



An Evaluation of Peter McVerry Trust (PMVT) and their Operations during the Covid-19 Pandemic for Persons Experiencing Homelessness



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GLOSSARY OF TERMS

Alcohol detox - sudden absence of alcohol use typically coupled with the use of medication (e.g. Librium) to limit the effects of withdrawal.

Benzodiazepine - psychoactive drugs which typically lower brain activity (similar to depressants).

Chronic Homelessness – In this report, chronic homelessness refers to one episode of homelessness that lasts more than a year or multiple episodes of homelessness over the past two years.

Cocooning – In this report, cocooning refers to vulnerable individuals staying at home under government guidance to protect them from SARS-CoV-2.

COVID-19 - a respiratory illness caused by contracting coronavirus.

Clinical observation – in this report, clinical observation refers to health and wellbeing assessments of service users conducted by a nursing team.

Dual diagnosis - presence of a substance use disorder and one other psychiatric/mental health disorder simultaneously.

Harm reduction - interventions designed to reduce the immediate negative consequences associated with substance use (e.g. clean needle exchanges, supervised injection facilities)

Homelessness – In line with ETHOS guidance, homelessness in this report refers to anyone living roofless (i.e. sleeping rough), houseless (i.e. sleeping in temporary shelters), in insecure housing (i.e. at risk of housing exclusion due to eviction or domestic violence), or in inadequate housing (i.e. unfit or overcrowded arrangements).

Isolation – in this report, isolation will refer to the isolation of an individual with a confirmed infection with SARS-CoV-2.

Logistic regression - a statistical technique used to see if one variable predicts another, or if a predictor variable predicts an outcome variable. The outcome variable can only have two possible responses (e.g. yes or no).

Morbidity – refers to an illness experienced by an individual or among a population.

Mortality – refers to death.

Pandemic – In this report, pandemic refers to the global outbreak of SARS-CoV-2, the virus that causes COVID-19

Quarantine – in this report, quarantine refers to the isolation of an individual who has been exposed to or has a suspected, but unconfirmed, case of SARS-CoV-2.

Shielding - In this report, shielding refers to individuals cocooning within a homelessness support service

Substance use – in this report, substance use refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.

Substance use disorder - a mental health disorder that affects one's behaviour, resulting in the use and potential dependence on a substance (e.g. alcohol or other drugs).

Standard deviation/error - refers to a statistical value used to determine the variance of responses of the group members. I.e. these figures represent the extent group member responses differ from the mean.

Substitution Treatment - refers to substituting a substance an individual was dependent on with a medically prescribed substance (e.g. Suboxone or Methadone) after displaying withdrawal symptoms.

Population- refers to the total amount of participants in the study, represented by "N". Here "n" refers to a subset of the total population.

EXECUTIVE SUMMARY

During the COVID-19 pandemic, people experiencing homelessness (PEH) faced heightened vulnerability due to adverse living conditions and pre-existing health issues. This report, conducted by Peter McVerry Trust (PMVT)- a national housing and homelessness charity in Ireland, investigates the response to COVID-19 for those who are experiencing homelessness and who drug use. This study aims to identify lessons to inform future recommendations and improve healthcare provision to these marginalised groups.

Methodology and Aims: The study encompasses a mixed-methods approach, combining literature synthesis, clinical data analysis, and stakeholder perspectives. It focuses on understanding the experiences of PEH during the pandemic, emphasising the role of PMVT in providing crucial services.

Clinical Data Analysis: Data from 2893 service users revealed that the majority were Irish nationals (60%), with a substantial portion from Dublin City Council (55%). Most participants faced recent homelessness, primarily due to family circumstances. The average length of stay with PMVT was 32 days.

Subsample Analysis: Further analysis of the service users who had a higher level of needs highlighted varying demographics and health conditions (n=483). Notably, those with a higher level of needs had shorter stays, emphasising the need for tailored support.

Qualitative Insights: Qualitative interviews with stakeholders underscored the challenges faced, including limited substance access, changes in living conditions, and healthcare staffing issues. Despite difficulties, positive outcomes emerged, such as improved access to opioid substitution therapy and a sense of community among service providers.

Collective Intelligence Group Findings: A collective intelligence group revealed a surge in service adoption during the pandemic. Participants addressed challenges through resourceful strategies, acknowledging the interdependence of stable housing and overall well-being.

Collaboration across service sectors aimed to provide personalised support to individuals with complex needs.

Recommendations: The comprehensive recommendations derived from the study on the impact of COVID-19 on homeless and drug-using populations are centred on enhancing support, tailoring interventions, and fostering inclusivity. It is imperative to recognise the diverse needs within the homeless community and implement specialised outreach programmes and case management services. For individuals with higher levels of needs, a coordinated approach involving healthcare professionals, mental health specialists, and social workers is crucial. Integrated health and social inclusion, substance use disorder treatment, and gender-responsive services, including safe and gender-inclusive accommodation, are pivotal for holistic care. Recommendations also emphasise trauma-informed support, culturally and linguistically sensitive services, and gender-specific outreach strategies. Training, collaboration with specialised organisations, and ongoing evaluation are highlighted to ensure continuous improvement. Additionally, responsive healthcare practices involve promoting cultural competence, streamlining administrative processes, upskilling the workforce, providing language support, engaging with the community, prioritising holistic care, and fostering a continuous evaluation and learning culture. These recommendations aim to address the multifaceted challenges faced by homeless individuals, particularly during crises, and guide the development of responsive and sustainable healthcare strategies for vulnerable populations.

Conclusion: This comprehensive study sheds light on the nuanced impact of COVID-19 on homeless and drug-using populations. Recommendations include tailored support for diverse needs, increased collaboration among service sectors, and strategies to address emergent challenges. These findings offer valuable insights for shaping responsive and sustainable healthcare strategies for marginalised populations in future public health crises and beyond.

RESEARCH TEAM

Professor Jo-Hanna Ivers is an Associate Professor in Addiction. She holds the only addiction-specific academic post in Ireland. She is the first Associate Dean of Civic Engagement and Social Innovation at Trinity College Dublin. Jo-Hanna leads the Neurobehavioural Addiction Research Group at the Department of Public Health & Primary Care, School of Medicine. Jo-Hanna is the Director of the M.Sc. in Addiction Recovery. She has been appointed by several Ministers and Government Representatives to Special Taskforces and Expert Review Groups examining drug and alcohol use. She is a Member of the European Monitoring Centre on Drug and Drug Addiction (EMCDDA) Scientific Committee. She was the Scientific Advisor on Drugs Use to the Citizens Assembly on Addiction and Recovery.

Jo-Hanna's research focuses on the biological, social and environmental factors that contribute to an individual's vulnerability to dependence and addiction. Her research includes interventions, policies and practices that help develop recovery pathways. These pathways are best understood as a spectrum and include harm reduction, abstinence and long-term recovery. Her populations of interest include people who use drugs, those experiencing addiction, individuals in recovery, their families, communities affected by drug use and wider members of society. Before returning to academia, Jo-Hanna gained extensive experience working with adolescent and adult populations in specialist addiction services in the national health service.

Mr. James Lyons was a Research Assistant with the Neurobehavioral Addiction Group in the Discipline of Public Health & Primary Care at the Institute of Population Health, School of Medicine, Trinity College Dublin. Before joining the research team, James gained experience working with adolescents, adults and families impacted by addiction at Aiséirí. James has previously worked on a number of quantitative research projects previously with the Centre for Neuroimaging, Cognition and Cognitive Genomics (NICOG) and the Irish Centre for Autism and Neurodevelopmental Research (ICAN) research groups at Ollscoil na Gaillimhe - University of Galway. James led the development and analysis of the clinical data (chapter 4).

Neil Dunne is a Research Assistant with the Neurobehavioral Addiction Group within the Department of Public Health & Primary Care at the Institute of Population Health, School of Medicine, Trinity College Dublin. Neil possesses a diverse set of research skills encompassing qualitative and quantitative methodologies, systematic reviews, and various research techniques. His contributions to the field have been acknowledged through publications in esteemed international peer-reviewed journals. Prior to joining the Neurobehavioral Addiction Group, Neil successfully completed his Masters in Neuropharmacology at the National University of Ireland, Galway.

ACKNOWLEDGEMENTS

We express our utmost gratitude to all the stakeholders who took part in this research. Engaging in research can be challenging. However, undertaking research while working on the frontline during a global pandemic is next level. We sincerely appreciate the dedication and commitment shown by everyone involved. We would like to extend a heartfelt thank you to the members of the research advisory group for their support and invaluable feedback throughout the study—a particular word of gratitude to Ms. Elizabeth Peña for her insight and guidance throughout.

We also wish to thank Ms Julia Corey. Julia was a Research Assistant in the early phase of the research and led the scoping review.

RATIONALE FOR THE CURRENT STUDY

People experiencing homelessness (PEH) were especially vulnerable to adverse outcomes of COVID-19 throughout the pandemic. This group are more susceptible to infection due to often crowded living conditions and they are at greater risk of morbidity and mortality due to the prevalence of issues such as mental health conditions, chronic diseases, and substance addiction. An estimated 2% of the homeless population in Dublin was infected with COVID-19 in June 2020, compared to 1% of the wider population. The infection rate among PEH and people using drugs was much lower than the best-case-scenario predictions.

The closure or reduced support from services at the onset of the outbreak, to slow the spread of the virus, further exacerbated many pre-existing vulnerabilities for PEH. Peter McVerry Trust (PMVT) is a national housing and homelessness charity in Ireland, which aims to reduce homelessness and harms associated with substance misuse and social exclusion. PMVT was instrumental in the response to the COVID-19 pandemic for PEH and helped to provide housing for isolation and protection, meals, medication, and on-site healthcare services for people in need.

This mixed-methods study explored the response to COVID-19 for homeless and drug using populations with a view to identify lessons learned to inform future recommendations and develop a sustained and improved method of providing healthcare to these populations.

CHAPTER 1: Background

**Koronavīruss
COVID-19**

Novērsiet koronavīrusa infekciju



- Mazgājiet rokas
- Aizsedziet muti, kad klepojat vai šķaudāt
- Neaprobeļojieties un nepaņemasiet
- Trīst priekšmetu virsmas
- Neietiet blīvē ar citiem cilvēkiem

Vinass izpausis, āķu pīrņu vīdā, kad šķūmekļa šūauda vai šķūnī - šūnā
regulāri veicet mazgāšanas, lai samazinātu vīrusa izplatības riskus.

Apmeklējiet vietni HSE.ie
Lai uzreiz saņemtu papildu informāciju un
atbalstu, vai zvaniet 1850 24 1850

Atvairība pret koronavīrusu.
Tā ir mūsu roka.



INTRODUCTION

It is estimated that there are almost 100 million people experiencing homelessness (PEH) worldwide (1). Estimates from 2019 suggest that at least 700,000 people in the European Union (EU) were sleeping rough or in emergency accommodations (2). Homelessness can be described as chronic, intermittent, or crisis homelessness (3). Homelessness experienced for a period of more than one year, or multiple episodes of homelessness experienced within two years, is considered chronic homelessness. The term intermittent homelessness is used to describe repeated cycling in and out of homelessness, often accessing housing or institutional care between episodes and crisis homelessness refers to homelessness experienced for less than one year due to unexpected circumstances (3).

Several individual, structural, and systemic factors interact to contribute to the causes of homelessness (3). Poverty (4, 5), adverse childhood experiences (6-8), psychiatric disease (5, 9), and addiction to drugs and alcohol are individual factors that can increase an individual's vulnerability to experiencing homelessness (4). Physical and sexual assaults, as well as ongoing victimisation, are also common among this population (10-12). Structural factors that may increase vulnerability to homelessness include the lack of low-cost housing, absence of employment opportunities for low-skilled workers and the lack of government income support (3, 13, 14). Systemically, severe poverty and coming from disadvantaged minorities are factors that can perpetuate homelessness (3) and are independently associated with poor health (15, 16).

HEALTH AND HOMELESSNESS

Mortality among PEH is reported to be much higher compared to the general population (17-19). A study in Dublin, Ireland by Ivers et al. (18) found the mortality ratio for PEH was 3–10 times higher compared to the general population. Factors contributing to excess mortality include both communicable and chronic diseases, substance misuse, smoking, and mental health disorders, with many co-occurring in PEH (19). Extensive social exclusion is also associated with excess mortality (20) and the longer an individual experiences homelessness, the more likely they will suffer negative health consequences (3).

Studies in the United States suggest that one-fifth of PEH will become chronically homeless (3, 21). Negative childhood experiences, recent physical abuse (22), and incarceration (23) increase the likelihood that an individual will experience chronic homelessness. Those experiencing chronic homelessness are more likely to experience increased rates of communicable diseases such as tuberculosis, hepatitis, and HIV (24, 25) in addition to chronic diseases (25, 26). People 50 years and older who are experiencing homelessness have also been found to experience increased rates of geriatric conditions such as frailty, dementia, multi-morbidity and functional decline, compared to their housed counterparts 20 years older (27). Furthermore, homelessness creates barriers to accessing scheduled healthcare and increases the need for unscheduled emergency care (28-31). A study conducted in Ireland found a 20-fold increase in the use of unscheduled hospital care by PEH compared to the general population (32).

MENTAL HEALTH AND SUBSTANCE USE AMONG PEH

Mental health conditions and substance use (19, 25, 26, 32-34, 35-37) are prevalent among PEH, conditions that are often intensified by the traumatic experiences and difficulties associated with living rough or in temporary shelters (4, 38-41). The most common mental health conditions reported include substance use disorders, schizophrenia spectrum disorders, and major depressive disorder (42, 43). Opiates, alcohol, cannabis, and cigarettes are among the most often used substances by PEH (44, 45). Poor treatment by service providers, absence of privacy and autonomy, and threats of or actual experiences of violence contribute to negative mental health among PEH (41). In many cases, PEH use substances as a way to escape social isolation and material reality, assimilate to their social network, and cope with trauma (38, 41). In addition to the high risk for overdoses, substance misuse may contribute to breakdowns in family relationships and friendships and exacerbate feelings of isolation. Substance misuse is also known to increase risky behaviours and may worsen mental health difficulties (46-49).

Dual diagnoses of both substance use and mental health disorders are more common among PEHs, with a prevalence estimated between 58-65%, compared with less than 1% in the general population (3, 36). Dual disorder diagnoses are associated with both poor health and lower service uptake (50). Treatment services for substance use range from high-threshold, abstinence-based programmes, to lower-threshold programmes that focus on harm-reduction interventions such as safe syringe exchanges, take home naloxone, or opioid substitution therapy (OST) (51). The tumultuous life circumstances, distress, fear of stigmatisation, and distrust in health professionals may contribute to barriers to access or treatment adherence for some PEH (50). Structural barriers, including service availability, lack of cross-sector collaboration, long waiting times, financial difficulties, and proximity to services, also play a role in poor service uptake among PEH (50, 52, 53). Rapid and sustainable housing programmes have proven successful in supporting many PEH to recover from both substance use disorders and mental health conditions (54-56). Unfortunately however, barriers to health care and housing access are reported among many PEH in both Ireland and abroad (57-59).

THE PANDEMIC IMPACT

Since SARS-CoV-2, the virus that causes Coronavirus Disease 2019 (COVID-19) emerged, more than 519 million people around the world have experienced a confirmed infection, and more than 6.2 million people have died from the disease (60). Despite a large reduction in the risk of virus transmission and severe disease due to widespread vaccination and booster implementations (61), COVID-19 remains a serious threat to human health, particularly among the most vulnerable populations (62, 63). Data from several studies suggest that PEH may be at higher risk for infection, morbidity, and mortality from COVID-19 compared to the general population (64-68). Several factors, including the lack of safe housing, limited access to healthcare, difficulties adhering to public health guidelines, closure of support services, and higher risk for co-morbidities such as mental health conditions, substance addiction, and chronic diseases contribute to this increased risk for adverse outcomes (65, 69).

Although PEH have been disproportionately affected by infections, morbidity, and mortality from COVID-19 (64, 67), health consequences of the pandemic extend beyond infection and illness from the virus. For example, wide-scale closures of public facilities reduced access to toilets and basic hygiene and sanitation for PEHs living unsheltered (70, 71). Reduced financial support from the public due to lockdowns and stay-at-home advisories, as well as closure or reduction of social support services, also exacerbated barriers to accessing food and hygiene facilities (71, 72). International and local travel restrictions interrupted the supply chains of alcohol and drugs, in turn increasing costs (73) and reducing access for many, leading some PEHs using drugs to shift from their preferred substance to using substances that were potentially more dangerous (74). In some cases, harm reduction interventions, as well as addiction treatment and support services for PEH, were closed, reduced, or inaccessible (75-78). The new challenges that emerged during the pandemic further exacerbated existing mental health conditions for many people experiencing homelessness. Studies indicate higher rates of self-harm, depression and anxiety (79, 80), in addition to increasing difficulties accessing mental health services (72).

Whilst the pandemic has negatively affected many PEH, unprecedented policies and service provision implemented to reduce the spread of the virus have also contributed to the improvement of the health and well-being of PEH in some communities. Examples of positive changes include rapid re-housing and shielding of vulnerable PEH (81, 82), expansion of harm reduction interventions and addiction treatment services (81, 83, 84), as well as collaboration across service sectors that increased access to mental health services (85).

THE IRISH CONTEXT

Prior to the COVID-19 pandemic, more than 10,000 adults and children were experiencing homelessness in Ireland, most of whom were located in Dublin (86). The Irish government recognised PEH as an especially vulnerable group for both infection and adverse outcomes of the virus and facilitated a number of changes in practice to safeguard the health and well-being of this population (51, 81). The Health Service Executive (HSE) and the Dublin Regional Homelessness Executive (DRHE) supported COVID-19 testing and isolation accommodation for PEH with confirmed or suspected cases of the virus, as well as their close contacts, early in the disease outbreak (81). The de-congregation of homeless shelters was also supported and PEH, who were identified as especially vulnerable to severe COVID-19 outcomes due to older age or comorbidities were also provided single occupancy accommodation. PEH who were using drugs were also considered a vulnerable group, and rapid access to opioid substitution therapy (OST) was recognised as crucial to support compliance with isolation and shielding. The waiting times for the initiation of OST were rapidly reduced from 12 to 14 weeks to just two to three days, and medication delivery to isolated and protected clients was supported. Naloxone access was also broadly expanded (81). Dublin exceeded the best-case expectations for COVID-19 mortality among PEH and drug-using populations. The infection rate among PEH in the city was approximately 2% by June 2020, compared to 1% among the general population (81).

As of September 2023, 12,827 people were accessing emergency accommodation in Ireland (87). Sustaining and improving healthcare services for PEH in the face of the growing public health threat posed by COVID-19, as well as other health threats, is vitally important.

PETER MCVERRY TRUST

The Peter McVerry Trust (PMVT) is a national housing and homeless charity that provides addiction and homelessness services in Ireland. During the pandemic, PMVT offered emergency accommodation and sheltered PEH using drugs. Service users who tested positive for COVID-19 were provided a place to isolate by PMVT during the pandemic. In Dublin, isolation sites included Paramount (for singles or couples), Augustine (family apartments), Keltoi (non-Dublin Region Homeless Executive/DRHE referrals as well as two sites with the International Protection Accommodation Services (IPAS) for families, singles or couples, and asylum seekers. PMVT had access to a shielding hotel with 100 rooms during the pandemic, and 100 apartments on Augustine Street. Using a mixed-method approach, this research aimed to capture valuable lessons learned from the PMVT COVID-19 response. The findings provide an evidence base for developing a sustained and improved way of providing healthcare to minimize the risk of infection in PEH.

CHAPTER 2: Methodology



Coronavirus COVID-19

The Facts

At Risk

Anyone who has been to an affected region in the last 14 days AND is experiencing symptoms

Anyone who has been in close contact with a confirmed or probable case of COVID-19 (Coronavirus) in the last 14 days AND is experiencing symptoms

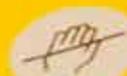
Prevention



Wash
Wash hands often and
thoroughly with
soap and water.



Cover
Wear a face mask
when coughing or
sneezing, and
avoid touching
your face.



Avoid
Avoid close contact
with people who
have respiratory
infection.



Clean
Use alcohol-based
hand sanitizer
when hands are
not soiled.

Symptoms

• Cough • Shortness of breath • Sore throat • Fever • Headache • Muscle aches

Affected Regions

Check the list of affected regions on www.hk.gov.hk

What to do if you are at risk

I've been to an affected region in the last 14 days and

- I HAVE symptoms**
 - Stay at home after arrival
 - Wash hands often with soap and water
 - Wear a face mask
 - Avoid public places

I DO NOT HAVE symptoms

- Wash hands often with soap and water

I've been in close contact with a confirmed or probable case of COVID-19 (Coronavirus) in the last 14 days and

- I HAVE symptoms**
 - Stay at home after arrival
 - Wash hands often with soap and water
 - Wear a face mask
 - Avoid public places

I DO NOT HAVE symptoms

- Wash hands often with soap and water



CHAPTER 2: METHODOLOGY

STUDY DESIGN

The study design incorporated a combination of quantitative and qualitative research methods. Mixed methods research capitalises on the strengths of both qualitative and quantitative methodologies by combining approaches in a single research study to increase the breadth and depth of understanding. Moreover by corroborating findings across clinical settings, utilising various datasets, and eliciting views of key stakeholders can reduce the impact of potential bias by including information collected through different methods. This design also allowed the research team to simultaneously assess the extent to which the targets were achieved while also examining the processes and contexts in which these results occurred. The study consisted of two distinct work packages designed to meet the goals and objectives presented below.

AIMS

This study aimed to evaluate the policies and practices implemented in Ireland to minimize the risk of SARS-CoV-2 infection among people experiencing homelessness and using drugs. The study drew on both clinical data as well as first-hand experiences from individuals who accessed, provided, or developed services for persons experiencing homelessness to learn from their lived experiences and inform recommendations for developing a sustained and improved way of providing healthcare.

The Present Study:

Using a mixed-methods approach, this study aimed to capture valuable lessons learned from PMVT's COVID-19 response. Findings provide an evidence base for developing a sustained and improved way of providing healthcare to minimise the risk of infection in PEH who use drugs.

OBJECTIVES

The objectives of this research were:

1. To conduct a scoping review to explore the health impacts of the COVID-19 pandemic on PEH in North America and Europe.
2. To collate data from PMVT and cross-sectionally analyse the characteristics, healthcare usage, morbidity and mortality of PEH who were using drugs during the COVID-19 pandemic.
3. To conduct interviews with service providers and developers of PMVT to understand their experiences implementing policies and practices during the COVID-19 pandemic to minimise infection risk in PEH who were using drugs.
4. To conduct interviews with PEH and using drugs to understand their experiences accessing PMVT services during the COVID-19 pandemic.
5. To assess the impact PMVTs improved accommodation provisions on health during the COVID-19 pandemic.
6. To use findings to develop a comprehensive dissemination plan to inform service users, the public, frontline staff, service providers, policymakers, and the scientific community about lessons learned from responding to COVID-19 to inform future service provision.



DATA COLLECTION AND ANALYSIS

The study consisted of two distinct work packages both of which are outlined below:

Work Package 1- Quantitative Study (Objective 2)

A retrospective analysis of data from PMVT was conducted. Data from service users was recorded by PMVT staff on Salesforce, an online secure software database containing confidential service user information. These data were then exported to an offline password protected excel document and later transferred to the Statistical Package for Social Sciences Version 27.0 (SPSS Inc, IBM) for analyses. Data were collected from August 2020 until January 2022. This data was anonymised by PMVT before provision to Trinity College Dublin.

PMVT collected data related to referral source, demographics, next of kin, medication status, and unmet medical needs from all service users. PMVT were able to access substance use medication for PEH using drugs. In some cases, this was for PEH who never received substance use treatment before. COVID-19 vaccination status, testing, health symptoms and observations were collected, dated and signed by staff. Information on attending services (e.g., meal provision, nursing updates, clinical observations) was also documented. Clinical observations were typically made once daily, by nurses or more frequently where needs of service users were higher or if someone had a diagnosis of COVID-19. These observations were then used to inform nursing input or medical reviews. A COVID-19 isolation tracking document collected data on the reason for referral to the isolation unit, referral sources, demographic information, and whether COVID-19 swabs were taken (swab taking was not performed at the service level at the beginning of the pandemic but is now carried out by PMVT). Also, the number of individual crisis management plans (ICMPs) were collected. ICMPs are used as a record or set of instructions for staff members to refer to if present with a client during an emergency, typically for persons with a history of mental health or complications to substance use.

Data Analysis

Data were entered into a Microsoft Excel file and later forwarded as a password-protected document by PMVT staff members to the research team. Upon inspection of the file, our research team analysed the demographic, clinical, and substance related data. This will be represented in Tables below with percentages or mean values, accompanied by variance figures (i.e., standard deviation or error). A subsample was then analysed. This group consisted of people who presented to PMVT with a higher level of needs than average. For this group, we

also outline percentages in the same format and completed a statistical method known as logistic regression to understand which variables were associated with one another. A logistic regression is used to investigate if one factor predicts the occurrence of a second factor (where the latter has only two possible responses). For example, we wanted to see what variables predicted whether service users were ever dependent on drugs or if they initiated Suboxone, Methadone, Librium, or Benzodiazepine while in service with PMVT.

Work Package 2- Capturing Experiences in the Covid-19 Response (Objectives 3 and 4)

Qualitative interviews are a valuable data collection tool in health research. Qualitative interviews give voice to stakeholders and enable researchers to explore patient and clinician experiences. Semi-structured in-depth interviews were conducted with a sample of service users (n=8), service providers (n=10), and key informants (n=10) who were instrumental in the response of PMVT to COVID-19 for PEH homelessness and using drugs. Participants were recruited using purposeful sampling. All interviews were conducted in English and recorded with participant consent. On average, the interviews lasted a duration of 65 minutes. As data collection took place during Covid restrictions, the interviews (n = 14) with service providers and key informants were conducted on Zoom. The collective intelligence group (n=10) with key informants from across PMVT who had a key strategic or managerial role in the organisation during covid was conducted in person at a central PMVT. This group ran for 90 minutes. Only study participants and interviewers were present for data collection. All participants provided informed consent.

Individual Interviews

The interview recordings were transcribed by a professional transcriber. The transcripts were anonymized and linked only to a participant identification code. The authors read the transcripts multiple times to familiarise themselves with the material. Data coding was guided by thematic content analysis (88). Two researchers independently coded the same first four transcripts and then compared codes to develop a universal codebook. The researchers then used the codebook to code the remaining transcripts. Upon completion, codes were exported to Microsoft Excel and examined according to themes and sub-themes that emerged. Findings are presented in Chapter 5.

Collective Intelligence Group

In qualitative research, a collective intelligence group is a methodological approach that harnesses the diverse perspectives and experiences of a carefully selected group of individuals to collaboratively generate insights, ideas, and knowledge related to a specific research topic. This approach recognises that the collective and varied experiences of participants can produce nuanced and comprehensive understandings that may not be accessible through individual interviews or observations alone.

The process of a collective intelligence group entails facilitated discussions. Participants are encouraged to openly share their thoughts, perspectives and experiences. The underlying principles that guide a collective intelligence group in qualitative research are as follows:

Diversity: The group should consist of participants from diverse backgrounds, perspectives and areas of expertise relevant to the research topic. This diversity enhances the richness and depth of insights generated.

Equality: Each participant's input is regarded as equally important and valuable, irrespective of their status or background. This principle fosters an inclusive environment where everyone's voice is heard and respected.

Collaboration: Participants collaborate in a cooperative and inclusive manner to generate insights and knowledge. Through collective effort, the group can delve into complex phenomena and arrive at comprehensive understandings.

Respectful dialogue: Open and respectful dialogue is cultivated to encourage the exchange of ideas, perspectives, and opinions.

Ethical Approval

Ethical approval was obtained from the Ethics Committee of the Faculty of Health Sciences of Trinity College Dublin.

Chapter 3: Findings from a Scoping Review

This section presents findings from a scoping review. References in this section represent those of the published article. These results are published in the International Journal of Environmental and Public Health and can be found here:

Corey, J., Lyons, J., O'Carroll, A., Stafford, R., & Ivers, J. (2022). A Scoping Review of the Health Impact of the COVID-19 Pandemic on Persons Experiencing Homelessness in North America and Europe. *Int J Environ Res Public Health*. 19 (6), 3219.

<https://doi.org/10.3390/ijerph19063219>

Screening Process

The initial search returns of five databases and a grey literature search (figure 1). A total of 1554 articles were identified for screening. Of these, 734 were automatically removed as duplicates, leaving 820 articles for title and abstract screening. After screening titles and abstracts, 313 full-text studies were assessed for eligibility. One additional study was identified by two authors (R.S. and A.O.C.) with extensive knowledge in the field and assessed for eligibility. Following the review of full texts, 96 articles met the inclusion criteria for data extraction and analysis.

Study Breakdown

The majority of studies included in this review collected primary data to answer a specific research question (n = 85), while studies conducted analysis of secondary data. PEH were the primary population of focus in 74 studies, while other literature looked at PEH as a smaller subset of study populations, such as general patient populations (n = 6), persons living with HIV (n = 5), COVID-19 patients (n = 3), multiple vulnerable groups (n = 3), or others (n = 5), as outlined in Table 1. Most of the included studies were original journal articles (n = 48); however, given the time-sensitive nature of information during the current pandemic and the often lengthy process of peer-review, a number of different article types were included in the current review, including brief reports (n = 8), research letters (n = 6), preprints (n = 4), short communications (n = 4), case studies (n = 4), reports (n = 4), letter to the editor (n = 3), and others (n = 15), as detailed in Table 1. Studies were conducted in more than ten countries across North America and Europe. Most (n = 51) were conducted in the United States U.S., followed by the United Kingdom U.K. (n = 9), France (n = 9), and Canada (n = 6).

Table 1 provides a full breakdown of study locations. Studies also differed by design, as presented in Table 1. Detailed data extraction from each included study and more information as to the methods used for data collection can be found in the published article.

PRISMA Flow Chart

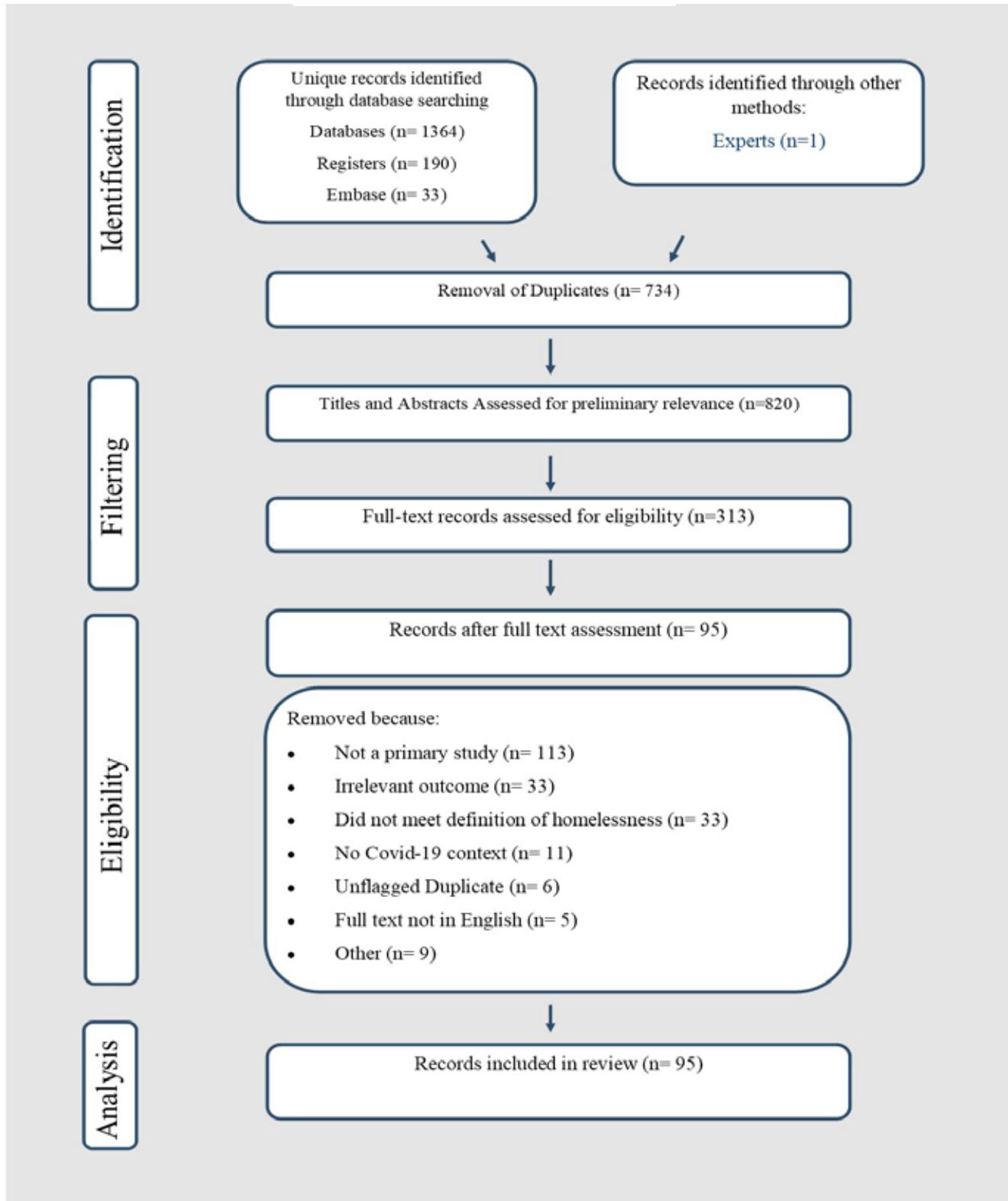


Table 1: Study Characteristics

Country	Study Design	
U.S.	51 Cross-sectional	30
U.K.	9 Unspecified	7
France	9 Longitudinal	4
Canada	6 Mixed methods	4
Spain	5 Pilot	4
Italy	4 Case study	4
Germany	4 Qualitative	3
Denmark	2 Report	3
Belgium	2 Case report	2
Multiple	2 Case series	2
Slovakia	1 Retrospective	2
Ireland	1 Cross-sectional seroprevalence	2
Primary Population of Interest	Analytical observational	1
PEH	74 Community-based participatory research	1
General patient populations	6 Cross-sectional community-based	1
People living with HIV	5 Cross-sectional community-based surveillance	1
Multiple vulnerable groups	3 Cross-sectional multicentre cohort	1
COVID-19 patients	3 Cross-sectional retrospective chart review	1
Persons using drugs	2 Descriptive	1
U.S. Veterans	1 Disease prevention protocol	1
African Americans in Southern U.S.	1 Interrupted time series	1
Criminal justice-involved women	1 Longitudinal ecological	1
Publication Type	Matched-case control observational	1
Journal article	48 Nationwide cross-sectional seroprevalence	1
Brief report	8 Nonconcurrent cohort	1
Research letter	6 Nonrandomised observational pre/post	1
Short communication	4 Nonrandomised pre/post	1
Case study	4 Observational retrospective	1
Preprint	4 Point prevalence	1
Report	5 Population-based prospective	1
Letter to the editor	3 Population-based retrospective e-cohort	1
Research note	2 Pragmatic randomised controlled trial	1
Weekly report	2 Prospective	1
Notes from the field	2 Qualitative exploratory	1
Rapid communication	1 Quality improvement programme	1
Practice full report	1 Rapid case study	1
Case report	1 Repeated cross-sectional	1
Brief research report	1 Retrospective chart audit	1
Concise communication	1 Retrospective cohort	1
Short report	1 Retrospective cross-sectional	1
Research brief	1 Retrospective serological	1
Review	1	

SARS-CoV-2 Infection and Morbidity

A number of included studies reported infection attack rates of SARS-CoV-2 among study participants: 29 studies measured positivity rates (i.e., current infection)^{13,33–60}, seven measured seroprevalence (i.e., prevalence of antibodies for SARS-CoV-2, indicating historic infection^{61–67}), and four measured both positivity and seroprevalence rates^{68–71}. Additionally, data regarding SARS-CoV-2 symptoms reported by study participants were provided by 32 articles^{7,8,33–36,38,42,45–52,55–58,61,62,68–70,72–76}. Positivity rates among PEH ranged from 0 to 66%, while seropositivity among PEH ranged from 0 to 94%. Among studies that measured positivity rates, 13 included testing of participants in response to an outbreak^{34,36,38–40,43–45,48,50,55,56,68}. In addition, surveillance testing (i.e., testing not prompted by a confirmed or suspected outbreak) was conducted for all participants regardless of symptoms in 16 studies^{33,35,36,38,40–44,46,47,52,58,69–71}. Of these, six reported that routine surveillance testing occurred regularly^{35,41,44,52,58}. Eight studies described close-contact- or symptom-based testing strategies^{36,44,49,53,54,56,58,71}, and one study did not specify reasons participants were tested⁶⁰. Two studies reported positivity rates using retrospective⁵⁷ or prospective (person-level data from COVID-19 surveillance and reporting systems)³⁷ data from cohorts of the populations that were tested for SARS-CoV-2. One study by Jatt et al.³⁶ described how testing progressed from only symptomatic individuals and close contacts to outbreak testing and finally to routine surveillance testing from 11 March to 29 April 2020 in a large healthcare facility in Los Angeles. Of the 33 studies that measured infection rates, polymerase chain reaction (PCR) tests were the most commonly reported tests used for diagnosis (n = 24^{34,36,40–44,46–54,56,58,60,68–71,77}). Other measures included self-reported positive test results (n = 3^{13,59,70}), antigen testing (n = 1³⁵), and assays (n = 1³³). Five studies did not specify the tests used for SARS-CoV-2 diagnosis^{37–39,55,57}.

Multiple unique risk factors for SARS-CoV-2 positivity were identified among PEH. Three studies reported that PEH were at increased risk for infection compared to the general population^{37,62,78}, though one study found that among people living with HIV, experiencing homelessness was not associated with seropositivity⁶⁴. Among haemodialysis patients, Rincón et al.⁴⁵ found that living in a nursing home or experiencing homelessness was an independent risk factor for testing positive for SARS-CoV-2. Three studies reported risk of COVID-19 based on specific shelters of residence^{43,47,68}. While no statistical significance was reported, Rogers et al.⁴⁴ noted that most positive cases 79% were detected among shelters housing older male residents and with shared day services, showering facilities, and rotating staff. Similarly, Ghinai et al.⁴⁸ reported that increased numbers of private bathrooms were associated with lower prevalence rates. Living in a congregate or crowded setting⁶¹ and shared sleeping arrangements⁴⁸ were also identified as risk factors. In addition, a study by Roland et al.⁶⁹ reported that persons who shared a room with someone who tested positive, or did not know, were significantly more likely to test positive. Rogers et al.⁴⁴ reported that 86% of positive cases in their study of

homeless shelters in King County, Washington slept in a communal space in the past week, compared with 78% of residents with negative tests; however, no statistical significance was provided. Three articles noted that the shelters in their studies with the largest outbreaks had more transient resident populations^{33,35,46}. Similarly, Ghinai et al.⁴⁸ reported an association between the proportion of residents leaving and returning each day and increased prevalence rates. A study of congregate shelters in Rhode Island found that 70% of participants with negative tests had spent more than two weeks at their shelter, compared with 43% of participants with positive tests⁴⁶. The same study reported that three shelters that had stopped accepting new residents at least two weeks prior had zero cases at the time of testing⁴⁶.

Additional risk factors were identified by several studies. Two studies found the presence of symptoms to be associated with testing positive for SARS-CoV-2^{47,61}, while four studies found no statistical significance between symptoms of persons testing positive and negative^{33,38,46,69}. Two studies reported a relationship between older age and increased likelihood of testing positive among PEH^{38,48}, though this relationship was not statistically significant in the study by Kiran et al.³⁸, and after adjusting for individual level factors and clustering at shelters, positivity rates no longer differed significantly by age in the study by Ghinai et al.⁴⁸. Another study by Ly et al.⁴⁷ reported that younger PEH 18–34 years old had more than three times higher odds of testing positive. Karb et al.⁴⁶ reported no statistical differences in age between people testing positive and negative. One study reported that 84% of PEH testing positive for SARS-CoV-2 were male, though men accounted for 72% of participants⁵⁰, and three found no significant difference in gender between people testing positive or negative^{46,48,69}. Prevalence of the virus was higher among non-Hispanic white PEH than among non-Hispanic Black PEH in a study by Ghinai et al.⁴⁸, though after adjusting for individual-level factors, the positivity rates no longer differed. Karb et al.⁴⁶ also reported no differences in race between persons testing positive or negative. PEH in Belgium with an Urgent Medical card had significantly higher proportions of SARS-CoV-2 infections than those without access to the health system, 7% vs. 3%, respectively,⁶⁹ and shelter residents in Toronto who tested positive were significantly less likely to have a provincial health insurance card than those who tested negative^{54% vs. 72%, respectively}³⁸. In France, Rahi et al.⁷⁹ found that PEH were more likely to be infected during a lockdown (March 17th – May 11th, 2020) than before (5% vs. 1%, respectively). One study reported significantly lower seroprevalence among shelter residents consuming tobacco^{3%} compared to those who did not^{8%⁶¹}, and another study similarly found that current smoking among shelter residents was associated with lower prevalence of infection, compared with never smoking⁴⁸. PEH who tested positive in a study by Karb et al.⁴⁶ had significantly lower prevalence of comorbidities than those testing negative (20% vs. 40%, respectively). Seroprevalence was also reported to be lower among PEH with psychiatric and/or addiction comorbidities than among those without (3% vs. 6%, respectively) in a study by Loubiere et al.⁶¹. Prior chronic respiratory disease⁶⁹ and

self-reported medical history⁴⁸ were not significantly associated with positivity status in two other studies^{48,69}.

COVID-19-Related Hospitalisation

Nine studies provided information regarding COVID-19 related hospitalisations among PEH ^{8,34,48,49,55,68,73,75,76}, among which six provided hospitalisation rates ^{34,48,49,55,68,73}. A study by Imbert et al. ⁷³ reported that 8% of shelter residents who tested positive between April 5th and April 15th 2020 required hospitalisation, and a study by Tobolowsky et al. ⁵⁵ reported that 20% of residents that tested positive between March 30th and April 1st, 2020 were hospitalised. Among symptomatic persons with COVID-19, significantly more PEH were hospitalised than those in the general population (29% vs. 11%, respectively ⁴⁹). Another article reported that among the 13% of shelter residents that were hospitalised due to COVID-19 (testing positive between April 1st and May 1st, 2020), 33% required intensive care unit (ICU) admission ⁴⁸. In Paris, 24% of residents across three homeless shelters that tested positive were hospitalised, of which 12% were transferred to an ICU ⁶⁸. Data from one shelter in the same study indicated that patients over 65 years old, those with heart conditions, those with chronic kidney disease, and those with more than two risk factors were hospitalised more often ⁶⁸. In a Toronto refugee shelter, 4% of residents that tested positive for SARS-CoV-2 were admitted to the hospital for isolation requirements rather than clinical severity; there were no reported cases of ICU admission at the time of the study (20th–21st of April, 2020) ³⁴. A U.S. study by Cha et al. ⁷⁶ reported that among patients experiencing homelessness hospitalised with COVID-19, 54% were hospitalised for 4 days, 17% were admitted to the ICU, and 11% had mechanical ventilation, most commonly patients 65 years (20%) and those with no underlying health conditions (21%). Schrooyen et al. ⁸ reported that incidences of hospitalisation for COVID-19 were three times higher among PEH (650 per 100,000) compared to the general population ^{194 per 100,000}. Among all adult patients with COVID-19 treated from March 1st to May 18th, 2020, at the Boston Medical Centre ^{BMC}, PEH accounted for 16% of all patients, 24% of non-ICU inpatients, 16% of ICU admissions without mechanical ventilation, and 15% of ICU admissions with mechanical ventilation ⁸⁰. Hospitalisations among COVID-19 positive PEH in the BMC system were reduced by 28% following the opening of the COVID-19 Recuperation Unit, located adjacent to the BMC, which provided space for PEH to isolate, quarantine, and receive treatment for substance use ⁷⁵.

COVID-19-Related Mortality

Mortality from COVID-19 among PEH was evaluated in 12 studies^{5,8,37,48,49,53,68,72,73,76,80,81}. Data regarding case fatality rates (CFRs) were available from eight studies^{5,37,48,53,68,72,73,76}, with six studies reporting at least one death^{5,37,48,49,53,68,73,76}. A study from France by Husain et al.⁶⁸ reported the highest CFR at 6% among the included studies, using data from PEH in shelters who received positive PCR tests for SARS-CoV-2 between March 1st and May 31st, 2020. Leifheit et al.⁵ found that, when compared to the wider population, CFRs in Los Angeles were significantly increased for PEH under the age of 65, and that the opposite was true for those ages 65 and over. A study by Hsu et al.⁸⁰ reported that among adult patients with confirmed COVID-19 that were treated at BMC, 15% of those who died were PEH. Additionally, 15% of deaths among PEH in Wales between February and July 2020 were registered as COVID-19 involved, compared with 14% among the general population⁸¹, though no statistical significance was provided. One study reported no significant association between housing problems and mortality from COVID-19⁸.

Fear of COVID-19

Fear or perceived threat of COVID-19 among PEH was discussed by ten studies^{12,13,82–89}. Fear varied across studies; in Los Angeles, 65% of tenants of permanent supportive housing surveyed by Henwood et al.⁸⁵ in March 2020 regarded COVID-19 as a serious risk to their health, while 33% of those surveyed in Los Angeles by Kuhn et al.⁸⁷ from December 2020 to February 2021 perceived it as a high threat. A third study in Los Angeles carried out from April to June 2020 reported that 53% of young PEH (18–25 years old) were not at all worried about COVID-19, and 15% were very or extremely worried⁸⁸. One study by Rodriguez et al.¹² reported that PEH in Tippecanoe County, Indiana had an overall low risk perception of COVID-19, while authors of a study in France found that PEH felt that the virus was indeed a threat but was not a major concern compared to the other risks they regularly faced¹³. Using data from Hamburg, Hajek et al.⁸⁹ found that increased fear of COVID-19 among PEH was associated with younger age, absence of chronic alcohol consumption, increased perceived own risk of contracting the virus one day, and a higher agreement that a diagnosis of COVID-19 would ruin their life. Similarly, Henwood et al.⁸⁵ reported that having a pre-existing health condition was associated with increased odds of perceiving COVID-19 as a serious health risk among PEH. They also noted that men in their study had significantly lower odds of perceiving the virus as a serious health risk than women⁸⁵.

PEH's perceived threat of COVID-19 impacted some aspects of their health and behaviour. In one study, increased loneliness was associated with a high self-perceived risk of contracting COVID-19⁸⁴. Kuhn et al.⁸⁷ reported PEH in their study who perceived the virus as a high threat were significantly less likely to be vaccine hesitant. Perceiving COVID-19 as a serious threat was also associated with increased odds of handwashing and social distancing among PEH in a study by Henwood et al.⁸⁵. Finnigan⁸⁶ found that 27% of PEH surveyed in Sacramento, California, reported avoiding shelters due to fear of the virus. One study in Hamburg reported increased physician visits or likelihood of hospitalisation was not associated with fear of COVID-19 among PEH⁸².

COVID-19 Vaccine Acceptance

Five studies measured attitudes toward COVID-19 vaccination. Three studies took place during December 2020 or later, when vaccines first became available in the U.S. and Italy^{59,87,90}, while two were conducted earlier in 2020, before vaccines received any emergency use authorisation^{83,91}. Four studies examined attitudes exclusively among PEH^{59,83,87,91}; vaccine hesitancy was reported as 41%⁸³ and 48%⁸⁷ in two studies, while vaccine acceptance was found to be 56%⁹¹ and 64%⁵⁹ in another two studies. Fear of side effects (37%), wanting more information (30%), or rejecting all vaccines (37%) were cited as reasons for vaccine hesitancy among PEH in a study by Kuhn et al.⁸⁷. Moore et al.⁹⁰ reported that housing insecurity was associated with more than sevenfold increased odds of vaccine resistance among American Americans living in the southern U.S.

Several factors that may contribute to vaccine hesitancy among PEH were identified. In France, Longchamps et al.⁸³ found increased odds of vaccine hesitancy among females vs. males, those living with a partner vs. living alone, decreased odds of vaccine hesitancy among those with no legal residence vs. French/legal residence, and those with higher health literacy vs. low. Similarly, Lacoella et al.⁵⁹ found that vaccine acceptance was higher among male PEH in Rome than females (74% vs. 59%, respectively). Kuhn et al.⁸⁷ reported that those trusting official sources were significantly less likely to be hesitant, and those engaging in highly protective behaviour were significantly more likely. A study in Los Angeles reported no significant differences regarding vaccine attitudes or uptake based on race/ethnicity, gender identity, sexual orientation, or testing history among young PEH (18–26 years old)⁹¹. Nearly 80% of participants in the same study felt that having access to primary prevention services and personal protective equipment^{PPE} were important to promoting uptake, and 70% expressed that access to COVID-19 treatments, text-based prevention information and support, and the ability to get vaccinated in non-traditional medical settings were crucial for them to be vaccinated⁹¹.

Housing

Many included studies reported substantial impacts of the pandemic on housing for PEH. Three studies indicated that the pandemic may have led to an increase in PEH^{21,86,92}. Between February and May 2020, Irwin et al.²¹ reported a 91% increase in persons experiencing unsheltered homelessness in Arlington County, Virginia and noted an 88% increase in Black individuals and 48% increase in white individuals. Several studies also noted that the pandemic led some people to experience homelessness or be recognised by homeless support services for the first time^{13,23,93}. Barbu et al.⁹⁴ reported that some persons newly experiencing homelessness during the pandemic had difficulties accessing emergency accommodation.

Several studies described how the pandemic exacerbated insecure living conditions for PEH. Four studies reported shelters restricting new admissions^{12,46,95,96}, and three reported shelters closing during the pandemic^{44,73,94}. One study reported that authorities in France dismantled a squat³⁹, and in Salamanca, Spain, PEH were not allowed to live on the street during the initial lockdown period²⁶. Additionally, Allaria et al.¹³ reported 42% of PEH in their study changed accommodation since the onset of the pandemic. Court proceedings delayed due to the pandemic slowed intake of some PEH, particularly those leaving incarceration, into shelters, according to a study by Pixley et al.⁹⁷. A study in Los Angeles by Tucker et al.⁸⁸ reported that 29% of young PEH (18–25 years old) indicated that the pandemic made finding a safe place to spend the night more difficult, and 42% indicated that it was now harder to find or keep stable housing. Some shelter residents in a study by Parkes et al.²³ also felt that support within accommodations was reduced during the pandemic.

Despite the negative impact of the pandemic on housing insecurity, many studies described instances in which housing supports were provided or improved for PEH. Ten articles noted that shelter services were expanded, or new temporary shelters were established, as part of the pandemic response^{26,36,48,54,74,94,98–101}, and 21 reported that PEH were temporarily housed in repurposed hotels^{7,12,23,38,39,47,48,54,58,60,61,94,95,97–104}. Two studies mentioned participants staying in hotels but did not indicate whether their stay was related to temporary pandemic housing programmes^{87,105}. Two studies reported that those leaving non-congregate hotel accommodation were given support in finding permanent housing^{58,99}, 83% of participants in the study by Aitken⁹⁹ found suitable alternative accommodation. An additional four studies reported those leaving medical care sites were supported with a discharge plan for housing^{72,99,106,107}. However, a report by Barbu et al.⁹⁴ noted that when some temporary accommodation supports eventually closed, some PEH returned to rough sleeping. In Ireland, some PEH in temporary emergency accommodations expressed concern over uncertainties of future accommodations¹⁰¹. Three studies indicated changes made to reduce crowding provided increased privacy in shelters^{44,96} or non-congregate settings⁹⁷. Leonardi and Stefani⁹⁶ also noted that shelters in Turin, Italy began operating 24 hours a day, which fostered

a sense of community among residents. Two studies reported shelters using incentives such as free meals, cigarettes, TV, and religious or spiritual events to keep clients indoors during the pandemic and reduce exposure to SARS-CoV-2^{67,71}. Both reported no positive cases among residents^{67,71}.

Isolation or quarantine accommodation for PEH who were symptomatic, confirmed cases was noted in 44 articles. Of these, the majority reported that access to temporary facilities to safely isolate or quarantine was provided^{34–36,39,40,42,43,45,47,49–51,54–56,69,72,74,75,80,94,97–99,101,107}, with 15 specifically describing hotels converted for this purpose^{12,21,33,40,41,46,53,58,73,86,99,100,106,108,109}. Fuchs et al.⁵³ found that premature discontinuation of hotel isolation or quarantine was associated with experiencing unsheltered homelessness and requiring quarantine as a close contact. Wang et al.¹⁰⁷ described the implementation of a trauma-informed care site in Chicago, with high satisfaction reported among patients. Three studies mentioned isolation of individuals who were symptomatic or positive but did not provide further details as to where isolation occurred^{48,68,110}. Six studies mentioned that PEH were unable to safely isolate or quarantine^{25,39,69,85,93,96}, three of which described a lack of safe isolation services in March and April 2020^{25,69,96}. Two studies noted that PEH were unable to quarantine or isolate in a safe place if needed because of a lack of necessities such as food^{85,93}, hygiene, or medication⁸⁵.

Access to Personal Hygiene and PPE

Multiple studies discussed personal hygiene. Unmet need for showers ^{12,39}, bathrooms ⁹⁷, and other hygiene products or services ^{44,97} for PEH during the pandemic were reported by several studies. In a study by Riley et al., ¹¹¹ 66% of women experiencing homelessness or unstable housing reported one or more subsistence needs, defined as insufficient access to food, clothing, housing, or hygiene resources. In some cases, barriers to hygiene were exacerbated by the pandemic; reduced access to showers ^{88,94,109}, toilets ⁹⁴, laundry ^{88,94}, and other personal hygiene products and services ¹³ were discussed by several studies, with some noting that barriers were due, at least in part, to public closures ^{12,94,97,109}. However, some studies indicated that PEH had access to showers ^{39,40,55,68,94,100}, toilets ^{39,68,94,100}, or laundry ^{94,100}. Access to general hygiene products or services was also noted in five studies ^{48,53,86,100,101}, all of which were provided by organisations or shelters. In a few studies, access to showers ^{39,55} and hygiene products ¹¹ was reported as improving for some PEH during the pandemic.

Other personal hygiene concerns brought up by studies included cleaning supplies and sharing of substances. One study reported that PEH had access to cleaning supplies ⁶⁰, three reported unmet need ^{13,40,94}, and one indicated decreased access as a result of the pandemic ¹¹. Sharing of substances among PEH as an infection risk was brought up by three studies ^{12,88,110}. One study noted that cigarettes were commonly shared among PEH ¹², and one found that many PEH avoided sharing cigarettes or drugs because of the pandemic ⁸⁸. In addition, Steer et al. ¹¹⁰ reported positive outcomes of a disposable cup intervention to reduce drink sharing among PEH, particularly among those using alcohol.

Hand hygiene among PEH was discussed by numerous studies. Many noted that PEH were able to wash their hands ^{11,13,41,42,44,47,66,85,88,100}, access soap ^{11,42,47,88}, or access hand sanitiser ^{11,39–41,60,69,88,100}. Use ¹⁰⁰ or provision ⁶⁶ of gloves to PEH was also mentioned by two studies. However, unmet needs for handwashing facilities ^{11,12,88}, soap ^{11,88}, and hand sanitiser ^{11,40,55,88,94} were also reported. Montgomery et al. ¹¹ reported that public closures and price surges of hand hygiene supplies triggered by the pandemic reduced access to soap, hand sanitiser, and handwashing facilities for PEH in Atlanta, Georgia, though supplies and handwashing stations were later provided. The same study found that unsheltered PEH were more likely to rely on hand sanitiser, bottled water, and disinfecting wipes for hand hygiene, and some PEH in shelters expressed concerns about crowding and long lines to wash hands ¹¹. Henwood et al. ⁸⁵ reported that among PEH living in Skid Row, those living in single room occupancies with shared bathrooms and those with mental health conditions were nearly half as likely to report hand washing compared to those in studios.

Personal protective equipment (PPE) was discussed in several studies. PEH were reported as having access to facemasks or face coverings in 21 studies ^{12,13,23,33,39,41,46–}

48,52,54,55,58,60,66,69,74,88,93,98,100, among which nine reported that these were required to be worn in shelters^{12,33,41,46,48,52,54,100} or quarantine and isolation sites⁷⁴. Three studies noted that PPE generally was available to PEH^{25,58,100}. PPE²⁶ and masks⁸⁶ were also reported as being worn during interviews for two studies. Additional studies noted that facemasks were enforced during health check-ups²⁰ or in public⁴² and encouraged while awaiting test results and in general patient areas of a health facility⁵¹. Rodriguez et al.¹² described difficulties enforcing masks among PEH in shelters, with some giving up and only requiring them to be worn by staff. Unmet need for facemasks/face coverings^{40,55,88,94} or PPE^{23,69,97} for PEH was discussed in 7 studies.

Physical distancing was also noted in several included articles. PEH were reportedly able to follow social distancing guidelines in 14 studies^{13,33,39–42,44,46,47,52,74,88,93,98,100}, among which seven reported that distancing was enforced in shelters^{40,41,44,52,98,100} or quarantine and isolation sites⁷⁴. Eight studies reported that some PEH were unable to follow social distancing guidelines^{12,25,33,39,46,88,94,103}, sometimes even despite markers indicating recommended spacing^{25,103}. Reluctance to follow and ambivalence regarding the importance of social distancing among PEH was noted in four studies^{12,23,25,93}. Physical distancing was enforced among some PEH accessing homeless support services in the U.S.⁹⁷, during health check-ups in Salamanca²⁰, and during interviews for a study in Spain²⁶ and encouraged among patients accessing a psychiatric emergency room in Los Angeles⁵¹ and shelter residents in Washington State⁵⁵. One study in Ireland reported accommodation services were expanded to support social distancing¹⁰¹. Henwood et al.⁸⁵ reported that among PEH living in Skid Row, those living in single room occupancies and those with mental health conditions were nearly half as likely to report consistent social distancing than those in studios. In a study by Kuhn et al.⁸⁷, 42% of PEH reported high COVID-19 protective behaviour, measured by frequency of wearing a mask, washing hands, distancing from others, and avoiding touching their face.

Access to Food

There were mixed impacts of the COVID-19 pandemic on access to food for PEH. Three studies reported unmet need for food during the pandemic^{85,97,111}. Riley et al.¹¹¹ measured subsistence needs, defined as insufficient access to food, clothing, housing, or hygiene resources, and found that 66% of women experiencing homelessness in the study had at least one unmet subsistence need. Additionally, when asked if they would be able to shelter in place for 14 days if needed, 45% of PEH in a study in Los Angeles responded no, with 91% citing lack of food as a reason⁸⁵. Three studies reported finances as a barrier to PEH accessing food^{88,93,94}. In addition, five studies reported that food services for PEH were reduced or halted because of COVID-19^{12,25,97,102,109}; three reported that these were closed or limited because of risk of virus transmission among PEH accessing services^{12,25,102}, and two did not provide specific reasons for closure^{97,109}. Several studies noted that COVID-19 reduced access to food for PEH^{12,13,88,94,112}. In a study by Tucker et al.⁸⁸, 54% of PEH indicated that the pandemic made it harder to get enough food to eat. In a large city in France, when compared with PEH in shelters, persons sleeping rough were significantly more likely to have difficulty accessing food (24% vs. 60%) and water (5% vs. 39%) as a result of the pandemic¹³. The same study noted that access to food assistance was especially reduced for those more recently homeless compared with those living rough or in slums longer, who had established networks¹³. In Scotland, restrictions on movements limited options for some PEH, who were no longer able to travel to places with cheaper food¹¹². Transportation barriers were also noted in a study by Gaeta et al.⁷⁴.

Some articles did report examples of food needs being met, or even improving, as a consequence of the pandemic. Two studies reported outreach services were able to meet food needs for PEH^{60,109}, and one study noted that several participants felt they had easier and more regular access to food due to the support received during the pandemic⁹⁹. It was also frequently noted that meals were provided to individuals as patients^{41,58,72,74,101} or residents of temporary accommodation^{25,26,33,46,53,58,67,71,94,96,98–102,112}. However, a report from Scotland explained that while asylum seekers were rehoused into hotels and provided meals, the food was often poor in nutrition or culturally inappropriate, leading to malnourishment and mental health issues¹¹². In Ireland, PEH in temporary emergency accommodation felt that the lack of cooking facilities was a barrier to eating proper meals, and several suggested improved quality and frequency of meals¹⁰¹.

Substance Use

Active substance use among PEH during the pandemic was noted in 36 studies^{8,11-13,20,23,25,26,38,47,51,61,62,68,72,76,81,82,84,88,89,92,94,96,99,101-104,107,108,110,113-115}. Substances used included alcohol^{8,13,23,25,26,47,61,62,68,72,82,84,88,89,94,99,101,102,108,110,115}, tobacco^{8,12,13,38,61,62,68,88,108}, cannabis^{23,26,51,62,88,108}, cocaine^{26,51,62,72,113}, methamphetamines^{72,104,114}, heroin^{62,99,113}, stimulants^{108,110,113}, unprescribed benzodiazepines^{23,72,113}, fentanyl^{104,113}, amphetamines⁵¹, and gamma-hydroxybutyrate (GHB)¹⁰⁸. An additional four studies noted general opioid use^{26,72,108,113}, and 17 reported current substance use without further specification^{11-13,20,25,38,47,61,68,76,92,96,101-103,107,110,114}. Increased use of substances was reported in four studies^{20,23,88,104}. Increased use of marijuana (28%), tobacco (20%), and alcohol (20%) during the pandemic was reported by some young PEH (18–25 years old) in Los Angeles⁸⁸. In Scotland, the emotional impact of lockdown, isolation, and reduced support services contributed to increased drug use among some PEH²³. Similarly, individuals in a study by Scallan et al.¹⁰⁴ reported increasing substance use following loss of housing supports. Aguilar et al.²⁰ reported an increase in relapses among PEH during the first ten weeks of confinement in Spain, though this finding was reported in the discussion only, and supporting data was not available. One study reported reduced drug use among some PEH was facilitated by increased privacy and sense of safety they experienced since shielding or self-isolating in emergency accommodations¹⁰¹.

Many included studies discussed access to substance use treatment for PEH during the pandemic. Treatment was reported as available in 22 studies^{8,12,20,23,25,26,51,58,65,72,85,88,93,97,99,101,102,105,107,108,113}, and access or uptake was noted as improving in 12 studies^{23,25,26,72,88,97,99,102,104,107,108,113}. Tucker et al.⁸⁸ reported that 13% of young PEH (18–25 years old) in their study found substance use services easier to access since the onset of the pandemic. Nine studies noted that access to treatment improved within the context of accommodation services^{23,26,58,72,99,101,104,107,108}, five of which specifically noted that PEH initiated treatment for the first time within the service^{23,72,99,101,108}. Participants in a study by Pixley et al.⁹⁷ reported that PEH were more open and accepting to substance use treatment following the rollout of alternative services and improved housing standards in non-congregate sheltering. Both Fitzpatrick et al.¹⁰² and Parkes et al.²³ reported that reduced financial support from the public led PEH to seek prescription medication rather than illicit substances. The use of telehealth to support treatment was noted in seven studies^{20,25,65,101,107,108,113}. Preventative measures implemented for fatal overdoses among PEH were reported in two studies, with both reporting no fatal overdoses at the time of the studies^{72,108}.

Five studies discussed reduced access to substance use treatment services during the pandemic^{12,23,25,88,101}, three of which specifically noted that services for alcohol use disorders were limited^{23,25,101}. Tucker et al.⁸⁸ reported that 32% of participants in their study reported that accessing substance treatment services was harder since the onset of the pandemic. Service providers

interviewed by Rodriguez et al.¹² also expressed concerns regarding PEHs' access to substance treatment, with some noting that reduced addiction treatment services led some individuals to relapse. Another study in California by Appa et al.⁹² reported that fatal overdoses increased among PEH in the eight months following the onset of the pandemic (defined as 17th March 2020) compared with the eight months prior.

Mental Health

Numerous studies discussed the impact the pandemic has had on PEH's mental health. Poor mental health was reported in five studies^{51,84,101,111,115}. A survey of PEH in Hamburg revealed that 32% of PEH had problems with anxiety or depression and that those with health insurance had lower odds of experiencing these conditions¹¹⁵. Another study using the same dataset from Hamburg reported that 49% of those surveyed felt lonely, with increased loneliness associated with male gender, being single, originating from Germany, high frequency of sharing a sleeping space with more than three people, and a higher self-perceived risk of contracting COVID-19⁸⁴. In San Francisco, 55% of women experiencing homelessness and unstable housing had depression, and 42% had anxiety; factors significantly associated with depression and anxiety included recent homelessness, unmet subsistence needs, and social isolation¹¹¹. Increased difficulties accessing care for chronic medical conditions also increased risk of screening positive for anxiety more than threefold, and for depression, sixfold¹¹¹. Cardenas et al.⁵¹ reported that the majority of individuals presenting to a psychiatric emergency room in Los Angeles were PEH.

Nine studies indicated that the pandemic led to poorer mental health outcomes among PEH^{12,20,23,25,88,94,96,97,101}. Disruptions to routines¹², feelings of loneliness^{88,94,96,101}, exclusion, confinement,⁹⁴ nervousness,^{94,101} hopelessness⁸⁸, exacerbation of pre-existing mental health problems²³, and reduced access to services and counselling^{12,101} were all seen as contributing to negative mental health during the pandemic. In temporary emergency accommodations in Ireland, 39% of PEH surveyed in May and June 2020 reported worse mental health than one year prior, and 21% self-harmed, attempted suicide, or had suicidal thoughts in the past month¹⁰¹. Aguilar et al.²⁰ reported increased psychological destabilisation among PEH during the first ten weeks of confinement in Spain, though supporting data for this finding were not available. Three studies noted mental health improving for some PEH during the pandemic^{96,101,116}. In Turin, Leonardi and Stefani⁹⁶ described how night shelters that shifted to 24/7 services became residential communities, providing stability and improving mental health for some residents. A study by the Irish Health Service Executive (HSE)¹⁰¹ reported that 39% of PEH surveyed in emergency accommodations self-reported improved mental health compared with one year prior; increased privacy, sense of safety, and rebuilding relationships with family since shielding or self-isolating was noted by some as contributing to improved mental health. Additionally, a positive association was found in changes in moderate or total physical activity and mental well-being and self-esteem among young (PEH 16–24 years old) between the four weeks before and after the initial lockdown in the UK in a study by Thomas et al.¹¹⁶.

Access to mental health services was addressed in 11 studies^{23,25,26,58,67,72,88,97,99,101,106}. Of these, five indicated that mental health support was provided within temporary accommodations^{58,67,72,101,106}, and four indicated that PEH's access to support improved during the pandemic

^{25,26,99,101}. Parkes et al. ²⁵ reported that telephone and online support groups helped PEH in Scotland to maintain and improve their mental health. In a temporary shelter in Spain, significantly more patients were prescribed psychotropic drugs by the end of the programme than at the beginning (82% vs. 59%, respectively) ²⁶. Aitken ⁹⁹ reported that hotel accommodation provided a safe space for PEH experiencing mental health conditions and increased willingness to engage with support. Two studies reported that some PEH were discharged to mental health programmes after leaving temporary accommodations ^{26,72}. Unmet need for mental health services was noted in five studies ^{13,23,88,97,101}. In France, 24% of PEH in a study by Allaria et al. ¹³ reported unmet mental health needs, with the highest unmet need reported among those sleeping rough (33%), and the lowest, among those living in squats (17%). Parkes et al. ²³ reported that telephone and online support groups were not enough to offset increased social isolation due to the pandemic. Similarly, Pixley et al. ⁹⁷ noted barriers to accessing online support among PEH. In Ireland, some PEH in temporary accommodations noted that they were unable to access their psychiatrists and that provided mental health services could be improved ¹⁰¹. A study in Los Angeles by Tucker et al. ⁸⁸ reported that 44% of young PEH (18–25 years old) felt that accessing mental health counselling was more difficult since the onset of the pandemic.

Access to Health Services

Beyond healthcare directly related to COVID-19, substance use, or mental health, several studies discussed PEH access to healthcare during the pandemic. Seven articles reported unmet health needs ^{12,13,65,101,115,117,118}. In Marseille, France, 17% of PEH reported unmet physical health needs, with the highest unmet need reported among those in shelters (21%), followed by those living rough (18%) and in squats (12%) ¹³. Van R uth et al. found that only 69% of PEH living in Hamburg during the pandemic reported having health insurance ¹¹⁵. In Ireland, 32% of surveyed PEH in temporary emergency accommodations did not have an up-to-date care plan, and 15% did not know ¹⁰¹. Substantially fewer PEH in county Dublin (35%) reported having an up-to-date care plan than in Galway, Limerick, Clare, and Tipperary (70%) ¹⁰¹. For some, the large shift toward telemedicine was a barrier to health services. In Indiana, PEH were unable to avail of telehealth services because of lack of access to phones, computers, or places to charge or store devices ¹². Another study found that U.S. veterans experiencing homelessness were 11% less likely to use video care during the pandemic than those not experiencing homelessness ¹¹⁷. Similarly, Hickey et al. ⁶⁵ reported that PEH accounted for 9% of those reached prior to a scheduled telehealth visit and 17% of those not reached. At a large HIV clinic in San Francisco, Spinelli et al. ¹¹⁸ reported that PEH were offered telehealth visits significantly less often than the average population (32% vs. 54%, respectively) and had fewer no-shows during shelter-in-place (1st–30th of April, 2020) than the average population pre-shelter-in-place (December 1st 2019 to the 29th of February 2020), and that viral non-suppression was higher among PEH during the pandemic than before. Barriers to primary healthcare were also exacerbated by the pandemic, with PEH in Edinburgh being turned away from the A&E for problems unrelated to COVID-19 and unable to meet with general practitioners (GPs) or access wound care, sexual health, or dentistry services ²³. Reduced access to STD services such as condoms, testing, or PrEP due to the COVID-19 pandemic was also reported in a Los Angeles-based study ⁸⁸.

While some articles described unmet healthcare needs among some PEH, eight studies reported instances in which health needs of PEH were supported during the pandemic ^{25,60,71,99,100,107,109,114}. Three studies described medication delivery for PEH; two described this in relation to enabling PEH to shield ^{25,71}, while the third delivered prescriptions to PEH who were isolating with COVID-19 ¹⁰⁷. In addition to prescription delivery, PEH isolating in care sites in Chicago were supported through telehealth visits and transportation to and from outpatient haemodialysis ¹⁰⁷, and those residing in three shelters on the Slovakia borders received regular GP visits ⁷¹. Some patients admitted to an Intermediary Care Unit in Edinburgh for recovery from acute illnesses were able to reengage with primary care, access hepatitis-C treatment, or receive care for chronic health conditions ⁹⁹. One HIV clinic in San Francisco reported that the proportion of PEH visiting the clinic each month was similar before and during the pandemic

and that viral suppression did not worsen among patients¹¹⁴. In addition, 15% of the patients were temporarily housed in hotels, enabling navigators to conduct both phone and in-person outreach¹¹⁴. An intervention for persons living with HIV with experience of homelessness in Boston provided phones to patients without devices, facilitating biweekly contact to ensure that medical and prescription needs were met⁶⁰. The intervention found that 57% of patients that were unhoused kept their appointments with their HIV primary care providers, though this was a significantly lower proportion than among those who were currently housed (75%)⁶⁰. Redondo-Sama et al.¹⁰⁹ described collaboration between social workers and health services, enabling advocacy for vulnerable patients, and Brown and Edwards¹⁰⁰ reported that health support was delivered to unsheltered homeless encampments in California by the Emergency Operation Centre, though details of the health support were not provided.

In some cases, the pandemic improved access to health services for PEH. Some residents of temporary emergency accommodation in Ireland reported accessing new supports, such as primary care services, on-site nursing, housing support, and project worker support¹⁰¹. The same study noted that the number of respondents engaging with keyworkers or case managers increased during the outbreak period (April–June 2020) compared with before September 2019–March 2020¹⁰¹. In England, homeless services' closer connections with the health services helped PEH to receive better health assessments¹⁰². In addition, some providers of HCV test and treat interventions for those temporarily housed in England reported that increased freedom and flexibility allowed them to provide clients all of their medication upon treatment initiation, reducing the consequences of losing contact while people moved between accommodations¹⁰³. Providers also felt that the lockdown and accommodations provided time and space for some PEH to reflect on and reengage with their health¹⁰³. A study by Cironi et al.⁹⁵ in New Orleans reported that 60% of those testing positive for HCV as part of a pilot programme among persons in COVID-19 temporary housing were previously unaware of their infection. The programme was therefore able to communicate diagnoses with residents and link them with follow-up care⁹⁵.

Other Health Impacts

A few studies explored other health impacts of the pandemic, such as violence^{97,105}, sense of safety¹⁰¹, physical activity^{101,116}, emergency department use^{101,105}, local health centre use, quality of life, and general health status¹⁰¹. Pixley et al.⁹⁷ explained that while domestic and interpersonal violence had been associated with homelessness and housing insecurity prior to the pandemic, new financial fears or fear of SARS-CoV-2 may prevent some individuals from leaving violent or abusive situations. A study by Riley et al.¹⁰⁵ noted that 33% of women experiencing homelessness or housing insecurity in San Francisco decided where to sleep based on avoiding violence during the pandemic. In Ireland, 70% of surveyed PEH in temporary emergency accommodation reported feeling safe or very safe in May and June 2020, and 46% reported feeling safer than they did one year prior¹⁰¹. Regarding physical activity, some participants in the same study in Ireland noted more appreciation for exercise in the emergency accommodations while others felt that not having a gym or facing difficulties walking negatively impacted their well-being¹⁰¹. Thomas et al.¹¹⁶ found that physical activity among young PEH (16–24 years old) generally increased in the UK during the four weeks following lockdown restrictions introduced in March 2020 compared with four weeks before. Increased physical activity following lockdown was significantly higher in participants considered ‘inactive’ prior to lockdown than in those considered ‘active’¹¹⁶. Riley et al.¹⁰⁵ reported that, unlike the general population, women experiencing homelessness and housing insecurity in San Francisco did not reduce emergency department use during the pandemic. Experiencing homelessness was significantly associated with emergency department use¹⁰⁵. In Ireland, visits to local health centres and the emergency department declined among PEH who were accessing emergency accommodations in most areas during the outbreak period (April–June 2020), except county Galway, where a 17% increase in emergency department use was reported¹⁰¹. In the same study, 54% of respondents described their quality of life as good, very good, or excellent; 28% described it as fair; and 18% self-reported poor or very poor quality of life¹⁰¹. Respondents also self-reported their general health status; 46% described it as better than one year prior, 34% reported it as worse, and 30% indicated no change¹⁰¹.

CHAPTER 4: Clinical Data Results



CHAPTER 4: FINDINGS FROM CLINICAL DATA

The following chapter presents the clinical data from service users accessing PMVT services:

The Total Population:

Table 2 describes the demographic information of the entire sample i.e. all persons admitted to PMVT during the specified period (N=2893). Percentage values reflect a percentage of the total population (N=2893), and where missing data occurs, values were not assumed. Due to this, factorial percentages in the same category may not add up to 100%.

Demographics: The average age was 42 years old, with 69% (n=2005) of the sample recorded as male, 30% (n=879) as female, and less than 1% (0.3%; n=1) as transgender. The majority (39%; n=1139) of the sample had a high level of English proficiency, while 7% (n=204) had limited English proficiency. Nationality was split as follows: Ireland (60%; 1735), rest of Europe (12%; n=339), Africa (8%; n=230), Asia (3%; n=78), United Kingdom (1%; n=17), the Americas (0.4%; n=14), and Oceania (0.1%; n=3).

PMVT COVID Services: Among the study population, 92% (n=2670) availed of PMVT Dublin Region Homeless Isolation services, 14% (n=415) went to HSE Isolation services only and 9% (n=256) availed of PMVT-Direct Shielding services. The average length of stay during the specified period was 32 days. On average, service users from this sample were admitted once. The most common local authorities for service users were located in Dublin city council (55%; n=1595), followed by Fingal County council (5%; n=145), other county councils (4%; n=107), and Dún Laoghaire-Rathdown County council (3%; n=85).

Nature of Homelessness: The most frequent period in which our sample experienced homelessness for the first time was more than 3 years ago (20%; n=568). This was followed by between 2-3 years ago (7%; n=210), and a year or less (5%; n=140).

However, the most common reasons for experiencing homelessness for the first time was due to family circumstances (11%; n=319), other unexplained reasons (9%; n=260), and substance use-related issues (6%; n=173). Alternatively, the least commonly reported reasons included family separation due to a person's sexual orientation (0.1%; n=3), being re-accommodated to direct provision services (0.1%; n=3), and separation from a partner (0.5%; n=15)/notice to quit (0.4%; n=12)/domestic violence (0.4%; n=11)/leaving hospital (0.3%; n=9).

Table 2: Demographic characteristics of the entire population studied (N=2,893). M=Mean; %=percentage value (where % is based on available data, and is % of total population N= 2893) SD=standard deviation; n=total number of people. The data was collected on the frontline during a global pandemic, thus not all variables were complete for all cases.

Variable	M/%	SD/n	Variable	M/%	SD/n
Age	42	15.4	Length of stay	32 days	81.4
18-24	11%	297	Number of clinical observations	12	9.8
25-34	27%	756	Number of times presenting to service	1.4	0.9
35-44	30%	844	Nationality:		
45-54	20%	574	Ireland	60%	1735
55-64	9%	255	Rest of Europe	12%	339
>65	3%	87	Africa	8%	230
Gender:			Asia	3%	78
Male	69%	2005	UK	0.7%	17
Female	30%	879	Americas	1%	14
Transgender	0.03%	1	Oceania	0.1%	3
Services attended:			Initial reason for homelessness:		
PMVT Dublin Region Homeless Isolation Services	92%	2670	Family Circumstances	11%	319
HSE Isolation Service	14%	415	Other	9%	260
PMVT - Direct Shielding Provision	9%	256	Substance Use Issues	6%	173
Booking type:			Asylum Seeker	3%	78
Ever booked as a confirmed case	60%	1710	Asked to leave Accommodation	3%	73
Ever booked for self-isolation	56%	1627	Leaving Prison	2%	64
Ever booked for cocooning/shielding	40%	1155	Evicted from Accommodation	1%	32
English proficiency:			Mental health condition	1%	26
Full English Proficiency	39%	1139	Leaving Care	1%	25
Limited English Proficiency	7%	204	Separation	0.5%	15
Local authority:			Notice to Quit	0.4%	12
Dublin City Council	55%	1595	Domestic Violence	0.4%	11
South Dublin Council	10%	282	Leaving Hospital	0.3%	9
Fingal County Council	5%	145	Family Separation – Sexual Orientation	0.1%	3
Other County Council Authorities	4%	107	Re-accommodation - Direct Provision	0.1%	3
Dún Laoghaire-Rathdown County Council	3%	85	First year of homelessness:		
			>3 years	20%	568
			2-3 years	7%	210
			0-1 year	5%	140

Population Subset: The High Needs Population (n= 488)

A descriptive and predictive analyses of information on service users identified by PMVT staff as having higher (complex, multifaceted) levels of need than other service users in our dataset was performed. These were people who required a greater amount of support from PMVT services (table 3). Percentage values reflect a percentage of the subset population (n= 488), and where missing data occurs, values were not assumed. Due to this, factorial percentages in the same category may not add up to 100%.

Demographics: In comparison to previous sample, the high-level needs subsample had an average age of 41 years, with 68% (n=333) noted as male, 32% (n=154) as female and 0.2% (n=1) as transgender. Interestingly, 42% (n=204) of our sample had full English proficiency, with the remainder (7%; n=32) having limited English proficiency. The majority experienced homelessness for the first time more than 3 years ago (20%; 104). 3% (n=17) experienced homelessness for the first time up to a year ago, while 6% (n=30) experienced homelessness between 2 and 3 years ago. The majority of this sample were located in the Dublin city council area (60%; n=295), followed by South Dublin (10%; n=49), Fingal (6%; n=27), and Dún Laoghaire-Rathdown or other council authorities in Ireland (3%; n=13). More generally, the most common nationality was Irish (78%; 382), followed by nationalities among the rest of Europe (10%; n=49) and Africa (6%; n=29).

PMVT COVID Services: In terms of bookings with PMVT, 96% (n=467) had ever stayed with PMVT Dublin Region Homeless Isolation Services, 15% (n=72) with PMVT HSE Isolation Service and 10% (n=47) with PMVT shielding services. In relation to booking types, 60% (n=292) had ever booked in for self-isolation, 38% (n=186) as confirmed case, and 20% (n=98) for cocooning/shielding. Average length of stay was 39 days and the average number of times people presented to services was twice that of our previous samples.

Supports Needed: The most common supports this subsample had access to were social supports (3%; n=15), safe practices (3%; n=14), and referral and links with specialised services/advocacy/commencing medication and compliance (3%; n=13). The least common supports included language (0%; n=0), family connection support (0.4%; n=2), and 1% had community connection support (1%; n=7) or activities of daily living (1%; n=5). 17% (n=81) had a history of rough sleeping, 3% (n=13) were in care, and 4% in custodial (n=20).

Substance use: In terms of substance use, 11% (n=56) admitted to being dependent on one substance, while 7% (n=33) were dependent on at least two of the substances listed. The most common of these were opiates (11%; n=54), followed by Benzodiazepines (10%; n=49) and Methadone (2%; n=12) or crack (2%; n=12). In terms of substance use treatments, 16% (n=80)

engaged in OST and 10% (n=50) engaged in prescribed Benzodiazepine medication prior to admission. Upon entry to PMVT, 12% (n=59) initiated Methadone OST, 10% (n=49) initiated Benzodiazepine stabilisation, 7% (n=32) initiated Librium detox, and 0.2% (n=1) initiated Suboxone OST treatment while in-service over the study period.

Personal Health: 25% (n=121) had ever received a medical health condition diagnosis, while 5% (n=23) had ever received a dual diagnosis. The most common health conditions among this cohort were being at risk of seizure (18%; n=88), depression (5%; n=25), and asthma (4%; n=20) or epilepsy (4%; n=19).

Table 3. Demographics of high-level needs subsample only (n=488). M=Mean; %=percentage value (where % is and based on available data and is the % of the total subsample (n=488); SD=standard deviation; n=total number of people. The data was collected on the frontline during a global pandemic, thus not all variables were complete for all cases.

Variable	M/%	SD/n	Variable	M/%	SD/n
Age	41	14.5	Scalar variables:		
18-24	8%	39	Number of clinical observations	8	12.0
25-34	30%	143	Length of stay	39 days	95.3
35-44	29%	140	Number of times presenting to service	2	1.6
45-54	21%	100	Substance dependency:		
55-64	9%	42	Dependent on one drug	12%	56
>65	3%	14	Dependent on at least two drug	7%	33
Gender:			Opiates	11%	54
Male	68%	333	Benzodiazepine	10%	49
Female	32%	154	Alcohol	8%	38
Transgender	0.2%	1	Methadone	3%	15
Services ever attended:			Crack	3%	12
PMVT Dublin Region Homeless Isolation Services	96%	467	Cannabis	2%	11
PMVT HSE Isolation service	15%	72	Cocaine	0.4%	2
PMVT shielding service	10%	47	GHB	0%	0
Booking type:			Health conditions:		
Ever booked for self-isolation	60%	292	Seizure risk	18%	88
Ever booked as a confirmed Case	38%	186	Depression	5%	25
Ever booked for cocooning/shielding	20%	98	Asthma	4%	20
Access to:			Epilepsy	4%	19
Social supports	3%	15	Anxiety	3%	16
Safe practices	3%	14	Schizophrenia spectrum disorders	3%	15
Advocacy	3%	13	High blood pressure	3%	12
Commencing medication and compliance	3%	13	Hepatitis C	2%	11
Referral and linked to specialised services	3%	13	Back problems	1%	7
Entitlements	2%	8	COPD	1%	7
Community connection support	1%	7	HIV	1%	7
Activities of daily living	1%	5	Diabetes	1%	7
Family connection support	0.4%	2	Personality disorder	1%	6
Language supports	0%	0	Bipolar disorder	1%	6
History of:			PTSD	1%	4
Medical condition(s)	25%	121	ADHD	1%	3
Rough sleeping	17%	81	Brain injury	0%	0
Dual diagnosis	5%	23	Detox:		
Custodial	4%	20	Engaged in OST prior to admission	16%	80
Care	3%	13	Methadone OST initiated in service	12%	59
English proficiency:			Engaged in prescribed Benzodiazepine prior to admission	10%	50
Full English Proficiency	42%	204	Benzodiazepine stabilisation initiated in service	10%	49
Limited English Proficiency	3%	32	Librium detox initiated in service	7%	32
Local authority:			Suboxone OST initiated in service	0.2%	1
Dublin City Council	60%	295	Nationality:		
South Dublin County Council	10%	49	Ireland	78%	382
Fingal County Council	6%	27	Rest of Europe	10%	49
Dun Laoghaire Rathdown County Council	3%	13	Africa	6%	29

Other County Council Authorities	3%	13	Asia	2%	7
First year of homelessness:			UK	1%	4
>3 years	21%	104	Oceania	1%	3
2-3 years	6%	30	Americas	0.2%	1
0-1 year	3%	17	Number of times presenting to service	2	1.6
			Number of clinical observations	8	12.0
			Length of stay	39 days	95.3

Regression Analyses of the High Needs Population (n= 488):

Exact figures for table 4 are available in supplementary table 1. Below are example instructions or legends for how to read the results in colour coded tables to follow:

1. Significant results are marked by either an orange or green box;
2. Orange boxes mean there is a negative relationship between our predictor (listed in first column of table 2) and outcome variables (on top row of table 2);
3. Green boxes mean that there is a positive relationship between our predictor and outcome variables;
4. If boxes are blank (i.e. not green or orange), then there is no relationship between the two variables. Only significant relationships will be described.

Legend 1: Orange case examples for reading regression results.

Variable	Suboxone OST initiated in service	Methadone OST initiated in service	Librium detox initiated in service	Benzodiazepine stabilisation initiated in service	Drug dependency
Age					

In the first example (Legend 1), age is related to the initiation of Librium treatment and the stabilisation of Benzodiazepine. In both cases, this relationship is orange, meaning that younger persons were more likely to start Librium treatment and Benzodiazepine stabilisation while in service with PMVT.

Legend 2: Green case examples for reading regression results.

Variable	Suboxone OST initiated in service	Methadone OST initiated in service	Librium detox initiated in service	Benzodiazepine stabilisation initiated in service	Drug dependency
Age					

In Legend 2, the relationship is now green. This means that older service users were more likely to start Librium treatment and Benzodiazepine stabilisation while in PMVT service.

The following sections will consist of the results of the logistic regression accompanied by a brief description of what these results mean.

Subset Analysis results:

Below is a list of only significant factors listed after each outcome variable from our previous analyses on people who attended service with *higher level of needs*.

Suboxone OST initiated in service

Those who had access to safe practices were more likely to commence Suboxone treatment while in PMVT.

Methadone OST initiated in service

Service users who had booked into PMVT Dublin Region Homeless Isolation Services were less likely to initiate Methadone OST treatment, while those who booked into PMVT shielding service or ever booked in for a self-isolation or cocooning/shielding were more likely to initiate Methadone OST.

Those who had access to supports, entitlements, medication and compliance support, community connection supports, activities of daily living, referral and linked to specialised services or social supports were also more likely to initiate Methadone OST. Having a lower level of English, history of rough sleeping, care, custodial, and dual diagnosis was also predictive of initiating Methadone treatment. Diagnosis of a number of health conditions (i.e. personality/bipolar/depressive/post-traumatic disorder, asthma, back problems, HIV, hepatitis C, seizure risk) were associated with initiating Methadone treatment.

Finally, individuals from the UK, those who did not have access to advocacy, or service users with a higher length of overall stay within services were less likely to initiate Methadone treatment.

Librium detox initiated in service

Older service users or those who were booked as confirmed case were less likely to engage in Librium detox at PMVT.

Those who had ever booked in for self-isolation were more likely to initiate Librium detox treatment in PMVT. Additionally, those with a history of rough sleeping, custodial, or dual diagnosis were more likely to initiate Librium detox while in service at PMVT. Service users who had depression, anxiety, or high blood pressure were more likely to initiate Librium detox. In

addition, those who initially experienced homelessness due to their mental health or separation from a partner were more likely to require Librium detox with PMVT.

Benzodiazepine stabilisation initiated in service

Similar to Methadone initiation results, those had access to advocacy were less likely to initiate Benzodiazepine treatment.

Those who presented for self-isolation were more likely to initiate Benzodiazepine stabilisation. Access to a variety of the supports (entitlements, commencing medication and compliance, community connection support, activities of daily living, referral and linkage to specialised services, safe practices and social supports) indicated service users were more likely to initiate Benzodiazepine stabilisation. Further, all health conditions except for anxiety or high blood pressure (i.e. personality/schizophrenia spectrum/bipolar/depressive/post-traumatic disorder, asthma, back problems, HIV, epilepsy, hepatitis C, seizure risk) were predictive of initiating Benzodiazepine treatment.

Drug dependency

Only one factor was predictive of having a drug dependency among this subgroup. Those who booked in as cocooning/shielding were less likely to report being dependent on drugs.

Table 4. Relationships between predictors and outcomes of subset-2 (high-level needs) only (n=488).

Variable	Suboxone OST initiated in service	Methadone OST initiated in service	Librium detox initiated in service	Benzodiazepine stabilisation initiated in service	Drug dependency
Age					
Services ever attended:					
PMVT Dublin Region Homeless Isolation Services					
PMVT shielding service					
Booking type:					
Ever booked for self-isolation					
Ever booked as a confirmed Case					
Ever booked for cocooning/shielding					
Access to:					
Entitlements					
Advocacy					
Commencing medication and compliance					
Community connection support					
Activities of daily living					
Referral and linked to specialised services					
Safe practices					
Social supports					

Variable	Suboxone OST initiated in service	Methadone OST initiated in service	Librium detox initiated in service	Benzodiazepine stabilisation initiated in service	Drug dependency
History of:					
Rough sleeping					
Care					
Custodial					
Has dual diagnosis					
English proficiency:					
Limited English Proficiency					
Scalar values:					
Length of stay					
Health condition:					
Personality disorder					
Bipolar disorder					
Anxiety					
Schizophrenia spectrum disorder					
Depression					
High blood pressure					
PTSD					
Asthma					
Back problems					
HIV					
Epilepsy					
Hepatitis C					
Seizure risk					
Nationality:					
UK					

Chapter Summary

Total Population: This study examined 2,893 service users accessing PMVT services for homelessness in Ireland. The average age of the participants was 42, with a majority being male (69%). The most common nationality was Irish, and Dublin councils were the primary source of cases. Most individuals experienced homelessness within the past three years, with family circumstances being the main cause. The study also explored subsamples of those who attended on multiple occasions and those with higher needs. These subsamples showed variations in demographic characteristics, health conditions, substance use, and engagement with detox treatments. The length of stay and number of clinical observations also differed among the subsamples.

Nature of Homelessness: most of the participants had experienced homelessness for the first time within the past year or less (5%, n=140). A considerable portion reported experiencing homelessness 2-3 years ago (7%, n=210), while the remaining individuals had been homeless for over three years (20%, n= 568). Family circumstances were the most frequently cited reason for initial homelessness, whereas reasons related to sexual orientation and being re-accommodated to direct provision sites were the least common (0.3% each). On average, the participants had undergone 12 clinical observations, and their average length of stay with the Primary Medical and Vocational Training (PMVT) programme was 32 days.

Subsample The subsample with Higher Level of Needs (n=488): The average age for this cohort was 41 years, with 68% identifying as male, 32% as female, and 0.2% as transgender. 78% (n=382) of these reported as Irish nationality. Only 17% of these individuals had a history of rough sleeping, indicating that the majority had not experienced prolonged periods of street homelessness. Additionally, 25% of the subsample had been diagnosed with a medical condition, and 5% had a dual diagnosis. Seizure risk remained the most commonly reported health issue (18%), while brain injury was the least frequently reported condition (0%).

Substance use in Subsample: 12% (n=56) of the subsample reported being dependent on one substance, while 7% (n=33) reported dependence on at least two substances. Opioids were the most reported substance of dependence (11%, n= 54), whereas GHB had the lowest prevalence (0%). Among those who engaged in detox treatment, 16% (n=80) utilised OST, and 10% (n=50) engaged in Benzodiazepine treatment before admission to the PMVT programme. During their stay in the programme, 12% (n=59) initiated Methadone OST, 10% (n=50) initiated Benzodiazepine treatment, 7% (n=32) initiated Librium, and 0.2% (n=1) initiated Suboxone OST. The number of clinical observations for this subsample was reduced to approximately four on average. Moreover, the average length of stay decreased to 39 days compared to the total sample.

Conclusion: The findings of this study provide valuable insights into the characteristics and needs of service users accessing PMVT services for homelessness in Ireland. The results highlight the complexity and diversity within the homeless population, with variations observed in demographic profiles, health conditions, and substance use patterns. These findings emphasise the importance of tailored interventions and support services to address the specific needs of different subgroups within the homeless population. The study underscores the significance of continued research and comprehensive approaches to combat homelessness and improve outcomes for PEH in Ireland.

Recommendations:

1. **Enhancing Supportive Services and Tailoring Interventions for Subgroups:**

Recognise and address the diverse needs of PEH by strengthening and expanding support services. Tailor interventions to address the specific needs of different subgroups within the homeless population, such as individuals with a history of rough sleeping or those with higher levels of gender, trauma, psychological, and cultural needs. Implement specialised outreach programmes and case management services, and expand coordinated efforts among healthcare providers, social services, and community organisations to meet the unique challenges faced by those with complex needs.

2. **Addressing the Needs of Individuals with Higher Levels of Needs:** For individuals with complex medical conditions, mental health disorders, or co-occurring substance use disorders, a comprehensive and coordinated approach is crucial. Specialised teams consisting of healthcare professionals, mental health specialists, and social workers should collaborate to develop individualised care plans. Integrated care models can provide holistic support, facilitate access to appropriate resources, and ensure seamless coordination and continuity of care.

3. **Integrated Health and Social Inclusion:** Implement an integrated approach that combines healthcare, mental health support, and social services for PEH. Foster collaborative efforts among healthcare professionals, social workers, and community organisations to ensure comprehensive care that addresses underlying complex health issues and provides the necessary support for mental well-being.

4. **Develop Substance Use Disorder Treatment:** Recognise the high prevalence of substance use disorders among homeless populations captured in the study and prioritise accessible and evidence-based substance use treatment programmes. Expand options for opioid substitution therapy (OST), in particular, the suboxone programme detoxification and peer support services.

5. **Develop Gender-Responsive Services and Assessments:** Develop gender-responsive services that recognise and address the unique needs and experiences of diverse genders within the homeless population, including women, transgender individuals, and non-binary individuals. Conduct comprehensive needs assessments to collect disaggregated data and understand the specific challenges faced by each gender. Allocate resources and develop targeted interventions accordingly.

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6. **Safe and Gender-Inclusive Accommodation:** Ensure the availability of safe and gender-inclusive accommodation options for all individuals experiencing homelessness. Provide designated accommodation for women, transgender individuals, and non-binary individuals, considering privacy, safety, and comfort. Accommodation should be accessible, free from discrimination, and equipped with appropriate facilities, such as gender-neutral bathrooms and showers, to meet diverse needs.
 7. **Trauma-Informed Gender-Specific Support:** Integrate trauma-informed gender-specific support into service provision, recognising that women, transgender individuals, and non-binary individuals may have unique experiences of trauma, violence, and discrimination. Provide specialised support services, including trauma-informed counselling, peer support, and advocacy, tailored to the specific needs of each gender. Collaborate with community-based organisations and specialist services to ensure comprehensive care.
 8. **Culturally and Linguistically Sensitive Services:** Ensure that services are culturally and linguistically sensitive to meet the needs of diverse populations accessing homeless services. Recognise the intersectionality of culture with identities, race, ethnicity, religion, and language. Engage with community organisations, provide interpretation services, and employ staff knowledgeable about cultural nuances and specific needs of communities and cultures accessing homeless services.
 9. **Gender-Specific Outreach and Engagement:** Implement gender-specific outreach and engagement strategies to effectively reach and support individuals of different cultures experiencing homelessness. Tailor outreach efforts to address unique barriers and vulnerabilities, including safety concerns, information on available services, and building trust. Employ outreach workers with lived experience or specialised training in engaging with those with gender, trauma, or cultural needs.
 10. **Training and Capacity Building:** Provide training opportunities for service providers to enhance their understanding of gender diversity and deliver gender-responsive services. Address gender sensitivity, cultural competency, and the specific needs and experiences of different genders. Include training on gender-based violence, trauma-informed care, and the impact of social determinants on gendered experiences of homelessness.
 11. **Collaboration with Gender, Trauma and Culturally Specific Organizations:** Foster collaboration and partnerships with Gender, Trauma and Culturally Specific

Organizations: and community groups addressing the needs of women, transgender individuals, and non-binary individuals experiencing homelessness. Ensure coordinated and comprehensive service provision grounded in the expertise of organisations with a deep understanding of gender-related issues.

12. **Regular Evaluation and Feedback:** Regularly evaluate the effectiveness of Gender, Trauma and Culturally Specific services through feedback from service users and ongoing monitoring of outcomes. Incorporate feedback from diverse genders within the homeless population into service improvement efforts.
13. **Support Ongoing Research and Evaluation:** Promote continuous research and evaluation to inform evidence-based practices and policies. Regularly monitor and evaluate interventions and services to identify gaps, measure effectiveness, and guide future improvements in addressing homelessness and associated challenges.
14. **Evaluation and Continuous Improvement:** Regularly evaluate interventions targeting subgroups to assess effectiveness and identify areas for improvement. Collect data on outcomes, service utilisation, and participant satisfaction. Seek ongoing feedback from individuals within subgroups to ensure interventions are responsive. This iterative process contributes to the refinement and optimisation of interventions tailored to subgroups within the homeless population.

Implementing these recommendations requires a comprehensive and multi-faceted approach involving policy changes, increased funding, community engagement, and collaboration among various stakeholders. Prioritizing these recommendations can significantly progress in addressing homelessness, improving outcomes, and promoting social inclusivity and well-being for individuals experiencing homelessness in Ireland.

By enacting these detailed recommendations, tailored interventions can effectively address the specific needs and challenges faced by subgroups within the homeless population. This targeted approach acknowledges the diverse experiences of individuals experiencing homelessness and aims to provide appropriate support and resources to improve their outcomes and well-being.

CHAPTER 5: Service Provider Perspectives



CHAPTER 5: FINDINGS FROM INTERVIEWS WITH SERVICE PROVIDERS

Experiences and Challenges of Staff Providing Services during the COVID-19 Pandemic: A Qualitative Analysis

Introduction

This qualitative analysis aims to explore the experiences and observations of staff members working in various roles during the COVID-19 pandemic. Through thematic analysis of interview transcripts, several key themes were identified, shedding light on the impact of the pandemic on their work and the challenges they faced. Each theme is supported by relevant quotes from the interviewees, providing valuable insights into their perspectives and experiences.

Interviewee Profile:

The staff interviewed encompassed a wide range of roles and experience levels, including both long-term employees and those newly hired during the pandemic. Their roles varied from front-line support work to clinical and managerial positions, offering a diverse perspective on the challenges faced in delivering services during the pandemic.

Theme 1: Initial Lack of Knowledge and Preparedness

The first theme identified is the initial lack of knowledge and preparedness among staff accommodating for individuals who tested positive for COVID-19. The interviewees acknowledged the difficulties faced during the early stages of the pandemic when they had to learn on the go and lacked expertise in managing COVID-positive individuals.

"At the beginning, it was just learning as we went... but now thankfully we're much more expert at what we're doing..."

This quote highlights the initial challenges faced by staff and their subsequent development of expertise to improve their response to COVID-19 cases.

Theme 2: Challenges in Managing COVID-Positive Individuals with Complex Needs

The second theme reflects the challenges faced in managing COVID-positive individuals with complex needs, particularly those who use drugs. The interviewees describe the difficulties that came with the restrictions that prevented individuals from leaving the premises. They also mention the non-compliance with protocols and guidelines and the struggles encountered when relocating individuals to different hospitals. The following quote illustrate this theme:

"We didn't know how to deal with COVID-positive people; we were saying, 'Oh, no, just stay in your room. We will bring you everything you need, but they had all that time alone with only checks and food drops. These are people who don't deal well with isolation and loneliness".

This quote highlights the initial difficulties in managing COVID-positive individuals and the complexities associated with their unique needs and behaviours.

Theme 3: Challenges in Dealing with Aggressive Individuals

The third theme relates to the challenges faced when dealing with aggressive individuals who resisted being confined to their rooms. The interviewees describe instances where individuals vehemently denied having COVID-19, making it challenging for staff members to enforce necessary precautions or protocols. This often resulted in the release of these individuals without any recourse.

"If you tried to hold somebody, they could fight back, and they would be like, 'I don't have COVID, I don't have COVID,' and you would have to let them go, and there's nothing you could do".

"Making sure everyone did what they were supposed to was very hard sometimes like people would not do what was expected and what can you do...but ask we were trying our best, but if you pushed, they would kick off".

These quotes shed light on the difficulties faced by staff when dealing with aggressive individuals who denied their COVID-19 status, posing challenges to infection control measures and compounding the pressure on staff.

Theme 4: Complex Needs and Services Provided

The fourth theme highlights the diverse and complex needs of individuals experiencing homelessness and addiction during the pandemic. Interviewees discuss the various services provided, including food, risk assessments, wound dressings, and other support services.

An interviewee who was working as a trained PMVT healthcare professional acknowledges the diverse and complex needs of the individuals they serve, ranging from food requirements to risk assessments and wound dressings. They describe the initial chaotic period when they had to address a wide range of needs. However, their dedication and persistence enabled them to establish the necessary systems to handle such demands effectively. This emphasises the comprehensive support provided to individuals, addressing various aspects of their well-being during the pandemic:

"Loads of it wasn't new, well, except COVID, but it was everything that people needed daily. It was a lot."

"There was a lot to do for people to support addiction, mental health, homelessness and Covid! and try to keep everyone safe".

The interviewee recognises the comprehensive range of needs individuals have beyond just addressing COVID-related concerns. They highlight the initial challenges faced in meeting these needs during the chaotic period but also emphasise the successful establishment of systems to address them effectively.

Theme 5: Support for Low-Threshold Individuals

The fifth theme highlights support for those with low thresholds. The interviewees explain that their focus was on providing support to individuals with addiction and mental health needs, particularly those categorised as "low threshold." Low-threshold individuals refer to those who may face multiple challenges and barriers to accessing traditional support systems, requiring specialised assistance:

"We were supporting individuals who would fall into the category of low threshold, who had identified addiction and mental health needs."

This interviewee described their target population and highlights the importance of tailored support for individuals facing multiple challenges. They recognise the specific needs of low-threshold individuals and the importance of providing appropriate assistance to address their addiction and mental health concerns.

Theme 6: Isolation and Infection Control Measures

The interviewees were involved in isolation services where individuals suspected or confirmed to have COVID-19 were separated into different buildings. This was a condition that was Covid specific and an addition to the complexities of the day-to-day job:

"It was an isolation service. So, anybody that was suspected of having COVID, we'd put into... one building, and people who have confirmed COVID into two buildings, that was that."

"This [isolation] was new. A Covid thing. We never had anything like this before. It was a strange thing but what could we do"

The interviewee describes the implementation of isolation measures to separate individuals based on their COVID-19 status. They acknowledge the challenges faced due to the pandemic and the need to ensure adequate infection control measures in providing a safe environment.

Theme 7: Staffing Issues, Burnout, and an Unpredictable Environment

The interviewees observations regarding staffing issues provide insights into the challenges faced by the healthcare team, including understaffing and its subsequent impact on mental health and burnout among team members. These observations underscore the unsustainable nature of the workload due to COVID-19 and the potential consequences for both staff well-being and the quality of care provided during this period.

The interviewees described the strain experienced by the healthcare team. The excessive workload and demanding nature of their responsibilities led to burnout among the staff:

"And like, we were like the Fantastic Four except there were 10 of us... people burnt out because it was really, it wasn't sustainable for anybody."

"We were pulling out all of the stops. Day after day, and there was never any clear end in sight; like we knew something had to give, we were supposed to have teams of double what we actually had. Staff were getting sick themselves, like how can you sustain this?"

Variations in staffing levels further exacerbated the challenges faced by the healthcare team, particularly during the initial stages of the pandemic. One interviewee recounted instances where they would be informed that seven staff members would be present, but only three would actually be available. This unpredictability and shortage of staff placed additional strain on the team, compromising their ability to deliver optimal care.

"During the days, as our staff members would vary... we might be told that we're going to have seven staff on the day and only have three."

Interviewees reflect on their experience of a constantly changing and demanding work environment characterised by unpredictability and high levels of activity. The healthcare team faced daily challenges, unsure of what to expect each day. The workload ranged from busy to extremely hectic, with some days being particularly overwhelming.

"It seemed like every day...you wouldn't know what to expect...it could be really busy, like really, really hectic...every day some days we'd have days...often we were just flat to the mash hectic".

The demanding work environment took its toll on the healthcare team, particularly on relief staff who were thrown into such a fast-paced setting. The interviewee expressed that relief staff, while essential, were insufficient in number to handle the workload. As a result, these staff members often struggled to cope with the demands placed upon them. The interviewee remarks:

"People burnt out...relief staff...being thrown into a service that's really hectic...they tend to be...glad to have them there. But you'd need probably two relief staff to do the work, but it wasn't possible, and people were not prepared...well, I suppose no one could be."

Theme 8: Additional Challenges for People Who Use Drugs

The interviewees highlight the challenges faced when providing support to PEH with addiction issues during the pandemic. The sudden isolation and limited substance access posed difficulties for this vulnerable population, requiring alternative strategies and resources. Interviewees also highlight the negative impact of such transitions on individuals with addiction and the potential disruption of their stabilisation progress:

"The low threshold users, so people that are really chaotic, and they ended up getting moved to different hospitals, often without warning or consultation, which was traumatic and completely unsettling..."

Theme 9: The Impact of the Pandemic on PEHs' Mental Health

The interviewees acknowledged the profound impact of the pandemic on the mental health of PEH, highlighting the presence of fear and uncertainty. During the initial wave of the pandemic, the unknown circumstances and the heightened fear associated with the virus affected the homeless population, particularly those with existing health issues. This heightened fear further exacerbated their mental health challenges:

"During the first wave, it was very much so unknown, unknown quantity, a lot of fear was a lot of people, and particularly the homeless population who have ongoing health issues, who were very frightened..."

Furthermore, the interviewees attested to the toll the pandemic took on the mental health of the healthcare team. The immense pressure, uncertainty, and challenges of providing care in a pandemic context had adverse effects on the well-being of staff members. Some struggled to cope with the overwhelming circumstances, leading to a decline in their mental health.

"I had staff that simply couldn't cope with it all. Their mental health took a dip, and they were really affected"

Theme 10: Positive Impacts of the COVID Response

Despite the challenges, many interviewees noted positive outcomes resulting from the pandemic response, particularly regarding access to opiate substitution therapy. They observed improved timelines for individuals to access necessary medication, indicating a flexible response from addiction services. This improved access likely had positive implications for individuals managing addiction during the pandemic.

As stated by one interviewee:

"We have definitely seen an improvement in regard to the time periods in which one can access opiate substitution. It has been a very flexible response from the addiction services overall".

Another positive outcome highlighted by the interviewees is the ability to initiate methadone treatment promptly. The introduction of a specialised nurse empowered to prescribe methadone allowed for faster initiation of treatment for stable individuals. This development was considered a significant breakthrough, as individuals previously had to wait years to access this treatment.

"One of the really great things that happened was with methadone initiation. We were able for the head of nursing to prescribe methadone. She's like a special nurse of some kind. And some people were started on methadone if they were stable. This was massive for us people were years waiting before, and suddenly this was opened up."

The interviewees shared their observations regarding the positive impact of individuals having individual apartments during isolation. This change allowed clients to have a dedicated space, offering a sense of stability and autonomy. However, the interviewees also acknowledged variations in how clients managed their living conditions. While some clients took pride in their newfound independence and kept their living spaces well-maintained, others faced challenges in maintaining cleanliness and hygiene.

"Many participants enjoyed having their own little apartment in isolation...Some clients became very house proud very quickly".

“A lot of service users struggled with their apartments and maintained them. Normally this is the support that they would get from the settlement teams; there was no time for that in Covid”.

The provision of individual apartments to those in need ensured that everyone completing isolation had a place to stay. This support was crucial in ensuring the well-being of individuals and reducing the risk of further transmission.

As one interviewee explains:

“Anybody who completed isolation was assigned a bed somewhere, so everyone got helped; everyone had somewhere”.

The interviewees highlighted the positive experiences of many participants who appreciated having their own space during isolation. For some clients, having their own apartment allowed them to regain a sense of pride and responsibility.

Theme 11: Sense of Community and Support

The interviewees expressed their gratitude for the support received from various stakeholders, including the community, public health departments, and hospitals. This support played a crucial role in ensuring that the necessary resources were provided to meet the needs of the service users to maintain their well-being.

The collaborative efforts and support from the community, public health departments, and hospitals were instrumental in enabling the healthcare team to fulfil their responsibilities effectively. The interviewees highlight the exceptional collaboration and response from the organisation and the larger community. They emphasise the positive impact of such collective efforts.

"We all worked together...there was a lot of good collaboration there; it was genuinely amazing the response of the organisation and the bigger community."

The interviewees further emphasised the organisational ethos and the unwavering commitment of the team members to meeting the needs of their clients. The shared dedication of the team has been a significant asset in providing ongoing support and services. Despite the challenges faced, this interviewee expresses pride in being part of an experience that overall had a positive impact.

"Our ethos.. . we need to do what we need to do in order to meet that need... everybody's commitment to doing what we did and continues to commit to doing what we're doing is something that was of massive benefit." They conclude by expressing their pride in being part of this experience"

Chapter Summary

In summary, the interviewees' insights reveal the additional challenges faced by PEH with addiction issues during the pandemic. The limitations on access to substances and the sudden changes in living conditions posed significant difficulties. Staffing issues, including understaffing, contributed to burnout among the healthcare team, further straining the provision of care. The hectic and unpredictable work environment added to the overall challenges. However, amidst these difficulties, positive outcomes emerged, such as improved access to opioid substitution therapy and a sense of community and support among the workforces. Individual apartments provided a positive impact on support and living conditions for people in services, although variations in managing these spaces were observed. Overall, the experiences shared by the interviewees provide valuable insights into the nuanced effects of the pandemic on individuals with addiction and the healthcare professionals serving them.

Recommendations

Several key recommendations can be made to address the challenges faced by homeless individuals with addiction issues during the pandemic and to support the healthcare professionals providing care to this vulnerable population. These recommendations aim to improve access to resources, enhance support systems, and mitigate the impact of a demanding work environment.

- 1. Strengthening Access to Substance Use Support:** Efforts should be made to ensure that individuals with addiction issues, particularly those who are homeless, have access to essential substances and support services. This may involve establishing outreach programmes that provide harm reduction supplies, including clean needles and overdose prevention measures. Collaboration between addiction services and community organisations can help bridge the gap and provide support to those in need.
- 2. Enhancing Mental Health Support:** Given the significant impact of the pandemic on the mental health of both homeless individuals and healthcare professionals, it is crucial to prioritise mental health support. Adequate resources should be allocated to provide counselling services, therapy, and psychiatric care. Training programmes can also be implemented to equip healthcare professionals with the necessary skills to address mental health challenges effectively.
- 3. Addressing Staffing Challenges:** Staffing issues, such as understaffing and burnout, need to be urgently addressed to ensure the provision of quality care. Adequate staffing

levels should be maintained to distribute the workload effectively and prevent burnout among healthcare professionals. Staffing needs should be regularly assessed and adjustments should be made to accommodate fluctuations in demand and ensure adequate coverage.

4. **Promoting Collaboration and Support Networks:** Foster collaboration among stakeholders, including community organisations, public health departments, hospitals, and addiction services. Establishing strong support networks can provide a safety net for homeless individuals with addiction issues and enhance the effectiveness of care provision. Regular communication, coordination, and resource sharing among these entities are essential.
5. **Improving Housing and Living Conditions:** Providing safe and stable housing options for homeless individuals is crucial, particularly during times of crisis. Efforts should be made to expand the availability of individual apartments or temporary shelter accommodations. Additionally, support services should be provided to help individuals maintain cleanliness and hygiene in their living spaces. This can include educational programmes, assistance with housekeeping, and access to necessary supplies.
6. **Enhancing Training and Preparedness:** Healthcare professionals should receive comprehensive training on addiction issues, harm reduction strategies, and crisis management. This training should be incorporated into their education and ongoing professional development to ensure they are equipped to provide effective care in challenging circumstances. Preparedness plans should also be established to address future crises, ensuring that healthcare professionals are well-prepared to respond promptly and effectively.
7. **Continuity of Care and Long-Term Support:** Efforts should be made to ensure continuity of care for homeless individuals with addiction issues, even during times of crisis. Establishing protocols and support systems to prevent disruptions in treatment and access to medications is essential. Long-term support programmes should be implemented to provide ongoing assistance and rehabilitation opportunities to individuals seeking recovery.

In conclusion, addressing the challenges faced by PEH with addiction issues during the pandemic requires a comprehensive and collaborative approach. By strengthening access to support, enhancing mental health services, addressing staffing challenges, fostering collaboration, improving housing conditions, providing adequate training, and ensuring

continuity of care, we can create a more supportive and effective healthcare system for this vulnerable population. These recommendations aim to mitigate the negative impacts of the pandemic and improve outcomes for individuals struggling with addiction and homelessness.

CHAPTER 6: Service User Perspectives



CHAPTER 6: SERVICE USER PERSPECTIVES

Introduction

The data presented in this chapter is derived from a series of in-depth qualitative interviews conducted with service users of PMVT. The primary aim of these interviews was to gain a nuanced understanding of the experiences and perspectives of individuals who have engaged with PMVT's housing and addiction services during the pandemic. Through these conversations, we sought to identify key themes and insights that could inform future improvements in service delivery.

Thematic analysis was employed to systematically examine the interview transcripts, allowing for the identification of recurring themes and patterns within the data. This method facilitated a rich and detailed exploration of the participants' lived experiences, highlighting both the strengths and areas for improvement within the current service provision.

Interviewee Profile

The interviewees in this study are diverse individuals who have utilised various PMVT services, including emergency isolation accommodations, transitional housing, and recovery support programmes. They ranged in age from their early twenties to late fifties and came from varied socioeconomic and cultural backgrounds. Despite these differences, they share common experiences of homelessness, addiction, and the subsequent journey towards recovery and stable housing during the COVID-19 pandemic.

Background and Demographics

The interviewees in this study are diverse individuals who have utilised various PMVT services, including emergency isolation accommodations, transitional housing, and recovery support programmes. They range from their early twenties to late fifties and come from varied socio-economic and cultural backgrounds. Despite these differences, they share common experiences of homelessness, addiction, and the subsequent journey towards recovery and stable housing.

Demographic snapshot:

- Age from 20 to 59 years old
- Male and female participants

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- Diverse socio-economic and cultural backgrounds
 - Duration of service use from two months to 10+ years

Common Experiences

Homelessness: All interviewees had experienced homelessness and had utilised a range of PMVT services, including homeless, addiction and housing support services as part of their experience.

Addiction and recovery: Each participant had engaged in addiction and treatment programmes, with varying degrees of success and challenges.

Service engagement: Interviewees had accessed a range of PMVT services, including emergency isolation accommodations, transitional housing, addiction, and support programmes aimed at facilitating long-term recovery and stable housing prior to interview.

Thematic Analysis

Five key themes emerged. These are presented below.

Theme 1: Importance of Social Connection

Throughout the interviewee's transcripts, each one asserts the importance of having and maintaining social connections. They believe that being able to socialise, with the "right" people in their minds, is very beneficial to their mental health and recovery. Their abilities to go out and meet their usual social networks were altered by the need to isolate during the pandemic, leading to difficulties.

"It was hard to be confined... I want that social connection and when that's took it's like woah, what's going on?"

"Even though you can go out and stuff it's not easy, It's just basically you and yourself. It's tough."

In cases where social interaction was impossible due to isolation, the interviewees reflected on the beneficial efforts of the staff to talk to them.

“They’d [staff] sit down in the apartment with me and stay for a while... it was a lot more interactive... I’d still be able to stop and have a proper chat with them.”

Another interviewee states that these relationships developed with staff during isolation were maintained after leaving isolation:

“I’ve followed it through with some of the staff that come through the services. I’d still be able to stop and have a proper chat with them and have a good relationship with them. They’re not just staff anymore.”

The interviewees also expressed the importance of connecting with their peers, those also in recovery. The interviewees felt that it was necessary to have someone who would understand what they were going through and that relationships with staff, while helpful, were not always enough.

“(Staff are) always there for a chat with you. Still you got up to your room, like they have their own lives, but this is your life.”

“With people that haven’t really been around people that experienced that sort of (addiction), and they’re just studying from a book, they don’t get it the same way... I surround myself with people in early recovery or in recovery a long time”.

“This is number 1 for me... the ones in recovery and doing well, they’re who I associate with.”

Further benefit was observable in those who were living in recovery-centred accommodation:

“It’s helped me in a way to keep sober... I don’t think I would have done it without them [peers]... you have someone there to speak to you..., having people like you living around you who are in recovery.”

Despite the above benefits of peer connection, some interviewees expressed dissatisfaction with recovery centred groups and meetings like AA, or fellowship orientated groups. Some just did not find the experience beneficial, and others felt that fellowship programmes could become hierarchal, with unhelpful behaviours and attitudes.

"I've done my [fellowship] meetings and my day programmes, but I don't go as much (because) we're not all the same, everyone's different... sometimes... I'd go back to the meetings."

"I struggle with meetings... they can be very cliquey, and a lot of image goes on, people forgetting where they come from, people getting very arrogant with that."

Overall, the interviewees expressed that maintaining social connections was important to them, particularly with others in recovery. While recovery meetings and groups may, at times, have a hostile atmosphere, they may also suit some individuals more than others. While isolation can be a very difficult experience, the staff at PMVT provided some much needed social interaction to service users and maintained these relationships even after they left isolation.

Theme 2: Effectiveness of an Open Line Policy

The open line phone policy was consistently praised by Interviewees. Having the ability to call and speak with someone at PMVT provided significant mental health support. This service was considered a crucial safety net, offering reassurance and immediate assistance when needed.

"It gives you something you can fall on at any time... I still get the odd phone call asking me if I'm okay and that means a lot to me."

"The phones always there if you need help or a dig out, they'd talk you through on the phone which is great."

"(The keyworker) gave me a great boost and you know anytime I needed something I just had to make a phone call and they were always there."

The interviewees made it clear that the relationships service users had built with the staff at PMVT and their effort to be available on the phone to address any issues they may have had was a key piece of their support network and PMVT's service.

Theme 3: Poor Experience of Emergency Isolation Accommodation

Interviewees unanimously reported poor experiences in emergency isolation accommodations, likening them to prisons and concentration camps. This starkly contrasted with the chaotic freedom of hostels and street life, posing significant adjustment challenges. Key areas of concern included the confining atmosphere, poor quality of food, lack of amenities for past time, and inadequate staffing.

This narrative emphasises the drastic change and challenges the Interviewees faced when moving from homelessness to isolation units, highlighting the additional mental and emotional strains.

The Interviewees, who were experiencing homelessness, faced significant challenges when moved from the chaotic environments of hostels and the streets to the confining conditions of isolation units. This transition highlighted numerous issues that compounded their difficulties during isolation.

The Interviewees described the confining atmosphere:

"It was so antiquated and depressing. Mother of Jesus I thought I'd never get out. It was like prison."

"it's like being in a concentration camp. Aw it was like going back into Oliver Twist, with the steel beds and my t shirt was thicker than the mattress."

"It was horrendous to be honest with you"

They went further to highlight the contrast with their previous environment. The isolation units were a stark contrast to the chaotic, often unpredictable environments of hostels and streets, which, despite their dangers, offered more freedom and social interaction.

Some ongoing issues were feeling trapped:

"They weren't great, communication wasn't good... I was having confrontation with the staff."

"I think I was there for like 8 days and a girl came up and I told her I have to get out of here I'm going crazy, I feel like the walls are coming on top of me."

"I wanted to leave after the second day but I had to stay there."

The Interviewees had challenges adjusting, and the feeling of being trapped was exacerbated by the sudden shift from a life of mobility and social networks, however fragile, to a confined and regulated space.

The Interviewees went on to detail the poor quality of food:

"I don't mean to sound ungrateful, but I wouldn't say the food was the greatest."

"Food wasn't good, so I ordered takeaway every night."

The poor quality of food in isolation units added an unnecessary strain on those already struggling, contrasting with the communal meals or variance in the food assistance they might receive while on the streets or in hostels.

A contributor to the interviewee's poor experience was the lack of amenities and activities, stating in some cases they had nothing to pass the time:

"The TV didn't work... there was nothing to pass the time."

Another suggested an idea to reduce the psychological impact of isolation:

"Maybe something like a community room in them - like I know you're supposed to be isolating, but at least then you could isolate together."

The lack of activities or communal spaces to pass the time made the isolation experience more mentally taxing, especially for those used to the constant activity and social interactions of street life.

Another Interviewees felt that there was inadequate staffing and a need for more support:

"(It could be improved with) more staff, and someone there to talk to... the building itself it wasn't bad... I was too sick to eat the food."

Theme 4: Lack of Solid Information and Confirmation

Interviewees expressed anxiety regarding the uncertainty of their accommodation support duration and the possibility of eviction despite an eviction ban being in place. As the pandemic disrupted plans made prior to the outbreak, adding to their anxiety and uncertainty about the future. Many reported feeling uninformed about the housing application process and the transition from PMVT support to long-term accommodations. This lack of information heightened their fears about the future and their ability to secure stable housing.

The norm for the Interviewees was already one of instability and uncertainty. The pandemic skewed this further, intensifying their vulnerabilities. Despite the eviction ban, the fear of being left without shelter persisted, exacerbated by the lack of clear communication and support from service providers.

“I’d another month in my treatment of 3 months, and I was getting a bit anxious and scared about what was going to happen after, there was no one there.”

“I thought it was only a certain amount of time I had, I was like Jesus where am I gonna go after this.”

Interviewees further expressed the difficulty in progressing through PMVT onto more long-term accommodations:

“I didn’t know how to apply to the housing list”

“Getting from the trust to housing, that’s the hard part... it should be more accessible, open, and easier to get through... like who wants to live in a hostel for the rest of their lives?”

Overall, the Interviewees would have greatly benefited from clear confirmation or reassurance about the duration of their accommodation availability and guidance on how to access further housing services. This need for clarity was particularly pronounced due to the pandemic, which led to fast-changing information at national and global levels, significantly impacting normal service provision and the availability of stable accommodation.

Theme 5: Benefits of PMVT-Led Accommodation

For some Interviewees, the changes brought about by the pandemic had positive effects outside of the emergency isolation accommodations. Many interviewees expressed satisfaction with PMVT accommodations during this period, particularly those that implemented social distancing measures, which allowed for private spaces. Positive interactions with staff and organised social activities contributed to a more supportive and beneficial living environment.

These improvements starkly contrasted with pre-COVID hostel experiences, which were often described as chaotic and unsafe. The pandemic's shifting guidance brought about new living conditions that some Interviewees found preferable, highlighting some positive side effects of COVID-19. The enhanced living conditions and improved safety protocols underscored the potential for more stable and supportive accommodations during and beyond the pandemic.

"(It's better because) you have your room, your own toilet, you can close your door."

"They have a social night... coffee day... which is great..., I go for a walk with the lads."

Interviewees were very satisfied with the recovery housing provided by PMVT and stated:

"I don't think I would have done it without them (support in the house). If I had gone into accommodation on my own, I don't think I'd be where I am in today... Someday you'll have a bad day and someone around you will pick up on it. That's the benefit"

Compared to experiences prior to pandemic, interviewees mentioned their negative experiences in hostels:

"They're very manic... I woulda had to go the hostel before I got set up here and the hostel is only a temporary fix hostel at the time, but the hostel was crazy I've never seen anything like that before in my life. That affects your mental health. I chose to sleep on the streets rather than be in the hostel. I found myself safer on the streets... there's people doing everything in your rooms, waking up with people dead across from ya, nobody should have to live with that"

The efforts of PMVT staff, especially those aimed at enhancing support, along with the provision of private accommodation, have contributed significantly to improving client

satisfaction. It is important to note that hostels, previously identified as problematic environments by clients, have since been closed, addressing one major area of concern.

Chapter Summary

Overall, Interviewees stressed the inadequacies of emergency isolation and hostel accommodations while appreciating the improved conditions in other PMVT-led accommodations. Key beneficial aspects included peer engagement, the open call policy, and supportive staff relationships. Identified areas for improvement focused on bridging the gap to long-term housing and providing clearer information about available services, albeit in a fast-paced, changing environment. The positive impact of staff efforts and single unit accommodations was a recurring theme, suggesting a direction for future service enhancements.

Key Recommendations

- 1. Facilitate Social Connections:** Encourage and facilitate social interactions among peers in recovery through organised activities and support groups. Explore alternative recovery support formats for those who do not benefit from traditional group settings like AA.
- 2. Maintain and Expand Open Line Policy:** Continue the open line phone policy and consider expanding it to include more frequent and proactive check-ins with service users.
- 3. Enhance Communication and Information Provision:** Implement clear, accessible information channels to inform service users about the duration of their accommodation support and the process for applying for long-term housing.
Provide regular updates and reassurances to alleviate anxiety about future housing stability.
- 4. Improve Emergency Isolation Accommodations:** Upgrade facilities to provide a more comfortable and less confining environment, including better quality food. Ensure that in-room entertainment options are functional and consistently maintained. Increase staff presence to offer more support for those in isolation.

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- 5. Support Transition to Long-Term Housing:** Develop and implement a structured pathway for transitioning from PMVT support to long-term housing for all service users, making the process more accessible and understandable. Offer dedicated assistance for housing applications and navigating the housing systems.

By addressing these areas, PMVT can enhance their service users' overall experience and outcomes, ensuring a more supportive and effective recovery experience.

CHAPTER 7: Collective Intelligence Group



CHAPTER 7: COLLECTIVE INTELLIGENCE GROUP

Ten key-informants, that is individuals identified by the PMVT as having played a key strategic or management role in the delivery of services during the pandemic participated in the collective intelligence group. Through collaborative discussions, the group emphasised the importance of capturing service development and maintaining an upward trajectory of progress made during the COVID-19 response by PMVT. Key discussions, summary of findings and recommendations are outlined below.

Eight key themes emerged these are discussed below.

Theme 1: New challenges, New Skills

The onset of the pandemic caused an array of unforeseen circumstances, which required rapid adaptations to accommodate the evolving landscape. Participants were faced with the task of managing both the immediate emergency response required by the pandemic and the ongoing provision of essential services. This duality of responsibilities posed a considerable challenge, requiring the participants to navigate competing demands and allocate resources effectively.

The increased sense of urgency and the increasing needs within the community led to an unprecedented surge in the demand for their services. This surge required a substantial expansion of their operations, including the mobilisation of additional personnel, the procurement of the necessary resources, and the implementation of additional services.

The pandemic brought about a range of interconnected challenges, spanning physical health, mental well-being, and cultural services. Consequently, participants were faced with the task of developing comprehensive approaches to meet these diverse needs, often requiring collaboration with other service providers and community organisations.

The experiences shared by the participants highlight the magnitude of the obstacles encountered during this period. The simultaneous management of emergency response efforts alongside regular service provisions demanded adept decision-making, strategic planning, and effective resource allocation. Additionally, the significant increase in workload required the participants to adapt swiftly, implement innovative strategies, and leverage available resources to meet the escalating demands.

“COVID was 24/7... we would be working throughout the evening, day and weekends... we had to be ready for people to come in at any given time... to make sure the flow of people in and out was quite constant”.

“how are we going to build our capacity as quick as we need to in order to meet the needs?”.

“It was a very hectic pace, continuously every day. And yeah, I suppose. Like the work that was done by everybody involved was absolutely unbelievable, it was unreal what we achieved.” .

Participants reflected on the difficulty of maintaining their previous quality of service, including clinical standards, during the COVID-19 pandemic. They faced an overwhelming surge in service demand while striving to meet the evolving needs of their clients. The almost critical atmosphere in place added an unprecedented level of complexity to their responsibilities. A nurse shared her experience, shedding light on the challenges faced in ensuring the maintenance of clinical standards in these extraordinary circumstances.

“the fear of medication errors, individuals waiting a significantly longer time in order to get their medication, because we still have to maintain our documentation and still have to maintain correct procedures in order to know we can't just go get them willy nilly, you know, everything we'll have to system still has to be in place to protect residents and ourselves as nurses. And so the fear that you know someone will become very unwell and it will not be caught trying to manage all the pieces”.

With the initiation of this new environment, there was a substantial increase in the number of service users, as acknowledged by all interviewees. They unanimously expressed a significant increase in service acceptance during the pandemic, reflecting the increased demand for assistance and support in these times of unprecedented change.

This surge in service users can be attributed to several factors. First, the widespread impact of the pandemic itself created new challenges and intensified existing ones, prompting people to seek essential services and resources. The disruptions caused by the pandemic, such as the closure of day services, coffee shops, and drop-in services, as well as an increase in populations

experiencing homelessness but who traditionally did not engage with services, necessitated a greater reliance on available support systems.

The participants highlighted the overwhelming nature of this surge in service users. Service providers had to adapt rapidly to accommodate the increase in demand, ensuring that their services remained accessible and responsive to the evolving needs of the community. This often involved expanding resources, implementing innovative service delivery models, and improving coordination among different organisations to effectively address the diverse and complex challenges presented by the pandemic.

“We did not know what we would face each week. It was just go and trying to get it done”.

“There was cultural pieces around food and educational needs of children from communities like the Roma, that we were working with but other services were not available at that time”.

The experiences shared by the participants underscored the critical role of service providers in meeting the amplified demand for support. They highlighted the dedication and commitment of these providers who went above and beyond to ensure that services were available to those who needed them the most. This included extending work hours, implementing telehealth options, and working with community partners to reach marginalised populations.

“the volume increased drastically- of the amount of people coming to us day by day”.

“because of the numbers we were working with, it did come with its challenges. But challenges were more so in and around, how are we going to build our capacity as quick as we need to in order to meet the needs.”.

Within the expanded client base, participants observed a notable increase in individuals with complex needs, including requirements for housing and mental health support, substance use assistance, or increased medical care needs. This change required a more nuanced and multifaceted approach to address these complex needs, highlighting the need for a holistic

framework within housing services that balances the different types of people who access support.

“It was about recognising the different needs of each group, and ensuring that they weren't impacting each other”.

“What we would have been seen is that they were all coming to the one place, which they wouldn't have all been under one roof before... I don't think that the group that we work with completely changed. But I suppose how we worked with them changed” .

To effectively support individuals with complex needs, participants recognised the importance of adopting a holistic approach that included various dimensions of well-being. This approach involved acknowledging the interplay between stable housing and mental health, substance use, and medical care requirements. By acknowledging these interdependencies, PMVT could better address the underlying factors contributing to homelessness or inadequate housing, thus improving the prospects for long-term stability and improved overall well-being.

“We tried to ensure that like there was social supports being provided... because somebody was feeling suicidal, somebody may have attempted suicide, while they were with us, you're trying to manage all of those people, even though it was during times of COVID... What we could manage on site we would manage on site without putting anybody at any risk.”.

Implementing a holistic approach within housing services entailed the integration of multiple disciplines and service sectors. Collaboration between PMVT, mental health professionals, public health specialists, and medical practitioners became essential to address the diverse needs of this population effectively. The participants highlighted the importance of establishing strong partnerships and fostering communication across the sector to facilitate seamless and coordinated care provision.

“(clients) coming in with a lot of complex needs, so we would have put some assessments mental health and addiction assessments in place.”.

“Knowing we had the support of the [names removed] Doctors, Public Health meant we had everyone we needed”.

“we've gone about continuing to provide more complex needs placements, using isolation services even with few isolations- but it's being used, we've been able to use it to give respite and be a bit more creative in terms of placements as well to meet the needs of the participant group.”.

Participants acknowledged that the pandemic presented them with extraordinary levels of stress, demanding rapid decision making and the ability to navigate uncertain and rapidly evolving circumstances. In response to these heightened stressors, the participants developed an increased ability to manage and cope with high-stress situations effectively. They acquired valuable skills in maintaining standards, prioritising tasks, and making informed decisions under pressure. This increased resilience and capacity to navigate stressful scenarios contributed to their professional growth and effectiveness in delivering services during challenging times.

Adaptability emerged as another crucial skill that participants developed during the pandemic. The dynamic nature of the crisis necessitated continuous adjustments to established practices, protocols, and service delivery models. Participants reported an increased ability to adapt quickly to changing circumstances, embrace innovative approaches, and implement alternative strategies as needed. This adaptability enabled them to respond effectively to emerging challenges, optimize resources, and deliver services that remained responsive and relevant in the face of evolving needs.

“I think one of my key lines has been the importance of being adaptable in your approach... like you didn't know sometimes what you were walking into, which, you know, I think that that's something that has stayed.”.

“My memory is unbelievable now because at that time, I had to remember so many individuals and their clinics.”.

Participants emphasised the significance of the team being able to adapt as circumstances evolved, demonstrating their own experiences of swiftly adjusting to changing conditions and requirements. They shared instances where they were faced with sudden changes in client

needs, emerging challenges, and evolving guidelines or protocols. In response, they underscored the importance of being able to adapt and change their approaches promptly and effectively. These adaptations allowed them to maintain service provision and meet the changing needs of their clients.

“I think it was a lot of reflection and learning as we went on, continually learning and adapting, ye.”

The participants emphasised that adaptability was not only important for their professional growth, but also to ensure the best results for their clients. Being adaptable, they could tailor their services to meet the changing needs and preferences of their clients, fostering client-centred care that aligned with the evolving context. This adaptability allowed them to provide safe, timely, relevant and effective support to individuals and communities during uncertain and challenging times.

“each individual comes with their own set of needs, and complexities. And the system has to be adaptable, to be able to meet the need of people individually, rather than saying, this is what you need. And you need to come and fit into this box in order to be served.”

Theme 2: The Benefits of Integrated Health and Housing Supports

The adaptation of the system to the challenges posed by the COVID-19 pandemic involved expanding services beyond traditional provisions. A significant aspect of this expansion was the integration of medical care within housing services. This approach was designed to minimise client movement and reduce the risk of infection by providing essential health services within the familiar and supportive environment of the PMVT housing facilities.

By combining healthcare services with existing housing provisions, participants recognised several substantial benefits for clients. They observed that individuals who may not typically seek medical attention, such as rough sleepers, were now able to conveniently access essential healthcare services. This integrated approach addressed barriers to healthcare access that clients likely had previously encountered, such as wound dressing, foot care, mental health, and

substance use support. It provided an accessible alternative, ensuring timely medical interventions, preventive care, and ongoing health management.

The participants emphasised the positive impact of this integrated approach on the well-being of the clients. By extending medical care within the housing facility, the need for clients to seek outside healthcare services, such as visiting hospitals or general practitioners, was significantly reduced. This not only minimised the risk of exposure to infectious diseases, including COVID-19, but also provided a sense of trust, comfort, and continuity of care. Clients felt more supported and engaged in their healthcare, resulting in improved adherence to medical treatments and better health outcomes.

“A lot of our participants don’t go to the hospital. And a lot of our participants have complex needs which are not met at the hospital... extending the inclusion health aspect to the community setting was extremely helpful and would be something particularly important”.

“Nursing and social care that collectively came together... it built... the ability to, you know, to meet people where they were at”.

The provision of a diverse range of on-site services within isolation accommodations was perceived by the participants as a means of improving healthcare access for individuals who would typically face barriers to accessing such services. This expanded scope of services aimed to address disparities in access to healthcare and subsequently contribute to an improved quality of life for the individuals served.

The participants noted that the provision of onsite healthcare services led to noticeable improvements in the quality of life of the individuals accessing these services. With improved access to healthcare, people were able to receive timely interventions, preventive care, and ongoing management of their health conditions. This, in turn, led to improved health outcomes, better management of chronic conditions, and an overall improvement in well-being:

“A huge number of people who would have come in for us, for COVID isolation purposes, it was an opportunity for them to stabilise [their drug use].’ So, they stabilised during their time with us with prescribed medication that followed them out into the community”.

"a lot of clients did well... went to stabilised accommodation and are still doing great."

The integration of healthcare services within isolation accommodations also fostered a supportive and inclusive environment for individuals who often faced social and healthcare disparities. It created a sense of trust, comfort, and continuity of care within familiar surroundings. When receiving healthcare services in a setting that provided both physical and emotional support, people felt more empowered and engaged in their healthcare, leading to an improved overall quality of life:

"I would say that more people received a positive outcome... being able to assess somebody and recognise this person's needs, and pick up on underlying health needs that may not have been observed for a number of years".

"the assessments were carried out and the services that they typically wouldn't engage in or hadn't been offered previously, were now being offered on site, and were being maintained effectively to support an improvement or a change in their quality of life. And that was really a significant piece".

"... And we saw people's health improve, because of the nurses on site, people were able to get wound care, people were able to receive mental health assessments, addiction assessments, people were able to use that time".

In general, integration of health and housing services led to more people receiving medical care than before the pandemic, further highlighting the need for this integration to continue.

Theme 3: Reaching a Reluctant Group

Among those who received an increase in healthcare due to its integration with housing services, were a group of clients who were previously known to be suspicious or reluctant to access and engage with services prior to the pandemic. Increased access to healthcare for this

group of clients had significant implications for their well-being. By accessing integrated housing health services, they could receive timely interventions, preventive care, and ongoing treatment of their health conditions. This comprehensive approach resulted in better health outcomes and an improved quality of life.

Furthermore, the integration of healthcare services within housing facilities encouraged a more holistic and patient-centred approach to care. It allowed for more established meaningful relationships with these clients, understanding their unique needs, concerns, and preferences. This personalised approach contributed to a sense of trust, empathy, and understanding, which further motivated clients to actively participate in their healthcare journey. The participants spoke of the use of opportunities for care to be reintroduced into the housing system for a better long-term effect, conveying the benefit of combining health and housing care.

“They may be people that are just going around different services and didn't solely have maybe a key worker that was able to support them around the housing piece. So while they were in isolation, sometimes we kind of extend or move people to cocoon and try to support them back into housing, rather than back into services.”

The integration of healthcare services within housing not only improved healthcare access for this previously suspicious or reluctant group of clients, but also provided an opportunity for healthcare providers to address the underlying causes of their scepticism. By consistently providing high-quality care, demonstrating empathy, and building trust, clients could gradually overcome the barriers that had previously hindered these clients from seeking and engaging in services.

“(clients in isolation services) helped build that trust and move on and stay in services.”

“We were able to do it on a bigger scale, in a way and reach those that would normally never be presented (to a service) because they will not know about all that. But they are there because they're isolating.”

The introduction of the healthcare system in a dignified and comfortable setting also had broader implications. It positively influenced the client's perception of the healthcare system, fostering a sense of trust and confidence in seeking health services. This change in perception could have long-lasting effects, encouraging people to continue engaging with health services even after their time in isolation.

Theme 4: Creating an Environment to Enable Sustainable Change

The utilisation of isolation services offered clients, including those who were rough sleeping, a chance to access healthcare in a more comfortable and dignified manner. By providing single, private room accommodations, their living situations improved significantly, promoting a sense of privacy, security, and well-being. This change in environment helped remove barriers and foster a greater sense of dignity and respect. The introduction to healthcare in this setting improved access to essential services, allowing timely interventions, preventive care, and ongoing management of health conditions. This approach positively influenced the perception of the healthcare system by clients, fostering trust and confidence in seeking care. It also highlighted the importance of person-centred care and the recognition of individuals' rights to dignified living conditions. Overall, this approach addressed healthcare disparities, supported well-being, and emphasised the role of social determinants in providing comprehensive and equitable healthcare services:

"We were able to just do it on a bigger scale, in a way, and reach those that would normally not want to be reached and never presented or have someplace like (housing service) because they won't know about it. But they are there because they're isolating."

Moreover, the provision of single, private room accommodations within isolation services demonstrated a commitment to person-centred care and the recognition of every individual's right to dignified living conditions. This approach not only contributed to immediate improvements in client well-being but also highlighted the importance of considering the broader social determinants of health, such as housing, in delivering comprehensive and equitable healthcare services:

“The population didn't necessarily change that PMVT works with... (some who have a) history associated with not availing or taking off beds. And we were able to land those individuals in services and maintain the placements, because of the relevant support measures were in place... because of the fact we were working in apartments and blocks, those people with more intricate needs, we were supporting them in single placements and ensuring the comprehensive, you know, needs assessments were carried out and that services that they typically wouldn't engage in or hadn't been offered previously were being offered.”

Participants expressed the importance of maintaining these relationships and expanding PMVT services and the associated governing bodies guidelines to be able to continue to reach these previously unreached groups:

“...the system has to be adaptable, to be able to meet the need of people individually, rather than saying, this is what you need. And you need to come and fit into this box in order to be served.”

In general, participants felt that COVID was beneficial to this particular group in some instances, as the need to isolate almost built a bridge between themselves and the available services, facilitating an introduction that has continued to serve to date.

Theme 5: Differing Cultural Needs

One group who were not previously engaging in great depth prior to COVID were immigrant families, for example those from the Roma community. This upsurge in service for a lesser known client group represented a challenge for the staff in that their needs were explicitly different in terms of language, but were also culturally specific, for example, dietary needs, restrictions or sensitivities, family dynamics, and social norms. In light of this, the participants engaged systematically and reflected on how best to respond to these needs as an organisation, deliberating on the methodologies they employed and the innovations they implemented to improve the accessibility of services for these individuals, families and communities:

“We took a lot of learning from what we are doing with iPad services, in terms of communication and, you know, plain English pictographs, all of that type of stuff and access to interpreters, etc. So, going back to the community and using the resources are there for other agencies to make sure that we were looking at all aspects”.

Highlighting the different needs of some clients originating from other jurisdictions, one participant reflected on practicing extra diligence when addressing these needs, as they were aware of the difficult situation these clients were in:

“That’s when we are working with people where there were no payments in place, there was no access to benefits, there were language barriers, there were very significant intricacies in terms of diet and nutritional requirements, and I suppose even being able to support their needs, because no doubt this was a very frightening experience for them.”.

With this, participants addressed their desire to see more done for this group in the future, stressing a need for future preparation, rather than a reactive response:

“In terms of the Roma population... There is a certain part in knowing (what) the needs are and being preinformed about their needs as well, rather than waiting for the family to tell you their need”.

In general, non-Irish service users presented another under-reached group of service users who had their own specific needs, and further preparation should be made to address and meet these needs in the future.

Theme 6: Dismantling Bureaucracy

The participants expressed unanimous agreement on the benefits of dismantling bureaucratic obstacles in service access and delivery. The removal of red tape allowed for increased efficiency and flexibility, enabling participants to enhance the benefits provided to service users and effectively respond to ever-changing needs during the pandemic.

By being given more responsibility and leeway in their work, the participants experienced a sense of empowerment and autonomy. This newfound flexibility allowed them to streamline processes, make timely decisions, and adapt their approaches to meet the evolving needs of service users. The absence of unnecessary bureaucratic hurdles enabled participants to efficiently navigate the challenges and allocate resources where they were most needed.

The dismantling of red tape had a profound impact on service access and delivery. With greater freedom to innovate and implement tailored solutions, participants were able to offer more personalised and effective support to service users. They could address individual needs and circumstances with greater precision, resulting in improved outcomes and client satisfaction:

“There was more opportunity to ask for forgiveness later I think with some of their placements and otherwise because the need superseded the practicalities and the county breakdown and stuff that exist in terms of then catchment areas and otherwise”.

Furthermore, the removal of bureaucratic constraints fostered a culture of adaptability within the service delivery framework. Participants highlighted the importance of being able to respond quickly to emerging challenges and evolving circumstances during the pandemic. By having the flexibility to adjust protocols, modify service models, and implement creative solutions, they could effectively meet the changing needs of service users.

“they were coming in in the morning time, and by afternoon, they were initiated (on OST)”.

The participants also emphasised that the dismantling of red tape contributed to improved collaboration and interdisciplinary approaches. With fewer bureaucratic barriers, different teams and departments were able to work together more seamlessly, combining their expertise and resources. This collaborative environment facilitated efficient problem solving and comprehensive service provision, resulting in a more holistic approach to address the complex needs of service users:

“We were able to cut red tape... (which) allowed for a lot of fluidity in terms of how we responded and how the sector as a whole responded as well”.

“The red tape fell away... someone coming for isolation with an identified need for OST could be initiated that afternoon.”

Despite this, further changes were considered necessary, particularly regarding the governmental segregation of areas and services into certain blocks. When confining services to one aspect, i.e. a health service or to one area, i.e. Dublin, participants felt that there was a reduction in efficacy and that some client needs were not being met.

“they're kind of left in limbo between not being eligible for placement and Dublin and not having the right type of placement opportunity open to them outside of Dublin”.

“Sometimes, they actually have to bring the service to the individual in order to actually meet the needs. And I think an extension of the inclusion of health could really support that process.”

As seen above, the isolation units led to an increase in access to services for typically outlying clients, and with the closure of these, participants felt that this increased access may be reduced and that the service users who had stabilised during COVID due to the isolation unit would be thrown back into services that may not have worked for them previously.

“This is the first time he'd ever had his own place... And it was just really moving and it was just really, really sad... knowing I would have to ask him to leave.”

‘We had provision in our isolation unit for people who might not fit the remit of the Dublin region... the opportunity has gone away from us now.’

Recognising the above criticisms, participants expressed their satisfaction with the leadership actions during the pandemic, particularly with regard to their communication and flexibility:

"I suppose, from an interagency point of view, linking with public health, linking the HSE, DRHE, (I saw) the commitment from the top down and across those organisations in terms of removing the red tape".

"There was a lot of (reflection and learning) and I think it's that- I think from a senior management level, anyway, definitely, there was a lot of discussion and a lot of like, looking at what needs to be done in regard to policies, a lot of trying to communicate.".

"The guidance that was always available through the HSE and public health in terms of changing isolation times, advice on PPE, on the vaccine throughout the vaccines... all of that was, I suppose, driven from the top down. And it was very supportive to the sector as a whole, not just ourselves.".

Overall, while participants believe that leadership were communicating and flexible during the pandemic, this needs to continue, alongside the introduction of less needs or area-specific services like the isolation units, so that those who may not meet the criteria for an addiction center, or a Dublin region service, can still have a place to go.

Theme 7: Increased Collaboration

All participants reflected on the increased level of inter-agency collaboration and the benefits of this during the pandemic. In general, participants felt that this increased inter-agency collaboration was not only beneficial to clients, but also made their own jobs easier, and cross-training social care staff in healthcare techniques allowed a bridging of the gap between disciplines, enabling the building of relationships that will directly benefit the client:

“Any organisation or any team will always be focused in building that sense of cohesion... nursing and social care collectively came together... I think it definitely built resilience, cohesion, and the ability to, you know, to meet people where they were at.”

Within this collaboration, social care staff learnt some clinical techniques like PCR testing so that nursing staff could be freed up for more clinically orientated tasks:

“The social care staff team got trained up and PCR testing. So they were able to come in and provide additional support to the nursing team, it was a small thing but made a big difference”.

Such collaboration was seen as a benefit, especially in the case of staffing, where COVID led to increased absenteeism due to illness:

‘I suppose we were within ourselves working in partnership and working to help each other and make sure that our resources were not depleted in any one area too much... we are looking at levels of staffing, absence, absenteeism or sick leave due to COVID and planning in response to that as well in terms of how we coordinate and calibrated our staffing across the organisations to meet those needs so those gaps are zero’.

“It was very difficult and a challenge in terms of what every day brought because it was very different. And I am not just saying it because the people are here, but sometimes it was those pieces in the middle of the mania of the day and what you are trying to do-

when we came together as a team, and we would be discussing things and we kept going through humour or understanding or support or whatever it was.”

Highlighted to be of particular importance was the sharing of information regarding clients as they navigate through different services, expressing that PMVT has developed in this sense, previously trying to be self-sufficient:

“because of the sheer size of The Peter McVerry Trust, we're very self-reliant. And I think, you know, what (PMVT) has learned to is to have more and more structure in terms of linking (with other) services and establishing very clear pathways in terms of participant care”.

The participants went on to describe that this collaboration has been maintained, leading to increased benefit for clients and staff alike:

“The two [community-based GP] prescribers who would have worked alongside us remain very flexible in that process... I definitely think that it has definitely led to an improvement in terms of community responses to needs that previously had been unmet for prolonged periods”.

Participants recognised the importance of striking a balance between the human and clinical aspects of service delivery during the pandemic. They highlighted the importance of understanding the holistic needs of their clients, not only focussing on clinical interventions but also on their emotional well-being and broader social circumstances. Participants applied their skills in fostering compassionate and person-centred care, valuing human connection, and recognising the importance of empathy and understanding. By striking this balance, they were able to provide comprehensive, safe support that addressed both the clinical needs and the broader context in which their clients were navigated during the pandemic.

Additionally, the implementation of various restrictions and lockdown measures led to a reevaluation of priorities, as individuals and communities faced the realities of the pandemic:

“Isolation became a challenge for people with COVID and affected people's mental health. impacted on their substance misuse.”.

“Even though during COVID times people still experienced overdoses, people still experienced seizures... so we were still working with those issues that we're working with now that we have to deal with in a different way”.

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Theme 8: Balancing the Clinical and Human Aspects

Maintaining a balance between the clinical advice given and the human needs and experience of the individuals was repeatedly reflected upon by the interviewees. Recognising emotional aspects like loneliness, the ever-changing environment, and the uncertainties of the pandemic while keeping in mind analytical aspects such as public health advice and the best financial decisions was a challenge that stayed with the service.

The participants reflected on the experience of a man who was very proud and content to finally have his own apartment, in the form of single-room private isolation accommodation, but who then would have to give up this due to the end of the pandemic:

“he said to me, do you think am I keeping the apartment okay for them?... he asked me to come in and check the apartment. So I went in and checked the apartment and it was absolutely spotless, there wasn't a crumb out of place. He had the cushions in the diamond shape... Yeah, everything, everything was absolutely perfect. And he told me, you know, this is this is the first time I've ever had my own place... it was just really moving and it was just really, really sad... me knowing that I was going to have to ask-

him to leave, you know, when his time was up... there was a lot of emotional days and emotional stories during that time, as well as the numbers and figures.”.

Participants highlighted the aspect of naivety regarding the emotional needs of that service users, that was not considered in the earlier public health measures:

“The idea or the notion that we will place individuals in an apartment, you know, and they will remain present during the recommended isolation period. And everything was going to be okay, was never going to work.”.

The continued evaluation of needs and the use of applied clinical judgment was clear from participants, balancing physical and mental health needs were essential, particularly with regard to restricted times for patients in isolation and the need to balance care and mitigate possible indirect consequences:

“When you think of somebody experiencing quite significant mental health related challenges, or otherwise, the recommendation was no more than 15 minute exposure... when you would log in and see somebody in an absolute situation of distress.. at no point are going to walk away and say, actually, that’s been 15 minutes, I’ll be off now... when I talk about calculated risks, there’s oftentimes where we would have had to go over that time to ensure the safety of the individual.”.

Participants expressed the benefit of providing service users with some company and comfort through social interaction, as many service users would be living in private accommodations during isolation:

“This particular gentleman has a number of mental health issues. Fortunately, whenever he sees me will say “Oh, nurse, remember that time you saved my life over there.” ... And in actual fact, I think the most we done was actually the time we spent with him, and it was the same conversation that was had over and over but he got comfort from it”.

Further developing on this, the staff believed that the initial panic of the pandemic disregarded this human aspect and that maintaining the intricate balance became easier as time went on, due to them working directly with service users and developing a response a holistic response to all aspects of COVID symptoms:

“The practicality associated with isolation was what it was, but it was the intricacies associated with the human element of the individual and our work was something that was gradually built upon throughout the pandemic... there was a significant panic in-terms of not foreseeing what the pandemic was going to be in the initial stages. And I think it is only through the learning and feedback that was acquired as part and part of living the process that we were able to meet those needs”.

Chapter Summary

Participants unanimously recognised a significant increase in service adoption during the pandemic, which prompted service providers to adapt and implement strategies to ensure accessibility and responsiveness to evolving community needs.

The interviewees faced challenges such as balancing emergency aspects of pandemic response, managing increased workloads, and attending to the complex needs of an expanded client base. They used resourceful strategies to address these difficulties and provide optimal support to clients during the crisis. They further observed a significant increase in people with complex needs looking for housing services within the expanded client base. They embraced a holistic approach that went beyond traditional interventions, recognising the interdependencies between stable housing and other aspects of well-being. Collaboration was established among various service sectors to provide personalised support to individuals with complex needs.

The pandemic served as a transformative learning experience for the interviewees, enhancing their skills in managing high stress situations, adaptability, and balancing the human and clinical aspects of service delivery. These skills enabled them to navigate challenges, provide responsive care, and foster a compassionate and holistic approach to service provision. The dismantling of red tape in service access and delivery provided increased flexibility and empowerment to the interviewees. This enabled them to offer personalised support, adapt to changing circumstances, and collaborate effectively across disciplines, leading to improved outcomes for service users. The integration of healthcare services within housing facilities improved healthcare access for previously suspicious or reluctant clients. This approach created a positive perception of the healthcare system, resulted in improved health outcomes and improved relationships.

Isolation services, particularly the provision of single, private room accommodations, introduced people to healthcare in a dignified and comfortable manner. This improved living environment improved overall well-being and facilitated better access to essential healthcare services. Efforts were made to improve the access to services for communities less engaged, including migrant families. Strategies included cultural competency training, language support, and community engagement to create an inclusive and respectful environment that met their unique cultural needs.

Participants highlighted the need for continuous evaluation and applied clinical judgement to balance their response to physical and mental health needs during COVID, particularly regarding the limited interaction of staff and clients in isolation and the need to mitigate against potential indirect consequences.

KEY RECOMMENDATIONS

Based on the key points highlighted by the staff, the following set of recommendations can be made to improve service provision and build on the key lessons learnt when addressing the challenges faced during the COVID-19 pandemic:

- 1. Strengthen flexibility and responsiveness:** PMVT should continue to adapt their practices and procedures to meet the evolving needs of service users. This includes developing contingency plans, implementing adaptive strategies, and fostering a culture of innovation and flexibility in service delivery.
- 2. Promote cultural competence:** Training programmes on cultural competency should be provided to PMVT staff members, equipping them with the knowledge and skills necessary to understand and meet the cultural needs of diverse client groups. This will improve service access, inclusivity, and overall experience for migrant groups.
- 3. Foster collaboration and interdisciplinary approaches:** PMVT should continue to actively promote collaboration among its different service sectorial partners. Interdisciplinary approaches facilitate comprehensive assessments, coordinated care plans, and streamlined communication, ultimately improving client outcomes and well-being.
- 4. Enhance client-centred care:** Service providers should prioritise person-centred approaches in service delivery. This involves tailoring support to individual needs, preferences, and circumstances. By actively involving clients in decision making, service providers can empower them and improve their overall experience and results.
- 5. Streamline administrative processes:** Efforts should be made to streamline administrative processes and reduce unnecessary bureaucratic hurdles. This can be achieved through continuous evaluation and improvement of service delivery systems, ensuring efficient resource allocation and maximising the time spent on direct client care.
- 6. Upskill the social care workforce:** Opportunities should be sought to train social care personnel in appropriate areas of screening and routine care to allow nursing staff to focus on complex clinical care.

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7. **Provide language support:** Service providers should ensure the availability of interpretation services and multilingual resources to overcome language barriers and facilitate effective communication with non-Irish individuals. This will improve access to services and improve the overall experience for people with limited English proficiency.
 8. **Promote community engagement:** Service providers should establish partnerships with community organisations and cultural mediators to bridge the gaps in awareness and knowledge about available services. Community engagement efforts can improve outreach, education, and collaboration, facilitating greater access to services, and improving the overall well-being of diverse client groups.
 9. **Prioritise holistic care:** Recognising the complex needs of service users, inclusion health should extend its care services to the community to provide a holistic approach that considers the interdependencies between stable housing, physical health, mental health, and other aspects of well-being. This involves collaboration and coordination among different service sectors to ensure comprehensive and integrated care delivery.
 10. **Continuously evaluate and learn:** PMVT should foster a culture of continuous evaluation and learning. Regular evaluation of service delivery models, client feedback, and emerging best practises can inform ongoing improvements and improve the effectiveness and quality of services provided.

By implementing these recommendations, service providers can improve their ability to meet the unique challenges posed by the pandemic, promote equitable access to services, and provide high-quality care to individuals and communities in need.

CHAPTER 8: Conclusion



CHAPTER 8: CONCLUSION

Strengths

A strength of this project is the large representative sample included in the quantitative analyses of the PMVT services. The sample included 2,893 individuals, while the subsamples of 488. The subsample population helps validate the suitability and reliability of using a logistic regression based on available data. As a rule of thumb, the clinical field suggests the formula “ $n = 100 + 50i$ where i refer to number of independent variables in the final model”⁸⁹. This corresponds with our approach, as we only included one predictor variable and one outcome variable at a time.

Qualitative research capturing the experiences of service users, staff and wider stakeholders is a further strength of this project. This research methodology enabled the researchers explore the topic in depth with the interviewees. Human experiences can communicate a more powerful message than other data. Practical daily life experiences are captured where in other cases they may be missed, and this type of data is typically specific to a particular cohort rather than generalisable⁹⁰.

Limitations

Some limitations of this research must be acknowledged. Inclusion criteria for the scoping review were limited to studies that were written in English, potentially excluding relevant articles from more diverse contexts. Additionally, time constraints limited the double extraction of relevant data by two researchers to only 16 articles, rather than all 96. All data extraction was cross-checked for validity by a second reviewer; however, some data may have been missed. The qualitative interviews were conducted with stakeholders, including policymakers, service providers, and service users. Individuals experiencing homelessness in Dublin at this time, who did not access the PMVT services were not included in this study and therefore their perspectives and potential barriers they may have faced when trying to access services are not captured.

Future Directions

Future research could include health assessments and psychometric questionnaires gathered during COVID-19 to assess the impact of interventions similar to the services provided by PMVT on overall health and wellbeing. For PMVT, collecting long-term follow up data on clients

included in our current report may help inform whether the interventions implemented in during the pandemic has long-lasting effects. Also, given that there is a global shift from online to more face-to-face contact, conducting qualitative interviews in person may provide a more personable environment for service users and other stakeholders rather than meeting people online for the first time.

Concluding Statement

The PMVT took on the enormous task of adapting to the almost instantaneous arrival of COVID-19 in Ireland, tasked with caring for one of the most vulnerable cohorts of the Irish population. As detailed in this report, the pandemic brought both challenges and improvements to the sector, which highlight adjustments that must be made and convey areas that would benefit from being maintained post-COVID. Further insight was gained in the nature of homelessness, highlighting areas that can be targeted outside of the accommodation level.

This comprehensive study sheds light on the nuanced impact of COVID-19 on homeless and drug-using populations. Recommendations include tailored support for diverse needs, increased collaboration among service sectors, and strategies to address emergent challenges. These findings offer valuable insights for shaping responsive and sustainable healthcare strategies for marginalised populations in future public health crises.

As Ireland experiences a demographic shift, increasing differences in culture, language, and gender and sexual identity will warrant further attention and adaption to address the specific needs of these service users. Through inaction of these recommendations, improvements can be made in the service availability, access, safety, and quality for these novel populations as well as the existing service user demographic.

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Supplementary table 1: Figures produced from all of our logistic regression analyses which helped inform Table 4 of our high-level needs subsample only (n=488). Where * indicates “p < .1”. ** indicates “p < .05”; and *** indicates “p < .01”. The lower the p value, the more significant the association.

Variable	Suboxone OST initiated in service	Methadone OST initiated in service	Librium detox initiated in service	Benzodiazepine stabilisation initiated in service	Drug dependency
Age	(.68-1.15)	(.97-1.01)	(1.00-1.05)*	(.97-1.01)	(.98-1.01)
Gender:					
Male	(Reference)	(Reference)	(Reference)	(Reference)	(Reference)
Female	-	(.63-2.00)	(.25-1.39)	(.94-3.14)	(.79-1.92)
Services ever attended:					
PMVT Dublin Region Homeless Isolation Services	-	(1.13-12.16)*	-	-	(.51-1.63)
PMVT shielding service	-	(.22-.99)*	(.30-3.53)	(.30-1.84)	(.78-4.11)
PMVT HSE Isolation service	-	(.91-7.38)	-	(.87-9.45)	(.63-2.13)
Booking type:					
Ever booked for self-isolation	-	(.18-.66)**	(.17-.93)*	(.10-.50)***	(.48-1.16)
Ever booked as a confirmed Case	-	(.69-2.18)	(1.14-7.00)*	(.93-3.49)	(.53-1.25)
Ever booked for cocooning/shielding	-	(.26-.86)*	(.32-1.70)	(.34-1.31)	(1.01-3.32)*
Access to:					
Entitlements	-	(.02-.33)**	-	(.04-.76)*	-
Advocacy	-	(2.21-21.07)**	(.15-9.48)	(1.26-14.34)*	(.27-3.73)
Commencing medication and compliance	-	(.05-.45)**	(.11-6.66)	(.05-.52)**	(.27-3.67)
Community connection support	-	(.04-.81)*	-	(.03-.65)*	(.21-15.11)
Family connection support	-	-	(.00-1.12)	-	(.02-4.77)
Activities of daily living	-	(.01-.54)**	-	(.03-.99)*	-
Referral and linked to	-	(.03-.33)***	(.11-6.66)	(.05-.52)**	(.27-3.67)

specialised services					
Safe practices	-	(.04-.37)***	(.09-1.90)	(.06-.57)**	(.30-4.00)
Social supports	-	(.05-.41)***	(.10-2.04)	(.07-.63)**	(.33-4.32)
Language supports	-	-	-	-	-
History of:					
Rough sleeping	-	(.10-.34)***	(.11-.47)***	(.08-.26)***	(.69-2.27)
Care	-	(.09-.99)*	-	(.07-.80)*	(.20-2.19)
Custodial	-	(.09-.61)**	(.06-.54)**	(.09-.65)**	(.26-1.82)
Has dual diagnosis	-	(.09-.57)**	(.07-.63)**	(.02-.13)***	(.39-2.95)
English proficiency:					
Limited English Proficiency	-	(.01-.80)*	(.03-1.91)	-	(.43-2.21)
Full English Proficiency	(Reference)	(Reference)	(Reference)	(Reference)	(Reference)
Scalar values:					
Length of stay	(.96-1.04)	(1.00-1.01)**	(1.00-1.00)	(1.00-1.00)	(1.00-1.00)
Health conditions:					
Personality disorder	-	(.01-.36)**	-	(.02-.54)**	-
Bipolar disorder	-	(.03-.67)*	()	(.01-.29)**	-
ADHD	-	-	-	(.02-2.47)	-
Anxiety	-	(.12-1.27)	(.06-.63)**	(.10-1.02)	(.28-2.82)
Schizophrenia spectrum disorder	-	(.15-1.96)	-	(.07-.63)**	(.44-8.86)
Depression	-	(.13-.82)*	(.07-.51)**	(.08-.51)**	(.37-2.41)
High blood pressure	-	(.11-1.52)	(.05-.76)*	(.16-9.76)	(.32-6.96)
PTSD	-	(.02-.97)*	(.02-2.03)	(.02-.78)*	(.09-8.67)
Asthma	-	(.05-.30)***	(.10-1.35)	(.06-.37)***	(.50-5.98)
Back problems	-	(.02-.44)**	(.05-3.54)	(.02-.36)**	-
COPD	-	(.10-1.08)	-	(.11-1.46)	(.51-30.73)
HIV	-	(.04-.81)*	-	(.03-.65)*	()
Diabetes	-	(.10-6.96)	-	(.08-5.64)	(.21-15.11)
Epilepsy	-	(.13-1.05)	(.13-2.63)	(.08-.61)**	(.59-11.45)
Hepatitis C	-	(.02-.25)***	(.09-5.61)	(.02-.28)***	(.15-1.78)
Seizure risk	-	(.04-.12)***	-	(.00-.03)***	(.55-1.62)
Nationality:					
Ireland	-	(Reference)	(Reference)	(Reference)	(Reference)
Asia	-	(.64-18.21)	-	(.66-18.74)	(.06-4.55)

Rest of Europe	-	(.87-4.26)	(.88-5.94)	(.37-2.67)	(.40-1.73)
Americas	-	-	-	-	-
Oceania	-	-	-	-	-
UK	-	(1.17-62.37)*	-	(.30-28.87)	(.11-10.53)
First year of homelessness:					
0-1 year	-	-	-	(.05-3.58)	(.18-2.55)
2-3 years	-	(.09-1.82)	(.04-2.64)	()	(.46-2.90)
>3 years	-	(Reference)	(Reference)	(Reference)	(Reference)



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