
Circles Within Circles: Dublin's Frontline Homeless Sector Workers Discuss the Intersectional Issues of Homelessness, Mental Illness and Addiction

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› **Abstract** *This article explores the experiences of staff in Dublin's homeless sector of working with clients with mental health issues, the training they receive, and their knowledge of mental health concerns. Semi-structured interviews were conducted with nine participants from a range of Dublin-based homeless organisations. Interviews were audio-recorded, transcribed and thematically analysed. Three main themes emerged: 'mental health and medical service issues', 'dual diagnosis' and 'staff knowledge and training'. The results highlighted difficulties with psychiatric/ medical and addiction services, including access issues, lack of out-of-hours facilities, and poor services for those dually diagnosed with a mental illness and addiction. Inadequate in-service training also emerged as an issue. The most prominent finding was the lack of cohesion, collaboration and communication between homeless, psychiatric/medical and addiction services. Staff working with homeless clients with mental health issues and addictions experience great difficulty in accessing appropriate services for their clients, and lack sufficient knowledge to navigate the mental healthcare and medical systems. The results suggest that there is an urgent need for an overhaul of the services available for homeless people with mental health issues, and of the information available to staff.*

› **Keywords** _ *Homelessness, mental health, mental illness, training, dual diagnosis*

Introduction

The connections between homelessness and mental illness have long been recognized (Frazier, 1985; Timms, 1996). However, homeless people with mental health issues continue to lack access to appropriate care and services (DoHC, 2006). Homelessness is on the increase across the Western world (USICH, 2010; FEANTSA, 2014; Coalition for the Homeless, 2015), and the needs of mentally ill people, who make up a large proportion of the homeless population, are currently not being met (DoHC, 2006).

In the EU, it has been estimated that 4.1 million people per year experience homelessness (EC, 2013), with a recent rise in rates in most EU states (EC, 2013; FEANTSA, 2014). As in much of the rest of Europe, Ireland is experiencing a sharp rise in its levels of homelessness. The number of people accessing emergency homeless accommodation services in Dublin during the last quarter of 2015 was 3,464 – over a thousand more people than three years previously (DRHE, 2016).

Homeless people suffer from more mental health problems than housed populations (Holohan and Holohan, 2000). Mental illness and substance misuse are widely considered to contribute to, perpetuate and result from homelessness (Fazel *et al.*, 2014). Multiple studies have demonstrated higher rates of alcohol and substance misuse disorders, psychosis and personality disorders amongst homeless populations (Feeney, 2000; Holohan and Holohan, 2000; Fazel *et al.*, 2008). The mental health of homeless people directly impacts their morbidity and mortality – e.g., through higher rates of suicide (Fazel *et al.*, 2014). Homelessness in itself can directly affect the ability of people to access appropriate healthcare and can negatively impact adherence to treatment regimens. Non-adherence among this population has been linked to more frequent attendances at emergency departments, which can lead to the inappropriate use of health resources (Hunter *et al.*, 2014).

In many jurisdictions, severe mental illness amongst homeless populations is estimated at 25-50% (DoHC, 2006), with similar rates in Ireland (CPsychI, 2011). When taking mild to moderate levels of mental illness into account, some studies suggest higher rates: Prinsloo *et al.* (2012) found that 81.6% of residents of a Dublin homeless hostel met the criteria for a mental illness. Those who have a dual diagnosis of mental illness and substance abuse have been found to constitute 10-20% of homeless populations (Drake *et al.*, 1991). According to Holohan (1997),

significant numbers of homeless people in Dublin were dually diagnosed. Furthermore, Keogh *et al.* (2015) found that 39% of the Dublin homeless population they studied had an addiction disorder, and 53% met the criteria for having an alcohol problem.

People who are homeless are at a distinct disadvantage in terms of accessing psychiatric services in Ireland. This is largely due to the sectorization of services into a catchment-area based system, meaning that access to local services is based on one's home address, creating obvious access issues for those with no permanent address (DoHC, 2006; CPsychI, 2011). Multiple other barriers to access have been identified including "stigma, financial obstacles, lack of knowledge about state entitlements, healthcare system barriers, the competing priorities of homeless persons themselves and lack of community care" (CpsychI, 2011, p.1). The access issues created by a lack of crisis/out-of-hours psychiatry services have also been highlighted (DoHC, 2006). Stigma is high on the list of barriers (CPsychI, 2011). Stigma towards homeless people is a longstanding phenomenon; being homeless appears to carry equal stigma to that of mental hospitalization and leads to a situation where the trauma of homelessness is worsened by the burden of being stigmatized (Phelan *et al.*, 1997). In the same way as the general public, medical staff sometimes stigmatize homelessness (Wen *et al.*, 2007).

Since the 1990s, experts in the mental health of homeless people have been highlighting the important role that frontline homeless sector staff play in the mental healthcare of their clients. For example, staff in homeless hostels in the UK carry out tasks that would be more usually performed by nurses in a mental health setting, from monitoring behaviour and medications to providing psychological and social support and referral to health services (Timms and Borrell, 2001). However, most staff have little training and can be excluded from some of the information, supervision and support necessary to perform the role of primary carers. Lack of knowledge and training can have adverse effects on clients, increase staff and client vulnerability, and can lead to staff misinterpretation of various behaviours (Vamvakas and Rowe, 2001); for example, misinterpreting the paranoia and amotivation associated with schizophrenia, or attributing it to the client's 'attitude' rather than symptoms, can lead to inappropriate reactions and lack of appropriate care (Burke, 2005). As such, there is a need for mental health training for homeless sector staff (Prinsloo *et al.*, 2012).

In a 2006 report on access to health for homelessness people, Europe's federation of homeless organisations, FEANTSA (2006), emphasized the role that homeless sector workers play in providing healthcare and advice for their clients. Their report highlighted an urgent need to train service providers in mental health issues, including education on clinical features, accessing local psychiatric services, and

techniques for use in crisis situations (FEANTSA, 2006). Homeless sector workers are an underutilized human resource that act as a link with health services and have long been flagged as essential in engaging clients in treatment (Onyett, 1992). As Timms (1998) suggested, training hostel and day centre staff is a valuable option in treating those who are most difficult to reach and treat, such as those who have fallen foul of the main psychiatric system and those with dual diagnoses of substance misuse and psychiatric illness. These staff are far more likely to be successful in engaging clients, and developing trust and a therapeutic alliance, than traditional psychiatric service workers (Onyett, 1992).

There is a need to re-address the models of psychiatric and social care for homeless people with mental health issues, as recent models have failed (Fazel *et al.*, 2008). For many years, researchers have recognized that the situation homeless people find themselves in is “fundamentally at odds with the objectives of equity, quality of service and accountability which are at the core of health care policy in Ireland” (McKeown, 1999, p.3). The literature points to a need for more integrated care, combining housing interventions, addiction services and mental health services (Drake *et al.*, 1997; Fazel *et al.*, 2008). Psychiatric services, addiction services and housing services have long been separate entities with little interaction between them. However, in many cases these three issues are intertwined, and attempting to address them in isolation contributes to a cycle of social exclusion (CPsychI, 2011).

McKeown (1999) suggested that voluntary organisations have a unique and important role to play in treating homeless people with mental health issues and, as such, must invest in training and develop more specialized services, rather than the generic one-approach-fits-all homeless services. In recent years across Europe and North America, the ‘Treatment First’ model for homeless adults with mental illness has been found to be relatively ineffective and costly (O’Sullivan, 2012). This led to its replacement by the more evidence-based ‘Housing First’ model (Greenwood *et al.*, 2013). The Treatment First model dictated that clients progressed through various stages of supported housing before permanent placement once their mental health and addictions had been treated (Stergiopoulos *et al.*, 2014). Unfortunately, this ‘staircase’ model often led to stepping back down the staircase – e.g., with relapses in addiction or mental illness (O’Sullivan, 2012). The Housing First model prioritizes accommodation above all else, and separate from treatment (Tsemberis, 2010). Studies have shown that a Housing First approach results in rates of sustainment of housing of approximately 80%, with additional positive results for cost effectiveness (O’Sullivan, 2012).

It is becoming increasingly clear that more integrated approaches are required (FEANTSA, 2006; Mares and Rosenheck, 2010; Patterson *et al.*, 2012), whereby mental illness, housing and addiction are dealt with together rather than sequentially or in parallel. This may take the form of on-site person-centred holistic approaches (McKeown, 1999) or improved interagency collaboration (Rosenheck *et al.*, 2003). The current Housing First model could be adapted to achieve this by developing mechanisms to identify and address psychiatric and addiction needs early on (Stergiopoulos *et al.*, 2014). Indeed, in Ireland the ‘housing-led’ approach, a variant of the Housing First approach, is closer to a more integrated model; though housing is the first priority, this approach recognizes the need for supports in tandem with housing provision. This model does not preclude the co-delivery of housing and mental health/addiction services, but rather it prevents mental health and addiction issues from negatively impacting upon tenancies (O’Sullivan, 2012).

The Irish Context

Homeless services

A diverse range of services are provided by various homelessness agencies in Dublin. These services are largely run by voluntary and non-governmental organisations, which have developed independently over the years. In recent years services have become more co-ordinated. Over the past three decades, multiple government policies have been produced, resulting in a more cohesive national plan for homelessness (O’Sullivan, 2008). With the international transition to Housing First, Irish homelessness policy shifted towards the European Housing-led approach, as discussed above. Early moves towards this model emerged around 2008, as hinted at in the Government’s policies at the time: *A Key to the Door* (Homeless Agency, 2007) and *The Way Home* (DoEHLG, 2008) – optimistic and ambitious documents aspiring to end homelessness by 2010. A more definitive shift in government policy to a housing-led approach did not occur until 2013 with the *Programme for Government and Homelessness Policy Statement* (DoECLG, 2013).

With specific evidence-based policies now in place on homelessness and housing, Ireland is better positioned to address the issue of homelessness. Nonetheless, there is a homelessness crisis in Dublin currently. The reasons for the difficulties in realizing these policies are complex, but include: the current severe shortage of affordable rental stock in Dublin; recent difficulties in the Irish economy; personnel changes in homeless organisations (O’Sullivan, 2008); and, as suggested by some, a lack of desire to fully realise these changes in some homeless agencies (Brownlee, 2008).

Mental health services

Public adult mental health services in Ireland are primarily community based, coordinated by multidisciplinary community mental health teams (CMHTs), each responsible for patients within a given geographical catchment area. As a rule of thumb, to access catchment-area services, a patient must permanently reside in that area. In Dublin, some homeless psychiatry services are provided with an outreach component. A Vision for Change (DoHC, 2006) recognised the access issues that the catchment-area system poses for homeless people. Recommendations were made, including guidelines on the responsibilities of CMHTs for homeless patients in their area and recommendations for increased resources and longer operating hours for the homeless teams. Many of these recommendations are yet to be realized. Addiction services and psychiatric services are generally regarded as separate. Usually patients must self-refer for drug or alcohol treatment. Psychiatric services often do not accept patients whose active addiction is deemed to be the primary issue.

Study Overview

As the President of Ireland, Michael D. Higgins, a long-time advocate for homeless people, stated: “it will be crucial that the voice of those who are at the coalface in delivering the services...will be heard and will inform the policies that are chosen” (The Irish Times, 2015). There has been little research into the interaction between homelessness and mental health in Ireland, and no study has documented the experiences and training of homeless service staff in relation to mental health.

This research aimed to identify what formal or informal training homeless sector staff receive in relation to mental health and what knowledge staff have of mental health issues; and to examine the experiences of homeless sector staff of working with people with mental health issues. It also aimed to identify whether homeless sector staff believe that training in mental health issues would benefit them and what form they think this training should take.

To achieve these aims, the following research question was applied:

What training, knowledge and experience do frontline homeless sector staff in Dublin have of working with clients with mental health issues?

Methods

Ethical approval was granted by the Health Policy and Management and Centre for Global Health Research Ethics Committee at Trinity College Dublin. Permission was granted by managers at each service to recruit participants from staff working within the service. This study was conducted within an interpretivist phenomenological framework (Crotty, 1998). A qualitative approach was used to explore the sensitive topics and complex relationships at system, individual and interactional levels, which would be impossible to examine using quantitative methods (Barriball and While, 1994).

Using purposive sampling techniques (Marshall, 1996), key informants were recruited via emails sent to a number of Dublin-based homeless service organisations. Participation was voluntary, and key informants were free to withdraw at any time. The final sample consisted of five female and four male participants. Eight were frontline/project workers, one was a manager, and all were salaried employees with daily contact with homeless clients. The sample included staff from a wide selection of services provided by four different homeless organizations, including supported temporary accommodation, drop-in food and drug services, one-night-only accommodation and long-term accommodation services. Face-to-face interviews were conducted by the principal researcher (RC) in April and May 2015, and were audio-recorded with the prior written informed consent of each participant. The interview process continued until saturation was reached. The average interview time was 35 minutes.

An interview guide was developed following a review of the literature to identify major themes to be discussed, and using the principal researcher's experience of working in the field of psychiatry. The guide consisted of open-ended questions asking interviewees to relate their experiences with clients with mental health issues; their knowledge about mental health issues; their experiences of training relating to mental health and homelessness; their knowledge and understanding of the mental health services and referral processes; difficult situations experienced with clients with mental health issues and how these situations were handled; important aspects to include in a mental health training programme for homeless service staff; and suggestions on how mental health, medical and homeless services could be improved to better serve the needs of homeless clients with mental health issues.

The interview data was thematically analysed using NVivo version 10 (QSR International, Victoria, Australia). Data was interpreted using inductive coding, axial coding (Coleman and Unrau, 2011), and selective coding processes (Strauss and Corbin, 1990). Selective coding identified the most pertinent themes, based on the importance given to them by participants, the literature and their relationships to

each other. The 'core category' (Strauss and Corbin, 1990) identified during this phase was 'mental health and medical service issues', around which a high proportion of the other issues revolved, particularly the themes of 'dual diagnosis' and 'staff knowledge and training'.

Results and Discussion

Mental health and medical service issues

Issues with access to, and interactions with, various mental health/medical services emerged as the main theme among participants' responses, and there was an evident lack of connection between mental health/medical and homeless services. When discussing the difficulties of working with clients with mental health issues, the role of the mental health services in these dominated the discourse, with interpersonal difficulties with clients being secondary to interactional issues with components of the health system.

Access issues

Difficulty in accessing mental health services was a major concern for participants, who admitted to being unaware of how to access certain services, being confused about referral pathways, and finding it difficult to link a client in with psychiatric services:

It's just the main issue is referring people, trying to get people connected... it's just a huge struggle. (Participant 8)

Unclear referral pathways and confusion around where to seek care are major barriers to homeless clients receiving appropriate mental healthcare. Not knowing how to access services has been cited in the literature as the most common barrier, closely followed by financial issues, long waiting times, "confusion" and "hassle" (Rosenheck and Lam, 1997, p.388).

The configuration of psychiatric services into catchment areas poses a particular difficulty for homeless people, who, as they have no permanent address, do not have a local catchment area *per se*:

Well I know that they say you have to go back to your local area, which makes sense, but for our clients, being homeless, a lot of times they don't have a local area. (Participant 9)

Participants referred to the difficulties of linking clients in with services, and the problems this caused for those clients, which included issues with their housing:

... one of them is just free-falling, kind of, and I just can't get her in anywhere, no-one wants her, so keeping track of that and building a case for someone to take her on so that she can get, because she could live independently really well probably but she needs some support around her mental health to be able to successfully probably maintain a tenancy. (Participant 5)

Several participants referred to a 'merry-go-round' type of situation, whereby clients or referrals were passed from team to team, often ending in refusal. It seemed that, after exhausting all avenues, A&E (Accident and Emergency Department) was the only option, in both emergency and non-emergency situations:

I've also realised that it's very, very, difficult to get linked in with services, your main option is to go to A&E, which isn't ideal for everyone, a lot of people with mental health [issues] would not want to go near A&E in order to be seen. (Participant 8)

The lack of services other than A&E was particularly evident in crisis presentations, with many participants discussing how unsuitable it is for mentally unwell clients, who, in an Irish A&E, may have to spend hours waiting to be seen by a doctor:

Because there isn't really another option other than go to A&E... I hate A&E and I'm feeling in the best of my health but when you're not feeling well... it's unrealistic that they're going to stay there. (Participant 1)

Mental health issues do not confine themselves to a 9-5 working week schedule, and crises often occur late at night and at weekends, when most services are closed. This was a major concern for participants, who described having nowhere to turn to. In spite of the Irish mental health commission's best practice guidelines for care plans to include crisis planning (MHC, 2009), preferably not involving A&E, and the recommendation that that each catchment area team should provide 24-hour crisis facilities and beds in 'crisis houses' (DoHC, 2006), many mental health services do not provide a 24-hour crisis service. Even within working hours, often the only option in an emergency is to attend A&E, an environment wholly unsuitable for the treatment of mental illness.

This led to many participants strongly endorsing the need for crisis services; some mentioned a need for crisis beds, and others discussed drop-in services specific to mental health:

Back in the day, Saint... [psychiatric hospital] used to have an assessment unit, so when I worked here in the old [name of service]... if you were unwell you could just go over and you'd be seen to in about two hours, so you'd see a psychiatrist and that might be all you needed to do was to meet someone and talk... and say "you'll be alright" or maybe "you won't be alright for a little while but this will help". (Participant 1)

Medical staff treatment of clients

Another issue which seemed to affect access to care for homeless clients with mental health issues was an element of stigma from healthcare staff in relation to homelessness:

Again, you're homeless – you're not seen... And I can understand doctors and the medical carers, and I can see their side of it: it's difficult to engage with people who, I suppose the way doctors look at it, they don't really care about themselves, they're not going to take their prescribed medication, they're not going to be able to look after themselves properly in that way and in many ways that's true. (Participant 2)

Homeless people can feel stigmatized, disrespected and invisible to healthcare workers (Martins, 2008). Participants who had heard accounts from clients, and who had attended hospital with clients, felt that at times there was reduced speed and quality of care for homeless people in mainstream hospitals:

There is definitely a stigma towards homeless people coming in and... I don't know if they get the same service, I'm sure they do once they get through but there's certainly gaps and there's difficulties I think. (Participant 6)

I've heard of... not so much discrimination but... being treated differently, being asked to wait longer, I suppose it would be a type of discrimination against homeless [people] accessing A&E. (Participant 8)

Given the increasing demands on A&E departments, participants displayed understanding of the stressful job carried out by A&E staff; nonetheless, they felt that disrespectful treatment of clients was unacceptable. Homelessness stigma seemed to be prevalent in the health services, with clients being regarded as somehow at fault for their situation, not wanting to take responsibility for their own health and being subjected to longer waiting times and subpar treatment. Indeed, in studies amongst homeless people themselves, feeling unwelcome and 'dehumanized' was a barrier to accessing healthcare (Wen *et al.*, 2007) – an assertion supported by the experiences of participants in this study.

Continuity of care and communication issues

Another hurdle appeared to be a lack of communication and continuity of care once a person was discharged from hospital. Poor continuity of care following discharge from hospital was a cause for concern among interviewees. This was also highlighted in FEANTSA's 2006 report, which commented on "unacceptable discharge practices", such as "the fact that hospitals and other institutions systematically discharge people who are homeless and recovering following hospitalisation into the care of homeless services that are simply not equipped to meet their needs" (FEANTSA, 2006, p.31).

Several interviewees referred to hospitals using hostels as a “dumping ground”, with clients discharged from hospital to the hostel with no communication between the two services, leading to issues with provision of care:

This particular situation is hard because he presented self-harming, he cut himself really really badly, and we’ve never seen that before, but then he was released right away the same night... and I know beds are hard to come by but at the same time I don’t know what happened with that, like I don’t know if that consulting psychiatrist called his actual psychiatrist... so then I’m trying to race around and figure out who communicated what and so I think it would just be helpful if that was communicated back to us... (Participant 5)

Issues with follow-up on discharge were also apparent, including psychiatric services operating a ‘one-strike-and-you’re out’ system, whereby missing one appointment might lead to discharge from the service:

... basically there’s just no kind of follow-up, if you’re on a psychiatric ward and you’re released, if you miss your outpatient appointment you’re just... put back to square one so in order for her to link in with a psychiatrist then she needs to go through A&E again even though she’s already done that, she just missed one appointment. (Participant 8)

Alongside substandard discharge practices were inadequacies in communication from medical and psychiatric services, with staff in homeless services being left uninformed of a client’s diagnosis or medications. Though this is often unavoidable due to confidentiality issues, staff noted that they had experienced difficulty in contacting health professionals.

Causal link between lack of services and critical incidents

Participants drew a causal link between the aforementioned problems and the occurrence of avoidable critical incidents. Critical incidents led to loss of a bed, discharge from services, imprisonment or admission to forensic units. These outcomes often followed aggression, self-harm and criminal acts, such as arson, which participants felt would have been avoided had the client had access to services sooner. Participants felt that these incidents could have been averted if the services had been in place to assist clients, and spoke of the need to highlight this to the mental health services.

One participant detailed an incident where issues of access and continuity led to a poor outcome for a client, and highlighted the issues with access, the frustration of staff and the system failing that individual:

We... dealt with a very severe case a couple of years ago, we got this guy to the hospital, the ambulance services came in, they brought him up to hospital, we spoke to the consultant on duty that day, we described the guy... "yeah, yeah, yeah, yeah... brilliant, we'll look after him". Within an hour or so we got a phone call saying that "we were releasing this chap from care because he wasn't in our catchment area". That night the guy went and he burned down [name of public building], that drove us mad... but like I said for us the fact that we'd asked for help, he'd asked for help, that just annoyed me, regardless of whether it was in his catchment area or not, the guy was unwell and needed help, and the state or the hospital or the services or whatever you want to call it, failed us and definitely failed him, he's now in [forensic psychiatric hospital]. (Participant 2)

Frustration and powerlessness

The difficulties discussed above led to a palpable sense of frustration amongst participants, with the system in general, and with individual professionals:

What do you do or what do you advise people to do? (Interviewer)

[Laughing] Bang my head off the wall! (Participant 2)

If there was a clearer referral system or if we knew that there was a respite service that they could access or there was something they could get but we just know, no matter what we do, it's going to be a futile exercise, really. (Participant 9)

Frustration appeared to be due to several issues relating to the mental health and medical professions, including a feeling that medical services had landed issues on them:

Sometimes we have situations that are really, really, desperate and you're left with no avenue to go to, because if they rob a phone they're going to be put out, they could still go and hang themselves... and you just feel like what's the point? And I'm not saying mental health services are there to be punch-bags, but nor are we. (Participant 9)

Frustration among participants also arose from a feeling of powerlessness in the face of the system's inflexibility, and from having their opinions undervalued:

Well, most of the mental health services, apart from the [homeless psychiatry team] who actually their brief is in relation to homelessness... I find the mental health professions tend to be quite cagey, exclusive, very procedural and they don't... tend to take anyone apart from a medical professional seriously, so they would... well... the opinion of a staff member in a voluntary or non-profit organi-



sation, they wouldn't take that into account to any great extent I would find, they would say "no... the referral has to come from a doctor, really I'd need to speak to a doctor about this." (Participant 7)

Interviewees were evidently frustrated with the medical and psychiatric services as a result of the reported difficulties. There was also a marked sense of powerlessness when the opinions of homeless sector staff were disregarded. Staff had pushed for their concerns to be heard with such infrequent success that they had begun to feel that there was no point in trying.

Potential solutions

Participants proposed a number of solutions, including suggestions for crisis mental health teams and crisis beds (as discussed above). Better communication between services was also suggested, as well as placements for health professionals and students in homeless services. Many participants also recommended putting in place on-site mental health professionals:

I think there's a huge, huge opportunity if they put professional services on site, I think it's good to have... community mental health teams but if you really wanted to really resource people in homeless services you need to put professional people on-site. (Participant 6)

I think also it would be useful to have... some sort of dedicated staff member or members in these organisations with a brief around mental illness... this is such a big issue. (Participant 7)

The current trend in homeless services is a move towards a Housing First model, as opposed to the other major model of Treatment First (Padgett *et al.*, 2010). However, as apparent from this study, a more holistic, person-centred and integrated model may be more appropriate, whereby, as Participant 6 suggested, the services are "wrapped around" the individual, and housing, mental illness and addiction are addressed concurrently, coordinated by a single agency. Putting mental health professionals on-site may be the most manageable of the proposed solutions, and is in line with a more integrated model of having a single agency taking responsibility for housing, mental health and addiction (McHugo *et al.*, 2004).

Addiction and dual diagnosis

Multiple gaps in services were identified; however, the gap that most dominated the interviews was the lack of services for those with a 'dual diagnosis' (i.e., having both a mental illness and a drug or alcohol addiction). Neither the psychiatric nor medical services currently take ownership of addiction services, a longstanding issue due to the historic divisions between psychiatric and addiction services.

The theme of vicious circles arose repeatedly, with participants referring to people being trapped in homelessness – the vicious circles of homelessness and mental illness, and mental illness and addiction, combining to create circles within circles, rendering escape and recovery almost impossible.

Dual diagnosis is a major issue for homeless people (Drake and Mueser, 2000) and, as participants pointed out, it is a significant element in their daily work:

Put into the mix... drug use and alcohol, so if you have a mixture of mental illness and drug use, poly-drug use and alcohol addiction plus *highly* stressful conditions in terms of your living conditions, you're sleeping rough, you're subject to violence, all of that, so you have clients who are very, very, troubled... you would deal with these people on a daily basis. (Participant 7)

Participants frequently referred to difficulties distinguishing between mental illness and the effects of drugs and alcohol.

... definitely 50 percent plus would present with mental health issues. It is quite difficult to kind of distinguish whether it would be substance or alcohol related as well. It could be a combination of the two, or it could be brought on by substance use, or substance use could be kind of a symptom of the mental health as well. (Participant 8)

As discussed by participants, for clients with a dual diagnosis, addiction issues and mental illness are intertwined and cannot be easily isolated from one another, being referred to as a "chicken and egg situation" by two participants.

Dual diagnosis services lacking

In recent years there has been an increase in the prevalence of drug use amongst Dublin's homeless population (O'Carroll and O'Reilly, 2008). Despite the high prevalence of dual diagnosis, there is a lack of services for dually diagnosed people and these people continue to fall through the cracks (NACD, 2004). This is not a new issue; when Dublin's homeless population was surveyed in 1997, one of the main issues homeless clients themselves identified was the lack of services for individuals with co-occurring drug problems (Holohan, 1997).

Interviewees described inflexible practices in the psychiatric services, and the requirement to be “squeaky clean” (Participant 1). Every participant had experienced clients being rejected from psychiatric services due to their addiction issues:

... nobody will go there, once there is any type of drug addiction or alcohol addiction doctors are loath to get engaged with it... (Participant 2)

When asked about recommendations for mental health and homeless services, many participants responded similarly:

... joining up addiction and mental health services, I think, because a lot of it's like chicken and the egg... they can't get their addiction treated until their mental health is sorted but the mental health organisations won't... they say “oh we can't help you with this because it's been caused by your addiction”, so there's very few that I know of that actually join up the two and can treat both at the same time... it's like a carousel... (Participant 3)

Some homeless accommodation services themselves were portrayed as prescriptive in their requirements, despite evidence that stable accommodation helps with recovering from mental illness and addiction, as per the Housing First model (Tsemberis and Eisenberg, 2000):

That's another thing, like people who do mental health housing, it's like, well you want to remember to fit into a very small niche to get into one of their houses. (Participant 1)

Addiction, mental health and housing services generally do not take responsibility for issues considered outside their remit. This contrasted with an ideal holistic and person-centred model described by one participant, with mental health, addiction and housing services interconnected on site, and services tailored around the individual:

The big problem is you need housing. The best way for people to improve, and for... mental health services to work and the homeless services is housing... you can't state that enough. I mean, the 'Housing First' model would work in Dublin if it was funded appropriately and if all the supports are put in place, and that's what I'm... thinking when I'm saying put people on site, if you put someone into accommodation and support them there eventually they won't need you, so it's putting the supports around the service user. (Participant 6)

Traditionally, mental health and addiction services in Western contexts have been very separate (Minkoff and Cline, 2004). Concern regarding the effect of this fragmentation of services has been growing over the past few decades (Rosenheck *et al.*, 2003), as clinicians have begun to realize just how intersectional these two issues can be (Harrison *et al.*, 2008). It became clear during the interviews that this

was a group of clients who were triply vulnerable, due to homelessness, addiction and mental illness; yet, they had the fewest services. Minkoff and Drake (1992) even referred to homelessness as a 'third diagnosis'. It is evident that those unfortunate enough to meet these three 'diagnoses' are chronically underserved.

Accessibility of drugs in services

The high prevalence of dual diagnosis was likely compounded by the availability of drugs within the services themselves. Participants referenced cases in which clients with mental health issues developed drug problems on entering hostels due to the easy accessibility of drugs, and spoke about the contribution of drug dealing at addiction treatment centres to the continued use of illicit substances by clients.

There's a rake of drugs... you can get anything and everything here. (Participant 1)

Some participants discussed how clients without a drug problem to begin with could develop one whilst in homeless services due to a lack of appropriate housing for people with mental health issues:

Some people here will never live by themselves but they have to stay in here, pick up a few... drug habits, come out, sometimes improve their mental health, but develop massive big debts and massive big... drug habits where they didn't have before... so I think there needs to be smaller services and also there needs to be more beds for people regardless... (Participant 1)

Participants were acutely aware of the major service gap for people with dual diagnoses and many of their recommendations related to "joining up addiction and mental health services" (Participant 3), as does the extant literature (Drake *et al.*, 2001). Others suggested more collaboration between services, which is also recommended in the literature (Rosenheck *et al.*, 2003). Between the easy accessibility of drugs, the lack of services for those with a dual diagnosis and a lack of appropriate housing, participants felt that recovery for clients in these situations remained an unlikely prospect unless structural change could occur.

Staff knowledge and training

Staff knowledge, training, and training needs were extensively discussed during the interviews. A quantitative measure of staff's knowledge was not applied; however, interviewees discussed what they thought their own knowledge levels and deficits were. During the literature search, a gap around mental health training for homeless staff was noted, leading to a focus in this study on issues around training and training needs. Participants revealed a lack of any formal standardized mental health training for staff, which ties in with the paucity of literature on the subject.

Experiences of training

Participants were asked about their experiences of training since taking up employment in the homeless sector. In most services it was mandatory to attend 'TCI' (Therapeutic Crisis Intervention), a short course focusing on de-escalation techniques, not specifically directed at mental health issues but with relevance to dealing with clients with mental illness, though participants were unsure how often they were supposed to receive refresher courses.

Otherwise, training was un-standardized, with some agencies providing no training, some providing non-mandatory basic workshops, and others permitting leave to attend external workshops. Several participants had attended ASIST (Applied Suicide Intervention Skills Training), a two-day suicide first aid workshop run by the Health Service Executive, which they found useful. Some participants had experience or training relating to mental health from courses or jobs prior to entering employment in the homeless services. Otherwise, most training took place in an informal manner from colleagues.

Where training was facilitated by the organisation, participants considered it basic or unsatisfactory:

The organisation that I work for does provide optional mental health training: one-day mental health trainings for staff... very basic training, providing you with the sort of medical model of... a neurosis versus psychosis type, diagnosis of mental health... illness. (Participant 7)

Mental health training for homeless sector staff has long been suggested by experts in homeless psychiatry as a route to treating the most vulnerable and difficult to reach clients (Timms, 1998). Maslin *et al.* (2001) identified that frontline staff working with people with mental illness or dual diagnosis have high training and support needs, and homeless sector staff most certainly fit this description. Despite the clear need, and the benefits that mental health training would confer on these frontline workers, a deficit of formal or standardized mental health training was evident.

Learning on the job and from experience

Most learning took place on the job, from colleagues and from experience, resulting in fragmented knowledge and lack of staff confidence in their own abilities. Participants cobbled together their own approaches from various sources – most often experienced colleagues and peers.

To be honest with you, when I first started here I shadowed a number of experienced staff... So, I think I took a little bit from everyone, and then made my own method... (Participant 4)

Some also learned from mental health professionals, and one of the homeless psychiatry teams was singled out as being particularly helpful in providing informal training and advice.

Well I would have had a certain amount of, I would have picked up here and there, knowledge, partly through experience... and linking in with mental health services in relation to mental health and mental illness but it would have been fairly... bits and pieces picked up along the way as opposed to being systematically trained or learned. (Participant 7)

Perhaps because of this, participants reported occasional uncertainty as to whether they were taking the right approach:

I think there's a lot of stress around it, not knowing... if you're handling it properly. (Participant 5)

As a result of this unsystematic knowledge accrual, participants expressed a need for training to consolidate and reinforce their knowledge:

Like I say... it just makes you aware that you're doing quite a lot of things correctly... it's nice to hear that... you're getting affirmation about the way you're operating is maybe not a hundred percent correct but it's, it's nearly there. (Participant 4)

Knowledge, knowledge gaps and training needs

A lack of training and knowledge on mental health can lead to misinterpretation of behaviours linked to a person's mental illness and potentially inappropriate or overly strict treatment of these individuals due to a lack of understanding of their illness (Vamvakas and Rowe, 2001; Burke, 2005). This was confirmed by participants who spoke of the fear and lack of understanding of some staff. Within homeless services there appeared to be some stigma surrounding mental illness:

I think people are just really scared to make it worse and so people kind of just don't really want to be around it at all. (Participant 5)

I think there is probably stigma... whether people want to know it or not, tacit stigma amongst staff around people with mental health issues... there's definitely fear there. (Participant 6)

There was also a suggestion that lack of training and knowledge could lead to fear, stigma and avoidance of dealing with mental health issues by management and staff. For example, Participant 1 highlighted the lack of ability to connect symptoms with mental illness:

I think... we can't name it sometimes, like... someone isn't [saying] "you're lazy or unmotivated"... I'm not saying staff would call people that, but the idea of... "they're not doing anything for themselves". It's like, well there's something, obviously if you're using heroin, it's a depressant. If you're drinking every night of the week, you're going to feel depressed. So I think, linking it together. (Participant 1)

This lack of understanding sometimes also extended to management level:

The problem with some homeless services is... they don't want to take any of the risk on. I think personally because they don't understand it, and they want outside services to take on everything else. (Participant 6)

Participants commented on several areas in which they could benefit from more training, including diagnosis, recognizing signs and symptoms and medication. However, unexpectedly, referral processes surfaced as the major knowledge gap and training need:

I think what we really lack is a training on referral process, and how to actually access services. I would love to do training on it but I don't know of any that actually exists. (Participant 8)

Participant 7 also discussed basic in-service training:

I think they didn't cover... what I would have found useful would have been more coverage of how to link people into existing mental health services, the procedures for actually getting people into mental health services, legislation, all that sort of stuff – the actual practicalities I would have found quite useful as well. There wasn't so much of that. (Participant 7)

Despite poor in-service training, many participants felt that they had a reasonable knowledge of certain aspects of mental health issues acquired from ASIST training, training prior to entering homeless services, learned on their own time and from experience. However, staff expressed a desire to have more training in several domains, including medication, signs and symptoms, diagnosis and management. The sparse literature in this area points to a need for training on dual diagnosis, assessment, when to seek help, treatment and accessing resources (Maslin *et al.*, 2001). The configuration of the mental health system remained a mystery to most participants, who described a lack of clarity around the referral process, and building their own knowledge in a haphazard manner from sources such as websites, colleagues and friends, and from calling different services. This led to stress, frustration and disenchantment amongst staff.

These knowledge gaps generate inefficiency, which could be addressed via a number of approaches – for example, through inter-professional learning, an emergent tool in the social and healthcare sectors (Barr, 2005; Maddock, 2014).

Participants discussed the benefits of informal learning from services such as homeless psychiatry teams. Some interviewees suggested that doctors and students spend some time on placement or visiting homeless services to foster understanding and communication. Some such interdisciplinary learning endeavours exist, such as a mental health training module run for homeless staff by nursing students in Philadelphia (August-Brady and Adamshick, 2013). Though few other examples surfaced in the literature, this type of collaboration heralds a potential opportunity for training of both medical and homeless sector staff. As recommended by FEANTSA (2006), inter-sectoral working is paramount to realising the right to health for homeless people.

Conclusion

This study sought to identify: *What training, knowledge and experience do frontline homeless sector staff in Dublin have of working with clients with mental health issues?* Interviews with front-line homeless service workers highlighted gaps both covered in, and absent from, the literature. The main concerns highlighted were at system rather than individual level. Most apparent from responses was the lack of accessible and cohesive services for those affected by the triple vulnerabilities of homelessness, addiction and mental illness.

These findings suggest a need for a restructuring of the way mental health and homeless services operate in relation to clients with mental health issues, as these are being failed by the current system. Participants made several recommendations for how services could be improved to better meet the needs of homeless people who are mentally ill, including crisis services, on-site mental health professionals and a better outreach component to mental health teams. There is evidently a need for new approaches, which should be more person-centred.

As suggested in the literature, to tackle current service gaps, housing, mental health and addiction services ought to be integrated and co-located (FEANTSA, 2006; Mares and Rosenheck, 2010; Patterson *et al.*, 2012). Instead of narrow views of homelessness services as exclusively housing-based, a focus could be placed on developing more holistic models, with investment in mental health training for staff and hiring of mental health professionals. Similarly, mental health and addiction services should stop viewing their specialities in isolation and adopt collaborative approaches. Restructuring and aligning addiction and psychiatric services is required and is long overdue. Furthermore, the mental health services must reconsider the provision of adequate out-of-hours cover in order to move away from the current situation where the Emergency Department is the only port of call in a crisis. Both sectors need to work to improve communication between them and avail of

inter-professional learning opportunities. Links between services should be made and strengthened in order to work towards integrated services. As suggested by Frazier, “in the long term, patient-oriented, system-wide solutions will be more humane than quick fixes.” (Frazier, 1985, p.462). Evidence-based policies exist; however, they remain under-acted and under-funded. For their goals to be realized there must be governmental and non-governmental will; as one participant starkly stated:

“If [the Government] wanted to resolve homelessness, they could.” (Participant 6)

Study Limitations

This study focused on the experiences of a small group of homeless service staff in Dublin, Ireland. As such, it may help sensitise other professionals to key issues when working in this region. Although the diversity of configurations of homelessness services across different countries means that this study’s findings cannot be generalised across the European context, it is likely that the results are transferable, and can help inform policy relating to service integration, as they provide a perspective from the ‘bottom-up’, directly identifying needs as perceived by staff on the front-line of implementation.

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