Anne O'Farrell (HSE intelligence unit)
2016 census

- 81% increase since 2011 in homeless people
- majority of rough sleepers male

#1 reason: lack of affordable housing
260% increases in number of emergency inpatient admission of homeless 2005-2016
average LOS – 7.3days
reasons over-represented in this population – injury and poisoning, mental and behavioral, skin and SQ tissue
14.1% homeless popn vs 10% gen popn had ACSCs
need for interaction between hospital admission, primary care and homelessness

'fixed abode' – an underestimation of the true homeless population

- hostel address, family member address

Caroline O'Dowd: expert by experience
once discharged, not much longterm in place to keep patient healthy and out of hospital
scheduling OPDs via key worker
everyone in the service – including porters, cleaners, security to undergo training to learn more about homelessness. Front line service providers should have to uphold certain values.
Difficult to get anywhere with making complaints about service members.
External way to examine complaints?
More than one night of a bed after coming out of hospital
Practical issues preventing homeless seeking help in hospital – where to put their stuff/tent, dogs

Addiction and Homeless services – Cork/Kerry
Trying to standardize services
1st and only Integrated service prison, homeless and addiction
Electronic shared drive between liaison psychiatry and social inclusion
Building an acute referral pathway from acute to drug and addiction, homelessness

AHIT – adult homeless integrated team
Team: medical, addiction eg counsellors, mental health, administration and manager social inclusion

- Combine services

Hospital interface initiatives

- Antenatal service for homelessness/addiction
    - Dedicated nurse/midwife
    - Specialist clinic
    - Methadone in antenatal services
    - Teaching service providers about treating pain relief of patients

Discharge planning – member meets patients in hospital before d/c

The collaboration ladder – DeepEnd Scotland

- Service you receive shouldn't depend on the provider you get

TUH inclusion model
In hospital or post discharge assessment
Majority referrals to hospital liaison outreach worker from ED, psychiatric unit (drug induced psychosis), long term illness secondary to D&A
Referred out to tier 4 residential services, supported community detox with GPs
44% of those referred engaged with services
primary substance: 62% alcohol, 15% crack/cocaine

SJH inclusion health
Focus is on homeless
Tailoring service to user
Interface with people who engage with homeless who aren't in health service eg hostels

Social inclusion office SRF project
SRF = service reform fund
Aims:

1. Support 100 additional housing first tenancies in Cork, Limerick and Galway
2. Review health supports in Dublin and enhance existing housing
3. Interagency homeless hospital discharge

Delayed discharges – emergency departments especially an issue
Communication with local authorities - **link between housing and health**
Expanding James' inclusion model to Mater