HSE National Office for Suicide Prevention

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# The effects of COVID-19 on a marginalised cohort in the Dublin region: A longitudinal qualitative exploration

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Connecting for Life

**PROJECT TITLE**

# The effects of COVID-19 on a marginalised cohort in the Dublin region: A longitudinal qualitative exploration

**KEY MESSAGES**

The restrictions necessitated by the COVID-19 pandemic increased the level of isolation for a cohort who already experience social exclusion as a result of mental ill-health, substance or alcohol use and homelessness. This led to deterioration in their mental health and their ability to manage their substance use.

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## CONTEXT AND BACKGROUND

Mental-ill health, Substance Use Disorder (SUD), Alcohol Use Disorder (AUD) and Homelessness or Housing Insecurity (HHI) issues are, in many cases, inextricably linked. While difficulty in one area may trigger the onset of another (i.e., homelessness may lead to substance use), there is evidence that, once in motion, there is a non-linear relationship between mental-ill health, substance use and homelessness. In short, there is an enmeshed relationship between the three issues, where any one issue changes the outcome or path of any other.

Prior to 'Sharing the Vision - A Mental Health Policy for Everyone', the latest mental health strategy in Ireland in 2020, there was a lack of access to services to treat those experiencing mental-ill health and SUD/AUD (dual diagnosis). Most services are in a position to provide treatment for one aspect only (substance misuse or mental-ill health) leaving those presenting with both unable to access treatment for either.

The World Health Organisation declared COVID-19 a pandemic on March 11th 2020 and a wide range of COVID-19 related restrictions were introduced by the Irish Government (27.03.2020). Particularly vulnerable individuals were identified (e.g. people with underlying health conditions, the elderly), and included were those who were homeless, due to their living conditions and high morbidity levels, often accompanied by SUD/AUD and/or mental-ill health. The response to the threat 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.

However, while the homeless and substance use 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 asked to self-isolate as part of a vulnerable group. Restrictions meant that services experienced considerable interruption, with most services unable to provide supports in the manner that they had prior to the pandemic. This led to reduced social interaction for a group of people already experiencing social exclusion, and there was also evidence of higher risks to mental ill-health and increased substance use as a result of this isolation.

Both MQI and HSE ACCES provide support to individuals experiencing mental-ill health and/or SUD/AUD and/or HHI. Both organisations had to pivot services quickly to continue responding to the needs of their clients while the COVID-19 restrictions were in place.

This small longitudinal qualitative study tracked the experiences of 10 adults in Dublin, Ireland experiencing SUD and/or Alcohol Use Disorder (AUD), and/or mental ill-health and/or homelessness at early (Autumn 2020) and later stages (Summer 2021) of the COVID-19 pandemic. Ireland entered a severe lockdown in March of 2020, which lasted until July 2020, and re-entered a second lockdown in Christmas period of 2020/2021.

## AIM/OBJECTIVE(S)

This study aimed to explore the lived experiences of the COVID-19 pandemic for people engaging in services with MQI and HSE ACCES. Its key objectives at Phase 1 were:

- To identify challenges experienced by people with issues around mental ill-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 users.

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 (i.e., Phase 2) 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 ill-health
    - Substance Use
    - Housing
    - Social Isolation
    - Ability and capacity to access support services
    - Capacity for digital support

## METHODOLOGY

The research used a qualitative approach. One-to-one guided in-depth interviews were conducted with 10 participants (at two time points) allowing them to explore their own understanding of the impact of COVID-19 restrictions on their mental-ill health, SUD/AUD and homelessness at both phases. This allowed for a longitudinal exploration of their experiences, particularly in terms of their mental health.

**Inclusion 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, in receipt of services from either organisation and have experience of mental-ill health, SUD and/or AUD and/or homelessness, both before and after March 2020. They also had to have the capacity to give informed consent.

**Recruitment, Consent, Data Collection and Ethics:** 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. They were given a period of one week to decide whether or not to participate.

Data collection took place over October and November 2020 for Phase 1. Five participants from HSE ACCES were interviewed face-to-face and opted to do so without the presence of the service provider. However, the move to a higher level of restriction meant that the remaining five interviews could not be conducted in person. Two of these interviews were facilitated by MQI at Riverbank via a Zoom call (attended by their case worker) and a further three were conducted by phone without the presence of a case worker. By Phase 2, the restrictions continued and again, five participants from HSE ACCES were interviewed in person and the remaining participants by phone.

In the absence of an expedient route to Ethics Approval, a Scientific Advisory Body was established to oversee the research study. This comprised three professionals with extensive experience of research in this area and included: Dr Suzi Lyons, Health Research Board; Dr Paula Mayock, Trinity College Dublin; Dr Kieran Harkins, General Practitioner.

A distress protocol was in place for the study. This protocol is used within the HSE and was developed by the NOSP under its Connecting for Life initiative. It was agreed in advance with MQI and HSE ACCES staff that if a participant became distressed during interview, or indicated suicidal ideation with or without planning, that the interviewer would, in the first instance, listen calmly to the participant. If these concerns were corroborated by the participant, the interviewer would acknowledge the distress and advise that they were seeking immediate help for the participant. In one instance at Phase 2, the protocol was triggered and the interviewer immediately phoned the participant's Case Worker who had trained in the ASIST suicide intervention programme. While the Case Worker was aware of the distress of the participant and a GP appointment had been set up, she nonetheless immediately contacted the participant and arranged to meet. With this immediate intervention and subsequent continued support, this participant is now securely housed, in recovery, and this had led to considerable improvements in the participant's mental ill-health.

## RESULTS / FINDINGS

Of the ten participants, half (n=5) presented with enduring mental-ill health (schizoaffective/ bipolar disorder) and five with depressive illness. Eight participants co-presented with SUD and/ or AUD, and in total, seven were experiencing homelessness (5 were in hostels and 2 were street homeless).

### Phase 1

- All participants expressed feelings of abandonment, loneliness and increased social isolation.

**Mental ill-health findings**

- For the five participants presenting with severe mental-ill health, two required hospitalisation, one reported suicidal ideation with planning and one reported increased depression and anxiety.
- For the five participants presenting with depressive illness, all reported increased depression, four-reported increased anxiety and three reported suicidal ideation. One participant, who had self-harmed in the past, had returned to self-harming.
- Participants reported that in all instances where suicidal ideation with or without planning was evident, Case/Social Workers were aware of this as a result of continued engagement through their Assertive Outreach Teams (AOT) and supports were in place. In both HSE ACCES and MQI, this support was provided by their mental health teams.

**Substance Use findings:**

- For the five participants presenting with severe mental-ill health, one co-presented with AUD, one co-presented with AUD and SUD and one with SUD only. This participant returned to SUD having been in recovery. Alcohol intake increased for two, while one participant remained in SUD recovery.
- For the five participants presenting with depressive illness, two reported reduced alcohol intake and three reported a return to SUD having been in recovery.

### Phase 2

**Mental Health findings:**

- For participants presenting predominantly with severe mental-ill health, four of the five had been hospitalised for their mental-ill health by Phase 2 of the study. Two had reported suicidal ideation with planning – one of which was attempted but unsuccessful. Four of the participants reported increased depression/anxiety as the restrictions continued.
- For the participants with depressive illness, four reported increased depression, three-increased anxiety and two reported suicidal ideation, one with planning as the restrictions wore on. While all expressed a more positive outlook at Phase 2, this is viewed as tenuous as improvements made were based on recovery and changes in housing, both of which are viewed as tenuous.

**Substance Use findings:**

- For the five participants with severe mental-ill health, one had increased their alcohol intake, one had decreased their alcohol intake and one had decreased their SUD.
- For those presenting with depressive illness, all were in recovery. Two participants were abstinent from alcohol and of the remaining three, one was on a Methadone Maintenance Treatment (MMT) Programme, one had just completed a residential detox/rehab programme, and one was on a harm reduction programme.

## Changes between Phase 1 and Phase 2:

### Housing

- For those presenting with severe mental-ill health, three remained securely housed. A further two participants were in the same hostel as at Phase 1 but both had been listed for Housing Assistance Payments or Housing First Tenancies and were waiting to move.
- For those presenting with depressive illness, all had been homeless at Phase 1. By Phase 2, one was securely housed, three were in supported recovery hostels and one participant was in Recovery/ Aftercare housing. These changes in homelessness were driven by changes in SUD/AUD.

### Family/Social Connections

- All ten participants at Phase 1 reported feelings of loneliness, abandonment and isolation, eight had limited contact with family and the same number reported no friendships. By Phase 2, five participants continued to report feelings of loneliness and isolation while six had re-established family relationships. This was as a result of changes in housing (in supported accommodation) and gains in recovery from SUD/AUD viewed as tenuous.

### Capacity for Online support

- At Phase 1, only three participants (all of whom were securely housed) had capacity for online support. The remaining seven participants continued to have no capacity for online support throughout both phases of the study. This was due to a number of reasons including lack of access to Wi-Fi, having nowhere to charge a phone or having phones with no internet capacity.

## RECOMMENDATIONS

As a small qualitative study, the findings of this research are not generalizable to a whole population. However, 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.

### Overall Recommendations

Provide 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
- Enabling 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

### Provide 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

- 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.

### Recommendations for Policy Makers

Provide 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 SUD
- Provide safe spaces for homeless women both in housing and in recovery hostels
- Arrange gender specific services for women in addiction and/or homeless.

### General Housing:

- Provide increased availability of Housing First initiatives as per new Housing for All policy
- Reduce bureaucracy levels required for housing for vulnerable populations

## Recommendations for Frontline Practitioners

*Specifically, for those with severe mental-ill health:*

- Offer more opportunities for social/ community engagement to reduce social isolation
- Arrange access to specialist counselling services (eg domestic/sexual violence professionals).

## Recommendations for Services

*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.

## LINKS / SUPPLEMENTARY MATERIALS

The full report is available here:
**https://mqi.ie/content/uploads/2022/03/Final-MH-report.pdf**

## CONTACT DETAILS

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