Executive Summary

This longitudinal qualitative research study explores the effects of changes that ensued in service delivery as a result of COVID-19 for people living in Dublin experiencing mental-ill health, substance use disorder (SUD) and/or homelessness/housing insecurity. The research was carried out in two phases. Interviews were carried out during the period October and November 2020, and again in July/August 2021 with the same participants.

The research focusses on the lives of ten participants who are engaged in two services that provide care to people experiencing mental ill-health, substance misuse and homelessness in the Dublin area - Merchants Quay Ireland (MQI) and HSE ACCES. MQI is an NGO which provides a range of support services for those experiencing homelessness, those in substance use and their families. MQI provides day programmes, residential detox and drug-free rehabilitation services, needle exchange as well health and counselling services and a homeless drop-in service.

HSE ACCES is a statutory mental health service for homeless people that uses a multidisciplinary approach. Established in 2004, it has a team which comprises of a social worker, occupational therapist and psychologist as well as mental health nurses and psychiatrists. The goal is to treat homeless people with severe mental ill-health (such as Schizoaffective Disorder) who may also be experiencing substance use issues.

Both services experienced substantial changes in service delivery as a result of the COVID-19 pandemic, and this research aims to explore the impact that this has had on the day-to-day lives of the people that are supported by both organisations.

Policy and Prevalence of Mental Health, Substance Misuse and Homelessness in Ireland

The implementation of mental health policy in Ireland has suffered from lack of funding as well as the reorganisation of the health service during the economic downturn. National spend on mental health is half of that in the UK at a time when there is a noted increase in mental ill-health within the population. The newest mental health policy 'Sharing the Vision' prioritises mental health as a major societal issue, and takes a life cycle approach.

National drug strategies, initially evolving from a criminal justice approach, have since developed and the most recent strategy 'Reducing Harm, Supporting Recovery', aims to provide a continuum of care model for the first time. This integrated approach has at its core social care – family, housing, educational, criminal justice and healthcare supports. Homelessness in Ireland has been a major political issue for a number of years, with the availability of social housing extremely limited, leading to a continuous rise in numbers of people experiencing homelessness year on year. Housing policy 'Rebuilding Ireland' is seen to have been largely a failure in addressing the issue. A new housing policy 'Housing for All' has a number of key targets on housing provision. One such target is to increase Housing First tenancies as a way of providing stable accommodation for people with complex issues, including SUD and/or mental ill-health.

The prevalence of mental ill-health and substance use disorder, as well as true figures for homelessness, is difficult to estimate. For those experiencing mental ill-health, there is both a lack of a coherent pathway for engaging with services and a stigma around mental ill-health. For people with SUD, analysis is provided by figures for those accessing treatment only, and excludes those who do not seek treatment. Homelessness prevalence is also difficult to determine, with the actual

numbers thought to be much higher than those provided by statutory agencies as a result of both changes in enumeration methods and the limited definition of homelessness used by the state.

The Complexity of Mental Health, Substance Misuse and Homelessness

Mental ill-health, substance misuse and homelessness issues are, in many cases, inextricably linked. While difficulty in one area may trigger the onset of another (ie homelessness may lead to substance use) there is evidence that, once in motion, there is a non-linear relationship between mental health, substance use and homelessness. Prior to the latest mental health strategy, there has been a lack of access to treatment for those experiencing mental ill-health and substance misuse (dual diagnosis), with most services in a position to provide treatment for one aspect only (SUD or mental ill-health) leaving those presenting with both unable to access treatment for either.

COVID-19 Declaration of a Pandemic and Service Response

The World Health Organisation declared COVID-19 as a pandemic on March 11th 2020, and a wide range of COVID-related restrictions were introduced by the Irish Government (27.03.2020). Particularly vulnerable individuals were identified as at-risk (people with underlying health conditions) as well as those living homeless due to their living conditions and high morbidity levels, often accompanied by substance misuse. The response to the threat that COVID-19 posed to this group was to form a cohesive strategy comprising specialised homeless GP services, harm reduction and homeless services. This approach worked in that the number of confirmed cases of coronavirus in this population was much lower than expected.

While this response could be said to be successful, there was limited

awareness of the impact that the restrictions would have on the mental health of the nation as a whole, and particularly those who are part of a vulnerable group.

Restrictions meant that services experienced considerable interruption, with most organisations unable to provide supports in the way that they had prior to the pandemic. This has led to reduced social interaction for a group of people already experiencing social exclusion, and even at Phase 1 of data collection, there was evidence of higher risks to mental health and increased substance use as a result of this isolation.

A Safe Return to Services and the Digital Divide

A safe return to previous service delivery envisaged a three-phase reintroduction of health and social care services within a COVID-19 environment. However, continued restrictions mean that it is unclear when this will actually happen. In the meantime, many services have moved to on-line or phone, and this has met with mixed results. It also gives rise to the problem of technological exclusion. This 'digital divide' underlines the disadvantage of those who have no regular (or any) access to phones and/or the internet, meaning that such services are only available to certain groups within the population.

STUDY AIMS AND OBJECTIVES

This research at Phase 1 aimed to explore the lived experiences of the COVID-19 pandemic for people engaging in services with MQI and HSE ACCES.

It's key objectives were:

- To identify challenges experienced by people with issues around mental health, substance use or homelessness (or any combination of all three) that have arisen from the COVD-19 pandemic;

- To examine the factors associated with participants' service experiences, especially at the time of the first lockdown and following partial re-opening of services.

- To understand the perceived impact of the reduction in services in terms of the mental health of the service uses.

It became clear, as the restrictions necessitated by the pandemic continued, that these participants (representative of an especially vulnerable group) would continue to experience difficulties as services reoriented to provide support. As a result, Phase 2 of the research focussed on further exploration of these issues with a view to tracking changes, if any, over a period of time.

Study Design

The study uses a qualitative approach, allowing participants to articulate their own personal perspectives on the effects of COVID-19 on their lives, particularly in relation to their mental health. In doing so, it reflects the move in recent Irish policy towards engaging service users in the planning and delivery of services going forward.

Sampling and Inclusion/Exclusion Criteria

Purposive sampling was used to provide a sample which reflected the broad demographic of service users for both MQI and HSE ACCES. Participants had to be over 18 years of age, be in receipt of services from either organisation and have experience of mental ill-health, substance misuse and/or homelessness, both before and after March 2020. They also had to have the capacity to give informed consent.

Recruitment, Consent and Data Collection

MQI and HSE ACCES acted as 'gatekeepers' for the study, ensuring that only people with the capacity to give informed consent would be approached to partake in the study. All participants were given a participant information letter, outlining the purpose of the study and what would be expected of them. They were also given a copy of the consent form to read in advance.

Data collection for Phase 1 took place over October and November 2020. Five participants from HSE ACCES were interviewed face-to-face and opted to do so without the presence of the service provider. A further five participants, recruited from MQI, were interviewed by phone or Zoom. For Phase 2, interviews took place in July and August 2021, using the same approach. Of the ten original participants, nine were available for interview at Phase 2 and four of these interviews were conducted face-to-face while the remaining five were conducted by phone.

Data Analysis, Data Protection, Ethical Issues and Payment

Interviews were transcribed verbatim and potentially identifying information removed. Each participant was assigned an alpha-numeric code for the purpose of data storage and interviews were held in accordance with GDPR regulations.

In the absence of an accessible and expedient pathway to formal ethics approval, a number of experts in the field of research, mental health, homelessness and substance use were invited to form a Scientific Advisory Committee (SAC) to oversee the study and provide feedback. A Data Protection Impact Assessment and an Ethics form were drawn up to provide a framework for the ethical conduct of the research study. Participants were not paid to participate but were given a gift voucher for an Irish-owned supermarket to the value of €20.00. This gift was not signalled in advance of the interviews.

Challenges with the Study

Recruitment of participants engaging with HSE ACCES was relatively smooth but for those linked in with MQI, recruitment was more challenging. The HSE ACCES building remained open during the pandemic but access to Riverbank (MQI) was more restricted. These latter participants also had more precarious housing situations.

While sampling had suggested that the study should have a ratio of 6:4 (male: female) reflecting service use, in the event more women than men participated, reflecting previous findings on low male engagement in health research.

Of the participants, four were male and six were female. They ranged in age from 32 to 58 years, with an average age of 40.5 years. Three participants had achieved education to primary school level only, while three had completed their Leaving Certificate. Four had started tertiary education but only one achieved their primary degree. All were unemployed at the time of Phase 1 of the study. Six of the participants were single, three were separated and one was widowed. Five participants (all female) had children.

Five participants reported a severe mental illness and of these, the majority (n=4) had been diagnosed with Schizoaffective Disorder. The remaining five participants had experienced depressive illness throughout their lives. Two participants had a severe mental health issue with no co-presenting substance use history.

At Phase 1, four had a mental health issue co-presenting with alcohol use and the remaining four co-presented with substance use either at the time of the study or in the past. Reported substance use included cocaine and MDMA (in the past), heroin, benzodiazepines and crack cocaine (at the time of the study).

All of the participants had, or were at the time of the study, experiencing homelessness. At Phase 1, three were housed, a further two were street homeless and the remaining (n=5) participants were living in hostels. The majority (n=8) had entered into homelessness as a result of family/relationship breakdown which arose as a result of severe mental health difficulties and/or substance use. They had been homeless for between 9 months and 18 years, with an average duration of homelessness of five years.

General Findings

Challenges to People with Mental Ill-Health, Substance Use Disorder and Homelessness

The findings of the study confirmed the enmeshed relationship between mental ill-health, SUD and homelessness. All of the ten participants had experienced homelessness or housing insecurity at some point in their lives, either as a result of SUD, mental ill-health or a combination of both.

Mental Health Issues

All ten participants had experienced mental ill-health, with half (n=5) presenting with severe mental ill-health (schizoaffective disorder/bipolar disorder). Suicidal ideation, with and without planning, was evident in this group as was increased depression and anxiety.

Substance Use Challenges

The majority (n=8) of the participants reported SUD (alcohol and/or illicit substances) co-presenting with mental ill-health.
Mental Ill-health and Dual Diagnosis
Participants reported having been referred for treatment for SUD while experiencing severe mental ill-health and vice versa, pointing to a lack of a co-ordinated dual diagnosis service in Ireland.

Housing Challenges

All ten participants had been homeless at some point in their lives, with an average length of time homeless of five years. At Phase 1, only three participants were securely housed. Drivers for homelessness included SUD and mental ill-health, leading to a breakdown in family relationships. Two single mothers had surrendered their properties because of anti-social behaviour.

The COVID-19 Pandemic and Changes in Service Delivery

Both MQI and HSE ACCES continued to provide services to the participants over both phases of the study by reorienting their services during the pandemic in response to the restrictions and focussed on outreach teams to support clients, without any additional funding. Included in this reorientation was a concerted effort by case workers to reach isolated service users, which was facilitated by greater levels of inter-agency collaboration.

For HSE ACCES, support was provided by phone, text or in some instances by meeting up with service users for a walk. At MQI, the Outreach services provided daily contact with their service users, who in many instances would have no interaction with other people and were completely isolated. Crisis Contact workers focussed on the accommodation needs of service users, many of whom (in the absence of the required documentation) were referred to private emergency accommodation. The easing of restrictions has led to increased access to Riverbank, but this is still limited to operating within Government guidelines.

Findings Phase 1 and 2

The Effects of Continued COVID-19 Restrictions on the Mental Health of the Participants

At Phase 1, all participants expressed feelings of abandonment, intense loneliness and social isolation. By Phase 2 it became clear that the effects of the restrictions had greater implications for those with severe mental ill-health (linked into HSE ACCES), who reported greater levels of hospitalisation, suicidal ideation and paranoia. In total, four of the five had been hospitalised for their mental ill-health over the period of lockdown, even as in-patient admissions decreased in the general population.

While one participant had reported increased depression at Phase 1, this had risen to four by Phase 2. Over both phases of the study, three reported suicidal ideation with planning, one of which was unsuccessfully acted upon.

For the participants accessing services via MQI, there was a change between both phases of data collection. While the four participants available for interview at Phase 2 reported increased depression as the pandemic wore on, at the time of interview they were more optimistic, due to changes in housing and SUD. Three of this group had experienced suicidal ideation at Phase 1, and while this had dropped to two at Phase 2, one participant had also planned their suicide.

The impact of the pandemic on suicide rates is not yet known, but there is concern that increases in suicide rates are likely to be evident later than the pandemic and may last a period of years.

The Effects of Continued COVID-19 Restrictions on the Substance Use Patterns of the Participants

As with other findings, there was evidence of increases and relapses in alcohol and substance use as a reactive behaviour to the pandemic. At Phase 1, of the eight (n=8) participants who co-presented with SUD and mental ill-health, only two reported reducing their intake (in this instance alcohol). The remaining six (n=6) had reported increased or new substance use where they had previously been in recovery.

At Phase 2, this pattern had shifted. Of the four reporting alcohol use (n=4) two were alcohol free and one was reducing their alcohol intake. For those using illicit substances (n=4) one person was in a residential detox/rehabilitation unit and drug free, while another participant was drug free and on an MMT programme. Two had reduced their

substance use (crack cocaine/cocaine n=1: heroin n=1) and the latter was hoping toget onto an MMT programme.

Participants used a combination of services to achieve recovery, including the MQI Assertive Outreach Teams, the Community Detox Scheme and the HSE ACCES Outreach Team, linked in with an in-reach addiction service.

The Effects of Continued COVID-19 Restrictions on Housing Patterns for Participants

At Phase 1, only three participants were securely housed – by Phase 2, this had risen to four. At Phase 1, five participants were in hostels and two were street homeless. All reported that their accommodation was inappropriate and/or unsafe, with widespread availability of illicit substances. By Phase 2, three (n=3) of these participants were in recovery hostels and one was in a residential detox/rehabilitation and due to move to recovery housing. The recovery hostels provided meals, a service which was absent at Phase 1.
Two participants, both of whom experience severe mental ill-health, were in the same hostels as at Phase 1. However, one was due to move on a Housing First initiative, and the other had been accepted for HAP tenancy, though finding it difficult to secure a tenancy.

Reduced Social Connections and Impacts on Mental Health

At Phase 1 of the study, all ten participants reported feelings of loneliness, abandonment and isolation. The majority (n=8) had limited or no contact with family, and eight reported no friendships.
At Phase 2 this pattern had shifted, as a result of changes in both SUD and housing, with four of the five participants now in recovery having re-established family relationships. Their narratives at Phase 1 suggest

that these reconnections are dependent on gains in recovery in SUD and mental health. For those with more severe mental ill-health however (n=5) the majority (n=4) continued to report feeling socially isolated.

Experiences of Changes in Service Use with ongoing COVID-19 Restrictions

Reductions in face-to-face services, necessitated by the pandemic, has seen a move towards a number of online/technological supports for mental health amongst the general population. However, in both phases of data collection, participants report the continued need for face-to-face support, largely in the absence of other social supports. Services at both MQI and HSE ACCES continue to be curtailed and the participants have found this challenging.

As in Phase 1, the issue of digital divide emerged in Phase 2, with seven of the nine available participants reporting no access to reliable phones or WiFi. Of the total number available for interview at Phase 2 (n-9) only two participants utilised online supports, and did so while also receiving face-to-face contact.

Absent at Phase 1, there was discourse around inter-agency collaboration at Phase 2, with the majority of participants discussing being linked in with other services. These ranged from support services provided by community groups, NGOs and voluntary organisations for a range of issues, including housing, in-reach counselling, community engagement and family support.

Experiences of the Threat of COVID-19

Fear of contracting the coronavirus did not feature in the discussions of the participants at Phase 1, with the majority (n=7) more concerned with activities of daily living (food, shelter, washing facilities etc). By Phase 2

this had changed as a result of housing transitions, reduced SUD and re-engagement with family and seven (n=7) participants expressed concern and anxiety about contracting the virus. Of the nine available participants at Phase 2, the majority (n=8) had received COVID-19 vaccinations. One respondent was unsure of the safety and efficacy of the vaccine and had declined to be vaccinated.

Challenges for People with Issues Around Mental Health, Substance Use and Homelessness

It is clear that mental health, substance use and homelessness are inextricably linked, with all of the participants having experienced homelessness at some point in their lives, as well as SUD and/or mental ill-health.

Changes in Mental Ill-Health

For those with severe mental ill-health, diagnosis had come late in their lives and at Phase 1 they discussed lack of support and understanding in their earlier years. As the pandemic progressed, they continued to experience greater levels of social isolation, leading to increased depression, suicidal ideation with planning, paranoia and high levels of hospitalisation.

For those co-presenting with SUD and depressive illness, the initial stages of the pandemic had led to increased depression, anxiety and suicidal ideation. This had increased over the winter months, and while changes in their housing and substance use patterns has led to a greater level of optimism and the time of Phase 2 of the study, these gains are tenuous. Both of these findings reflect poor investment in mental health services at statutory level in Ireland.

Changes in Substance Use

The majority (n=8) of participants reported the use of substances (drugs and/or alcohol) over their lifetime, as well as mental ill-health at Phase 1. These participants report having difficulty accessing support for SUD while experiencing mental ill-health, pointing to a lack of dual diagnosis service provision.

Initial increases in SUD, evident at Phase 1, had reversed by Phase 2, with support from the outreach teams at both services. Of the eight co-presenting with SUD, seven (n=7) were in recovery. However, it should be noted that all had previously been in recovery or drug free prior to the pandemic and had a history of lapses in their recovery journeys. SUD is best viewed as a chronic illness which requires lifetime support.

Changes in Housing Patterns

The difficulties experienced by the participants in accessing and retaining secure housing points to continued failure of Irish policy on this issue. At Phase 1, only three of the ten participants were securely housed, rising to only four at Phase 2. Of the remaining six, two (both with severe mental ill-health) remained in the same hostel, where illicit substance use was prevalent.

Of the other participants (n=3) available for interview, all had moved to recovery hostels, and while they reported being largely content with their new living arrangements, this has to be measured against previous living conditions and the length of time they will have to remain in hostels until such time as secure housing becomes available.

CONCLUSION

The findings of this study underline the ongoing impact on the lives of individuals who received incorrect or no diagnosis of mental ill-health early in their lives, as well as issues that have emerged as a result of a lack of a care route for dual-diagnosed individuals. The high levels of homelessness/housing insecurity experienced by this group reflects the failure of policy to date to tackle these issues at a holistic level.

The ongoing restrictions around COVID-19 to exacerbates the symptoms of those with severe mental ill-health as a result of continued social exclusion. For those co-presenting with SUD and depressive illness, their gains at Phase 2 are tenuous at best and dependent on continued support to remain in recovery as well as to accessing and retaining secure housing.

Many of the findings of both phases of this study reflect the very real need to continue to attend to the psychological impact of the pandemic, especially for vulnerable groups. The findings reflect emergent literature that the effects on mental ill-health will continue to be evident for some time after restrictions end, and that this needs to be acknowledged and supports put in place to continue to support vulnerable populations. The recommendations include:

Ring fenced funding for mental health support at statutory, voluntary and community level

- Allowing services to adapt and respond in emergency situations

- Increased emergency access to suicide intervention for those at-risk
- Enable direct access to specialist counselling services (e.g.: domestic/sexual violence counselling professionals)

- Ensure face-to-face engagement continues
  - which is not dependent on digital capacity

- The provision of funding for the employment of professional staffing for dual diagnosed service users

Specifically, for those with severe mental-ill health

- Increased opportunities for social/community engagement to reduce social isolation

- Increased access to specialist counselling services (eg domestic violence/sexual violence counselling professionals)

- Increased Outreach/In-reach staffing and funding

Even when services return to 'normal' there is evidence of a clear need to expand outreach for individuals who remain in hostels/street homelessness, as well as in-reach services to support gains in recovery

- Increased funding for Outreach Teams
- Expansion of in-reach based services for hostels and in private emergency accommodation
- Expanded staffing to allow for follow-up to maintain recovery for those presenting with SUD and/or Mental Ill-health

Increase in Substance Free/Recovery Support Hostels

- Participants with poor or severe mental ill-health require drug and alcohol free hostels to support recovery and stability
- Community detox/stabilisation beds are required for those tackling PSUD
- Establishment of safe spaces for homeless women both in housing and in recovery hostels
- Gender specific services for women in addiction and/or homeless

Housing

- Increased availability of Housing First initiatives as per new Housing for All policy
- Reduction in bureaucracy levels required for housing for vulnerable populations

Inter-Agency Collaboration

Review frameworks for inter-agency collaboration between Statutory and Community/NGO/Voluntary services in both mental health and addiction with a view to establishing greater levels of access to supports for people with multi-layered needs.