2017 and two in 2016. That does not represent a huge variation, particularly as we know that there has been an increase in the numbers of homeless people.

We looked at median age. Median age is the middle age. For example, if three people died, aged 42, 47 and 49, respectively, the median age would be 47. The median represents the person in the middle. It is important to recognise that the median age depends on the population. For example, the median age of death in a nursing home will be much higher than the median age of death in a secondary school. The median age for homelessness has not varied that significantly and was not much higher in 2020 than in previous years.

As for the location of death, eight people died outdoors. Of those, seven were single people experiencing homelessness. Four had been sleeping in their own accommodation. They had had emergency accommodation for a few months prior to their deaths and had been sleeping in that accommodation the night prior to their deaths, so they were literally out one night when they died. Three people had been rough sleeping regularly.

One of the big things to point out is that the main determinants of early death in people experiencing homelessness are structural causes related to poverty causing a lower life expectancy. Poverty is also associated with drug addiction, which is one of the main determinants of

death. We know this both in Ireland and internationally. It is probably the main determinant of early death due to overdose and spread of blood-borne viral infections as well as other causes. Therefore, poverty and its effects, namely addiction and increased illness, including increased mental health illness, are the main causes of early death.

The main recommendations of the report are that if we want to learn from deaths, we need first to gather information. We should gather information like this on deaths every three to five years because that allows us to look at and see trends in death. Very importantly, however, you learn a lot more from a single death sometimes than from looking at all the deaths. You might look at the case of a person who died, find out where they died, find that they died outside, find out what services they had been in touch with, find that they had been in touch with a hospital, a drug addiction service or homelessness services and find out what happened, when they linked in with those services and whether anything could have been done to prevent what happened to them eventually. For example, two people died from overdoses last December in the Phoenix Park. We chased that up. We found they had been on methadone but had stopped attending appointments the previous month. We have now tried to get people who default from methadone treatment back into services. We have taken action. Often you learn from looking at single deaths, as part of what we call critical case analysis. This needs to be done in a non-blame environment.

We also need to reduce long-term homelessness, and the Housing First model is the best way to achieve that. We should have a multi-agency committee to review five-year mortality rates. We should ensure there is access to primary care in private emergency accommodations. We need to improve access to mental health treatment, particularly for those with dual diagnosis, that is, people who have coexisting drug addiction and mental illness. We know of interventions to help to reduce overdose fatalities, including improved access to naloxone, supervised injecting centres and access to opioid substitution therapy. We need a protocol for overdose risk assessments and need to develop protocols for review of non-fatal overdoses.

Lastly, we know there are interventions to help to improve mental health that we need to implement. Overall, we need to address social inequality, stop people from becoming homeless, address housing issues, support Housing First to reduce long-term homelessness, address overdose suicidality and have a learning system to improve the quality and safety of services.

Vice Chairman: I have no doubt but that Dr. O'Carroll will have an opportunity to expand further on those recommendations as part of his responses to the questions from members.

Senator Mary Fitzpatrick: I thank Dr. O'Carroll for his report and all the work he does. I thank everybody who works with him as well. Their work is incredible. We are all humbled by it. I acknowledge that in his report Dr. O'Carroll says Ireland can be very proud of our response to Covid-19. He and everybody who works with him can be very proud too. It has been a tremendous response and is one we need to sustain. I agree with him on that. I also agree completely with his conclusion that it all has to start with housing. There are inequalities created by homelessness and housing poverty. We have to address those root causes. There is no dispute at all on that, and that is this Government's top priority.

In his report Dr. O'Carroll talks about collecting the data and the fact that it is an interim report because the data that are available to him are incomplete. He suggests that a database should be created to capture and report on the deaths. Which organisation does he think is best positioned to capture those data? Is it the DRHE? Is it the coroners? I would like him to advise us on that.

When we talk about homelessness and this segment of homelessness, deaths in homelessness, we see that males are disproportionately represented in the homeless population. Single males are further disproportionately represented in the homeless population generally. Really sadly, in this report that trend is mirrored absolutely. It is really alarming to see this crisis for males, and as a society we have to accept, recognise and address it. It is stark that three quarters of deaths in the homeless population between 2005 and 2015 were among males and that 33 of the 44 single deaths Dr. O'Carroll reports on, or 75%, were among males. Beyond addressing housing - there is absolutely no dispute about that, which is why I am not focusing on it - I wonder if as a society we need to explore this issue more. What are we doing to support young men and to support boys to become young men? What is it that is making them so vulnerable and so susceptible to this terrible crisis?

The report published yesterday focused on homelessness over a five-year period. It stated that in Dublin in particular we have a big issue with predominantly single homelessness and male homelessness. There is also, however, the issue that in Dublin homeless people stay in emergency accommodation for longer than in any other part of the country, exceeding six months easily. Dr. O'Carroll's data show us that those who remain in emergency accommodation for longer are more vulnerable to increased mental health issues and death, ultimately. In Dublin we see this a lot. There are two political arguments going on. One is the argument about the building of single units. There is also a lot of campaigning on our need for family accommodation. Of course we need family accommodation, but most of our built housing stock is already family accommodation and it is difficult to push the argument for good-quality single accommodation, which is desperately needed if we are to deliver on Housing First. I would like Dr. O'Carroll's view on that.

Furthermore, Dr. O'Carroll will know that in the constituency we share we have a predominance of emergency accommodation, which I consider a substandard form of accommodation. I appreciate it meets a need in an emergency but it is not suitable for long-term accommodation.

Vice Chairman: Senator, you have just one minute remaining in your slot.

Senator Mary Fitzpatrick: I will be very brief. In the interim, what is Dr. O'Carroll's view on our taking long-term leases to provide suitable accommodation for a secure period such as 25 years? The city council has done this, and I would be interested in his view on that as well.

I thank Dr. O'Carroll for coming before the committee.

Vice Chairman: Dr. O'Carroll, you have just half a minute left, unfortunately, to get through all that, but you might get through other questions later when responding to other speakers.

Dr. Austin O'Carroll: I thank Senator Fitzpatrick. The DRHE collects the data and could use data analysis to look at the data. It could also work with the coroner as well as do the critical incident analysis.

As for homeless males, I think there are multiple issues. Poverty is a significant one. Males in poverty are often isolated. They often do not have familial roles or are single parents. Also, drug addiction tends to affect males more often than women, so I think that is why they end up that way more than women.

As for single homeless people spending longer periods in homelessness, again, drug addiction unfortunately has a much more significant effect on homelessness in Dublin. Drug addic-

tion and mental illness are probably the two determinants of long-term homelessness.

There is always a crux between whether you get singles accommodation or housing. I would favour putting the investment into housing and good singles accommodation, though I agree with Senator Fitzpatrick that we need to have certain standards of singles accommodation that people can survive in, particularly if they are going to be there in the long term. The focus should be on housing rather than accommodation.

Vice Chairman: I will move on to the Sinn Féin speaker, Deputy Eoin Ó Broin.

Deputy Eoin Ó Broin: It is good to meet Dr. O'Carroll. I thank him for the report. It is a comprehensive piece of work and will be useful to this committee and, I hope, the Government and the DRHE in the time ahead. Rather than make a statement, I want to tease out a little bit more the most immediate actions Dr. O'Carroll feels are necessary for the Government to try to ensure a reduction in the number of deaths people experience in homelessness. I am conscious some of the reporting on this issue has given the impression homelessness is the cause of death when it seems to be that overlapping of addiction, mental ill health and a greater risk of early mortality that arises from homelessness. If this committee was of a mind to write to the Minister on foot of this meeting and recommend two or three absolute priority actions that need to happen immediately to see that mortality trend reduce, what would Dr. O'Carroll ask us to really focus on to get the best bang for our buck in terms of our influence with the Minister?

Dr. Austin O'Carroll: There are four things I would ask for. The first is reduce the length of homelessness through pushing the Housing First policy. That is the most important one. Second, there are interventions to reduce overdose that we know of and need to expand, such as the use of naloxone. We know the supervised injecting incentive is coming down as so the committee should make sure they happen. The third is increased health supports in private emergency accommodations. The HSE has already got nurses in there and is looking at getting GPs. It is just to make sure that happens but I know it is in process. The fourth one is the mental health team for dual diagnosis for which we have been asking for a long time. Deputy Ó Broin asked for three actions but I am giving him five. The last one is the critical incident analysis in order that we can start learning from individual deaths.

Deputy Eoin Ó Broin: On that last point, I was reading research recently in Britain. It has had a significant increase in deaths of people experiencing homelessness and one of the mechanisms it has is an adult safeguarding review. Is that the same kind of idea Dr. O'Carroll is talking about, in that there is a look-back when there is a death of somebody accessing any of those services to try to see what systems failures may have taken place or what interventions could have been used to try to improve those systems and supports in the future? If it is a different kind of intervention, maybe Dr. O'Carroll could talk in a little bit more detail about what it looks like and how it would operate.

Dr. Austin O'Carroll: Critical incident analysis exists in medicine. It would be similar to a safeguarding review. The key features are about becoming a learning organisation and trying to learn from what happen to improve. A key feature is you have to do it in a non-blame culture. Obviously, if someone has stepped way outside his or her brief and acted totally unprofessionally, you cannot defend that, but what often happens, especially when there are deaths, is you get an outburst in the media and people return to a defensive position. The critical incident analysis is where you say to people this is not about blame, it is about learning and improving services.

There are processes already. The HSE has similar processes for critical incident analysis

as part of its quality and safety element. It would just be a question of applying those systems. What would happen is that once a death occurred, you would review the death. It is called a desktop analysis. If this was someone who was dying of cancer, it is an expected death and you do not need to do critical incident analysis. If it is someone who died of an overdose in the park, let us do a critical incident analysis. You would then approach all agencies that have been in touch with that person. It could be the homeless, outreach and drug services but it also could include the police, courts and prisons. You look at all services and ask what we could have done.

You could find out that the person who had an overdose had an intervention with the Garda. You could ask whether the Garda could do something about looking at whether this person should have been on methadone. That is the type of thing you would do to learn whether this could have been prevented. You need to do it in a non-blame analysis in order that people are open and you can get all the information to find out what exactly happened and identify where you could have intervened to potentially have prevented that death. Does that answer the Deputy's question?

Deputy Eoin Ó Broin: It absolutely does. Given the importance of this report - and unfortunately far too many reports end up sitting on the shelf and gathering dust - it would be really important for us to have Dr. O'Carroll before us again in six months' time to give us an indication as to what, if any, of the recommendations have been lifted and whether there has been progress on any of these from his independent point of view. We should not do just this one hearing. As a committee, we should take an active interest, track this and keep making recommendations to the Minister and homeless services providers, especially the DRHE, and to the larger local authorities.

Vice Chairman: For Fine Gael, do we have Deputy Higgins or is it Senator Seery-Kearney?

Deputy Emer Higgins: I will go first. I thank Dr. O'Carroll. That was an informative report and the presentation was a good whistle-stop tour of its recommendations. I will start by saying I do not want to live in a society in which people are living rough in a canal and I know that nobody on this committee does. That is not the Ireland that anybody wants. I really appreciate all the work our homeless services are doing to change that. Dr. O'Carroll mentioned that eight people who died in homelessness died outdoors and that four of them were sleeping in their own accommodation the night beforehand. Do we have any information as to why they were sleeping rough on that particular night?

Dr. O'Carroll has already touched on this from the last two contributors, in that we all agree services should address any preventable causes of premature mortality. We all need to develop the processes that review death statistics and critical incident deaths. What does Dr. O'Carroll feel are the causes of premature mortality that can be dealt with through processes and practical measures? How does Dr. O'Carroll think we can build those into our services?

While the determination of cause of death is solely a matter for the coroner's office, there is further need to rapidly review clusters of deaths that may be linked. That is clear from Dr. O'Carroll's report. What factors does he feel may have linked these clusters of deaths?

Dr. Austin O'Carroll: With regard to the four people sleeping rough, we do not know what the story was there. We probably have to wait for the coroner's report. If we had a critical incident review process, it would have answered that question. That is one of the reasons for having that incident review. My guess is people sometimes sleep rough because they meet friends and stay out as a couple or, in the scenario about which I would be more concerned, they were

out with a group using drugs and stayed out to use drugs. We know overdose is one of the main causes of premature mortality. However, we do not know and that is why the critical incident review would make a big difference.

With regard to the causes of premature death, the biggest determinants are the social determinants. Of the ones we can prevent, that is the one we should focus on. The way we can prevent it is to stop homelessness. Drug addiction is the big one. If I was concentrating on the one area, it would be drug addiction and after that is mental health and suicidality because we have interventions that can help those.

As for the rapid review, for example, two people died in Phoenix Park last year and you would want to find out why two people died together and what was going on. You may find that people who are using drugs die at the same time. You may be worried there is a bad batch of drugs going around that needs to be identified.

They are probably the main types of things. There was an increase in the number of people getting infectious diseases such as HIV. While this is not death, it gives you an example. When we reviewed why they were getting HIV, we found out it was due to a change in the type of drug use at the time, especially with this drug called snow blow. We were able to identify that caused spread of infection. It would be a similar thing. You ask whether there is something happening that causes this increase in death amongst homeless people with drug addiction or the types of drugs being the main issue you would be trying to address.

The other one is suicidality. Sometimes if there is one suicide, there is a spate of suicides. That is something you would also want to be watching out for.

Senator Victor Boyhan: I welcome Dr. O'Carroll to the meeting. His interim report makes for fascinating reading. I do not believe there is anything particularly new in it that we would not have known but how it is presented is important as are the statistics, the charts and so on. It confirms what many of us already thought. I do not have questions as such but I have comments.

I note it is an interim report and a work in progress, which we should continue to track and engage on with Dr. O'Carroll. What jumped out at me most, and which I am always very conscious of, is the quote on childhood adversity. We all know this but to me it is the most important one in the report:

> Most homeless people have been exposed to high levels of childhood adversity. Childhood adversity is predictive of a lower life expectancy.

Earlier we spoke about death, but the first point is to prevent homelessness. Why is it that so many people are single and homeless? Where is the sense of belonging and of connectivity, the sense of social bonds in formation? If one tracks many homeless people and if talks to them on the streets, as I and other members of the committee would do regularly, there is a sense that they are isolated. They have never been able to form bonds. Many of them have come from institutional care. Many of them have been rejected time and again. All of that bonding is critically important in early childhood. There is an expression that we see the world from where we stand and our experiences within it. Whether we like it or not each and every one of us brings to our daily life our experiences, be they good, bad or indifferent. Somehow we need to turn back the clock and go way back to find out why it is that so many people in institutional care become homeless. Why is it that so many people who have come

from mental health services are homeless? Why does a high proportion of people who were in the Defence Forces and who left under certain circumstances become homeless? Issues around bonding, support, social support, care, affirmation, love and affection are way, way back there. This is important. I would like to hear more from Dr. O'Carroll on that aspect of his work. For me it is the most important aspect. It is something that we can do and we can change. It will take a long time but we can start now with our children and through how we can support them. Perhaps Dr. O'Carroll will share with the committee some of his own experiences in relation to those issues, especially around early childhood and how that impacts on homelessness.

Dr. Austin O'Carroll: I thank Senator Boyhan who has struck on the issue. There is much evidence coming through now on the concept of childhood trauma that has identified nine specific traumas in childhood, which include: physical abuse or physical neglect; emotional abuse or neglect; sexual abuse; parental separation; parental illness; and parental addiction. It has been identified that the more of these traumas a person is exposed to in childhood, the lower his or her life expectancy. If there are more than five adverse childhood events, a person's life expectancy is 20 years less. It causes the person to be more likely to be a smoker and overweight and a plethora of other things. It also causes the person to be more likely to be drug addicted and to be a perpetrator or a victim of violence. There is evidence that childhood trauma has actual effects on the way the brain chemistry works. This is why the effect of childhood trauma is often quite so permanent.

Unfortunately single biggest determinant of trauma is poverty. The levels of trauma among people in poverty is very high. As the Senator so rightly pointed out, people who experience homelessness have had a huge level of trauma. Work has been done on this by Dr. Sharon Lambert of University College Cork among people who are homeless.

One of the interesting aspects is that there is now a new approach around adopting a trauma-informed care approach in services. This can apply to any service, from schools to colleges and to health professionals. It would be particularly useful in homelessness. The trauma-informed care approach is about recognising that people's behaviour is related to trauma, and responding in a way that ensures there is connectedness, as the Senator said, rather than exclusion, and in a way that reacts more empathically to these people.

There are whole strategies about how we can provide trauma informed care. I am aware that the Dublin Regional Homeless Executive and the HSE are looking at trying to expand this concept among the services. It would be extremely welcome.

With regard to how we could reduce childhood trauma, the biggest determinant of that is poverty, so again it would be about addressing poverty. Unfortunately, trying to address such things in children who end up in homes or trying to reduce the level of children who are separated from parents is a huge determinant also.

Senator Victor Boyhan: I thank Dr. O'Carroll.

Vice Chairman: I will to the Green Party's Deputy Steven Matthews. Deputy Matthews may be at oral questions in the Chamber so will Deputy Duffy come in now?

Deputy Francis Noel Duffy: I thank the Vice-Chairman. I will take the slot.

I thank Dr. O'Carroll for the valuable insight and for his presence here today to discuss the issue of premature mortality in people experiencing homelessness. I have two questions based

on Dr. O'Carroll's report. I would like to get the witnesses thoughts on Housing First. It has been referred to already that with Housing First, in the context of reducing premature mortality in people experiencing long-term homelessness, a safe secure and stable home improves quality of life. I am aware there is no specific research done on this but is it Dr. O'Carroll's view that there could be a correlation between expanding Housing First and a decrease in such premature mortality?

There is a strong recommendation in the report to improve access to primary care services for people experiencing homelessness to treat preventable illnesses. As is mentioned in the report, people who experience homelessness have access to free GP care and specialised services by obtaining a medical card but there are also many outreach organisations and agencies that provide specialised services for homeless people. In Dr. O'Carroll's view why is it that people who are experiencing homelessness have poor access to mainstream GP and specialised services?

Dr. Austin O'Carroll: I thank Deputy Duffy. On the Housing First programme, the evidence that it reduces mortality is not huge but it would make sense that it would reduce mortality rates because we know that it improves mental health, it reduces suicidality and it reduces drug addiction. I have seen this myself. When people get into their own houses the level of drug use reduces and their mental health improves. The presumption is that if it has an effect on mortality it will not be immediate and that it will take place over a period of years. In other words, the longer a person is away from homelessness the less the chance of dying younger. It is key. During the Covid crisis we have seen the importance of accommodation to health. I have seen many cases of people in Housing First whose lives were very chaotic and who have since totally reduced their drug use and their mental health has improved dramatically. Housing First is definitely key in going forward.

On access to primary care, we should be fair here in that Dublin is probably one of the two best cities in the world for access to primary care for people who are homeless. I did my doctorate on the subject of why homeless people do not access primary care. I could wax lyrical on this for hours. The simplest way to put it is that our health system is designed for housed people. It is designed for people who can make appointments, have diaries and can keep slots. When people get appointments from the hospital, they actually receive them by post and can keep them because they have made a slot for them. Housed people are comfortable in sitting in waiting rooms and they do not feel excluded. They do not feel nervous about doctors or intimidated by doctors. They also care about their health because they have a future. One of the key determinants for people who are homeless not accessing healthcare is that they do not expect to live very long because they see so many people dying young. They ask, "What is the point taking good care of my health?" I do not know if the committee members are aware of Maslow's triangle of needs. At the bottom is food and housing, healthcare is quite higher up, and self-actualisation is at the top. For people who are homeless, particularly if they are addicted to drugs, they are probably at the bottom of the pyramid. Their priorities are, first, to get up and feed their addiction, if they have addiction issues such as alcohol or drugs, and then they have to organise accommodation and food, so health moves way up the priority list.

I have only given the committee a few of the issues that affect why they do not access health primary care. That is why specialised services go to where they are and bring the services to where they are. Dublin is probably the one of the two best cities in the world in this regard and we should be proud of what we have. We also have fantastic secondary care services, with inclusion health models developed in St. James's and the Mater by Clíona Ní Cheallaigh and Tara

Grogan. We have really good services. In particular, what we are suggesting is that they are particularly focused on State temporary accommodation, and we need to refocus them on private accommodation. The HSE is doing this at present so I know the issue is being addressed, as we speak. I hope that answers the question.

Deputy Cian O'Callaghan: I thank Dr. O'Carroll for his report and for all the work he is doing. On the critical incident review analysis, I know from talking to many people working in services for people experiencing homelessness that they want to see that in place, and it is very important that it is in place. They want to be part of the process of learning. They are usually suffering the bereavement themselves and have come to know the people well. The fact there is no process like this is something they see as a critical gap.

With regard to the recommendations on key things that need to be done, a number of those have been around for years, such as dual diagnosis and the need for mental health teams, on which Dr. Sharon Lambert and others have done a lot of work. There is a good evidence base for many of these, good expertise and good general recognition that this is what needs to be done. From his perspective, what does Dr. O'Carroll see as the blockages or slowness in getting a lot of this implemented and what can we do to help on that front?

Dr. Austin O'Carroll: To be honest, the critical incident analysis has not been recommended. It was recommended briefly in a previous report but it was not specifically mentioned as a process of critical incident analysis. Critical incident analysis has developed over the last five or six years in the HSE, so I think it is just that the step of transferring it has not been realised. There is a commitment from the DRHE to put this in and, to be honest, a lot of this report was done while keeping the DRHE informed of what is coming out because it is best that people are brought on board. I know there was a significant commitment from the DRHE and it very much supported everything in that in order to get it in place. The support of the committee would be fantastic because it would ensure the momentum is maintained to get this critical incident analysis across the line.

There is a bit of work to be done. Part of the issue is data protection because, obviously, if we are getting different agencies involved, we have to have data sharing agreements. There is a bit of work to be done initially but I think it could be done over a number of months to set up that process. I intend to meet the DRHE soon to see how we progress this because I intend to try to follow through on the recommendations and, as I said, the DRHE is very much part of the process. All support would be welcome in making sure it happens.

Deputy Cian O'Callaghan: Dr. O'Carroll might add to that on the dual diagnosis side. A very important point he made is on the training and support for staff in services around trauma-informed care and empathy. Unfortunately, many of us, as public representatives, have seen staff in the local authorities or elsewhere sometimes not given that training and support, and then being in very stressful situations and not having the kind of interactions that we would all hope for or expect. That is understandable when they are not given that kind of training and support. It is important that this is done. It can be terribly humiliating for people trying to access a service when they are faced with somebody who is stressed in trying to manage with limited resources, and they come out of that feeling dehumanised. That is very important, and a lot has to be done to train and support front-line staff on an ongoing basis.

Dr. O'Carroll might comment further on dual diagnosis and what needs to happen to move that along because it has been recognised for several years as being under-resourced.

Dr. Austin O'Carroll: Dual diagnosis has been known for years and has been recommended by several reports. It is just a question of the HSE acting. I understand it is looking at this but the momentum definitely needs to be maintained to ensure this happens. It has been recommended previously by the 2018 report, Homelessness: an Unhealthy State. I totally agree with the Deputy on that.

I also agree with him on trauma-informed care. Dr. Sharon Lambert has done great work on this in Cork. To explain what this means, we cannot blame people in an organisation for reacting to people with challenging behaviours in a negative way if they have not been given training on how to understand and respond to it. The way I explain it is this: I can go to a doctor and say, "My name is Austin O'Carroll and I need this", and I am able to assert myself in a good middle-class way. If people come from a background of trauma where people enforced their rules with stick and fist, when someone tries to enforce rules they will react the way they did as children - they will respond with anger and with challenging behaviours. If we do not recognise that is coming from their trauma, we will react by saying, "You should not be treating me that way and you need to get out of the service", and that ends up with them being excluded from the service they most need. They are the people who are most likely to die young and the ones least likely to get services. To be trauma-informed means understanding these challenging behaviours, working with them, helping the client to understand that their behaviours emerge from their trauma and that their behaviours do not get them what they need, and trying to train them in other types of behaviour to get the help they need. Ultimately, it helps the service provider to have empathy and an understanding of where this emerges, and the deep hurt that causes these behaviours, so we end up with a much more understanding service. I agree with the Deputy that we cannot expect people to react with empathy if we do not give them the understanding and skills to do that.

Vice Chairman: Thank you. I call Senator Seery Kearney.

Senator Mary Seery Kearney: I thank Dr. O'Carroll for the report and for all of the work he has been doing throughout this, especially most recently. At the end of his presentation, he talked about a learning system. I would be keen to have him elaborate on that, looking at reflective analysis and decision-making. In particular, if we are putting in place a learning system, I would ask how quickly decisions can be made and whether the process has to come back to the Government or there is sufficient discretion within the services. Perhaps he could elaborate on that. That is the first question.

Second, with regard to staff, having worked in homeless services some time ago, I know there was a tendency in the voluntary sector supporting the services to have quite a staff turnover. I am curious about how that impacts and whether there is a loss of continuity of skills and experience, and even personal knowledge of the individuals presenting for services. How is that managed? Dr. O'Carroll might give a flavour of that.

When we discuss homelessness, it always strikes me that we have almost academic and political discussions about the matter without the people who experience it being at the table - it is always their representatives. In our process, when we reflect practice, when we are learning or following a critical incident, do we involve the people around the deceased, and do they get a voice in saying what might have happened? How is that represented, how is that included and is their voice in it?

Dr. Austin O'Carroll: I thank the Senator. There are three key elements to the learning system. The first is the five-yearly reports, which will be reviewed by a multi-agency panel

to try to ensure any recommendations are reviewed and put into action. The second one is the critical incident analysis, as we described, to ensure that we learn from individual deaths. The third one, to which we also alluded, was the rapid review of clusters of deaths. Having those three elements would provide a significant learning system. We must also ensure that the learning derived is put into place. As was mentioned, there is no point in having reports and recommendations gathering dust. Therefore, part of a learning system involves reviewing and ensuring the effective use of existing learning. As we said, there is nothing new in this report. It has sometimes mentioned things previously recommended. We must ensure that is part of the learning cycle as well.

Senator Mary Seery Kearney: If I can cut in, what are the impediments to learning being put in place?

Dr. Austin O'Carroll: Someone must be made responsible for it and this involves governance. When a report is produced, who will be responsible for ensuring it is acted upon? It is best to have one person or agency in that role, because diffusing such responsibility to different agencies may result in nobody following up on what has been learned. For example, I have not been given a brief in this regard but I intend to follow through to ensure that these recommendations are acted upon. It is crucial, therefore, to identify one person to ensure recommendations are enacted, or, if they are not, to determine why not and if better recommendations could be made. It can be learned from such a process that the right approach might not have been taken initially and that there could be a better way. Therefore, the key point here is having one person or agency charged with following through on recommendations and reporting on the progress made. This is where it is extremely useful to have a committee such as this one overseeing this area and ensuring that things are followed up.

Turning to the issue of staff, I agree with the point made. Staff turnover has dropped in recent years, however. There are two aspects to keeping staff happy. One facet obviously concerns pay and conditions. In the area of homelessness, though, another key concern involves the vision and the mission. Staff must feel a sense of purpose in what they are doing. Many agencies are beginning to recognise that it is important to ensure that staff know what the mission is and are part of making a significant difference to people's lives. Another crucial aspect is imparting the skills to staff to enable them to maintain empathy. People who have negative interactions all the time lose empathy a little and it wears them down. However, if staff are given the skills we talked about, such as the trauma-informed care approach, they will then be able to convert negative interactions into positive interactions. Staff realising that they are having a positive impact in helping people is what keeps staff and maintains high staff morale. The important points, then, are the pay and conditions and ensuring that people have a sense of vision and mission and the skills to have positive relationships.

Moving onto the concept of experts by experience, this perspective is being developed in the United Kingdom. The initiative there involves identifying people who are then trained up to become experts by experience. Those trained people are then used to represent an organisation at all levels. Depaul is developing a peer programme and one already exists in St. James's Hospital with the hepatitis C programme. It would be helpful to develop more of these peer programmes whereby we can get people who are homeless to input into the services. I have always felt that these programmes could be supported by the Department of Social Protection in respect of models that could be used to bring people into forms of employment. Peer programmes would be a great model in that regard. For example, we have people who were previously homeless involved in the hepatitis C programme going around and recruiting other

people into hepatitis C treatment. The peers working in Depaul are going to be taking people to hospital for appointments and recruiting them into programmes to address their mental illness and drug addiction issues. I agree it is crucial that peers also be represented on these critical incident reviews, in addition to families and people who were involved with the deaths.

Senator Mary Seery Kearney: I thank Dr. O'Carroll for his response.

Vice Chairman: I thank Dr. O'Carroll, and I call Deputy Gould.

Deputy Thomas Gould: I thank Dr. O'Carroll for attending today and for his report. One of the recommendations concerns getting data and analysing what has happened to people in respect of tracking and tracing why homeless people are dying. This is a major issue for me as well. As a Deputy for Cork North-Central, I have been raising this issue with the Minister for Housing, Local Government and Heritage, Deputy Darragh O'Brien, for months. There are no figures in this regard for Cork. As far as I know, no figures are available nationally for the numbers of homeless people dying. Specifically regarding Cork, is there any way to get such figures? Is there something we can do to collate these figures? To give an example, in March this year two men died within two weeks of each other on the streets of Cork city. We cannot even begin to tackle the problem if we do not know the size of it, and that is the simple truth. The recommendations that have been presented here are probably relevant to Cork as well. I believe there should be a regional homeless executive to enable us to collate these figures and to work to try to reduce and prevent homeless deaths. What would Dr. O'Carroll's opinion be in that regard?

Regarding the excellent point made on addiction, it has been found that 80% of people on the streets had substance misuse issues previously, but figures for those currently in active addiction are much lower. What I hear in this regard is that when people are doing everything right, and engaging with services, going into treatment and working on recovery, one of the big problems that then arises occurs when they come out and go back into homelessness. Those people are then faced with the choice of either going into a hostel, where they know people are using drugs and drug use is openly seen, or going onto the streets. From what we can see, therefore, homelessness itself is one of the biggest barriers to people getting into recovery. We must work on that aspect and drill into it. This goes to the point Dr. O'Carroll made about critical incident analysis. I refer to tracking if people who have passed away had an addiction, were on a journey or had attended residential treatment. I would love to discuss loads of things with Dr. O'Carroll regarding this report.

Groups such as Cork Penny Dinners work in the city. Many good voluntary groups help those in homelessness, but Cork Penny Dinners provides doctors, dentists and hairdressers and that organisation deals with homeless people as human beings. Caitríona Twomey and her volunteers do unbelievable work. The group also provides housing. Why are we relying on such voluntary groups to do this work? Surely this is work that the State should be doing. Moving to the points Dr. O'Carroll made about poverty and child trauma, I agree with him completely in this regard. If we can prevent such occurrences, it will have a profound impact in reducing homelessness and deaths. I thank Dr. O'Carroll very much and I hope he will have an opportunity to respond to some of these points.

Vice Chairman: Dr. O'Carroll has just one minute to respond, unfortunately.

Dr. Austin O'Carroll: I thank Deputy Gould. Starting with problems concerning data gathering, collecting all the data and keeping it on a computer database will make it possible to

do what is called large data analysis. It could be set up to generate mortality reports and other statistics automatically. I would not then have to be doing all the analysis every five years. It could be done almost every year automatically. The DRHE is looking at that idea of large data analysis. That is the first thing that should be done. The critical incident analysis process would also be helpful in Dublin and Cork. It would not just be about Dublin. The DRHE report I did is specifically for Dublin, but the same model could be applied anywhere in the country.

Turning to the Deputy's point regarding substance misuse, the critical incident analysis could track the journey undertaken by those experiencing substance abuse to find out if there could have been interventions. I totally agree with the Deputy that the chances of a relapse significantly increase when people come off drugs, get clean and then end up back in a hostel. It would be absolutely ideal if it were possible to have a model where people could go into drug treatment, come out clean and then go into drug-free accommodation or their own accommodation. The State should be more responsible for providing this accommodation. However, the Dutch model in this regard often uses housing agencies to provide housing services for the State and I think it is a successful model. I also absolutely agree with Deputy Gould regarding poverty and childhood trauma. We must look at how we can reduce both of those impacts on lives. Early school interventions, such as Sure Start, have been used in the UK. Education and childhood support at primary school and preschool levels are critical in this regard.

Vice Chairman: I thank Dr. O'Carroll. I am taking the second Fianna Fáil slot. Many of the questions have already been asked. I would like to briefly clarify a few points. During this committee's work, we have focused on the provision of homeless services by private operators or contractors. Did Dr. O'Carroll compare the mortality rate among the people who were in those private services with those who were in services provided by the State?

Dr. Austin O'Carroll: STA is funded by voluntary agencies such as Depaul Ireland, the Peter McVerry Trust, the Simon Communities and Crosscare. The private emergency accommodation, PEA, agencies are the private funders. The death rate in the STAs was actually higher than in PEAs, but that was to be expected because the DRHE knows that people in STA have higher medical and social supports so it tends to put people who are more unwell into those agencies. Therefore, that explains why there is a higher death rate. However, the death rate between PEAs and STAs is narrowing, and also the number of people in PEAs is becoming closer to the number of people in STAs. Traditionally, more people were in STAs than in PEAs, but that gap is narrowing and the mortality rate is also narrowing. We definitely need to look at how to address issues such as access to healthcare in PEAs and to social supports in them. Does that answer the question?

Vice Chairman: Yes. Could he give us a comparison of the figures for the two?

Dr. Austin O'Carroll: If I just open up my slides I will find the figures. The crude mortality rate in STAs in 2018 was 11% while in PEAs it was zero. In 2019, it was 11.2% in STAs and 6.8% in PEAs. In 2020 it was 17.3% in STAs and 12.3% in PEAs. That is where the mortality rates were narrowing. The population has been constantly rising in both. I will give the statistics for the past three years. In STAs, it was 1,623 in 2018, 1,689 in 2019, 1,678 in 2020 compared with 629 in PEAs in 2018, 888 in 2019 and 1,214 in 2020. The number in STAs has stayed fairly stable over the past three years but the number in PEAs has increased significantly and has almost doubled.

Vice Chairman: Because it is a DRHE report, the figures relate to Dublin. How does the mortality rate compare with other cities across Europe?

Dr. Austin O'Carroll: Again, mortality rates vary. The mortality rates in Ireland are at the low to mid-level. They are not the lowest, but they are on the lower side compared with mortality rates internationally. I cannot say how we compare with other countries in Europe. I am thinking of rates across the US and Europe. It is difficult to compare because the US, as a result of poorer social protections, has a significantly worse problem with homelessness than is the case in Europe. Our rates are not excessively high internationally.

Vice Chairman: Dr. O'Carroll mentioned that there is one single agency. Given that the report was commissioned by the DRHE, does he believe it should be the agency that has the main responsibility for the implementation of the recommendations, as opposed to attributing responsibility across numerous sectors? It would require additional support from the Department. I tend to agree with Dr. O'Carroll that unless a responsible agency is nominated, it can be very difficult to get the recommendations of a report implemented. Does he believe the DRHE should be the body?

Dr. Austin O'Carroll: To clarify, the problem is that some of the recommendations relate to issues that are within the remit of the DRHE, such as Housing First, but that many of the others , such as access to primary care and mental health services, are within the remit of the HSE. The DRHE is also responsible for the data collection and the critical incident analysis. One person or a single point of contact is required to deal with the recommendations, although a number of agencies will have to take actions to address them. Either the DRHE is the overall responsible body, but has to work with the HSE to ensure that it is implementing the recommendations or else one person is appointed to follow through and chase it up, if that makes sense. The person involved would contact the DRHE and see how it is doing on its elements of the recommendations and the HSE as well.

Vice Chairman: My final question relates to dual diagnosis. A new clinical lead for dual diagnosis has been nominated and it is proposed to recruit up to 50 additional staff for that area. How does he see the general service for dual diagnosis, which is very welcome, interacting with the homeless services? Unfortunately, Dr. O'Carroll has a very short time to answer.

Dr. Austin O'Carroll: I think the key element is that whatever service is available for dual diagnosis in mental health it must have a huge outreach component. Many of the services are waiting for homeless people to go into them, but they do not do that. Homeless people will not attend appointments. Whatever the service is, it must have an outreach component. It is great to see a dual diagnosis service, as long as it is willing to come out and visit hostels. It does not have to be always doctors, it can be outreach workers, but it has to have that outreach component.

Vice Chairman: I thank Dr. O'Carroll. I will move on to Deputy Steven Matthews.

Deputy Steven Matthews: I thank Dr. O'Carroll for attending and for presenting his report at short notice, which we really appreciate. When the committee was formed back in September or October of last year, we set out work themes we wanted to address and one of them was homelessness, particularly the issue of deaths in homeless services. I was not aware of Dr. O'Carroll's work and I regret that we did not have the opportunity to invite him in at that time. His report would not have been prepared then, however, so perhaps the timing is good. We did have some very good witnesses in Eoin O'Sullivan, Alice Leahy, the DRHE and Novas. We produced a report based on the submissions made by those witnesses, the questions we were able to ask them and some observations from members. We plan to launch the report shortly. We would have launched it much sooner except that we have been very restricted in our work.

I know we had technical difficulties with Dr. O'Carroll's slide presentation but I would be very much of a mind, subject to the agreement of Dr. O'Carroll and the committee, to include some of the findings from his report in our report on homelessness. It could be in the format of the slide presentation which we might be able to present with it. We hope to do a public launch of the report. With the agreement of the committee, it would be great if Dr. O'Carroll was available to attend the launch. I know he has a busy work schedule and I do not want to push our luck by trying to get him in twice at short notice, but the report he presented is assisting us in looking deep down into the issues that exist in homelessness and deaths in homelessness. That would be great.

I normally chair the committee. I thank Deputy McAuliffe for stepping in at short notice. I was at the convention centre putting questions on the referendum on the right to housing, which is a transformative matter. There was a good and positive response on that. The housing commission will examine the matter with some urgency.

I cannot remember which of the witnesses made a suggestion in the original presentation that the double welfare payment had contributed in some way to overdoses and, possibly, deaths. Would any of the figures Dr. O'Carroll has looked at correlate with that?

Dr. Austin O'Carroll: I would be delighted for the committee to include any of the findings it wants in its report. I am interested in getting the recommendations into action and I would be delighted to do anything I can do to support the committee.

I cannot comment on the double social welfare payment. This is where we need to have coroners' findings. We cannot comment on the causes of death in mortality reports. However, a critical incident analysis or a rapid review of a cluster of deaths would have helped to get information on that if they were in place, which would have enabled us. The suggestion is that the double payment would have meant that they had more money and that led to an increase in overdoses due to a greater availability of alcohol or drugs. I would be careful about jumping to presumptions because a lot of things were happening during Covid such as increased isolation. The comment has already been made that the Covid response from the DRHE and the HSE had a fantastic outcome. The rate of Covid was half that in the general population. Up to 50% of homeless people in France were affected, whereas in Ireland that percentage was only 2.3%. It was a fantastic response. There are many factors that need to be looked at before jumping to that single presumption.

Deputy Steven Matthews: I take Dr. O'Carroll's expertise and guidance on that and I thank him for answering my questions. The committee will discuss the issue of his attendance at the launch and engage with him outside of this forum in that regard.

Vice Chairman: The next speaker is Deputy O'Donoghue.

Deputy Richard O'Donoghue: I thank the Vice Chairman. I appreciate everything Dr. O'Carroll is doing. He is doing a fantastic job. What about Limerick? All of the reports to date have been in regard to Dublin. Limerick and every other county in Ireland should be monitored with the same capacity as Dublin has experienced. We are seeing a massive increase in homelessness throughout the country and it is likely it will escalate further as a result of the shortage of houses and the cost of rents. We are all seeing increased prices in regard to housing materials, which thus far have escalated by over 40% and 50%. Owing to economics and an inability to be able to afford to buy or rent a home, many people who otherwise would not have been on homeless lists previously will be affected. When will the current report be completed and,

when completed, will it report on a county by county basis?

It has been stated that a great deal of homelessness is city-based. There is a great deal of county-based homelessness as well and the figures in this regard have been increasing for the past couple of years for various reasons. I have sympathy for anyone who finds himself or herself homeless regardless of the reason for it. The charity organisations in Limerick do great work to support different agencies to support homelessness and people with mental health and financial issues. Whether short-term or long-term, a great deal of work is done by the charities in Limerick. I would like to know if the report when completed will report on a county by county basis.

Dr. Austin O'Carroll: I thank Deputy O'Donoghue. I have done a great deal of work with, and visited, all of the services in Limerick. There are great services in Limerick. I know them well. Unfortunately, I was commissioned by the DRHE. The HSE, however, is commissioning a national report on deaths in homelessness. I will not be specifically looking at deaths in homelessness but the HSE is commissioning a separate report in that regard. I do not know when it will be delivered but I presume it will be in the next year or two.

I agree with the Deputy that we need to look at homelessness nationally and to identify and address the issues. In many areas, the same issues are arising.

Deputy Richard O'Donoghue: I thank Dr. O'Carroll.

Vice Chairman: The next speaker is Senator Mary Fitzpatrick. I ask the Senator to clarify that Deputy Flaherty is not present.

Senator Mary Fitzpatrick: He is not. On PEAs, I take Dr. O'Carroll's point that the numbers being accommodated in PEAs has significantly increased and has doubled. It now accounts for two thirds of the spend on emergency accommodation. As stated by Dr. O'Carroll the mortality rate is also increasing and almost on a par. We need to be concerned about that. The committee raised this issue with Brendan Kenny of the DRHE during its meeting with him a number of months ago. There is a commitment to a follow-up meeting with him. We insisted that wraparound supports be provided and we accept that that has been done. There should be a strong recommendation from this meeting as well that the private emergency accommodation be phased out. It is substandard and it does not give people the opportunity to move on with their lives. I think we should add that recommendation to the five recommendations made by Dr. O'Carroll. Would Dr. O'Carroll agree?

Dr. O'Carroll mentioned the critical incident review. My understanding of his responses in that regard is that it is purely an operational decision now in that there is acceptance that this is a good initiative and it should be implemented. The committee should, probably, add that to its agenda for follow-up with Brendan Kenny and the DRHE. In terms of the trauma informed response, I concur with Dr. O'Carroll's remarks in that regard but I believe the response needs to start before people get to Parkgate Street or engagement with homeless services. We need that trauma informed response to start at Intreo and city council offices level. As a committee, we should write to the Minister for Social Protection on that and to the chief executives of all of the local authorities to ask them to build into their staff training and supports a trauma informed response for people who are in crisis when they come seeking help and who have suffered considerably before they arrive at that point.

In relation to the committee's report, I thank Dr. O'Carroll for allowing us to include his

submission in it. It would be great if Dr. O'Carroll could be involved in the future workings of the committee. As a committee, we have committed to homeless issues addressed, at least, on a six monthly basis. Dr. O'Carroll's recommendations are very strong. I thank him for giving us his time.

Dr. Austin O'Carroll: I thank Senator Fitzpatrick. In terms of PEAs, there are some very good ones, but rather than comment on whether we should have PEAs or STAs, I think we need to ensure there is a proper standard of care provided and that includes wraparound services and health services. That is the key element that I am recommending. On Housing First, we still need to focus on getting people out of homelessness. I agree with the Senator that we need to address that issue and that the services need to be all on a par. We cannot have one service that is less than another. I agree on that point.

I agree also with the Senator's remarks in regard to trauma informed care. I will give an example of that care by way of a story I often tell. I had two clients who had been homeless for five years and addicted to several substances who ended up in the casualty department in a hospital due to hypothermia. The guy was losing consciousness. As the doctor and nurse were cutting of his clothes the doctor turned to his partner and said "this is disgusting the condition you've got yourselves into" and made them feel so bad that when they left, they swore they would not go back to hospital unless they were dying. I do not blame that doctor because he or she is in a system where there is stigma and as he or she is probably overworked and over-stressed the stigma gets concentrated. Those two patients went to a different doctor in a mobile health unit run by Safetynet and staffed by a GP trainee who helped them to see Dr. Clíona Ní Cheallaigh, who referred them to us. They are no longer in addiction and the woman has qualified this year for one of the top universities in Ireland. This shows that with a proper response and someone who understands what people have gone through can lead to a totally different path. Again, I do not blame that doctor. We need to train everybody how to interact people through trauma informed care. I agree with Senator Fitzpatrick that this care should provided through all of the social welfare offices and health services. It could also be taught in schools as well. We need to teach the teachers.

Vice Chairman: We have just enough time for our final speaker, Senator Cummins.

Senator John Cummins: As I am off campus, I will not be able to contribute, but I have been listening intently to the entire discussion. I thank Dr. O'Carroll for his work. We look forward to continuing to engage with him.

Dr. Austin O'Carroll: I also look forward to that.

Vice Chairman: I thank Dr. O'Carroll for attending today. He might be sorry he accepted our invitation because on several occasions I heard members suggesting we would have him back to discuss different items. We will be back in touch with him on that. I again thank Dr. O'Carroll for circulating his report and slides, and for being so helpful.

The joint committee adjourned at 11.31 a.m. until 12.30 p.m. on Tuesday, 29 June 2021.