

**Primary Care Access for Homeless People:
identifying best practice using Merchants Quay Ireland
as a model of primary care pProvision**

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Abstract

'Specialist Scheme' models of health care provision have been set up in order to facilitate better access to health care for marginalised groups. One such scheme operates at Merchants Quay Ireland which aims to address the health care access needs of homeless people. Through the utilization of one-to-one interviews with service users, health care staff and policy makers, this study assesses the model in terms of (a) how and whether the special scheme addresses the primary health care needs of homeless people and (b) the gaps in service provision that exist in both the special scheme service and broader mainstream services.

Findings demonstrate that access to primary health care is greatly enhanced as a result of the 'Specialist Scheme'. However gaps in services were found to persist at the level of primary and secondary care and in particular for clients who present with complex needs. Issues around discharge planning and follow-on care continue to present challenges for the provision of primary care to homeless people. Study findings are used to identify best practice in primary care access for homeless people in the context of the National Primary Care Strategy.

Homelessness; Primary Care Access; Best Practice

Disclaimer

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Section 1: Introduction

1.1 Background to the Project

The aim of Government Health Care policy as set out in *Quality and Fairness* and in the Primary Health Care Strategy is to have equitable access to health care for all. In terms of ensuring access for particularly marginalised groups, such as homeless persons, drug users, Travellers etc., the traditional approach has emphasised integrated service provision whereby the health needs of the target group are met by existing mainstream or generalist services (i.e. their healthcare is integrated with general population healthcare). Yet marginalised groups find it difficult to access mainstream services which are often criticised for inflexibility. More recently some 'Special Schemes' have been developed for marginalised groups. The focus of the Special Schemes model is on advocating on behalf of the target group for access to mainstream services on an integrated basis and providing direct transitional primary health and social care services.

One such Special Scheme is the multi-disciplinary primary health care service for homeless persons operated by Merchants Quay Ireland (MQI) in partnership with the Health Services Executive (HSE). The core aims of this study are to carry out an assessment of the effectiveness of that service in addressing the primary health care needs of homeless people and in improving access to mainstream services for this group. In so doing it will document best practice in making primary care accessible to the target group and will contribute to a greater understating of homeless people's health services access needs in the context of the National Primary Care Strategy.

More specifically, the objectives of the study are:

- To profile the background, and health care needs of homeless persons availing of the Primary Health Care Service at MQI
- To see if the service is attracting the target group and is effectively addressing their health care needs
- To examine the strengths and weaknesses of the 'special services' model of health care delivery

- To examine the links between the specialised service and generalist service providers with a view to exploring whether the service provides a pathway towards inclusion in generalist service provision, or if it tends to marginalise and ghettoise homeless service users by leaving generalist providers 'off the hook'
- To document the uptake of mainstream primary care services by those using the existing services related to the primary health care needs of homeless people and identify gaps in statutory and voluntary services
- To investigate any issues and barriers for the service users in accessing mainstream services
- To influence policy development regarding accessibility of primary care services for homeless people.

1.2 The Primary Health Care Unit at Merchants Quay Ireland

MQI in partnership with the HSE run a primary health care unit for homeless people at the premises on Merchants Quay in Dublin. The service is primarily nurse-led, and also has a GP, a dentist, a counselor, and a chiropody service. It is located in close vicinity to the needle exchange service and facilitates a shared care, low threshold model for working with clients' general health needs and/or those who are engaged in both unsafe injecting and sexual risk behaviour. In addition to these services, an acupuncture service is also available at the project. Key to the model of working is making primary care services accessible to the target group, and advocating on behalf of clients for referral to mainstream services. The table below presents the number of visits to each of the services including the needle exchange service during the year 2006.

Table 1.1 Visits to MQI Primary Care Services and Needle Exchange - 2006

Nursing Staff	Counselling	Dental Service	GP Service	Chiropodist	Acupuncture	Needle Exchange
3,228	300	500	940	100	324	39,460

Source: Merchants Quay Ireland Annual Report, 2006.

The Primary Health Care Unit and needle exchange are within close proximity of the Open Access Homeless services at MQI. The Open Access service is

a drop-in service offering a range of interlinked services meeting the day-time needs of clients with the twin purpose of minimizing harm associated with life on the streets and offering clear pathways towards settlement and reintegration. The MQI primary care service is linked in with a primary care network and state support services that are particular to Dublin. These are set out in Appendix 1.

1.3 Structure of the Report

Section 2 reviews the literature in relation to the health issues and health services access issues experienced by homeless people. It examines these issues in the context of a broad concept of health that encompasses health and well-being. Key policy documents relating to both homelessness and health are also examined. **Section 3** presents an outline of the methods employed in the study and is followed by **Section 4** which details participating service users general profile, housing status, and drug and alcohol use, along with an examination of associated risk behaviour. **Section 5** presents participants feedback regarding self-reported physical and psychiatric health status, while **Section 6** explores service users perspectives of service provision in both specialist and mainstream settings. Following this **Section 7** explores the issue of service provision from the perspectives of health care providers. The report concludes in **Section 8** with an identification of best practice in health care access for homeless people based on the report's findings.

Section 2: Literature Review

2.1 Homelessness and Health

People living in poor social and economic circumstances become sick more often and continue to die younger. Homeless people are one such group of people who experience extreme forms of poor social and economic circumstances. The link between homelessness and health is well established although national and international literature demonstrates that poor health can be both a precursor to as well as a consequence of homelessness (Holohan, 2000, Quilgars & Pleace, 2003). In comparison to general population statistics, higher rates of mortality and morbidity have been found among homeless persons in cities throughout the world (O'Connell, 2007; Bond et al, 2004). Mortality rates have been found to be three to four times higher than housed persons of the same age. While the literature presents evidence that homeless people suffer worse health than the general population, it also warns against generalising health characteristics and need among the homeless population as they are a diverse group (National Health Scotland, 2002).

2.2 Defining Homelessness

There is no universal definition of homelessness. In Ireland the legal definition of homelessness is set out in the Housing Act 1988. It is as follows: A person shall be regarded by a housing authority as being homeless if –

- (a) there is no accommodation available which, in the opinion of the authority, he, together with any other person who normally resides with him or who might reasonably be expected to reside with him, can reasonably occupy or remain in occupation of, or
- (b) he is living in a hospital, county home, night shelter or other such institution, and is so living because he has no accommodation of the kind referred to in paragraph (a), and he is, in the opinion of the authority, unable to provide accommodation from his own resources.

Some authors have argued that this definition is far too narrow and does not take account of experiences of homelessness that are not easily visible such as people residing with friends or family, in overcrowded situations, or at risk of homelessness when leaving an institution for example. In order to broaden the definition of homelessness O'Sullivan outlined three categories of homelessness which are (1) visible homelessness, (2) hidden homelessness, and (3) at risk of homelessness. The author points out that it is important to broaden the definition as the size of the homeless population will depend on how we define the concept of homelessness and this in turn will determine the policy responses to the situation (O'Sullivan, 1996:5).

2.3 Extent of Homelessness

2.3.1 National

Under the Government's Integrated Strategy on Homelessness (2000) each local authority is now required in conjunction with the Health Boards and voluntary bodies, to draw up a city or county level plan for addressing homelessness. In meeting that objective local authorities have been given the responsibility for carrying out homeless counts in their catchment areas, based on the legal definition set out. Figures from the most recent all Ireland count (2005) demonstrate that there was a total of 2,339 homeless individuals in the country, 70% of whom reside in Dublin, the capital city. It has been argued that these national assessments lack important detail such as information on age, marital status, family formation, nationality, health status and source of income (Focus Ireland et al, 2003). These details are particularly important in terms of policy making and service planning.

2.3.2 Dublin: Number and Profile of Homeless People

A count of homelessness in Dublin is carried out every three years. The most recent figures recorded in the 2005 count demonstrated that there were 2,015 homeless adults (1,552) and child dependents under 18 years (463) in Dublin (see Wafer, 2005). This computed to a 19 per cent decrease in the total number of homeless households¹ from the previous homeless count carried

¹ Households is used to refer to single persons as well as those family members who normally reside together (Wafer, 2005)

out in 2002. In the 2005 count, 63 per cent of respondents were male, and the majority were in the 26-39 age group (46 per cent) followed by those in the 40-64 age group (32 per cent). A picture of long-term homelessness emerged where the highest percentage of people counted were out of home for more than 36 months (43 per cent, n=467).

A changing profile within the homeless sector has more recently been highlighted in Irish literature where growing numbers of migrants are presenting to homeless services, particularly within the Dublin area (Bergin & Lalor, 2006; O'Sullivan, 2007). The literature points to the need for adaptations within services to ensure that they have the capacity to provide support to migrant groups.

2.4 Social Determinants of Health

The wide and complex range of factors which determine health demonstrate how health is an issue for all public policies and service sectors. The Dalghren and Whitehead model (1991) of health determinants illustrates the need to think about good health in broad terms.

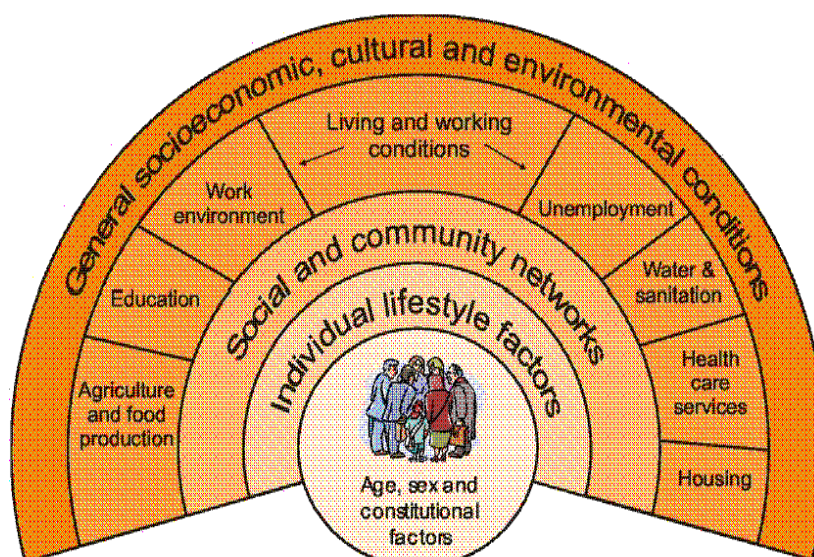


Fig. 2.1 Social Determinants of Health (Dalghren & Whitehead, 1991)

National and international literature profiling homeless people consistently demonstrates that this group have high levels of unemployment, low levels of education, and high levels of dependence on state benefits (Feeney et al, 2000; Smith et al, 2001; NHS Argyll & Clyde, 2002; Adcook, G., 2003; Corr,

2003; Lawless & Corr, 2005, among others). Homeless people experience health inequalities according to a range of factors and not only due to a lack of appropriate housing. This will inform a broader understanding of the health issues set out below.

2.5 Health Issues of Homeless People

2.5.1 Acute and Chronic Physical & Mental Health Issues

Homeless adults contend with both acute and chronic physical conditions (McMurray-Avila et al, 1998). About two thirds of the physical problems homeless people present to primary health care sites are acute in nature. These include upper respiratory tract infections due to exposure to the elements and crowded shelters; trauma due to life on the streets; minor skin ailments due to exposure to the elements, shelter conditions, lack of hygiene, and foot problems associated with inappropriate footwear and long periods of walking (Holohan, 1997). The other third are chronic in nature. These include seizures, chronic obstructive pulmonary disease, arthritis and other musculoskeletal disorders. Hypertension, gastrointestinal diseases, vascular disease, diabetes, anaemia, and TB are also prevalent and are found to be often inadequately controlled or undetected for long periods of time as a result of being homeless (Hwang, 2001). European-wide statistics demonstrate that dental health among homeless people tends to be below the norm for the general population and research suggests that this type of care is particularly difficult to access for homeless people (Feantsa, 2005). Poor mental health such as depression, schizophrenia, personality disorders and anxiety disorders have been found to affect between 30 per cent and 50 per cent of the homeless population internationally (Warnes et al, 2003, Rowe, 2003). McKeown (1999) estimated that there were about 1,500 people in Ireland who are both mentally ill and homeless. Along with the constant unrelenting demands to source safety and shelter, factors compounding the risks associated with mental illness include long term homelessness, and alcohol and/or drug use (Crisis, 2003, O'Neill et al, 2007; Holohan, 1997).

A number of cross-sectional studies have been carried out with homeless people in Ireland over the last ten years. These studies have found high rates of acute and chronic physical disease among adult homeless populations (Holohan, 1977; Feeny et al, 2000) along with high rates of mental health complaints (Feeny et al, 2000; Hourigan & Evans, 2003). Mental health issues among a sample of homeless women were also found to be high (70%), half of which was found to be untreated (O'Brien, et al 2000). Links between long term homelessness and deteriorating health status have been found (Holohan, 1977), as have associations between accommodation and health issues, Feeny et al (2000) noted that health complaints among hostel dwellers were associated with lifestyle risk behaviours, including alcohol use, drug use, and poor diet. The detrimental effects on the physical and emotional development of children living in temporary, unsettled or overcrowded accommodation has also been demonstrated (O'Brien et al 2000). Similarly, associations between rough sleeping and poor health status are well documented and are not only due to coping with the elements, but also as a result of the constant threat of violence, and risk behaviours associated with the high levels of drugs and alcohol use found among this group (Griffiths, 2002; Lawless & Corr, 2005). Street based sex workers are also particularly vulnerable to poor health (Rowe, 2003)

Although causal relationships between homelessness and health cannot be determined from these studies the data generated demonstrates the high level of need for accessible health and social care services.

2.6 Access to Primary Care

The nature of homeless people's lives means that they invariably have a range of health care needs. But their personal circumstances are such that they are often the least able to attend to these needs through traditional medical services (Rowe, 2003). Even where they have rated their health as poor homeless people may not be any more likely to use health services, perhaps indicating that something beyond simple recognition of health need is required for services to be used by this group (Holohan, 1997).

The barriers to primary care services experienced by homeless people are well documented and are often found at both the individual and structural level. The lack of flexibility in the healthcare system to address the mobile lifestyle of homeless people has been identified as major barrier for this group. Institutional barriers such as opening hours, appointment procedures, and location of services in primary care settings and in hospital departments have all been identified as presenting access difficulties for various groups of homeless people (Griffiths, 2002). In an Irish context in particular catchment based mental health services present obvious difficulties for this transient population. Co-occurring mental health problems and substance abuse problems can complicate the pathway towards mental health treatment (McKeown, 1999). Similarly, difficulties obtaining a medical card due to the lack of an address, full GP medical card lists, and as a result of experiences of negative attitudes to the target group present barriers for homeless people (Holohan, 1977). Homeless drug and alcohol users have been found to experience difficulties accessing appropriate services due to an insufficient amount of services and resulting long waiting lists (O'Sullivan, 2007; Lawless & Corr, 2005).

The literature also points out that homeless individuals themselves often do not prioritise their health which also acts as a barrier to accessing health care (Griffiths, 2002). Homeless people may face more immediate 'survival' needs, such as food and shelter, which can mean that all but the most pressing healthcare needs are ignored (Quilgars and Pleace, 2003).

Literature from the UK and Ireland has highlighted how poor access to primary care services has also been found to have a direct impact on other health care services, with an increased likelihood of people using A&E as a surrogate for a GP (Crisis, 2003, Griffiths, 2002, Holohan, 1997). This often means that homeless people are not getting timely and appropriate care and has extra cost implications for hospital services (Griffiths, 2002; Crane and Warnes, 2001).

2.7 Irish Policy Context

2.7.1 Health

Inequalities in health and health services access have been recognised at national policy level (Department of the Taoiseach, 2006 and 2007; Government of Ireland, 2007) and targets have been set out to address these issues. Two key health strategy documents that reinforce the policy commitment to meet these targets are the Health Strategy, *Quality and Fairness: a Health System for You*, (2001), and Mental Health Strategy *A Vision for Change* (2006). These documents include actions aimed at improving the health of homeless people and drug users by delivering existing national strategies such as *Homelessness – An Integrated Strategy* (2000), and the *National Drugs Strategy 2001-2008*.

2.7.2 Primary Care Strategy

In 2001 the Government document *Primary Care, A New Direction* was published which set out policy concerning the roll out of primary care as a key component of the Government's Health Strategy "*Quality and Fairness A Health System for You*". **Equity** is one of the key principles of the National Health Strategy and is taken to mean that health inequalities are targeted and people are treated fairly and according to need.

The definition of *health* in the National Health Strategy is adopted from that used by the World Health Organisation which states that health is,

a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity.... A resource for everyday life, not the objective of living; it is a positive concept emphasizing social and physical resources as well as physical and mental capacity.

Primary Care is defined as an "approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social well-

being.” The policy document argues that a properly integrated primary care service can lead to better outcomes, better health status, and better cost-effectiveness, particularly as it aims to reducing the current reliance on the hospital A&E and outpatient departments. It also states that primary care should be readily available to all people regardless of who they are and where they live. Specialist primary care services for specific groups are referred to in the document but details of how these will operate are not set out.

2.7.3 Homelessness Policies

In the Government's policy documents *Homelessness – An Integrated Strategy* (2000), *The Homeless Preventative Strategy* (2002), and *The Youth Homelessness Strategy* (2001) it is recognised that the issue of homelessness is complex; that being homeless is not only an accommodation issue, but that health, care and welfare, education and training, and prevention all need to be addressed simultaneously if homelessness is to be tackled effectively.

Section 3: Methodology

3.1 Study Design

Quantitative and qualitative methods were employed in this study. A client questionnaire was compiled and administered, and one-to-one semi-structured interviews were conducted with health professionals and policy makers.

3.2 Data Collection

3.2.1 Sampling Strategy. A convenience sample was employed, involving 32 clients who avail of the primary care services at MQI. Of those interviews 2 surveys were deemed incomplete and as a result the total number of questionnaires utilised was 30. The criteria for inclusion in the project was that participants were currently homeless (using a broad definition employed in this study) and access the primary health care unit at MQI.

The sample size in this study is small and consequently it should be noted that inferences to the MQI client group more generally, nor to the homeless population in Dublin or nationally can be made from the findings that have emerged.

In terms of recruiting service providers for participation in the study it was decided to interview five health care providers who work out of MQI, and five additional interviewees, either health care providers in mainstream settings or policy makers to provide perspectives.

3.2.2 A client questionnaire was designed to gather both quantitative and qualitative information. It was decided that using a quantitative approach with service clients would facilitate comparisons between this and other cross-sectional studies in the literature. A demographic profile of the survey participants was gathered along with information concerning alcohol and drug use, risk behaviour, sexual health, use of mainstream health services and barriers to same. An assessment of service provision at MQI explored the

degree to which respondents were aware of and used the services at MQI, along with an assessment of clients' attitudes concerning the accessibility of the services across a range of measures. Throughout the questionnaire provision was made for additional comments and responses that participants wished to include.

Payment of Respondents: Respondents were given €15 as an acknowledgement for their time given to the research process.

3.2.3. One to one semi-structured interviews were carried out with service providers. The semi-structured approach allowed for flexibility in the context of a number of differences among the service providers who participated. Each of the health professionals interviewed who provide services at MQI, worked different hours each week, provided different services and supports, and while some were direct employees of MQI, others provided in-reach services that were funded directly by the HSE. The flexibility of the semi-structured approach also meant that it facilitated the inclusion of health professionals/policy makers who were not based at MQI. A total of ten one-to-one interviews were carried out, five with staff working in the MQI Primary Care Unit and five with mainstream healthcare providers and/or policy makers.

The one-to-one interviews with service providers examined a range of service issues relevant within the special services setting and for the delivery of mainstream health services. Interviews were approximately one hour in duration and were structured around the following key areas:

- Existing policy and practice in working with people who are homeless
- The perceived capacity of existing services to work with homeless people and drug users
- The issues surrounding health care provision for people who are homeless
- Gaps in health care policy that impact on homeless people

3.3 Data Analysis

The quantitative data collected was entered into SPSS, the Statistical Package for the Social Sciences which was utilized for the analysis of the survey data.

The qualitative data gathered from service providers and policy makers were analysed with the assistance of the Nud*st 6 software package. The interviews were analysed thematically.

Section 4: Client Profile

4.1 Introduction

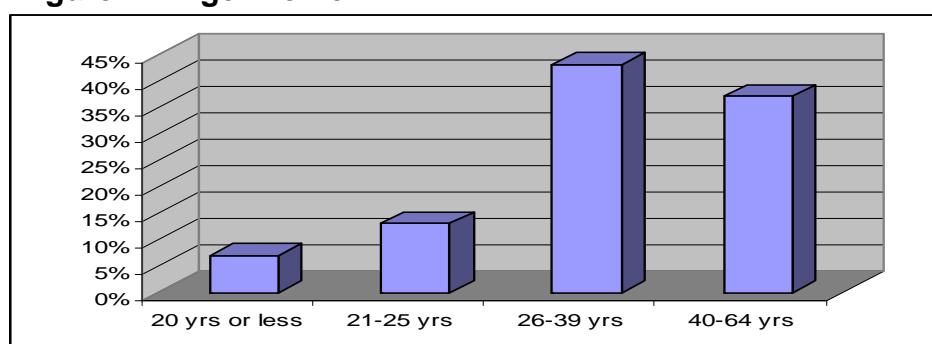
This section will present background details of the 30 participants who took part in the study. This section is divided into four main sub-parts which will set out key issues in relation to their socio-demographics, housing status, drug and alcohol use, and an examination of both injection and sexual risk behaviour.

4.2 Socio-demographics

4.2.1 Gender, Age & Family Status

Male participants made up 77 per cent (n=23) of the study sample. In terms of age most of the sample were in the 26-39 years age group (43 per cent, n=13) and 37 per cent (n=11) were in the 40 – 64 years age category. The graph below demonstrates the findings.

Figure 4.1 Age Profile



N=30

The majority of respondents were single (60 per cent, n=18), and a further 20 per cent (n=6) were living with a partner. 3 per cent (n=4) were separated, one person was married (3 per cent), and one person was divorced (3 per cent).²

² This study did not have the resources/capacity to produce questionnaires in languages other than English, or to recruit interpreters, and as a result it was not possible to include non-English speaking clients in this study who were accessing the primary care service at MQI. This will have had an impact upon the findings reported here.

4.2.2 Country of Origin & Ethnicity

The majority of respondents (83 per cent, n=25) were from the Republic of Ireland. Of those who responded to a question on ethnicity (N=27) 96 per cent (n=26) identified themselves as white and one respondent (4 per cent, n=1) reported that they were a member of the Travelling community.

4.3 Housing Status

4.3.1 Main Place Stayed Last Month

Emergency accommodation was identified the most often (37 per cent, n=11) as the main place that respondents stayed in the last month. Rough sleeping (17 per cent, n=5), B&B accommodation (17 per cent, n=5), and long term hostel accommodation (17 per cent, n=5) were identified as the second most frequent 'main places' stayed in the last month. One participant identified transitional housing (3 per cent, n=1). The remaining 10 per cent (n=3) stated 'other'.

Table 4.2 Main Place Stayed Last Month

Accommodation	n	Per cent
Emergency Accommodation	11	37%
Rough Sleeping	5	17%
B&B Accommodation	5	17%
Long-Term Hostel Accommodation	5	17%
Transitional Housing	1	3%
Other	3	10%

4.3.2 Length of Time Homeless

The majority reported being currently homeless for more than 36 months (65 per cent, n=17), while only two people (8 per cent) reported being homeless for under six months.

4.4 Drug & Alcohol Use

4.4.1 Current Alcohol Use

When asked how long ago they had consumed alcohol, 40 per cent (n=12) replied 'in the last week'. Over one quarter of the sample (27 per cent, n=8) reported that they would consume alcohol in a typical week, each of those reporting that they would consume alcohol on a daily basis. Analysis revealed that over one quarter also (27 per cent) drank over the recommended weekly limits of alcohol consumption³.

4.4.2 Current Drug Use⁴

Table 4.2 below sets out detail of participants reported current licit and illicit drug use. 23 (77 per cent) respondents reported current licit⁵ drug use and 25 (83 per cent) respondents reported current illicit drug use. A total of 70 per cent (n=21) of the sample reported they were currently using both licit and illicit drugs. Four respondents (13 per cent) out of the total study sample did not report using either licit or illicit drugs.

Table 4.3 Current Drug Use

Current Drug Use	<i>n</i>	Per cent
Licit Drug Use	23	77%
Illicit Drug Use	25	83%
Both Licit and Illicit Drug Use	21	70%

N=30

87 per cent (n=26) of the total study sample reported that they were using prescription and/or non-prescription drugs during the four weeks prior to interview. The most commonly used drug in those 4 weeks prior to interview was heroin (70 per cent, n=21). This was followed by the number of people who reported using methadone (60 per cent, n=18). All 18 respondents who reported using methadone were receiving it on prescription. The mean

³ The recommend weekly units of alcohol consumption are 14 for women and 21 for men.

⁴ Current Drug Use refers to use 'in the last four weeks'.

⁵ Licit drugs here are inclusive of any drugs that are available on prescription, which are inclusive of methadone, sedatives/tranquilisers/anti-depressants, and steroids. Tobacco use and alcohol use are not included here.

amount of methadone prescribed to participants per day was 68 millilitres.

Table 4.3 details participants' current drugs of use.

Table: 4.4 Current Drugs Used

Prescription Drugs	<i>n</i>	<i>Per cent</i>
Methadone	18	60%
Sedatives/Tranquilisers/Anti-depressants	10	33%
Other	9	30%
Non-Prescription Drugs	<i>n</i>	<i>%</i>
Cannabis	17	57%
Ecstasy	3	10%
Heroin	21	70%
Cocaine Powder	10	33%
Crack	0	0%
Hallucinogens	0	0%
Amphetamines	0	0%

4.4.2.1 Polydrug Use⁶

There was a high level of polydrug use found among the study sample. Ten respondents reported currently using four different drug types. One third of the total sample (n=10) reported using both heroin and cocaine powder. All of the respondents who reported being on prescription methadone (n=18) also reported using one or more other drug.

4.5 Risk Behaviour

4.5.1 Current Injection Use and Practices

Twenty-two respondents (74 per cent) reported that they had 'ever' injected their drugs, and nearly two thirds of the sample (n=19, 63 per cent) reported 'current' injection drug use (i.e. use of injection in the last four weeks). Poor

⁶ Polydrug use is the concurrent use of more than one drug.

injection use related practices were reported by a high percentage (58 per cent, n=11), and 53% of injectors reported experiencing difficulty finding an injection site. A minority reported involvement in injection sharing practices (26 per cent, n=5), but over half reported injecting alone (59 per cent, n=10) a practice which increases risk of fatal overdose.

4.5.2 Sexual Risk Behaviour

40 per cent of participants (n=12, 10 men and 2 women) reported being sexually active at the time of the study and over half of them (58 per cent, n=7) were also current drug injectors. Half of those who were sexually active (50 per cent, n=6) stated that they had a regular sexual partner and 2 (17 per cent) reported having more than one sexual partner in the last 3 months, both of those respondents being male. Three respondents (2 male, 1 female) reported not using any contraception. Five respondents from the total sample (17 per cent) reported having had an Sexually Transmitted Infection (STI) at some point in their lives, and only one reported having had an STI in the last year.

4.6 Summary and Conclusions

The profile of the target group demonstrates that the majority are male, between the ages of 26 and 39 years and from the Republic of Ireland. Just under half left home between the ages of 15 and 24, while 26 per cent (n=7) reported leaving home for the first time under the age of 15. The duration of the current episode of homelessness was reported as being for longer than 36 months for the majority of participants (65 per cent, n=17). In terms of the 'main place stayed last month', emergency accommodation was reported the most often (37 per cent, n=11). 87 per cent (n=26) of the total sample reported currently using licit and/or illicit drugs and 70 per cent of the sample reported using both licit and illicit drugs. Heroin was the drug most commonly used in the four weeks prior to interview, and was identified as being the primary drug of use by the majority of the sample (62 per cent, 62%). A considerable amount of polydrug use was also found. A high rate of current injection drug use was found (63 per cent, n=19), as were high rates of risky

injection use practices such as the use of more dangerous injection sites, and injecting alone in public places.

Section 5: Health Issues

5.1 Introduction

An examination of participants' self-reported HIV and Hepatitis status will be presented in this section along with details of participants' self-reported physical and psychiatric health status. Physical health status will consist of an examination of a self-rating on a five point scale as well as a more detailed exploration of a range of health complaints. Detail on participants' self-reported psychiatric health status will also be presented. A health information needs assessment will be carried out to identify which areas of health that participants feel they would like to know more about.

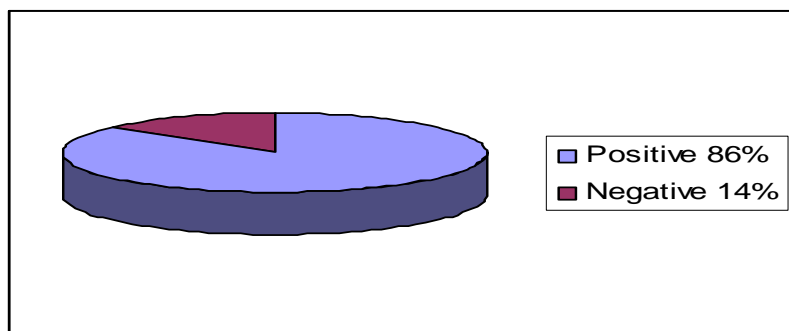
5.2 HIV and Hepatitis Status

All respondents were asked if they had ever had been tested for or vaccinated against hepatitis B. Over half of respondents (57 per cent, n=17) reported that they had received the test, and two thirds (60 per cent, n=18) reported that they had received the vaccination. Of those that had received the vaccination 3 (17 per cent) people reported that they did not finish the course. Hepatitis B vaccinations are given in three stages in quick succession necessitating three separate visits to health service providers. Barriers to health services may present challenges for service users in terms of the need to attend for follow-up vaccinations.

One third of respondents (33 per cent, n=10) reported that their hepatitis B status was negative, while 17 per cent (n=5) stated that it was positive. 2 (7 per cent) individuals did not know what their status was.

Asked if they ever had a hepatitis C test, 21 participants (70 per cent) stated that they had. Of those tested, 18 respondents (86 per cent) reported being hepatitis C positive, and of those, 2 (11 per cent) were receiving treatment.

Fig. 5.1 Hepatitis C Status

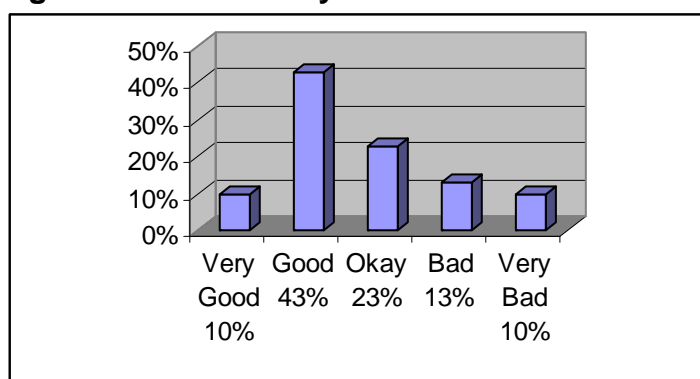


19 respondents (63 per cent) stated that they had previously been tested for HIV. Participants were asked if they wished to volunteer their HIV status. 2 (7 per cent) participants reported being HIV positive and 5 (17 per cent) stated that they were HIV negative.

5.3 Physical Health Status – Self Reported

Respondents were asked to rate their physical health on a five point scale. Just over half of the sample perceived their health to be either ‘good’ (43 per cent, n=13) or ‘very good’ (10 per cent, n=3). 7 participants perceived their health to be ‘bad/very bad’ (23 per cent) and a further 23 per cent (n=7) felt that their health was ‘okay’.

Fig 5.2 Self-Rated Physical Health Status



Even though the majority of participants perceived their health as being ‘good’ or ‘very good’, all reported at least one health complaint. Just under one third of the sample (30 per cent) reported having between 8 and 13 of the health complaints inquired into below, and a further 15 (50 per cent) reported having between 4 and 7 complaints. The mean number of complaints reported was 6. The table below presents the list of complaints reported.

Table 5.1 Self-Reported Health Complaints

Health Complaint	<i>n</i>	<i>Per cent</i>	Health Complaint	<i>n</i>	<i>Per cent</i>
Sleep problems	24	80%	Urinary tract	7	23%
Dental problems	19	63%	Eye/Ear complaints	7	23%
Weight problems	16	53%	Rheumatic disease	6	20%
Poor appetite	16	53%	Asthma	6	20%
Bones/Joints	14	47%	Foot problems	5	17%
Headache	13	43%	Bronchitis/Emphysema	4	13%
Stomach pains	11	37%	High blood pressure	3	10%
Nausea/Vomiting	9	30%	Gastro-Intestinal	2	7%
Skin wounds/infections	9	30%	Epilepsy	1	3%
Dizziness/faintness	8	27%	Peptic ulcer disease	1	3%

N=30

5.4 Smear Tests

Of the seven female participants in the study four (57 per cent) reported ever having had a cervical smear. Two woman reported having had their last tests between 1 – 2 years ago, and one other reported that it was 2-3 years ago.

5.5 Injection Related Health Issues - Self Reported

18 participants supplied feedback to a question about injection related health issues. Of those 18, 78 per cent (n=14) reported experiencing one or more injection related complaint. A mean of 2.85 complaints were reported by the 14 participants. The figure below demonstrates the findings.

Table 5.2 Injection Related Health Issues

Injection Related Issues	<i>N</i>	<i>Per cent</i>
Scarring/bruising	13	72%
Collapsed Veins	12	67%

Abscesses/skin Infections	7	39%
Dirty Hit	5	28%
Overdose	3	17%

N=18

5.6 Psychiatric Health Status - Self Reported

Eleven participants (37 per cent) reported having concerns about their mental or psychiatric health. An equal number of participants reported that they had 'ever sought' (45 per cent, n=5) and had 'never sought help' (45 per cent, n=5) about mental health issues, while the remaining 1 respondent (9 per cent) reported that 'did source help but could not get it'. Participants were also asked if they had experienced any symptoms of mental illness. The table below details the findings.

Table 5.3 Psychiatric Health Symptoms

Psychiatric Health Symptoms	<i>n</i>	<i>Per cent</i>
Depression	20	68%
Anxiety	13	45%
Felt unable to cope	14	48%
Felt isolated	13	44%

N=29

Twenty three respondents (79 per cent) reported having at least one of the symptoms listed above. Of those ten (43 per cent) stated that they had experienced all four complaints on the list in the last six months and a further four (17 per cent) identified between 3 and 4 complaints.

12 (41 per cent) participants reported that they had undergone a psychiatric assessment previously, while 7 (24 per cent) respondents stated that they had been admitted to a psychiatric hospital at some point. Only one respondent reported that they had ever been diagnosed with a psychiatric health illness, also reporting that they were currently receiving treatment for the illness.

5.7 Summary and Conclusions

Over half of respondents (57 per cent) reported having being tested for hepatitis B and 70 per cent were tested for hepatitis C. High reported rates of being hepatitis C positive were found among the sample. A high percentage of respondents (53 per cent) rated their physical health as 'good' or 'very good' on a five point scale while the mean number of health complaints reported among the total sample was 6 with high rates of sleep problems (80 per cent), dental problems (63 per cent), weight problems (53 per cent) and poor appetite (53 per cent). Injecting related health issues were also found to be high among the sample. Psychiatric health concerns were reported by approximately one third of the sample and 68 per cent (n=20) reported experiencing depression. One person reported ever having been diagnosed with a psychiatric illness.

Section 6: Service Provision – Client Perspectives

6.1 Introduction

This section will look at health services accessibility issues in a range of settings from the perspectives of participating service users. Firstly feedback relating to the special scheme primary care setting at MQI will be examined. This will then be followed by participant perspectives relating to mainstream primary care services accessible to the general population and secondary/tertiary care services, or those services based either in the community or hospital based that patients are referred to via primary health care settings.

6.2 Primary Care

6.2.1 Special Scheme Primary Care Service (Merchants Quay Ireland)

6.2.1.1 Awareness /Use of Primary Care Special Scheme Service

Participants' awareness of the range of services available and their use of those services was examined. The findings are set out in Table 6.1.

Table 6.1 Awareness/Use of Primary Care Services (MQI)

Primary Care Unit Services	Aware of Service		Use of Service (Ever)	
	<i>n</i>	<i>Per cent</i>	<i>n</i>	<i>Per cent</i>
GP	29	100%	21	72%
Nurse	28	97%	22	76%
Dentist	27	93%	12	41%
Chiropodist	25	86%	5	17%
Counselor	22	76%	4	14%
Needle Exchange	28	97%	18	62%
Acupuncturist	25	86%	14	48%
Multi-Disciplinary Team	8	28%	3	10%

(each percentage is based on N=29)

All participants reported being aware of 3 or more services available at MQI while 24 (83 per cent) reported being aware of 6 or more of the services on the list. In terms of service use, 5 people (17 per cent) reported using just one

of the services listed, 3 of those reporting that the needle exchange was the one service they had ever used. The mean number of services used by respondents was 3.34 services.

6.2.1.2 Attitudes to Primary Health Care Access (Merchants Quay Ireland)

An attitudinal assessment was carried out in order to gather a picture of clients' views of the accessibility of the primary care services at MQI. A range of indicators were examined as set out in the table below. Respondents were asked to rate their opinion of the statements on a scale from 1 to 5, one being that they did not agree with the statement at all and five meaning that they were in full agreement with it. The table below presents the mean score for each of the 13 statements based on the number of answers given for each statement (N).

Table 6.2 Access/Accessibility to Primary Care Services (MQI)

Indicators of Accessibility	N	Mean	Range
Staff are welcoming and friendly	30	4.70	3-5
You have not experienced prejudice/discrimination	30	4.57	1-5
Waiting times are not too long	30	4.57	1-5
The service could address your needs	28	4.79	3-5
You have trust in the service	26	4.54	1-5
It is easy to understand the staff	28	4.96	4-5
The staff have sufficient skills to work with homeless people	29	4.69	1-5
You do not feel embarrassed to use the service	29	4.14	1-5
The service is confidential	29	4.28	1-5
The service hours are suitable	28	4.64	2-5
The location is easy to get to	28	5.00	5-5
Enough time is given to health care visits	30	4.83	1-5
You are referred onwards appropriately	11	5.00	5-5

The findings demonstrate that clients rate the process of service provision highly. The issue that received the lowest rating was 'you do not feel embarrassed to use the service' (mean 4.14, range 1-5) and suggests that

accessing health care can be challenging for homeless people, even where services are set up to target this specific group.

Respondents were then asked if they had any suggestions for making the health services at MQI more accessible. The following issues were raised:

- More regular GP and dental clinics
- The need for longer needle exchange (NEX) hours, particularly earlier NEX opening hours (e.g. 6:30am) to accommodate rough sleepers, and emergency hostel dwellers.
- An injecting facility

6.2.2 Mainstream Primary Care Services

The following sub-section will present feedback from clients in relation to general population primary care services.

6.2.2.1 Medical Card Access

One of the services offered at MQI is fast track access to medical cards for clients. Table 6.3 below details that only 46 per cent of the sample were in possession of a current medical card. This would suggest that homeless people continue to experience barriers to accessing medical cards.

6.2.2.2 GP Services

19 (63 per cent) respondents stated that they were currently registered with a mainstream GP service. Of those 13 (68 per cent) reported the length of time it took to complete the registration process. 5 stated that they were always registered with their GP. The remaining eight participants reported that it took 'less than 2 weeks' (n=3), 'between 4 and 6 weeks' (n=2), and '6 weeks or more' (n=3) to get registered.

Table 6.3 Medical Card Status

Medical Card Status	<i>n</i>	<i>Per cent</i>
Yes	13	46%
Yes, out of date	5	18%
No, can't get one	5	18%

No, don't need one	2	7%
Process of applying	1	4%

n=28

The **difficulties with GP registration** experienced by participants included (a) 'being on methadone', (b) full GP medical card lists, and not being able to find a GP that would take them on, and (c) feeling intimidated going into a GP's surgery because of being homeless and sometimes being unclean because of living circumstances. Of the 8 respondents who reported having had difficulties registering with a GP, 3 reported that they were currently registered with a GP.

GP attendance and satisfaction rates found that of the 22 respondents who supplied answers to a question on GP attendance in the last 6 months, seven reported that they had attended. Of those the majority reported that they were 'extremely satisfied' with their last visit (71 per cent (n=5).)

6.2.2.3 Methadone Programmes

Of twenty respondents who provided feedback in relation to accessing methadone programmes seven (35 per cent) reported experiencing programme access difficulties. Difficulties were related to the length of time it took or is taking to get onto either a bus or clinic programme. Waiting times of 4-6 months were reported by two participants, while another reported a two year waiting duration.

6.2.2.4 Addiction Related Counselling

17 participants (57 per cent of the total population) reported ever having had counselling for their drug or alcohol use. Of those 13 (76 per cent) stated that they felt there were benefits gained from those links, for example, the importance to individuals of 'having someone to talk to'. Three respondents associated their links to a counsellor with periods of '*cleaning up*' or ceasing their drug use. According to one participant,

Yes, [there were benefits], I cleaned up completely, I did a holistic detox in the UK. (Male, 37 years).

Counselling was also identified as having an impact on accessing methadone maintenance programmes for two respondents. One respondent stated that the support of a counsellor in a prison was very helpful and,

it meant that I linked in with a methadone programme [in the community] when I came out [of prison]. (Male, 36 years)

Four respondents reported having **difficulties accessing a counsellor**. The main difficulty reported was a lack of knowledge of where to access a counsellor, particularly during the time prior to being linked in with methadone maintenance services. One participant said that the difficulties experienced were as a result of having to be on a waiting list for counselling services.

6.2.2.5 Pharmacy

Ten people reported use of a pharmacy in the last 6 months. Three of those reported doing so to pick up their methadone.

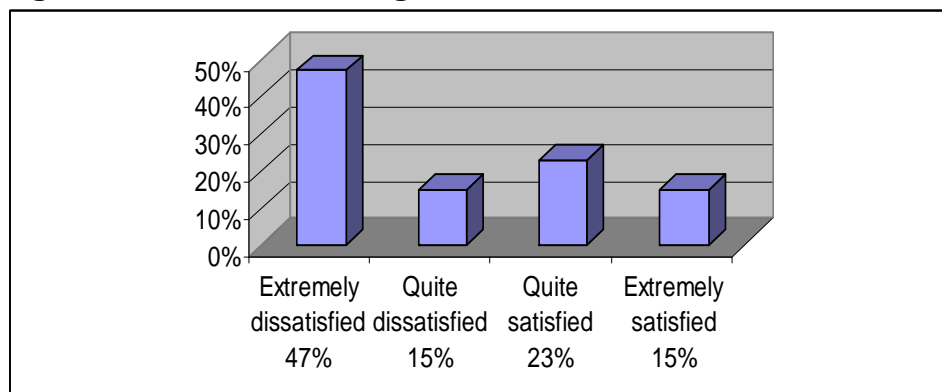
6.3 Secondary Care Health Services

6.3.1 Accident & Emergency Services

A high percentage of participants reported Accident and Emergency (A & E) attendance in the last 6 months (43 per cent, n=13). In terms of referral routes to A & E, self-referral was reported the most often (38 per cent, n=5). This was followed by those who reported being brought to A & E by ambulance (30 per cent, n=4). The remaining 4 respondents reported being referred by their GP, their drugs clinic or MQI services.

Reasons given for accessing A&E included suicidal ideation, depression, broken bones, accidents, pneumonia, wounds requiring stitches or treatment or blood clots.

Fig. 6.1 Satisfaction Rating - Most Recent A & E Visit



n=13

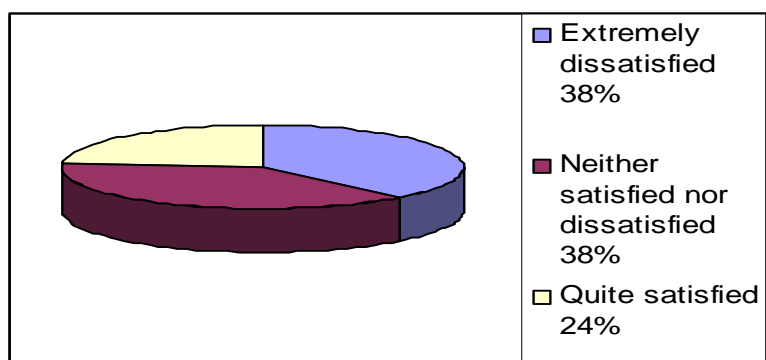
In the chart above the majority reported being either ‘extremely dissatisfied’ (47 per cent, n=6), or ‘quite dissatisfied’ (15 per cent, n=2) with their A&E experience. Length of time waiting was the primary reason for participant’s dissatisfaction, followed by ‘poor treatment’.

6.3.2 Outpatients Department

8 respondents reported that they had accessed hospital outpatients departments in the last six months. Most referrals were as a result of follow-up appointments, while one each was made on the clients’ behalf by MQI services, their drugs clinic, and by their GP. The reasons for outpatient visits were in connection with testing for and monitoring of blood borne viruses (BBVs). Three were follow-up visits relating to bone breakages and wound treatment.

Outpatient satisfaction ratings found that of the eight respondents who had accessed the outpatients department 3 (38 per cent) were ‘extremely dissatisfied’, 2 (24 per cent) were ‘neither satisfied nor dissatisfied’ and 3 (38 per cent) reported being ‘quite satisfied’.

Fig. 6.2 Satisfaction Rating – Most Recent Outpatients Department Visit



6.3.3 Other Secondary Care Services Accessed in the Last 6 Months

18 participants supplied answers to a question about other secondary care services that they had accessed during the 6 months prior to interview, 6 respondents reported accessing 2 or more of the services listed. Percentages therefore do not add up to 100 per cent.

Table 6.4 Other Secondary Care Accessed Last 6 Months

Service	N	Per cent
GUM/GUIDE Clinic	4	22%
In-patient in hospital	4	22%
Psychiatrist	1	6%
Physiotherapist	1	6%

n=18

6.4 Summary & Conclusions

Service users demonstrated that there were high levels of awareness of the services on offer at MQI and that there were also high levels of service use among the study group. As expected the services used the most were the GP and nursing services. The needle exchange was also used by all of the participants who reported injection drug use. The service that participants were least aware of and used the least was the multi-disciplinary team, the HSE service that links homeless people with mainstream primary care services. This is a city wide service which works with a range of other homeless specific health services which would explain the lower level of use found here. The attitudinal assessment found that the MQI model is found to make health services accessible to the target group on a range of levels that have been identified in the literature as barriers regularly encountered by

homeless people. Special scheme service improvements suggested by service users included more regular access to the GP, longer needle exchange access hours, and the establishment of an injecting facility.

In relation to mainstream service access issues, the lack of a medical card, and GP access issues emerged as difficulties for the target group. Similarly, access to methadone services and addiction related counselling were found to be challenging for 35 per cent and 13 per cent of the study group respectively. A high percentage of A&E (62 per cent) and outpatient's department (38 per cent) attendees reported being dissatisfied with their recent visits. Length of waiting times, and poor treatment received were given as the main reasons for these perspectives.

Section: 7 - Service Provision Service Provider Perspectives

7.1 Introduction

This section will focus on the feedback received from service providers in relation to both the special scheme primary care setting and mainstream primary and secondary services in the context of meeting the health care access needs of homeless people. Firstly, feedback from health professionals concerning the strengths and challenges of the special scheme at MQI will be detailed. This will then be followed by feedback from service providers with regard to gaps that exist in mainstream primary and secondary health services.

7.2 'Special Scheme' Primary Care Provision - Strengths

7.2.1 Drop-In

Many of the health care providers delivering services at MQI spoke about how initial plans of setting up an appointment system were discarded in order to make their services more accessible for clients. It was felt that the appointment system would be a barrier and as a result a less structured approach of a drop-in service was adopted.

Well, if you wanted to run it like [other similar services] you wouldn't have any clients. A lot of our clients would find it very hard to keep appointments. And so for that reason, if they drop-in on a day and I'm free, I'll see them there and then" (Health Care Provider, MQI)

7.2.2 Accessibility of Staff to Clients

As well as being a drop-in service it emerged that extra lengths were taken to ensure accessibility to individual staff members as another way of challenging barriers that may exist for clients. Many of the health care professionals spoke about linking in with clients on a more casual basis within the homeless Open Access drop-in service, where they could introduce themselves and inform potential clients of the services that are available to them.

It would be very much on an informal basis in one way, where clients will get to know me over [in the drop-in service] and then they'll decide they want to

have a chat. It's not as regulated as some services would be. (Health Care Provider, MQI)

This approach was highlighted by another provider as one that helped challenge fears that clients may have.

In fact, I used to go over to (the homeless Open Access service). People got to know me quite well.. They'd say "Oh there's [names service provider]. Yeah, I need to go. And I would literally take them by the hand and bring them over because they would be quite [scared]. As time went by, we became more familiar with them, and they more familiar with us. (Health Care Provider, MQI)

7.2.3 Facilitating Access to Medical Card Prescriptions

The GP service at MQI has an arrangement with the HSE whereby they can write medical card prescriptions for clients who do not have medical cards. This was described as being a positive service as getting a medical card can be problematic for homeless people on a number of levels. A clear example of this service is where non-medical card prescriptions are written by hospital services, clients can bring them to MQI where the prescription will be re-written on a medical card prescription form which will in turn entitle the person to free medications.

7.2.4 Crisis Intervention

Service providers in the specialist setting very often described the delivery of services in the context of meeting crisis needs, or of being crisis driven. Service providers spoke of dealing with emergency situations, keeping clients 'patched up' and working with the array of issues that homeless people present to health services with 'there and then'. One service provider described the service at MQI as being like a mini A&E. Contrary to this being perceived as a negative aspect of the service the interviewee below argues that it is a positive aspect in terms of meeting clients' needs.

I think primarily, the service at MQI is crisis intervention and will always be and will always be needed. But the beauty of that is how you meet someone within the service.. and then they move on and then also they may have another crisis, [and MQI is there to facilitate those needs]. (Health Care Provider, MQI)

The feedback suggests that the notion of 'moving on' (for example to secure accommodation or to mainstream health services) should be thought of as part of a cyclical process rather than a linear one.

7.2.5 In-house Referrals – Health, Homeless and Drug Services

Once a client accesses any of the services at MQI it was stated that internal referrals to any of the other services can be made quite easily. Referrals from one service to another were described as happening in an informal rather than a formal manner. This eliminates the need for appointments and greatly reduces waiting times.

And then informally, like I mean I would maybe bring somebody to the GP's attention, the nurse or vice versa, they'd bring someone to me. (Health Care Provider, MQI)

Referrals were made not only between the health services but also between health care providers and project workers within the organisation that work with clients on a wide range of individual needs. This also facilitates links to broader social services, and was felt to be a positive client centred approach to working.

I think sometimes you can over bureaucratize things and definitely from my end the nature of drop-in service is unstructured to a certain degree as in when and how clients present. I think you can't put structure on it – it would be a false structure. I think currently it works very well. (Health Care Provider, MQI)

Also stated was that health and social services together facilitate the prioritisation of clients needs, as clients' present with these.

Of course because they're homeless, that is their priority oftentimes. And it is very hard to deal with other problems when that's such [a big one]. You know, you have to deal with the biggest problems first. (Health Professional, MQI)

7.2.6 Working at Clients' Pace

Another key factor in making services available to clients is having the time to spend during consultations. The dentist referred to the needs to give an

appropriate length of time to consultations in order to make dental visits more accessible.

You know, you would be going through people's medical history, their social history because they are so phobic [about dental visits]. Sometimes it can take 40 minutes. But having said that, that 40 minutes is probably the best 40 minutes spent because they are in a very pleasant environment in this room. They can be very open about their medical history. Because there is no judgement here, so that they do return time after time. (Health Care Provider, MQI)

A similar issue was raised in relation to consultations concerning blood tests for hepatitis or HIV. The nurses inform clients of the service and part of their role is to promote its use among those accessing the health care unit. Because of the nature of many client's lives it may not be the right time, emotionally, for them to have blood tests done. The nursing staff will offer a pre-test discussion (differentiated from a counselling session) where they give the client information on hepatitis and HIV, and inform them of the procedures around testing.

And, if you know, you feel that they can't cope [with having the tests done at that time] you might suggest they come back or they do counselling and then come back. (Health Care Provider, MQI)

The primary care service at MQI strives towards providing a service that can work between the parameters of (a) the importance of making blood testing available but (b) in a way that is client centred.

This is the kind of standard we want, you know. That everyone gets their bloods done, but by working with clients at [their pace]. That you discuss it with them... Because for a lot of people it is a big psychological issue. (Health Care Provider, MQI)

Achieving this standard of practice means devoting time to client visits for discussion and information dissemination and a flexibility of service provision that can operate at the level of individual need.

I think there's a lot of services out there who want to change the client to fit the service, whereas I think the service here has always been more to suit the client.

(Health Care Provider, MQI)

7.3 'Special Scheme' Primary Care Provision - Challenges

The challenges that the special scheme model of primary care provision at MQI face are in relation to its capacity and fall under two headings (a) to meet the specific primary care health needs and supports that homeless clients present with, and its capacity to (b) meet a standard of internal procedures that it would like to achieve.

7.3.1 Meeting Client Health Care and Support Needs

7.3.1.1 In-house nurse prescribing: Due to the fact that the GP service is provided on a part-time basis, prescriptions need to be organised around these clinics. As the nursing staff are based at MQI on a full time basis, having nurse prescribers would speed up this service and make the service more accessible.

7.3.1.2 Mental Health Care

The need for mental health care provision as part of the primary care team for homeless people was highlighted as a key service provision gap in the special services primary care team. It was suggested that an in-house position for the role of mental health nurse would greatly enhance service provision for clients. The need for a mental health nurse is discussed by one of the staff members in the quote below.

Because with mental health, it's not like general health where you bring the person in and see them quickly.. You know, we need to observe, assess, take time and get to know the person. That doesn't happen through meeting somebody once for an hour.. (Health Care Provider, MQI)

7.3.1.3 Increasing Service Capacity of Existing Services

Staff pointed out a range of service areas where they felt the capacity of existing services could be increased. Among these were:

(a) Overdose Management: The need to raise the capacity of both health care staff and project workers so that they would be able to respond to situations of overdose was also highlighted.

Overdose is a huge issue for [this service]. I think we are obliged to train the staff in here to do CPR, because of what they see [among the client group].
(Health Care Provider, MQI).

(b) Health Promotion: The Government health strategy “is centred on a whole-system approach to tackling health in Ireland. It goes beyond the traditional concept of ‘health services’. It is about developing a system in which best health and social well-being are valued and supported” (Government of Ireland, 2001:15). Central to meeting this aim is the promotion of healthier lifestyles and well-being in general. Balancing the demand for crisis intervention and health promotion can be difficult.

We are all very much dealing with the crisis end of things here. If it is quiet I will try to do some health promotion work. But, it's very hard to get the time.
(Health Care Provider, MQI)

(d) Sexual health: While a degree of sexual health services are delivered at present, it was felt that raising the capacity to carry out smear tests and sexual health screenings would be a positive service development.

(e) Foot care: Current service capacity does not facilitate the level of foot care needed by many of the homeless clients. Having the capacity to provide better foot spa facilities would alleviate tired and sore feet, and prevent foot problems from escalating.

(f) Hepatitis B vaccination procedures: The Hepatitis B vaccination is administered in three separate stages. While the vaccination is administered in the services in MQI, difficulties around completion of the three stages have arisen where clients do not attend for all three appointments. The health care

staff are interested in developing new approaches to ensuring that clients receive the full course of vaccinations.

(g) Referral Advocacy: The need for advocacy work to accompany referrals to mainstream health services was also raised by service providers.

Examples of this kind of advocacy included phoning the client on the day of their appointment to remind and encourage them to attend, or contacting mainstream health services on behalf of clients who had missed appointments to explain why this had occurred and to arrange a new appointment on behalf of the client. Others spoke about the need to attend appointments with clients not only to ensure that they overcome barriers associated with keeping appointments but also to act as an advocate for clients during consultations. It was acknowledged that this is a labour intensive service, but often needed to ensure client access.

(d) Communications

More recently migrants who speak a variety of languages have begun accessing the homeless services. Staff within the primary care services highlighted some of the difficulties that they have working with this group because of language barriers.

That would have lately, presented a huge problem for us in terms of the language barrier, trying to organise prescriptions, trying to get a proper assessment done. You can't get a proper assessment done on somebody you can't talk to.

(Health Care Provider, MQI).

7.3.2 Increasing Capacity of Existing Internal Service Procedures

7.3.2.1 Record Keeping

Due to the high demand for the health services, and the very often crisis nature of need, some service staff reported that it can be challenging find the time to write up detailed records.

You see many people all the time, so if you were to try and reflect on that and write up on that and develop it every day, you'd be addled. You'd never have any time to do anything else. (Health Care Provider, MQI)

7.3.2.2 Internal Staff Communications

Similarly, the capacity to hold regular case management meeting presented challenges for the staff.

A couple of us [staff] members try to have a meeting about clients, but it's very, very hard to find the time in here. (Health Care Worker, MQI)

7.3.2.3 Number of Weekly Service Days

Service providers pointed to the need for health services to be available to clients seven days of the week rather than five. The quote below highlights this issue.

I think we should have a Monday to Sunday nursing service. I mean Saturday and Sunday are the days when A&E is so busy. Saturday and Sunday is no different to clients.. in terms of their drug use. Also, they can't access their GP's (if they have them). (Health Care Provider, MQI)

7.3.2.4 Consistency of Service Provision

It was also highlighted that consistent service provision is essential to facilitating access for the target group. Because some of the services that are provided at the Health Care Unit at MQI are provided by outside agencies⁷, control over the consistency of service provision lies in the domain of these agencies. The fact that services can be reduced or provided on an inconsistent basis has a negative impact on accessibility for clients. This may also impact negatively on how clients perceive health service provision as a whole.

7.4 Gaps in Mainstream Services - Primary Care

7.4.1 General Practitioner Access

The difficulties of registering with a mainstream GP continue to present challenges for the homeless population. It is continually found that GP's have reached medical card patient capacity making it difficult for homeless people to register. Also highlighted was the fact that a reluctance by some GP's to

⁷ An example at MQI is that the Dentistry Service is provided directly by the Health Services Executive.

take homeless people onto their lists still persists. The need for better training for GP's around issues relating to homelessness was raised.

If you have no experience as a GP, or little, you might just feel I'm not able to do this because I don't know what's required... so there's definitely work that needs to be done within GP services to help that integration a bit better.
(Health Care Provider, MQI)

This GP working in mainstream primary care also highlighted the need for an advocacy role to assist homeless clients overcome a range of accessibility barriers that they might experience.

Obviously people challenged in all sorts of ways won't come here unless they have, for example, a key worker with them. So we do rely a lot on the homeless services to actually physically bring clients to us. I mean for every person that does arrive and gets seen to, there must be dozens out there who don't. (Practice Based GP)

7.4.2 Accessing the Range of Medical Card Services

As the medical card ensures access to a range of health services such as eye testing, hospital based services, and the dentist, GP registration related difficulties accessing the medical card means clients experience barriers to a range of associated services. The quote below highlights this issue.

I feel strongly that those services should be detached from a patient's need to sign up with a GP because they still need those services but they may not be able to get a GP or they may not be in a 'place' where they are not ready for that structure yet. (Health Care Provider, MQI)

7.4.3 Community Based Mental Health Services

A service gap that was highlighted regularly by service providers in the special services setting and in mainstream health service settings was appropriate community based mental health services for homeless people. It was acknowledged that a homeless mental health team (the ACCESS Team) currently exists, but that the criteria for access to that team is not inclusive of the needs of many clients who have acute mental health needs.

It was stated that clients who present with acute mental health issues and are drug dependent have few service options, some service providers stating that

appropriate services 'don't really exist at all'. This was mainly because the current referral option of A&E was often described as being 'inappropriate'.

If someone needs hospital admission (for mental health issues) we still have to get the mainstream services to look after them and that means you have to send them through casualty and casualty just doesn't work for our clients. (Health Care Provider, MQI)

Casualty was described as being '*a terrible place*' for anyone with crisis mental health issues to have to wait for long hours, due to it being busy and noisy. For homeless drug users, the need to leave casualty to have a 'fix' may mean that they are put to the bottom of the list again.

If you know someone can't follow-through. Is it reasonable to ask them to do something impossible or nearly impossible? (Health Care Provider, MQI)

7.4.4 Methadone

A service need identified by service providers was fast access to what was described as 'community methadone'. This service would be aimed at clients who need to regain some level of stability in order to address pressing health issues.

Some sort of crisis methadone management, say when clients are really unwell you could give them community methadone. They may not be ready willing or able to do that on a long-term basis but on the short-term it might just mean that they'd be better able to attend for dressings... it would be a bit of support that they would need in the short term. (Health Care Provider, MQI)

7.5 Gaps in Mainstream Services - Secondary Care Services

7.5.1 Accident and Emergency Services

The need for more accessible A&E services for the target group was identified. In general it was felt that referrals to emergency services are problematic as very often the client group of homeless people some of whom are drug users are unlikely to go through with the referral made on their behalf. A member of the health care team at MQI highlighted that when a client presents to the MQI services with an issue that needs a hospital

confirmatory test, the barriers encountered in accessing emergency services by clients can often mean they do not attend for those tests.

So I'm fairly certain this client has [a medical issue in need of quick attention]. I'm asking him to go up to A&E and I'm hoping the queue isn't long because if it is.. he needs to get his gear (heroin) this afternoon.. and if he won't wait [the condition could become serious]. (Health Care Provider. MQI)

7.5.2 Hospital Based Clinics (Outpatients)

It was highlighted that hospital based clinics that offer an out-of-hours service on a drop-in basis greatly improves access for homeless clients who would ordinarily find it difficult to meet appointment schedules.

It's fantastic, [that hospital based clinic] has three walk-in clinics a week.. and a range of hours and that means people get access. (Health Care Provider, MQI)

Many felt that this hospital based clinic out-of-hours model would greatly improve access to mainstream services for marginalised groups in general. While links between hospital based services and the special services setting at MQI were found to be positive, it was felt that often access difficulties persisted for homeless clients.

We have a relationship with the wound clinic in [a local hospital] and they have been very helpful to us... if we ask them to see someone urgently they do respond. The difficulty with our clients is that sometimes they're not able to make those appointments...(Health Care Provider, MQI)

The challenges around accessing mainstream health service provision places the specialist setting in a situation of trying to striking a balance between onward referral and providing whatever level of service that they can themselves.

We do a small amount of screening here, but we refer clients to the sexual health clinic, which is good, but also, people don't make it there. I've had loads of cases where you send people and they just don't go, so you have to be practical and provide what you can for them here. (Health Care Provider, MQI)

7.5.3 Mental Health Referrals

A mental health service provider working in secondary care pointed to the fact that he felt a knowledge gap exists in the primary care setting in relation to mental health issues. As a result mental health referrals made to secondary care are often felt to be inappropriate. This gap obviously creates frustration for all concerned: primary and secondary care providers, and most importantly the service user. Frustration at the lack of mental health referral routes has already been highlighted by primary care providers in this report, and dovetails with feedback from the secondary care setting. This clearly demonstrates a gap in access to mental health support for the target group.

7.5.4 Discharge Procedures/Follow-Up Care

Discharge procedures were highlighted as an issue that continue to present problems for continuity of care by services providers in all care settings. Staff in the special services setting (MQI) highlighted that this is of greatest concern to them in situations where clients are discharged and 'fall through the service net', when they have strict follow-up treatment plans for health issues that need close attention. Health issues such as deep vein thrombosis, a health issue that is not uncommon among drug users, need prompt and ongoing follow-up care. This service provider highlights some of the situations where clients 'get lost to follow-up',

It's a significant problem that we see clients that have diagnosed clots and are on an injectable anti-coagulant and they often get lost to follow-up. They're on a methadone clinic and they drop off or they are discharged from hospital with a prescription and they don't have a GP. They don't know the importance of [the prescription] and they might present [to MQI] a week later.. and it's very important and very serious that the treatment is followed up on... (Health Care Provider, MQI)

Feedback from service providers also highlighted that discharge complications arise due to catchment area based mental health services. The homeless population by its very nature is 'area less' and as a result a gap in post discharge community based services exist for this group.

7.6 Other Service Gaps

7.6.1 Respite Services

The need for respite beds for homeless people who are discharged from hospital is closely linked to the lack of appropriate accommodation that is available to this group. Poor capacity for recuperation contributes to higher readmissions to hospital services after discharge. Having somewhere to go to recuperate is essential.

We think there is a gap because people coming from hospital and they're straight out into their own accommodation or without accommodation without any follow on care. (Practice Based GP)

This GP highlighted that because homeless services are unable to hold beds for homeless people who are in-patients in hospitals, any chance of follow-on care for that individual very often 'falls apart'.

7.6.2 Detox

The long waiting lists for a methadone detoxification are regularly addressed in the literature. This gap in drug service provision was again highlighted by health care providers, and in the quote below the suggestion of creating a service that facilitates the homeless population is suggested.

If clients are ready and want to detox to go into [drug rehab] they need to be on 30mls of methadone to access those services. They can't because the waiting list very long. If there could be some kind of slightly specialist service for the homeless with regard to methadone. (Health Care Provider, MQI)

7.6.3 Accommodation

A key service gap that was identified was accommodation. Many health care professionals spoke about a number of the service gaps identified as being directly related to a need for appropriate housing. This gap in services was felt to be particularly problematic for homeless drug users. The lack of appropriate accommodation options for this group means that addressing health needs continue to be a challenge.

It's the old problem of if a person is a drug user there is a very limited amount of places (accommodation) that they can go anyway. I think accommodation needs to be at the top, and then everything else would follow. (Health Care Professional, MQI)

The lack of accommodation was also highlighted as being an issue that contributes to the difficulties for service providers in mainstream settings.

You get people coming back to you time and again saying... "This is what I'm fed up about.. I'm fed up with going through the homeless persons unit. I'm fed up with them telling me that I can't get a B&B and I can't get this and I can't get that and every time they send me to the (names hostel) and I'm not going there. I'd rather sleep on the streets.." That's not something I can resolve... (Mental Health Care Professional)

Services that are set up to meet specific health issues do not have the capacity to facilitate the complex needs of the homeless population.

7.7 Summary and Conclusions

Key to the strengths of the special scheme model of primary care provision as operated by Merchants Quay Ireland and found in this study are, that the service operates on a drop-in basis, that the staff are easily accessible to clients who access one or more of the range of services that the organisation offers, that it can facilitate the need for crisis care, and that it is client centred in its approach to service provision. Also key is the ease of in-house referral between the range of not only health, but also drugs and homeless services, something which facilitates easier client information exchange. The capacity to provide a fast track access to medical cards and to exchange non-medical card prescriptions greatly enhances access for the target group. Challenges mainly revolve around capacity issues, for example, more regular access to medication prescriptions, and the capacity to provide mental health services. Key areas of health provision where the need to raise capacity was indicated included overdose management, health promotion, sexual health, foot care, hepatitis B vaccination schedules, referral advocacy, and language barriers due to a changing client profile. Similarly, the need for greater capacity was highlighted in order to facilitate better record keeping, more frequent internal

staff meetings, a seven day a week service, and consistency of service provision.

Gaps in mainstream primary care services included GP access difficulties and medical card services access difficulties, similar to the feedback received earlier from clients. Accessible community based mental health services continue to provide a core referral challenge for primary care providers. Many patients are currently referred to A&E, an option deemed inaccessible for homeless people, particularly homeless drug users. It was also suggested that a lack of knowledge of mental health issues exists in primary care settings which can result in inappropriate referrals to secondary care. This points to a significant gap in services and demonstrates how this gap can contribute to the inappropriate use of scarce resources. A positive finding was that the drop-in model used by some hospital clinics has been found to make those services more accessible to homeless people. Methadone and detox services continue to present challenges for homeless drug users mainly as a result of long waiting lists. Homeless people face numerous challenges while on a waiting list for detox services.

Poor discharge and follow-up procedures were found to persist where homeless clients are discharged from secondary care without appropriate accommodation, and without clear links to follow-up primary care. The need for respite beds for homeless people was highlighted as a service necessary to meet this gap. More generally, the need for appropriate accommodation was highlighted by study participants as key to meeting peoples broader health and social well-being needs, and that without it meeting needs at the level of primary care continue to be complex and challenging. Without appropriate accommodation any chance of improving health outcomes and overall quality of life for homeless people that are central to Ireland's National Health Strategy are severely compromised, if not impossible.

Section 8: Best Practice in Primary Health Care Access for Homeless People

Table 8.1. Model of Primary Care proposed in the National Primary Care Strategy (2001)

Proposed Primary Care Teams:	Proposed Primary Care Networks:
<ul style="list-style-type: none"> • GP • Nurse/Midwife • Health Care Assistant • Home Help • Physiotherapist • Occupational Therapist • Social Worker • Receptionist • Clerical Officer • Administrator 	<ul style="list-style-type: none"> • Chiropodist • Community Welfare Officer • Community Pharmacist • Dentist • Dietician • Psychologist • Speech & Language Therapist

FEANTSA, The European Federation of National Organisations Working with the Homeless outlined what they identify as the fundamental elements of a health strategy to meet the health needs of homeless people:

- (1) The promotion of a greater understanding of the complex needs and interdependent nature of the health need of homeless people;
- (2) Integrated and accessible health services;
- (3) A broad rights-based approach to the provision of health services that incorporates a holistic notion of care that goes beyond simple health needs to a greater conception of the general mental, physical and social well-being. Assuring the individual's holistic well being through mental and physical good health, but also access to adequate housing, access to work or to meaningful occupation and a stable income should be the ultimate goal of health policy. Thus the integration and cooperation of social and health services is fundamental.

Recommendations

Based on the findings in this study and in line with the FEANTSA health policy for homeless people set out above, recommendations in relation to ensuring primary health care is accessible to homeless people are as follows:

Primary Care Team inclusive of homeless people's needs should consist of the following:

- GP
- Nurse/Midwife
- **Dentist**
- **Mental Health Nurse**
- **Counsellor**
- **Chiropodist**
- **Dedicated Service Link Team**
- Physiotherapist
- Occupational Therapist
- Social Worker
- Clerical/Administration Staff

Primary Care Services: Procedures

Service access: Should be on a **drop-in** basis for homeless people. This study demonstrates that the drop-in approach to service provision removes a barrier to health services for homeless people. **Low-threshold** services also enhance accessibility for homeless people.

Opening hours: Primary Care Services should be accessible on a **seven day a week** basis, and an **out-of-hours** service should be available to the target group. The lack of access to primary care at weekends in particular was found to be a gap in service provision for the target group. Attendance at A&E services at weekends was found to be problematic for homeless people as this is often the busiest time of the week for those services.

Medical card services: (a) The **fast track** medical card facility should be continued; (b) The capacity to provide **medical card prescriptions** for homeless clients in receipt of non-medical card prescriptions from other health services should be available in all primary care settings.

Training for Primary Care Team:

(a) to better understand the range of issues relating to homelessness
(b) on health issues particular to homeless people including issues specific to homeless drug users such as harm reduction and overdose management.

Communications: In line with the new national integration strategy *Migration Nation* (Office for the Minister for Integration, 2008) the need to make services accessible to all migrants living in Ireland is necessary. Language barriers are a main barrier to meeting the service needs of this group.

Governance in relation to the provision of, and access to, primary care services should be provided by a body with specific knowledge of homelessness and health related issues. An example of such a body may well be the Safetynet service that is being developed in the Dublin area (see Appendix I).

Dedicated Service Link Team:

An outreach function should target locations where homeless people are (e.g. street/hostels) in both urban and rural areas. Building trust with homeless people and providing a link to the primary care team will greatly improve access to primary health care.

Links to Drugs Services: High rates of drug use have been found among the homeless population in the national literature (Lawless & Corr, 2005). The need for better routes to drugs services for homeless people is evident both from this study and from the literature (ibid).

Hospital Discharge: The need for better discharge procedures to prevent homeless people from falling through service gaps at the point of leaving institutional care was evident in this study. A dedicated link service would provide transparency at the point of hospital discharge and ensure that homeless people are linked appropriately back into community services.

Referrals to secondary/tertiary care: There is also a role for a homeless liaison worker dedicated to advocating on behalf of homeless people around referrals to secondary/tertiary services. This study found that although referrals from the primary to the secondary care settings were being made on behalf of clients, barriers to following up on these referrals were common among the target group.

The **multi-disciplinary team** which operates in the Dublin area (see Appendix I) is an example of a model which could be drawn from and adapted in order to appropriately meet the dedicated service link needs at local and regional level. Best practice in the delivery of these link services should be outlined.

Primary Care Network, Secondary, Tertiary Services:

Increase **out-of-hour** and **drop-in** access to the wider Primary Care Network and Secondary Services based in both hospital settings and in the community.

Identify ways of meeting the **mental health care needs of homeless people.**

The current need for mental health care services for this group has fallen between a number of service areas namely the homeless, mental health, and addiction services and as a result homeless individuals experience a range of barriers to accessing appropriate support. The presence of a **mental health nurse** in the primary care setting would meet the need for making appropriate referrals to secondary care services, and would facilitate better joint working between primary and secondary care. This would also fill a knowledge gap that has been identified at the level of front line of services.

Make available **respite** beds for homeless people being discharged from health care services in need of time to recuperate. Without appropriate accommodation regaining health is extremely difficult. This recommendation is in line with recommendations made by O'Carroll et al (2006) in their report highlighting the need for intermediate care services for homeless people leaving hospital care.

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Appendix I.

1. 'Safetynet'

The Primary Care Unit at Merchants Quay Ireland is part of the new and evolving *Safetynet* Service which was established in 2007. The service is made up of ten Special Scheme services delivering health care to homeless people throughout Dublin city. The aim of this service is to provide comprehensive primary healthcare services targeted at people who are homeless. Central to this is an integrated internet-based system which allows GPs from different clinics to access the full details of a patients' medical records. The key aim here is to provide continuity of care to homeless people who move between the services. *Safetynet* will also have a role in providing clinical governance to the special services settings.

2. Homeless Specific Health Services and Referral Routes for People in Dublin

The Multi-Disciplinary Primary Care Team is a service set up by the Health Services Executive for homeless people. The purpose of the team is to ensure that homeless people in the Dublin Region have access to primary health care thus improving the health and social gain of homeless persons ideally through linking them to mainstream services. A northside and southside team operates at either side of the river Liffey which runs through the city centre. The teams respond to calls from agencies in contact with people who are homeless. The services provided by the Multi-D Team are Community Welfare Officer, Drugs Outreach Worker, Primary Healthcare Nurse, Outreach.

The Assertive Community Care Evaluation Service (ACCES) is a mental health service provided by the Health Services Executive for people who are homeless with a severe and enduring mental health illness. The ACCES team is a referral service only.

The Dental Service for Homeless People is located at Cornmarket Dental Clinic. The service run by the Health Services Executive (HSE) provides full treatment for people who are homeless. The dental service that is run at Merchants Quay Ireland is an outreach service of the Cornmarket Clinic.