The Effects of COVID-19 on People Experiencing Mental Ill-health, Substance Use Disorder and Homelessness or Housing Insecurity in the Dublin Region: A Longitudinal Qualitative Exploration

December 2021
Kathyan Kelly
Independent Research Consultant

MQI
Merchants Quay Ireland

ACCES

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 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.

X

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 three 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.

"I went the whole pandemic on the streets. No place to go wash. Had to get up and wash your face and hands just using baby wipes the whole time. It's disgraceful for a human being.

'My only answer was out. The only way I could see out of it was suicide, you know what I mean?

'I think it was the thought of them [the MQI Outreach Team] happening to come around and find me, after me doing something silly [taking my own life], I wouldn't have never forgave.... the thought, I couldn't get over that. So, yeah, when they came round in the morning to make sure you were ok, they'd bring you anything you wanted, a cup of tea or something to eat. They'd go and get it and bring it back to you. You know the outreach team are very good."

Sandra (aged 35 - 39), discusses the value of the MQI Outreach Team who maintained contact with her during the pandemic. Sandra had planned to take her own life just before Christmas having spent most of the pandemic living on the streets. Sandra is now securely housed and in recovery.

ACKNOWLEDGMENTS

GLOSSARY OF TERMS USED

AOT Assertive Outreach Team

BZD Benzodiazepine

CAMHS Child and Adolescent Mental Health Services

CMHTs Community Mental Health Teams

CfL Connecting for Life

DHLGH Department of Housing Local Government and Heritage

DPHLG Department of Planning, Housing and Local Government

DRHE Dublin Regional Homeless Executive

EMCDDA European Monitoring Centre for Drugs and Drug Addiction

ETHOS European Typology on Homelessness and Housing Exclusion

FEANSTA European Federation of National Organisations Working with the Homeless

GAD Generalised Anxiety Disorder

GDPR General Data Protection Regulation

GP General Practitioner

HRB Health Research Board

GLOSSARY OF TERMS USED

HSE Health Service Executive

HSE ACCES Health Service Executive Assertive Community Care Evaluation Service

HIV Human Immunodeficiency Virus

ICON Inner City Organisations Network

IT Information Technology

MQI Merchants Quay Ireland

MDMA Methylenedioxymethamphetamine

MMT Methadone Maintenance Treatment

NACD National Advisory Committee on Drugs

OST Opioid Substitution Treatment

PIL Participant Information Leaflet

PSUD Poly Substance Use Disorder

QSR Qualitative Research Software

RCSI Royal College of Surgeons in Ireland

SAC Scientific Advisory Committee

SUD Substance Use Disorder

WHO World Health Organisation

TABLE OF CONTENTS

1.0 INTRODUCTION

This longitudinal research study explores the psychological effects of changes in service delivery brought about by the COVID-19 pandemic for people in Dublin experiencing mental ill-health, substance use disorder (SUD) and/or homelessness or any combination of these.

Two services engaged in the care and support of this population, Merchant's Quay Ireland (MQI) and HSE ACCES, experienced considerable change in the way in which service users were supported, requiring a reorientation of services and a high degree of flexibility.

Phase 1 of the study (published 2020 MQI 2020) indicated that participants in both groups were experiencing considerable difficulty on a number of fronts. Greater levels of social isolation as a result of the restrictions had impacted their mental health and there was evidence of suicidal ideation and planning. Where participants co-presented with SUD, there was evidence of lapses in substance use where they had previously been in recovery. Of the ten original participants only three were securely housed.

As a result of these findings, a decision was made to conduct a follow-up study to explore how these participants coped as the pandemic wore on in terms of their mental health, SUD and housing situation. Interviews were conducted in July and August of 2021 for this second phase. This report provides an analysis of the findings of both phases of the study. The first section of the report briefly reviews Irish policy and response to COVID-19 in terms of mental health, SUD and housing.

The second section documents the methodological approach to the study, while the third section provides a brief demographic profile of the participants. This section also charts a profile of their mental health, SUD and housing at Phase 1 and Phase 2.

The fourth section presents the findings of the study – briefly referring to findings at Phase 1. This provides an analysis of the lived experiences of the participants and the meanings that they attach to those experiences, especially in relation to their mental health.

The fifth section places these experiences in the context of relevant research in the area. The final section provides a conclusion and recommendations based on input from, and analysis of, the discourse of the study's participants.

2.1 Introduction

This section briefly reviews Irish policy in relation to mental health, substance use disorder (SUD) and homelessness, as well as the prevalence and complexity of all three issues. It focusses on the continued impact that COVID-19 restrictions has had on people experiencing any one, or all, of these issues especially in relation to access to services and social isolation. It also examines statutory responses to the pandemic in terms of mental health, SUD and housing supports.

2.2 Irish Policy Review

2.2a Mental Health Policy Ireland generally has a low national spend on mental health services – at 6% of the total health budget (compared with 12% in the UK) as well as the third lowest number of psychiatric beds in Europe. This follows de-institutionalisation, and most acute psychiatric care in Ireland is now provided within general hospital units (Walsh 2015). Mental health services are underfunded across the board in Ireland (O'Connor et al 2020). Ireland's first national mental health policy (A Vision for Change – HSE 2006) missed many of its targets as a result of internal restructuring and an economic downturn, leading to increased waiting lists for treatment even as mental health needs were increasing (Mental Health Reform 2015). 'Sharing the Vision', the newly launched mental health strategy, aims to restructure and fund mental health services, prioritising mental health as a major societal issue, taking a life cycle approach and noting the need for a collaborative approach on the issue of dual diagnosis (people presenting with SUD and Mental Ill-Health) (Department of Health 2020).

Prior to the new mental health strategy, and in reaction to concerns about high levels of suicide, the National Office for Suicide Prevention

(NOSP) was launched in 2015, in recognition of the need to implement a national strategy for suicide prevention (Department of Health 2020) in Ireland. It's Connecting for Life (CfL) policy has been tasked with formulating a strategic approach to suicide prevention across the HSE in collaboration with a number of sectors (NOSP 2021).

2.2b Mental Health and Dual Diagnosis

Long-term substance misuse (both alcohol and drugs) is often accompanied by poor mental health (depression and anxiety), and clients presenting for substance misuse also experience mental ill-health (Iro and O'Connor 2009; Lyne et al 2010). For people with more enduring/severe mental disorders (schizoaffective and associated disorders) more than two-thirds have been using alcohol and cannabis over prolonged period of time (Kamali et al 2000).

Dual diagnosis is a term generally used to describe a person presenting with both addiction (either drugs and/or alcohol) and mental ill-health. Early mental health policy in Ireland placed responsibility for those with severe co-morbid mental illness and substance abuse outside of the mental health system and within the remit of Community Health Care Teams (CHCTs) (Department of Health 2006; Mental Health Reform 2015).

However, this resulted in people with dual diagnosis left in a vacuum, unable to access community health, mental health or addiction services and often cycling between the three continuously and receiving no treatment at all (Proudfoot, MacGabhann and Phelan 2019). New mental health policy 'Sharing the Vision' recognises that gap in provision, and notes that those with co-existing mental ill-health and addiction should also be able to access services. regardless of which is the primary presentation, (Department of Health 2020).

2.2c Substance Use Policy

Initial Irish policy approach to substance use (Misuse of Drugs Act 1977) was predominantly a medical model, with a strong emphasis on the illegality of substance use, and community services were absent (Butler 2002).

This focus shifted towards a harm reduction approach (O'Gorman 1998) and opioid management was introduced (Opioid Substitution Treatment – OST) through the use of Methadone Maintenance Treatment (MMT), with a focus on reducing the health-related harms of (injecting) heroin use and levels of criminal activity coupled with increased policing around supply and organised crime (Butler 2002). However, policy endorsement of this approach came much further down the line (EMCDDA 2016). Problem alcohol use is recognised as a considerable public health issue in Ireland and is linked to morbidity, health issues, poor mental health and suicide (Mongan and Long 2016). Alcohol dependency in those presenting for treatment has increased from 66.6% (in 2014) to 72.0% (in 2020) (O'Neill, Carew and Lyons 2021).

While initial drug policy in Ireland did not include alcohol as a substance misuse issue, more recent Governmental response 'Reducing Harm, Supporting Recovery' recognises the health and social problems associated with both drug and alcohol misuse. Focussing on a health-led response to substance misuse, responsibility for the policy lies within the remit of the Health Service Executive and its Social Inclusion Division (Department of Health 2021; Department of Health 2017). The policy recognises that people caught in a cycle of substance misuse need a comprehensive range of services in order to enable them to live meaningful lives (Mayock, Butler and Hoey 2018). SUD is increasingly viewed as a chronic, disabling condition which requires lifetime support (Goodwin and Sias 2014).
In proposing a 'continuum of care model' as new policy, the aim is to

provide access to the supports needed for individuals to attain personal recovery goals where intervention is focussed on social care (family, housing, education, criminal justice and healthcare supports). The strategy acknowledges the need to develop an 'integrated care pathway' which is the shared responsibility of a number of key stakeholders at national, local and personal levels (Department of Health 2017).

2.2d Housing Policy

Housing in Ireland is covered by a number of key legislative Acts and homelessness has a narrow definition which is at odds with the more inclusive ETHOS definition developed at European level (FEANSTA 2011; Housing Act 1988). Consequently, estimates of the number of people experiencing homelessness in Ireland is somewhat limited since many who would be included under the FEANSTA definition are excluded. Furthermore, the Department of Planning, Housing and Local Government (DPHLG) changed the way in which homelessness was recorded in 2019, excluding those in 'own door' accommodation and therefore lowering the overall numbers of homeless (DRHE 2019; Focus Ireland 2020).

The main drivers of homelessness are associated with individual factors (relationship breakdown, mental health issues, substance misuse, domestic violence) or structural factors (lack of affordable housing, loss of employment and poverty) or a combination of both (Focus Ireland 2020).

Policy response was to focus on a 'whole of Government' approach to housing using a 'Housing First' Model for those with complex health needs. The HSE embarked on an integrated approach to homelessness and addiction (DHPLG, Local Authorities, Department of Health, HSE) in line with policy (Rebuilding Ireland) (HSE 2018).

On a number of fronts the policy was unsuccessful and homelessness figures increased year on year as a result of an inadequate supply of social/affordable housing (Hearne 2020; Social Justice Ireland 2020), even though there is evidence that dual-diagnosed adults can remain stable in housing without increasing their substance use (Padgett et al 2006). Other issues with Housing First include problems with fidelity to the model, which is challenged by a shortage of housing as well as a burden of bureaucracy, which may be beyond those in homelessness due to a number of factors including poor literacy (Manning, Greenwood and Kirby 2018; O'Donovan et al 2020).

A newly launched housing policy 'Housing for All' (DHLGH 2021) sees Ireland committed to promoting the prevention of homelessness as well as the provision of support services to those who are homeless. It is committed to achieving 1,200 new Housing First tenancies over the next five years through a number of joint initiatives with government departments in housing, health as well as local authorities liaising with NGO partners (DHLGH 2021).

Housing is identified as an important non-medical, or social, determinant of health in that the health and future health outcomes of individuals are directly impacted by the conditions of their daily lives and the level of resources available to them (Whitehead and Dahlgreen 1991; WHO 2013).

2.3 Prevalence of Mental Il-Health, Substance Use and Homelessness

Estimating the prevalence of mental ill-health, substance use and homelessness in Ireland is not straightforward. In mental health, estimates are difficult due to the lack of a coherent pathway for engaging with services and societal stigma. However, there is evidence that these

problems are significant and growing, with numbers increasing by nearly one third (28.7%) between 2011 and 2016 (Mental Health Reform 2018).

Ascertaining figures for death by suicide is also a complex issue, as the decision made to record such deaths is not within the remit of the HSE or medical doctors, as it is classed as an unnatural death and therefore subject to investigation by a Coroner. Such investigations can take a considerable length of time resulting in delays in reporting of such deaths and those registered as 'undetermined' may include hidden cases of suicide (NOSP 2021).

The needs of homeless people with mental health issues are significant, with over half of this cohort reporting a diagnosis of depression and nearly one-third having expressed suicidal ideation. Irish research indicates that one in four homeless people had attempted suicide in their lifetime, and one in ten in the previous six months (Glynn 2015: O'Carroll 2021).

For substance use prevalence, figures are derived from a number of sources and exclude those who do not view their substance use as problematic, who have never been engaged in treatment or in the criminal justice system (EMCDDA 2019).

Analysis of drug use, based on the National Drug Treatment System over a seven year period points to a number of drug uses (opioids, cocaine, cannabis and benzodiazepines) with the majority presenting for treatment reporting poly-drug use (58.5%), with co-occurring alcohol use in 37.3% of that cohort. Drug treatment in the homeless population has also increased from 6.5% in 2013 to 11.0% in 2019 (O'Neill, Carew and Lyons 2019).

Accurate figures for homelessness are also difficult to enumerate. In

August 2021, there were 4,220 homeless adults in Dublin, 66.0% male and 34.0% female (DHLGH 2021). This figure excludes family homelessness as well as those sleeping rough, couch surfing, in hospitals, prisons, direct provisions as well as women in domestic violence refuges (Peter McVerry Trust 2021). Women, while less likely to be homeless than men, have different experiences of homelessness and are often vulnerable to abuse by a predominantly male homeless population (Depaul 2020; Grotti et al 2018).

2.4 Complexity of Mental Ill-Health, Substance Use Disorder and Homelessness

Mental ill-health, substance use and homelessness issues are in many cases often inextricably linked. While one difficulty may appear to influence the onset of another (or vice-versa) it is also the case that once in motion, there is a non-linear relationship between mental health, addiction and homelessness. Each factor has a role to play in contributing to the subsequent onset of or exacerbation of the other (Murphy, Mitchell and McDaid 2017).

The numbers of people becoming homeless as a result of an addiction issue continues to rise (Glynn et al 2017). People in homeless services (hostel accommodation) can become involved in drugs and alcohol for the first time (Merchants Quay Ireland 2017). Homelessness can often be a trigger for an increase in drug use, even among those in stable OST programmes (Mayock, Butler and Hoey 2018).

People in Ireland experiencing homelessness are more likely to utilise healthcare in a sporadic and unplanned manner (Cheallaigh et al 2017). Homeless persons, most often presenting to Hospital Emergency Departments (EDs) for medical treatment, have significant prevalence of substance and alcohol use and also a lower rate of assessed psychiatric disorder than those housed (McLoughlin, Feeney, Cooney 2020).

Within homeless services, there is an absence of screening for mental health and substance use issues in order to provide appropriate treatment (Lee et al 2017).

Homeless people have mortality rates that are much higher than that of those housed population (Keogh et al 2015; O'Reilly et al 2013; Prinsolo, Parr and Denton 2012). Homeless men experience mortality at a rate of three to ten times higher, and women six to ten times higher, than the general population (O'Carroll 2021). There are a number of factors in play including excess morbidity, substance misuse, accidental (or violent) death, poverty, childhood adversity as well as suicidality. Median age of death for homeless men was 42 years and for homeless women 36 years over the period 2011 to 2015 (Ivers and Barry 2018).

2.5 The COVID-19 Pandemic

The World Health Organisation (WHO) declared COVID-19 as a pandemic on March 11th, 2020. This led to dramatic organisational change in the delivery of healthcare in Ireland, coinciding with a wide range of COVID-related restrictions introduced by the Irish Government beginning on March 27th, 2020 (HSE 2020).

Healthcare delivery in Ireland in both acute and community settings continues to be severely affected. While the initial anticipated surge in COVID-19 was managed in the early months of the pandemic, the emergence of new and more transmissible strains led to continued restrictions. A brief return to opening over the Christmas period was immediately followed by a Level 5 lockdown which continued until the end of Q3 in 2021. Even with a return to some level of freedom, normal health-care services have not been reintroduced (September 2021), leaving those more vulnerable without many of the day-to-day services they depend upon, especially those in situations of homelessness,

experiencing mental ill-health and/or substance misuse issues (HSE 2020).

Homeless people were identified as an especially vulnerable group early in the pandemic, with higher rates of addiction as well as poorer physical and mental health than the housed population (O'Carroll 2021).

2.5a Substance Use and Suicide Risk during COVID-19

There is a high prevalence of suicidal ideation and planning in people with substance use issues (Arribas-Ibar et al 2016; Bakken and Vaglum 2007; Breet, Goldstone and Bantjes 2018) and while the impact of COVID-19 on suicide rates in the general population is not yet clear (John et al 2020) it is rising (Banerjee, Kosagisharaf and Rao 2021). Previous research on the effects of pandemics on suicide suggests that there is likely to be short-term spikes in suicidal behaviour, particularly for vulnerable groups (Devitt 2020). While primary care practitioners have an especially important role in intervening with people presenting with suicidal behaviours (Nelson and Adams 2020) this is not the healthcare route normally taken by those in homelessness services as discussed earlier (Cheallaigh et al 2017; McLoughlin, Feeney and Cooney 2020). Dual diagnosed individuals are at high risk of suicidal behaviour, and SUD with bi-polar disorder is a significant predictor of suicide attempts, while bi-polar disorder coupled with alcohol use results in nearly twice as many suicide attempts than those without alcohol use issues (Sher 2020). Suicide attempts and fatal outcomes are much higher in those experiencing mental ill-health than in the general population (Baldessarini 2019).

The effects of the pandemic has already shown relapses in alcohol use and higher levels of opioid and stimulant use (Abramson 2021), and people with SUD may increase their substance use as a reactive

behaviour or shift to other substances (Chiappini et al 2020) while there is every likelihood that the pandemic may lead to the onset of new dual disorders (Sher 2021). Increases in suicide rates are likely to be evident later than the actual pandemic, and may be present for a long time (Sher 2021).

Substance use issues are known to be a significant problem among homeless populations, and a history of substance use (or current substance misuse) is more likely to result in multimorbidity (O'Brien et al 2015; O'Carroll 2021; O'Carroll and Wainwright 2019).

Identified as a particularly vulnerable group due to these factors, a cohesive strategy was put together comprising homeless specialised General Practitioner (GP) services, harm reduction services in Dublin, the Dublin Homeless Executive (DRHE) and coordinated by the Social and Addiction Services of the Health Service Executive (HSE) (O'Carroll, Duffin and Collins 2020).

2.5b Mental Health Response to COVID-19

While the outbreak of COVID-19 necessitated a priority for healthcare resources to focus on the physical health implications of the virus worldwide (WHO 2020), there is a significant mental health impact related to COVID-19 (Torales et al 2020). Psychological and psychiatric care had been neglected in the initial stages of the pandemic (Xiang et al 2020). In the US, 40.9% of adults had reported at least one adverse mental health condition, including substance use, at a rate of three to four times higher than the previous year (Simon, Saxe and Marmar 2020). In particular, vulnerable populations (the homeless, people with disabilities, the chronically ill) tend to have an accumulation of risk factors, including poor physical and mental health as well as limited

access to services and limited control on their everyday lives (Kelly 2020) Changes in psychological well-being can in turn lead to increased stress levels and psychological distress (Mafham et al 2020; Hamza et al 2020; Shevlin et al 2020; Qiu et al 2020; Wang et al 2020; Xiang et al 2020) and increased stress levels can be a factor in the development of, and relapse in, both substance and alcohol misuse (Brady and Sonne 1999; Sinha 2001).

Changes in service delivery in Ireland necessitated by the need to control the virus saw a reduction in face-to-face services for mental health and substance use, as well as a decrease in admission rates for in-patient psychiatric treatment in 2020 in the order of 8.5%. There was evidence of increases in hospitalisation in those with no fixed abode and 60.0% of admissions were single people (Daly and Craig 2021).

2.5c Substance Use Response to COVID-19

The substance use response was rapid in the Dublin region, with an early recognition that people in active addition were less likely to be able to isolate or shield. Actions taken included rapid access to treatment, with the existing limits on numbers that could be facilitated in a service removed – for example MQI OST services increased four-fold from 50 to 200. Another change was the more widespread availability of Naloxone, the drug used to counteract the effects of opioid overdose (Clarke and Eustace 2016; HSE 2020; Lyons 2014).

Irish data indicates changes in the patterns of SUD since the onset of COVID-19 restrictions with some users reporting more frequent use (cannabis) and others (using cocaine and ecstasy) ceasing (Mongan 2021). However, an overall European report (EMCDDA 2021) points to widespread availability of a diverse range of highly potent drugs, resulting in use patterns becoming more complex (poly-substance use disorder - PSUD) leading to greater health harms.

Drug production and trafficking has adapted to pandemic-related restrictions (EMCDDA 2021)

The effects in the general population of 'shielding' or 'cocooning' requires a level of social isolation. Such social distancing provides the opportunity for increases in addictive behaviour and organisations working in addiction psychiatry face additional challenges in providing high levels of care within those restrictions (Columb, Hussain and O'Gara 2020).

2.5d Homelessness Response to COVID-19

The homelessness response in Dublin (co-ordinated by the DRHE and the HSE) focussed on protocols for identification and testing for COVID-19 of homeless clients, after which the Dublin Regional Homeless Executive (DRHE) rapidly provided them with accommodation suitable for isolation. Those deemed especially vulnerable were moved to single occupancy accommodation to allow for shielding from infection, and many more were transferred to other sites in order to decrease occupancy levels and reduce the risk of spread of COVID-19 (O'Carroll, Duffin and Collins 2020).

As the pandemic restrictions continued, and with the realisation that 3,300 adults were accessing emergency accommodation (May 2020) a proactive and preventative response was put in place. Local authorities provided significant extra emergency accommodation to all homeless people to meet the required level of social distancing, and the DRHE arranged 500 additional beds in the Dublin area for single adults (NISO 2021).

The start of the pandemic saw a reduction in homelessness figures, but this has risen steadily in the past three months as a result of rising rents and evictions (which could not be carried out during the pandemic) (Focus Ireland 2021).

2.6 Social Issues around COVID-19 Restrictions

The key measures required to control the COVID-19 virus, including self-isolation, cocooning and quarantine, requires isolation and can have significant negative effects on mental health (Kelly 2020). There is substantial evidence from previous epidemics that quarantine has a detrimental effect on psychological health (Mukhtar et al 2020).

In Ireland, initial findings (based on data collected in late March 2020) indicate that mental health problems were common among the Irish population, with 35% of those surveyed displaying clinically meaningful levels of depression, anxiety or post-traumatic stress that would indicate the need for clinical care as a result of the pandemic (Hyland et al 2020). In examining those most vulnerable to developing a mental health problem related to COVID-19, research found that the most significant risk occurred in those who expressed higher levels of loneliness (Hyland et al 2020). Secondary consequences of social distancing is associated with a negative psychological effect and may increase the risk of suicide (Hughes et al 2020; Lynch, Morgan and Leen 2020).

2.6b Reduced Social Connections and impacts on Mental Health

This higher risk of mental health problems, due to COVID-19 as a result of social isolation, while affecting the general population (Hyland et al 2020), is of particular significance to people who experience mental health problems, substance misuse or homelessness as their experiences of any one, or any combination of more than one issue, already leads to social exclusion (Kelly 2020). Substance misuse and mental ill-health are linked to disruption and conflict in family relationships, often leading to permanent loss of these supports (Copello et al 2010; Duggan 2007; Orford et al 2010; Rossow and Hauge 2004; Von Kardoff et al 2016).

A growing body of research recognises the influence of social relations in mental health and psychological well-being, and that those experiencing mental ill-health place great importance on social connections (Wang et al 2017). Mental health service users report greater levels of loneliness and have smaller social networks than the general population (Clinton et al 1998) and there is evidence of an association between loneliness and suicidal behaviour, personality disorders and psychoses (Goldsmith et al 2008; Richman and Sokolove 1992; Deniro 1995). For those with enduring or severe mental ill-health, loneliness and/or social isolation can lead to higher levels of delusions and lack of insight (Garety et al 2001; White et al 2000).

Homelessness is also inherently linked with social exclusion, and recognised as an extreme manifestation of social isolation, as many of the characteristics of homelessness (lack of housing, debt, lack of social support) are also viewed as components of social exclusion. (European Commission 2008; Fazel et at 2014; Van Stratten et al 2018; Vrooman and Hoff 2013).

2.7 COVID-19, Telemedicine and the Digital Divide

A safe return to previous service delivery envisaged a three-phase re-introduction of health and social care services in a COVID-19 environment, which has not yet been actioned (HSE 2020). The continued disruption of access to services for people with addictive disorders is likely to increase the extent and severity of such disorders since they are impacted particularly severely by existing poverty, physical and mental health issues (Marsden et al 2020).Noting the lack of face-to-face contact, services in other countries have adapted the approach to interacting with service users using technology, but this has been met with mixed results (Columb et al 2020). In Ireland a virtual OST clinic was established in the Midlands and this is currently being evaluated.

Even in the event that telepsychiatry and telemedicine become widely available there is evidence that many service users will not be able to interact due to what has become known as the 'digital divide' (Mohan et al 2020). The move towards online medical appointments, bookings and prescriptions are all inaccessible to certain groups and, beyond that, it has consequences for well-being and mental health with the ability to be able to connect with other people seen as critical (Watts 2020).

2.8 COVID-19 in Early 2021 The HSE provided additional funding of €5.5m to improve services for people who were homeless and in addiction as part of its Winter Plan covering 2020/2021. Noting that those individuals experiencing homelessness and addiction are a vulnerable group with complex needs, the plan aimed to continue protective public health measures already in place while expanding GP services for people living in emergency accommodation in Dublin and elsewhere and providing 'continuity of care' for individuals who may require emergency hospital treatment (HSE 2020). However, the funding was geared predominantly towards physical health, and none of this funding was made available to MQI or HSE ACCES.

2.8a Planning for COVID-19 and Beyond

Absent from this plan was consideration of how to meet the needs of people with mental ill-health, more disadvantaged as a result of this pandemic (Cullen, Gulati and Kelly 2020). Research indicates the need for a 'ring-fenced' additional budget for mental health services to allow these services to build capacity and adapt in responding to the ongoing pandemic (Holmes et al. 2020). With evidence that the number of suicidal deaths is rising, suicide prevention should be an integral part of public health response to pandemics (Banarjee, Kosagisharaf, Rao 2020). In reviewing the effects of pandemics on suicide rates, research indicates

that while evidence-based suicide prevention strategies work, they may need a level of adaptation to meet differing needs, and that outreach, close follow-up and increased access to healthcare is needed for vulnerable populations (Wasserman et al 2020). The mental health impact of the pandemic is likely to be long lasting (Galea et al 2020) and has implications for mental health services going forward. As a result, there is a need for enhanced access to such services, including early assessment, treatment and psychosocial support as well as screening and support for specific groups (Kathirvel 2020).

This section outlines the methodological approach to the study, as well as the specific methods used. It also outlines issues around ethics and participant consent as well as a number of challenges related to the conduct of the study.

Initially designed as a one-off qualitative study to explore the impact of COVID-19 on the lives of participants accessing either Merchant's Quay Ireland or HSE ACCES services, data collection took place in the fourth quarter of 2020 (October and November of that year). However, as data collection began, the Irish Government announced a prolonged Level 5 lockdown to curb the spread of the virus. It became clear at this stage that the restrictions necessitated to control COVID-19 were set to continue for an unknown length of time and that this could result in a considerable burden on the mental health of an already vulnerable population.

On publication of Phase 1, funding was successfully sought from the HSE National Office of Suicide Prevention (NOSP) to conduct a follow-up study with the same participants under it's 'Connecting for Life' research strategy. Data collection started in the third quarter (July and August) of 2021. At this stage the participants had experienced one of Europe's longest lockdowns with restricted access to supports over the Winter and Spring period in Ireland. 3.1 Study Aims and Objectives
People with mental health issues have traditionally been excluded from having a say in their own treatment. Mental Health Reform recommendations state: (2015: pp.9) 'Involvement of service users and their carers should be a feature of every aspect of service development and delivery'.

Two agencies, Merchants Quay Ireland and HSE ACCES, support people who experience mental health difficulties, substance misuse and/or homelessness, or any combination of all three. The HSE ACCES team, set up in 2004, is a mental health service for homeless people that uses a

multidisciplinary approach. The goal is to treat homeless people with severe and enduring mental illnesses (such as Schizoaffective Disorder or Bipolar Affective Disorder) who may or may not also be experiencing substance use issues. Merchant's Quay Ireland is a national NGO which provides care and support to homeless people, substance users and their families. The Merchant's Quay service comprises a range of supports across a number of locations. They include day programmes, drug-free rehabilitation programmes, residential detox service, community detox programmes, needle exchange as well as counselling and a drop-in homeless service. MQI also provides mental health and suicide intervention supports to service users.

A qualitative research study was carried out in late 2020 and launched in December 2020 (MQI 2020). This report detailed the experiences of ten participants (five each from MQI and HSE ACCES) and explored their experience of the effects of the pandemic on their mental health, substance use and housing. Its findings indicated that the participants were experiencing social isolation, increased mental ill-health and suicidal ideation as well as lapses in substance use.

Phase 1 Objectives

The objectives in Phase 1 were:
- To identify the challenges experienced by people with issues around mental health, substance use or homelessness (or any combination of all three) that have arisen from the COVID-19 pandemic.
- To examine the factors associated with participants' service experiences, especially at the time of lockdown and following the partial re-opening of services.
- To understand the perceived impact of these changes (lack of in-house face-to-face contact; closure of night café; move to outreach services; increased formality of contact) in terms of the mental health of the service users

2 Objectives

As the findings from Phase 1 suggested that the participants were experiencing considerable difficulty on a number of fronts, a decision was made to follow up with the same group of participants after a period of nine months. The objectives of this phase were:

- To explore the progress of the participants as the pandemic continued over the Winter months, especially during continued Level 5 restrictions in terms of their:
  - Mental health
  - Substance Use
  - Housing
  - Social Isolation
  - Ability and capacity to access support services
  - Capacity for digital support

3.2 Research Design

Phase 1 and 2 of this study used a qualitative approach, allowing participants to articulate their personal perspectives on the effects of COVID-19 on their lives, particularly in relation to their mental health. The was achieved by the use of semi-structured interviews, using open-ended questions which allowed the participants to move between narratives reflecting the complexity of their experience. This method of data collection permits the presentation of that data in an explanatory way (Charmaz 2007; Corbin and Strauss 2014). By allowing the research to focus on phenomena in a natural setting in order to understand how people manage their daily lives, participants are able to explain their social meanings in a way that reflects their lived experience (Miles and Huberman 1994; Rhodes 2000). Qualitative research is particularly useful in the context of mental health, as it allows for the emergence of new insights into poorly understood areas, such as developing an understanding of subjective experiences of mental disorders (Fossey et al 2002).

In following up at Phase 2 with the original participants, the study takes on a qualitative longitudinal enquiry, which allows for an exploration of lived experience in the context of social change (Thomson 2011; Saldana 2003). Recent Irish policy on both mental health and substance misuse encourages the participation of individuals who are in receipt of services to have an input into the planning and delivery of those services (Department of Health 2017; Department of Health 2020).

3.2a Sampling

Purposive sampling was employed at Phase 1 to ensure that the sample reflected the broad demographic of service users who were in receipt of services from either MQI and/or the HSE ACCES programme.
To be eligible for participation in the research, individuals had to:

- Be over the age of 18 years;
- Be in receipt of services (in-house or through outreach) from MQI and/or HSE ACCES before and after the first COVID-19 lockdown (before March 2020);
- Have experience of mental health and/or substance use and/or homelessness before and after the first COVID-19 lockdown (before March 2020);
- Have the capacity to give informed consent.

3.2b Recruitment, Retention and Consent

Phase 1 of the study aimed to recruit between 8 and 12 participants (4 – 6 from each service). Access to the potential participants was granted by both MQI and HSE ACCES, who acted as 'gatekeepers' for the study. In MQI this was Head of Services and, at HSE ACCES, the Consultant Psychiatrist on the team.

While there is concern over the use of gatekeepers in social research,

particularly research involving the participation of vulnerable groups where the gatekeeper provides a service to the participant (Broadhead and Rist 1976), access to the study participants would not have been possible without their co-operation.

In Phase 1 gatekeepers were provided with a participant information leaflet (PIL) and a copy of the consent form (See Appendix 1) which outlined the aims of the study and explained what would be required of the participants if they agreed to participate, which allowed them to decide who they would invite to participate and provide with a separate, service users PIL (See Appendix 1). This PIL also stated that their participation, or a decision to decline the invite to participate, would in no way impact on their access to services. Potential participants were then given one week to decide if they wished to participate. When individuals indicated an interest in participating, the researcher either contacted them directly (with their permission) to set up a date and place for an interview, or arranged an interview facilitated by their support worker via Zoom or phone.

While this was not originally designed as a longitudinal study, participants were asked at the time of interview if they would agree to follow-up with additional questions if needed. All ten participants indicated that they would be agreeable to do so. Follow-up contact was again made by the gatekeepers at MQI and HSE ACCES (See Appendix 2) , and of the 10 original participants, nine were available and agreed to be re-interviewed.

In Phase 2, participants who expressed an interest in a second interview were read consent over the phone (See Appendix 2) where a face-to-face meeting could not take place, and specific consent was sought for audio recording.

3.2c Data Collection

Data collection for Phase 1 in the form of face-to-face interviews was due to take place in October 2020. However, as a result of restrictions, interviews could only take place by phone/Zoom where the case worker was directly in contact with the potential participant at an outdoor location. Three interviews were conducted by phone, and two by Zoom.

At Phase 2, there was still no facility for face-to-face interviews with the participants from MQI so 4 of the 5 interviews took place by phone. One participant was in an MQI residential detox/rehab treatment facility and had restricted phone access and did not participate.

Interviews with the participants from HSE ACCES were conducted for Phase 1 and 2 at their building in Parkgate Hall where the researcher and participant met in a suitable room with the requisite PPE in place. Of the five participants, four agreed to interview in person and one by phone. In total, eight of the nine participants agreed to audio-recording, while one participant requested that audio-recording was not used at specific points under discussion and shorthand note taking was used instead with their consent.

3.2d Service User Interviews

Prior to interview, the researcher explained the purpose of the research again and the consent form was read out to them. Any further questions were answered at this stage and participants were reminded that they could withdraw at any time, refuse to answer any question and reassured that this in no way would impact their access to services, either now or in the future. The interview schedule for Phase 1 (See Appendix 1) comprised a series of open-ended questions covering a number of topics. These included a brief background chat to ascertain

some biographical information as well as questions about their history of mental health/substance use/homelessness (as relevant). Interviewees were also asked about the manner in which they accessed services, both before and after the first lockdown in March 2020, and how that has impacted the management of their day-to-day lives as well as how they felt it had affected their mental health.

The Phase 2 the interviews (See Appendix 2) specifically revisited these topics to ascertain any changes in mental health, substance use and housing, and salient points from the first interview were brought up for discussion. The interview also asked about changes in attitude to COVID-19 restrictions and if participants had been offered vaccination.
Interviews for Phase 1 lasted for between 17.05 and 41.36 minutes, with the average duration being 27.1 minutes. For Phase 2, the interviews were shorter as sociodemographic information did not need to be collected a second time. The interviews lasted between 14.07 and 25.12 minutes, with an average of 20.0 minutes.

3.3 Data Analysis and Anonymisation

The interviews were transcribed verbatim and all potentially identifying information was removed from the transcripts. Each participant was given an alpha-numeric code and the data was fully anonymised. Each participant was assigned a pseudonym for use in the final report.

Interviews were analysed using NVivo 12, which is widely used in the analysis of qualitative data. Double coding was applied to the data, where overall responses were used initially to code the data followed by the production of comparative nodes for further analysis. This provided a framework for emerging recurrent themes to be placed within coding frames which generated a lucid, synthesised and valid interpretation of the interview data.

3.3a Data Protection and Ethical Issues

For Phase 1, in the absence of an accessible and expedient pathway to formal

ethics approval, a number of experts the fields of research, homelessness, mental health and substance misuse were invited to form a Scientific Advisory Committee (SAC). Scientific Advisory Committees routinely advise (both formally and informally) and comprise members with expertise relevant to the area of study (CoPSAC 2011; Groux, Hoffman and Otterson 2018). At the study outset, an ethics application form in use by the Royal College of Surgeons in Ireland (RCSI) was completed to act as a guide for the study and sent to the SAC for review. A DPIA was also drafted and issued for review to ensure that the highest standards of data protection were afforded to the study.

GDPR guidelines were strictly adhered to, and all of the data gathered for the research was held in accordance with those guidelines. All computers and recording devices were doubled encrypted and stored in a secure location. Signed consent forms were stored in a locked filing cabinet in a locked office.

These guidelines were similarly adhered to for Phase 2 of the study.

3.4 Working with vulnerable groups

A vulnerable group is defined as a number of people who share social characteristics that differentiate them from the general population in terms of poverty risk and social exclusion, such as people experiencing homelessness, addiction or with enduring mental illness (Frolich and Potvin 2008). However, as mentioned previously, recent Irish Government policy advocates the participation of such groups in allowing them to have a say in determining their own lives (Department of Health 2017; 2020). Research also indicates that taking part in research can be both positive and empowering for people within vulnerable groups and that it can be especially important in self-advocacy and helping to overcome social exclusion (Hail 2010).

Payment

No payment was offered for participation. However, participants were given a gift voucher for an Irish owned supermarket chain to the value of €20.00 for both Phase 1 and Phase 2. This gift was not signalled in advance of securing individuals' agreement to participate and only issued following completion of the interview. It was therefore a way of thanking and acknowledging the time invested by participants in assisting with the study.

3.5 Challenges with the Study

Recruitment

Recruitment for Phase 1 and Phase 2 from the HSE ACCES service was relatively smooth because Parkgate Hall remained open. Participants were comfortable with the space and, in many instances, scheduled an interview before or after meeting with another team member. Recruitment of participants from MQI in Phase 1 proved considerably more difficult as face-to-face access was limited and this had not improved at Phase 2. Also, in some instances contact phone numbers had changed, which is not uncommon in this cohort (McClure et al 2013). The Outreach case-worker made contact with all five of the original participants and four were available and agreeable to a second interview. One participant was in residential rehabilitation treatment and not available.

COVID-19

Restrictions meant that face-to-face contact was an option only for HSE ACCES participants at both phases of data collection. Access to MQI participants via Riverbank was limited due to the pandemic. Services

were reoriented to outreach and take out points due to the restrictions, and so all interviews were conducted by or Zoom (n=2 at Phase 1) or phone.

Sample Size and Gender Issues

The initial aim of the project was to interview between 8 and 12 participants to generate an in-depth understanding of the effects of COVID-19 on the mental health of the participants. Qualitative research sample size is not concerned with making generalisations to a larger population but, rather, more inductive and emergent in nature (Charmaz 1999). As such, there is no ideal 'sample size' and data collection is complete where no new or relevant data emerges (Mason 2010).

Attempts were made by gatekeepers in both MQI and HSE ACCES to recruit a sample that was broadly representative of their service users (predominantly male). However, the end sample (n=10) is predominantly female (a ratio of 6:4), reflecting a more widespread unwillingness on the part of men to engage in health research (Markanday et al 2013).

3.6 Participant Profiles

SOCIODEMOGRAPHIC PROFILE OF PARTICIPANTS AGE RANGE GENDER EDUCATION EMPLOYMENT STATUS MARTIAL STATUS CHILDREN 55 - 59

AGE RANGE	GENDER	EDUCATION	EMPLOYMENT STATUS	MARTIAL STATUS	CHILDREN
55 - 59	Female	Primary	Unemployed	Single	4 - 8
45 - 49	Male	Tertiary	Unemployed	Single	None
34 - 39	Male	Tertiary (incomplete)	Unemployed	Single	None
40 - 44	Male	Tertiary	Employed (at Phase 2)	Single	None
30 - 34	Female	Tertiary (incomplete)	Unemployed	Single	None
30 - 34	Female	Primary	Unemployed	Widowed	1 - 3
35 - 39	Female	Post-primary	Unemployed	Separated	1 - 3
30 - 34	Female	Post-primary	Unemployed	Single	1 - 3
45 - 49	Male	Post-primary	Unemployed	Separated	1 - 3
40 - 44	Female	Primary	Unemployed	Separated	4 - 8

MENTAL HEALTH AND SUBSTANCE USE PROFILE OF PARTICIPANTS AT PHASE 1 & 2

AGE RANGE	MENTAL HEALTH DIAGNOSIS	SUBSTANCE USE PHASE 1	SUBSTANCE USE PHASE 2
55 - 59	Bipolar Affective Disorder	Alcohol	Alcohol
45 - 49	Schizoaffective Disorder	Cocaine (in the past) Alcohol	Alcohol only – currently reducing
34 - 39	Schizoaffective Disorder	Crack, Cocaine, MDMA	Cocaine only – currently reducing
40 - 44	Schizoaffective Disorder	None	None
30 - 34	Schizoaffective Disorder	None	None
30 - 34	Depression	Heroin (smoke) had been on MMT	Reducing heroin use to start MMT
35 - 39	Depression	On MMT and heroin	MMT only
30 - 34	Depression/PTSD	Heroin/BZD	In Residential Treatment
45 - 49	Depression	Alcohol	None
40 - 44	Depression	Alcohol	None

HOUSING PROFILE OF PARTICIPANTS AT PHASE 1 & 2

AGE RANGE	LENGTH OF TIME HOMELESS	DRIVER FOR HOMELESSNESS	HOUSING PHASE 1	HOUSING PHASE 2
55 - 59	>18 years sporadically	Mental Health/Family breakdown	Housed	Housed
45 - 49	<2 years	Mental Health/Family Breakdown	Housed	Housed
34 - 39	>2 years	Mental Health/Family Breakdown	Hostel	Hostel (as previous)
40 - 44	<4 years	Mental Health/Family Breakdown	Housed	Housed
30 - 34	>2 years	Mental Health/Family Breakdown	Hostel	Hostel (as previous)
30 - 34	>2 years	Anti-social behaviour at previous location	Tent	Recovery Hostel (more secure)
35 - 39	>18 years sporadically	Relationship breakdown	Tent	Housed
30 - 34	> 1 year	Substance Use/Family breakdown	Hostel	Residential Detox – will transfer to Aftercare Housing
45 - 49	<4 years	Relationship breakdown	Hostel	Recovery Hostel (more secure)
40 - 44	<2 years	Anti-social behaviour at previous location	Hostel	Recovery Hostel (more secure)

This section presents the views of the study's participants on their mental health, substance use and housing in the context of ongoing COVID-19 pandemic restrictions. It allows for reflection on changes since Phase 1 of the study in terms of their lived experiences and the challenges that they have faced both retrospectively and the challenges that they feel they will face into the future.

4.1 Mental Health Challenges

Of the ten participants in Phase 1, all had experienced, or continued to experience, mental ill-health. For five of those participants, their mental ill-health is of a severe nature (schizoaffective/bipolar disorder) which emerged during their developing years and has led to difficulty in social and economic functioning in terms of relationships, education and employment. The remaining five had all experienced depression and/or anxiety throughout their lives.

During Phase 2 interviews, it emerged that for those with more severe mental ill-health the isolation necessitated by COVID-19 restrictions was having a more profound effect on their mental health.
At Phase 1, two participants with severe mental ill health had required hospitalisation for relapses in their mental ill-health. At Phase 2, this number had increased to four.

For both Margaret and Roisin, hospitalisation occurred in the immediate aftermath of Christmas. Margaret, who has bipolar disorder with alcohol use, has a history of suicide attempts over her lifetime. In this instance she had taken an overdose of her medication but was unsure of her reasons at the time. She had been on new medication and felt it didn't suit her.

'I overdosed on it. [I don't know why]. I would just do that. You know.' (Margaret, aged 55-59).

Margaret described a stressful Christmas period where her adult child, who has addiction issues, came to visit and stay and feels, on reflection, that this may have precipitated the suicide attempt.

Roisin, who has schizoaffective disorder found the prolonged lockdown very difficult.

'I was just finding it very tough. I get very depressed – no control over my life and I have very little money. [And then] with the lockdown after Christmas – there was nowhere to go. I would normally go out for a coffee once a day, but I couldn't even do that. It was all very strange and isolating. I definitely suffered with depression with it all – for me that makes me have a loss of energy, a loss of happiness and no optimism.'

(Roisin aged 30 - 34).

Roisin did not feel that she needed to be hospitalised. She described having engaged in behaviour which she felt acted as a 'red flag' to her care team.

'I guess they thought I was having a relapse, as I was going through a very difficult time. I wasn't happy about [ending up in hospital for two months] – I was angry. I felt a bit violated.'

(Roisin aged 30 - 34).

Two respondents reported increased feelings of paranoia at the time of Phase 2 interviews, and David, who had been hospitalised during Phase 1 explained that, having lost his job, not attending college and having no interaction with other people meant that his mind was constantly 'ticking over' and that his level of suicidal ideation was high.

'Like, I've a lot of paranoia that goes on, you know. I can get paranoid about all sorts of things. It has really badly affected my mental health.'

(David aged 45-49).

David, who had reported a planned suicide in Phase 1, referred to a present struggle with an inner voice urging suicide.

'They want me to commit suicide, but I don't want to be a victim anymore.'

(David aged 45-49).

Sean, who had been hospitalised just before Phase 1, discussed feeling very depressed in the last year, and describes how his anxiety comes in waves.

'It's like a panic attack. Well, the anxiety comes in with those episodes that I get, you know. It's just in my head. My body, my hands and my legs shake, you know. It's very scary, yeah. It's just all that fuels the drug use as well because you just...when you're going through it you just want to get out of it, you know. it just gives you that bit of escape for a few hours or a little while, you know.'

(Sean aged 34 - 39)

For those with less severe mental ill-health, the prolonged lockdown brought additional challenges, with reports of severe depression and suicidal ideation with planning. These respondents also talked about the importance of housing in relation to their mental health, with increased mental ill-health being driven by loss of housing throughout their lifetime narrative.

Mairead, who was rough sleeping at Phase 1 found the continued isolation really difficult:

'

I always suffered with my mental health, but I stopped it for the last few years, harming myself and I got back on track but then back on the streets again [and no-one around] made everything worse again. I was very depressed.'

(Sinead, aged 30 – 34).

Sandra, who was also rough sleeping at Phase 1 described her struggle with depression as the isolation during lockdown continued and had arranged a time and manner of implementing her suicide plan.

'Yeah, I was shook up I was, to be honest. I never thought I'd see light at the end, you know what I mean? I thought this is going to be my life for the rest of it. Get up every morning, out, getting down begging, really getting high, the same thing. So, that's why my only answer was out. The only way I could see out of it was suicide, you know what I mean? I know it was selfish at the time but that's the only way out I could see.'

(Sandra aged 35 - 39).

The day before Sandra was to implement her suicide plan, she received word that she had been successful in securing a place to live.

'I was…going to kill myself before Christmas. That's the honest truth. Then I was offered a place. I didn't think I'd get offered a place.'

(Sandra aged 35 - 39)

heroin and benzodiazepines (n=1) cocaine (n=2) and MDMA (n=1) and crack-cocaine (n=1). Three participants had been in receipt of methadone maintenance treatment (MMT) in the past for their heroin use.

At Phase 1, two participants had reported reduced alcohol use (due to pub closures) while one reported increased alcohol use. Four participants who had been in recovery or drug free in the past had reported a return to substance use. However, at Phase 2 this had changed considerably. Two of the participants, who had issues with alcohol and also lived with depressive illness, reported no alcohol use.

At Phase 1, they were both living in a hostel but by Phase 2 had moved to a recovery hostel.

'No, I have not touched a drink at all and, do you know what, it doesn't even bother me, the pubs even opening back up, doesn't bother. I have more money in my pocket now.'

(Michael aged 45 – 59).

Sinead, who was street homeless at Phase 1, reported lapsing back to heroin use as a result of the isolation of the pandemic and her housing situation. She had previously been in recovery and stable on MMT. Sinead was now hoping to return to MMT with the support of a community detox team and was subsequently tapering off her heroin use and had stopped using any other illicit substances. Now in a recovery hostel, Sinead puts the start of her recovery journey down to no longer living on the streets.

One participant, Miriam (aged 30 – 34), had been using both heroin and benzodiazepines at Phase 1 was not available for interview at the time of data collection for Phase 2. Miriam had engaged with the community detox team and had subsequently entered an MQI detox and rehabilitation programme early in 2021 and was reported to be doing very well. At the time of writing, Miriam was drug free and waiting to move into aftercare housing.

Sean, who lives with severe mental ill-health, had been drug free for a number of years prior to the pandemic and was working. Having lost his job and subsequently his accommodation, he was living in a hostel at Phase 1 where drugs were freely available at Phase 1. This had resulted in his starting to use crack cocaine in addition to cocaine.

At Phase 2, Sean reported that he was no longer using crack cocaine, and was reducing his cocaine intake with the support of in-reach drug counselling from another agency:

'Substance abuse is gone down lately, out of necessity really. But the lockdown really, kind of, drove my substance abuse…just the boredom and the constraints of COVID just, kind of, fuelled my drug abuse. I'm seeing a drug counsellor from (Dublin NGO) … she comes [to the hostel] … it was every week now it's every two weeks – there's a room we can use in the hostel."

(Sean aged 34 - 39).

4.3 Transitions in Housing/Homelessness

At Phase 1, only three of the 10 participants were securely housed, all of whom had a severe mental illness. This had increased to four at Phase 2, with Sandra, (who had SUD) being assigned a secure apartment in Q2 of 2021 having been in and out of homelessness for 19 years. For those with severe mental ill-health, three remained housed as at Phase 1. For the remaining two who had been in hostels at Phase 1, there was no change, although there was talk about securing accommodation through Housing First and HAP initiatives in the near future.

Both Rosin and Sean (who both have Schizoaffective Disorder) remain in the same hostel as at Phase 1. Sean has received word that he is due to be housed shortly.

,

'I'm on a list but I've been taken on to Housing First....I basically got medical priority with them. So that bumps me up, I think, to the top 10 on the list. Or thereabouts, you know. But I was on to them last week and they were saying that they've signed off on a number of properties in … it's just a matter of time before I get mine, you know.'

(Sean aged 34 - 39).

And while Sean said he had no idea where he might end up living, that he didn't really care as long as he had his own place:

'Good to have my own place, yeah. Cook my own meals and all.'

(Sean aged 34 - 39)

Roisin who has a severe mental illness (with no co-occurring substance use) continues to live in a hostel where drug use is widespread. She has found hostel living very challenging and explained the difficulty she faces securing alternative accommodation, even with HAP approval:

'I find it difficult. I was sent hundreds of applications [and the forms are endless] and I've barely gotten any word back from anyone. One of them (landlord) looked me up and down. Like he didn't like the look of me. Maybe he thought that I looked rough or something … I just thought they were judging me. Kind of given up a bit, yeah.'

(Roisin aged 30 - 34).

.Of the remaining five participants presenting with SUD and depressive illness, three (n=3) were living in hostel accommodation and two were street homeless at Phase 1. By Phase 2, all of the participants presenting with depressive illness and SUD had changed accommodation type.

Two of the rough sleepers (Sinead and Miriam) were no longer on the streets. Miriam had transferred into residential detox, with a subsequent move planned to aftercare (recovery) housing. Sinead, who had been living in a tent at Phase 1, had moved to a recovery hostel.

For Pauline, who was living in a hostel in Phase 1, the experience was very depressing. She describes fighting and violence as well as poor living conditions:

'The dampness and everything. It as mouldy it was. The amount of stuff I had to throw out was, like, it was unbelievable. I was so depressed. [But] the minute I got transferred, I'm grand now. Grand now, you know?'

(Pauline aged 40 - 44).

She stated that the Hostel had subsequently closed. Pauline has since moved to a recovery hostel, giving her a greater sense of security, though she describes living in one room (which she shares with her partner and their new baby) stressful at times.

'It's difficult because we have, like, the cosy bed thing for the baby, we've all his clothes, we've our clothes, we've a lot of stuff, like, but...and there's not the space there for it. So, it can feel quite stuffy at times. It is a bit draining.'

(Pauline aged 40 - 44).

Michael, who is now no longer drinking, has also moved to a recovery hostel, where staff were very helpful. He pointed to the fact that meals were provided, which took the pressure off having to chase food stops as he had done earlier in the pandemic.

Michael and Pauline are now on the Council housing list and hope to be informed of a place of their own soon.

Sinead, who had been street homeless at Phase 1 recently moved into a recovery hostel and is reducing her heroin intake with the intention of returning to an MMT programme. Sinead finds the hostel very helpful as meals are provided and drug use is not permitted.

'Oh, it's brilliant. Absolutely brilliant it is, yeah. And I got a letter off the council saying I have an appointment for HAP scheme, for a HAP house.'

(Sinead aged 30 - 34).

Sinead also talked about the difficulty of living on the streets as a female, and says that she would have preferred an all-woman hostel.

'When you're living on the streets it's very, very hard and you see a lot of teen girls out there now and it's very hard for them as well. There should be separate things for women. [It would have given me] more headspace for myself'.

(Sinead aged 30 - 34)

Sandra, who now has her own apartment talked about the difficulty of living on the streets during a pandemic:

'I went the whole pandemic on the streets. Like it was hard, very hard. No place to go wash. Had to get up and wash your face and hands just using baby wipes the whole time. It's disgraceful for a human being. A

woman my age as well, like.'

As discussed earlier, Sandra felt the whole situation was so hopeless that she had decided to take her own life. The day before she was due to execute that plan, she was notified that she would be housed. However, she now feels that her life has taken a significant turn for the better.

'[I have] a 2 bedroom apartment out in (outer western suburb of Dublin) and I don't know myself. It's brilliant, you know what I'm saying? It's great to have that security and knowing that I don't have to worry about where I'm going to stay tonight. Not going around dirty anymore and I'm in the process of getting my medical card so I'm getting going getting my teeth done and you know what I mean? So, things are looking good for me.'

4.4 Experiences of Changes in Service use Pre-and Ongoing-COVID-19

Prior to the restrictions necessitated by the pandemic, half (n=5) of the participants were linked in with HSE ACCES. All had a severe mental health issue and, in most instances, (n=4) were referred to the service following hospitalisation. At HSE ACCES, services accessed include medication, health and occupational therapy and counselling on a face-to-face basis. Service users were supported to engage in their local community through supported employment, volunteering or as part of community engagement programmes. Appointments were generally arranged in advance, but participants were also able to drop in ad-hoc for additional support.

For those linked in with MQI (n=5) they described at Phase 1 an informal service which felt 'like a family'. Participants could avail of a range of services including face-to-face counselling, substance use services, general and mental health services as well as for meeting practical needs such as showering, clothes washing and food. MQI was also referred to as a point of social contact for those who were isolated while living in hostels or on the streets.

However, with the onset of restrictions, both services experienced unprecedented changes in how participants were able to access supports. At HSE ACCES, access to support became much more formalised, and was described in Phase 1 as 'very clinical' with a lack of 'openness'.

The restrictions were more severe for those accessing MQI supports, with the closure of the night cafe many services (food, personal hygiene services, overnight stays) were no longer available. Some health services were available through the Homeless Health Link Team and GP services continued to operate.

Both MQI and HSE ACCES reoriented 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. While there was limited access to the MQI building,

appointments had to be made in advance and in many instances service users had either no phone, or no phone credit, so were unable to make appointments in this way. The easing of restrictions has led to increased access to Riverbank, but this is still limited to operating within Government guidelines.

4.4a Ongoing COVID-19 Service Use

In all instances (n=9), participants had continued to receive face-to-face support, either in HSE ACCES or through MQI Outreach Teams. Capacity for online support continued to be an issue at Phase 2, with the same number of participants (n=3) having capacity for online support, while the other six available participants available for interview had limited access to phones, most with no internet access.

In Phase 2, the majority of participants (n=7) engaged in face-to-face support, with only two participants using a combination of online and face-to-face supports. Both of those participants are securely housed. David, who is linked in with HSE ACCES and housed, says he feels very fortunate in the help that he has received. David had planned to take his own life at Phase 1, but his plan had been stopped by an intervention from one of his mental health support workers online. He is now engaged in phone and face-to-face support. While he reports struggling with paranoia, he is aware of the benefit of the support he receives:

'My social worker … calls me once a week and she's trying to get me involved in things…I have been having one to one sessions with the psychologist every week – that has been very helpful.'

(David, aged 45 – 49).

Peter, who is now in full time employment, was the only respondent who

was able to engage fully with online supports but also felt that it was very important that he continued face-to-face contact with someone. He describes his Social Worker:

'She'd be in contact with me every so often from the outreach team. And I'd get out for a walk, and I'd meet up with her in a park or something like that and we'd go for a stroll, and just chat, you know and catch up and let her know how I was getting on and that sort of stuff.'

(Peter aged 40 - 44).

Sean, also linked in with HSE ACCES, is seeing a psychologist every two weeks for face-to-face counselling sessions.

'I haven't gone near online. I find the one on one to me is much better, you know. And thankfully throughout the lockdown it's been available, you know.'

(Sean aged 34 - 39).

Margaret, who is also linked into HSE ACCES, still finds the restrictions very challenging.

'Yeah, well I don't like the restrictions. You know the way people are going on. You know all this...I can't...like 'Stand back' and all this. I find that very, sort of, hard you know ... and you have to wait outside [HSE ACCES building] ... you're standing around and people are looking ... at you an all saying, "What you waiting there for?" You always feel when you're left outside the place that you're not welcome or something like that you know? You always feel as if like oh you can't go in, like, what's the story here?' (Margaret aged 55-59).

For those co-presenting with depression and SUD, the value of outreach was evident in their discourse:

Sinead, linked in with MQI described the loneliness that the closure of Riverbank caused:

'Yeah, to [not be able to] go in and have a talk to the girls down there and to go in and have something to eat and have a shower and all, was very, very hard. Cause that's the main service everyone goes down to… it was very, very lonely cause Merchants Quays had not opened.'

Sinead talked of the importance of the outreach team:

'She always rings me, and all. Yeah, rings me the whole time. And I haven't got any counselling yet, but I can talk to her.'

(Sinead aged 30 - 34).

For Sandra, the contact provided by the MQI Outreach Team was vital and may have prevented her suicide:

'Do you know what? I think it was the thought of them happening to come around and find me, after me doing something silly, I wouldn't have never forgave…. the thought, I couldn't get over that. So, yeah, when they came round in the morning to make sure you were ok, they'd bring you anything you wanted, a cup of tea or something to eat. They'd go and get it and bring it back to you. You know the outreach team are very good.' (Sandra aged 35 - 39).

4.5 Interagency Support

At Phase 1, all ten participants discussed the services provided only by

their main point of contact – for half (n=5) this was HSE ACCES, and for the remaining number (n=5) this was through MQI.

By Phase 2, it became evident that case workers were able to engage the services users with a range of supports from other agencies.

Pauline, who had a baby at Christmas and is now living in a recovery hostel, described being linked in with a number of non-MQI supports.

'I have early learning initiative for the baby … she's lovely. She rings me twice a week and it's like…she's the family support. It's like talking to me mother. To be quite honest. Like even if I needed her now, she would ring me if I text her, you know? we have the support there, you know? But we have to do things ourselves as well.'

(Pauline, aged 40 – 44).

Peter, who was housed and had capacity for online support, describes being linked in with a number of community support programmes:
'I was studying … they had an outreach sort of thing as well where most days I'd be online with a class on Zoom. So that was really helpful as well. They'd send us an email like, and you'd have to go out and do your jog or do your walk. Yeah, you'd have to record it on a map and send it to them and say, 'This is the walk I did or this is the jog I did' or whatever.'

'Then there was loads of courses and stuff like that … Mental Health Ireland was offering all sorts of courses … How to Manage Stress was the course that I did. It was really useful. Well. It was just nice to hear different opinions and people with different abilities on how to manage the stress you know?'

(Peter aged 40 - 44).

Sean, who was using crack-cocaine and cocaine at Phase 1 had stopped using crack and was reducing his cocaine use with the support of In-reach addition counselling from an NGO involved in addiction recovery. 'Yeah, I've stopped using crack. I see a drugs counsellor from [non MQI NGO]... it was a suggestion from my psychologist. It's one-to-one ... It's very good.'

(Sean aged 34 - 39).

4.6 Experiences of Social Isolation

At Phase 1 all of the participants talked about feeling isolated. Of the ten participants eight (n=8) had either no or very limited in-person or phone contact with family as a result of their mental ill-health or substance use. Only three (n=3) of the ten participants at Phase 1 reported face-to-face contact with other people (through volunteering or contact with family/friends). All three participants were linked in the HSE ACCES and were housed. The remaining seven respondents had no family contact, mostly as a result of disrupted family relationships due to addiction or mental ill-health.

Even at Phase 2, for those with severe mental ill-health, there was a discourse around the enduring nature of the isolation that comes with severe mental ill-health.

Margaret, who has bipolar affective disorder and also uses alcohol talks of social exclusion throughout her life:

'I'm used to a lot worse than COVID – people with mental health problems isolate themselves. I was looking at it from this perspective – like say I was in a psychiatric ward, and no one was coming to visit me.

It'd be just the same. I spent a lot of time in psychiatric wards.'

(Margaret aged 55-59)

And while Margaret has some interaction with her family, it is limited:
'Other than that, like, you wouldn't see anyone from one end of the day to the other, like. So, you're kind of lonely and kind of missing people and just beingaround people and that. Very isolated, yeah. I'm kind of used to being on my own and being isolated anyway so...'

(Margaret aged 55-59).

Peter also describes difficult family relationships:

'I get on alright with my mother ... I just don't see them often and I don't see my brother that often or my sisters but when we are together, we all, kind of, get on. We get on alright, like...there was never any big sharing of emotions or anything in our family. It was always very hands-off type of thing. You know what I mean? There wasn't...just... I would have liked to have a different type of family but that's the family I have so. You have to love what you have.'

(Peter aged 40 – 44).

Peter, who has schizoaffective disorder, talked of enduring loneliness and his constant efforts to stay engaged with people:

'Yeah because of mental health is one of the reasons. I wouldn't like to blame it all on that. I'm always trying to think of ways of getting out there

and meet people and that. People are alone a lot during the pandemic. I was on my own almost all the time. I'm lucky I have friends though. I'm on the phone every night to my friends.'

<p align="right">(Peter aged 40 – 44).</p>

For those whose substance used had decreased as restrictions were lifting, there was a shift in family relations. However, for many who had been in recovery prior to the pandemic, the nature of these reconnections was tenuous. Sean, who had stopped using crack-cocaine and was reducing his cocaine intake, talked of a recent family get-together:

'My birthday was a good day. We had a barbeque there, 2 weeks ago. And my parents were there and most of my family were there, you know. It was good, yeah, good.'

<p align="right">(Sean aged 34 - 39).</p>

However, he has not seen his family since then.

For those presenting predominantly with SUD, being in recovery had led to a healing of family rifts. In Phase 1, all had reported loss of family connections as a result of SUD, describing alienation from family. Sandra, who has recently been housed and is in recovery has re-established a relationship with her daughter.

'Yeah, I'm doing very well. I'm still off all drugs and I don't be in town anymore. I only have to go into the doctors and now I'm still on my methadone but other than that, that's all. I have my daughter back with me at the moment … her dad drops her up to me now. Now she can stay

.

whenever she wants.'

Pauline, who is also in recovery housing and has ceased using alcohol, talked of linking in with her children again and has re-connected with her father and feels that her family now support her:

'I do be up in me dads nearly every second day now. I do be – and I get great support from [family].'

However, she was completely alienated from her family while using alcohol, and this has remained a factor throughout her life while in and out of recovery.

Sinead, who is currently in a recovery hostel is trying to reconnect with her children. She talked of missing many family occasions over the years because of addiction, and worries about missing out on her children's significant milestones:

'I've been trying the social workers and all but they're not getting back to me at all, so they're not. Yeah, they're not returning my calls because I'm homeless. It's wrong, it's very wrong.' She felt that if she was housed, the situation would be different: 'I think if there's back up behind me to prove that I have all that [secure housing], they would [engage] with me.'

4.7 Living with the Threat of COVID-19

Participants at Phase 1 indicated that social isolation, lack of adequate housing, access to services and the requirements of daily living (food, shelter, washing facilities etc) were their main concern, with little discussion of the threat of contracting COVID-19. However, where their housing or substance use situation changed and, in many instances, re-connected with family at Phase 2, there was a shift in attitude to the threat of contracting COVID-19, with considerable discussion around fear of the illness itself.

Of the nine people who participated in Phase 2, eight (n=8) were vaccinated at the time of interview. Six of the nine respondents were concerned about contracting the virus.

Margaret, who lives on her own was particularly concerned about the Delta variant, even though she is vaccinated:

'I just hope I don't get that variant – I wouldn't like to. That's worse than the first one – well I think so from what I heard on the radio or on the news.'

(Margaret aged 55-59)

Peter, who visits an elderly relative at weekends, said that he worried he might get the virus and transmit it to his relative.

'When I was going on buses ... and in shops. I was nervous I might get the virus – I was worried ... bringing the disease over ... I think I still have a bit of anxiety, but I still go on buses and stuff. It doesn't stop me from getting on and doing stuff.'

(Peter aged 40 - 44).

.

Sandra, who is in recovery and housed, expressed concern about the Delta variant, as she suffers with breathing problems.

'To be honest, I've been a bit worried in case I caught it and, knowing my luck after being on the streets for the worst of it and I didn't catch anything and now that I'm happy and settled ... knowing my luck I'd probably get it.'

(Sandra aged 35 - 39).

Roisin, who is living in a hostel with a shared bathroom is concerned about hygiene levels, but not especially worried about contracting the virus:

'I'm still sharing a bathroom and that's very unhygienic. I wasn't worried about catching the virus. I had a head cold for a couple of days and they took me out of a hostel and put me in a nice hotel room in the city centre for a couple of days until the test came back.'

(Roisin aged 30 - 34).

Sean, who is the only participant not vaccinated, was also not especially concerned about contracting the virus.

'I don't really worry about having COVID. I'm ... intentionally not getting the vaccine. I just don't believe it's safe enough. The majority of cases lately with COVID are with people that are actually vaccinated.'

(Sean aged 34 - 39).

4.8 Positives from the Pandemic

Participants were asked if they felt that there was anything positive about the COVID-19 restrictions. Four of five participants who had either moved into their own accommodation (n=1) or into recovery housing (n=3) felt that the process had probably been expedited by COVID-19. This sentiment was echoed by the other participants (n=2) who were waiting on either a Housing First allocation or a HAP tenancy.

However, for Margaret, who talked of being isolated and stigmatised throughout her life because of her mental ill-health, there was hope that the widespread experience of mental ill-health might open up more discussion on the issue, leading to normalisation and better understanding around psychological ill-health:

'Well people who thought that they couldn't be…that this wouldn't happen to them [experience mental ill-health]. They seemed to realise that things would happen to them you know. They might understand a bit better about [how things can go wrong in your life]. You see, when people like nurses and A&E's are talking about their mental health, then people will talk about it. You know, they're asking to see people. So, people would talk about it more.'

(Margaret, aged 55 – 59).

4.9 SUMMARY OF FINDINGS

The following is a summary of the findings, and reviews changes in mental ill-health, substance use and housing between Phase 1 and Phase 2. This summary also briefly examines perceived changes in service use and in social capital.

PHASE 1	PHASE 2
Mental Ill-Health, Substance Use, Homelessness Overview (n=10)	**(n=9)**
5 presenting with severe mental health	
3 co-present with substance use	2 have reduced alcohol and substance use intake
3 housed	No change
2 in Hostels	No change
5 presenting with depressive illness	
5 co-present with substance use	5 in Recovery
5 Homeless	1 Securely Housed
3 in Hostels	3 in Recovery Hostels
2 Street Homeless	1 Securely Housed, 1 in Recovery Aftercare Housing

PHASE 1	PHASE 2
Effects of Restrictions on Mental Health (n=10)	**(n=9)**
5 presenting with severe mental ill-health	
2 required hospitalisation	4 required hospitalisation
1 reported suicidal ideation with planning	3 reported suicidal ideation with planning – one unsuccessful attempt
1 reported increased depression/anxiety	4 report increased depression/anxiety
5 presenting with depressive illness	
5 report increased depression	4 available reported increased depression – now resolved
4 report increased anxiety	3 report increased anxiety
3 report suicidal ideation	4 reported suicidal ideation, 1 with planning

PHASE 1	PHASE 2
Effects of Restrictions on Substance Use (n=10)	**(n=10)**
5 presenting with severe mental ill-health, 3 co-presenting with Substance Use Disorder	
Alcohol intake increased – remained in recovery from substance use	Currently reducing alcohol intake
Alcohol intake decreased	Alcohol intake increased
Return to substance use having been in recovery	Substance use decreased
5 co-presenting with Substance Use Disorder and depressive illness	
2 report reduced alcohol intake	2 in Recovery
3 report increased/ a return to substance use having been in recovery	3 in Recovery: 1 on MMT; 2 in recovery (one waiting to get on MMT/ 1 has completed a detox/rehab programme)

PHASE 1	PHASE 2
Pre and ongoing COVID service use (n=10)	**(n=9)**
Pre-COVID Service Use	Ongoing COVID Service Use
HSE ACCES – structured but informal element - welcoming	Clinical, formal, structured. Face-to-face contact still provided plus Outreach. Evidence of inter-agency collaboration to support service users. One participant uses online support in addition to face-to-face contact
MQI – semi-structured/unstructured – like a home	Drop-in element absent. Contact provided via Outreach Teams in person. Evidence of inter-agency collaboration to support service users No online service use reported.

PHASE 1	PHASE 2
Loneliness/Lack of Social Capital (n=10)	(n=9)
10 Report feelings of loneliness, abandonment, isolation	5 report feelings of loneliness and isolation
8 have limited contact with family	6 have re-established family relationships
8 report no friendships	7 report no friendships

This section briefly reviews the findings of Phase 1 of this study, which examined the experience of the participants prior to, and over the period of, the ongoing pandemic in terms of their mental health, substance use and housing.

In exploring the impact of restrictions associated with the pandemic, this discussion seeks to track changes in those experiences at Phase 2, especially in relation to delivery of services and the effects that this has had on the participants psychological well-being.

5.1 Phase 1 - Challenges to People with Mental Ill-Health, Substance Use Disorder and Homelessness

The findings of this study point to the enmeshed relationship between mental health, substance use and housing. All of the participants had experienced homelessness at some point in their lives, either as a result of substance use disorder, mental ill-health or a combination of both, and this study points to the non-linear relationship between all three (Murphy, Mitchell and McDaid 2017).

Mental Health Issues

All ten participants had experienced mental ill-health, half (n=5) of a severe nature (Schizoaffective Disorder/Bipolar Disorder) while the other five reported a clinical diagnosis of depressive illness at some point in their lives, and continued to struggle with depression and/or anxiety. Suicidal ideation with and without planning was evident, as was increased depression and anxiety.

Substance Use Challenges

The majority (n=8) of participants in this study reported SUD (alcohol or illicit substances) co-presenting with mental illness. For those with severe mental ill-health, one person was alcohol dependent while a further two had used cocaine or MDMA in the past, as well as present use of crack cocaine.

For those with depressive illness, two reported alcohol issues, and a further three had used heroin and other substances, at the time of Phase 1 of the study.

Mental Health and Dual Diagnosis

The findings reflect the clear link between long-term SUD and mental health disorders (Iro and O'Connor 2009; Kamali et al 2000). In line with pervious findings, participants in the study at Phase 1 reported having been referred for SUD while experiencing severe mental ill-health (at earlier points in their lives) and vice versa indicating a lack of co-ordinated dual diagnosis service provision in Ireland (Proudfoot, Mc Gabhann and Phelan 2019).

Housing Challenges

All ten participants had been homeless at some point in their lives, with an average length of time in homelessness of five years for the sample. At Phase 1, only three participants were housed, and all are representative of a group with complex histories of SUD and mental ill-health and a key target group for a Housing First initiative (Social Justice Ireland 2020).

Drivers for homelessness in this study included family/relationship breakdown, either as a result of mental ill-health or SUD, while two participants (both single mothers) had surrendered their properties

because of anti-social behaviour, in line with previous findings (Focus Ireland 2020).

Participants in homelessness services reported widespread use of illicit substances both on the street and in hostel accommodation, confirming earlier studies that homelessness can trigger increased SUD (Glynn et al 2017; Mayock, Butler and Hoey 2018; MQI 2017).

5.2 The COVID-19 Pandemic and Changes in Service Delivery

The declaration of COVID-19 as a pandemic by the World Health Organisation (WHO) in March 2020 led to significant organisational changes in the delivery of healthcare in Ireland, both in acute and community care (HSE 2020).

Healthcare delivery in Ireland continues to be severely affected as a result of the emergence of new strains of the virus leaving the most vulnerable without many of the day-to-day services on which they depend. This cohort, identified as an especially vulnerable group due to higher rates of SUD and mental ill-health, have significant needs. Over half report a clinical diagnosis of depression and nearly one-third expressed suicidal ideation, with one in four having attempted suicide over their lifetime (Glynn 2015; HSE 2020; O'Carroll 2021).

HSE ACCES and MQI Response

In spite of reduction in face-to-face services, the HSE ACCES Team was able to continue to see service users in person throughout the pandemic, although access was more restricted. They also initiated an Outreach Service ensuring that they kept in touch with service users by phone, text and email. The main building accessed by service users linked to MQI (Riverbank) remained closed for most of the early stages of the pandemic, but GP services continued to operate by appointment

throughout the entire. As restrictions eased, face-to-face services were operated in a different manner with food being made available as a take-out service, and showers etc. by appointment. In collaboration with the HSE Health Link Team, two Assertive Outreach Teams (AOT) started to work on both homelessness and harm reduction. While the collaboration ended in late summer, by early Autumn 2020 MQI continued to provide harm reduction, community engagement and an Assertive Outreach to the most vulnerable. This was achieved largely without additional funding and required a reorientation of work practises within the organisation.

5.3 Phase 2 - The Effects of Continued COVID-19 Restrictions on the Mental Health of the Participants

The effect of restrictions for participants in the study at Phase 1 had stark repercussions, with all expressing feelings of abandonment, intense loneliness and social isolation. At Phase 2, and as the restrictions had continued, the effects of the pandemic had greater implications for those with severe mental ill-health (n=5). The participants with severe mental health issues (n=5) linked in to HSE ACCES, experienced greater levels of hospitalisation, suicidal ideation and paranoia.

Of the five (all of whom had a diagnosis of severe mental ill-health) two had been hospitalised prior to Phase 1 and a further two required hospitalisation prior to Phase 2 – a total of four hospitalisations over the period, even as in-patient admissions had reduced by 8.5% nationally because of reduced bed capacity (Daly and Craig 2021).

At Phase 1, one participant reported increased depression and anxiety but by time of interview in Phase 2, this had risen to four. Of that number (n=4), over both phases of the study, three reported suicidal ideation with planning, one of which was unsuccessfully acted upon,

which is reflected in previous findings that people with severe mental ill-health are at high risk of suicide (Baldessarini 2019). Two participants at Phase 2 interview expressed increased feelings of paranoia, resonating with research that greater isolation and loneliness leads to higher levels of delusion and lack of insight for those with severe mental ill-health (Garety et al 2001; White et al 2000).

Of the five participants accessing MQI, all of whom had a clinical diagnosis of depression co-presenting with SUD, there was some change in mental ill-health between the two phases of data collection. While four of the original participants who were available reported increased depression as the pandemic wore on, at the time of interview for Phase 2, their housing and SUD circumstances had changed, leading them to report higher levels of optimism and hopefulness.

There was one less report of anxiety (n=3 at Phase 2 v n=4 at Phase 1). However, while three had reported suicidal ideation at Phase 1, this had reduced to two participants at Phase 2, but one of those participants had planned their death. Drivers for suicide discussed by the participants included isolation and a lack of social connections, which can predict suicidal behaviour (Clinton et al 1998; Deniro 1995; Goldsmith et al 2008; Richman and Sokolove 1992; Wang et al 2017).
This ties in with findings that dual diagnosed individuals have a high risk of suicidal behaviour than the general population (Baldessarini 2019; Sher 2020), and that suicidal ideation is prevalent in people with SUD (Arribas-Ibar et al 2016; Bakken and Vaglum 2007; Goldstone and Bantjes 2018).

The impact of the pandemic on suicide rates is not yet known (John et al 2020), and while some research indicates that numbers have not increased (NOSP 2021), there is concern that increases in suicide rates

are likely to be evident later than the pandemic and may last a period of years (Banerjee, Kosagisharaf and Rao 2021; Sher 2021). Previous research on the impact of pandemics on suicide rates suggests the likelihood of a short term spike in suicidal behaviour for vulnerable groups (Devitt 2020). Primary Care Practitioners are seen to have an important role to play in intervention for those with suicidal behaviours (Nelson and Adams 2020) though this is not the healthcare route generally accessed by this cohort (Cheallaigh et al 2017; Mcloughlin, Feeney, Cooney 2020).

5.3a The Effects of Continued COVID-19 Restrictions on Substance Use Patterns of the Participants

As with other findings, there is evidence of increases and relapses in alcohol and substance use as a reactive behaviour as a result of the pandemic (Abramson 2021; Mongan 2021; Chiappini et al 2020; Sher 2021).

Certainly, in Phase 1 of data collection this was evident in that of the eight participants who co-presented with SUD and mental ill-health, only two reported a reduction in alcohol use while the remaining six reported increases or relapses in alcohol or substance use. In four instances, participants who previously had been in recovery or drug free for heroin (n=2), or heroin with BZD (n=1) and cocaine/MDMA (n=1) had returned to heroin use (n=3) and crack cocaine (n=1). For those using alcohol (n=4) two had reduced their alcohol intake while two had increased their alcohol intake. This is in line with findings that the level of social isolation required for 'cocooning' during the pandemic also provides opportunities for increases in addictive behaviours (Columb, Hussain and O'Gara 2020).

At Phase 2, SUD patterns had shifted significantly. For those with alcohol use (n=4), two were alcohol free, and one was reducing their alcohol intake. Only one person reported increased alcohol use. For those using illicit substances (n=4) one person was in a residential rehabilitation programme and was drug free at the time of writing and reported to be doing well. One participant was drug free and engaged in MMT treatment while a further participant was reducing their heroin use with a view to starting MMT. The participant on crack cocaine had ceased it's use and was only using cocaine at time of interview, reducing their intake with support.

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

5.3b The Effects of Continued COVID-19 Restrictions on Housing Patterns for Participants

The homelessness response in Dublin was coordinated by the DRHE and the HSE, and two participants spoke of being moved to alternative accommodation while waiting test results for suspected COVID-19 infection. At a wider level, the cohesive strategy initially drawn up comprising statutory, voluntary and community services in homelessness and harm reduction had the input of the DRHE and was co-ordinated by the Social and Addiction Service of the HSE (HSE 2020; O'Carroll, Duffin and Collins 2020). This was coupled with increased supply of accommodation for single adults (NSIO 2021).

At Phase 1 of data collection, only three of the ten participants were securely housed. Five were in hostels and two were street homeless. Even though there was an increase in accommodation availability for single adults (NSIO 2021), the discourse of the participants suggests that the hostel accommodation was inappropriate and unsafe.

By Phase 2, one additional participant was securely housed, having been street homeless. This participant had co-presented with SUD and depression, and had been homeless for nineteen years and was now in recovery (MMT). Two participants who had been in hostels (presenting with alcohol use) had moved to recovery hostels, and one participant who had been street homeless had also moved to a recovery hostel – these hostels provided food for the participants, a service which was absent at Phase 1. One further participant who had been street homeless was in residential detox/rehab with the intention of moving into recovery housing. Two remaining participants (both of whom had a diagnosis of severe mental ill-health) were in the same hostel as they had been at Phase 1.

Dual diagnosed individuals who may be experiencing homelessness are already socially isolated, often as a result of disruption or breakdown in family relationships, in many instances of a permanent nature due to their SUD or mental ill-health (Copello et al 2010; Duggan 2007; Hyland 2020; Kelly 2020; Orford et al 2010; Rossow and Hague 2004; Von Kardoff 2016).

However, one of those participants was waiting to hear about housing and one had been approved for HAP, though finding it difficult to secure a rented property. Two participants reported having accessed housing or were on a housing list through a Housing First initiative. The continued use of emergency accommodation, while improved between Phase 1 and 2 of the study, points to issues with Housing First in terms of ability to access accommodation and availability of appropriate housing stock (Manning, Greenwood and Kirby 2018; O'Donovan et al 2020).

5.3c Reduced Social Connections and Impacts on Mental Health

The key measure for controlling the pandemic requires isolation, which has detrimental effects on mental health for the general population

(Hyland et al 2020; Kelly 2020; Mukhtar et al 2020) and secondary consequences of social distancing is associated with negative psychological effects (Hughes et al 2020; Lynch, Morgan and Leen 2020).

Dual diagnosed individuals who may be experiencing homelessness are already socially isolated, often as a result of disruption or breakdown in family relationships, in many instances of a permanent nature due to their SUD or mental ill-health (Copello et al 2010; Duggan 2007; Hyland 2020; Kelly 2020; Orford et al 2010; Rossow and Hague 2004; Von Kardoff 2016).

Certainly, this is borne out by the discourse of the participants in the study. At Phase 1, all ten participants reported feelings of loneliness, abandonment and isolation. The majority (n=8) had limited contact with family and eight also reported no friendships.

However, at Phase 2, with changes in both substance use and homelessness, there was evidence of a shift in this pattern, though there was a marked difference between the two groups. Of the nine available participants, just over half (n=5) continued to report feeling socially isolated – the majority of which (n=4) were participants with severe mental-ill health.

Of the remaining participants (n=5), four had re-established family relationships, mostly as a result of being in recovery from SUD. Their narratives at Phase 1 suggest that re-connecting with family is dependent on mental health and recovery in SUD, underlining the need for continued support to maintain recovery, and the need to view SUD as a chronic condition (Goodwin and Sias 2014). There was little change in reported friendships, with seven of the nine still reporting no friendships as opposed to eight at Phase 1.

5.4 Changes to Service Use During and After COVID-19 Restrictions

Restrictions in services in Ireland resulted in less face-to-face services for mental health and substance use as well as decreased admission rates for in-patient psychiatric admissions (Daly and Craig 2021) a number of online and phone initiatives were launched to support people throughout the pandemic in terms of their mental health. However, the issue of digital exclusion arises for vulnerable cohorts (Mohan 2020; Watts 2020).

Availing of services at both HSE ACCES and MQI had been severely curtailed. Service users have found this challenging, and disliked the absence of a drop-in service. All participants talked of the value of face-to-face contact via their Outreach Teams. Services have been fully open since July 2021, and there has been a constant increase in footfall into MQI Riverbank, in accordance with Government COVID-19 guidelines. Findings at Phase 1 indicated the existence of a digital divide, with the majority (n=7) having no access to reliable phones or to Wi-Fi. This had not changed by Phase 2, and only two participants used online support in addition to face-to-face contact. All other participants used face-to-face supports either via HSE ACCES (by making an appointment) or via the Outreach Teams at MQI.

However, there was evidence of inter-agency collaboration at Phase 2 of data collection, which was absent at Phase 1. The majority of participants discussed linking in with other support services provided by community groups, NGOs or voluntary organisations for a range of different issues, including accessing housing, in-reach addiction counselling, community engagement and family support.

5.5 The Threat of COVID-19

There was little discussion of fear of contracting COVID-19 at Phase 1 of data collection with only three of the ten original participants expressing concern about a direct threat to their health. The majority (n=7) were more concerned with social isolation, housing and limitations around access to services needed for daily life (food, shelter, washing facilities etc.).

By Phase 2, three of the participants had moved to supported recovery hostels, where food was being provided on a daily basis and washing facilities were available. One participant had moved into secure housing. This, coupled with increases in social interaction and the onset of the Delta variant of COVID-19, led to a change in their narrative, with the majority of the respondents (n=7) expressing fears around their health and the health of those close to them (family).

Of the nine participants available for interview, the majority (n=8) had received a vaccination and all of these bar one had arranged for vaccination themselves. Only one respondent was unsure of the safety and efficacy of the vaccine and had declined to be vaccinated.

This study had a number of objectives over Phase 1 and Phase 2, most notably to explore the challenges of people with mental ill-health, SUD and or homelessness, as they navigated services utterly changed by the COVID-19 pandemic.

People experiencing mental ill-health, SUD, homelessness or any combination of these three issues experience high levels of social isolation and have limited or no social supports and networks as a result. This places them at risk of relapse in mental ill-health and/or substance use.

Changes in Mental Ill-health

The most marked change between both phases of data collection was around mental ill-health. For those with SUD co-presenting with depressive illness, the early part of the pandemic had led to increased depression, anxiety and suicidal ideation.

As the pandemic wore on, this increased further. Subsequent changes in both housing and/or substance use had led to a reduction in reported levels of depression at the time of interview in Phase 2. However, this reduction in reported levels of depression is largely dependent on being in recovery, maintaining family connections and housing, all of which can be viewed as precarious.

Levels of anxiety had also changed in this group, and anxiety at this point tended to relate to the threat of contracting COVID-19, which was not evident at Phase 1. For both groups, eight of the nine available for interview had received vaccinations.

For those with more severe mental ill-health (n=5), their outcomes as the pandemic progressed was more detrimental to their mental health. As the restrictions continued, depression, suicidal ideation (with and

without planning – including one unsuccessful attempt) had increased in the majority of this group. Four of the five were hospitalised for their mental-ill health and at the time of Phase 2 interview, two participants expressed increased paranoia. Four also continued to express feelings of loneliness and social isolation, limited family contact and friendships.

Changes in Substance Use

With the increased levels of social isolation required to manage COVID-19, at Phase 1 of data collection, the majority had experienced relapses in SUD where they had previously been in recovery. By Phase 2, with the support of Outreach Teams at both MQI and HSE ACCES, this pattern had changed with almost all back in recovery.

However, it should be noted all had been in recovery prior to the pandemic and had a history of lapses in their recovery journey.

Changes in Housing Patterns

There was also evidence of changes in homelessness patterns between both phases of data collection but only across one group. For those with severe mental ill-health, there was no change with three remaining securely housed, and two still living in hostels (where drug use was widespread). Both of these participants were waiting on housing, one through Housing First and one via HAP. However, the potential HAP tenant was experiencing considerable difficulty obtaining tenancy. For those with depressive illness co-presenting with substance use at Phase 1, two had been street homeless and three were in unsupported hostels. By Phase 2, one had obtained secure housing, one was in residential detox/rehab, and a further three had moved to recovery hostels. This latter three had only recently moved to new hostels and, while content at time of interview, this has to be measured against previous living conditions and the length of time they will have to remain in confined living spaces prior to housing.

Policy Failure

Phase 1 of this study underlined the ongoing impact on the lives of individuals who have received incorrect or no diagnosis of mental ill-health early in their lives, as well as the issues that have arisen as a result of a lack of a care route for dual-diagnosed individuals (SUD co-presenting with mental ill-health). The high levels of homelessness/housing insecurity in this group reflects the failure of policy to date to tackle these issues at a holistic level.

Restrictions around COVID-19 have served to highlight policy failings in mental health, SUD and housing policy in Ireland. For those with severe mental ill-health, they remain socially isolated, which exacerbates their mental ill-health. For those with SUD co-presenting with 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 adequate 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 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/sexual violence professionals)

Increased Outreach/In-reach staffing and funding

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

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

Increased funding for Outreach Teams

- Expansion of in-reach based services for hostels and in private emergency accommodation

- Increased 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

REFERENCES

Abramson, A. (2021). Substance Use during the Pandemic. American Psychologic Association, 52(2), 22.

Arribas-Ibar, E., Suelves, J. M., Sanchez-Niubò, A., Domingo-Salvany, A., & Brugal, M. T. (2017). Suicidal behaviours in male and female users of illicit drugs recruited in drug treatment facilities. Gaceta Sanitaria, 31, 292-298.

Bakken, K., & Vaglum, P. (2007). Predictors of suicide attempters in substance-dependent patients: a six-year prospective follow-up. Clinical Practice and Epidemiology in Mental Health, 3(1), 1-11.

Baldessarini, R. J. (2020). Epidemiology of suicide: recent developments. Epidemiology and psychiatric sciences, 29.

Banerjee, D., Kosagisharaf, J. R., & Rao, T. S. (2020). 'The dual pandemic' of suicide and COVID-19: A biopsychosocial narrative of risks and prevention. Psychiatry research, 113577.

Brady, K. T., & Sonne, S. C. (1999). The role of stress in alcohol use, alcoholism treatment, and relapse. Alcohol Research & Health, 23(4), 263.

Breet, E., Goldstone, D., & Bantjes, J. (2018). Substance use and suicidal ideation and behaviour in low-and middle-income countries: a systematic review. BMC public health, 18(1), 1-18.

Broadhead, R. S., & Rist, R. C. (1976). Gatekeepers and the social control of social research. Social problems, 23(3), 325-336.

Chiappini, S., Guirguis, A., John, A., Corkery, J. M., & Schifano, F. (2020). COVID-19: the hidden impact on mental health and drug addiction. Frontiers in psychiatry, 11, 767.

Charmaz, K., & Belgrave, L. L. (2007). Grounded theory. The Blackwell encyclopaedia of sociology.

Charmaz, K. (1999). Stories of suffering: Subjective tales and research narratives. Qualitative health research, 9(3), 362-382.

Cheallaigh, C. N., Cullivan, S., Sears, J., Lawlee, A. M., Browne, J., Kieran, J., ... & Bergin, C. (2017). Usage of unscheduled hospital care by homeless individuals in Dublin, Ireland: a cross-sectional study. BMJ open, 7(11).

Clarke, A., & Eustace, A. (2016). Evaluation of the HSE Naloxone Demonstration Project.

Clinton, M., Lunney, P., Edwards, H., Weir, D., & Barr, J. (1998). Perceived social support and community adaptation in schizophrenia. Journal of Advanced Nursing, 27(5), 955-965.

Columb, D., Hussain, R., & O'Gara, C. (2020). Addiction psychiatry and COVID-19: impact on patients and service provision. Irish Journal of Psychological Medicine, 37(3), 164-168.

Copello, A., Templeton, L., & Powell, J. (2010). The impact of addiction on the family: Estimates of prevalence and costs. Drugs: education, prevention and policy, 17(sup1), 63-74.

CoSPAC (2011). Available at: https://www.gov.uk/government/publications/scientific-advisory-committees-code-of-practice. Accessed 01.08.2021.

Corbin, J., & Strauss, A. (2014). Basics of qualitative research: Techniques and procedures for developing grounded theory. Sage publications.

Cullen, W., Gulati, G., & Kelly, B. D. (2020). Mental health in the Covid-19

pandemic. QJM: An International Journal of Medicine, 113(5), 311-312.

Daly, A. and Craig, S. (2021). Annual Report on the activities of Psychiatric Units and Hospitals in 2020. Available at: https://www.hrb.ie/fileadmin/2._Plugin_related_files/Publications/2021_publications/NPIRS/AIPUH_annual_report_2020.pdf. (Accessed 09.08.2021)

Davidson, L., Ridgway, P., Kidd, S., Topor, A., & Borg, M. (2008). Using qualitative research to inform mental health policy. The Canadian Journal of Psychiatry, 53(3), 137-144.

Deniro, D. A. (1995). Perceived alienation in Individuals with residual-type schizophrenia. Issues in Mental Health Nursing, 16(3), 185-200.

DePaul (2020). Dealing with COVID-19 and Beyond. Available at: https://ie.depaulcharity.org/policies/dealing-with-covid-19-and-beyond/ (Accessed 04.08.2021).

Department of Health (2006) A Vision for Change. Available at: https://www.hse.ie/eng/services/publications/mentalhealth/mental-health---a-vision-for-change.pdf. (Accessed 20. 08.2021).

Department of Health (2017) Reducing Harm. Supporting Recovery. Available at: http://www.drugs.ie/downloadDocs/2017/ReducingHarmSupportingRecovery2017_2025.pdf. (Accessed 02.08.2021).

Department of Health (2020). Sharing the Vision. Available at: file:///C:/Users/kathy/Dropbox/My%20PC%20(DESKTOP-S7D7ECL)/Downloads/76770_b142b216-f2ca-48e6-a551-79c208f1a247%20(1).pdf. (Accessed 26.08.2021).

Department of Health (2020). Connecting for Life. Ireland's National Strategy to Reduce Suicide. Available at:

https://www.gov.ie/en/publication/7dfe4c-connecting-for-life-irelands-national-strategy-to-reduce-suicide-201/. (Accessed 28.08.2021). DHLGH (2021).

Department of Housing, Local Government and Heritage. Homelessness Data. Available at: https://www.gov.ie/en/publication/e28d6-homeless-report-august-2021/.(Accessed 27.09.2021).

DHLGH (2021). Housing for All. Pathway 2. Eradicating Homeless, Increasing Social Housing Delivery and Supporting Social Inclusion. Available at: https://www.gov.ie/en/publication/ef5ec-housing-for-all-a-new-housing-plan-for-ireland/#view-the-plan. (Accessed 07.09.2021).

Devitt, P. (2020). Can we expect an increased suicide rate due to Covid-19? Irish journal of psychological medicine, 37(4), 264-268.

DRHE (2019) Policy and Legislation Available at: https://www.homelessdublin.ie/info/policy. (Accessed 09.08.2021).

Duggan, A. P., & Molineux, B. A. L. P. (2004). The reciprocal influence of drug and alcohol abuse and family members' communication. Routledge handbook of family communication, 463-478.

EMCDDA (2016). Drug Policy Profiles Available at: https://www.emcdda.europa.eu/system/files/publications/737/TDAP120 01ENC_408266.pdf Accessed on: 20.08. 2021).

EMCDDA (2021). European Drug Report:2021: Trends and Developments. Available at: https://www.emcdda.europa.eu/system/files/publications/13838/TDAT21 001ENN.pdf. (Accessed 23.08.2021).

European Commission (2008). Social Affairs. Unit E., & Equal Opportunities. (2008). Joint report on social protection and social

inclusion. Office for Official Publications of the European Communities.

EMCDDA (2019). Available at: https://www.emcdda.europa.eu/countries/drug-reports/2019/ireland/drug-use_en. (Accessed 19.08. 2021).

FEANSTA (2011). Counting the Homeless Population. Available at: https://www.feantsaresearch.org/download/feantsa-studies_02_web8204705709124732086.pdf. (Accessed 06.08.2021).

Focus Ireland (2020). About Homelessness. Available at: https://www.focusireland.ie/resource-hub/about-homelessness/. (Accessed 19.08.2021).

Focus Ireland (2021). Homelessness Data. Available at: https://www.focusireland.ie/knowledge-hub/latest-figures/. (Accessed 27.09.2021).

Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. Australian & New Zealand Journal of Psychiatry, 36(6), 717-732.

Frolich, K. L., & Potvin, L. (2008). Transcending the know in public health practice. Am J Public Health, 98(2), 216-21.

Galea, S., Merchant, R. M., & Lurie, N. (2020). The mental health consequences of COVID-19 and physical distancing: the need for prevention and early intervention. JAMA internal medicine, 180(6), 817-818.

Garety, P. A., Kuipers, E., Fowler, D., Freeman, D., & Bebbington, P. E. (2001). A cognitive model of the positive symptoms of psychosis. Psychol Med, 31(2), 189-195.

Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., & Bunney, W. E. (2002). Reducing suicide: A national imperative. National Academies Press.

Glynn, R. (2016). Homelessness, health and drug use in Dublin 2016. Available at: https://www.hse.ie/eng/about/who/primarycare/socialinclusion/about-social-inclusion/researchreports/homelessness-health-and-drug-use-in-dublin-2016.pdf (Accessed 19.08.2021).

Glynn, R. W., Lynn, E., Griffin, E., Fitzgerald, M., & Ward, M. (2017). Self-harm, methadone use and drug-related deaths amongst those registered as being of no fixed abode or homeless in Ireland.

Goodwin Jr, L. R., & Sias, S. M. (2014). Severe substance use disorder viewed as a chronic condition and disability. Journal of rehabilitation, 80(4), 42.

Grotti et al (2018) Available at: https://www.ihrec.ie/app/uploads/2018/06/Discrimination-and-Inequality-in-Housing-in-Ireland..pdf. (Accessed 08.08.2021).

Groux, G. M., Hoffman, S. J., & Ottersen, T. (2018). A typology of scientific advisory committees. Global Challenges, 2(9), 1800004.

HAIL (2020) Available at: http://www.hail.ie/. (Accessed 04.08.2021).

Hamza Shuja, K., Aqeel, M., Jaffar, A., & Ahmed, A. (2020). COVID-19 pandemic and impending global mental health implications. Psychiatria Danubina, 32(1), 32-35.

HRB (2014). Treatment Problem Alcohol Use in Ireland: 2012. Figures from the National Drug Reporting System. Available at:

https://www.hrb.ie/fileadmin/2._Plugin_related_files/Publications/2019_P
ublication_files/2019_HIE/NDTRS/2012-
2018/Alcohol_treatment_in_Ireland_2012_to_2018.pdf. (Accessed
08.08.2021). .08.2021).

HRB (2016). Alcohol in Ireland: Consumption, harm cost and policy
response. Available at:
https://www.drugsandalcohol.ie/25697/1/HRB_Alcohol_in_Ireland_consu
mption%20harm%20cost%20and%20policy%20response.pdf. (Accessed
08.08.2021).

HSE (2004). Available at: https://www.hse.ie/eng/services/list/4/mental-
health-services/dsc/south/acces-team-homelessness-mental-health-
services-/acces-team-homeless-mental-health-service-.html. (Accessed
01.08.2021).

HSE (2006). A Vision for Change 2006. Available at:
https://www.hse.ie/eng/services/publications/mentalhealth/mental-
health---a-vision-for-change.pdf (Accessed 26.08.2021).

HSE (2018) Housing First. Available at:
https://www.housing.gov.ie/sites/default/files/publications/files/housing_
first_implementation_plan_2018.pdf. (Accessed 02.08.2021).

HSE (2018). Service Reform Fund. Available at:
https://www.hse.ie/eng/about/who/primarycare/socialinclusion/homeles
sness-and-addiction/homelessness/projects/ (Accessed 20.08.2021).

HSE (2020). A Safe Return to Health Services: Restoring health and social
care services in a COVID environment. Available at:
https://www.lenus.ie/handle/10147/627958 (Accessed 22.08.2021)

HSE (2020). Guidance on Contingency Planning for People who use Drugs
and COVID-19, Dublin. Available at:

https://www.hse.ie/eng/about/who/primarycare/socialinclusion/other-areas/health-inequalities/contingency-planning-for-people-who-use-drugs.pdf. (Accessed 08.08.2021).

HSE (2020). Winter Planning within the Covid-19 pandemic. Available at: https://www.hse.ie/eng/services/publications/winter-planning-within-the-covid19-pandemic-october-2020-april-2021.pdf. (Accessed 08.08.2021).

HSE (2021). National Office of Suicide Prevention. NOSP Briefing on Suicide Statistics. Available at: https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/nosp-briefing-cso-may-2021.pdf. Accessed 09.08.2021).

Hearne, R. (2020). Housing shock: The Irish housing crisis and how to solve it. Policy Press.

Holmes, E. A., O'Connor, R. C., Perry, V. H., Tracey, I., Wessely, S., Arseneault, L., & Ford, T. (2020). Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science. The Lancet Psychiatry.

Hughes, H., Macken, M., Butler, J., & Synnott, K. (2020). Uncomfortably numb: suicide and the psychological undercurrent of COVID-19. Irish journal of psychological medicine, 37(3), 159-160.

Hyland et al (2020). Mental Health Available at: https://www.maynoothuniversity.ie/research/spotlight-research/covid-19-mental-health-survey-maynooth-university-and-trinity-college-finds-high-rates-anxiety . (Accessed 28.07.2021).

Iro, C., & O'Connor, J. (2009). Dual diagnosis in a Dublin tertiary addiction centre-A cross-sectional study. Irish journal of psychological medicine, 26(4), 191-193.

Ivers, J. H., & Barry, J. (2018). Mortality amongst the homeless population in Dublin. Dublin: Department of Public Health and Primary Care. Institute of Population Health, School of Medicine, Trinity College Dublin.

John, A., Okolie, C., Eyles, E., Webb, R. T., Schmidt, L., McGuiness, L. A., ... & Gunnell, D. (2020). The impact of the COVID-19 pandemic on self-harm and suicidal behaviour: a living systematic review. *F1000Research*, 9.

Kamali, M., Kelly, L., Gervin, M., Browne, S., Larkin, C., & O'Callaghan, E. (2000). The prevalence of comorbid substance misuse and its influence on suicidal ideation among in-patients with schizophrenia. *Acta psychiatrica scandinavica*, 101(6), 452-456.

Kathirvel, N. (2020). Post COVID-19 pandemic mental health challenges. Asian journal of psychiatry, 53, 102430.

Kelly (2020). Coronavirus Disease Challenges for Psychiatry. Available at: https://www.lenus.ie/bitstream/handle/10147/628344/coronavirus_disea se_challenges_for_psychiatry.pdf?sequence=1&isAllowed=y. (Accessed 03.08.2021).

Keogh, C., O'Brien, K. K., Hoban, A., O'Carroll, A., & Fahey, T. (2015). Health and use of health services of people who are homeless and at risk of homelessness who receive free primary health care in Dublin. BMC health services research, 15(1), 58.

Lee, K. H., Jun, J. S., Kim, Y. J., Roh, S., Moon, S. S., Bukonda, N., & Hines, L. (2017). Mental health, substance abuse, and suicide among homeless adults. Journal of evidence-informed social work, 14(4), 229-242.

Lynch, D., Morgan, M., Leen, B., & Cole, N. (2020). Evidence summary: What impact is cocooning and the increased level of anxiety due to COVID-19 having on the mental health of those identified as at-risk due to a chronic disease [immunocompromised]?

What interventions have been identified and deemed efficacious? [v1. 0].

Lyne, J., O'Donoghue, B., Clancy, M., Kinsella, A., & O'Gara, C. (2010). Concurrent cocaine and alcohol use in individuals presenting to an addiction treatment program. Irish journal of medical science, 179(2), 233-237.

McClure, E. A., Acquavita, S. P., Harding, E., & Stitzer, M. L. (2013). Utilization of communication technology by patients enrolled in substance abuse treatment. Drug and Alcohol Dependence, 129(1-2), 145-150. , S. (2002). Social capital and mental health. The British Journal of Psychiatry, 181(4), 280-283.

Mcloughlin, A., Feeney, A., & Cooney, J. (2020). Homelessness, emergency care and mental health. Inner-city emergency department psychiatry referrals: a retrospective descriptive analysis. Irish Journal of Medical Science (1971-), 1-4.

Mafham, M. M., Spata, E., Goldacre, R., Gair, D., Curnow, P., Bray, M., ... & Deanfield, J. E. (2020). COVID-19 pandemic and admission rates for and management of acute coronary syndromes in England. The Lancet, 396(10248), 381-389.

Manning, R. M., Greenwood, R. M., & Kirby, C. (2018). Building a way home: A study of fidelity to the housing first model in Dublin, Ireland. European Journal of Homelessness _ Volume, 12(3).

Markanday, S., Brennan, S. L., Gould, H., & Pasco, J. A. (2013). Sex-differences in reasons for non-participation at recruitment: Geelong Osteoporosis Study. BMC research notes, 6(1), 104.

Marsden, J., Darke, S., Hall, W., Hickman, M., Holmes, J., Humphreys, K., … & West, R. (2020). Mitigating and learning from the impact of COVID-19 infection on addictive disorders. Addiction.

Mason, M. (2010, August). Sample size and saturation in PhD studies

Miles, M. B., & Huberman, A. M. (1994). Qualitative data analysis: An expanded sourcebook. sage.

Mohan et al (2020). Learning for all? Second Level Education in Ireland during COVID-19. Available at: https://www.esri.ie/system/files/publications/SUSTAT92_3.pdf. Accessed 03.08.2021.

Mongan, D. (2021). Impact of COVID-19 on drug use in Ireland. Available at: https://www.drugsandalcohol.ie/33957/1/Drugnet_Ireland_76.pdf. (Accessed 23.08.2021).

Mukhtar, M. S. (2020). Mental health and psychosocial aspects of coronavirus outbreak in Pakistan: psychological intervention for public mental health crisis. Asian Journal of Psychiatry.

Murphy, R., Mitchell, K., & McDaid, S. Homelessness and Mental Health: Voices of Experience.

NOSP (2019). National Office for Suicide Prevention Annual Report available at: https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/nosp-annual-report-2019.pdf (Accessed 09.08.2021).

NOSP (2021). National Office for Suicide Prevention Annual Report 2020. Available at:

https://www.drugsandalcohol.ie/34809/1/nosp-annual-report-2020.pdf. (Accessed 07.09.2021). National Social Inclusion Office (2021).

National COVID-19 Homeless Service User Experience Survey: report of findings. Available at: https://www.lenus.ie/handle/10147/628798. (Accessed 08.09.2021

O'Brien, K. K., Schuttke, A., Alhakeem, A., Donnelly-Swift, E., Keogh, C., O'Carroll, A., … & Fahey, T. (2015). Health, perceived quality of life and health services use among homeless illicit drug users. Drug and alcohol dependence, 154, 139-145.

O'Carroll, A., & Wainwright, D. (2019). Making sense of street chaos: an ethnographic exploration of homeless people's health service utilization. International Journal for Equity in Health, 18(1), 113.

O'Carroll, A., Duffin, T., and Collins, J. (2020). Saving Lives in the time of COVID-19. Case Study of Harm Reduction, Homelessness and Drug Use in Dublin, Ireland. Available at: https://www.drugsandalcohol.ie/32291/. (Accessed 20.08.2021).

O'Carroll, A (2021). Interim Report on Mortality in Single Homeless Population 2020. Report available at: https://www.homelessdublin.ie/content/files/Interim-Report-on-Mortality-in-Single-Homeless-Population-2020-Dr-Austin-OCarroll.pdf. (Accessed 09.08.2021).

O'Connor, K., Wrigley, M., Jennings, R., Hill, M., & Niazi, A. (2020). Mental health impacts of COVID-19 in Ireland and the need for a secondary care mental health service response. Irish Journal of Psychological Medicine, 1-9.

O'Donovan, M. A., Lynch, M. E., O'Donnell, M. L., & Kelly, M. K. The

experience and risk of homelessness for people with intellectual disabilities and/or autism and their families in Dublin. A mixed methods study.

O'Gorman, A. (1998). Illicit drug use in Ireland: An overview of the problem and policy responses. Journal of Drug Issues, 28(1), 155-166.

O'Neill, D, Carew, A.M., and Lyons, S. (2021). Alcohol Treatment Data. Available at:

https://www.hrb.ie/fileadmin/2._Plugin_related_files/Publications/2021_publications/NDTRS/Alcohol_Bulletin/Alcohol_treatment_in_Ireland_2014_to_2020.pdf. Accessed 24. 08.2021.

O'Reilly, R., Allison, S., & Bastiampiallai, T. (2019). Observed outcomes: an approach to calculate the optimum number of psychiatric beds. Administration and Policy in Mental Health and Mental Health Services Research, 46(4), 507-517.

Orford, J., Velleman, R., Copello, A., Templeton, L., & Ibanga, A. (2010). The experiences of affected family members: A summary of two decades of qualitative research. Drugs: education, prevention and policy, 17(sup1), 44-62.

Orford, J., Copello, A., Velleman, R., & Templeton, L. (2010). Family members affected by a close relative's addiction: The stress-strain-coping-support model. Drugs: education, prevention and policy, 17(sup1), 36-43. Rossow and Hauge 2004

Padgett, D. K., Gulcur, L., & Tsemberis, S. (2006). Housing first services for people who are homeless with co-occurring serious mental illness and substance abuse. Research on social work practice, 16(1), 74-83.

Peter Mc Verry Trust (2021). Homeless Statistics. Available at:

https://pmvtrust.ie/news/facts-and-figures/. (Accessed 16.08.2021).

Prinsloo, B., Parr, C., & Fenton, J. (2012). Mental illness among the homeless: prevalence study in a Dublin homeless hostel. Irish journal of psychological medicine, 29(1), 22-26.

Proudfoot, D., MacGabhann, L., & Phelan, D. (2019). Dual diagnosis: a community perspective.

Qiu, J., Shen, B., Zhao, M., Wang, Z., Xie, B., & Xu, Y. (2020). A nationwide survey of psychological distress among Chinese people in the COVID-19 epidemic: implications and policy recommendations. General psychiatry, 33(2).

Rebuilding Ireland (2020). Action Plan for Housing and Homelessness. Available at: https://rebuildingireland.ie/wp-content/uploads/2016/07/Rebuilding-Ireland_Action-Plan.pdf. Accessed 28.10.2021).

Rhodes, T., & Coomber, R. (2010). Qualitative methods and theory in addictions research. Addiction research methods, 5978.

Richman, N. E., & Sokolove, R. L. (1992). The experience of aloneness, object representation, and evocative memory in borderline and neurotic patients. Psychoanalytic psychology, 9(1), 77.

Rossow, I., & Ramstedt, M. (2016). Challenges in estimating population impacts of alcohol's harm to others. Nordic Studies on Alcohol and Drugs, 33(5-6), 503-514.

Saldaña, J. (2003). Longitudinal qualitative research: Analyzing change through time. Rowman Altamira. Shevlin, M., McBride, O., Murphy, J., Miller, J. G., Hartman, T. K., Levita, L.., and Bennett,

K. M. (2020). Anxiety, Depression, Traumatic Stress, and COVID-19 Related Anxiety in the UK General Population During the COVID-19 Pandemic.

Sher, L. (2020). An infectious disease pandemic and increased suicide risk. Simon, N. M., Saxe, G. N., & Marmar, C. R. (2020). Mental health disorders related to COVID-19–related deaths. Jama, 324(15), 1493-1494.

Sinha, R. (2001). How does stress increase risk of drug abuse and relapse?. Psychopharmacology, 158(4), 343-359. Social Justice Ireland (2020). Housing First key to addressing homelessness. Available at: https://www.socialjustice.ie/content/policy-issues/housing-first-key-addressing-homelessness. (Accessed 10.08.2021).

Torales, J., O'Higgins, M., Castaldelli-Maia, J. M., & Ventriglio, A. (2020). The outbreak of COVID-19 coronavirus and its impact on global mental health. International Journal of Social Psychiatry, 0020764020915212.

Van Straaten, B., Rodenburg, G., Van der Laan, J., Boersma, S. N., Wolf, J. R., & Van de Mheen, D. (2018). Changes in social exclusion indicators and psychological distress among homeless people over a 2.5-year period. Social indicators research, 135(1), 291-311.

Von Kardorff, E., Soltaninejad, A., Kamali, M., & Eslami Shahrbabaki, M. (2016). Family caregiver burden in mental illnesses: The case of affective disorders and schizophrenia–a qualitative exploratory study. Nordic journal of psychiatry, 70(4), 248-254

Vrooman, J. C., & Hoff, S. J. (2013). The disadvantaged among the Dutch: A survey approach to the multidimensional measurement of social exclusion. Social indicators research, 113(3), 1261-1287.

Wakeman, S. E., Green, T. C., & Rich, J. (2020). An overdose surge will

compound the COVID-19 pandemic if urgent action is not taken. Nature Medicine, 1-2.

Walsh, D. (2015). Psychiatric deinstitutionalisation in Ireland 1960–2013. Irish Journal of Psychological Medicine, 32(4), 347-352.

Wang, J., Lloyd-Evans, B., Giacco, D., Forsyth, R., Nebo, C., Mann, F., & Johnson, S. (2017). Social isolation in mental health: a conceptual and methodological review. Social psychiatry and psychiatric epidemiology, 52(12), 1451-1461.

Wang, C., Pan, R., Wan, X., Tan, Y., Xu, L., McIntyre, R. S., ... & Ho, C. (2020). A longitudinal study on the mental health of general population during the COVID-19 epidemic in China. Brain, behaviour, and immunity. Brady, K. T., & Sonne, S. C. (1999). The role of stress in alcohol use, alcoholism treatment, and relapse. Alcohol Research & Health, 23(4), 263.

Wasserman, D., Iosue, M., Wuestefeld, A., & Carli, V. (2020). Adaptation of evidence-based suicide prevention strategies during and after the COVID-19 pandemic. World Psychiatry, 19(3), 294-306.

Watts, G. (2020). COVID-19 and the digital divide in the UK. The Lancet Digital Health, 2(8), e395-e396.

Whitehead,. M., and Dhlgren, G. (1991). What can be done about inequalities in health? Lancet, 338 (8774), 1059-1063.

WHO (2013). World Health Organisation. Social Determinants of Health. Available at: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1. (Accessed 10.08.2021).

WHO (2020). Declaration of a pandemic. Available at: https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-

march-2020. (Accessed 24.08.2021).

Xiang, Y. T., Yang, Y., Li, W., Zhang, L., Zhang, Q., Cheung, T., & Ng, C. H. (2020). Timely mental health care for the 2019 novel coronavirus outbreak is urgently needed. The Lancet Psychiatry, 7(3), 228-229.

PHASE 1 DATA COLLECTION

PARTICIPANT INFORMATION LEAFLET FOR CASEWORKERS

Study Working Title: An exploration of the impact of Covid-19 on the mental health of service users

What is the study about?

We are currently conducting a research study and would like your assistance.

This is a study about people who are accessing services for homelessness, substance use or mental health, and who may have had their services affected by Covid-19.

Why have I been asked to take part?

As a person who has been supporting individuals to access services, we are asking you to identify people who would be able to tell us of their experiences around the changes that Covid-19 had on their services as well as on their mental health and well-being.

The overall aim of the research project is as follows:

An exploration of the impact of Covid-19 on the mental health of service users.

Specifically, the research aims to document and analyse the experiences of individuals linked in to services in order to:

- Discover the challenges to people with issues around substance use, mental health or homelessness, or all three in light of Covid-19

- Examine the factors associated with these issues in terms of services, especially at the time of lockdown and following partial re-opening of services

- Understand the impact these changes have made in terms of the mental health of the service users

By participating in this research, you will be helping us to get a clearer picture of the problems the participants might face and what they feel may be needed going forward.

In particular, we want to know how the response to Covid-19 has affected them in terms of their psychological health and well-being.

- Who will we be talking to?

We are asking a number of individuals with mental health, substance use and/or homelessness experiences to talk to us in the form of an audio recorded interview.

- What do you need me to do?

We would greatly appreciate your assistance with this research by agreeing to act as a contact point/gatekeeper for some of your service users. We would hope to speak to 12 people in total.

The criteria for inclusion is as follows:

- Be over the age of 18 years
- Have experienced homelessness or housing instability, mental health or substance use issues of a combination of any of these before and during Covid-19 restrictions

Be in receipt of services from MQI and/or HSE Mental Health Team
Have the capacity to give explicit and informed consent

How will the interviews be conducted?

The interviews will take on average 40 minutes and will be conducted at a place and time chosen by the participant. This may mean that you will have to provide a space for the interview at your location or at a pre-arranged place (such as a coffee shop). It may also mean that you may have to sit in on the interview if this is what the participant wishes. Each participant will be given an Information Leaflet and a Consent Form beforehand to explain the research study and what they are agreeing to in terms of GDPR. If you feel you know someone who would like to participate, please let us know.

What happens next?

We can give you the information to pass on to them and given them some time to make a decision (usually a week). If they agree to participate, we will contact them (or set up an interview through you) and go through the consent form again with them.

We appreciate you taking the time to read this letter and look forward to working with you in the near future. Please do not hesitate to get in contact with me if you need any questions answered.

Kind regards,
Kathyan Kelly, Researcher.
Tel: 086 8591463 or kellyk12@tcd.ie

An exploration of the impact of Covid-19 on the mental health of service users.

What is this study about?

This is a study about people who are accessing services, who may have had their services affected by Covid-19 and how this is affecting their mental health and well-being.

Why have I been asked to take part?

As a person who has been accessing these services, we are asking you to tell us about your experiences around the changes that Covid-19 is having/has had on your services as well as on your mental health.

Specifically, the research aims to document and analyse the experiences of individuals linked in to services in order to:

- Discover the challenges to people with issues around substance use, mental health or homelessness, or all three in light of Covid-19

- Examine the factors associated with these issues in terms of services, especially at the time of lockdown and following partial re-opening of services

- Understand the impact these changes have made in terms of the mental health of the service users

By participating in this research, you will be helping us to get a clearer picture of the problems you might face and what you feel may be needed going forward. In particular, we want to know how the response to Covid-19 has affected you in terms of your health and well-being.

Do I have to take part? Can I withdraw or change my mind?

We are asking for you to participate in this study, however participation is your decision entirely. You can decide to withdraw at any time.

How is the study being carried out?

If you do consent, this participation will take the form of an interview which will be audio-recorded. The information you give us will be private and your name will not be mentioned in any report.

What happens if I decide to take part?

Our researcher or your case worker will contact you to set up a time and place that suits you and will ask for your opinions in an interview. The interview will take about 40 minutes. Again, you can withdraw at any stage or refuse to answer questions if you wish.

Are there benefits to taking part?

We hope that by writing a report that takes the views of people who have experience of what happened during Covid-19, and how it has affected them will help inform the development of services going forward.

What information about me will be in this study?

While your opinions will be included as part of the study, you will not be identified in any way when the report is being written. We will take care to make sure that any identifying information is removed.

What happens to my personal data?

Personal data given to the researchers by you will be processed only as necessary and with as few people involved as possible. All data will be stored with Merchant's Quay Ireland by the Data Protection Officer for a period of 7 years, after which it will be destroyed. Your information will be held under a special code which ensures that you are not identified.

You have rights to see what we have written, to change or delete some of the information you have given us as well as the right to correct things if they are wrong.

Who is organising the study?

This study is being funded by the HSE and MQI.

Is there any payment for taking part?

There is no payment for taking part in this study. We will travel to you to conduct the interview so that travel does not affect your ability to participate.

What happens next?

If you feel you would like to participate, please let us know and we will contact you regarding a consent form and some more information about the research if you need it. If you decide that you do want to take part and then change your mind this is fine.

What is the lawful basis to use my personal data?

By law we can use your personal information for scientific research (in the public interest). We will ask for your explicit consent to use your data

as a requirement of the Irish Health Research Regulations.

Thank you for taking the time to read this leaflet and considering your participation. Please do not hesitate to contact me if you have any further questions.

Kathyan Kelly, Researcher. Tel: 086 8591463 or kellyk12@tcd.ie

An exploration of the impact of Covid-19 on the mental health of service users.

As you know, we are currently conducting a study on how people have coped with changes in services during Covid-19 lockdown and afterwards. We are asking a number of people to tell us about their experiences around this issue.

In particular, we want to know what effects Covid-19 has had on you in terms of your mental health. We also want to know what you think can or should be done about this. We would particularly like to know of instances of particular difficulty for you.

We also want to know generally what you think should be done going forward to help with these issues.

We are asking for you to participate in this study, however participation is your decision entirely. If you do consent, this participation will take the form of a 40 minute interview which will be audio recorded. We will ask you some general questions about your background as well as questions about how you are currently coping on a day-to-day basis.

Your responses will be anonymous. You will not be named in any report. Your participation is voluntary. You can withdraw form participation at any time before, during or after your reflection is completed.

Privacy

Your responses will be anonymous. No information from which you could be directly or indirectly identified will be published. Data will be stored securely on a double encrypted computer and only the research team will have access to your transcripts. No names, contact or other personal details will be assigned to your responses. Data storage will meet the requirements of the Data Protection Acts 1988 - 2018

and the 2018 General Data Protection Regulation (GDPR). All data will be stored for a period of 7 years and then destroyed.

Your input will be included into an overall research study, which will be made publicly available, but again anonymously.

Consent to participate:

Please tick as appropriate:

I have read and understand the information leaflet for the above study. The information has been fully explained to me and I have been able to have any questions answered.	
I understand that this study is entirely voluntary, and if I decide I do not want to take part, I can stop at any time without giving a reason. I understand that deciding to withdraw or not participate will not affect my future support.	
I understand that I will not be paid for taking part in this study.	
I know how to contact the researcher if needed.	
I agree to participate having been fully informed of the risks and benefits set out in the information leaflet.	
I understand that my data will be protected, and that I will not be identified and that my information will only be shared in the form of a report.	
I understand that there are no direct benefits to me from participating in this study.	
I understand that I can stop at any time without giving a reason and refuse to answer any questions I do not like.	
I consent to audio-recording of the interview.	

Name: _____

Date: _____

Researcher Name and Date: _____

An exploration of the psychological effects of Covid-19 Restrictions on people experiencing mental health, homelessness and/or substance use issues

Hi, thanks for taking the time to talk to me. Maybe we could start off by telling me a little about yourself? (probe: education, employment, housing, marital status)

Is it ok to ask you now about the kind of services that you have been using with (MQI and/or HSE) before the Coronavirus lockdown started? (prompt: this is from March – St Patrick's Day) (probe: reason for service use, type of supports accessed, length of time accessing services)

And can you tell me about the kind of changes that the Covid-19 restrictions had on those services? (prompt: this is from March – St Patrick's Day) (probe: changes in: availability of services; prescribing; needle exchange; mental health support (counselling); housing).

Can you tell me how you are managing these changes? (probe: have they been difficult; if move to online, do they have internet access; do they miss face-to-face contact/group therapy).

And can you tell me about how easy or otherwise it has been to comply with regulations? (probe: social distancing; hand washing; mask wearing; shared spaces)

And what about contact with friends and family? (probe: less face time contact; loss of family routines/support)

Was there anything good about the lockdown and changes that have taken place since? (probe: in some instances, this may have been of benefit – i.e. improved housing situation/increased take-aways for MMT etc.)

What do you think has been the most difficult thing about the virus for you? (probe: has it been social isolation; higher levels of anxiety/depression; lack of choice/control autonomy; paternalism/infantilism).

Is there anything that you feel would help make things better for you? (probe: changes in service delivery)

Is there anything else you would like to share with us that you think would help other people in the same situation as you?

Is there anything that I should have asked that I left out?

Do you have any questions for me?

Thank you very much for taking the time to participate. Talking about your experiences has been very valuable for the research project.

An exploration of the impact of Covid-19 on the mental health of service users.

What is this study about?

This is a study about people who are accessing services, who may have had their services affected by Covid-19 and how this is affecting their mental health and well-being.

Why have I been asked to take part?

As a person who has been accessing these services, we are asking you to tell us about your experiences around the changes that Covid-19 is having/has had on your services as well as on your mental health.

Specifically, the research aims to document and analyse the experiences of individuals linked in to services in order to:

- Discover the challenges to people with issues around substance use, mental health or homelessness, or all three in light of Covid-19
- Examine the factors associated with these issues in terms of services, especially at the time of lockdown and following partial re-opening of services
- Understand the impact these changes have made in terms of the mental health of the service users

By participating in this research, you will be helping us to get a clearer picture of the problems you might face and what you feel may be needed going forward.

In particular, we want to know how the response to Covid-19 has affected you in terms of your health and well-being.

Do I have to take part? Can I withdraw or change my mind?

We are asking for you to participate in this study, however participation is your decision entirely. You can decide to withdraw at any time.

How is the study being carried out?

If you do consent, this participation will take the form of an interview which will be audio-recorded. The information you give us will be private and your name will not be mentioned in any report.

What happens if I decide to take part?

Our researcher or your case worker will contact you to set up a time and place that suits you and will ask for your opinions in an interview. The interview will take about 40 minutes. Again, you can withdraw at any stage or refuse to answer questions if you wish.

Are there benefits to taking part?

We hope that by writing a report that takes the views of people who have experience of what happened during Covid-19, and how it has affected them will help inform the development of services going forward.

What information about me will be in this study?

While your opinions will be included as part of the study, you will not be identified in any way when the report is being written. We will take care to make sure that any identifying information is removed.

What happens to my personal data?

Personal data given to the researchers by you will be processed only as necessary and with as few people involved as possible. All data will be stored with Merchant's Quay Ireland by the Data Protection Officer for a period of 7 years, after which it will be destroyed. Your information will be held under a special code which ensures that you are not identified.

You have rights to see what we have written, to change or delete some of the information you have given us as well as the right to correct things if they are wrong.

Who is organising the study?

This study is being funded by the HSE and MQI.

Is there any payment for taking part?

There is no payment for taking part in this study. We will travel to you to conduct the interview so that travel does not affect your ability to participate.

What happens next?

If you feel you would like to participate, please let us know and we will contact you regarding a consent form and some more information about the research if you need it. If you decide that you do want to take part and then change your mind this is fine.

What is the lawful basis to use my personal data?

By law we can use your personal information for scientific research (in the public interest). We will ask for your explicit consent to use your data as a requirement of the Irish Health Research Regulations.

Thank you for taking the time to read this leaflet and considering your participation. Please do not hesitate to contact me if you have any further questions.

Kathyan Kelly, Researcher. Tel: 086 8591463 or kellyk12@tcd.ie

PHASE 2 DATA COLLECTION

Interview Schedule

An exploration of the psychological effects of Covid-19 Restrictions on people experiencing mental health, homelessness and/or substance use issues – PHASE 2

Hi, thanks for taking the time to talk to me. I just want to go over the consent again if that's ok? (read consent if not physically present and request permission to audio-record).

So, the last time we talked was in September/October and that was just before we went into a really prolonged lockdown – before Christmas. So, I just want to get a sense of how you've coped with that? (probe: mental health, substance use, loneliness, isolation etc – specify as per previous interview notes).

And over Christmas, when everything opened up for a bit- did you get to spend time with friends/family at all? (probe: was Christmas especially difficult./lonely/trigger reduction in mental health/increase in substance use).

And what about contact with friends and family at the present time? (probe: face time contact; family routines/support)

And the last time we talked your housing situation was? (recap and prompt for changes).

And when we last spoke, we talked about the change to online or phone support for mental health services. Can you tell me how that has been for you? (probe: changes in availability of services; mental health support counselling; housing).

Can you tell me how you are managing these changes? (probe: have they managed to move to online services phone/zoom etc; do they miss face-to-face contact/group therapy).

And can you tell me a bit about outreach services? (probe: availability, usage, importance etc.).

Have you been offered a COVID vaccination? (probe – how, when – accepted or refused).

Was there anything good about the lockdown and changes that have taken place since? (probe: in some instances, this may have been of benefit – i.e. improved housing situation/increased take-aways for MMT/less opportunity to use substances etc.).

What do you think has been the most difficult thing about the virus for you? (probe: has it been social isolation; higher levels of anxiety/depression; lack of choice/control autonomy; paternalism/infantilism).

Is there anything that you feel would help make things better for you? (probe: changes in service delivery; additional services that have been absent)

Is there anything else you would like to share with us that you think would help other people in the same situation as you?

Is there anything that I should have asked that I left out?
Do you have any questions for me?

Thank you very much for taking the time to participate. Talking about your experiences has been very valuable for the research project.

***An exploration of the impact of Covid-19 on the mental health of service users.* Phase 2**

As you know, we conducted a study on how people have coped with changes in services during Covid-19 lockdown and afterwards. We are following this study up to see how things have changed for you since we last interviewed you.

In particular, we want to know what effects Covid-19 has had on you in terms of your mental health and/or substance use and/or housing as the pandemic wore on. We also want to know what you think can or should be done about this. We would particularly like to know of instances of particular difficulty for you.

We also want to know generally what you think should be done going forward to help with these issues.

We are asking for you to participate in this study, however participation is your decision entirely. If you do consent, this participation will take the form of a 30 minute interview which will be audio recorded. We will ask you some general questions about your background as well as questions about how you are currently coping on a day-to-day basis.

Your responses will be anonymous. You will not be named in any report. Your participation is voluntary. You can withdraw form participation at any time before, during or after your reflection is completed.

Privacy

Your responses will be anonymous. No information from which you could be directly or indirectly identified will be published. Data will be stored securely on a double encrypted computer and only the research team will have access to your transcripts. No names, contact or other

personal details will be assigned to your responses. Data storage will meet the requirements of the Data Protection Acts 1988 - 2018 and the 2018 General Data Protection Regulation (GDPR). All data will be stored for a period of 7 years and then destroyed.

Your input will be included into an overall research study, which will be made publicly available, but again anonymously.

Consent to participate:

Please tick as appropriate:

I have read and understand the information leaflet for the above study. The information has been fully explained to me and I have been able to have any questions answered.	
I understand that this study is entirely voluntary, and if I decide I do not want to take part, I can stop at any time without giving a reason. I understand that deciding to withdraw or not participate will not affect my future support.	
I understand that I will not be paid for taking part in this study.	
I know how to contact the researcher if needed.	
I agree to participate having been fully informed of the risks and benefits set out in the information leaflet.	
I understand that my data will be protected, and that I will not be identified and that my information will only be shared in the form of a report.	
I understand that there are no direct benefits to me from participating in this study.	
I understand that I can stop at any time without giving a reason and refuse to answer any questions I do not like.	
I consent to audio-recording of the interview.	

Name: _____

Date: _____

Researcher Name and Date: _____

If you have any questions, please do not hesitate to contact the Researcher, Kathyan Kelly at kelly.k12@tcd.ie or on 086-8591463.