Financial Savings Review of the Focus Ireland 'My Home, My Choice' Project

EXECUTIVE SUMMARY

BACKGROUND

- Funded by Genio, Focus Ireland's 'My Home, My Choice' project was established in Kildare in 2012. It supports individuals with a mental health diagnosis and who are recognised as having a housing need by their local authority. Focus Ireland procures accommodation and provides a holistic and tailored support service both before and after transitioning to independent living.
- As the name of the service suggests, 'My Home, My Choice' project prioritises the perspective of the customers themselves. The service aligns with the Government's mental health strategy, 'Vision for Change', in providing accessible, community-based and specialist services for people with mental health diagnoses in a way which promotes integration and community participation.
- Focus Ireland commissioned independent research consultants Quality Matters to conduct a financial savings review of 'My Home, My Choice' project

METHODOLOGY

- The study seeks to outline and cost accommodation and the supports/services used by customers of 'My Home, My Choice' both before and subsequent to their initial engagement with Focus Ireland.
- Data was collected through 10 semi-structured interviews which yielded detailed information on the type, number and duration of interventions and service use during two periods of time: 1) the 12 months *prior* to their engagement with Focus Ireland; and 2) the 12 months *after* their first engagement with Focus Ireland.
- While this financial savings reviews has limitations in terms of its scope and scale, it nonetheless provides a broad overview of the patterns and costs of service use contact both before and after engaging with 'My Home, My Choice'.

Full Report Available from Focus Ireland

Study Undertaken By:

Quality Matters
supporting improvement in social services

MENTAL HEALTH SERVICES

- Since transitioning to 'My Home, My Choice' housing, there was a substantial decrease in the reported number of psychiatric / locum visits, representing estimated savings of **€18,654.**
- Substantial increase of engagement in community day centres resulting in a **€11,232** cost increase.
- Small increase in engagement with primary health centre resulting in a **€891** increase in spending.
- Moderate decrease in the number of public health and community psychiatric nurse visits resulting in **€4,784** and **€798** savings respectively.
- Moderate increase in engagement with a community men's group resulting in **€1,040** increase in costs.

Costs and Savings Identifed: Before/After

GP SERVICES

Small reduction in the number of visits to GPS representing **€624** in savings.

ACCIDENT AND EMERGENCY SERVICES

There was a marginal increase in the number of A&E visits representing a **€268** increase in spending.

INPATIENT HOSPITALISATION

There was an increase in the number of inpatient admittance resulting in a **€4,580** more spending.

HOUSING SERVICES

- Substantial savings among those who transitioned from congregate settings into independent accommodation resulting in **€16,475** savings.
- Substantial cost increases of **€15,588** were recorded among participants who transitioned from their family home into independent accommodation.
- For those residing in the private rented sector (PRS), they recorded improvements in terms of security of tenure and quality of accommodation. Savings among those who remained in PRS were **€650.**

CONCLUSION

- There was a total savings of **€6,896** across the sample of ten participants.
- The most significant savings captured in the study related to the reduction in use of psychiatric services and the move away from congregate living situations.
- Areas of increased spending were in the areas of housing provision and increased use of community services.
- The findings highlight the potential cost-effectiveness of interventions such as 'My Home, My Choice', whilst also signalling that the project increases housing stability for customers and enhanced engagement with community-based services.

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September 2016

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Contents

1. Preface

The Government's *Vision for Change* strategy for mental health service provision sets out an objective of providing accessible, community-based, specialist services for people with mental illness. The Strategy prioritises the need for 'maximum recovery from mental illness' in a way which can 'achieve meaningful integration and participation in community life' (A Vision for Change, 2006). In exploring what contribution, we could make to deliver the objectives of Vision for Change, Focus Ireland brought over 30 years' experience of tenancy sustainment and an understanding of the central importance of a secure home for everyone.

It was within this policy context that the *My Home My Choice* project emerged, with the collaboration of Kildare County Council and HSE Mental Health Services (Kildare) to address both the housing and support requirements for individuals with mental health needs in Kildare and the surrounding area.

Having been awarded funding by Genio in 2013, the *My Home My Choice* project was established to target individuals with diagnosed mental health difficulties who are assessed as having a housing need and who wish to live independently in the community. *My Home My Choice* provides a response which integrates accommodation with an individualised, person-centred, tailored support service. Drawing from previous Focus Ireland experience, support is provided before the tenant transitions into the new accommodation and continues until the tenancy is considered stable and the person is integrated into their new community. As reflected in the project name, the choices of the individual about location and the sort of accommodation they want are central to the programme.

Due to the positive impact it has made to the lives of clients who are now housed in Kildare and surrounding areas, Focus Ireland - with the support of Genio, the HSE and local authorities - has expanded the service model to South Dublin and Limerick.

It is central to Focus Ireland's work that we build on the successes of individual innovative programmes to inform mainstream provision. One of the positive elements of working with Genio's Innovative Funding programme is that it shares this commitment. Independent expert evaluation is key to understanding the effectiveness and outcomes of a particular intervention and the current report, prepared by Quality Matters, represents an important step forward in this process. The report is not designed to give an overall service evaluation of the project but rather, to formally review the project from a value and cost-savings perspective.

The research approach sought to prioritise the clients' own perspectives of their service use and needs, both before and after their contact with *My Home My Choice* team. The findings reveal cost savings but also increased engagement of clients with community-based supports. These findings have important implications in understanding the cost-savings accrued through the provision of housing and community-based services, but also offer reflections on homelessness prevention and the potential benefits of cross-disciplinary partnership in service delivery.

I would like to sincerely thank the Focus Ireland clients who offered their time and energy in participating in one-to-one interviews for the purpose of this study. Their engagement has advanced our knowledge in this area which not only benefits organisations such as Focus Ireland and the HSE, but also informs the planning and delivery of mental health services more broadly. I would also like to thank Kildare County Council and HSE Mental Health Services

(Kildare) for their collaboration on the project, and of course, our funders Genio. This evaluation is funded through the generous support of our individual and corporate donors.

We hope this publication stimulates further debate on this important issue and that services such as *My Home My Choice* can, above all, effectively advance the core principles of the progressive *Vision for Change* model.

Catherine Maher

National Director of Services, Focus Ireland

2. Acknowledgement

The authors of this report would like to thank all the respondents who gave their time to provide detailed information on their service use history over the last few years. Their patience and generosity in being involved is gratefully acknowledged. Appreciation is also due to the Focus Ireland staff team who organised the interviews, as well as being instrumental in sourcing some cost estimates. Particular thanks to staff at Kildare County Council as well as the community mental health team in Kildare for all their willingness to help with ascertaining costs for services.

3. Executive Summary

3.1 Background

- Focus Ireland's 'My Home, My Choice' project – a project funded by Genio – was established in 2012. It supports individuals with a diagnosed mental health diagnosis and who are recognised as having a housing need by their local authority. Focus Ireland procures accommodation and provides a holistic and tailored support service both before and after their transition to independent living.
- As the name of the service suggests, 'My Home, My Choice' project prioritises the desires and the needs as identified by the customer themselves. The service aligns with the Government's 'Vision for Change' mental health strategy in providing accessible, community-based and specialist services for people with mental illnesses in a way which promotes integration and community participation.
- Focus Ireland commissioned independent research consultancy Quality Matters to conduct a financial savings review of 'My Home, My Choice' project.

3.2 Methodology

- The study seeks to outline and cost accommodation and supports/services used by customers of 'My Home, My Choice' both before and after their engagement with Focus Ireland. The study involved 10 clients.
- The data was collected through semi-structured interviews which yielded detailed information on the type, number and duration of interventions and service use during two periods of time: 1) the 12 months *prior* to engagement with Focus Ireland; and 2) the 12 months *subsequent* to their engagement with Focus Ireland.
- Service use costs that were captured included: accommodation; engagement with mental health services; GP care; A&E services; inpatient hospitalisation; and housing.
- While this financial savings reviews has limitations in terms of its scope and scale, it nonetheless provides a comprehensive overview of the nature of service contact among those who engaged with the programme and the costs associated with their service use, using the best available estimates.

3.3 Financial Savings Analysis – Overview of Key Findings

1. Mental Health Services – the following savings/spending increases were identified:

- Substantial decrease in the number of psychiatric / locum visits after engaging with 'My Home, My Choice' project, representing savings of **€18,654**
- Substantial increased engagement in community day centres resulting in a **€11,232** increase.
- Small increase in engagement with primary health centre after engagement, resulting in a **€891** increase in spending.
- Moderate decrease in the number of public health and community psychiatric nurse visits resulting in **€4,784** savings and **€798** savings respectively.
- Moderate increase in engagement with a community men's group resulting in **€1,040** increase.

2. GP Services – the following savings/spending increases were identified:

- Small reduction in the number of visits to GPS representing **€624** in savings.

3. Accident and Emergency Services

- There was a marginal increase in the number of A&E visits representing a **€268** increase in spending. It is worth noting that a number of the participants stated that they had presented to A&E on a regular basis two years ago or more, however this data is outside the timeframe of the study and so not captured in the analysis.

4. Inpatient Hospitalisation

- There was a small increase in the number of inpatient admittance resulting in a **€4,580** increase.

5. Housing Services

- Significant improvements were captured in housing for research participants since engaging with 'My Home, My Choice'.
- Substantial savings were recorded among those who transitioned from congregate settings and into independent accommodation resulting in **€16,475** savings.
- Substantial cost increases of **€15,588** were recorded among participants who transitioned from their family home and into independent accommodation. Importantly, the positive benefits of living independently were emphasised by participants during interviews.
- For those residing in the private rented sector (PRS), they recorded improvements in terms of security of tenure and quality of accommodation. Savings among participants in the PRS resulted in **€650.**

3.4 Conclusion

- In conclusion, across all the areas of measurement, there was a total savings of **€6,896.22** across the sample of ten participants.
- The most significant savings captured in the study related to the reduction in use of psychiatric services and the move away from congregate living situations.
- Areas of increased spending were in the areas of housing provision and increased use of community services. However, these areas of increased costs also reflected housing stability, independent living, increased engagement in community services, and community integration – all of which are likely to have had positive implications for participants
- The findings highlight the potential cost-effectiveness of interventions such as 'My Home, My Choice' whilst also signaling that the project increases housing stability and engagement with community-based services.

4. Introduction

Homelessness is one issue of a multitude of social and health crises requiring immediate resolution by the state, therefore requiring investment of state finance and resources. In such a competitive environment with limited resources available charity run services are increasingly compelled to show the extent to which (if at all) they benefit society and the degree to which programmes or interventions provide value for money.

Homelessness causes significant burdens not just on the people who experience it and their families - but also on society as a whole. While the costs to individuals and families experiencing

homelessness are numerous and have been articulated in research (1), a cost less frequently discussed is the cost of homelessness to state services.

This financial savings study draws on a growing body of international literature that provides an understanding of how homeless services can contribute to savings for the state (2–10). This study involved conducting semi-structured interviews with individuals using homeless services who also frequently use public services (e.g. hospitals, A&E, psychiatric hospitals). The interviews involved supporting clients to compare their use of these services at two points in time - before and after Focus Irelands' intervention. This marks a first step in a process to assess the impact and value of the specific interventions within homeless services.

International research studies have shown that the impact of homelessness is more expensive to society than the cost of solving the problem (11). One of the earliest US studies - "The Culhane Report" tracked the public service use of 4,679 homeless individuals in New York over the course of nine years (12). This significant study calculated that a person experiencing homelessness costs taxpayers $40,451 a year. The study found that supportive housing reduced these annual costs by a net amount of $16,282 per housing unit. Drawing on Culhane's work, Malcolm Gladwell's 2006 New Yorker article, 'Million Dollar Murray' detailed the story of Murray Barr, an alcoholic homeless man with mental illness who ran up the largest medical bill in Nevada of more than $1 million. This case illustrated the consequences of frequent use of public services by those experiencing homelessness (13).

More than a dozen US studies have since quantified the way homeless people utilise various public systems, including hospitals, emergency rooms, psychiatric hospitals and prisons (2–10,14–21). Research in Canada and Australia has further confirmed that those high costs alluded to previously are not unique to the US (21). These studies show that preventing homelessness or providing a pathway to long-term housing can result in significant cost savings to the State, as well as improvements in the lives of people experiencing or at risk of homelessness (22–24).

This research, independently undertaken by Quality Matters, a social research charity, seeks to identify the cost savings to the state from the Focus Ireland, Genio funded project, operating in Kildare since 2012. The focus of the study compares the repeated use of services typically used by individuals who are both homeless and report mental health issues against the cost of the running of the *My Home My Choice* service.

This study does not address causality or attribution nor does it attempt to define and value the experience of the client or the outcomes accruing to them. The study concentrates solely on the number of savings to state services. The outcome of the study will be one of the following:

- Savings are made to other state services as a result of the intervention
- The service does not provide savings however provides better client outcomes
- The service provides neither cost savings or better outcomes

While the scope of this analysis is modest, compiling data from the experiences of ten clients in one Focus Ireland service - this study aims to contribute to an understanding of how homeless services can support cost reductions in allied health and social services. The research ends with a summary of client use of social and health services and provides recommendations, primarily relating to how this research project can be embedded into Focus Ireland's ongoing data collection systems.

1. The 'My Home, My Choice' Project

1.1 Overview

Suitable housing is a key aspect of the reintegration of individuals with a psychiatric disability into their community whereby they can, potentially, be provided with some choice and control over where and with whom they live (25). The Focus Ireland, Genio funded 'My Home, My Choice' project procures accommodation for homeless people with mental health difficulties, through a case management model. Mental health diagnoses of clients include a history of self-harm; depression; eating disorders, Schizophrenia (including paranoid Schizophrenia) and Schizoid-affective Disorder. The service aims to enable service users to move through the different stages of recovery and progress towards the goal of independent living. Working closely with the multi-disciplinary mental health team in Kildare, the project provides a flexible, person-centred, home-visiting service to address any support needed to develop independent living skills, while a housing officer with a background in estate agency supports clients to source suitable long term accommodation. The result being that some thirty-eight tenancies have been secured to date.

Over 71 households were referred to the service since it began in 2012. The target for year 1 was to engage with 10 households, and for each subsequent year to engage with 12 households. Capacity was increased as learning from Year 1 indicated that several households may withdraw from the service over time. Twenty–six referrals were not deemed suitable; however, the majority of these occurred within the first year of the project when referrers were not clear on the remit of the service. The primary reasons for non-acceptance of a referral was: individuals not engaging with their community mental health teams; individuals feeling that they were not ready for independent living; individuals feeling that they did not want the service or require support or individuals presenting with multiple and complex needs who required intensive and onsite support and care.

Table 1 'My Home, My Choice' Client Demographics

Age Category	No. of Clients[1]
26 - 40	20
41 +	35
18 - 25	5

Gender	No of Clients
Male	27
Female	33

The intervention provided by Focus Ireland includes a combination of supportive housing or sourcing subsidised housing in the private rental market. Other housing options are utilised as these can be matched with client need (27). The Focus Ireland housing stock used within the project comprises twelve housing units. However, the service has a rolling caseload of 16 households at any given time. When a case was closed, a new case would be taken on. The result being that to date this model of service has secured 38 tenancies. The clients who live in

[1] Information is on based on 60 service users despite the number of referrals being 71. Collating information on previous clients was complicated by the fact that some were no longer on Pathway Accommodation & Support System (PASS). The Pathway Accommodation & Support System (PASS) is a shared client support and bed management system for homeless services, and forms part of the priority actions in the National Homeless Strategy(26).

this accommodation were homeless or living in unstable housing; they previously had no housing, or lived in unsuitable private rented or in HSE-funded hostels for an approximate duration of 6 months to 12 years. Under the auspices of this project, eight clients have moved on from HSE Care Homes to their own homes in the last 3 years.

The HSE Social Care Operations Plan 2014 has highlighted the role of 'demonstration' projects such as 'My Home, My Choice' in managing the transition to a new model of support (28). An example is the recently published report 'An *Economic Analysis of a Community-Based Model for Dementia Care in Ireland'* funded by Genio and Health Research which explored community based dementia care across four geographical areas; Mayo, Stillorgan- Blackrock, South Tipperary and Kinsale (29).These are typically small scale and innovative projects, and have drawn on international best practice in the reform of disability services. The key characteristic of personalisation, the central focus of many demonstration projects, is an emphasis on self-determination and tailoring supports around the specific needs of the person (30).

Genio, a non-profit organisation funded by the State and philanthropic donations, is the leading organisation in Ireland for such demonstration projects and as part of this function provides financial support to organisations and individuals wishing to promote more personalised, community-based supports(30).

2. Introduction to Financial Analysis

2.1 Overview

People experiencing homelessness, as a group, utilise more social and health services than those who are not homeless (31–33). The financial savings approach (34,35) used in this analysis compares and contrasts the financial cost of accommodation and support use costs for the 12 months preceding engagement with the Focus Ireland project (i.e. prior to their transition to independent living) against accommodation and service use costs (for the same individual) after their transition to independent living and engagement with Focus Ireland.

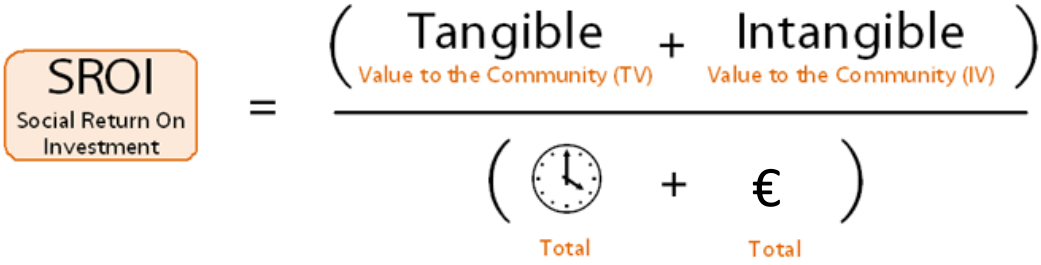
The clear benefit of focusing on the financial costs of homelessness is that the role of homeless services in reducing state costs can be understood. A reduction in the superfluous or non-essential use of state-funded services (other than homeless services) by people experiencing homelessness can potentially create whole-of-government budgetary savings, referred to as cost offsets. Cost offsets for use of these services (Accident and Emergency Departments, prisons etc.) can include a reduction in people living rough repeatedly visiting A&E, or the reduction in the costs associated with the criminal justice system (36). Therefore another way of describing a financial savings analysis is a review of the delivery of cost offset by homelessness services (37). This can also be referred to as 'cashable saving', meaning other services will not have to spend money that they would otherwise have had to spend. If the scale of service provision at the housing end was large enough this would lead to actual reductions in expenditure. This is in contrast to a non-cashable saving where the costs of running a service will remain the same, even though the costs for the individual may be avoided (38).

It is important to highlight a caveat in relation to this report: focussing solely on State financial savings can obscure the purpose and value of homeless services. This analysis should only be used to support rights-based arguments to end homelessness, not to undermine them. People have a right to a home and the financial implications of creating this should at no time be a barrier to enacting this human right for all people. This report simply conveys the ancillary financial benefits to the state of doing so. In short, a rights-based approach should always predominate when considering why it is necessary to prevent and reduce homelessness and care (39).

2.2 Items Excluded from Financial Savings Analysis

It is important that exclusions from the analysis and methodological limitations are addressed prior to providing the financial analysis. The wider benefits to society are **not** taken into account when a Financial Savings Analysis is conducted; as a methodology, the financial savings analysis is much less encompassing than Social Return on Investment (SROI) or other cost benefit analysis. Social Return on Investment (SROI) is a process for understanding, measuring, and reporting the social, economic and environmental value created by an intervention, programme, policy or organisation (40). In short SROI attempts to monetize the entire costs of homelessness (35). It includes costs with a socio-economic value, those that can be monetised such as health and other publicly funded services, and costs with an entirely social value – costs associated with homelessness and with a definite intrinsic value but difficult to monetise (40) (see fig. 1). These latter costs could include the loss of economic productivity among homeless people who face barriers to paid employment, the loss of outcomes for family members, and the costs associated with visible street homelessness (rough sleeping) for city centres, such as perceived damage to tourism or commerce (36). Thus, the SROI stakeholder list includes clients, their families, state services and society as a whole while this analysis considers only the direct saving for the state and its agencies.

Figure 1 Social Return on Investment



Also of note is that a Financial Saving Analysis does not infer that an intervention is responsible (or indeed not responsible) for the proportion of the change that has occurred. In contrast a core feature of cost-benefit and SROI methodologies are efforts to describe causality and explore how much causality is due to other organisations or interventions. In SROI terms this is called attribution (40). An example of attribution is that someone who leaves homelessness may result in costs savings to the state of several thousand per year, however when the case is analysed this is unlikely to be due to one intervention, when in complex cases there are a number of people, organisations or interventions responsible for contributing to the change. In this case the value accrued would need to be assigned to these various actors. Another way of describing this is that one organisation could not claim all the cost saving as a result of their intervention.

Another important feature of SROI analysis is the question of how much positive change a service user would have experienced without the intervention. This is known as deadweight. Deadweight is a measure of the amount of outcome that would have happened even if the activity had not taken place. It is calculated as a percentage and is reduced from the value of any benefits.

Similarly, an SROI will rarely use per unit service costs when calculating costs saving to the state as a result of an intervention, except in cases where those reductions are big enough to actually close a service. For instance, if an intervention results in less people committing crimes and therefore less people spending time in prison, to claim as a benefit the full per unit cost of the equivalent time in prison would not be reflective of any real cost saving to the state. High infrastructure and fixed costs (wages etc.) for an institution such as a prison mean that, in the logic of SROI, the only savings to the state will be the marginal costs of imprisonment (i.e. those costs associated with additional prisoners), or possibly another real economic benefit such as the value of reduced overcrowding (35). In such cases resources are 'freed up' rather than 'paid back' to the taxpayer – again this more methodologically robust logic is **not** included in this financial costs review, where full per unit costs have been used.

3. Literature Review

3.1 Overview

Homelessness and poor housing have a long-term detrimental impact on the physical and mental health of individuals affected by it. In this section the Irish policy context for housing and those engaging in mental health services is explored at length in order to show how the My Home My Choice project supports national policy. The psychological and physical impact of homelessness is then explored followed by an account of the impact this has on the use of public health services.

3.2 The Policy Context

Irish policy regarding care for the mentally ill encompasses a series of related policy areas, of which housing forms a crucial part. As early as the 1960s Irish policy in form of the Report of the Commission of Enquiry on Mental Illness (1966) emphasised the closing of psychiatric hospitals and substituting institutional care with care in the community (41). Despite this, Ireland continued to have one of the highest institutionalisation rates in the world with hospitalisations in Ireland being two and a half times that of England between 1963 and 1978 (42). Policy continued to push towards deinstitutionalisation (42); the 1989 policy document Shaping a Healthier Future established departments of psychiatry in general hospitals with a view to providing more robust community supports (43). While progress was made in pursuit of the provision of care in community settings the closure of all large psychiatric hospitals was not fully implemented (44). During the 1990s Ireland reduced its hospitalisation levels slowly but in a geographically uneven manner (45).

In the new millennia the provision of suitable housing continued to be a key aspect of national mental health policy. A Vision for Change (2006), similar to earlier policy strategies, advocated for the relocation of long-stay patients from psychiatric hospitals to the community. However, what differentiated this document from its predecessor was its emphasis on the need to provide accessible, community-based, specialist services in tandem with community based housing with a view that people must 'achieve meaningful integration and participation in community life'(46). The subsequent 2011 Report of the Working Group on Congregated Settings also stressed that housing must form part of a wider person-centred support plan of community inclusion while explicitly acknowledging that 'dispersed housing in the community provides a better quality of life for people with disabilities than cluster-style housing' (47). Moreover, the working group recommended that housing for persons with or recovering from mental illness would be supplied by local authorities in standard social houses as stipulated under the Housing Act 2002 (48) as opposed to a disability/mental health service.

The National Housing Strategy for People with a Disability 2011-2016 gave effect to the previous policies in that it identified an array of mainstream housing supports[2] which, to date, are rarely availed of by people with disabilities and/or mental illness. The strategy also outlined how national protocols should coordinate effective interagency cooperation involving all relevant agents in the provision of housing for people with disabilities (49). The 2012 document Addressing the Housing Needs of People using Mental Health Services reiterated the importance of formal links with housing and support services - moreover there was a

[2] Mainstream housing supports include Rental Accommodation Scheme (RAS) and the Social Housing Leasing Initiative (SHLI), which leases properties from private owners for use by those on local authority waiting lists. Voluntary and Cooperative Housing was also noted, in particular, the Capital Assistance Scheme (CAS) which permits housing bodies to provide accommodation to meet certain specific categories of housing.

recognition that the range of supports which people with a mental illness need to maintain a tenancy varies (50). The Value for Money Review (2012), allied with the policy recommendations from its expert reference group, not only provides further endorsement for the policies outlined above, but recommends a major reconfiguration of the Disability Services whereby individualised budgeting or a 'money follows the client' model is introduced (51).

In recent years the Implementation Plan on the State's Response to Homelessness (May 2014 to December 2016) placed considerable emphasis on preventative policies; it encouraged the continued establishment of multidisciplinary Community Mental Health Teams (CMHT's) as recommended by A Vision for Change (52). In November 2014 the Government approved the 'Social Housing Strategy 2020' which supports a new vision "that to the greatest extent possible, every household in Ireland will have access to secure, good quality housing suited to their needs at an affordable price and in a sustainable community" (53). The aim of the strategy is threefold: to provide 35,000 new social houses over the period to 2020; to support up to 75,000 households through an enhanced private rented sector and to reform social housing supports. (53). Thus, the main housing requirement into the future will be for individualised, independent accommodation with some support, as appropriate, from the mental health services working cooperatively with the housing authorities – it is within this policy context that the My Home, My Choice project should be viewed.

3.3 Housing & Mental Health

Experiences of poor mental health, housing instability, and homelessness are intrinsically connected (54,55). People with poor mental health are susceptible to contributory factors that lead to homelessness such as poverty and isolation (56,57). While poor mental health elevates the risk of homelessness - evidence indicates that the relationship between mental health and homelessness is, in fact, cyclical; mental health amplifies the risk of homelessness, but the stresses inherent in experiencing homelessness can also induce a mental disorder (58,59). This firm causal link between mental health and homelessness means that rates of mental illnesses among people experiencing homelessness are disproportionately high (55,60–63). Moreover, substance use disorders very frequently coexist with mental illness (64–72). Studies have found a strong correlation between mental illness, substance abuse, chronic homelessness and housing instability. While point-in-time studies can overestimate numbers, a 2011 Simon Community 'point in time' study found 47% of the 603 respondent who use Simon projects and services had a diagnosis of at least one mental health condition.

It is the co-existence of these problems that makes the resettlement of people experiencing homelessness particularly challenging (49, 56). People with dual diagnoses also experience greater barriers to accessible housing than their counterparts, including income deficits and stigma(73). Drug and alcohol use are known factors in increasing relationship tensions between neighbours or landlords while the financial costs of ongoing addiction may compete with housing costs (74). As a result people with mental illness or drug and alcohol problems remain homeless for longer periods of time than those without these co-occurring needs (60), have less contact with family and friends, and struggle to find suitable accommodation following discharge from services/hospitals (1,75–78). An audit carried out in the mental health unit in Tallaght Hospital, Dublin between October 2012 and September 2013 found 98 per cent of extended stay/delayed discharge in-patients had accommodation-related needs (79). Once again this report illustrates the correlation between homelessness and mental health difficulties.

3.4 Housing and Physical Health

Poor physical health is associated with poverty in general but research does indicate that it is more pronounced among those who are without secure tenure (54,55,60,80). The negative impact of homelessness on a person's physical health is well documented (69, 70). From the mid-1980s to the early 2000s, researchers consistently found disproportionately higher rates of hypertension, respiratory illness, tuberculosis, HIV infections, and other diseases among people experiencing homelessness compared with the general population (2–5). Although fewer international studies with recent data are available, research findings and reports have continued to show disparities in physical health between housed and homeless persons in samples drawn from homeless adults living in shelters,(83,84) those in prison (85) and individuals reporting HIV-positive status (86–88). In England, the 2014 Homeless Link Health Needs Audit found that 73% of homeless people reported a physical health problem - while 41% of those surveyed reported a long-term chronic condition compared with 28% of the general population (77, 78). Recent Irish research appears to reflect similar findings. In 2015 the Partnership for Health Equity (PHE) undertook a homeless health study in both Dublin and Limerick; 81 percent of the survey group had been diagnosed with a physical health problem while 58 percent had at least one mental health condition (91).

Researchers have long been interested in documenting the costs of homelessness to inform investments in alternative housing and services. Before reviewing the literature on interventions, we examine the assumption that not intervening carries significant additional costs.

3.5 Increased Usage of Health Services

As previously discussed, persons experiencing homelessness disproportionately suffer from medical illness, problematic substance use, and psychiatric disorders. For homeless individuals, these challenges are compounded by significant unmet needs and problems accessing primary and specialty care. This in turn can lead to an increased usage of hospital and accident and emergency services (92). Studies have found that there is an increased rates of acute health service use by people experiencing homelessness, including both A&E (93–95) and hospital admissions (95–99) when compared to the general population and to other lower socioeconomic groups (100). In-patient hospitalisation rates for homeless adults are two and a half to five times higher (63) in comparison to domiciled groups with substance use issues (101,102) mental disorders (93,103) and co-occurring disorders (98,100). Salit et al (97) found that homeless adults in public hospitals in New York City stayed on average 36 percent longer than other patients, controlling for differences in demographics and diagnoses. The accompanying increase in cost to the state due to this service usage appears to be significant. In 2011, Hwang et al (104) found that hospital costs in the USA associated with homeless people were $2,559 greater per admission than those of housed patients. While Flatau et al estimated an average, additional, cost to the Australian public health services of $250, 544 per homeless person, over the course of that homeless person's lifetime(105).

3.6 Increased Usage of the Criminal Justice System, Shelters & Other services

Homeless individuals' high rates of service use are not just confined to health-associated services. US research has found chronically homeless individuals are at increased risk of criminal justice involvement compared to those in stable housing. It is particularly true for homeless persons with substance use disorders. Substance-related offenses are responsible for 50% of all arrests of homeless individuals(106). In the UK, there is some evidence linking recurrent and sustained homelessness among people with higher levels of contact with the criminal justice system (107). In relation to shelters and other homeless services, the primary intervention for

housing individuals who are homeless is often to provide expensive shelter services, which offer temporary beds but fail to address the most long-term needs of chronically homeless persons (108). Pioneering US work in this area showed that a very high need group of long-term and repeatedly homeless people, who were only 10% of the homeless population, used 50% of the annually available bed-spaces in emergency accommodation(106). Thus it is clear that costs related to homelessness cross into many different services and are not confined to health services.

3.7 Supportive Housing and Its Potential to Provide Savings to the State

About fifteen years ago, researchers in the US began to focus on the economic impact of homelessness on governmental and public spending (109). Landmark studies such as that by Culhane et al. in 2002 (as mentioned previously) found that the cost of providing supportive housing to chronically homeless individuals with mental illness in New York City was almost offset by savings related to participants' reduced use of health, criminal justice, and shelter services (12). More than 60 replication studies have since demonstrated that in every US city where it was examined, high costs are associated with the most entrenched forms of homelessness (5–7, 113, 114). More recently, studies have begun to investigate service use and costs related to housing tenants in programs using a Housing First[3] approach. Researchers in cities such as San Diego, San Francisco, Florida, Seattle, Los Angeles have reported decreases in the use of many services, including emergency room visits, inpatient hospital stays, imprisonment, and increases in the use of desirable primary care services, including outpatient mental health and substance use services (4–7, 16, 18, 19, 115).

Of particular note is the Los Angeles Homeless Cost Avoidance study which found that typical annual public cost for homeless persons is $2,897 - five-times greater than their counterparts that are housed which is $605. The stabilising effect of housing plus supportive care is illustrated by a 79 percent reduction in public costs for these residents' (18). A Columbia University study in 2013 looked at two years of costs before placement/non-placement and one-year post for everyone who was placed or not placed into the housing between 2007 and 2009. Measuring public costs associated with participants' use of shelter, jail, cash assistance, food stamps, state psychiatric care and Medicaid – it found that, after subtracting housing and service costs, each tenant housed saved New York City an average of $10,100 a year. The savings varied widely by tenant population, with supportive housing for residents coming from State-operated psychiatric facilities saving on average $77,425 per tenant per year. Overall the NY/NY III project, as it was named, achieved either a complete cost offset or significant savings for all but two of the tenant populations (4).

In Europe there is less literature on the costs and benefits of homelessness services; the 2013 FEANTSA report 'The Costs of Homelessness in Europe' is a marked exception. This report noted that of the 13 countries that participated none reported that their country had a high quality evidence base on the costs and benefits of homelessness services (114). European countries have some way to go to match US and Australian evidence in this area. This report provides a modest step in this direction.

[3] Housing First approaches are based on the concept that a homeless individual or household's first and primary need is to obtain stable housing, and that other issues that may affect the household (e.g. unemployment, addiction issues etc.) can and should be addressed once housing is obtained (112).

4. Methodology

4.1 Overview

A financial savings analysis was conducted to estimate the potential role of the Kildare *My Home My Choice* project in reducing financial costs to the Irish state over a one-year period. Ten interviews were conducted in January & February 2016 with former and current clients of *My Home My Choice*. Detailed information on the type, number and duration of interventions, services and entitlements for the My Home My Choice client were collated for:

- The one-year period prior to their engagement with the project
- The first year of their engagement with the *My Home My Choice* project.

The 10 interviewees were questioned as to their accommodation and support needs in the year prior to their engagement with My Home My Choice and their accommodation and support needs at the end of their first year with the project. Information was sought on a range of supports during these very specific timeframes; their accommodation, rate of GP/A&E visitation, engagement with Drug and Alcohol services, engagement with Mental Health Teams, contact with criminal justice system etc. The primary aim was to explore resource use and costs associated with the use of health and ancillary services both prior to and post-engagement with the project.

4.2 Client Interviews

A semi-structured interview format was deemed most appropriate for this study; semi-structured interviews centre around a mixed framework of general themes and pre-established questions about service usage, while allowing for a conversational tone (117, 118). Informed consent was facilitated by the development of a Focus Ireland Informed consent and information sheet and checklist that was explained in full by the researcher prior to the interview beginning. Interviews took approximately 40 – 60 minutes and there was an expenses payment of €20 per participant to cover the costs of attending the interview. The interviews took place over a four-day period in early 2016; the majority of interviews took place in participant's homes – one participant requested to meet in a coffee shop whilst another preferred the anonymity of a health centre.

4.3 How Valuations Were Calculated

'Unit cost' is the term used to show the cost to the public purse of individual uses of various public service functions or 'units'. For the purpose of this study costs in terms of staff resources are being counted. In Ireland there is a lack of per unit cost data; service use and associated costs are not closely monitored, for both homeless people and for all other citizens (117). As a result, some unit costs in this study were based on recent ERSI research based not on the homeless sector but on palliative care. A report entitled Unit Cost Methods and Data from Economic Evaluation in Palliative Care in Ireland (2015) was a source of much data (118). The ERSI study applies the methods used by the Personal Social Services Research Unit (PSSRU) in the UK (119) to estimate units costs for Irish health care professionals involved in palliative care in Ireland.

Other costs were sourced from a recent report comparing and contrasting mental health services in Kildare entitled 'Value for money: a comparison of cost and quality in two models of adult mental health service provision' (120). Where costs could not be extracted from these reports data was collected on service costs from services directly or from other reports and sources. Where possible, less reliable data was triangulated to provide a more robust assessment of cost.

4.4 Ethical Considerations

The rights and dignity of respondents were respected throughout by adherence to standards of good practice in research relating to recruitment of participants, the voluntary nature of their participation in research and capacity to withdraw without negative impacts, achieving full and informed consent, protecting client privacy, maintaining confidentiality and ensuring information is retained in line with relevant legislation. A letter was sent to each client explaining the purpose of the financial benefit analysis project. Due to the level of information/data required from the client for these case studies, explicit written consent was obtained from each relevant client prior to the data collection phase of this project. Informed consent was facilitated by the production of Focus Informed Checklist (see Appendix 1). On first meeting with respondents the researcher directed the interaction by introducing research topic and explaining what the interview would entail. The researcher then provided a clear reiteration of the nature and purpose of the research and reaffirmed those issues detailed in the first paragraph.

4.5 Limitations to the Methodology

Cost analysis: Even with significant work and analysis, any monetary "cost-benefit" figure that is generated can only be an informed estimation because all costs are based on a range of assumptions as well as several other factors (35). The financial savings analysis conducted for the My Home My Choice project must be framed within these limitations.

Different methods used to calculate costs: There is at present no centralised body computing unit costs for the Irish health service (121). It is difficult to gather data in respect of costs across the Irish Health System due to a wide variation of unit costs regionally (117). As a result, this study used figures from a range of different sources that used differing methods to compute unit costs. While it is acknowledged that wherever possible researchers should try to access local data (35)- in the context of this study this was not always possible.

Causality and attribution: Quantifying costs and benefits is extremely complex and brings with it its own politics (such as deciding what costs could legitimately be included and what benefits can be attributed to the intervention). These decisions are important as they could potentially influence and skew decisions on investments for example, in this case, towards those with the most complex needs and therefore the greatest potential for saving expenditure by the state(122).

Moreover, many of the consequences of homelessness, such as misuse of drugs, may also have been causes of homelessness. Because the causes and consequences of homelessness can be blurred, it can be difficult to identify the true costs of homelessness and helping people out of it. For example, someone regularly using drugs may be arrested or taken to hospital regardless of their housing status.

The sample: The sample size was 10 participants; the scope of the research makes this an introductory study which can inform larger future studies which can result in more definitive findings.

Respondent induced bias - client memory: Interviews can provide a plethora of information, however, the results /findings of these interviews were solely based on the interviewees self-report and were, therefore, subject to the research participant over-reporting, underreporting or memory distortions (123). Some respondents were in their second not first year in their new

home, which made remembering patterns of use of services in the year prior to engagement sometimes difficult. The interviewer attempted to mitigate this by providing 'Memory Sheets' outlining major news or sports events for particular years to help clients pinpoint the period times in the last three years (see Appendix 2).

Respondent induced bias – courtesy bias: The dynamics of directly interviewing clients engenders potential biases in responses as a result of clients need to present themselves favourably or to 'please' the interviewer. Respondents in this instance may have been reluctant to discuss issues such as utilisation of substance misuse services or previous contact with criminal justice system (124).

Post-hoc analysis: Post-hoc analysis consists of looking at the data, after the experiment has concluded, for patterns that were not specified prior to (in this instance) the interview / data gathering (125). The major complaint against this approach is that (1) it capitalises on chance relationships in the data and (2) it allows social scientist / researcher to generate an explanation after the fact, and it is open to more bias as it relies on peoples' memory rather than an objective assessment of a state of being at different points in time (3).

5. Financial Savings Analysis

5.1 Overview

This chapter identifies the costs savings to the state and its agencies from 10 case studies. Alongside the very human impact on mental, physical and emotional health, there are a range of financial costs associated with homelessness. As previously discussed research has shown clear links between homelessness and increased use of emergency health services, use of GP, interaction with drugs and alcohol services, interaction with criminal justice and greater support needs (126).

5.2 Mental Health Services

International evidence highlights that those at risk of homelessness tend to be frequent users of GP and Emergency Department services, but are infrequent users of routine outpatient services, including mental health services (95,127,128). The primary care system – that is GPs, public health nurses, social workers and others in non-specialist settings addresses 90% of poor mental health in Ireland(129). By contrast, a small proportion (about 10%) will require mental health services delivered by the Community Mental Health Team (CMHT)(117,129) which are likely to include representation from administration, clinical psychology, nursing, occupational therapy, psychiatry, social work and support workers (130). Those who need such specialist mental health services cannot self -refer – instead they must be referred by a GP, other primary care staff member or through an Accident and Emergency unit (117,129).

All ten of the interviewees bar one were attending primary care centres' at least once in every three months, at the point of interview, to see a psychiatrist or locum. Indeed, attending specialist mental health services was one of the prerequisites for gaining entry to this project. Two interviewees continued to attend the clinic in order to see the clinic nurse, while one linked in with the Community Psychiatrist and one other with the Public Health Nurse. Community supports such as the Platinum Club and Abbeyview Centre provides opportunities, social/recreational activities and may also serve as a 'drop-in centre' for people experiencing stressful living conditions (130). Two interviewees utilised this community support with one attending Abbeyview for a nursing check-up every Friday afternoon.

Table 2 Health Centres where respondents link in with Community Mental Health Team

Athy Health Centre, Woodstock Street, Athy, Co. Kildare
Celbridge Health Centre, Maynooth Road, Celbridge, Co. Kildare
Kilcock Health Centre, Kilcock Medical Centre, Kilcock, Co. Kildare
Maynooth Health Centre, Maynooth, Co. Kildare
Newbridge Health Centre, Henry Street, Newbridge, Co. Kildare
Rathangan Health Centre, Rathangan, Co. Kildare

5.3 Resource Use Table - Psychiatrist / Locum

Unit	Client No.	Before	Unit Cost	After	+/-
Primary Health Centre- Psychiatrist / Locum	1	1 in every 3 months = **4 visits** June – Sept – up to twice weekly = 12 X 2 = **24 visits** **4 + 24 = 28 Visits**	€209.60	Attends Celbridge Clinic 1 in every 3 months = **4 visits**	*- 24*
	2	Discharged from clinic in April 2013 = **1 visit**	€209.60	Discharged - **0**	*- 1*
	3	Once a month = **12 visits**	€209.60	Once a month = **12 visits**	*0*
	4	Once a month = **12 visits**	€209.60	Once a month = **12 visits**	*0*
	5	Once - twice a week over 4-month period 16 X 1 = **16 Visits**	€209.60	Once every 3 months= **4 Visits**	*-12*
	6	Approx. twice a month 12 X 2 Visits = **24 visits**	€209.60	Once every 3 months= **4 Visits**	*- 20*
	7	Approx. twice a month 12 X 2 Visits **= 24 visits**	€209.60	Once a month = **12 visits**	*-12*
	8	1 every 3 months = **4 visits**	€209.60	1 every 3 months = **4 visits**	*0*
	9	Once a month = **12 visits**	€209.60	1 every 3 months = **4 visits**	*- 8*
	10	Twice a month 12 X 2 = **24 visits**	€209.60	Once a month = **12 visits**	*-12*
	Total in Increase / decrease in visits				**- 89**
	Overall Cost Savings –- 89 Visits x cost per Locum/Psychiatrist = 89 Visits X €209.60[4] per patient) = € 18,654.40 Savings				

[4]Unit Cost per Psychiatrist visit is €209.60 based on assumption that each Client visit is 30 minutes See Appendix 5: Unit Cost Methods and Data from Economic Evaluation in Palliative Care in Ireland (2015), p. 310e(131).

5.4 Resource Use Table - Primary Health Centre

Unit	***Client No.***	***Before***	***Unit Cost***	***After***	***+/-***
Primary Health Centre Clinic Nurse	*2*	Clinic Nurse administers injection 1 every 3 weeks = **2 visits**	€40.50	Discharged = **0 Visits**	**- 2**
	4	Bloods twice yearly **= 2 visits**	€40.50	Bloods twice yearly **= 2 visits**	***0***
	10	N/A	€40.50	Twice a month to get anti-psychotic injection 12 x 2 =**24 visits**	**+ 24**
	Total in Increase in visits				**+ 22**
	Overall Cost increases--22 Visits x cost per Clinic Nurse = 22 Visits x €40.50[5] = € 891.00 Increase				

5.5 Resource Use Table - Public Health Nurse

Unit	**Client No.**	**Before**	**Unit Cost**	**After**	**+/-**
Public Health Nurse	3	Nurse visited once to twice weekly 52 X 1 = **52 visits**	€92	Nurse no longer visiting = 0	**-52**
	4	Nurse visits approx. 1 every 3 wks. = **17 visits**	€92	Nurse visits approx. 1 every 3 wks. = **17 Times**	**0**
	Total Decrease in visits				**-52**
	Overall Cost decreases--52 Visits x cost per Public Health Nurse, 52 Visits x €92[6] per patient = € 4,784 Savings				

[5] Including Employers PRSI the total cost of a Clinical Nurse at the top of the pay scales amounts to €48,509 (provided by David Dooley, Management Accountant HSE Community Healthcare Organisation, South Dublin / Kildare / West Wicklow via email 21 April 2016)) According to ERSI research See Appendix 5: Unit Cost Methods p. 307 (131), healthcare professionals' such as Occupational Therapists work approx. 42.8 weeks per year, at 35 hours per week which totals 1.500 hours. Assuming 20% of non -contact time for administration (132) and no travel and no home visits - direct contact hours will be 1200 hours . Therefore, the cost per hour contact with patient is €40.42.

[6] Unit Cost Per Public Nurse Visit is €92 based on assumption that each visit is 45 minutes See Appendix 5: Unit Cost Methods and Data from Economic Evaluation in Palliative Care in Ireland (2015), p. 310 (131).

5.6 Resource Use Table – Community Psychiatric Nurse

Unit	**Client No.**	**Before**	**Unit Cost**	**After**		**+/-**
Community Psychiatric Nurse	5	Once every 1 to 2 weeks over a 4-month period. 16 X 1 = **16 Visit**	€66.50	Client links in when Nurse needed. Ascertained 4 visits **4 Visits**		**-12**
	Total Decrease in visits					**-12**
		Overall Cost decreases--52 Visits x cost per Community Health Nurse - 52 Visits x (131) **€66.50**[7] **per patient = € 798.00 Savings**				

5.7 Resource Use Table - Counselling

Unit	**Client No.**	**Before**	**Unit Cost**	**After**	**+/-**
Counselling	4	Once a week over a 4-month period 16 Visits	€50	No longer attending	-16
	10	Did not attend	€50	Once a week over a 4-month period – **16 visits**	**16**
	Total Increase / Decrease in visits				**0**
	Overall Cost decreases--0 Visits x cost per Counselling Session, 0 Visits x €50[8] **= 0**				

[7] Including Employers PRSI the total cost of a community Psychiatric Nurse commences on a salary of €45,552 per year, which increases to €54,044 at the top of the increments scale. Including ER PRSI the total cost per year at the top of the scale amounts to €59,854.According to ERSI research See Appendix 5: Unit Cost Methods p. 307 (131), healthcare professionals' such as Occupational Therapists work approx. 42.8 weeks per year, at 35 hours per week which totals 1.500 hours. Assuming 40% of non -contact time for administration (132) and travel for home visits - direct contact hours will be 900 hours . Therefore, the cost per hour contact with patient is €66.50

[8] Cost of counselling sessions in Ireland can range from €40 to €70 (133) in Dublin region – in this instance a conservative figure of €50 was decided upon.

5.8 Resource Use Table – Day Centres

Unit	**Client No.**	**Before**	**Unit Cost**	**After**	**+/-**
Abbey view Day Centre	8	Did not attend = **0 visits**	€36[9]	Attends Abbey view day Centre in Castledermot 3 days weekly. Seen by a nurse every Friday in Centre 52 X 3 = **156 visits**	**+156**
Platinum Club[10]	5	Not linked in	€36	Visits at least 3 times a week. 52 X 3 = 156	**+ 156**
	Total Increase / Decrease in visits				**312**
	Overall Cost Increase –- 312 visits to Day Centre = 312 Visits X €36.00 per patient = €11, 232 Cost Increase				

5.9 Resource Use Table – Men's Group

Unit	**Client No.**	**Before**	**Unit Cost**	**After**	**+/-**
Men's Group	10	Not applicable	€20	Men's Group in Athy 52 X 1 = 52	**52**
	Total Increase in visits				**52**
	Overall Cost decreases–-52 Visits x Men's Group - 52 Visits x (135) =€20[11] per client = €1,040 Cost Increase				

[9] Unit Cost Per Visit to Day Care Center is €36.00 See Appendix 5: Unit Cost Methods and Data from Economic Evaluation in Palliative Care in Ireland (2015), p. 315 (131).
[10] Adame and Leitner (134) describe the clubhouse as a recovery orientated community that offers the service user a place where they can find meaningful daily work, friendships and a sense of belonging and support. The clubhouse is usually operated by a board of directors and has its own budget.
[11] Costs out at €20 per hour (based on QM info from other services running community groups)

5.10 Summary

While the level of costs associated with community link in services such as day groups, clinic nurse and men's groups increased, interviewees use of psychiatrists, public health nurse, community psychiatric nurse decreased giving a total cost savings of **€11,073.40** (see Table 2 below).

Table 3: Summary of change in Costs / Savings in Mental Health Usage

Community Based Services	**Cost Savings / Increase**
Visit's to Locum & psychiatrist - Overall decrease of in visits (- 89)	**€18,654.40 Savings**
Clinic Nurse – Overall increase in visits (+ 22)	**€ 891.00 Increase**
Public Health Nurse – Overall Decrease in visits (-52)	**€ 4,784 Savings**
Community psychiatric Nurse – Overall decrease in visits (-12)	**€ 798.00 Savings**
Counselling – No change in visits	**0**
Day Groups = Increase in visits (312) =	**€11, 232 Increase**
Men's Group = Increase in visit (52)	**€1,040 Increase**
Total Cost Savings	**€11,073.40 Savings**

6. GP Services

6.1 Overview

As discussed in the previous section the majority of mental health care is delivered in primary care, with GPs referring only about 10% of their patients to specialist mental health services (117,129). Those at risk of homelessness face a number of barriers to receipt of appropriate healthcare services, including continuity of care, lack of medication adherence and a lack of coordination between healthcare services and difficulty affording prescribed medication and medication storage (94,135). General practice has been identified as an important setting to meet these needs and to provide an opportunity for early intervention(136). In the research cohort a majority of respondents demonstrated less GP visitation one or two years after programme entry.

6.2 Resource Use Table – GP Usage

Unit	**Client No.**	**Before**	**Unit Cost**	**After**	**+/-**
Visits to the GP	1	Once every 2 months for prescription plus 6 apmts.during winter months for colds etc. **Approx. 12 Visits**	**€48**	**Approx. 12 visits**	**0**
	2	On average 1 in 4 weeks. **Approx. 12 Visits**	**€48**	Less than once a month = average 7 times annually. Visited more often the first 3 months of moving in (Feb, Mar, April) due to financial worries Approx. 7 + 12 = **19 visits**	**+7**
	3	NA used Celbridge Clinic not GP which has already been accounted for	**€48**	NA used Celbridge Clinic not GP which has already been accounted for	**N/A**
	4	Visits at least 1 in every 4 weeks. More during winter - up to 11 visits between months Oct-Feb. 12 Visits + 6 Additional Winter = **18 visits**	**€48**	6 times yearly for physical illnesses= **6 Times**	**-12**
	5	Approx. **8 Visits**	**€48**	Approx. **5 Visits**	**-3**
	6	3- 4 times annually	**€48**	3- 4 times annually	**0**

	7	6- 7 annually = **6-7 visits**	**€48**	6-7 annually - does not include her sons GP visits in this number. If her son was included, it most likely be double this. **6- 7 visits**	**0**
	8	Average **7 visits**	**€48**	Average **4 visits**	**-3**
	9	Usually uses Athy Medical Centre Average **5 visits** annually.	**€48**	**2-3 visits annually**	**-2**
	10	N/A – Could not remember	**€48**	N/A – Could not remember	**0**
	Total in Increase / decrease in visits				**-13**
	Overall Cost Savings – 13 Visits X cost per GP visit = Visits X Cost per GP Visit in Kildare = 13 visits X €48.00[12]**= €624.00 Saving**				

6.3 Summary

The estimated cost saving for GP usage for this cohort of individuals is approximately €624.00. Within this area of service provision, it is apparent that the small scope of the study does not support or negate a hypothesis that housing services reduce GP use.

[12]Using average payment made by Primary Care Reimbursement Service (2012) to GP per eligible person of €257.93, a unit cost of €48 per GP visit is calculated. The average cost for private visits surveyed across 36 GP is €47 per GP visit. See Appendix 5: Unit Cost Methods and Data from Economic Evaluation in Palliative Care in Ireland (2015), p.310 (131).

7. Emergency Department

7.1 Overview

Homeless individuals exhibit increased rates of acute health service use, including both emergency department (93, 133) and hospital admissions(89, 96, 97) when compared to the general population and other low socioeconomic groups (100). Moreover, individuals attending Accident and Emergency (A&E) on a regular basis account for a disproportionally high number of all A&E visits. La Called and Rabin (138) in their systematic review found that patients visiting an A&E four or more times per year accounted for 4.5% – 8% of all A&E patients and 21% – 28% of all A&E visits.

This population places significant economic, time, and space burdens on A&Es (139). Indeed, several studies show that frequent A&E users have non-emergency conditions (140–143) and could receive better care in settings other than Accident & Emergency (144). In Ireland, A&E attendance among the homeless population has increased over time suggesting that the increased access to primary care services is not preventing use of acute secondary care services (91,145).

7.2 Resource Use Table – Emergency Department

Unit	**Client No.**	**Before**	**Unit Cost**	**After**	**+/-**
Emergency Department[13]	1	No attendance	**€268.00**	Attended once June / July 2015, Was suffering from palpitations. Blood pressure taken. 1 visit	**+1**
	2,3,4,5,6,7	No visits	**€268.00**	No visits	**0**
	8	No visits	**€268.00**	6 months ago due to a minor Stroke - 3 days overnight = **1 visit to A&E prior to admittance**	**1**
	9	October 2014 client was involved in car accident - required 1 night in Naas- **1 visit to A&E prior to admittance**	**€268.00**	No visits	**-1**
	10	Client went to Manoah A&E approx. 3-4 times. Admitted a couple of times for overnight **4 Visits**	**€268.00**	Since moving client has gone to Maynooth A&E approx. 3-4 times. Admitted a few occasions. **4 Visits**	**0**

[13] Some clients stated that they presented to the hospital via A& E and were hopitalisation. For the purposes of this study the cost to the state for A&E plus the costs incurred for overnight stays are computed. See next table.

	Total in Increase / decrease in visits	**+ 1**
	Overall Cost Savings / Increase of Cost – 1 Visits x cost per A&E visit [14]= €268 Cost Increase	

7.3 Summary

The estimated increase is €**268.00.** Among the respondents of this study there was no marked difference in utilisation of the Emergency Department in the year prior to engaging with Focus Ireland. Four of respondents stated that they had had attended A&E on a regular basis some years ago; two respondents revealed that two to three years ago they had presented to Accident and Emergency on an account of a series of overdoses, however this data is outside the timeframe of the study and is therefore not included. The two visits in the year of engagement with Focus were due to chronic ongoing physical illness. Within this area, it is apparent that the small scope of the study does not support or negate a hypothesis that housing services reduce A&E use.

[14] Unit Cost Per A&E Visit is €268. See Appendix 5: Unit Cost Methods and Data from Economic Evaluation in Palliative Care in Ireland (2015), p. 312 (75).

8. Inpatient Hospitalisation

8.1 Overview

In addition to high rates of first illness admissions, re-admission rates are higher within homeless populations (105, 142). Doran et al. (147) found that of homeless adults discharged from an urban hospital, over half were readmitted within one week, often for a similar conditions and diagnoses for which they had been discharged. The respondents in this study differ in that most of them were not currently 'out of home' at the time of interview – in addition their inpatient stays were linked with A&E visits with such visits usually leading to an inpatient stay.

8.2 Table Showing Resource Use – Inpatient Stays

Unit	**Client No.**	**Before**	**Unit Cost**	**After**	**+/-**
Inpatient Hospital Stays	1	No attendance	**€4,580**	Attended once June / July 2015, Was suffering from palpitations. Kept overnight	**+1**
	2,3,4,5,6,7	No visits	**€4,580**	No visits	**0**
	8	No visits	**€4,580**	6 months ago due to a minor Stroke - 3 days overnight = **1 visit to A&E prior to admittance**	**+1**
	9	October 2014 client was involved in car accident - required 1 night in Naas- **1 visit to A&E prior to admittance**	**€268.00**	No visits	**-1**
	10	Client went to Manoah A&E approx. 3-4 times. Admitted a couple of times for overnight **4 Visits**	**€268.00**	Since moving client has gone to Maynooth A&E approx. 3-4 times. Admitted a few occasions. **4 Visits**	**0**
	Total in Increase / decrease in visits				**+ 1**
	Overall Cost Savings / Increase of Cost – 1 Visits x cost per Inpatient Stay[15] = €4,580 Cost Increase				

[15] Unit Cost Per Inpatient stay is €4,580. See Appendix 5: Unit Cost Methods and Data from Economic Evaluation in Palliative Care in Ireland (2015), p. 314 (131).

8.3 Summary

The estimated cost difference is **€4,580** cost Increase since the sample group engaged with the My Home My Choice project. However as with other sections it is apparent that the small scope of the study does not support or negate a hypothesis that housing services reduce hospital overnight stays.

9. Self Harm / Suicide Services

9.1 Overview

As previously discussed the 2011 Simon Community 'point in time' study found 17% of the 603 had attempted suicide in the last six months (148). A more recent study in 2013 by the Partnership for Health Equity - a collaboration between the HSE, the North Dublin City GP Training Programme and the University of Limerick, found that one in three homeless people in Ireland has attempted suicide. This figure increases to one in two among those with a mental health condition (149).

9.2 Resource Use Table – Self Harm / Suicide Services

Unit	**Client No.**	**Before**	**Unit Cost**	**After**	**+/ -**
Self-Harm / Suicide Services	1	June 2013 - Suicide Ideation. With thoughts of suicide 2-3 times daily for 6-month period. Celbridge Clinic provided service	**€942.7** [16]	No longer has suicide ideation - currently attends Celbridge clinic once in every 3 months. **This has been recorded already in community mental health services**	**0**
	2,3,4,5,6	N/A	**€942.7**	N/A	**0**
	7	Had a stay in Pieta House circa 2013 - 2 years ago. Outside time period of study	**€942.7**	No Change	**0**
	8, 9	Not willing to discuss	**€942.7**	Not willing to discuss	**0**
	10	Took an overdose in 2014 the year before moving into a new apartment. Required overstay nights.	**€942.7**	Client has gone to Maynooth A&E approx. 3-4 times. Admitted a few occasions- Already recorded	**0**
	Total in Increase / decrease in visits – **already recorded**				**N /**
	Overall Cost Savings / Increase of Cost – already recorded under other costs such as hospitalisation				

9.3 Summary

The review showed that while one of the interviewees progressed from experiencing suicidal ideation to not experiencing this, the change in resource use was already accounted for in the mental health section of the review.

[16] These figures are from a published SROI analysis on a Self-Harm/ Suicide Prevention program that was undertaken by Quality Matters. The 2014 expenditure of €320, 510 divided against clients on file (340) = a cost of €942.67 per client.

10. Drug / Alcohol Services

10.1 Overview

Drug misuse in the homeless population has been identified as significant risky behaviour and has been reported to be a cause, contributor and consequence of homelessness (150). Drug use is known to be more prevalent in the homeless population (91,151) and studies have shown that it may be an increasing problem in this population. In surveys examining the prevalence of drug users among homeless population in Dublin, it was found between 29% and 64% had a lifetime problem with drugs or alcohol (152). Three interviewees stated that they had previously has difficulties with drugs and/or alcohol.

10.2 Resource Use Table – Drug / Alcohol Services

Unit	**Client No.**	**Before**	**Unit Cost**	**After**	**+/-**
Drug/ Alcohol Services	1	Did not access services but did take recreational drugs in an attempt to alleviate stress and emotional difficulties	€1,650	No longer smokes marijuana as it feels that it destabilises mood. Does not affect resource use	**0**
	2,3,4,5, 6, 9	N/A		N/A	**0**
	7	Was treated for alcoholism 3 years ago. However, this is outside the remit of the study	€1,650	No Change	**0**
	8	Not willing to discuss	€1,650	Not willing to discuss	**0**
	10	Attending Addiction Counselling once a week **Recorded under another heading 10.7**	€1,650	Attending Addiction Counselling once a week. **Recorded under other heading 10.7**	**0**
	Total in Increase / decrease in visits – **already recorded**				**N/A**
	Overall Cost Savings / Increase of Cost – already recorded under other costs, however unit cost estimate is €1,650[17]				

[17] These figures are from an unpublished cost per unit analysis that was undertaken by Quality Matters. The cost per unit analysis considered all income and divided this against each element of service delivery based on a weighting of staff time. While there are numerous national figures for residential treatment available, as a comparative for this project, a day programme with a similar key working function was considered a closer comparative to the experience received by these participants. Both Mojo and the comparative project refer onto residential programmes.

10.3 Summary

The values of two separate day programmes similar to this service were averaged; one a drug specific programme (€1,800) and the other a general substance misuse day programme, including alcohol (€1,500) The average valuation was €1,650. There was no change in service use in relation to drug and alcohol use.

11. Housing Services

The My Home My Choice project procures accommodation for individuals and families with mental health difficulties. The premise of this study was to explore whether respondents of this study used less state services following their engagement with this program. However, another facet of this study is the inherent cost to the state in providing housing for the respondents both *before* and *after* them 'linking in' with the Focus Ireland My Home My Choice project. In the following section the 4 different prior circumstances experienced by i respondents prior to gaining their own home are explored.

11.1 Overview – Private Rented Accommodation

Four of the respondents were living independent lives in private rented accommodation in the year before they sought support from Focus Ireland (see Table 16.2.). Three of the four were given notice to quit by their landlord for a variety of reasons such as sale of house, a rise in rent etc. One participant felt that as single mother in receipt of Rent Allowance she was at a distinct disadvantage in the rental market, stating '*I am competing against professionals from the likes of Hewlett Packard who have no baggage'*. Two of the four respondents did concede that their private rented accommodations were substandard and that the quality of the accommodation they were now residing in was far superior.

11.2 Resource Use Table – Housing Costs – Private Rented Accommodation

Unit	Client No.	Before	Unit Cost	After	Costs
Private Rented- *Left of own accord or Notice to Quit*	2	Moved from substandard Private Rented to New Private Rented with support of Focus Rent Allowance X 12mths = €433[18] X 12 = **€ 5,196**	**€433**	Moved to new accommodation Rent Allowance X 12 mths = €433 X 12 = **€ 5,196**	**0 Change**
	2	4 visits X Focus Support Worker= 4 X €81.24[19] = **€ 324.96**	**€81.24** per visit	4 visits X Focus Support Worker =**€ 324.96**	**0 Change**
	4	Rent Allowance X 12mths = €433 X 12 = **€ 5,196**	**€433**	Rent Allowance X 12mths = €433 X 12 = **€ 5,196**	**0 Change**
	4	4 visits X Focus Support Worker =4 X €81.24 = **€ 324.96**	**€81.24** per visit	0 visits X Focus Support Worker = 0	**€324.96** Saving
	6	Rent Allowance X 12mths = €750 X 12 = **€ 9,000**	**€750**	Rent Allowance X 12mths = €750 X 12 = **€ 9,000**	**0 Change**
	6	4 visits X Focus Support Worker =4 X €81.24 = **€ 324.96**	**€81.24** per visit	No longer needs support from Focus project worker = 0	**€324.96** Saving
	7	Rent Allowance X 12mths = €650 X 12 = € 7,800	**€750**	Living back with mother[20]	**Not Included**
	Overall Cost Savings = 324.96 + 324.96 = €649.92 Saving				

[18] http://www.citizensinformation.ie/en/social_welfare/social_welfare_payments/supplementary_welfare_schemes/rent_supplement.html#l62fd2

[19] As per information from Focus Ireland. Basic Hourly rate is €23.52, ER PRSI €2.53 and Pension €1.03 totalling €27.08 in total per hour. Hours per visit (including travel time) approx. 3 hours. Total cost is 3 X €27.08 = €81.24

[20] This client received notice to quit in the last 6 months and is currently living with family – therefore cost savings in relation to this particular client will not be included in the overall cost savings calculation

11.3 Overview – Group Homes

Two respondents stated that they were housed in a low support HSE Hostel prior to securing Focus accommodation. A low-support/group home unit is shared living and does not provide 24 hours support - it has input from the community mental health team during the day, but no night staff (130). Group living situations for those with a psychiatric disability are consistently cited as the least popular option (153). The two respondents' views mirrored such findings in that they expressed relief at leaving this accommodation - one male participant with daily access with his children felt 'uncomfortable with his children visiting him in the house.

11.4 Resource Use Table Group Homes

Unit	**Client No.**	**Before**	**Unit Cost**	**After**	**Costs**
Low-support/group home unit[21]	3	Shared HSE 'supported living' house.52 weeks X of HSE Supported Living (Per person) **€334.89 =€17,414.56**[22]	**€334.89** per week	Moved to new accommodation Rent Allowance X 12 mths = €433 X 12 = **€ 5,196**	**€12,218.56** Savings
	3	Psychiatric Nurse - 52 Visits x (131) €66.50 per patient **= €3,458.50**	**€66.50**[23]	No more visits from Nurse (see table 10.6)	**€3,458.50** Savings
	8	12 weeks X weekly cost Supported Living (Per person) = **€4018.80**	**€334.89** per week	Rent Allowance X 12mths =€433 X 12 = **€ 5,196 (3 yrs. ago)**	**€1,177.2** Cost
	8	Community Psychiatric Nurse - 12 Visits x (131) €66.50 per patient **= €798**	**€66.50**	No more visits from Nurse (see table 10.6)	**€798** Savings
	Overall Cost Savings / Increase of Cost = €16,475.06 Savings - €1,177.2 Cost = €15,297.86 Savings				

[22] Figure in relation to Low support hostels is the one furnished by the Value for Money report (pg. 15) which is Wicklow / Kildare based – '*Cost Centre 3095024 1 Other Hostels Med/Low Support = €278,633 spread over four different centre's'*. Therefore, figure for one year was calculated by €278, 633 divided by four hostels by four clients (16) =€17,414.56. Elizabeth Grehan, Principal Social Worker confirmed via email (27/05/2016) confirmed that Hazel Cottage is low support (four sharing a house) in that it does not provide 24-hour nursing care - instead the house is visited weekly by the Community Psychiatric nurse. David Dooley, Management Accountant HSE Community Healthcare Organisation 7, South Dublin /Kildare/ Wicklow confirmed that there are only four low support houses in the relevant catchment area

[23] According to ERSI research See Appendix 5: Unit Cost Methods p. 307 (131), healthcare professionals' such as Occupational Therapists work approx. 42.8 weeks per year, at 35 hours per week which totals 1.500 hours. Assuming 40% of non -contact time for administration (132) and travel for home visits - direct contact hours will be 900 hours. Therefore, the cost per hour contact with patient is €66.50

11.5 Living with Family

Four of the ten respondents prior to engaging with Focus, were either living in the family home or with relatives or friends. While research shows beneficial effects of family contact among people who become homeless (154,155), it also highlights that relatives of homeless adults, including parents of homeless adults, may themselves experience difficult challenges, including poverty and stress, limiting their abilities to provide support to their family members (156–158). Over time, this burden may lead adults who become homeless to become increasingly alienated from family relationships (1).

11.6 Resource Use Table - Living with Family

Unit	**Client No.**	**Before**	**Unit Cost**	**After**	**Costs**
Family / Relatives	2	Lived in Family Home	**€433 RS**	Rent Allowance X 12mths = €433[24] X 12 =	**€ 5,196**
	9	Lived in Family Home	**€433 RS**	Rent Allowance X 12mths = €433 X 12	**€ 5,196**
	10	Lived in Family Home	**€433 RS**	Rent Allowance X 12mths = €433 X 12	**€ 5,196**
	Overall Cost Savings / Cost expenditure- €15,588 Cost Increase				

One respondent stated that she was *'very grateful'* for her friends help and saw this as an important social support, however the remaining three respondents experience of living with family / relatives was largely negative. One respondent stated *'there's a reason why adult children should not be living with their parents'*. Respondents cited sibling resentment, parents continuing frustration with participant's mental health difficulties and lack of space as the primary cause of a fractious atmosphere in the house. One of the respondents was asked to leave her sister's house and was temporarily housed by Athy County Council. It is clear that family relationships complicated by homelessness can become both supportive and stressful for all involved (159). All three respondents stated that relationships with their family had improved on them gaining accommodations of their own.

[24]http://www.citizensinformation.ie/en/social_welfare/social_welfare_payments/supplementary_welfare_schemes/rent_supplement.html#l62fd2

11.7 Resource Use Table – Categorised as Homeless

Unit	Client No.	Before	Unit Cost of Daily B&B	After	Costs
Homeless	5	Categorised as homeless in May 2015- housed in temporary accommodation by Athy Council for a period of 8 weeks Cost of Temp Housing (B&B) X 8 weeks = 8 = 56 days X €45 = **€2,520**	€45 per night[25]	Living in Nass, Co Kildare for over 6 months. Private Rented Apt sourced by Focus - €433 (Rent Supplement) X 6 = **€ 2,598.00** 4 visits X Focus Support Worker =4 visits X Focus Support Worker =**€ 324.96**	**€2922.96**
	Overall Cost Savings / Cost expenditure = 56 days in B&B X €45.00 =€2,520 - (6 months' Rent Supplement + 4 visits from Support worker -€2922.96) = €402.96 **Cost increase**				

11.8 Summary

In 2015 Kildare county council spent €843,705 on emergency accommodation (160) for those who are homeless or at risk of being 'out of home'. One participant spent some eight weeks in emergency accommodation – in the absence of an official figure as to the weekly costs from a costing was gleaned from the average cost of a night in a B&B. Costs have clearly increased from those that have moved from family surroundings to private rented accommodation. However, the cost savings involved for those moving from group homes is significant at **€15,297.86.** Two respondents spent some one year and three months in this environment prior to securing housing with the My Home My Choice project.

[25] The Homeless Action Plan, May 2010 to May 2013 by the Mid-East Joint Homelessness Consultative Forum (Wicklow, Meath & Kildare County Council) continues to feature on the Kildare County Council website - http://kildare.ie/CountyCouncil/Housing/Mid-EastHomelessActionPlan/. The report states (p. 16) that Emergency Homeless Services in Kildare are Michael Garry House (16 beds), Cain Mire, Tahy (referrals usually for those with alcohol addiction but emergency beds are available to Kildare County Council for non-addiction issues), Mount Offaly House, Athy (14 beds) and Bed and Breakfast if the former residences are deemed unsuitable. In the absence of a Unit Cost figure for the cost to Kildare County Council of providing emergency on a weekly basis, a figure of €45 is used for daily B&B in Kildare Area. In Ireland for a moderately priced B&B, the average cost for a room with private bathroom is roughly €45 per person per night. See: http://www.frommers.com/destinations/ireland/697598#ixzz4AsNZsbic

11.9 Overall Cost Increases / Savings

The study found a slight decrease in costs to the amount of €6,896.22. There was a significant reduction in costs associated with visits to psychiatrists, however these savings were offset as a result of increased access to community services such as day groups or inpatient hospital stays. Furthermore, three of the respondents were living in the family home prior to being housed by the project – therefore rent allowance for one year for three persons were added to the costs in the year following engagement. It should also be noted that cost savings accrued on social worker visits is most likely underestimated. While most respondents were referred to the project by their social worker – within the interviews respondents were better able to identify service use reductions in areas focused of their medical supports, such as psychiatrist, public health nurses etc.

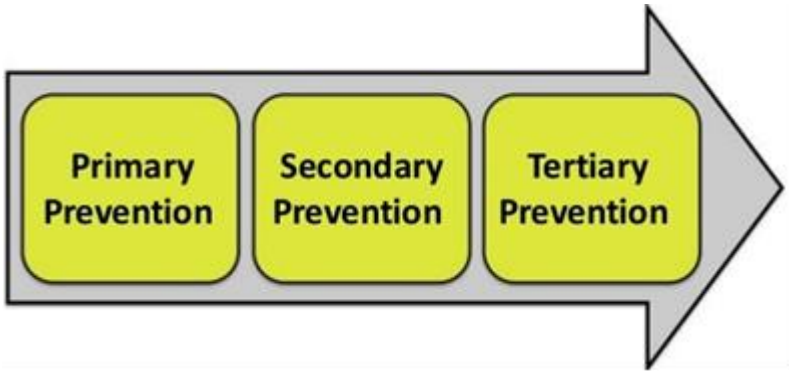
Table 4 Summary of change in Costs / Savings in Mental Health Usage

Table No.	Community Based Services	Cost Savings / Increase	Total Savings
10.2	Visit's to Locum & psychiatrist - Overall decrease of in visits (- 89)	**€18,654.40 Savings**	**€18,654.40**
10.3	Clinic Nurse – Overall increase in visits (+ 22)	**€ 891.00 Increase**	**€17,763.40**
10.4	Public Health Nurse – Overall Decrease in visits (-52)	**€ 4,874 Savings**	**€22,637.40**
10.5	Community psychiatric Nurse – Overall decrease in visits (-12)	**€ 798.00 Savings**	**€23435.70**
10.6	Counselling – No change in visits	**0**	**€23435.70**
10.7	Day Groups = Increase in visits (312) =	**€11, 232 Increase**	**€12,203.40**
10.8	Men's Group = Increase in visits (52)	**€1,040 Increase**	**€11,073.40**
11.2	GP Usage = Decrease (-13)	**€624.00 Saving**	**€11,787.40**
12.2	Emergency Department (+1)	**€268.00 Increase**	**€11,519.40**
13.2	Inpatient Hospitalisation (+1)	**€4,580 Increase**	**€6939.40**
14.2	Suicide/ Self Harm services (N/A)	*Other services such as A&E recorded in 12.2 & 13.2*	
15.2	Drug / Alcohol Services (N/A)	*Recorded in 10.7*	
16.2	Housing – Private rented	**€649.92 Saving**	**€7,589.32**
16.4	Housing – Group Home	**15,297.86 Saving**	**€22,887.18**
16.6	Housing – Living with Family	**€15,588 Increase**	**€7,299.18**
16.7	Housing in Homeless Accommodation	**€402.96 Increase**	**€6,896.22**

12. Cost Savings and the Role of Prevention

It is now widely recognised that preventing households from becoming homeless must be a key component in any strategy to tackle homelessness effectively. Due to the high public and personal costs of providing emergency shelter, governments increasingly view preventative strategies as cost-effective and socially progressive (22). A range of classifications of homelessness prevention has been suggested (23,24). A German and English based three-stranded framework described by Busch-Geertsema and Fitzpatrick (161) is perhaps most apt for the Irish environment. The three-tier model describes 'primary prevention' as preventative measures applied where people have not yet become homeless; 'secondary prevention' relates to people who are not yet homeless but are at 'high risk' or 'in crisis… likely to lead to homelessness in the near future' (p.73) while tertiary prevention targets people who have already been affected by homelessness (see fig 1). Paradoxically, the benefits of programs occur in reverse temporal order: tertiary prevention has the most immediate benefits, secondary prevention yields benefit that accrue further in the future, and primary prevention has the most distal benefits. Thus "prevention" spending is really tertiary prevention responses—efforts to stop a known problem from getting worse (38). One participant in this study fell into the latter category while the remainder of the cohort could be seen as having a higher risk of experiencing homelessness on the basis of having poor mental health

Figure 2 Three-Tier Model of Prevention



This increased emphasis on prevention can be seen, alongside the attention to 'Housing First' and 'Housing Led' approaches, as a paradigm shift away from the large-scale provision of emergency shelter. Rooted in the belief that housing is a basic human right, the Housing First approach deems access to an independent tenancy as a priority. Housing is separated from treatment and while a harm reduction approach is followed (112,162) it removes the requirements for sobriety, treatment attendance, and other barriers to housing entrance (112). Thus far, Housing First approaches have primarily targeted homeless people with serious mental illnesses and co-occurring substance use disorders (17,163).

Previous studies on Housing First and related programs demonstrate that within one or two years after program entry, a majority of respondents experience significant improvements in housing stability (112,164–166) mental health functioning (167) quality of life (163,165) and reductions in health service (emergency and inpatient) use as well as self-reported justice system use (165) . In addition to improved participant outcomes, several studies also report on the reduced costs of Housing First in comparison to traditional housing programs (165,167). The Focus Ireland My Home My Choice project in Kildare must be viewed from two angles in relation to cost saving; one is its ability to contribute to saving through a housing first model. The potential to create cost saving in this way is described within this report. The other lens through

which the service should be viewed is as a preventative service, preventing increased need and case complexity. However, this way of viewing savings, i.e. preventing further service use, has not been covered in detail in this financial review.

13. Recommendations in Relation to Future Data Collection

The following two recommendations relate to how Focus Ireland can better capture the benefits of its services into the future;

1. To develop a data collection system that collects information on the client's service usage and experience in the year prior to becoming a client of the service. Administrative and assessment datasets have considerable potential to be used for the study of cost offsets. If carefully adapted this could avoid being overly onerous on staff and clients (37)

2. To collect information on client outcomes and wellbeing pre and post intervention, this is core to demonstrating the difference an intervention makes to clients and would also enable a longitudinal study which would give a more nuanced view as to the whole cost benefit of services. This would also need to value the impact on service users and their families. It is suggested that methodologies such as SROI be explored as a framework for this.

14. Conclusion

An affordable, good-quality home is crucial to a person's well-being and social participation (168). While the relationship between housing and social inclusion is complex, suitable housing is widely regarded as an essential and fundamental social inclusion measure. Poor or inadequate housing impacts negatively on people's mental and physical health (169) in short the quality of housing is a key issue in people's recovery journey.

Research within the Irish context suggests service users are frequently living in supportive accommodation which is more reflective of a 'mini - institutional' culture rather than a recovery culture (44). For some years now Irish policy has advocated a shift in thinking from a position where housing needs of people with disabilities are viewed primarily in terms of "special needs" housing to a mainstream approach (46,47,49,51).

The 'My Home, My Choice' project adheres to the goals set out in current policy in that mainstream housing is accessed through the co-operation of the local council, Kildare mental health services, housing associations, Focus Ireland Long Term Housing and the private rented sector. In line with the 'Vision for Change', Report of the Working Group on Congregated Settings (2011) and Addressing the Housing Needs of People using Mental Health Services (2012) the 'My Home, My Choice' project emphasises the need to provide ongoing community based support in tandem with community based housing. There is a recognition that individualised and personalised support needs to be provided in order to maintain the tenancy.

Tracking the costs of homelessness and determining whether housing services result in a reduction in costs is inherently challenging. This is due to the preventive nature of housing services, in that these studies cannot account for resource use that was saved. Another challenge is presented methodologically in relation to the collection of data on service use and costs for services – many of which easily attainable in an Irish context. This report has negotiated these challenges and provided a foundation framework that can inform future data collection systems.

This study found a small decrease in resource use to the approximate amount of **€6,896.22.** This saving was made largely through a reduction in higher cost psychiatric service use. The study also found an increase in the use of community-based services. Had a number of individuals

not been living in the family home prior to the 'My Home, My Choice' intervention, this saving would have been significantly higher, as an increase in rent allowance associated with people attaining their own housing, offset by other health service costs.

This study represents an important 'first step' towards quantifying both the costs and cost savings of homeless services in Ireland. Consumers need data on services received and whether those services meet their needs. Funders require program-level performance data both to demonstrate that programs are delivering the services they are funded to perform, and to compare providers on standardised performance benchmarks. The public needs system-wide performance measures that demonstrate whether the system as a whole is meeting its primary objectives of improving the lives of homeless people and reducing homelessness, and to demonstrate if it is doing so in as efficient and cost-effective a manner as practicable.

This study which focuses on public costs and benefits does not provide a full societal cost-benefit analysis, as it does not include the value of services to clients or their families. However, the study highlights the potential cost savings to the state through funding preventative services. The Focus Ireland My Choice, My Home project has shown that a well-planned, person centred and collaborative approach to services can provide not only cost effective outcomes for those in need of a home whilst also demonstrating increased engagement with community supports and services.

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