BREAKING THE CYCLE: ADDRESSING MENTAL HEALTH AND HOMELESSNESS THROUGH INTEGRATED CARE

Research Brief – March 2025

tasc
Think-tank for action on social change
Mental Health Reform
DEPAUL
Homelessness has no place

Introduction

Depaul and Mental Health Reform commissioned an independent assessment of mental health needs and services available for people experiencing homelessness (PEH) in Ireland. The research was conducted by TASC .

Mental health difficulties (MHDs)1 are widespread in Ireland, with studies highlighting a growing demand for services. There is a well-documented need for mental health support across the general population. However financial investment in mental healthcare has been and continues to be lower than expected.

Published research also shows that PEH face significantly higher rates of MHDs than the general population. They are more likely to experience co-occurring substance misuse, encounter greater barriers to accessing care, and suffer the negative mental health impacts of homelessness itself.

This research brief provides an overview of the full report on the prevalence of MHDs among PEH in Ireland and the adequacy of existing mental health services to meet their needs. It summarises key findings on service accessibility, gaps in care, and the impact of systemic barriers. Additionally, it outlines recommended policy and service improvements, including person-centred, trauma-informed approaches, enhanced data collection, multidisciplinary collaboration, and increased investment in infrastructure and staff training.

1 Note that here and in the full report we follow the language used in Ireland's national mental health policy, Sharing the Vision. Further explanation is available in the full report.

Research Questions

The research project aims to explore critical gaps in understanding the mental health needs of people experiencing homelessness in Ireland by addressing these research questions:

1. What is the prevalence of different MHDs among PEH in Ireland?

2. How do MHDs and access to supports vary across different types of PEH?

3. How can access to and the quality of mental health supports for homeless populations be improved?

Methodology

In consultation with Depaul and Mental Health Reform, a two stage approach was designed to address the research questions:

Stage 1: Analysis of Existing Data

- Administrative data collected by Depaul and stored in the OTIS database were analysed to assess the prevalence of MHDs among PEH in Depaul accommodation settings from 2018-2023.
- The data were separated by housing type in order to assess prevalence of MHDs, including substance misuse.

Stage 2: Engagement With Stakeholders

Service User Interviews

- Residents in Depaul supported services were invited to semi-structured interviews. A total of 25 Depaul residents participated in interviews in the cities of Dublin and Cork.
- The topics covered included the resident's mental health journey, their access to mental health services, the effectiveness of these services, and their utilisation.

Service Provider Focus Groups

- 12 service providers participated in two online focus groups.
- Thematic analysis highlighted patterns in services which were identified in the survey.

Service Provider Survey

- 22 service providers working in housing support services in both urban and rural settings completed the online survey.
- Quantitative and thematic analysis identified patterns, barriers, and gaps in services.

Key Findings

The five overarching research questions were explored using the evidence gathered using the analysis of primary and secondary data. Each is examined in the sections below.

Prevalence

Research question 1 investigated the prevalence of various MHDs among PEH in Ireland by analysing Depaul's administrative data. The research also examined differences in prevalence based on factors such as gender and housing situation.

Data from 4,504 Depaul residents highlight a diverse population with varying residency durations, demographics, and MHDs. The average resident age was 37.4 years, with significant gender and nationality diversity.

15.9% **had a history of hospitalisation for mental health**, rising to **38.0%** among those who self-reported MHDs, overall.

19.9% of residents, in total, expressed experiencing **feelings of isolation.**

36.9% of residents in homeless housing expressed **experiencing MHDs when investigated by housing type,** compared to **19.5%** who were in International Protection Accommodation Services (IPAS).

- → Reported MHD prevalence according to the Depaul data are lower for some MHDs than would be expected from international literature, as well as prevalence in the general population.
- → Deviations from expected values in MHD prevalence by housing type may be explained by differences in data collection methods.

Access to Mental Health Support

Of Depaul residents:

4.2%

had access to a **psychiatric nurse**

9.4%

had access to a **counsellor**

8.1%

had access to a **social worker**

Substance Misuse

Of Depaul residents:

21.6%

reported **alcohol misuse**

30.7%

reported **drug misuse**

73.5%

of cases were among **male residents**

26.5%

of cases were among **female residents**

Variation in MHDs and Available Supports

Research question 2 explored how self-reported MHDs and supports vary across different groups of PEH. This included gaining first hand accounts from individuals working or living in a variety of housing situations, including emergency accommodation, long-term homeless services, or IPAS.

A variety of MHDs were identified by research participants, including anxiety disorders, depression, PTSD, schizophrenia and substance misuse. The mental health journeys discussed with participants experiencing short and long-term difficulties. Most residents mentioned during interviews that they were affected by more than one MHD and some substance misuse was co-occurring with other MHDs.

Individuals in all types of accommodation expressed experiencing MHDs. Some participants stated that living in accommodation for PEH was negatively affecting their mental health.

Residents and service providers frequently spoke about challenges to accessing key mental health supports, including psychiatric care, counselling, and peer-led services. They also mentioned that engagement with support services varied depending on individual circumstances, such as substance misuse or length of time experiencing homelessness.

A lack of a consistent approach was noted by individuals that have experiences with institutions.

Some with experience in prison and probation services felt supported in their housing journey, while many did not.

Anecdotal evidence suggests a gender disparity, with women receiving better housing and mental health support than men after prison release.

PEH with hospital experience reported inconsistencies in the mental health support they received.

Research participants highlighted a general lack of mental health support for PEH, with long waiting lists frequently mentioned as a barrier to access. Many emphasised the need for more one-to-one support, as group support is not always suitable for every individual's situation. Some interviewees also reported relying on medication to manage their mental health but were unable to access one-to-one counselling due to extended wait times.

Role of Key Workers and Housing Staff in Mental Health Support

Concerns and Support

PEH expressed having difficulties in managing their mental health and highlighted the support received from housing staff.

Practical Assistance

Key workers helped with medical appointments, advocacy, paperwork, medication, information sharing, and communication.

Emotional support

Some residents, not ready for counselling, relied on key workers for guidance and trust. Staff at times struggled with finding appropriate locations to have private and sensitive conversations.

Addiction Recovery

Key workers played a vital role in supporting residents through recovery.

Social Group Meetings

Residents valued meetings with peers, where key workers provided additional support.

Recommendations for Improvements

Research question 3 pinpointed how access to and the quality of mental health supports for homeless populations can be improved, focusing on identifying gaps in services, enhancing resource allocation, and ensuring more tailored and accessible care for individuals with diverse needs.

This report primarily focuses on accommodation for PEH and some residents in IPAS accommodation. Interviews with Depaul residents revealed inconsistencies in Ireland's approaches to addressing MHDs and alcohol and drug misuse among PEH. While some individuals have access to multidisciplinary supports, many face significant barriers to obtaining adequate assistance. The report then outlines recommendations to improve support systems for PEH at organisational, regional, and national levels. However, it is important to note that Depaul, and other providers, need sustained funding to ensure adequate mental health and housing supports for PEH.

Organisational Level

1. Data and Monitoring

Systematic recording MHDs in database and track staff inputs at the site level.

2. Staff Training

Train staff on MHDs, PEH barriers, and trauma impacts to improve client support.

3. On-Site Supports

Provide mental health and addiction services directly in homeless accommodations.

4. Peer Support

Establish peer support programmes to reduce stigma, especially for drug users and pregnant women.

5. Flexible Service Models

Use a hybrid model with scheduled support and flexibility for urgent needs.

6. Case Management

Implement case management to enhance service collaboration and continuity of care.

Regional Level

1. Collaborative Efforts

Strengthen partnerships between homelessness and MH services through co-location and shared protocols.

2. Multidisciplinary

Develop multidisciplinary teams in all regions to address complex needs with MH professionals, addiction specialists, and housing providers.

3. Outreach and In-reach

Provide mental health and addiction services directly in homeless accommodations.

4. Co-Location and Good Practices

Promote co-location of services and replicate successful models like those in Dublin and Longford for improved care and outcomes.

National Level

1. Full Legislative Reform

Reform the Mental Health Act (2001) to align with the United Nations Convention on the Rights of Persons with Disabilities, ensuring the protection of the rights of all persons with mental health difficulties.

2. Dual Diagnosis Model

Prioritise the Dual Diagnosis Model for integrated care for those with co-occurring mental health and substance use issues.

3. Single Bedroom Availability

Increase single bedroom accommodations to ensure dignity and privacy for those experiencing homelessness.

4. Funding and Infrastructure

Train staff on MHDs, PEH barriers, and trauma impacts to improve client support.

5. Systemic barriers

Address systemic issues hindering access to care, focusing on reducing administrative barriers and improving person-centred support.

6. Housing First

Scale up Housing First to address housing, mental health, and addiction needs holistically.

7. Family Unification

Address barriers to family reunification, particularly for mothers, and increase family-friendly hostels.

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