The HSE National Strategic Plan to Improve the Health of People Experiencing Homelessness in Ireland (2024-2027)

HSE Social Inclusion

Foreword

In recent years, the homelessness crisis has escalated, with increased numbers of people entering homelessness and need for comprehensive interventions that meet the complex health challenges faced by people experiencing homelessness in Ireland.

This document, guided by national strategic objectives and international best practice, sets out a number of principles, priorities, and actions aimed at supporting a collaborative response to the homelessness crisis, including the delivery of planned, long-term action and integrated quality healthcare initiatives that meet the needs of the changing profile of people experiencing homelessness.

In line with the principles that underpin the work of the HSE National Social Inclusion Office (NSIO), this document outlines the importance of social determinants on the overall health and wellbeing of individuals. Every individual has a right to housing, and it is well established that suitable housing conditions are a key determinant of health. In line with the Housing for All: A New Housing Plan for Ireland (2021), the HSE will continue to work with colleagues in Local Authorities, the Department of Housing, and the Department of Health to deliver the Housing First programme, which provides housing to individuals experiencing homelessness along with intensive wrap-around and comprehensive provision of services to support individuals in their own homes and prevent homelessness and ill health. Collaborative working relationships with partners that equally seek to address social determinants of health are key to the prevention and management of the health burden in socially excluded groups.

The recent COVID-19 pandemic emphasized the positive impact that working in close collaboration with partners has on the timely delivery, accessibility, and integration of care and the prevention of secondary care utilization. Collaborative, integrated, and assertive care and case management are brought into greater focus within priorities and actions set out in this document.

This is in line with reform programs and objectives set out in the Sláintecare Action Plan (2023) and builds on learning from the pandemic, as well as international literature and best practice in the sector.

Finally, gains in this area of healthcare will only be obtained if the voices of people with lived experience of homelessness are central in service development and planning. This is a key priority for the NSIO in 2024, and we hope to reflect the importance of service user engagement in the provision of effective, person-centered, and compassionate healthcare to people experiencing homelessness, at the strategic, service, and individual levels.

Last year, we undertook an extensive public consultation to seek your feedback on this document. During this consultation process, and to ensure the voices of those directly impacted by homelessness were heard, a Service Users Advisory Group was established specifically to gather input from individuals with lived experience of homelessness. Through this initiative, participants were invited to join the advisory group to provide insights on various sections and content of the strategic plan. The aim was to ensure that key topics relevant to individuals with lived experience were comprehensively addressed and that their perspectives were accurately reflected.

We would like to sincerely thank the many stakeholders who provided input into this strategic plan.

Yours sincerely,

National Lead, Social Inclusion

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1. Introduction

The National Social Inclusion Office (NSIO) in the HSE holds a remit for promoting health and well-being, improving health outcomes, and enabling access to health services for vulnerable groups and marginalised (socially excluded) communities. As such, the NSIO seeks to contribute to the *Sláintecare Implementation Strategy & Action Plan 2021-2023* (Department of Health [DoH], 2021), aligning with its focus on reducing health inequalities under 'Reform Programme 2'; its emphasis on targeting disadvantaged communities, concerns about the impact of the social determinants of health (SDoH); and the link between poverty, socio-economic status and health outcomes in the Healthy Communities Programme. The work of the NSIO is informed by a human rights-based and person-centred approach, with comprehensive national policies and strategies to inform all developments. The improvement of health outcomes for socially excluded groups in society – including those who experience homelessness or may be at increased risk of homelessness – is a key priority. Homelessness is a growing and significant public health issue in Ireland, associated with multiple complex and chronic health conditions, complex co-morbidity, decreased life expectancy, and an increased utilisation of secondary-care services.

The Model of Care for the Health of Persons Experiencing Homelessness in Ireland (NSIO, 2022), developed under action 3.12 in Housing For All: A new Housing Plan for Ireland (Department of Housing, Local Government and Heritage [DHLGH], 2021), was utilized for internal HSE planning purposes. It has been updated following a comprehensive review of current data and literature, incorporating evidence from new service developments like Housing First (HF) and findings from the Covid-19 national homeless response. This strategic plan (2024-27) replaces The Model of Care.

This document aims to provide rationale and working modalities to deliver social inclusion and other health-related services on a formal inter-agency basis in 2024 and beyond.

The underlying philosophy of the updated strategic plan is based on the requirement to provide a comprehensive range of services to all people who are homeless, based on non-judgemental, non-selective criteria and without exception. In line with national strategic objectives and international and national evidence and best practice, a set of core principles underpins the key priorities and actions that have been set out for 2024-27 in this document.

In line with government policy, the HSE – together with local authorities – has a responsibility and commitment to provide a person-centred and coordinated response to deliver homeless services, which include the provision of appropriate health and social supports that assist the service user in maintaining a tenancy and in maintaining his/her/their optimal physical and mental health. Such intersectoral collaboration is in line with new and existing government policies, strategies and frameworks, including Housing for All: A new Housing Plan for Ireland (DHLGH, 2021). A full list of related strategies and guiding documents can be found in Appendix 2: Strategic Alignment.

2. Principles Underpinning Strategic Plan

The following principles – based on a review of evidence, government policy, and national strategic frameworks – have shown to be effective in the delivery of services to people experiencing homelessness. These principles will underpin the ongoing delivery of an effective range of healthcare services, as outlined in this strategic plan.

Housing: A Social Determinant of Health

Formal collaboration between governmental departments, local authorities, the HSE and the voluntary sector is key to delivering housing settlement and health services to people who access homelessness services and those at risk of homelessness. Access to housing and health should not be regarded as a binary choice, but, rather, a collective, intensive, wrap-around, comprehensive provision of service. It is well established that suitable housing conditions are a key social determinant of health. Collaborative delivery of housing and health supports can ensure that no person is excluded from either, and that health support are an integral component of settlement and a person's return to independent living.

Integrated and Assertive Pathways to Care

The delivery of coordinated, assertive and integrated care involves close collaboration across agencies and governmental departments – to deliver health, social care, housing and other services – ensuring continuity from the first point of contact therein. Case management, shared assessment and shared care-planning are key to achieving a holistic, integrated and assertive delivery of care and improving the health outcomes of people experiencing homelessness or those at risk of homelessness. This partnership approach must be based upon equality of status – from statutory partners and NGOs to service users as equal stakeholders – ensuring the best outcomes. Key to reducing health inequalities and ensuring the delivery of joined-up care is the ability and commitment to share data, including shared care data systems. Services should acquire a recovery-orientated system of care, with a focus on a person-centered approach, which builds on strengths and considers the impacts of the individual's personal challenges.

Evidence-Informed Care

The standardisation, enhancement and integration of existing data systems will better inform healthcare service planning and delivery. The development of a comprehensive range of services should be informed by available data and evidence regarding the specific health and social needs of people experiencing homelessness or those at risk of homelessness. Integrated data systems are invaluable in informing decision-making at the top tiers of system levels. Policymakers can use analyses based on large numbers of integrated data system records (from which Personal Identifiable Information (PII) has been removed) to understand the overlap between cases that receive services from different systems and the impact of one system's policies and programmes on the outcomes in another. This information helps government officials and the voluntary sector to improve decision-making about policies and programmes, in order to improve client outcomes and experience.

Data and evidence should further inform the development of trauma-informed approaches and other training required to meet the changing needs of people experiencing homelessness or those at risk of homelessness.

Service User Engagement and Involvement

The person must be at the centre of his/her/their care, and the incorporation of the voices of those with lived experience into service planning, development and delivery is key to effectively and compassionately addressing the health needs of this population. Service user engagement can be understood as the spectrum where health services should strive toward co-production, wherein people who use the services, and those who support them, work with professionals who design and deliver services in an equal partnership towards shared health and healthcare delivery goals. To achieve meaningful participation, it is necessary to identify methods of involvement that allow users to express themselves in ways that are understandable, deemed valid by professionals, and contribute to the collaborative process.

3. Rationale

Ireland has witnessed a surge in the number of people in homelessness since 2014. In the ten years between mid- July 2014 and January 2024, the number of people entering homelessness has risen from 3,258 to 13,531 (DHLGH, 2024). The changing profile and growth in the scale of homelessness in Ireland over recent years, as well as the complex health needs of this population, require responses that include planned, long-term action and integrated quality healthcare initiatives aimed at the resolution and prevention of homelessness and its associated health burdens.

The following evidence review, which provides a rationale for key priorities defined in the strategic plan, is based on recent housing and health data and an in-depth literature overview[1].

3.1 Service User Profile and Trends in Homelessness

Research points to an emerging need to respond to shifts in the demographic profile and nature of homelessness across Ireland and the European Union, with young people, women who experience domestic violence, families, and new migrants entering homelessness, all of whom present with diverse, unique, multiple and complex health needs (Central Statistics Office [CSO], 2016; Regioplan Policy Research, 2014; Zólyomi et al., 2021). Both single and family and child homelessness are on the rise, as well as the number of people experiencing homelessness across all age categories. In addition, there are increased reports of failed family reunification, whereby people are being referred to homelessness services, and significant numbers in direct provision and international-protection accommodation who cannot move out, as they are at risk of becoming homeless.

3.1.1 Vulnerable Populations

The homeless population is not a homogenous one, and there are certain populations that experience greater health vulnerabilities than others. Young people, members of the LGBTQI+ community and women often stay in the situations of hidden homelessness before coming into contact with homeless services (Mayock, Sheridan and Murphy, 2014; Quilty and Norris, 2020; Mayock and Sheridan, 2012). A lack of systemic data collection on sexual orientation and gender identity is making it hard to grasp the true prevalence of homelessness within the LGBTQI+ community.

Secondly, the link between homelessness and sex work has been widely documented (Ruhama, 2018; Mellor and Lowel, 2012; Tweed et al., 2021), and further research is needed to explore the health needs of populations with intersectional identities.

Those leaving state care, prisons, and psychiatric hospitals are also at an increased risk of entering homelessness (Stein, 2006; Wade and Dixon, 2006; Seymour and Costello, 2005; Cowman and Whitty, 2016). An analysis of data from the Irish Prison Service and the National Psychiatric Inpatient Reporting System (NPIRS) has shown how the number of people with no fixed abode admitted to Irish prisons (Irish Prison Service, 2021) and psychiatric units (Health Research Board [HRB], 2021) has been on the rise in recent years. Integrated care pathways, continuum of care, and early discharge planning are needed to enable an effective transition into the community and prevent an institutional circuit of homelessness. Traveller and Roma communities and other ethnic minority groups are not only at higher risk of homelessness, but they also experience a range of health problems affecting their quality of life (CSO, 2016; Grotti et al., 2018; All-Ireland Traveller Health Study Team, 2010; Pavee Point Traveller and Roma Centre & Department of Justice, 2018). A higher proportion of ethnic minorities among the homeless population shows the need for the development of services that are culturally appropriate and culturally competent, and the standardised collection of ethnic identifiers, with the goal of identifying, addressing and eliminating ethnic disparities.

1 Data from the Department of Housing, Local Government and Heritage (DHLGH) on homelessness from 2014 until January 2024 has been integrated and analysed. These figures do not include people sleeping rough, people couch-surfing, homeless people in hospitals and prisons, those in direct provision centres, or homeless households in domestic violence refuges. These people are not included in the regular monthly homeless figures, as they are not accessing emergency homeless accommodation funded through Section 10 of the Housing Act.

3.2 Healthcare Needs and Service Utilisation

Many people experiencing homelessness have multiple/ simultaneous chronic conditions – termed multi-morbidity – as well as the complex co-morbidity or tri-morbidity of physical ill health, mental ill health and substance (drug and/or alcohol) misuse. People in homelessness experience higher rates of mortality than the general population and die prematurely (Ivers and Barry, 2018). An HRB study used 2020 mortality data among people known to be homeless from closed files in the Coroners' Service, with a total of 121 premature deaths recorded (Kelleher, Kegan & Lynos, 2024). Findings demonstrated premature mortality in this cohort, high prevalence of substance use, and high prevalence of mental health and medical conditions. Another issue that the homeless population is facing is premature aging (Fazel, 2014; Ní Cheallaigh et al., 2018; Ní Cheallaigh et al., 2017). In addition to how the homeless population is aging, there is a need to enhance service supports for older people experiencing homelessness, and to design and implement end-of-life care protocols.

As people experiencing homelessness encounter barriers to accessing healthcare and the earlier onset of multimorbidity, they rely less on primary care, and instead often use the emergency department (ED) as their initial point of contact with healthcare. As a study by Ní Cheallaigh et al. (2017) demonstrated, people with experience of homelessness in Dublin have much higher rates of inpatient admissions, with longer lengths of stay and increased readmission rates, compared to the housed population, which translates to higher costs for the healthcare system.

It is crucial that people in need have access to mainstream general practitioners (GPs) and healthcare services whenever possible. By promoting this approach, individuals experiencing homelessness can receive comprehensive care that addresses both their general health needs and their unique circumstances. Specialised homeless healthcare services should play a crucial role in facilitating the transition of homeless individuals to mainstream services, instead of operating in parallel to mainstream GP services The primary focus of specialised homeless services should be on providing initial support, addressing immediate healthcare concerns, and assisting patients in navigating the healthcare system to eventually access mainstream services. This integrated approach ensures continuity of care and helps individuals experiencing homelessness to access the full range of healthcare services available to the general population, ultimately promoting their overall health and well-being. It is important to note however, there will be a cohort of people entrenched in long-term homelessness who will need specialised homeless primary care services.

Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple interacting risk factors for poor health, such as stigma, discrimination, poverty, violence, and complex trauma. It recognises the increased need for healthcare in socially excluded people and the need for integration between health and social services to provide person-centred, coordinated care. Within the context of homelessness, the Homeless Hospital Discharge Program of work developed in Dublin region has a dual focus, emphasizing both acute care and the critical role of community services in a holistic care continuum for individuals experiencing homelessness: Within this program, an Inclusion Health Service aims to redesign health services to create wrap-around health and social care services to meet the needs of those most socially excluded, with the most outstanding health issues but who face significant obstacles in accessing healthcare through traditional approaches. This comprehensive approach not only addresses the immediate healthcare needs of people experiencing homelessness but also underscores the pivotal role of community services in delivering ongoing support and interventions to the homeless population.

Integrated care and case management services in the community are essential for addressing the multifaceted needs of people in homelessness. By combining health and social services, these programs offer tailored support, allowing individuals to access vital services like healthcare, housing assistance, and addiction treatments, enhancing care coordination.

Recent evaluation of the Dublin Hospital Homeless Discharge Protocol and Inclusion Health Services has highlighted the program's success and its positive impact on the quality of care for patients experiencing homelessness (Foley, 2023). Similarly, findings from the evaluation of a pilot Integrated Care and Case Management service for homeless individuals in Dublin indicate that the service has achieved its goals and is deemed essential by all stakeholders (Tieran, 2024).

3.2.1 Mental Health, Dual Diagnosis, and Addiction

Persons experiencing homelessness have a higher number of mental health issues than the general population (CSO, 2016). Data from the HSE's National Office for Suicide Prevention (NOSP) shows that 2% of people who died by probable suicide from 2015 to 2018 were identified as being homeless at the time of death – this includes sleeping rough and staying in hostels or supported accommodation (Cox, Munnelly, Rochford and Kavalidou, 2022). The National Self-Harm Registry has observed a yearly increase in the proportion of presentations to hospitals as a result of self-harm by persons experiencing homelessness, at 7.5% of all hospital self-harm presentations in 2020 (Joyce et al., 2022).

Especially vulnerable are people with dual diagnosis (co- morbid disorders due to substance use and/ or addictive behaviours, along with the presence of a mental disorder). The National Institute for Health and Care Excellence (NICE) guidelines outline a set of recommendations on integrated health and social care for people experiencing homelessness. According to the 2022 guidelines, the eligibility criteria should not exclude from services people experiencing homelessness who have co-morbid mental health and substance misuse issues.

While not all individuals experiencing homelessness use substances, O'Reilly et al. (2015) estimated that 80% of people experiencing homelessness in Dublin had a history of past or current drug use. In addition, there is an intersection between homelessness and high-risk drug use among people experiencing chronic and episodic (recurrent) homelessness (European Monitoring Centre for Drugs and Drug Addiction [EMCDDA], 2022). The foundational principles for effective addiction services for individuals experiencing homelessness typically revolve around ensuring stable housing, implementing harm reduction measures, and employing integrated approaches. Stable housing is recognized as a crucial element for both treatment success and social integration, as releasing individuals from treatment into homelessness or providing treatment without housing can exacerbate existing challenges. Delivering harm reduction services to this demographic is most effective when offered through easily accessible, low-threshold services that are responsive to clients' needs. Integrated strategies go beyond singular interventions by establishing interconnected support networks that link various services, such as housing, addiction treatment, and psychosocial support, tailored to each client's specific requirements (EMCDDA, 2022). Additionally, recent evidence review exploring international evidence for responding to substance use among people who are homeless, concluded that service integration and flexibility in service delivery are key to meeting this group's needs (Miler et al., 2021). As drug markets evolve, it becomes increasingly vital to monitor substance use trends and develop appropriate responses, particularly among homeless populations. The landscape of drug use is shifting, marked by the emergence of New Psychoactive Substances and a rising number of individuals seeking support for crack cocaine use.

It is important to note that cross-sectional medical research often captures those experiencing long-term homelessness. Although the focus of this strategic plan is primarily on those with more complex health needs, as a consequence of the research design, the majority of adults who experienced a stay in emergency accommodation are not captured in cross-sectional surveys. For this group, the primary reason for experiencing a stay in emergency accommodation was an 'inadequate supply of affordable housing coupled with a "shock" (economic or personal, such as the loss of employment or break up of a relationship)' (O'Sullivan, Pleace, Busch-Geertsema and Hrast, 2020, p. 133).

In order to support the aforementioned individuals, including rough sleepers, assertive outreach has been shown to be effective. A high number of people experiencing homelessness with mental health problems and substance misuse issues calls for further expansion of the case management approach across homeless services, an implementation of integrated strategies, harm reduction programmes, and stable housing.

3.2.2 Social Determinants of Health (SDoH)

The social determinants of health (SDoH) are the non-medical factors that influence health outcomes, the 'conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life' (World Health Organisation [WHO], 2023). Homelessness is a risk factor for poor health. Homelessness is also a consequence of accumulated disadvantage or adverse social and economic conditions. People experiencing homelessness face higher levels of poverty and unemployment and lower levels of education (CSO, 2016).

Care providers for people experiencing homelessness should champion three priorities: delivering trauma-informed and person-centred care, linking persons to comprehensive primary care, and engaging interdisciplinary community-based services. Traditional healthcare must be combined with efforts to address social determinants of health through culturally appropriate services, including housing provision, case management and harm reduction (Munthe-Kaas, Berg and Blaasvær, 2018; Luchenski et al., 2018).

3.3 Summary of Data from New Service Developments

3.3.1 National Housing First Programme

Housing First (HF) is an evidence-based, recovery oriented approach to ending homelessness that centres on housing individuals with complex needs who are experiencing long-term homelessness. HF participants are supported through individualised and client driven supports delivered by case managers and other professionals. A recent national evaluation of the HF programme demonstrated how, across Ireland, it is housing members of the target population, keeping them housed, and supporting them on their journeys to recovery and well-being (Greenwood et al., 2021). In addition, findings from HF Action Research (Cahill, 2021) – identifying strategies leading to the individual and system reform level for the HF national programme – will be further incorporated within this strategic plan, once the research is published.

3.3.2 Covid-19 Pandemic Homeless Response

The COVID-19 pandemic highlighted the importance of housing as a social determinant of health. People experiencing homelessness were at increased risk of:

a) acquiring COVID-19 infection, due to lack of safe housing and conditions in congregate living settings such as homeless shelters or drop-in facilities, i.e. shared living spaces, overcrowding, difficulty adhering to public health measures (e.g. physical distancing, isolation or quarantine), and high population turnover
b) delayed detection of illness during the pandemic, as a result of limited access to healthcare
c) poor clinical outcomes if they develop COVID-19, due to high prevalence of underlying chronic health conditions/ medical co-morbidities, and premature aging
d) other harms, such as those related to unsafe substance use and intimate partner violence, due to closure of or limited access to regular support services.

In order to curb the spread of Covid-19 infections among people experiencing homelessness, during the pandemic, the HSE NSIO – in collaboration with the Dublin Region Homeless Executive (DRHE), other local authorities and voluntary organisations – put preventative measures in place. As a result of those measures, Covid-19 infections and the death toll among the homeless population remained low.

Key components that resulted in the low mortality and Covid-19 infection rates were a well-coordinated government response and joint working, alongside housing provision and the expansion of harm reduction and case management services. Preventative measures such as hygiene, social distancing, self-isolation and shielding were seen as key to reducing the spread of the virus but challenging to implement in congregate homeless settings. Pandemic protocols and guidance were created by the HSE Social Inclusion, and mitigation strategies included: individual prevention (hygiene and social distancing); triage and testing – both inreach and outreach services; restrictions on visitors to homeless accommodation; special provision for people who use drugs or are on drug maintenance programs (people were fast tracked onto methadone programmes and methadone was delivered to those who were in isolation or shielding), and a decrease in density in existing emergency hostels with the provision of dedicated accommodation for self-isolation/quarantine (Lima, 2021; O'Carroll, Duffin and Collins, 2021;. Housing Ireland Magazine, 2023).

Study of the homeless service user experience during Covid-19 pandemic further outlined the need for improved access to mental health supports, stable, safe and private accommodation, access to key workers/case managers and the need for better care coordination. Of note is that less than 60% of study participants reported that they had an up-to-date care plan or key worker/case manager (NSIO, 2020).

4. Programme Areas

The following ten areas have been identified as priorities for the development of the national homelessness programme, based on strategic priorities and the evidence and rationale provided earlier on in this document.

1. Prevention and Early Intervention
2. Integrated Care and Case Management
3. Assertive Outreach Supports
4. Housing First (HF)
5. Mental Health and Addiction Supports
6. Addressing the Needs of Specific Populations
7. Research and Data
8. Service User or Peer Engagement
9. Capacity-Building
10. Collaborative working with Public Health

5. Priority Areas and Actions

PRIORITY AREA 1:
Prevention and Early Intervention

In the context of homelessness, prevention and early intervention encompass strategies intended to identify and address a problem or condition at an early stage. Certain populations are especially vulnerable in the transition from institutions to the community. Thus, systems prevention is crucial, in order to stop the flow of individuals in care of mental health services, child protection services, and correctional facilities in the transition from institutions to the community. Domestic, sexual and gender-based violence (DSGBV) has been recognised as a significant determinant of homelessness. Although DSGBV can affect all genders, women are especially vulnerable to it. DSGBV is both an important driver of human trafficking and a tool for manipulating and controlling victims across all forms of trafficking.

Early intervention strategies are designed to work quickly, to support individuals to exit homelessness at an early juncture, along with timely access to health services. The elements of effective early intervention include health assessment, case management, and emergency accommodation diversion strategies, such as HF.

Further to this, the longer that people are homeless, the worse their health problems become, making it more difficult and expensive to stably house them. To prevent people from becoming entrenched in long-term homelessness, it is necessary to develop early intervention strategies for people new to rough sleeping.

Reference	Action	Partners	Timeline
1.1	Support and deliver health actions within the *Housing for All* policy, in line with a social-determinants of health (SDoH) approach	HSE, DoH	Ongoing
1.2	Provide targeted interventions to support pathways into care (the process involved in managing a clinical condition) for those most at risk of homelessness, including those leaving different types of institutions (including Actions 2.4 and 8.3)	HSE, DHLGH, LAs, DoJ, Irish Prison Service, Probation Service, NGOs	Ongoing
1.3	Continue implementation and monitoring of the Homeless Hospital Discharge programme, to support the prevention of hospital readmission and the use of secondary care services (including Action 2.4)	HSE, NGOs	Ongoing
1.4	Provide support for children and pregnant service users in paediatric and maternity hospitals, as part of the Homeless Hospital Discharge pilot programme	HSE	Ongoing
1.5	Work in partnership with other governmental departments and agencies, including the Department of Housing, Local Government and Heritage (DHLGH), the Department of Children, Equality, Disability, Integration and Youth (DCEDIY), the Department of Education (DoE), the Department of Justice (DoJ) and Tusla, to further enhance HSE responses to those at risk of homelessness and resulting health conditions, including children and families at risk of homelessness and young people who have care experience, victims of domestic, sexual and gender-based violence, migrants and ethnically diverse populations, and people with disabilities	HSE, DHLGH, DCEDIY, DoE, DoJ, Irish Prison Service, Probation Service, Tusla, NGOs	Ongoing
1.6	Establish links between this strategic plan and the *Human-Trafficking Action Plan*	HSE, DCEDIY, DoJ	Q1 2025
1.7	Support the development of preventative initiatives and multi-agency work targeting premature deaths among people experiencing homelessness, including drug related deaths and deaths by suicide	HSE, DHLGH, LAs, DoJ, Irish Prison Service, Probation Service, NGOs	Ongoing
1.8	Support the development of social-inclusion indicators within hospital data systems, including data on those experiencing hidden homelessness, in order to utilise the potential of the health system to be one of the key actors in homelessness prevention (including Action 7.1)	HSE	Q3 2025
1.9	In collaboration with key partners, including HSE Health and Wellbeing and NGOs, support the implementation of interventions to reduce tobacco use in people experiencing homelessness	HSE, NGOs	Q2 2024

PRIORITY AREA 2:
Integrated Care and Case Management

At its core, integrated care and case management is an approach aiming to overcome care fragmentations, especially where this is leading to an adverse impact on people's care experiences and care outcomes. Integrated care may be best suited to people with medically complex or long-term care needs. People experiencing homelessness are much more likely to have multiple complex disorders that include chronic somatic conditions, coupled with mental health issues and/or substance misuse and tobacco use. Traditional models of care often rely on a system of referrals with multiple providers that can be confusing, especially for a patient group that is less able than others to navigate a complex system and has competing priorities for daily needs. In order to improve the quality and safety of care services for the homeless population, there is a strong need for ongoing and co-productive partnerships and the development of integrated care pathways. As identified by Miler et al., (2021), service integration and flexibility in service delivery are key to meeting the needs of people experiencing homelessness who use substances.

Reference	Action	Partners	Timeline
2.1	Roll out the joint Homeless and Addiction Integrated Assessment and Care Planning tool and training programme for homeless and addiction services on a national basis, supported by HSELanD e-learning training, 'Using the National Drug Rehabilitation Framework' and the 'Competency Framework for Addiction Services and Homeless Services'	HSE	Q4 2024
2.2	Review and enhance multidisciplinary primary care services for people experiencing homelessness, including in-reach primary care services, and enhance partnerships with appropriate services to support access to appropriate health and social services and create opportunities for positive outcomes	HSE, NGOs	Q1 2026
2.3	Develop a single integrated homeless case management team for Dublin and enhance homeless action teams outside of Dublin that will provide integrated individual assessment, case management, care-planning and service coordination	HSE	Ongoing
2.4	Continue implementation of the Homeless Hospital Discharge programme, commenced as a two-year pilot in 2020, including a hospital discharge protocol through hospital-based specialist homeless multidisciplinary teams in St. James's Hospital and the Mater Misericordiae University Hospital, and paediatric and maternity hospitals in Dublin. This will ensure appropriate access and continuity of care for persons experiencing homelessness leaving hospital, in partnership with local authorities and community service providers	HSE, LAs, NGOs	Ongoing
2.5	Based on the evaluation of Homeless Hospital Discharge programme in Dublin region, support scaling up, delivery and design of the programme and programme elements nationally in order to reduce barriers to access and engagement with health and social care for people experiencing homelessness	HSE	Q4 2025
2.6	Conduct a needs assessment and gap analysis in relation to the development of a shared IT case management system, to allow for joint care-planning, inter-agency working, and a better understanding of system-level operations and the effectiveness and efficiency of current resources in addressing the comprehensive needs of individuals experiencing homelessness	HSE, DoJ, Irish Prison Service, Probation Service, NGOs	Q1 2025

PRIORITY AREA 3:
Assertive Outreach Supports

Outreach can take various forms, such as meeting a person at a service or visiting them on the streets. The common element of all forms of outreach work is to actively approach clients with the intention of offering supports related to service provision and/or to establish engagement. A consistent or persistent approach (or assertive approach) – when engaging with people who sleep rough – supports the process of engagement by establishing a positive rapport and engagement between the outreach worker and client. The HSE currently provides outreach in the form of street outreach and engagement services, peripatetic outreach, a needle exchange programme, referrals to services, and other harm reduction outreach services.

Reference	Action	Partners	Timeline
3.1	Review and enhance current models of providing assertive and mobile outreach supports (particularly for people sleeping rough), to ensure rapid, proactive responses, the involvement of peers, and timely access to services and supports at the first point of contact (to be informed by the research project identified in Action 7.5)	HSE, LAs	Q3 2025
3.2	Support the review and implementation of a national assertive street outreach guide	HSE, Housing Agency	Ongoing

PRIORITY AREA 4:
Housing First (HF)

HF provides a comprehensive and holistic approach to addressing homelessness for people experiencing mental, physical, addiction, social, behavioural and/or other challenges, as well as long-term homelessness, including rough sleeping. A central pillar of the HF philosophy is the client's choice, focus on recovery, and access to permanent housing. The HF programme has proven successful in housing individuals prone to continuous instability due to their complex needs, as well as supporting them on their journeys to recovery and well-being (Greenwood et al., 2021). HF Action Research (Cahill, 2021), once published, will further inform key aspects of effective strategies, to support the development of individual and systems reform across the programme. HF serves as an example of an integrated strategy, wherein different stakeholders – including the DoH, HSE, DHLGH, NGOs and approved housing bodies – work together to support individuals with long histories of homelessness and complex support needs.

Reference	Action	Partners	Timeline
4.1	Continued provision of wrap-around supports for people experiencing homelessness with complex and multiple needs, as part of an integrated housing and health policy response, in line with the *Housing First National Implementation Plan 2022 - 2026*	HSE, DoH, NGOs	Ongoing
4.2	Support the expansion of targets in line with a revised implementation plan	HSE, DHLGH	Ongoing
4.3	Develop a national health-monitoring framework for Housing First and standardise programme eligibility assessment	HSE, Housing Agency, NGOs	Q2 2025

PRIORITY AREA 5:
Mental Health and Addiction Supports

People experiencing homelessness have disproportionately high rates of untreated mental health problems and are therefore particularly vulnerable. Rates of traumatic experiences among the homeless population are high, oftentimes across both childhood and adolescence and as a consequence of being unstably housed or homeless. In addition, this cohort experiences higher rates of mental health issues than the general population (CSO, 2016). Data from the NPIRS system has been integrated and analysed, showing how the number of people experiencing homelessness admitted to psychiatric hospitals and units has been on the rise over the past few years (Health Research Board, 2021). Considering the evidence, there is a need for increased mental health supports for the homeless population, both on an in-reach and outreach basis.

Dual diagnosis – co-morbid disorders due to substance misuse and/or addictive behaviours – along with the presence of a mental health disorder – is often underdiagnosed and poorly treated throughout the world, although it is highly prevalent in people suffering from mental illness and among those experiencing homelessness (Fantuzzi and Mezzina, 2020; Schütz et al., 2019). For that reason, there is a need to improve collaboration between mental health and addiction services, as well as the provision of training relevant to dual diagnosis, for service providers.

While not all members of the homeless population use substances, the rates of substance misuse are disproportionately high among those experiencing homelessness (O'Reilly et al., 2015). People who are homeless and engage in substance misuse have many issues, one of which is difficulty obtaining and maintaining employment and housing. The proportion of those who had become homeless primarily as a result of substance misuse increased from 23.8% in 1997 to 37.9% in 2013 (Glynn, 2016). In order to meet the rising need for addiction supports, there is a call for an increased level of a wide variety of addiction services, case management, and a harm reduction approach. In addition, the drugs market should be constantly monitored to prepare for and address the dangers of New Psychoactive Substances entering the market, as well as the increased number of people experiencing homelessness seeking support for crack cocaine use.

Reference	Action	Partners	Timeline
5.1	Improve access to mental health services for the homeless population, in line with the *Sharing the Vision: A Mental Health Policy for Everyone* strategy, including a stepped model of mental health care in Dublin, in collaboration with mental health services	HSE, DoH	Ongoing
5.2	Review the availability of mental health supports for young people in emergency accommodation and implement any recommendations identified in the new *Housing for All Youth Homelessness Strategy 2023-2025*	HSE	Q1 2024
5.3	Implement health actions for people who are homeless and in addiction, as identified as priorities in *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025*, in order to provide the most appropriate primary care and specialist addiction / mental health services for people experiencing homeless-ness. These include actions: 2.1.25, 2.1.27, 2.1.14	HSE, DoH	Ongoing
5.4	Support action in the Strategic Action Plan for the Nation-al Drugs Strategy 2023-2024 to develop harm reduction responses and integrated care pathways for high-risk drug users, including Supervised Injection Facilities (SIF) and Homeless Health Addiction Care Facility (HHACF)	HSE, DoH	Ongoing
5.5	Strengthen preparedness for drug overdoses in light of the emergence of new synthetic drugs and increase availability and training in naloxone	HSE	Ongoing

PRIORITY AREA 6:
Addressing the Needs of Specific Populations

There are specific populations within homelessness who are prone to continued instability. These are individuals in the institutional circuit of homelessness, defined by 'sequential stints in a series of institutions in place of a stable living situation' (Metraux and Culhane, 2006, p. 505). Especially vulnerable are individuals with a history of being admitted to psychiatric units and those with the experience of State care and incarceration. Further to this, homelessness is an intersectional phenomenon, with certain populations at higher risk of homelessness, such as members of the LGBTQI+ community, migrants, sex workers, those experiencing DSGBV, victims of trafficking, and ethnic minorities. If services are to address the support needs of the homeless population, there is a need to recognise how homelessness intersects with forms of exclusion that unevenly impact certain groups over others. Their different experiences with homelessness will affect what services and types of housing they need.

Reference	Action	Partners	Timeline
6.1	Improve the understanding of health and healthcare needs for specific groups, including but not limited to: women, victims of domestic, sexual and gender-based violence, victims of trafficking, young people, families and children, migrants (including undocumented migrants and International Protection applicants), the Traveller, Roma and LGBTQI+ communities, and people with disabilities who are in homelessness or at risk of homelessness	HSE, NGOs	Ongoing
6.2	As outlined in Action 6.1, based on research findings and recommendations, targeted interventions will be developed to support identified populations with specific needs	HSE	Ongoing

PRIORITY AREA 7:
Research and Data

In the context of homeless services, 'data' usually refers to information about people experiencing homelessness that is collected by the emergency accommodation system and other related agencies. However, this data does not necessarily provide insight into the predictive factors that contribute to homelessness, such as interactions with the justice system, and/or unmet health support needs. Socially excluded groups are often invisible in national datasets. Standardised data collection is necessary to improve planning, inform strategic decision-making, and measure outcomes of interventions. More work is necessary nationally, to identify measurable outcomes and indicators and to develop consistent data collection and reporting systems, to ensure that data is reliable, accurate, and comparable among agencies and within the health service. The programmes that people access, the way that they move between them, and the length of time that they stay in each one all have repercussions for other parts of the system. When the relationships between these interventions are well understood, a community can 'right-size' each component to address people's actual needs and preferences, achieving an efficient and effective allocation of resources.

Reference	Action	Partners	Timeline
7.1	Advocate for the integration, collection and collation of a standardised ethnic identifier, indicators for housing status, and other relevant indicators (equity stratifiers) into national and local data systems, to better understand the specific needs of vulnerable populations who are homeless or at risk of homelessness. Promote the uptake of ethnic equality monitoring (EEM) e-learning modules on www.hseland.ie to staff members of the HSE and HSE-funded agencies	HSE	Ongoing
7.2	Promote the development of an integrated data governance framework within the HSE	HSE	Q2 2027
7.3	Support the development and integration of key health indicators into PASS and promote data-sharing agreements between health, housing, and other voluntary agencies delivering services to people experiencing homelessness	HSE, DHLGH, LAs, NGOs	Q1 2026
7.4	Support the implementation of recommendations stemming from the research project 'Service Involvement in Health and Social Care for Lived Experience Populations Facing Inequalities and Social Exclusion - Towards an Inclusive and Effective Public and Patient Engagement Strategy,' to inform the Service User Engagement Framework (see Action 8.1)	HSE	Ongoing
7.5	Gain insight into the health needs of individuals sleeping rough, in order to develop a comprehensive understanding of their healthcare requirements and pathways to care	HSE	Q3 2025
7.6	Examine the intersection between sex workers and homelessness, in order to identify their health support needs and the best pathways to address those needs	HSE	Q3 2024
7.7	Examine the reasons for hospital admissions, ED attendance and ambulance call-outs, to inform improved treatment coordination and continuity of care (including Action 2.4)	HSE	Q3 2025
7.8	Establish a forum for homeless service providers, peers, and other key stakeholders, in order to identify gaps in the provision of health services to people experiencing homelessness, and to identify priority areas within evidence- based care and homeless health	HSE, NGOs, Service Users	Q3 2024
7.9	Determine the need for, and current availability of, long-term supported accommodation for people experiencing homelessness who would not be able to live independently, due to problems like addiction or mental illness	HSE, LAs, NGOs	Q1 2025

PRIORITY AREA 8:
Service User or Peer Engagement

Service user or peer engagement can be defined as the involvement of people who use services (or may use services) in the design and/or the decision-making processes affecting those services. There has been a growing focus on involving individuals with firsthand experience in shaping, implementing, and overseeing health and social care services, both within Ireland and globally. However, a key challenge lies in ensuring that this involvement encompasses individuals and groups who often face significant obstacles and disparities in accessing care, and whose voices are typically marginalized within service settings. Participation can be particularly empowering for groups whose opinions may all too often be sidelined, such as people experiencing homelessness.

Involving individuals with lived experience of homelessness in the design and production of services yields the development of person-centered services that are more attuned to the unique needs and realities of those experiencing homelessness. By actively engaging individuals who have directly faced homelessness, service providers gain invaluable insights into the challenges, preferences, and priorities of this population. Moreover, involving individuals with lived experience empowers them to play an active role in shaping the services intended to support them, thereby promoting a sense of ownership, dignity, and empowerment within the homeless population. As a result, person-centered services emerge that are not only more responsive and effective but also more respectful of the lived experiences and aspirations of those they seek to serve.

Although there has been progress with the involvement of those with lived experiences of homelessness into service delivery, there is a need to further integrate the shared expertise of the professionals who work in the services and the people who have experience of using them. When services are co-produced, they are more successful in matching what the client needs, as opposed to making assumptions about it. Meaningful service user or peer involvement should involve power-sharing and allow all participants to express their views and work together for service improvements.

Exploring service users involvement in health and social care for populations with lived experience of social exclusion, Carrol et al. (2023) identified varying levels of service involvement among different populations, including those experiencing homelessness. While some groups like mental health service users and the Traveller community have well-established involvement practices, others such as migrant and minority ethnic communities and the homeless are in earlier stages of involvement. Challenges like leadership and commitment, implementation and action, population capacities, trust and representation and stigma and discrimination hinder effective involvement. Addressing these challenges is crucial to ensure the voices of marginalized populations, particularly people experiencing homelessness, are heard and valued in service design and delivery. Recommendations from the study will directly contribute to the development of a HSE service user engagement implementation framework.

Reference	Action	Partners	Timeline
8.1	Support the development of a service user engagement implementation framework, in line with the *HSE Patient and Public Partnership Strategy 2019-2023*, the *HSE Patient and Public Engagement Framework* and the Department of Health's *Partner Voices* policy. This will provide additional guidance on engaging service users, incorporating the lived experience of social inclusion groups (including people experiencing homelessness) into service planning and delivery.	HSE	Q2 2025
8.2	Support the integration of lived experience into the ongoing development of the national Housing First programme, including provision and support for paid peer specialists (often called 'Experts by Experience')	HSE, Housing Agency, NGOs	Q1 2025
8.3	Support the development of peer-led programmes, including the Homeless Health Peer Advocacy programme, which supports referrals and linkages into community services and/or supports for those leaving hospital	HSE, NGOs	Ongoing

PRIORITY AREA 9:
Capacity-Building

Capacity-building is an ongoing process to strengthen the ability of individuals, agencies, networks, and the broader community to develop a meaningful and sustainable response to homelessness. The provision of adequate training for all agencies and service providers that come into contact with someone experiencing homelessness or at risk of homelessness is necessary, to ensure an adequate and timely response to multiple and complex health and social needs. Vital training (provided in collaboration with key partners) includes but is not limited to: trauma-informed practice and care, harm reduction training programmes, suicide prevention and risk assessment, and cultural competency training.

Reference	Action	Partners	Timeline
9.1	Develop, deliver and/or promote health-related training programmes for health, social care, and homeless service staff members, in collaboration with training partners (e.g. housing, mental health, NOSP). These include but are not limited to: • trauma-informed care and practice; • relevant substance misuse training, including harm reduction, naloxone, SAOR Screening and Brief Intervention, and Hidden Harm; • dual-diagnosis training; • suicide prevention gatekeeper training and post-intervention training; • anti-human-trafficking training; • domestic, sexual and gender-based violence training; • ethnic equality monitoring (EEM); • LGBTQI+ training; • cultural competency training; • person-centred care; • integrated assessment and care planning; • key working and case management/referral pathways; • self-care for members of support staff; • combatting stigma and discrimination, to improve access to mainstream health services; and • the provision of palliative care to (older) homeless people and addressing their specific needs.	HSE, NGOs	Ongoing
9.2	Design and deliver training sessions for the providers of homeless services, to ensure that they have the knowledge base to provide support and relevant information to disabled people (as identified in the new *Housing for All Youth Homelessness Strategy 2023-2025*)	HSE	Q4 2024

PRIORITY ACTION 10:
Collaborative working with Public Health

People in homelessness are at higher risk and acquisition of, and poor clinical outcomes from, health protection hazards, such as infectious and vaccine-preventable diseases, such as hepatitis C, HIV and tuberculosis. Early identification of risk factors for, and diagnosis of, communicable diseases can improve individual (clinical) and population-level (reduce transmission) health outcomes.

Individuals experiencing homelessness require systemic changes and access to comprehensive services to safeguard their health. This entails not only tackling the fundamental factors contributing to housing insecurity, such as economic disparities, social inequalities, limited educational opportunities, and safety concerns, but also acknowledging that prolonged periods of homelessness and inconsistent access to medical services exacerbate health deterioration and diminish overall well-being.

Public Health plays a crucial role in addressing homelessness by focusing on several key areas. Firstly, efforts are made to improve access to comprehensive healthcare services, including among else primary care, infectious disease treatment and chronic disease management. Secondly, Public Health interventions aim to prevent communicable diseases among people experiencing homelessness. By collaborating with homeless service organizations, Public Health aims to ensure safe accommodation and promote access to housing. Finally, Public Health research advocates for resource allocation towards increasing the availability of safe, sustainable, affordable housing to prevent homelessness and addresses upstream social determinants such as poverty and ethnic disparities to improve health outcomes.

The Covid-19 pandemic has had a profound impact on responses to homelessness. Homelessness has been identified as a public health emergency, and additional homelessness interventions have been set in place. A coordinated response, joint working, and good inter-agency collaboration have resulted in a low number of Covid-19 infections and mortality rates among those experiencing homelessness. There is a need to continue the efforts achieved during the pandemic, and to ensure that Covid-19 and vaccine-preventable disease rates remain low.

The Health Service Executive Health Protection Strategy 2022-2027 (HSE, 2022) aims to provide strategic direction to HSE Public Health on the prevention, early identification, preparedness and response to threats from all health protection hazards (infectious diseases and environmental), working in collaboration with key partners. Within the Health Protection Strategy, objective six, on inequities, identifies the population risk of infectious diseases and vaccine-preventable diseases based on the social determinants of health, and identifies that some groups require intensive, innovative and tailored approaches to ensure that their health protection needs are met.

Reference	Action	Partners	Timeline
10.1	Promote uptake of flu and Covid-19 vaccination among homeless service users and staff in identified risk groups (as per National Immunisation Advisory Committee (NIAC guidance)	HSE, Pharmacies, GPs	Ongoing
10.2	Promote uptake of vaccinations for Vaccine-Preventable Diseases (VPD) among homeless service users, including Primary Childhood Immunisations (PCI) among homeless families, and catch-up PCI according to the Irish schedule for homeless migrants	HSE, G4Ps, NGOs	Ongoing
10.3	Promote uptake of National Screening Service (NSS) programmes among homeless service users, e.g. Cervical Check, Breast Check etc.	HSE	Ongoing
10.4	Work with HSE colleagues to develop targeted approaches to screening for infectious diseases more prevalent in this population, including HIV, hepatitis B, hepatitis C, and tuberculosis	HSE, NGOs	Ongoing

6. Outcomes Framework

An outcomes framework is a conceptual tool, and not an end in itself. It allows for a comprehensive identification of indicators and targets, and acts as a systematic approach to tracking and reporting data.

While, in some instances, there are already existing indicators and targets on a national level, in other instances, these will be developed in partnership with other key stakeholders. Data-sharing and collaboration will be crucial in this aspect, to support an effective service delivery to people experiencing homelessness.

There are four goals that form the core around which the other domains are conceptualised and operationalised, as follows:

- *Goal 1 – Strengthening the prevention of homelessness and chronic health conditions:* Prevention and Housing First (HF);
- *Goal 2 – To improve healthcare delivered to people experiencing homelessness by enhancing integrated care pathways and a continuum of care:* Integrated care and case management and service user involvement;
- *Goal 3 – Enhanced access to health services and provision of the right support at the right time for those who become homeless:* Enhanced access to health services and mental health and addiction supports; and
- *Goal 4 – Progress an evidence-based practice in order to develop targeted, evidence-based initiatives tailored to the support needs of people experiencing homelessness:* Research and an increased understanding of the health and support needs of specific populations.

Each domain is characterised by a specific set of indicators. The outcomes framework will be subject to a defined periodic review and revision process, as information systems change or develop. Indicators may be subjected to a prioritisation process on the basis of EU requirements, statutory requirements, and/or policy priorities.

Goal 1 – Strengthening the prevention of homelessness and chronic health conditions

Homelessness and its associated poverty have life course implications for physical and mental health. Unstable living conditions can impact on the development of health issues such as depression, alcohol dependency, or other substance use disorders, which are made worse in such difficult situations. For that reason, stable housing not only provides privacy and safety, it is also a place to rest and recuperate. It is crucial to support people to exit homelessness as soon as possible, in order to reduce chronic homelessness and its negative impact on health. The two domains explored within Goal 1 are prevention and HF.

Domain	Outcome	Indicator description	Does baseline indicator exist?	Targets or data sources for the development of potential indicators	Relevant policies
Prevention	Cessation of discharges into homelessness	Percentage of homeless individuals discharged from hospitals to accommodation that meets their health- or social-care needs	Yes	Homeless Hospital Discharge programme in Dublin - Target: 95%	*Dublin Homeless Hospital Discharge Protocol* (HSE, 2018)
Housing First (HF)	Prevention of long-term homelessness among those with complex health and mental health needs	Number of HF tenancies created	Yes	DHLGH local authority regional performance reports – *Homeless Quarterly Progress Report* - Target: An overall total of 1,319 additional HF tenancies are to be delivered from 2022 to 2026	*Housing for All: A new Housing Plan for Ireland* (DHLGH, 2021) *Housing First National Implementation Plan 2022-2026* (DHLGH, 2021)
	Prevention of long-term homelessness among those with complex health and mental health needs	Percentage of service users admitted to HF programme whose health needs have been assessed and are being supported to manage their physical/general health, mental health and addiction issues as part of their care/support plan	Yes	HSE National Social Inclusion Office quarterly reports - Target: 87% of service users admitted to HF programmes will have their health needs assessed and be supported to manage their physical/general health, mental health and addiction issues as part of their care/support plan	*Housing for All: A new Housing Plan for Ireland* (DHLGH, 2021) *Housing First National Implementation Plan 2022-2026* (DHLGH, 2021)
	Reduced emergency service utilisation	Number of times HF clients have utilised emergency services over the course of 12 months	No	HF health-monitoring tool data	*Housing for All: A new Housing Plan for Ireland* (DHLGH, 2021) *Housing First National Implementation Plan 2022-2026* (DHLGH, 2021)

Goal 2 – To improve healthcare delivered to people experiencing homelessness by enhancing integrated care pathways and a continuum of care

The patient's perspective is at the heart of any discussion about integrated care. Achieving integrated care requires those involved with planning and providing services to 'impose the patient perspective as the organising principle of service delivery' (Lloyd and Wait, 2005.p. 7). Further to this, achieving integrated care requires that those involved with planning, financing and providing services have a shared vision, employ a combination of processes and mechanisms, and ensure that the patient's perspective remains a central organising principle throughout. Joint working and cross-departmental collaboration are crucial in this aspect, to ensure a variety of services for homeless people and a continuum of care.

Domain	Outcome	Indicator description	Does baseline indicator exist?	Targets or data sources for the development of potential indicators	Relevant policies
Integrated Care and Case Management	An individual's health-needs will be assessed upon entering homelessness	Percentage of service users admitted to homeless emergency accommoda-tion (hostels/facili-ties) whose health needs have been assessed within two weeks of admission	Yes	*HSE National Service Plan* - Target: 85% of service users admitted to homeless emergency accommodation (hostels/facilities) have their health needs assessed within two weeks of admission	*Homeless Action Plan 2022-24: A Framework for Dublin* (DRHE, 2022) *Housing for All: A new Housing Plan for Ireland* (DHLGH, 2021)
	Enhanced integrated care and case management	Percentage of key workers or case managers who engaged with patients at early stage of their hospital admission	Yes	Homeless Hospital Discharge programme in Dublin - Target: 95%	*Dublin Homeless-Hospital Discharge Protocol* (HSE, 2018)
	Enhanced integrated care and case management	Percentage of times when multidisciplinary teams were involved in integrated care planning for patient's discharge	Yes	Homeless Hospital Discharge programme in Dublin - Target: 95%	*Dublin Homeless Hospital Discharge Protocol* (HSE, 2018)
	Improved health status	Self-perceived general health – percentages within (or share of) the population indicating their health to be very good to very bad	No	NSIO data collected from service users	*Health System Performance Assessment (HSPA) Framework* (DoH, 2021)
	Improved health status	Long-standing health problem – percentages within (or share of) the population indicating that they have long-standing health problems	No	NSIO data collected from service users	*Health System Performance - Assessment (HSPA) Framework* (DoH, 2021)

Goal 3 – Enhanced access to health services and provision of the right support at the right time for those who become homeless

People experiencing homelessness experience poor access to healthcare, leading to delayed clinical presentation, increased reliance on emergency departments, and higher rates of hospitalisation, often for preventable conditions. Limited access to healthcare is often a result of competing needs and priorities, limited physical access to facilities, difficulties in contacting relevant providers, unreliable access to medications, discrimination, and inflexibility in the healthcare system. Similarly, people experiencing homelessness may ignore basic health recommendations because their needs for food and shelter are more urgent than others. The Covid-19 pandemic increased the vulnerability and health risks of people experiencing homelessness and highlighted the need for urgent access to accommodation, health services (including mental health supports), addiction services, and harm reduction programmes. The specific domains explored within Goal 3 are enhanced access to health services and mental health and addiction supports.

Domain	Outcome	Indicator description	Does baseline indicator exist?	Targets or data sources for the development of poten-tial indicators	Relevant polices
Enhanced Access to Health Services	Enhanced access to primary care services	Percentage of ser-vice users admitted to home-less emergency accommodation (hostels/ facilities) who have medical cards	Yes	*HSE Performance Report* - Target: 66% of service users admitted to homeless emergency accommodation (hostels/facilities) who have medical cards	*Healthy Ireland Strategic Action Plan 2021-2025* (DoH, 2021) *Sláintecare Implementation Strategy & Action Plan 2021-2023* (DoH, 2021)
	Enhanced access to primary care services	Percentage of homeless service users admitted during the quarter who did not have a valid medical card on admission and who were assisted by hostel staff to ac-quire a medical card during the quarter	Yes	*HSE Performance Report* - Target: 55% of homeless service users admitted during the quarter who did not have a valid medical card on admission and who were assisted by hostel staff to acquire a medical card during the quarter	*Healthy Ireland Strategic Action Plan 2021-2025* (DoH, 2021) *Sláintecare Implementation Strategy & Action Plan 2021-2023* (DoH, 2021)

Goal 4 – Progress an evidence-based practice in order to develop targeted, evidence-based initiatives tailored to homeless people's support needs

An evidence-based practice is commonly accepted as the conscientious and explicit use of current best evidence in making decisions about the care of a client. There is a whole complex series of issues that begin to emerge, in terms of pathways into homelessness and the routes out of homelessness – the complex interaction between homelessness, health, income, employment, education, ethnicity, etc. As people experiencing homelessness are not one homogenous group, evidence is needed to identify those populations who might be at higher risk of homelessness and negative health outcomes. Thus, the aim of the following indicators is to support the understanding of some of the complexities, so that the solutions that are being put in place address the real issues. Evidence-based practice is in line with the *HSE Action Plan for Health Research 2019-2029* (2019), where in the objective is to embed a culture of research, evidence-based practice and innovation in the health service. Goal 4 captures the research domain and specific populations in homelessness.

Domain	Outcome	Indicator description	Does baseline indicator exist?	Targets or data sources for the development of potential indicators	Relevant polices
Research	Improved evidence-based decision-making	Integration and analysis of national data on homelessness, in order to identify trends therein and gaps in available evidence, data collection and service delivery.	No	DHLGH data on homelessness	*HSE Action Plan for Health Research 2019-2029* (HSE, 2019)

Domain	Outcome	Indicator description	Does baseline indicator exist?	Targets or data sources for the development of potential indicators	Relevant polices
Specific Populations in Homelessness	Increased understanding of the health and support needs of specific populations in homelessness	Completed research study into the health needs and health service utilisation of sex workers, including those from different ethnic groups, migrants, and those at an intersection with homelessness	Yes	Research study is completed - Target: 100%	*HSE Action Plan for Health Research 2019-2029* (HSE, 2019)
	Increased understanding of the health and support needs of specific populations in homelessness	Identifying the support needs of the LGBTQI+ population and its intersections with other vulnerabilities – such as substance abuse, homelessness and risks based on ethnicity – by participating in the second LGBTQI+ Ireland study	Yes	Research study is completed - Target: 100%	*HSE Action Plan for Health Research 2019-2029* (HSE, 2019)
	Increased understanding of the health and support needs of specific populations in homelessness	Improved understanding of homelessness in the criminal justice system in Ireland by identifying the number, profiles, and progression routes of homeless persons before the courts, in custody, and on supervision in communities across Ireland	Yes	Research study is completed - Target: 100%	*HSE Action Plan for Health Research 2019-2029* (HSE, 2019)

7. Implementation

The actions in this strategic plan for health of people experiencing homelessness will be delivered in the context of a multi-agency approach, which is required to support people who are homeless or threatened with homelessness. Key roles will be defined in order to achieve greater clarity on how different departments and service providers will work together to reach the common goal of ending homelessness and affect the greatest positive change. Persons with the lived experience of homelessness are to be at the core of everything that this strategic plan seeks to deliver. By collaborating and co-designing with people with lived experience, the community sector, the voluntary sector and government, this strategic plan aims to design and deliver appropriate and flexible health services that respond to the diverse needs of the homeless population.

The national Homeless Advisory Governance Group (HAGG) will monitor implementation of the strategic plan. HAGG was established to ensure best practice and quality standards in relation to HSE responses to homelessness. Membership comprises representation by social inclusion managers across nine CHO areas and associated social inclusion staff members from the national office.

Throughout the different stages of the strategic plan implementation, the following operational principles will be adhered to:

- enabling connected, coordinated and collaborative responses to homelessness and health that put people at the centre;
- strengthening the integration of responses to prevent homelessness for key systems, including but not limited to health, mental health, substance misuse, housing, prison and probation services, and family and child protection services;
- improving the collection, sharing and use of data, information and intelligence; and
- strengthening commissioning and contracting, to make sure that responses align with the strategic plan and drive positive outcomes.

8. Outcomes and Measurement

Progress on key actions in *The HSE National Strategic Plan to Improve the Health of People Experiencing Homelessness in Ireland (2024-2027)* will be reported to the senior HSE management and the National Homeless Action Committee (NHAC) on an annual basis. Progress reports will further enable the NSIO to feed into the HSE's estimate process.

The appropriateness of current indicators will be periodically reviewed, in line with new developments within the HSE and other governmental departments, factoring in new strategies and operational factors. While, in the majority of cases, data sources for the development of indicators have been identified, it will be crucial to establish data-sharing policies with key stakeholders, in order to support joint responses toward a health strategic plan for those in homelessness, and to ensure that the desired outcomes are reflected through the use of appropriate indicators.

8.1 Data Analysis

The primary purpose for collecting and reporting data across different governmental departments is to identify and implement evidence-based responses to improve client outcomes.

Applying data analysis to the information collected makes it possible to:

- cut the data in different ways, e.g. looking through the lenses of different cohorts;
- compare data against the baseline data set input in the system at an aggregated level, to measure improvements in outcomes; and
- confirm the achievement of agreed KPIs (as applicable), subject to the local context and constraints.

8.2 Responding to Outcome Data

The monitoring of performance is important, as it enables service providers and stakeholders to monitor activities (and their associated inputs and outputs) that are delivered as part of the broader homelessness service programme, and to understand whether these activities are having a positive effect on people's lives.

Understanding the elements of the programme is essential for quality improvement, as it assists the sector in demonstrating what interventions are most effective, where innovation is required, and what support is required to enable change within an organisation and its delivery practices.

8.3 Communicating the Responses to Outcome Data

Measuring client outcomes, programme activity data and provider performance allows the provision of regular feedback to service providers, to enable them to make iterative improvements throughout the term of the contract. This process supports continuous learning, innovation, and improved service delivery to clients.

In order to leverage responses to outcome data identified at the local and national levels, there is a need to communicate and disseminate evidence of effective practice, as well as barriers/issues that have been escalated, to the statewide programme level. This provision of balanced feedback ultimately helps providers and the government to drive client outcomes.

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10. Appendices

APPENDIX 1: Abbreviations

CHO – Community Healthcare Organisation
CSO – Central Statistics Office
DCEDIY – Department of Children, Equality, Disability, Integration and Youth
DHLGH – Department of Housing, Local Government and Heritage
DoH – Department of Health
DoJ – Department of Justice
DRHE – Dublin Region Homeless Executive
DSGBV – domestic, sexual and gender-based violence
ED – emergency department
EEM - ethnic equality monitoring
EMCDDA – European Monitoring Centre for Drugs and Drug Addiction
GPs – General Practitioners
HAGG – Homeless Advisory Governance Group
HHACF – homeless health addiction care facility
HF – Housing First
HIV - human immunodeficiency virus
HSE – Health Service Executive
LA – local authority
LGBTQI+ – lesbian, gay, bisexual, transgender, queer, intersex plus
NICE – National Institute for Health and Care Excellence
NIO – National Immunisation Office, part of HSE Public Health - National Health Protection Service
NIAC – National Immunisation Advisory Committee
NOSP – HSE National Office for Suicide Prevention
NPIRS – National Psychiatric Inpatient Reporting System
NSIO – HSE National Social Inclusion Office
NSS – HSE National Screening Service
PASS – Placement Administration and Support System
PCI – Primary Childhood Immunisations
PII – Personal Identifiable Information
SAOR – support, ask and assess, offer assistance, refer
SDoH – social determinants of health
SIF – safe injection facility
VPD – Vaccine-Preventable Diseases

APPENDIX 2: Strategic Alignment

In line with government policy, the HSE, together with local authorities, has a joint responsibility and commitment to provide a preventative, person-centred and coordinated response to deliver homeless services that involve the provision of appropriate health and social supports, to assist the service user in maintaining a tenancy, together with ensuring his/her/their optimal physical and mental health.

Such intersectoral collaboration is in line with new and existing government policies, strategies and frameworks, including:

- *A Three-Year Strategic Framework* (NSIO, 2023, document in development)
- *Health Service Executive Health Protection Strategy 2022-2027* (HSE, 2022)
- *Health System Performance Assessment (HSPA) Framework* (DoH, 2021)
- *Healthy Ireland Strategic Action Plan 2021-2025* (DoH, 2021)
- *Housing First National Implementation Plan 2022-2026* (DHLGH, 2021)
- *Housing for All: A new Housing Plan for Ireland* (DHLGH, 2021)
- *Housing for All Youth Homelessness Strategy 2023-2025: A 3-year strategy working towards ending homelessness for young people aged 18-24 through prevention and exits; and improving the experience of young people accessing emergency accommodation* (DHLGH, 2022)
- *HSE Action Plan for Health Research 2019-2029* (HSE, 2019)
- *HSE Corporate Plan 2021-2024* (HSE, 2021)
- *HSE National Service Plan 2023* (HSE, 2023)
- *HSE Patient and Public Partnership Strategy 2019-2023* (HSE, 2019)
- *Human-Trafficking Action Plan* (DoJ, 2022, document in development)
- *The Model of Care for the Health of Persons Experiencing Homelessness in Ireland* (NSIO, 2021 internal document)
- *National Drugs Rehabilitation Framework Document* (Doyle & Ivanovic, 2010)
- *National Standards for Safer Better Healthcare* (HIQA, 2012)
- *National Traveller and Roma Inclusion Strategy 2017 – 2021* (DCEDIY, 2017)
- *National Traveller Health Action Plan (2022-2027)* (DoH, HSE, 2022)
- *Partner Voices* (DoH, 2021, document in development)
- *Public Sector Equality and Human Rights Duty*
- *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025* (DoH, 2017)
- *Public and Patient Engagement Framework* (HSE, 2021, document in development)
- *Sharing the Vision: A Mental Health Policy for Everyone* (DoH, 2020)
- *Sláintecare Implementation Strategy & Action Plan 2021-2023* (DoH, 2021)
- *White Paper on Ending Direct Provision (*DCEDIY, 2021)
- *Zero Tolerance: Third National Strategy on Domestic, Sexual & Gender-Based Violence 2022-2026* (DoJ, 2022)

NICE Guidelines: Integrated health and social care for people experiencing homelessness
The NICE guidelines (NICE, 2022) include recommendations on ways to improve access to, and engagement with, health and social-care services for people experiencing homelessness. They also give advice on how commissioners, planners, providers and practitioners across disciplines and agencies can work together to support and improve outcomes for people experiencing homelessness. The guidelines are one of the key documents in informing this strategic plan.

***Housing for All* Policy**

Housing for All: A new Housing Plan for Ireland (DHLGH, 2021) recognises that 'suitable housing conditions are a key social determinant of health. Collaborative delivery of housing and health supports will ensure that no person is excluded from either housing or health support and that health support will be an integral component of settlement and a person's return to independent living.'

HSE is committed to supporting the plan through actions in this document and relevant actions in the *Housing for All* policy (as follows).

Pathway to Eradicating Homelessness, Increasing Social Housing Delivery and Supporting Social Inclusion:

Relevant health actions

- 3.10 Maintain ***Covid-19 public health measures*** for people who are Ongoing DoH, HSE homeless and consolidate improvements in health care delivery
- 3.11 Continue to increase access to health supports and Ongoing DoH, HSE protections for homeless individuals, with an *individual health care* plan to be provided for all homeless individuals that need one and improved access to mental health services
- 3.12 Finalise a model of health care for people experiencing Q2 2022 DoH, HSE homelessness, including a ***health/ vulnerability assessment tool to assist in determining suitability for Housing*** First and level of support needed
- 3.13 ***Strengthen integrated care pathways*** for people who are Ongoing DoH, HSE homeless with chronic health needs based on an inclusion health model, to achieve better health outcomes and to reduce the incidence of premature death
- 3.14 ***Expand the case management approach*** for homeless people Q2 2022 DoH, HSE living with drug or alcohol addiction and enhance treatment options

The National Social Inclusion Office is committed to ongoing inter-agency collaboration, as set out in other relevant departmental policies and frameworks listed in this document. The priorities outlined herein are guided by, and aligned to, the aforementioned strategic frameworks, policies and guidelines, and national priority actions will, in turn, inform regional homeless action plans.

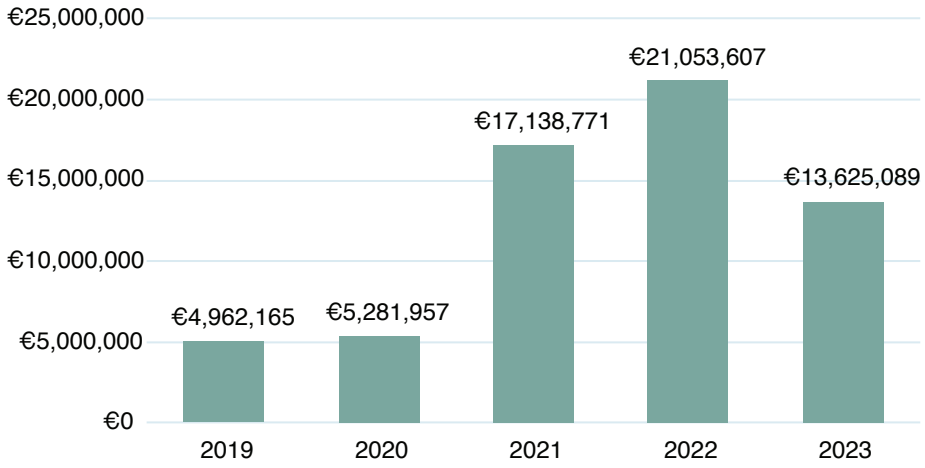
APPENDIX 3: Homeless funding

National Social Inclusion Office (NSIO) has spent €13,625,089 on homelessness health in 2023 as seen from *Graph 1.* This funding supported delivery of various projects across nine Community Healthcare Organisations (CHOs) aimed at addressing the complex health needs of individuals experiencing homelessness.

In 2023, the total national expenditure on homeless health, which includes NSIO funding, across nine CHO areas, amounted to €40,784,049. [2]

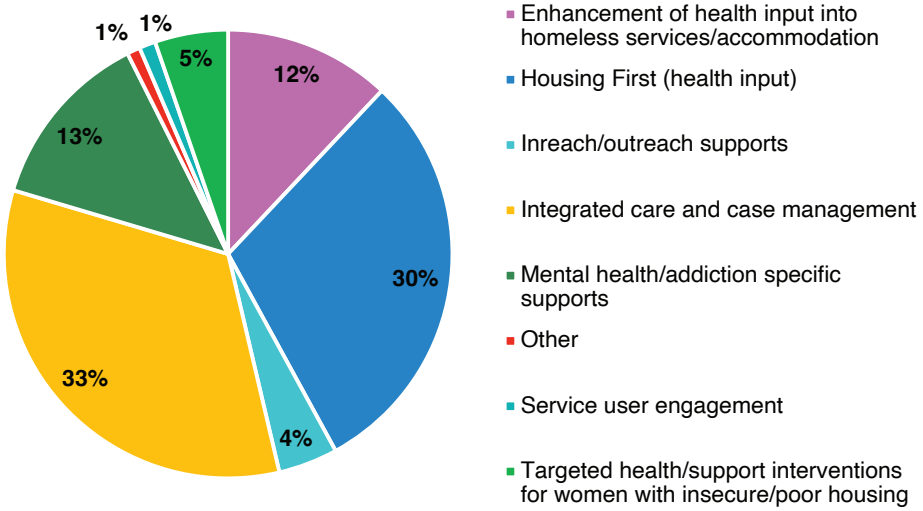
[2] In addition to this funding, other areas of the HSE provide services relevant to homeless health, including Mental Health, Addiction Services, Acute Hospital Services and Emergency Departments, Primary Care Services and GPs providing front line services

Graph 1 Total NSIO homeless health spend (2019-2023)



These initiatives were strategically divided into several program areas to comprehensively target the diverse challenges faced by this vulnerable population. Funding was directed towards enhancing health input into homeless services and accommodation, implementing Housing First approaches with a focus on health, providing inreach and outreach supports to reach those in need, facilitating integrated care and case management services, offering mental health and addiction specific supports, and engaging service users in the design and implementation of services. Additionally, targeted interventions were developed to address the specific health and support needs of women facing insecure or poor housing situations. Additional details regarding the breakdown of funding across programme areas can be seen from *Graph 2*.

Graph 2 Breakdown of NSIO 2023 national funding for the health of people experiencing homelessness across Ireland



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