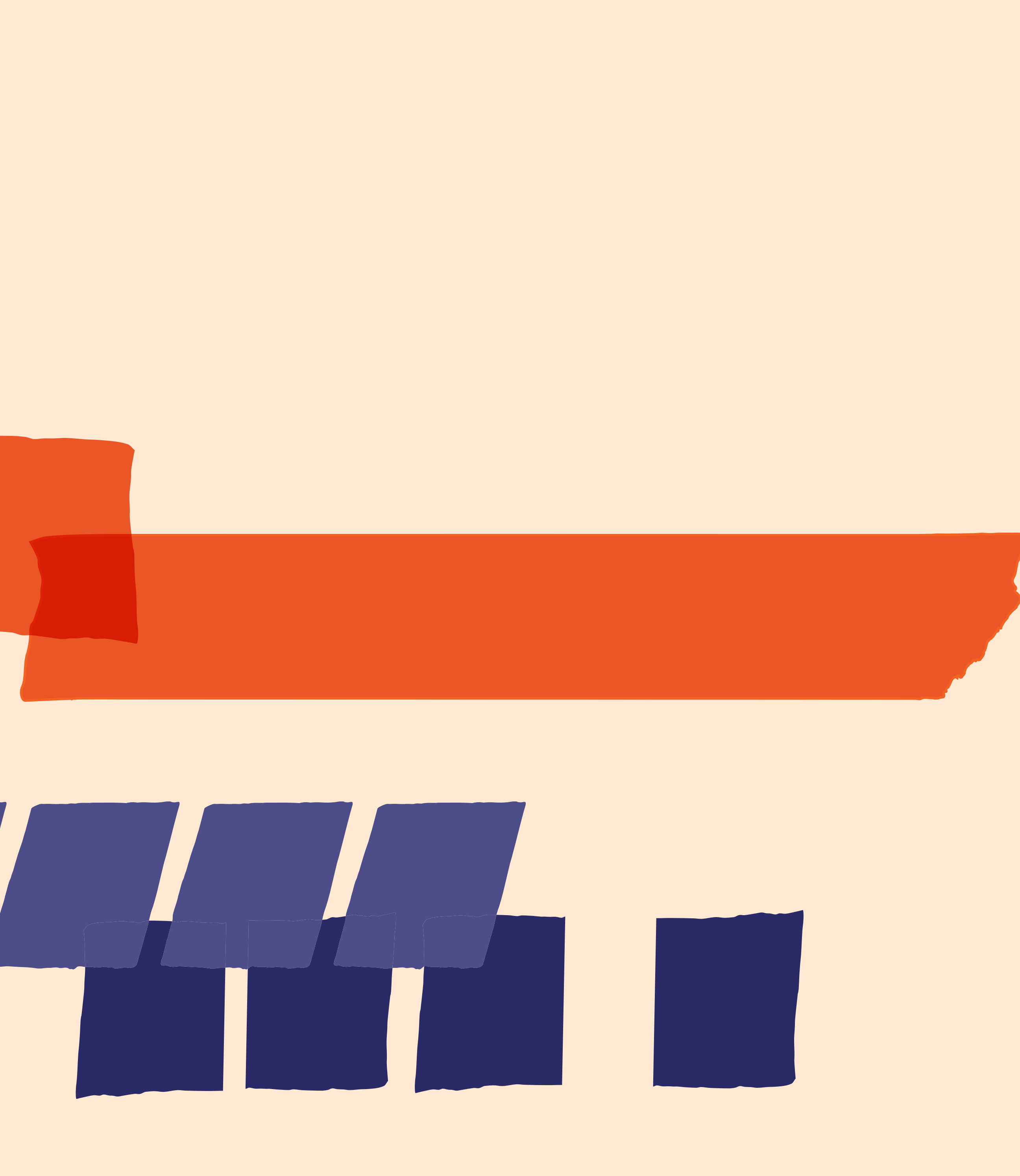
Research Report – March 2025



Acknowledgements

This report would not have been possible without the generous contributions of time, expertise, and lived experiences from a wide range of individuals and organisations.

Deepest gratitude is extended to the people who shared their personal journeys with homelessness and mental health difficulties. Your courage and willingness to share your stories have been instrumental in shedding light on the complexities of these issues and in shaping the findings of this report.

Immense thanks to the service providers and frontline workers who supported this work. Your insights, commitment, and dedication to addressing the challenges faced by individuals experiencing homelessness and mental health difficulties have provided invaluable perspectives throughout this project.

Special thanks to staff at Depaul and Mental Health Reform, including the Depaul Peer Advocates, for their guidance and practical support throughout this process. Your expertise and collaboration were vital in ensuring the accuracy and relevance of our findings.

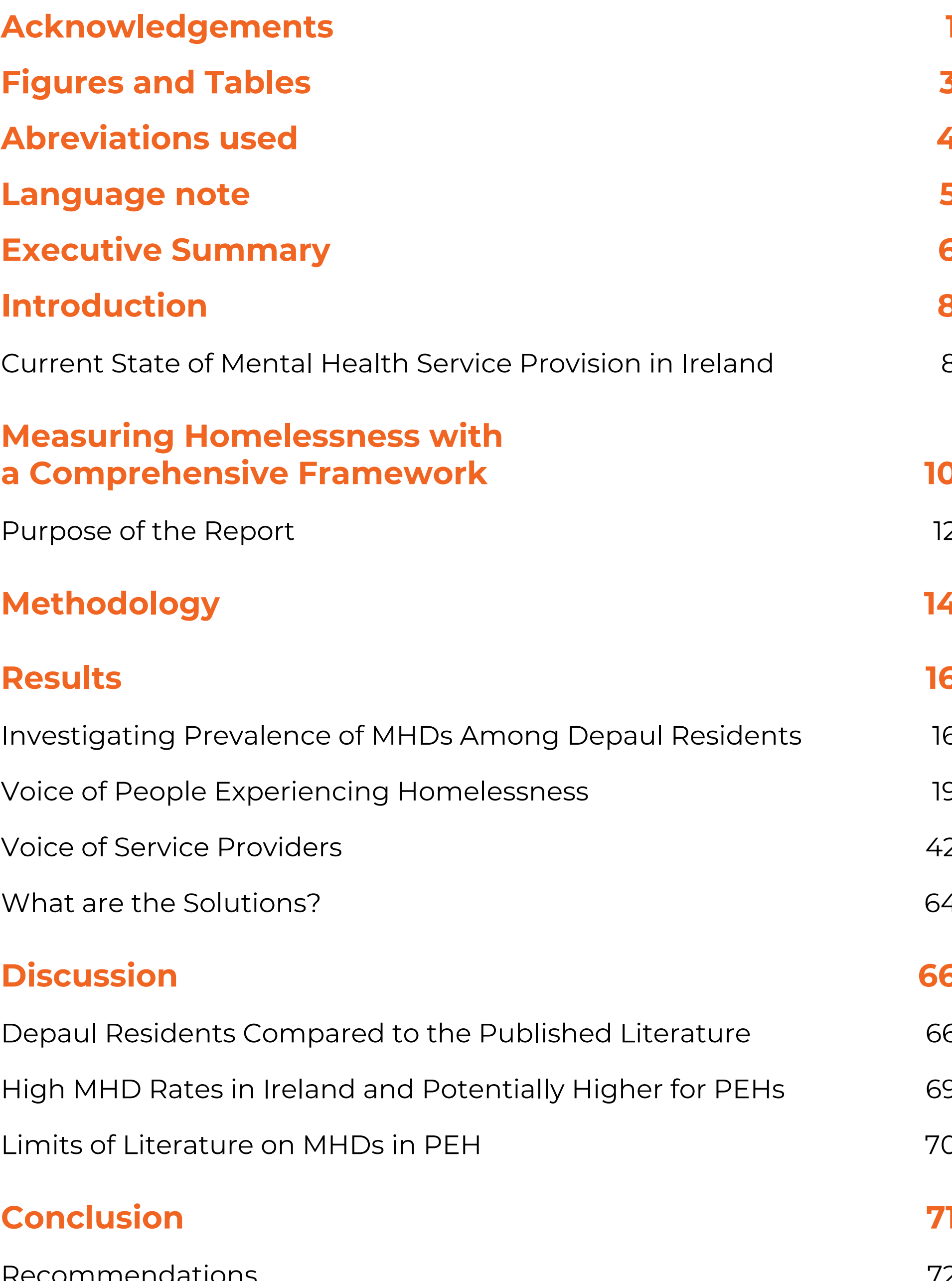
At TASC – Thinktank for Action on Social Change, thank you to Dr. Shana Cohen, Lauren Cotter, Katelin Bratt and Ciarán Ramsbottom.

This report was prepared for Depaul and Mental Health Reform by Adeelia Goffe, Senior Researcher for Health at TASC.

TASC receives support under the Scheme to Support National Organisations (SSNO) which is funded by the Government of Ireland through the Department of Rural and Community Development.

TASC receives support under the Scheme to Support National Organisations (SSNO) which is funded by the government of Ireland through the Department of Rural and Community Development.

Contents



Acknowledgements 1

Figures and Tables 3

Abreviations used 4

Language note 5

Executive Summary 6

Introduction 8

Current State of Mental Health Service Provision in Ireland 8

Measuring Homelessness with a Comprehensive Framework 10

Purpose of the Report 12

Methodology 14

Results 16

Investigating Prevalence of MHDs Among Depaul Residents 16

Voice of People Experiencing Homelessness 19

Voice of Service Providers 42

What are the Solutions? 64

Discussion 66

Depaul Residents Compared to the Published Literature 66

High MHD Rates in Ireland and Potentially Higher for PEHs 69

Limits of Literature on MHDs in PEH 70

Conclusion 71

Recommendations 72

Figures and Tables

Figure 1. Geographic Distribution of Organisations Surveyed (N=22) 42

Figure 2. Types of Homelessness and/or Housing Insecurity in which service users live (N=22) 43

Figure 3. Prevalence of mental health, behavioural and substance misuse difficulties (N=2) 44

Figure 4. Specific Difficulties (N=189) 46

Figure 5. Service Efficacy for Addressing Both Homelessness and Mental Health (N=21) 48

Figure 6. Biggest Barriers Preventing PEH From Accessing Mental Health Services (N=174) 51

Figure 7. Service Provider Rating of the Availability of MH Services to PEH (N=22) 56

Figure 8. Main Service Gaps (N=87) 58

Figure 9. Proportion of Service Providers who Feel that Policy Makers Understand the Connection Between MH and Homelessness (N=22) 62

Figure 10. Key priorities for service improvement (N=84) 63

Figure 11. Ways to Improve Service Integration (N=89) 64

Figure 12. Comparison of Mental Health and Substance Use Difficulties Across Studies 67

Table A1. ETHOS Categories and Definitions of Homelessness and Housing Exclusion 80

Table A2. Specific MHD Prevalence and Comorbidities: 81

Table A3. Specific MHD Prevalence: Schizophrenia, PTSDs, Depression, Anxiety, Suicidal Ideation, Suicide Attempt, Self-harm, Personality Disorder, Alcohol and Drugs 83

Abbreviations

CSO	Central Statistics Office
DOH	Department of Housing
ETHOS	European Typology of Homelessness and Housing Exclusion
GPs	General Practitioners
HSE	Health Service Executive
IPAS	International Protection Accommodation Services
MH	Mental Health
MHD	Mental Health Difficulties
MDT	Multi Disciplinary Team
PEH	People Experiencing Homelessness
PER	People Experiencing Rooflessness
PTSD	Post-Traumatic Stress Disorder
WHO	World Health Organisation

Language Note

Ireland's national mental health policy, *Sharing the Vision: A Mental Health Policy for Everyone*, uses the term 'mental health difficulties.' However, the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which Ireland ratified in 2018, refers to 'psychosocial disabilities' when discussing individuals with mental health difficulties or those who identify with this term. The UNCRPD affirms that its protections and rights apply to people with psychosocial disabilities.

Mental Health Reform (MHR) supports individuals' right to choose how they describe their own experiences, recognising that *"it is an individual choice to self-identify with certain expressions or concepts, but human rights still apply to everyone, everywhere."* This is not about a medical diagnosis but rather the interaction between a person with a mental health difficulty and their social environment. 'Psychosocial disability' refers to the barriers and functional impacts faced by individuals living with enduring mental health difficulties in their daily lives.

Executive Summary

Using Depaul administrative data and first hand stakeholder accounts, this research shows the urgent need for joined-up support services to help people in Ireland who are homeless and dealing with mental health and substance misuse difficulties. People who are experiencing homelessness often face higher rates of mental health difficulties and addiction, and these difficulties are being underreported in administrative databases.

These issues are made worse by difficulties in accessing services, with some individuals being less likely to disclose when they are in need of support because of previous negative experiences. Though accessing mental health services is difficult for the general population, the way services are currently organised can make things harder for vulnerable individuals.

This report calls for putting in place person-centred, trauma-informed, and flexible mental health supports for people experiencing homelessness. It points out gaps, like not enough funding, lack of staff training, and poor teamwork between homelessness, mental health, and addiction services. It also highlights good practices, such as teams with experts from different areas and services located in the same place. These approaches have shown better results and improved experiences for people using the services.

The specific recommendations focus on addressing gaps at organisational, regional, and national levels and cover these areas:

- **Adjusting Service Delivery Models**
- **Provision of Mental Health Supports**
- **Improving Access to Training and Good Practices**
- **Enable Collaboration and Systemic Improvements**
- **Invest in Infrastructure and Resources**
- **Improvements to Data and Monitoring**

Policy Implications for Ireland

The recommendations provided carry significant policy implications for Ireland, particularly in addressing the gaps in mental health and addiction support for people experiencing homelessness and residents in International Protection Accommodation Services. These include the need to integrate and streamline services and prioritising multidisciplinary and trauma-informed approaches to care. Policies should aim to enhance data collection and monitoring systems to better understand the prevalence of mental health difficulties among people experiencing homelessness, enabling more targeted interventions. Investments in staff training across clinical and non-clinical roles are essential to equip workers with the skills to provide effective, empathetic support while addressing stigma and barriers to care.

Expanding Housing First initiatives and co-locating homelessness, mental health, and addiction services would provide holistic support, ensuring that individuals receive timely and comprehensive care. The implementation of the Dual Diagnosis Model of Care and the establishment of multidisciplinary teams through Ireland would address the intertwined nature of mental health and substance use challenges, improving outcomes for people experiencing homelessness. Additionally, scaling up peer support programmes and flexible service delivery models would foster greater engagement and inclusivity, particularly for marginalised groups.

At the national level, adequate funding is crucial to support these initiatives, along with efforts to remove systemic barriers, such as administrative hurdles, that hinder access to care. Policies should also focus on enhancing housing dignity through single-bedroom availability and supporting family unification to strengthen social stability. Collectively, these measures underscore the importance of adopting a person-centred approach to tackling homelessness, mental health, and addiction issues in Ireland.

Introduction

Current State of Mental Health Service Provision in Ireland

High Demand for but Low Investment in Mental Health Services

Recent studies indicate a significant prevalence of mental health difficulties (MHDs) among the Irish population. A 2022 study found that 42.5% of Irish adults met the criteria for at least one MHD (Hyland et al. 2022). Additionally, 21% of the population in Ireland were estimated to have had a MHD in 2019 (European Commission 2023). This indicates that a substantial portion of the Irish population experiences MHDs.

However, despite the high prevalence of mental health disorders in Ireland, only

5.1% of total government health expenditure is allocated to mental health

5.1% of total government health expenditure is allocated to mental health, far below the WHO's recommended 12% and Ireland's own 10% target under Sláintecare (Hyland et al. 2022). In addition, Ireland has a lower proportion of psychiatrists, a higher vacancy rate in consultant psychiatry posts and fewer mental health beds than would be expected based on population size (Hyland et al. 2022).

Legislative Policy Developments

Ireland's Sharing the Vision policy, launched in 2020, provides a ten-year framework for the development of mental health services. The policy outlines a commitment to a more holistic, person-centred approach to mental health care, focusing on early intervention, community-based services, and integrated care (Department of Health, 2020). It prioritises reducing stigma, ensuring equitable access, and expanding support for vulnerable populations. Specifically identifying people experiencing homelessness (PEH) as a priority group. Key objectives include enhancing the mental health workforce, fostering cross-sector collaboration, and addressing the social determinants of mental health (Department of Health, 2020).

Mental Health Service Funding Commitments and Ongoing Challenges

Ireland's mental health service provision is undergoing significant developments marked by legislative reforms, increased funding, and ongoing challenges in service delivery. In July 2024, the Irish government approved the publication of the Mental Health Bill 2024, aiming to update definitions and practices within mental health services (Department of Health, 2024).

In 2024, Ireland allocated approximately €1.3 billion to mental health services (Oireachtas, 2024a) and €1.5 billion promised for 2025 (Oireachtas, 2024b). Despite this financial commitment, public concern persists regarding the quality and accessibility of mental health services, with reports highlighting long waiting times and systemic issues (Halpin, 2024). Particular concern has been raised regarding vulnerable populations (Halpin, 2024). Advocacy groups, such as Mental Health Reform, continue to call for sustained investment and policy reforms to address service gaps and ensure timely access to mental health care for all (e.g. Mental Health Reform, 2024).

Research consistently shows that PEH are disproportionately affected by MHDs compared to the general population: higher prevalence of MHDs (Fazel et. al. 2014), intersection of substance use (Tsai et al. 2017), higher barriers to care (Canavan, 2012; Carmichael, 2023) and the impact of homelessness on mental health (National Academies of Sciences, Engineering, and Medicine, 2018).

Measuring Homelessness with a Comprehensive Framework

European Typology of Homelessness and Housing Exclusion

European Typology of Homelessness and Housing Exclusion (ETHOS) is a standardised framework for understanding and defining homelessness (FEANTSA, 2005). ETHOS serves as a shared framework for discussing homelessness, allowing for consistent data collection and policy development across countries (Pleace et al., 2011). Under ETHOS, living situations are divided into four conceptual categories (see Appendix, Table A1):

- **Roofless**
- **Homeless**
- **Insecure**
- **Inadequate**

Each category describes distinct living situations that would qualify the person experiencing them as homeless. This research primarily concentrates on the operational categories that encompass individuals experiencing rooflessness and homelessness, including emergency accommodation, accommodation for the homeless and accommodation for immigrants.

Prevalence of Homelessness in Ireland

As of December 2024, 10,354 adults and 4,510 children are accessing emergency accommodation in Ireland according to the Monthly Homeless Report published by the Department of Housing (DOH), Local Government, and Heritage. Outreach Teams identified a further 134 individuals sleeping rough in Dublin during winter 2024, totalling 15,333 people experiencing rooflessness (PER) identified by this report in Ireland at the time, or 0.28% of the Irish population based on the most recent census figures from the Central Statistics Office (CSO, 2024). By comparing the number of PER from the Monthly Homeless Report with population figures from the CSO, we can estimate that there are approximately 284 PER for every 100,000 people in Ireland. In addition, PER statistics reported by the CSO have been increasing (e.g. CSO, 2016, 2022).

The above estimates reflect those PER, excluding other forms of homelessness (see Table A1). The actual number of PEH in Ireland is likely much higher, as the DOH's method of counting only includes those who are experiencing rooflessness. For example, under the ETHOS framework, people living in penal or medical institutions who stay longer than they need to due to a lack of housing would be considered to be experiencing homelessness. Gulati and colleagues (2018) found that over one-in-six people in custody were experiencing homelessness at the time of their incarceration. As of 31 December 2024, the Irish Prison Service (2024) reports that there are 5,001 people in custody in Ireland. There could be roughly 800 people incarcerated in Irish prisons who are experiencing homelessness.[1] This would raise the total number of PEH in Ireland to over 15,000. In April 2024, the DOH's count of people in emergency accommodation reached above 14,000 for the first time, a 14% increase on the 12,259 recorded one year prior (Gleeson, June 2024). In addition, there are currently well over 30,000 immigrants being housed in direct provision centres, which would fall within the umbrella of homelessness (IPAS, 2024). All evidence suggests that the true number of PEH in Ireland is rising and is likely higher than what is currently being reported.

1 Based on one in six people in custody experiencing homelessness at the time of incarceration (from Gulati et. al 2018).

Purpose of the Report

The high prevalence of MHDs in the general population, combined with the disproportionately high rates of MHDs among PEH, raises critical concerns about the adequacy of current mental health services in Ireland. Given the acknowledged challenges mental health services have been facing and the complexity of the issues faced by PEH, it is essential to evaluate whether the existing mental health care system is equipped to address the specific needs of this vulnerable group.

Using an internationally recognised framework for housing precarity, this research examines the extent and types of MHDs in this marginalised group. Drawing from diverse studies, including epidemiological surveys, clinical research, and primary data, this report offers a comprehensive overview of MHD prevalence rates among PEH.

By drawing attention to these issues, it contributes to broader research efforts aimed at developing targeted interventions. The insights gained will help shape more effective policies and programmes that address the unique mental health needs of this vulnerable population.

The review begins with a framework for understanding homelessness, then examines its prevalence in Ireland and the widespread occurrence of MHDs among PEH compared to the general population. While it cannot fully explore the complex relationship between MHDs and homelessness, it acknowledges their significant interplay, which profoundly impacts the lives and choices of PEH in Ireland.

Methodology

Assessing the Prevalence of Mental Health Difficulties Among People Experiencing Homelessness

A data analysis of Depaul client needs assessments data as recorded on the OTIS administrative database, was conducted to estimate MHD and the need for alcohol and drug support for those people resident during 2018-2023.[2] Demographic data were compared to national statistics to identify patterns and differences. The findings from both steps were integrated to provide a comprehensive understanding of the prevalence of MHD among PEH.

These data were then compared to MHD prevalence statistics found in Irish and international literature.

Mental Health Supports and Services

This stage explored the mental health services available to PEH in Ireland, evaluating their accessibility, effectiveness, and utilisation. Semi-structured interviews were conducted with 25 Depaul clients to gather insights into their experiences with mental health supports, including barriers and preferences. Participants represented diverse demographics and were resident across a range of services located in the cities of Dublin and Cork.

Service providers were surveyed and participated in focus groups to understand their experiences working with PEH. Recruitment focused on organisations serving different PEH subgroups and those providing mental health and other types of support. Data were collected through online surveys and interviews, with 22 service providers participating in the survey and 12 providers participating in the two focus groups. Analysis combined quantitative and thematic approaches, identifying patterns, barriers, and gaps in the services. The findings highlighted key challenges and provided recommendations to improve service delivery and accessibility for PEH.

Research Guidance by Depaul Peer Advocates

Depaul peer advocates[3] were an important part of the research process and used their lived experience as PEH as their work experience to provide important support to the research process. They offered research guidance throughout various stages of the project, including study design, as well as the development of interviews, focus groups, and surveys.

2 These data included all residents during 2018-2023, regardless of if their residency started prior to 2018 or ended after 2023.

3 Peer advocates have lived experience of homelessness and have been trained to deliver Depaul's Homeless Health Peer Advocacy Programme. For more information, see English 2024

Results

Investigating Prevalence of MHDs Among Depaul Residents

Background: Residency Duration, Age, Gender and Nationality

Background data on residents was provided by analysing an administrative database containing data from PEH who were resident in full or in part from 2018-2023. These data include individuals who were residing in homeless accommodation as well as those who resided in International Protection Accommodation Services (IPAS) accommodation. In total, 4,504 PEHs stayed in 32 Depaul services for an average duration of one year, with one individual remaining for up to 14.5 years. The distribution is highly skewed, with a median service duration of 0.66 years, indicating that many PEH's were resident for relatively short periods of time.

At registration, Depaul residents had an average age of 37.4 years, with the youngest being 18 and the eldest 82. Among them, 42.3% identified as female, 57.6% as male, and 0.1% as other.

When looking at the breakdown by gender category and age, significant differences in ages were found. Male residents (39.7 years) were found to be significantly older, on average than the other two gender categories, with female residents (34.2 years) significantly older than those who identified with other gender (24.5 years).[4]

The data reveals a diverse population with significant representation from various regions, with 91 different nationalities being supported by Depaul staff. Irish residents make up 60.5% of the total, followed by Nigerians at 4.1% and Zimbabweans at 4.3%. Somalis represent 2.6%, while Polish residents account for 2.5%. Additional representation comes from regions across Sub-Saharan Africa, the Middle East, Asia, and smaller groups from the Americas and Oceania. This diversity highlights the wide-reaching origins and multicultural makeup of the residents.

Mental Health Difficulties and Hospitalisation

A total of 36.9% of all residents in Depaul supported housing reported experiencing MHDs, with 44.5% identifying as female, 55.5% as male, and 0.1% as other. Among the residents, 4.2% had access to a psychiatric nurse, 9.4% had a counsellor, and 8.1% had a social worker. Hospitalisation for mental health was noted in 15.9% of residents, a figure that rose to 38.0% among those who self-reported mental health difficulties. Additionally, at the time of registration, 19.9% of PEH reported feelings of isolation.

A further breakdown by housing type is located in the following section.

A total of

36.9%

of all residents in Depaul supported housing reported experiencing Mental Health Difficulties.

Hospitalisation for mental health was noted in

15.9%

of residents.

4 The analysis examined mean differences among three gender groups: Female (N=1992), Male (N=2714), and Other (N=4). Females had a significantly lower mean value compared to Males, with a mean difference of −5.49 (SE=0.35, p=.001, 95% CI[−5.79,−5.19]). In contrast, Females had a significantly higher mean value compared to the Other group, with a mean difference of 9.70 (SE=0.83, p=.001, 95% CI[8.08,11.32]). Similarly, Males had a significantly higher mean value compared to the Other group, with a mean difference of 15.19 (SE=1.02, p=.001, 95% CI[13.57,16.81]).

Further breakdown of Mental Health Difficulties by ETHOS Housing type

In ETHOS operational categories 2 and 3, which includes people in emergency accommodation and homeless accommodation, 36.9% of residents reported having MHDs. In comparison, ETHOS operational category 5, encompassing people in accommodation for immigrants, showed a significantly lower percentage, with 19.5% of residents reporting MHDs.5 1Indicating that those resident in IPAS accommodation were less likely to have indications of MHDs reported in Depaul administrative databases, in comparison to residents in accommodation for PEH.

39.3%

of residents reported having MHDs.

Alcohol and Drug Misuse

Through a separate line of questioning Depaul residents were also asked specifically about alcohol and drugs. 21.6% reported having difficulties with alcohol misuse, while 30.7% indicated difficulties with drug misuse. Among the residents who reported both alcohol and drug difficulties, 26.5% were female and 73.5% were male.

21.6%

reported having difficulties with alcohol misuse.

30.7%

indicated difficulties with drug misuse.

5 A two-proportion z-test revealed a significant difference between the proportions of the homeless group (41.6%) and the immigrant group (17.4%), z=29.23, p<.001.

Voice of People Experiencing Homelessness

"I was priority on the housing list, into a place I was only there till night we went up, ended up back in the hospital. When I came back out, it didn't hold on to [my] place, that place for me was let go."

Diverse Backgrounds of PEH with MHDs

Twenty-six residents of Depaul services (14 female and 12 male) were interviewed in order to gain insight into the experiences of PEH who have MHDs. Minority groups represented include Irish Travellers, immigrants (e.g., Romanian and Brazilian nationals), asylum seekers, and members of the LGBTQ+ community, highlighting the diverse experiences within this population.

Many participants had histories with imprisonment or hospitalisation, while others also mentioned being raised in the foster care system. If someone's housing situation is not yet precarious, entering into an institution may make their situation unstable. One participant highlighted the instability and challenges of maintaining housing while managing health crises, sharing: *"I was priority on the housing list, into a place I was only there till night we went up, ended up back in the hospital. When I came back out, it didn't hold on to [my] place, that place for me was let go."*

Another participant reflected on his varied experiences with institutional systems, contrasting homelessness and mental health services with the structured routine of the prison service, which they found preferable.

Pathways Into Homelessness

Among men, the predominant factors contributing to homelessness were substance misuse difficulties, mental health difficulties, and family breakdowns. Women, on the other hand, often cited domestic violence, trauma, and mental health difficulties as primary causes.

The sale of properties by landlords also came up as a common pathway to homelessness. One person interviewed stated that the landlord went bankrupt and gave them two weeks' notice after they had been living in the house for more than 10 years with their children. The family was separated, with children going into care and the parents sleeping on the street. The parents slept rough for one year until they could find a hostel where the couple could be together.

One PEH spoke about how he arrived in Ireland, and after starting to raise a family in Ireland and separating from their ex-partner, he became homeless, struggling with the lack of a support system or direction. He said that when they were separated *"problems started because I had no place to go. And that way, I became a homeless person, you know, without any vision [of] how to deal with it."*

However, it was sometimes difficult to attribute homelessness to one particular event or difficulty. Often people were already vulnerable, when a second or third adverse event (or series of events) happened, and they were too young or did not have an adequate support network to continue coping.

Some participants directly attributed substance use to the onset of their homelessness. One resident shared that her struggle began after the loss of her partner, which triggered alcohol dependency. This led to a series of challenges, including legal issues, hospitalisations, and overdoses. The situation worsened following the deaths of a close relative and her partner's suicide, culminating in a period of imprisonment. Upon release, she found herself homeless but eventually secured a place in supportive housing. For another individual, alcohol consumption caused conflict within the home, and he was unable to return after being discharged from the hospital.

One participant attributed her homelessness to her partner's struggles with addiction and the chaotic lifestyle and housing insecurity that resulted from his lifestyle. After the birth of their child, she sought to find another option that was safe and secure for her and the child. As she had moved in with him, the only safe option was to leave him and enter homelessness. She went on to explain that being homeless, dealing with her ex-partner, raising their child, all while living in a shelter made her feel anxious and stressed: *"I cannot let him be way, like, you know, disrupt me from whatever I want to have my life. I don't want to stay here forever. I don't want to be like, unemployed forever. I don't want to be, you know, living [in] fear. It's not really a living fear, but like, be stressed, let's say with him."*

"I cannot let him be way, like, you know, disrupt me from whatever I want to have my life. I don't want to stay here forever. I don't want to be like, unemployed forever. I don't want to be, you know, living [in] fear. It's not really a living fear, but like, be stressed, let's say with him."

Complex Diagnoses and Overlapping Challenges

MHDs such as depression, anxiety, PTSD, and bipolar disorder were frequently diagnosed across genders, often compounded by substance misuse. Some individuals presented with unique challenges, including dyspraxia, psychosis, chronic pain, or physical disabilities. Overlapping diagnoses were common, with many experiencing a combination of mental health difficulties, addiction, and trauma-related conditions.

Nearly half (46.2%) of those interviewed mentioned that they had been struggling with severe depression, anxiety and suicidal thoughts/ideation/attempts for a large part of their lives and prior to experiencing homelessness. A few others who had been diagnosed with neurodivergence (7.7%) or schizophrenia (3.9%) in their childhood or their early 20s.

"I've had depression my whole life"

Many had started experimenting with alcohol and/or drugs before the age of 16. All of the residents interviewed who start drinking or using drugs before entering their teens mentioned at least one early life adverse event and or struggling with MHDs before the age of 12. However, a few participants mentioned that the trauma of losing a child in their late teens or early twenties is what triggered severe MHDs for them.

Navigating Personal Struggles and Recovery

Some interview participants also mentioned the need to prioritise their own mental health while accessing homeless services, and highlighted some of the difficulties they face.

They acknowledged their past difficulties with interactions, including a sense of disconnection due to their own perceived cognitive and emotional challenges. Interview participants often reflected on their past struggles and the process of becoming more aware of their challenges, such as addiction and depression, and their efforts to heal and regain control. Acknowledging the challenges of drug use, some have distanced themselves from substances, though alcohol may still remain a struggle.

Individuals who were living with long-standing MHDs (e.g. long-term depression), expressed experiencing a shift from ignoring or suppressing issues to actively confronting and addressing them. Personal growth was also emphasised, with a desire to re-enter society and contribute meaningfully again after a difficult period. Throughout, there is a focus on prioritising well-being, with individuals recognising the need to take charge of their mental health and work toward stability and self-improvement.

Some individuals acknowledged that they are heavy drinkers, but did connect their drinking with their mental health, or spoke about their drinking in relation to the use of other substances and discounted it as a mental health difficulty.

Each recovery journey was highly individualised, with some participants seeking or benefiting from either individual or group support. In contrast, others expressed concerns that the chaotic environment in homeless accommodation increased their risk of relapse. One participant highlighted the importance of protecting their recovery, saying:

> "I'm afraid to jeopardize my recovery for anything. You know that way, because it's, you know, I keep to myself, because I have to."

However, all interview participants expressed the importance of support towards improving their mental health or aiding their recovery journey.

Some residents in homeless accommodation are at higher risk than others, such as those exhibiting suicidal ideation or tendencies to self-harm, and may be subjected to regular checks every 15 minutes. All residents interviewed who were on these checks had considerable MHDs and were prescribed various medications to support their mental health. However, when asked, they reported having access to a psychiatrist for their medication management, though not all had access to a psychologist, counsellor, or therapist.

The reasons for entering homelessness varied widely. MHDs leading to relationship breakdowns were a recurrent theme, particularly among men. Women frequently reported escaping domestic violence or abusive relationships as a critical factor. Substance misuse, often resulting in housing instability or incarceration, was a significant issue for both men and women. Systemic barriers, such as challenges within direct provision, landlord decisions (e.g., selling property), and limited support networks, further exacerbated housing vulnerabilities. For younger individuals, adverse childhood experiences, such as early trauma or familial instability, played a prominent role.

Additionally, many individuals had involvement with the justice system, with prison stays often linked to addiction or mental health difficulties. Chronic illnesses and physical disabilities added further complexity to their situations. Long-term homelessness was commonly associated with intersecting issues such as substance misuse, incarceration, and strained family relationships.

The Importance of Key Workers

Data indicate that multiple contacts with these institutions are extremely disruptive to housing, with some participants having multiple stays in hospital and/or prison, losing their accommodation and/or their spot on the housing list. People mentioned facing difficult transitions through the various types of homelessness and housing insecurity. Some interview participants spoke about having to sleep rough and couch surf to get by as they had lost their accommodation.

Depaul residents mentioned being supported by staff at institutions in finding a place in homeless accommodation. However, others expressed that although they could have used housing support, none was offered and they spent some time rough sleeping before being able to find a place with services.

Some who had been in prison were supported by prison staff in finding accommodation, but others were not. The reasons why are unclear, but it appears that perhaps those with higher needs (e.g. those with physical disabilities, or on antipsychotic medication) were held for a bit longer until the prison staff/social worker could find them a place. While others, who may not have been seen as being as vulnerable, were not provided with targeted supports.

Similarly, some PEH who lost their accommodation while in hospital were supported in finding accommodation in homeless services. One participant who had been hospitalised, specifically mentioned being supported by a social worker and district nurse in finding accommodation in a hostel.

In general, those who have spent time in prison expressed feelings of disappointment in the lack of support that was offered to them upon their release and the difficulty in them finding out information about their housing situation. They stated that key workers in accommodation for PEH were essential in helping them to understand the system and in getting them back on the housing list, when they had been paused due to being in prison. For one person interviewed, he did not find out for two years that he needed to reapply to the housing list as his situation had not been made clear to him prior to leaving prison. He went on to emphasise the need for better planning and coordination to support individuals transitioning from prison to stable housing.

He advocated for a structured plan to be in place at least six months before a person's release from prison, since *"they know where you are. They know you're coming out".* A structured plan communicated early would ensure that people are registered on housing lists, assigned a caseworker, and informed about their housing options to facilitate a smoother transition to stable accommodation and avoid reliance on hostels. That way *"when you get out, you're actually you're on the system."*

Participants highlighted the severe mental health difficulties one might experience during the transition from street homelessness to supported accommodation. In particular, fear and distress for many residents was associated with emergency accommodation. The unofficial support provided by key workers was mentioned as being highly valuable and essential for residents.

Life in Direct Provision: Prolonged Challenges and Limited Support

One research participant was living in direct provision and spoke about her and her family's experiences. She explained that she, her partner and their four children had been living in direct provision since 2018 and have faced significant challenges. For the past three years, since receiving their permission to remain[6], they have been unable to find stable housing due to a lack of available accommodation outside of the direct provision system.

"We got our papers [...] ever since then, we've been struggling, looking for one way or the other, to get a house, at least, to move our kids out of this situation. Because no one should be in this situation for that long [a] time. You know, it's too long, especially for my kids. It's really terrifying them. They even at a point they were doing so badly in school because of the environment, it was affecting their studies."

At the time of the interview, the family was living in a single room with limited facilities, which has negatively impacted their mental health and the well-being of their children. They are repeatedly being pressured by the building management and IPAS to move, but have been unable to find accommodation elsewhere. The constant instability, lack of support, and overcrowding have led to anxiety, depression, and physical health issues for the family, including a hospitalisation of one of the parents and increasing difficulties with untreated PTSD and trauma for the other parent. While studying, she struggles to balance academics, work and family life. Although she has sought help from housing services and a GP, she feels unsupported, especially in accessing mental health care for herself and her husband.

6 https://www.citizensinformation.ie/en/moving-country/asylum-seekers-and-refugees/refugee-status-and-leave-to-remain/permission-to-remain/

"It's a very terrible situation for myself and my kids. I get depressed off and on. I just try to help myself, just to be strong for them, because it's really very sad that after you've gotten your papers and it's time to integrate in the community, there are no houses, there are no supports, [...] there's nothing at all."

Homelessness is Causing Anxiety and Depression

Some individuals reported that experiencing homelessness worsened their mental health, a pattern seen in both those with pre-existing mental health difficulties and those who developed them after becoming homeless. One participant noted that while homelessness provided some help in terms of having a bed to sleep in, it also increased stress, making it difficult to cope. This individual is taking medication to manage their depression but expressed frustration, saying the medication doesn't alleviate their suffering. (See also the section on living in direct provision)

The Importance of Personal Space and Security in Recovery

Other participants raised concerns around the behaviour of other residents when living in hostels. A man living in mixed accommodation described the chaos of the hostels: *"But, yeah, it's hard, it's tough, it's tough. Yeah, like so many different personalities and people's different hygiene levels and I'm lucky, I'm in a single room."*

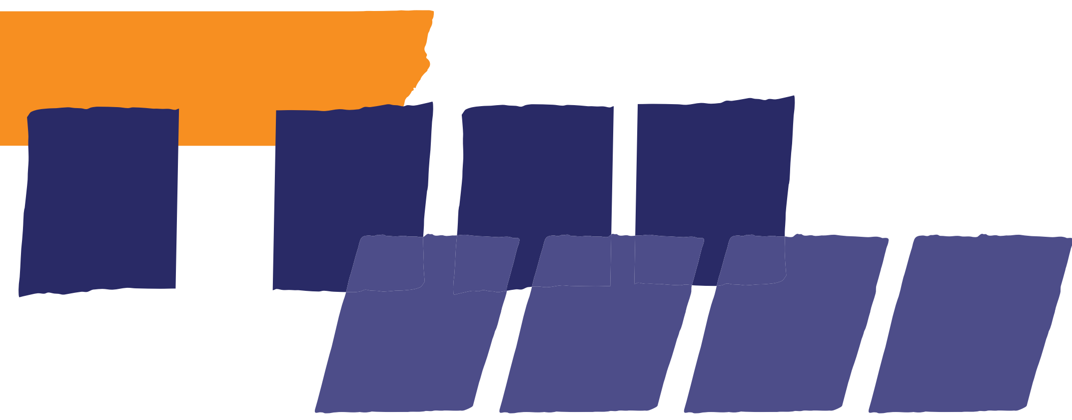
Another person interviewed stated her particular challenges around when she was sharing a room in a hostel: *"when you're trying to get off some drugs, you know, you're sharing a room with two, three others, and they're coming in doing whatever. It's very for you hard to try and stay clean."* She continued by explaining that her current living situation, with her own room, was the best homeless accommodation she had lived in thus far: *"this is the best place that has gotten me clean anyway."*

Participants repeatedly emphasised the importance of having their own rooms for both practical reasons and emotional well-being. One shared how having access to personal kitchen appliances, such as an air fryer and microwave, allows him to meet his basic needs and feel secure when working an irregular schedule. Reflecting on Maslow's hierarchy of needs, he explained that once his *"basic needs"* were met, he could focus on higher-level needs, such as peace of mind and independence. He also highlighted how his current living environment offers a sense of peace and quiet, which contrasts significantly with his previous experiences in housing services.

Interviews also highlighted the increased vulnerability that people with physical disabilities are faced with, as they may need accommodations (e.g. lifts, ramps, special beds) which are not readily available in all housing options. This may reduce their options for accessing properties on the housing list, as well as their opportunities regarding homeless accommodation.

One participant shared his feelings of frustration, describing the challenges of being in homelessness accommodation and the sense of stagnation, but also expressed optimism about his progress, having secured his own apartment he started working towards a better future.

"Yeah, because it is tough sometimes being in here, you just feel like you're just going around [in] circles. We're not getting anywhere. It is like I have my own place out there now, which is grand, like, my own little apartment, because I'm working now to get me there."



Personal Struggles with Substance Use

Interview participants spoke in depth about the profound impact that substance use has had on their lives. They described dangerous situations, family disconnection, and the loss of purpose that led them to reach out for help at their lowest point.

"Do you know that's where drugs brought me to, you know, drug debt and just, you know, terrible situations, you know, like dangerous situations for the young to be in, you know, like I had enough, like I had no purpose, no didn't know who I was for years, so I just needed help. I had to reach out. Brought me to my knees and nearly died. Basically, that was my rock bottom."

Overcoming addiction is challenging, especially when drugs are easily accessible. Residents need to be self-motivated and keep themselves busy, as they might easily slip. One woman expressed a strong desire for treatment and support, highlighting the difficulty of living in an environment where drugs are easily accessible just around the corner. She felt that the current programme that she is on, which is once a week, is insufficient, and that she needs more consistent, daily engagement to help her to cope and stay focused on her recovery.

"Where you're bored and [...] there's not enough to do. Like, I'm on a programme one day a week. Like, and that's not enough for me. I need to be on the course every day of the week."

Another participant reflected that problems are often internal rather than external, suggesting that addiction for them has been a personal struggle and that facing oneself is key to overcoming it.

"We are our the biggest enemies. So if you are addicted, your enemy is you. That's my opinion. You know, when you're addicted, you need to face with yourself. First of all, if you will not start from yourself, you might, you know, fly around many different styles."

Challenges of Dual Diagnosis: Navigating Addiction and Mental Health

One participant expressed dissatisfaction with the mental health support they received, particularly when dealing with both drug addiction and mental health difficulties. They noted that while support services were available, there was a reluctance to adequately address the needs of individuals facing both challenges, with drug use often being a barrier to receiving the appropriate care. She also highlighted that the mental health support they received, particularly from psychiatrists, was insufficient and did not fully address their needs.

"A couple of times when I was in my clinic, my own clinic, it wasn't really enough, and I should have got more support around all that. Like mental health is just not there. I know the support is there. But when you have a drug addiction and you're looking for support they just, they don't like dealing with drug addicts with mental health."

She went on to say that if she had received support and a diagnosis of depression when she was 18 and had lost her first child, her life would have been very different.

Though participants said that they were often using substances to self-medicate because of their poor mental health, they recognised that the relationship between the two was complex. Another interviewee reflected on the complex relationship between substance use and mental health, particularly the impact of crack cocaine on emotional well-being:

"The mental health [difficulty] is made bigger by the use of crack cocaine. If they stop smoking crack cocaine, they wouldn't be as bad in their own heads. But you can't see that when you're in the moment of smoking. It's only when you step back and you stop and then you start seeing things."

Another participant shared that she is currently managing their mental health with 20 milligrams of Prozac (brand name), which she finds effective. While she still experiences occasional low days, these are manageable and no longer as extreme as before.

She explained that her past mental health struggles were closely linked to her addictions, which stemmed from unresolved emotional trauma. Using drugs was a way to avoid confronting those emotions, but it ultimately worsened their mental health.
to avoid confronting those emotions, but it ultimately worsened their mental health.

"So at the moment, I'm down, and I'm staying on 20 milligrams of Prozac, so I find that quite effective. I do have my little down days, but they're just that. They're the normal ups and downs of life. They're not to the extreme that they used to be a lot of my mental health would have been linked with my addictions, and my addiction was linked with my emotions and the trauma and not wanting to visit that area. So I would have used [drugs] to avoid feeling any of those, those reactions to the traumas and that have not been affected my mental health."

ultimately worsened their mental health.
to avoid confronting those emotions.

One female participant discussed the challenges of living with a dual diagnosis, describing the difficulties of addressing both addiction and mental health simultaneously. She reflected on how addiction felt more manageable due to the clear, actionable steps involved, while mental health recovery initially seemed passive and less tangible. Over time, however, she recognised that integrating recovery principles into her mental health journey brought meaningful improvements. She explained:
"I think if you've got a dual diagnosis, it's tough, because you're battling two demons, you know, and you're not quite sure which one is stronger, you know? When I was told, when I admitted that addiction was a major part of my life, I was like, okay, I can deal with addiction, you know, I can work on that. I felt like I wasn't able to work on my mental health, like I was passive with regard to our mental health recovery. In fact, I never thought of it as mental health recovery. I just thought of as living with it. You know, carrying the cross of mental health, whereas with addiction, I felt there was something I could actively do about it, which was actively get involved with stopping the drugs, working on the issues behind it, work in the steps, or whatever, you know, going to meetings with mental health. It was like, go take a tablet, do therapy. I and in fact, if you apply some of the some of the stuff that they use in recovery to your mental health, it actually benefits your mental health hugely, you know, to be able to realize there are some things you can change and learn to kind of accept that you know, or I've learned to flip things. So if there's a negative, I've learned that there's also a positive, so I flip it. But before I would just go and have things dark and fucking miserable, I wouldn't see the fact that there's actually a sun behind that fight to come out, and it's still there. I just can't see it, you know, I didn't want to see it. I found addiction easier to deal with the mental health."

Residents felt a need to keep busy (e.g. recovery day programme, NA meetings, going to church, etc.) while waiting for residential addiction supports. This can be very difficult in a hostel environment because of the temptations that may be present.

Individuals also expressed their ongoing struggles with accessing consistent mental health support, especially in relation to their anxiety. Despite challenges in finding a psychiatrist, they are still able to manage their medication through their GP, though it remains a complicated issue due to their history with addiction.

"I have a doctor, like, just don't have a psychiatrist. You see, they couldn't really do anything with me because it was an addiction."

Medication and Impact on Daily Life

Residents had mixed feelings about taking their various medications. Some felt that the medications were helpful while others felt that they were unnecessary or spoke about the unwanted side effects (e.g. drowsiness, anxiety, and weight gain) as being reasons why they did not want to take their medication. At the same time they recognised that taking their medication helped them to manage living in the varied and unstructured environment offered within some Depaul housing services:

"I take quite a decent dose to have a solid sleep all the way through the night, you know, and not be scared at all."

One resident who had been struggling with depression, drug and alcohol difficulties after a bereavement spoke about the challenges of being on methadone:

> **"I was on methadone, but it was kind of like a robotic thing. Clinic, home, clinic, home. Now I'm getting out, doing myself up, and showing up."**

Other residents are taking their medication, but not feeling that they were benefiting from it: or they didn't *"feel it's really helping that much."*

One participant described how medication played a key role in stabilising their mood, allowing them to start processing difficult emotions, feelings, and memories in a healthy way. Working with their doctor, they gradually began reducing their medication dosage, with the aim of understanding and managing their emotions more effectively.

> **"[Medications] helped to kind of stabilise my mood enough for me to be able to begin to process the emotions that were coming up."**

Balancing Psychiatric Medication and Self-Management Strategies

One resident with MHDs, including dual diagnosis, was not satisfied with the medical supports provided and mentioned *"popping pills"* or *"drinking to insanity"* over a number of years to *"keep calm"* while doctors were adjusting their dosage levels. Another stated that he sometimes smoked cannabis to help him to relax, but not as a coping mechanism for his MHDs; he does not see it as problematic compared to his more intensive psychiatric medication (which he is in the process of reducing).

Others may have prescriptions for antidepressants, but don't get them filled as they hope to recover from their MHDs *"naturally"*, through walking, the gym and keeping busy.

Keeping distance from other residents in the hopes that they will be able to recover

> **"I'm afraid to jeopardize my recovery for anything. You know that way, because it's, you know, I keep to myself, because I have to."**

Disagreements and Communication Gaps Among Healthcare Providers

Lack of continuity regarding mental health support for PEH was a common theme which repeatedly came up in interviews. This came up in a variety of contexts, including the transitions among institutions and from institutions to rough sleeping and/or homeless accommodation.

Long term treatment can be made more challenging for PEH with MHDs as their doctors may change and there may be disagreements in their diagnoses and/or the appropriate course of treatment. For example, one resident diagnosed with psychosis and schizophrenia mentioned the confusion he faced with doctors disagreeing with his treatment plans. He said that it was hard to know what to do or think when *"you hear different things from people that are all supposed to be specialists, and they don't agree with each other"*. He went on to explain:

> **"I found very difficult to come off the medication. [...]. So you have a plan with Dr A, and then Dr B takes over, and Dr B wants a new plan, so you accept the new plan, and then Dr C takes over, and Dr C doesn't believe that Dr B made the right call, so you're not coming off the medication, but Dr A said you can come off the medication. So bouncing around, no communication between them, you know."**

He was among a group of those interviewed who had been on long-term medication and felt that their needs were being disregarded by healthcare professionals. Those who were on medication for their mental health often felt neglected in relation to their medical care and medication, with doctors and medication changing without notification or consultation with them. In addition, among some of those who were on medication for their mental health, were individuals not in receipt of formal psychological or counselling support.

However these gaps and inconsistencies do not always occur, with some individuals being able to remain with the same person for years and through various periods of housing instability and homelessness. Although rare, these consistent relationships with the same psychiatrist and/or counsellor benefitted participants greatly.

Experiences with Counselling

Some PEH access counselling and psychological supports while in prison. However, these supports are not always carried over once a person has been released. *"So after [being released], just once you walk out that gate, that's basically it"*.

Counselling services accessed while in institutions may or may not carry over once the person has left. The reasons behind these inconsistencies remain unclear. One resident spoke about attending weekly counselling sessions while in prison and said that they *"did help"*.

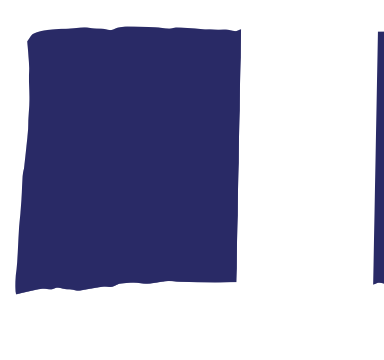
Some residents have access to counselling services regularly (e.g. weekly or monthly). It is unclear which individuals are able to access counselling services as some who are under psychiatric supervision would also like to access counselling, but have been unable to avail of one-to-one supports. Group counselling sessions are offered through various organisations, but sessions are not necessarily held at housing locations. Also, some residents expressed discomfort and distrust, which was prohibiting them from attending group sessions. They would prefer to be able to access one-to-one counselling, if possible.

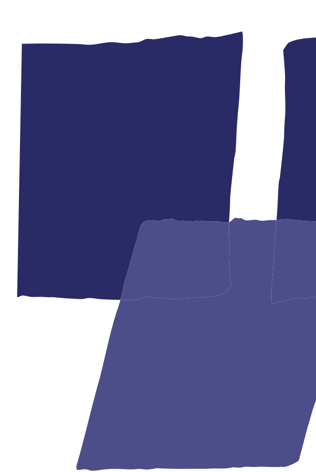
When asked about whether having onsite counselling supports would be helpful, one interview participant (who had been availing of counselling services for years) responded:

"Of course, it'd be nice for one to come here as well, because, like, I could speak to both, yeah, because there's no harm having that extra bit of help. Because, like, my counsellor, like, she knows a lot well. Obviously she knows a lot about me, but it's kind of, when I'm speaking to her, it's kind of like, oh yeah. But then when I get off the phone, I'm like, oh shit. I should have said this to I should have said that. So, like, it would, of course, I'd help. I think it'll help a lot of us in here."

One participant highlighted the persistent stigma surrounding mental health, particularly within certain groups, despite broader societal progress in reducing these barriers. They reflected on how this stigma might prevent some individuals from seeking help or discussing their struggles openly, out of fear of being judged or misunderstood. The participant emphasised the importance of confronting these fears to truly address mental health challenges. As they explained:

"Think there are some that may have a reluctance to kind of to look into certain areas in their life, because there's a fear among them, maybe, about where. There's still that stigma to mental health, even though it's it's reducing in the population. It that's that stigma doesn't seem to be as strong as it was. Amongst among some people, there would be a perception that if I really tell people what's going on inside my head, that they're going to think I'm crazy, whereas that's that's not the case when it comes to mental health and psychiatry. It's when you don't say those things that the there's the work, you know."





Those interviewed expressed frustration about having to repeat their stories due to staff turnover or changes in service providers. This issue arose regarding GPs, psychiatric, and counselling supports. Interviewees described feeling *"fed up"* with having to tell their stories *"over and over and over again,"* as well as inconsistencies in approach among health professionals.

Alternative Sources of Support in Mental Health Recovery

Other residents expressed that they were not interested or not in the right place to avail of counselling. Some of these individuals did explain that they had a key worker, or other staff member who they trusted that they could speak with.

"She's got so much heart. She really cares. Like, yeah, she really puts in, and she's helping me drug addiction and stuff. So yeah, I'm blessed at the minute with having my own room, having the support I have."

Reflecting on the support received during their recovery, a resident shared their positive experience with housing support services and the ongoing assistance from their key worker and the staff.

"I went with [...] my key worker to see the psychologist[...]. That went well. And I get lots of support—my key worker and the manager and the staff, yeah, can't complain. Won't complain."

Some housing locations have social group meetings where staff may attend, alongside residents. Key workers *"come to the social group meetings, yeah, they're very supportive. Anything you ask them to do, they help you with."*

This ongoing support has been essential in navigating both mental health challenges and daily life, providing the reassurance and guidance needed to make positive progress. This collaboration with the key worker has not only helped in addressing mental health needs but has also fostered a sense of security and hope for the future. The care and dedication of the key worker and staff have created an environment where the individual feels understood, supported, and empowered to continue their path to recovery.

Importance of Community Group Supports

Participants in the interviews expressed that both individual and group sessions were valuable for their recovery. Many found group sessions particularly helpful, as they provided opportunities to learn from others' experiences and build a sense of community. Participants noted the therapeutic nature of group meetings, highlighting how sharing challenges and coping strategies with others facing similar difficulties enhanced their understanding and resilience in recovery.

"I go to six meetings a week and one after care most weeks. Last week, I think it was five, but I find them very therapeutic, you know, and I learn a lot from them as soon as I do in in the groups, and I learn off the other residents here, you know what they've been through and how they've coped, or how they've faced challenges that have come up, challenges are going to come up. This is life. You know."

There was a preference noted for peer workers/peer-led supports. They said that having someone with prior addiction experience was helpful, as they could better understand and relate to the emotional and physical challenges of recovery, providing valuable support.

"One of them was an ex addict before. [...] So that's helpful as well, because he has experience. I feel sometimes when people have experience, they can understand it a little bit better. Do you know what I mean? From physical, like, the feelings and everything, point of view, like."

Coping Mechanisms and Social Environment

Need for Private Space

Some residents seemed to prefer solitude or seeking private spaces when feeling overloaded, indicating a need for distance from others during times of stress. This may be particularly important for individuals with psychosis to allow for space where they can regulate their own behaviours without being a disturbance to others.

Drinking as a Way to Cope

One resident, who described struggling with depression for his whole life said that he had *"been drinking heavily for years and have tried to stop but it's been tough...When I'm feeling down, I tend to isolate myself and drink."*

Social Network Support

Residents expressed mixed feelings about talking openly with family and friends. Some did not want to be a burden to children or were concerned about worrying family members which they were caring for.

One resident who had been struggling with depression, anxiety, addiction and had attempted suicide spoke about how she coped with the feelings she still has:

> **“Walking, going to the gym, doing my boxing, cleaning, cooking, anything that just slows the head down and stops me from thinking, open into like, talking to people like I used to hear talking to people. I wouldn’t need a tablet to speak, but I don’t, I’m widely able to speak, so I’m going to meetings as well with other addicts. Helps me, people understanding where I’m coming from.”**

Need for a Structured Environment

One participant shared their positive experience with the structured environment of the service, highlighting the importance of staff accountability, personal responsibility, and the supportive, women-only setting that made them feel more comfortable and safe. She said:

> *“I love it. I really do. I like the structure. I like the fact that the staff, if they have concerns, will raise them with you. We have responsibilities, responsibility to be on time, punctual, accountability. Where are you? Why were you not who you were supposed to be? So what happened, or why didn’t you tell us, you know, the kind of the honesty part of it, you know, I like the fact that we’re a women only service, you know, because I find them quite vulnerable when it comes to, I suppose, becoming more comfortable in a female environment, you know, I would be more vulnerable around men as well,”*

She continued:

> *“I like the fact that staff give us feedback, so if I’m I won’t see if I’m doing well or if I’m failing. Like the staff will let me know, you know, look, you’re doing all the right things. You hit in the ground running. You’re progressing nicely. Your confidence is improving, you know, keep doing what you’re doing and focus on yourself, you know. So I like it here. I like that structure. It’s not for everyone, and I know that it can be overpowering in some ways, but it is, for me, it’s productive. It’s very productive”*

A male participant, with a history of being in prison and hospitals, mentioned that he liked the structured routine of prisons. He mentioned that he said that he was *“starting to build [routines] all the time”* because he realised *“that that’s a structure that is handy”* for him.

Physical Activity as a Mental Health Support

A participant expressed frustration with her current coping strategies, acknowledging her struggles while also attempting to take positive steps, such as committing to regular gym attendance, to improve her situation. A number of other participants mentioned using exercise as a way to help them cope with their mental health. They mentioned walking or getting a gym membership as future goals they had for themselves.

Relationship with Professional Support Systems

Key Worker Support and Advocacy

Interviewees described a variety of important ways that key workers and other housing staff supported them with their needs:

- Booking appointments
- Attending and advocating in medical appointments
- Completing paperwork (e.g. housing applications)
- Administering medication
- Sharing information
- Being open to conversations
- Checking the housing list
- Coordinating with previous housing providers (e.g. to retrieve records)
- Helping to get their child out of care

They recognised the importance of this work and expressed their gratitude for the time and effort that staff spent supporting them.

Some participants highlighted specific locations as essential for their positive progress, particularly those where staff possess mental health training and support. Residents in these environments appreciate the staff’s ability to rebuild social networks and advocate for stronger family relationships, with some residents noting improved support from family members due to staff intervention. However, some individuals find it difficult to open up to available resources, despite expressing gratitude for staff’s willingness to help and encourage them.

Targeted mental health support, often based on ethnicity, was also mentioned as a valuable resource, particularly for individuals from specific communities, such as Irish Travellers, who can access specialised services like counselling and therapy. The availability of on-site professional mental health support was described as an ideal option by participants, with some residents particularly valuing the convenience of having psychiatrists and other health professionals available on-site. Participants expressed a preference for a combination of individual and group-based support, as this helps them connect with others and gain diverse perspectives on their recovery.

> **“I think all the staff, I don’t know for a fact, but just by observing, you know, how how they interact with us, and how how we interact with them and the feedback that they give. They all have an element of training in mental health, you know, whether it’s surface level or a little bit deeper, you can see that, and that’s really huge. You know, I’m happy with the services I have at the moment.”**

One interview participant highlighted the importance of support in addressing homelessness and addiction, noting that kindness, proper treatment, and available resources, can help individuals if they are open and self-aware enough to seek assistance. He also warned that some may turn to unhealthy coping mechanisms as a form of escape:

> *"There are very nice, kind people with good manners. They treating you properly. They offering you what you actually need if you need some support around addictions. I know that meetings provided by coalmind are organised in here, some of trainings, if you are open it to your key worker, you can count on huge support. So you just need to be open it, but you need to be in you know you need to function in understanding what are your needs actually, because you know, people, when they are facing with homelessness, they are grounded by the problems. And when person is facing troubles and is not able to handle it, I mean to you know, take about take care about problems, they pretty often just. Or mostly trying to find the escape, like alcohol, drugs, bad habits, smoking. So for them, it's a solution, but it's a trap."*

Challenges for PEH Living in Accommodation

There were a number of issues that came up for individual participants which were related to accommodation that they said affected their mental health:

- Long waiting lists for housing
- Lack of privacy (e.g. sharing rooms)
- Lack of services/long waiting lists for services
- Inability for families to unite in residential services for PEH (few options for (older) children to stay with their parents)
- Unable to have children visit homeless accommodation (further reducing contact children have with their parents)

While these are barriers for the general population of PEH, they were identified as additional sources of stress and anxiety for parents who spend years unable to have their children live with them.

Establishing Trust in Staff

For some participants, it is difficult to be honest and trust medical professionals. One man interviewed spoke about the difficulty of trusting psychologists, compounded by the challenges of living with schizophrenia, which makes it hard for him to be honest with others. He experiences an ongoing internal struggle between lying and telling the truth:

> **"So a mix of the two. Then I'm always in a battle, sometimes lying to people, sometimes I'm telling people the truth, you know, so it's difficult."**

This difficulty trusting can be compounded when medical staff are frequently changing (as mentioned previously).

During another interview, the participant expressed frustration with his interactions with medical professionals, criticising the perceived lack of meaningful dialogue or understanding when addressing his conditions. He suggested that doctors did not engage in a genuine conversation about treatment options, leaving him feeling misunderstood. He then went on to describe a desire to confront a group of doctors in an open and candid discussion, reflecting their perception that medical professionals often exhibited dismissive or disrespectful attitudes during these interactions.

Trust and Sensitivity in Staff-Resident Relationships

Although the majority of residents interviewed had positive things to say about their key workers and other staff members, a few raised specific concerns about specific staff actions which they described as not being sensitive to the needs and situations that PEH face. These included:

- Lack of sensitivity to personal information
- Inadequate understanding or responses from staff
- Frustration with the housing system
- Perception of profit prioritisation

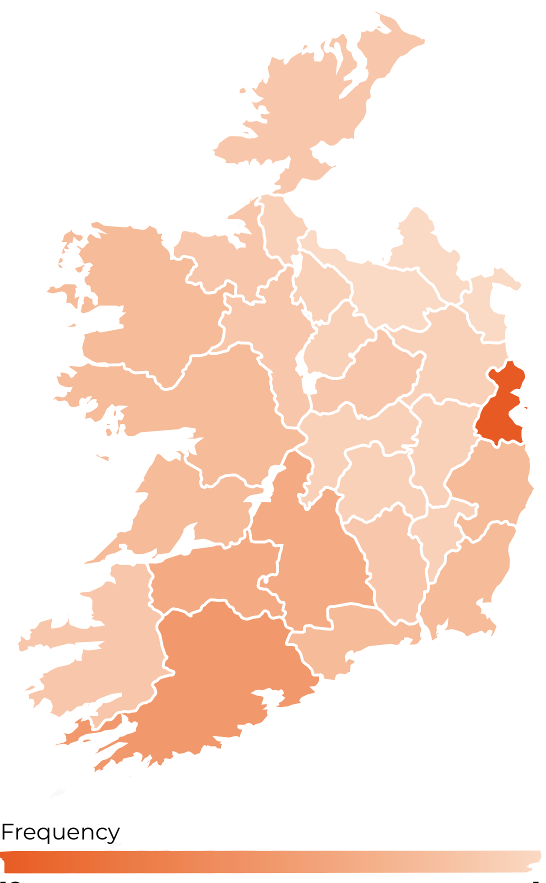
Voice of Service Providers

Service Provider Survey

Overview of Survey Responses

Of the 22 responses to the survey, 73% were from non-profit organisations, 23% from government agencies and 5% from the HSE. The majority (19%; N=18) of service providers included Dublin in their catchment area, however, many providers provided services over multiple counties (Figure 1). Organisations provided a variety of services to clients, including housing support (N=11), accommodation support (N=11), mental health services (N=10), healthcare (N=8) and food/clothing/hygiene products (N=7), among others.

Figure 1. Geographic Distribution of Organisations Surveyed (N=22) – Source: TASC, 2024



Roles of Staff Surveyed

The staff who took part had a range of roles. These included mental health professionals such as counsellors, psychologists, and psychiatrists (N=6), building or housing managers (N=5), social care workers (N=4), and one person each in the roles of administrator, advocate, community health worker, social worker, and support worker. Additionally, one person worked as both a social care worker and an administrator.

Focus group participants outlined that their organisations employ social care workers and health and wellbeing staff rather than clinical professionals. Here, while social care workers provide day-to-day support and are key workers for clients, they often lack the clinical training necessary to manage complex mental health crises. In some organisations, while there may be support services, such as drop-in counselling and project workers for dual diagnosis, they are primarily social care staff without expertise in mental health. However, this lack of dedicated clinical staff can be a challenge, especially as mental health difficulties become more complex among their client group. There is also a lengthy referral process for mental health services and addiction support, as well as the lack of a mental health lead on many teams. Although housing providers have some partnerships with external services and in-reach support for addiction, the uptake of these services is limited.

Types of Homelessness and Housing Insecurity

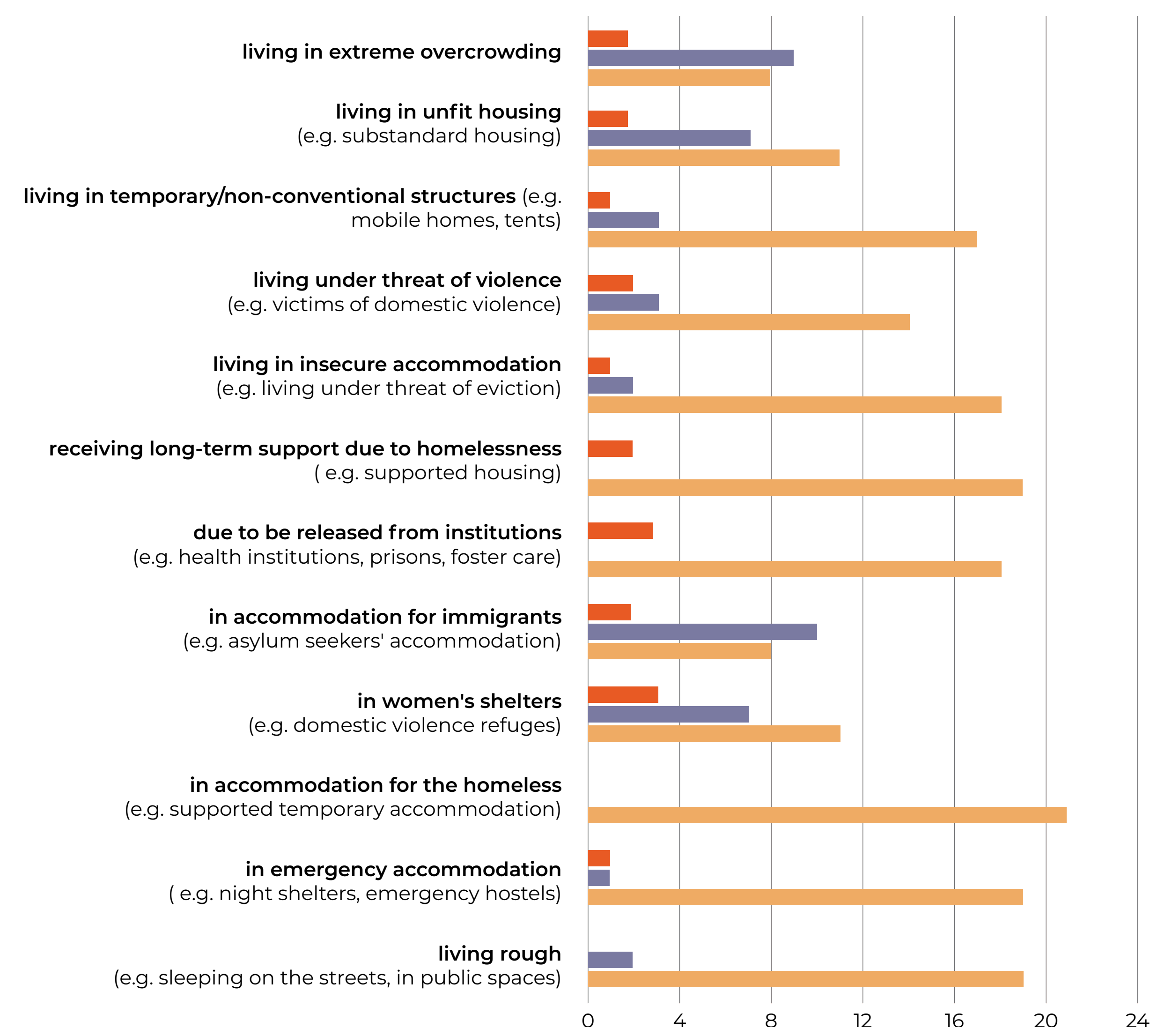
Service providers surveyed came across a range of individuals experiencing different types of homelessness and housing insecurity (Figure 2). All had worked with individuals who were residing in accommodation for the PEH.

One service provider spoke about the varied outcomes for clients, highlighting both success stories (e.g. individuals achieving stability and employment) and the cyclical nature of homelessness (e.g. clients being re-referred after years). Long-term stability for some individuals, despite prior progress, may be a challenge requiring individuals to continue to link into services when needed. They spoke generally about some people that have been able to move out of homeless accommodation and reintegrate into the community:

> *"I've been able to link in with some people in the community that are doing really well, and in terms of still attending appointments, and have now got actually work in the community and everything. So it's fantastic."*

Services seeking to support pregnant women described facilitating access to housing, with options including family hubs and placements with landlords who are supportive of mothers with babies. Some of these women are able to access long-term housing through councils after moving up the waiting list. However, there are significant challenges, particularly with the lack of appropriate housing and the cramped, challenging conditions within family hubs which may not have accommodation which is accessible to prams and buggies.

Figure 2. Types of Homelessness and/or Housing Insecurity in which service users live (N=22) – Source: TASC, 2024



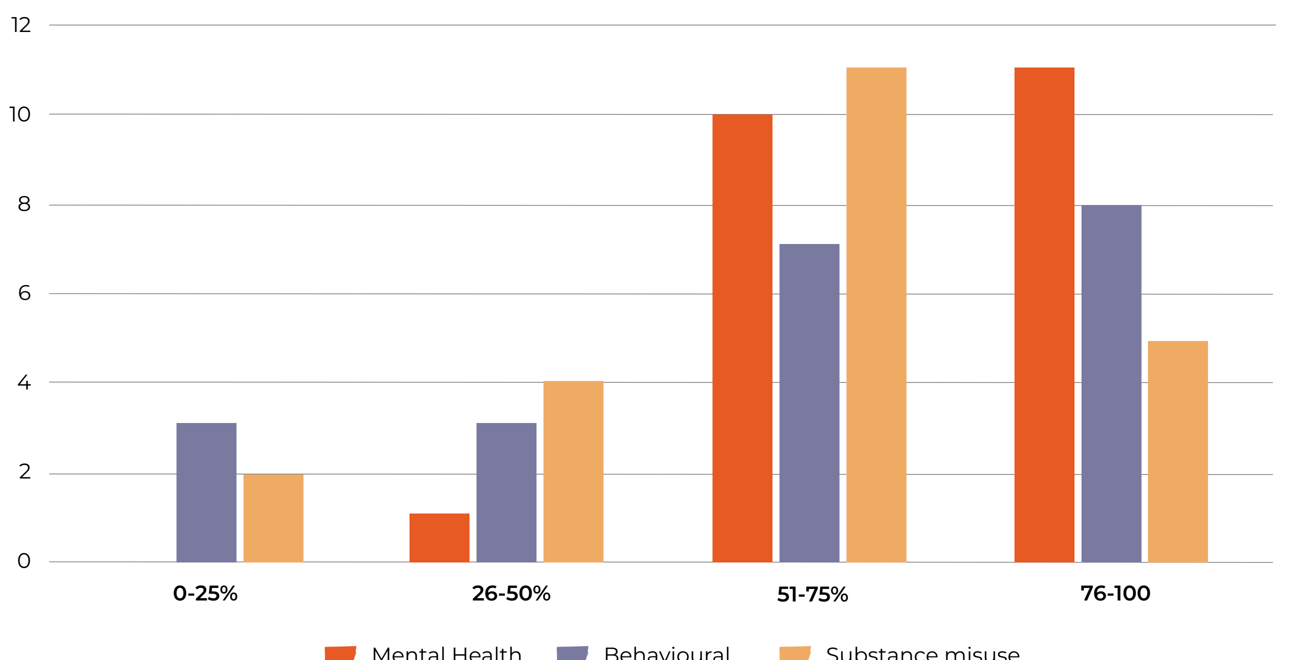
Mental Health Challenges Observed in Clients

Service Providers felt that mental health difficulties were more commonly observed in their clients than substance misuse and behavioural difficulties (Figure 3). Most respondents estimated that 51-100% of people experiencing homelessness face mental health challenges, with many leaning towards the higher range of 76-100%. For behavioural challenges, estimates varied widely, but most fell within 51-100%, while a notable minority reported lower figures of 0-50%. Similarly, the majority believed that 51-100% of people experiencing homelessness also experience substance misuse, though some respondents indicated lower estimates of 0-50%. Overall, the findings emphasise the overlap between homelessness and complex challenges like mental health, behaviour, and substance misuse, but they also reveal some diversity in perceptions.

Complex Cases, Complex Environments

One service provider discussed the complex interplay of trauma and mental health challenges in a shelter environment. Residents may include both survivors and perpetrators of severe trauma, such as child sexual abuse, living in proximity, which exacerbates stress and emotional challenges for some individuals. Many residents might not realise how this environment affects their stress responses or overall well-being, leading to unreported impacts on their mental and physical health. Without self-awareness of these underlying issues, individuals are unlikely to disclose them to medical professionals, further complicating diagnosis and treatment.

Figure 3. Prevalence of mental health, behavioural and substance misuse difficulties (N=2) – Source: TASC, 2024



Particularly Vulnerable Groups

There were several vulnerable groups within homeless services which were identified by service providers, particularly people already experiencing MHD, people experiencing menopause, pregnant people, care leavers and non-English speakers. People already experiencing MHD prior to entering homelessness may be more vulnerable to the chaotic environment and influences present at some locations. Menopause can increase anxiety and low mood, which may be overlooked, especially among women with chaotic lifestyles. Pregnant women may conceal mental health struggles due to fears of losing their child (see section on pregnant women for details). Care leavers, especially those not in full-time education, also face significant challenges as they lack adequate aftercare support. Non-English speaking individuals with mental health difficulties face language barriers and lack of adequate resources for interpretation and translation, which lead to disengagement and risk clients slipping through the cracks. These groups, dealing with multiple competing needs, often struggle to access the mental health support that they require.

Another service provider discussed the link between psychosis and past traumatic events, such as abuse. However, it was expressed that mental health practitioners frequently overlook the trauma behind the condition, focusing solely on symptoms and medication. The service provider emphasised the importance of addressing the trauma that caused the mental health difficulties, rather than just diagnosing and treating the symptoms, as for some people with schizophrenia, the voices they hear may reflect past abuse:

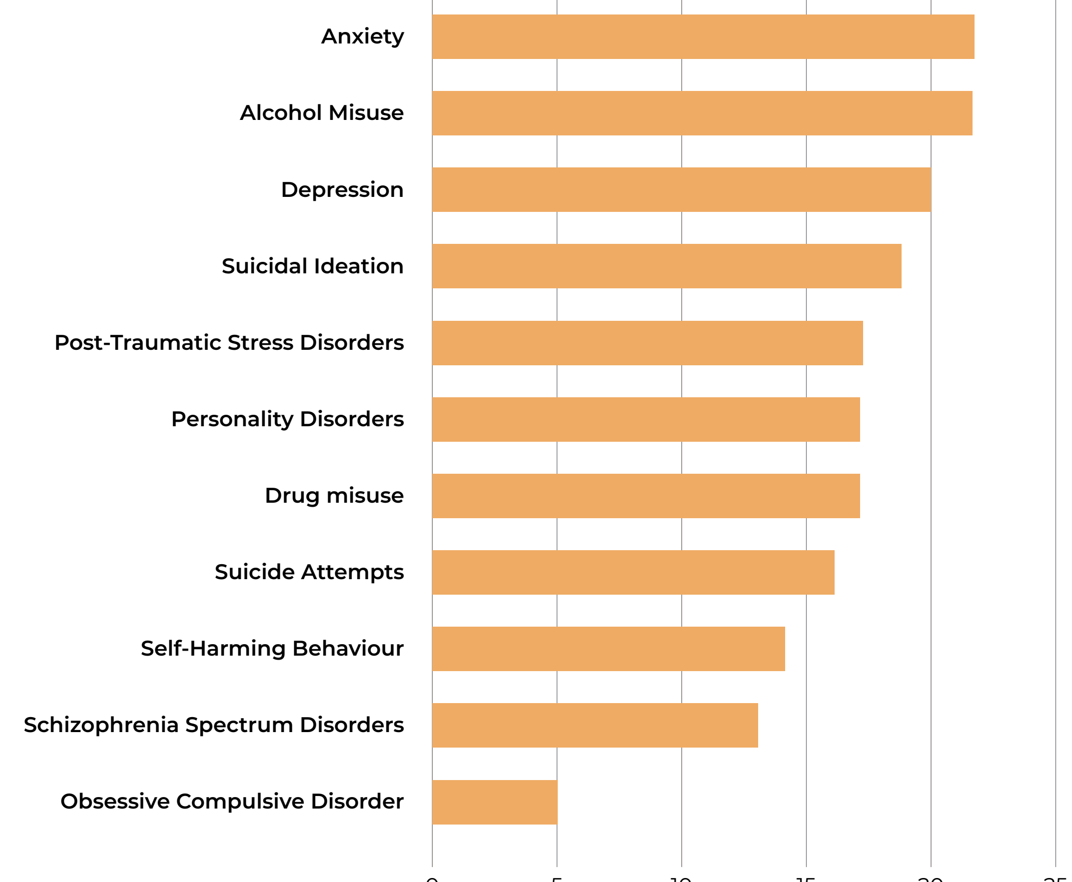
> *"For some people with schizophrenia, it was a voice of an abuser repeating in their head, cursing at them and replaying the abuse on tape, almost. So that would kind of need to be seen and treated as, rather than just seeing as, oh, you have this, and that's less than the symptoms, kind of addressing the trauma too."*

Common Mental Health and Substance Use Challenges

Service providers commonly deal with clients who are living with mental health or substance use difficulties (Figure 4). Anxiety and Alcohol misuse were the two most common difficulties service providers faced when working with clients. Followed by depression, suicidal ideation and post traumatic stress disorders.

Service providers discussed several key challenges faced by clients, particularly around mental health and substance use. Single men, especially those with mental health difficulties, are often reluctant to seek help due to stigmas and fear of institutionalisation. Additionally, individuals with social anxiety, particularly those who have experienced trauma, may struggle to attend appointments or engage with services, with some requiring significant time and support before they feel comfortable accessing care. Past negative experiences with medication, including bad side effects, also contribute to reluctance in seeking mental health treatment.

Figure 4. Specific Difficulties (N=189) – Source: TASC, 2024



Perceived Impact of Mental Health on the Onset of Homelessness

Service providers were undecided when asked about the role of MH in the onset of homelessness. Among the service providers surveyed, 24% believed that mental health always played a role in the onset of homelessness for their clients, 52% thought it often played a role, and 24% felt it sometimes did.

Some clarity was provided by the focus group discussions, where housing providers highlighted the role of socioeconomic factors. More specifically, concerns were raised about the tendency to assign mental health diagnoses, such as schizophrenia or borderline personality disorder, to individuals based on symptoms that may be more rooted in homelessness, addiction, and poverty. While those with mental health diagnoses receive appropriate long-term care and support, others may have their challenges attributed solely to individual mental health difficulties, obscuring the social factors contributing to their decline. Service providers were heavily critical of this approach, suggesting that it absolves society and the state of responsibility for addressing these social determinants of mental health.

"It's easy to use mental health as a thing to put it back on the individual and make it about them being resilient or not resilient or whatever, like when a lot of the time there's like social factors that have caused that decline into mental health."

"There's people that have genuine mental health diagnosis, and that's probably the reason for the descent into homelessness. And then there's those who have been in homelessness, poverty and addiction, and that have kind of descended into mental health problems."

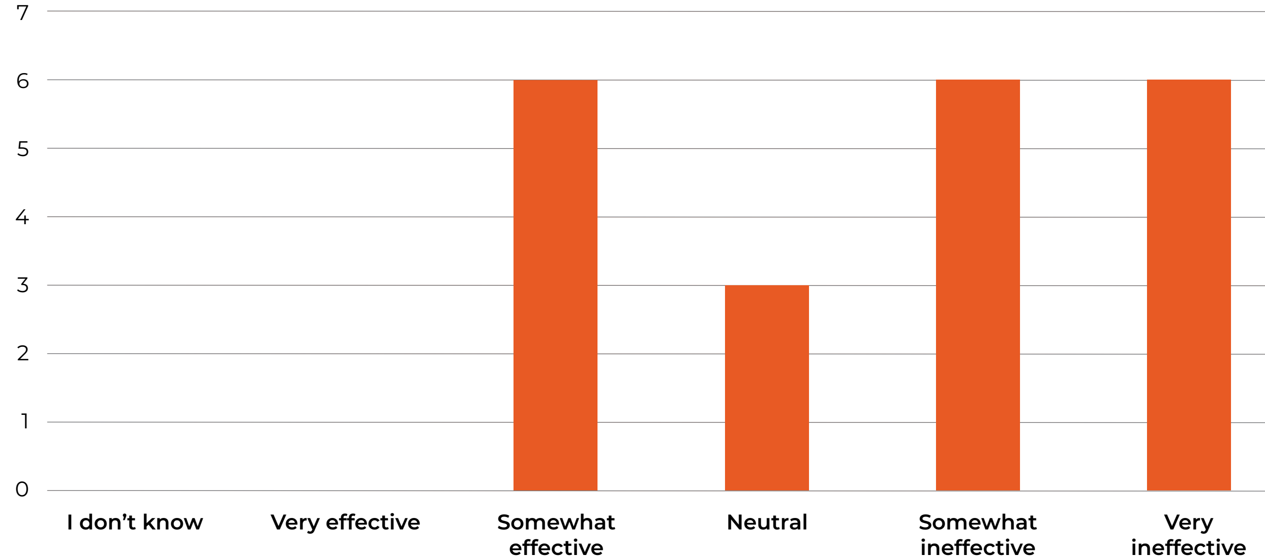
Effectiveness of Existing Mental Health Services

Service providers clearly do not feel that existing homeless services are effective at being able to address mental health difficulties faced by PEH (Figure 5). The majority of respondents perceived current services addressing both homelessness and mental health as ineffective, with many rating them as *"very ineffective"* or *"somewhat ineffective."* A smaller proportion found the services *"somewhat effective"* or *"neutral"*, indicating that there is significant room for improvement in integrating these areas of support.

The Importance of a Good First Impression

First meetings with clients are pivotal, especially for those with histories of negative experiences, as they may have difficulty attending and may approach the first meeting with defensiveness. A lack of compassion or understanding in these moments from receptionists and service providers can severely delay recovery. One housing provider gave the example of a former client who, after a dismissive comment from a doctor, avoided seeking help for years. Ensuring that such opportunities are met with empathy and trauma-informed care is essential for building trust and fostering engagement.

Figure 5. Service Efficacy for Addressing Both Homelessness and Mental Health (N=21) – Source: TASC, 2024



Challenges in Integrating Mental Health and Homelessness Services

Service providers noted that existing mental health services often struggle to meet the complex needs of their clients. There is a gap in services for individuals with dual diagnoses, which can lead to clients feeling unsupported or misunderstood. Additionally, negative past experiences with mental health services or medications can contribute to clients avoiding care altogether. Advocacy and medication reviews are often needed to ensure that clients' needs are being met and to adjust treatment plans accordingly.

Current practices within community mental health teams, particularly the over-reliance on psychiatrists prescribing medications without holistic interventions, was seen as being particularly ineffective. Service providers raised issues such as repeated prescriptions without psychotherapy or a multidisciplinary approach, resource constraints faced by HSE teams, and the hesitancy of professionals to address mental health difficulties when addiction is also present. Improvements could be made with better communication and integrated care to address these systemic gaps.

Lack of Flexibility

Other challenges which were mentioned include the rigid appointment systems, which do not accommodate the chaotic nature of clients' lives, and disruptions caused by frequent referrals and transience among homeless services. Flexibility, interagency collaboration, and proper implementation of the dual-diagnosis care model are urgently needed.

Opportunities in Integrating Mental Health and Homelessness Services

A successful collaboration between a service provider and a community addiction team, involving joint key working and shared communication was described by another service provider. They emphasised the value of consent-driven cooperation, on-site support, and coordinated follow-up actions, leading to positive outcomes for residents.

> *"We're actually very lucky now that our community addiction team come here once a week now, and we work like a joint key working and with the residents that we link in with them, and that communication has worked, and that we've seen a difference."*

Drop-ins from mental health teams (e.g. the HSE's Access Health Team) and in-reach addiction supports also help service providers to manage cases, conduct interdisciplinary meetings and follow up regarding clients.

Other providers spoke about the positive working relationship they have with flexible and supportive GPs and community addiction services who have *"pulled some strings"*. These services are able to work together to provide holistic care, helping individuals stabilise before making referrals. However, they noted that while they encounter complex mental health cases, addiction issues are not as prominent in their work, making it easier to manage.

Challenges Building Trust

Sometimes staff have challenges in terms of building trust and relationships with clients, especially those with language barriers or mental health difficulties. One service provider noted that it can take up to six months to establish effective communication and support, but it may take even longer.

Efficacy of Informal Peer Support

Informal peer support was emphasised as playing a significant role for women. Informal gatherings, like sitting around a table with coffee and scones, allow women to talk, share experiences, and offer advice to one another. This peer interaction is described as vital in preventing isolation and loneliness.

Flexibility

The experience of accessing healthcare services can significantly depend on the flexibility and understanding of individual professionals. An example of a female client who had never been to a GP, and struggled attending her first appointment was given in one of the focus groups. It was explained that the GP helped the client by providing consistent care, agreeing to be her dedicated doctor and offering continuity and familiarity in her healthcare experience. They adjusted appointment logistics to accommodate her needs by scheduling her as the first patient of the day, helping her avoid the triggering environment of the waiting room. Additionally, the GP collaborated with the client's key worker, ensuring the worker accompanied her to appointments, which provided essential emotional and practical support. These measures significantly improved her ability to engage with primary healthcare and reduced emergency interventions.

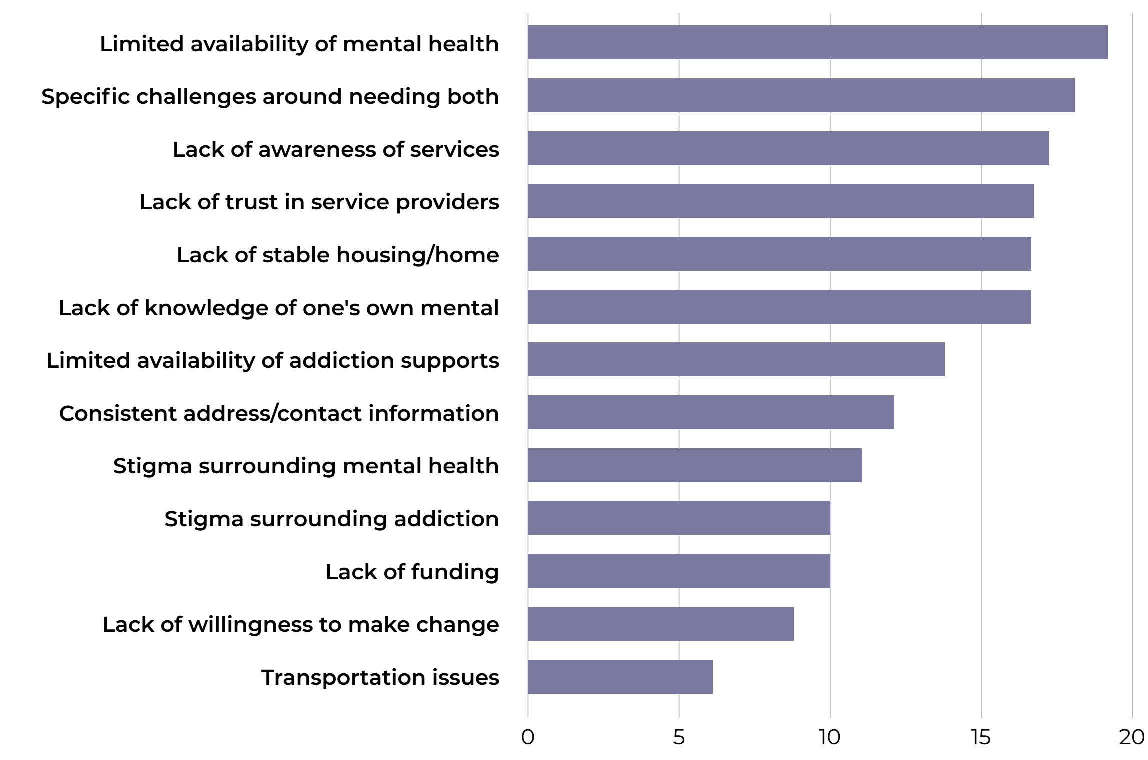
Support Workers

Service providers highlighted the beneficial work of support workers, who often assist clients in preparing for and navigating healthcare appointments by helping them articulate questions, advocating for them with GPs or receptionists, and accompanying them when necessary. This advocacy can address barriers such as literacy challenges, trauma, or stress and is particularly impactful early on.

Barriers to Mental Health Support for People Experiencing Homelessness

Survey respondents highlighted that the main barriers preventing people experiencing homelessness from accessing mental health services are lack of stable housing, limited awareness of available services, and a lack of trust in service providers. These factors, combined with the need for both mental health and addiction support, hinder access to care (Figure 6).

Figure 6. Biggest Barriers Preventing PEH From Accessing Mental Health Services (N=174) – Source: TASC, 2024



Stigma of Addiction

The stigma surrounding addiction, particularly in the context of homelessness, was an issue raised by service providers in the focus groups. They noted that while many service users may struggle with mental health or other issues, those with substance use difficulties, especially those struggling with drug use, face significant shame and judgement. The stigma that they face exists both within the service user community (e.g. others who drink and use drugs) and from society at large. While mental health is becoming more openly discussed and less stigmatised, addiction, particularly drug addiction, still carries heavy societal shame.

Lack of Empathy from Clinicians

Service providers also shared concerns about the lack of empathy and personalised care in some mental health services, particularly during crisis situations. One example provided was that of doctors *"reading the questions from the sheet and like, not looking at them"*. It was noted that some doctors have given very *"clinical"* responses to patients who were in distress:

> *"That hasn't been the first time I've heard that when they go in, they're just really clinical and like, someone's here telling them they're going to take their own life, and they're like, so how long have you been feeling like this and not really being empathetic and like that gives them a negative experience, like, I'm not going back there again, like, and or being sent away when they're really want help because they can't be admitted because there's no beds or whatever. So, like, it's actually the approach in which I'm not saying that to every doctor or any mental health professional, but that that has been some feedback that people have given and maybe some hands-on training, or, like, not just looking up at somebody when you're taught, when you're asking them questions."*

These experiences highlight the need for a more compassionate approach from professionals when interacting with individuals in distress.

Client Apathy

It was also noted that flexibility in service delivery is important and how rigid appointment systems or negative experiences with professionals can lead to client disengagement. Healthcare staff should be more mindful of clients' circumstances, such as childcare or transportation challenges, and make efforts to accommodate these needs. Additionally, there is a lack of time and awareness among some professionals in recognising and addressing these barriers effectively.

In addition, duration of time since diagnosis and previous interactions with mental health providers also serves as a barrier for some PEH.

> *"So people are really resigned. The older residents are very resigned to the system. They see it as kind of a machine. Some of them have been put on like lithium for eight years and have very bad experiences, and I've just kind of given up. They feel, oh, I'm well be heard. I'm not listened to I'm just plugged up medication to shut me up. So kind of adopting a different approach with them, offering to help with mood diary to log out they're feeling, and then coming with them and advocate and saying, look, they're feeling very low on these meds. Can something else be tried? And that's kind of worked in our case here, where the psychiatrists will be able to try and different things that they felt lift and really empowered them, that they will be listened to if they approach it in a certain way, in a respectful way."*

Pregnancy and Homelessness

Other service providers spoke about their experiences working with pregnant women experiencing homelessness and focused on linking them to perinatal mental health services, often through hospitals. These providers explained that this is particularly important as there is a high prevalence of trauma, childhood adversity, involvement in the care system, and feelings of rejection and abandonment, leaving them isolated and without support networks.

These women frequently prioritise housing over their own well-being or that of their baby, often lacking the resources to attend medical appointments or address their own personal health needs. These factors often exacerbate barriers to accessing care.

While pregnancy can offer an opportunity for positive change, these women often face anxiety about their future, such as moving on from supportive housing and managing their new responsibilities. Some women have complex needs stemming from past trauma, poverty, mental health difficulties, and dual diagnoses. For others, this may represent an opportunity to regain custody of older children, though adjusting to a stable life after years of chaos can be difficult.

A number of barriers were mentioned for these women, including long waiting lists, cultural stigma around mental health, cultural stigma around pregnancies outside of marriage, lack of childcare services, and lack of awareness about conditions like postnatal depression. Current housing policies create additional barriers. Women whose children are in care are classified as single individuals for housing eligibility, making it nearly impossible to reunite with their children in suitable housing. Service providers also described the shame that women feel about giving birth while homeless. Women are also anxious about safety in temporary housing. Services providing short-term accommodation offer a sense of safety and relief, but uncertainty about what comes next undermines their stability.

It was highlighted that women in one particular housing service are also struggling to access mental health support, particularly pregnant women, within Dublin-based services. The women residing at this women's centre faced systemic exclusion from healthcare providers, including primary care and mental health services, due to their homeless status.

Immigrants Living in Direct Provision

Service providers also mentioned the specific challenges that immigrants living in direct provision face, particularly asylum seekers, many of whom normalise mental health difficulties or do not recognise depression. Cultural differences and fear of being a burden prevent individuals from seeking help. A specific example is shared of a client who avoided seeking support due to these concerns and not knowing where to go.

> **"If it's depression, they are not aware like what is going on around them, surrounding them, and sometimes they might be scared of not being like a burden. I have seen a client of mine in which was going through all this but doesn't want to come forward because she doesn't want to become a burden and she doesn't even know where to go to so I think awareness is one of the barriers we have."**

It was also discussed that there are *"limited options for any sort of pre-treatment services for trauma, or any kind of trauma informed services"*. They went on to say:

> **"I think that's 10 times worse if you're kind of in rural areas and regions where often people are placed with no control over that. I think that as well, you can be so I guess it's houseless. You can be moved at any point by the Ministry of Justice.[7] It's, you know, you could be moved from one end of the country to another. So somebody might manage to get on a waiting list for HSE or other service, and then overnight they're told that they're being moved hundreds of kilometres away. So there's also that being like, all of that effort and preparation a person makes to kind of reach out and access support can be destroyed, kind of overnight."**

This sudden upheaval undermines their efforts to engage with support systems.

7 Note: DCEDIY's IPAS is responsible for residential movements of IPAs housed under the direct provision system.

Lack of Continuity for Immigrants Moving to Emergency Accommodation

One of the outreach team members described challenges faced when people are transferred from direct provision centres to emergency accommodation. These transfers often result in a lack of continuity in support, as different organisations manage services across different counties. The speaker notes that transitions between staff (e.g. case workers or key workers) may be abrupt, with little notice or clarity on who the person will be working with next, disrupting the trauma-informed care approach and halting ongoing support.

A significant barrier to accessing mental health services is language, particularly for residents whose first language is not English. The availability of translators is often limited, causing delays in crisis situations. Additionally, individuals who have been through systems like care or a residential mental health services, who may be reluctant to engage with institutions again, further hindering their access to support. These barriers create challenges for service providers in delivering timely and effective mental health care to vulnerable populations.

Lack of Resources

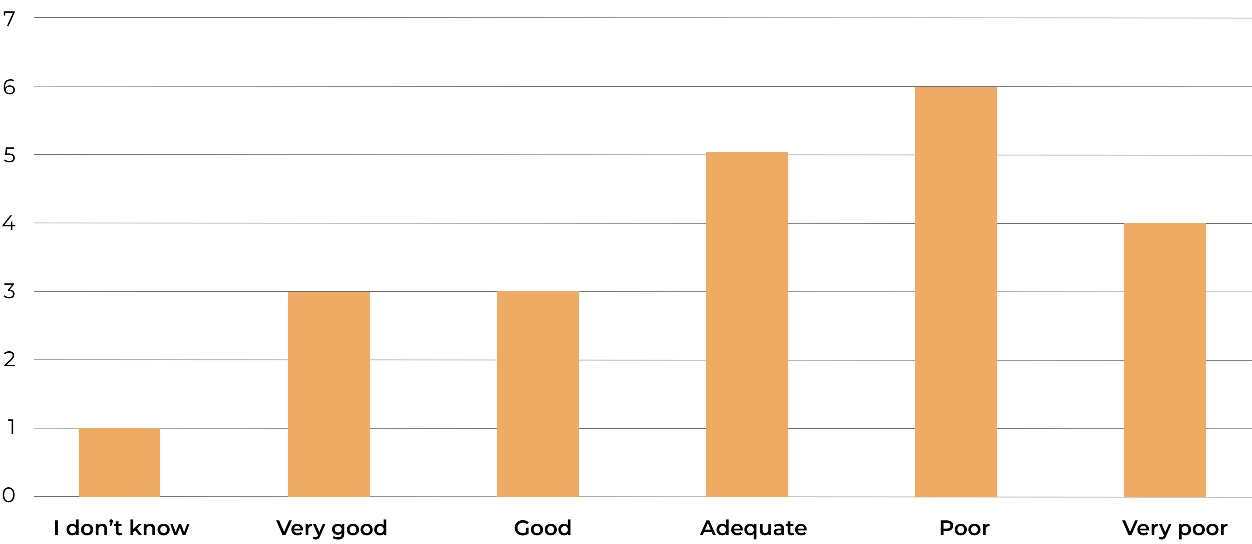
One service provider mentioned the need for more outreach services, particularly in mental health care, pointing out that current services are under-resourced and insufficient. They suggest that, similar to services in Barcelona,[8] mental health professionals should engage with clients directly in the community to overcome barriers to accessing care.

Quality of Mental Health Services for PEH

Of the MH services that are available to PEH, the majority of service providers (10 of 22) feel that they are *"poor"* to *"very poor"* (Figure 7). A notable number of respondents described the services as *"very poor"*, while some others reported *"good"* or *"very good"* availability, suggesting a mixed perception of service accessibility which may reflect different interagency relationships (i.e. the extent to which MH services are integrated into their housing sites).

8 No specific service was mentioned.

Figure 7. Service Provider Rating of the Availability of MH Services to PEH (N=22) – Source: TASC, 2024



Psychosis

Some staff supporting housing for PEH reported challenging experiences with residents who are experiencing psychosis. This topic came up repeatedly in both focus groups and examples were provided of what the experience is like for both the service users and service providers.

An example was given of a client residing in long-term accommodation in urban Dublin. This resident had untreated schizophrenia and had disengaged from mental health services for a number of years and his condition worsened due to drug use and psychosis. Despite repeated crises over 3 months, involving ambulances, psychotic episodes, and violent incidents, the mental health system failed to act, attributing the client's condition to drug-induced psychosis.

> *He wasn't managing his medication, and he was going out to the street. He was getting harmed pretty badly by just like random people that he would start fights with because, you know, hearing voices and stuff. [...] Within two weeks, we had various ambulances and stuff, but nobody, nobody would section[9], you know, they all said, Oh, it's drug induced. You know, it's just drug induced. He'll be fine.*

Multiple attempts to engage with three mental health teams were met with refusal or delays, leaving the housing support team overwhelmed.

> *"He'd get paid at midnight on a Thursday, and he would just be out all night, but by the time it comes to the Friday kind of afternoon, he was back at the like a level of psychosis. His mental health was on the floor, and obviously some of it was probably drug induced, but it just got to the point where, you know, you just it was in a really bad way. And nobody wanted to know we weren't equipped. Like we're not mental health. We can support people with their mental health, but we're not experts in any way. But nobody seemed to want to know for a very long time."*

Over a period of months, the housing team managed the client's medication in the community without adequate mental health expertise. Eventually, after significant deterioration and repeated advocacy, the client was assessed and supported, but only after enduring prolonged neglect by services.

Focus group data also suggest that there are contrasting responses to similar cases of mental health crises involving individual PEH who are experiencing psychosis. The example was given of two similar cases of young men with schizophrenia in Dublin and rural Sligo. Both cases involved disengaged clients exhibiting aggressive behaviours that disturbed neighbours. Efforts to engage mental health services varied:

- In Sligo: A formal letter prompted an involuntary intervention, with the individual being taken for inpatient care without prior consultation or collaboration.
- In Dublin: The response was slower, involving multiple visits and greater collaboration before a similar outcome was achieved.

The service provider criticised the lack of interagency communication and partnership in Sligo, advocated for case management meetings and collaborative planning as a preferred approach. They noted that while the person in Sligo returned to housing after inpatient care, they are again not taking their medication, though the response from services is now quicker and more coordinated.

The experiences of staff supporting individuals with psychosis highlight significant variations in mental health service responses, underscoring systemic challenges in providing timely and effective care. These discrepancies point to potential inconsistent practices between urban and rural settings, varying levels of interagency communication, and a lack of unified protocols for addressing mental health crises. Such variations exacerbate challenges for both service users and providers, highlighting the need for coordinated, collaborative, and equitable approaches across regions.

9 The speaker here is referring to involuntary admission. Please follow this link for additional information: https://www.citizensinformation.ie/en/health/health-services/mental-health/admission-to-a-psychiatric-hospital/#526c8d.

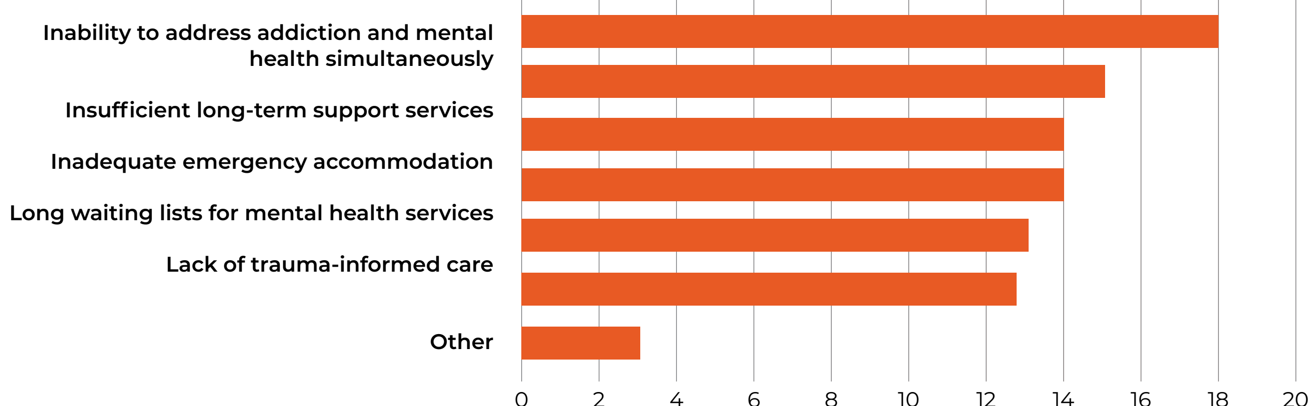
Frequency and Challenges of Staff Training

Training is one of the few ways in which service providers can ensure that their services are fit for the population that they serve. The training data shows that 41% (N=9) of people provide training when needed. Another 36% (N=8) provide training several times a year. Training happens once a year for 9% (N=2), and another 9% (N=2) do not provide training at all. Only 5% (N=1) provide training every two to three years. However, three of the service providers said that although they do provide training, resources are a consideration as they do not often have resources already allocated and have to find the funds elsewhere.

Service Gaps: Addressing Mental Health and Addiction

The main service gap identified by service providers was around the inability to address MHDs and addiction simultaneously, in addition to insufficient long-term support services, inadequate emergency accommodation, long waiting lists for mental health services and a lack of trauma informed care, among others (Figure 8). These gaps emphasise the need for more integrated and accessible services to meet the complex needs of this population.

Figure 8. Main Service Gaps (N=87) – Source: TASC, 2024



Dual Diagnosis

Focus group participants also highlighted dual diagnosis as a significant barrier for people with both mental health difficulties and addiction. They described that discrimination occurs when individuals are told to address their addiction before accessing mental health support, despite mental health often being the root issue. This creates a cycle where neither service takes responsibility, leaving individuals without help.

> *"Their mental health needs are what they need support with, and then addiction follows from that, so that's where the challenge can come."*

There is a HSE initiative under the Cork-Kerry case management scheme, which involves collaboration between various services to provide mental health and addiction support. While the initiative offers a range of professionals, such as psychiatrists, mental health nurses, and GPs, there are gaps in the system, particularly around referrals for psychological services.

> **"You can only get a referral to the psychologist or OT via the psychiatrist, and then that creates a gap as well, because sometimes people aren't they don't need a psychiatrist like they could just need like a psychologist. They could just need talk therapy."**

Additionally, the departure of key staff, such as a social worker and a drugs counsellor, has created challenges in maintaining service effectiveness. Despite these issues, the Cork-Kerry case management scheme is a resource which is seen as valuable, especially in times of crisis.

Dual diagnosis of mental health difficulties and addiction is another major barrier, with clients often being bounced between services that refuse responsibility, leading to gaps in care. Service providers attributed this being exacerbated by recruitment moratoriums stalling the implementation of the new dual-diagnosis care model. Service providers were not always clear how far this had been implemented in their area and on where dual diagnosis psychologists could be accessed by their residents.

> *"Yeah, I don't think the service is really there. It said it was common, but it hasn't really materialised. And it's like, it's incredible that it hasn't, because it's just so key."*

Service providers also highlighted the severe consequences of service rejection for individuals experiencing homelessness, including fatalities. They emphasised that being denied access to services not only limited immediate support but also worsened mental health outcomes. Rejection leads to compounded feelings of frustration, shame, and hopelessness, creating a damaging cycle that exacerbates the individual's mental health difficulties.

Counselling and Conversational Places

One service provider highlighted the pressing need for consistent, accessible counselling services, particularly in emergency shelters, where staff often struggle to meet residents' emotional and mental health needs:

> *"There is a real lack of just psychology or counselling, just somewhere for someone to talk for, like, an hour. I don't always have an hour to give my residents. You know, it's, it's very much an emergency shelter. It's very busy. Sometimes I do and sometimes I don't, but the consistency of having somebody to talk to. So I would like to see like a couple of therapists or counsellors that aren't psychiatrists, that aren't kind of going down that medical route, a little bit more holistic, drugs, and then specialists counselling, drugs, counselling, grief counselling is a massive one a lot of people, especially in addiction, or especially who've had friends with serious mental health issues have lost people quite young as well, you know, and probably haven't had any space to deal with that. So grief counselling would be, would be a massive one."*

The important issue of having the proper place for talking was also raised. It was noted that such conversations should not occur when staff are sitting at a computer, or at a desk between managing paperwork. Rather, "the environment and the time set allocated can make a huge difference as well".

Another participant described the challenges of working in an underfunded and overcrowded environment, highlighting the lack of trauma informed spaces and the impact this has on both staff and service users. They emphasised the need for a dedicated *"chill-out"* area and sufficient private spaces for conversations, which are often difficult to find. This lack of resources creates delays, disrupts workflows, and affects the quality of support that can be provided.

> **"We just don't have the space. We don't have the resources to actually provide the service that we should be providing."**

Gambling

Another concern which was raised is the growing issue of gambling addiction and the lack of specific resources and risk assessments to address it. One service provider pointed to the substance-focused nature of current addiction frameworks and the difficulty in finding suitable services for individuals with gambling as their primary addiction. This was raised as a significant concern as it is *"leading to people losing their tenancy and fall into homelessness"*.

Chemical Restraint: Lack of Trauma-informed Approach to Current Psychiatric Practices

There was also a comment concerning the increasing prescription of antipsychotics to individuals on methadone treatment in clinics, even when they do not have an official mental health diagnosis. It was also clarified by a few participants that prescription often occurs as a response to the individual's behaviour in a specific clinical setting rather than a thorough assessment, with the goal of calming them down in the moment.

> **"Psychosis is associated with crack cocaine use, and it's prevalent."**

This approach can result in the person receiving medication that they may not need or that has long-term consequences, especially when administered over extended periods, such as monthly or quarterly. When the long-term prescriptions are received by PEH living in homeless/supervised accommodation, housing providers/staff are then responsible for administering such medications. However, they may have a more holistic understanding of the situation of the person (e.g. regarding housing, addiction, etc.), than a clinician who briefly came across them.

Housing providers expressed their concerns regarding how mental health and trauma are treated when substance use is involved. The example of a young man was given who was prescribed antipsychotic medication after presenting with drug-induced psychosis, but the underlying trauma causing his hallucinations was not addressed.

"I was like, this guy clearly needs help and it was just he is on drugs, see you. And like, here's your anti-psychotic medication. No kind of further, kind of digging into that. And his hallucinations were speaking clearly about a lot of trauma."

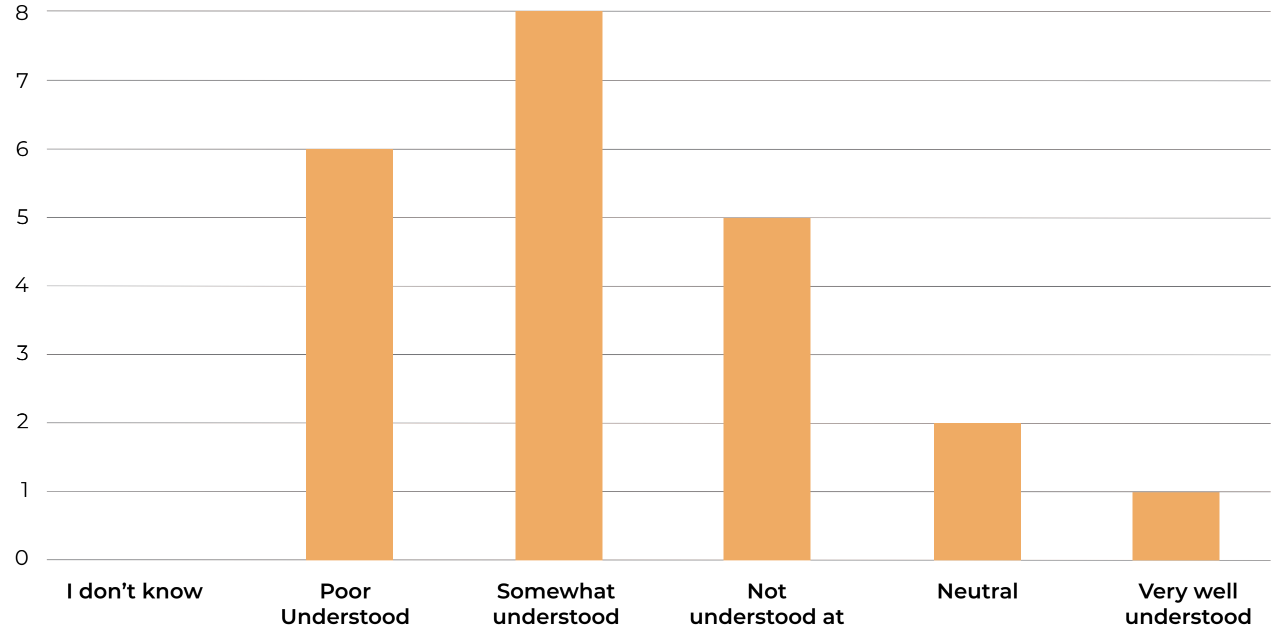
These situations highlight a failure to explore the potential trauma behind mental health symptoms, especially when substances are involved, as well as the added burden service providers are faced with by managing such prescriptions.

When individuals present with medication-related issues, particularly in relation to changes in prescribed medications, staff conduct a thorough risk assessment and create an individual support plan for medication management. However, the success of this process depends on the person's willingness to disclose their current medications, which may not always happen without the individual's full cooperation.

Perception of Policymakers' Awareness

Service providers feel that policymakers are not really aware of the issues that they are facing, with 19 (86%) of survey respondents giving policy makers a score of *"not at all", "somewhat understood" or "poorly understood"* (Figure 9).

Figure 9. Proportion of Service Providers who Feel that Policy Makers Understand the Connection Between MH and Homelessness (N=22) – Source: TASC, 2024



Resource Challenges and Barriers Identified by Providers

The lack of suitable long-term accommodation (N=18) was an issue which nearly all service providers who completed the survey were concerned about, followed closely by lack of resources (funding, staff, etc.) (N=17), difficulty coordinating with other agencies (N=16), insufficient support from government/policymakers (N=15), lack of appropriate training for staff (N=9) and lack of overall support and buy-in for proper peer-led work (N=1).

In one of the focus groups, service providers described the *"fractured nature"* of services, where support is scattered across different locations rather than being centralised. These types of services have specific challenges, including difficulty sleeping in shelters, managing appointments, high staff and resident turnover, and the resulting lack of stability that residents face. These factors make it hard for individuals to build relationships and engage effectively with services.

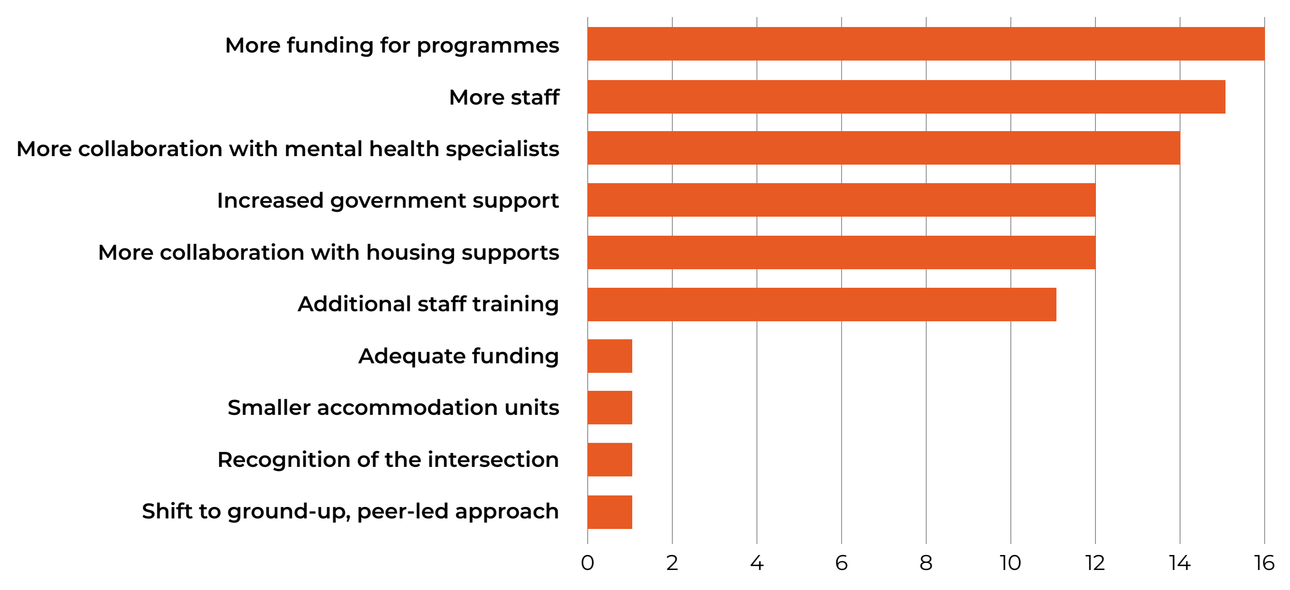
A gap in the support services available in Longford, where caseworkers, although trained in trauma-informed care, often have to work independently was identified. There, caseworkers provide individualised support to service users, attempting to link them with GPs and other medical referrals. However, the lack of integrated community or national services means caseworkers are often left to develop plans on their own, depending on the needs and situation of the residents.

Priorities for Improving Support Services

Service providers also highlighted key priorities for improving support services, with a focus on funding, staffing, and collaboration (Figure 10). It reflects a strong need for increased resources and partnerships, alongside calls for more government support and innovative approaches led by lived experience.

The teams work to educate women about mental health and encourage engagement, though delays of months for appointments are common. Recent improvements, such as phone consultations and triage by nurses, have been helpful. The service supports women during pregnancy and for six months postpartum, prioritising their mental health needs during this critical period.

Figure 10. Key priorities for service improvement (N=84) – Source: TASC, 2024



What are the Solutions?

Suggestions for Integrating Homelessness and Mental Health Services

Service providers felt that the integration of PEH and MH services could be accomplished through increased funding, increasing collaborations, training for service providers on MHDs, co-location of MH services and homelessness services and more outreach programmes, with funding being the most important improvement (Figure 11).

A focus group participant highlighted a positive aspect of service availability in Longford, where residents can access a community alcohol and drug service, as well as an outpatient psychiatric service. These services allow for quicker referrals and support for individuals in need of addiction and mental health care.

In Dublin, being part of a multidisciplinary team (MDT), specifically with the inclusion health teams, has proven useful to housing providers. These teams, which include mental health professionals and other specialists, provide immediate support and can address complex needs quickly. A housing provider praised the flexibility and responsiveness of these teams, though they acknowledge that not all services have access to such resources.

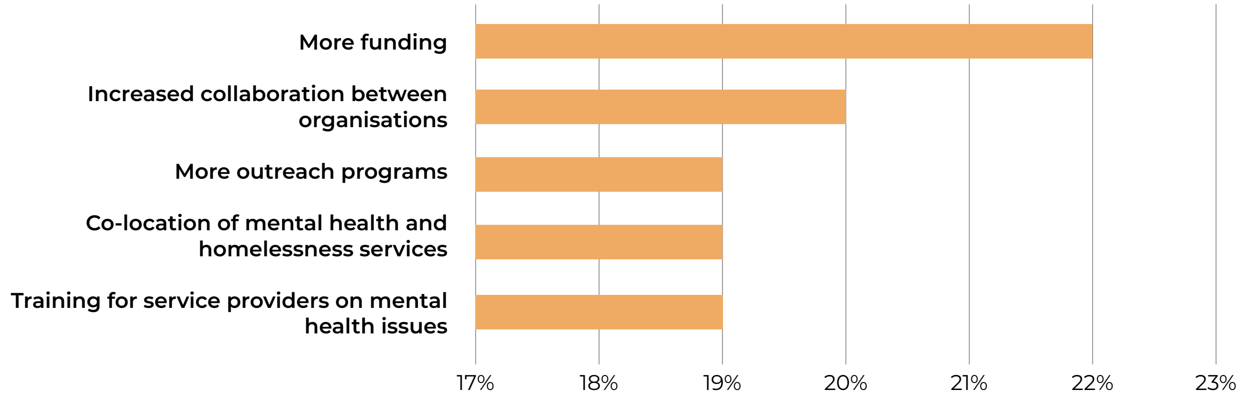
> *"Like, if we have someone who's in need, they're just incredible, and they'll do everything they can."*

Housing providers suggested improving collaborations between services through a case management approach and establishing dedicated teams (e.g. in-reach teams from community mental health services). The focus is on building stronger relationships, improving communication, and enabling better advocacy for clients by sharing insights into their challenges. Service providers discussed what they thought would work best:

> *"I would probably say both. So you have the option of knowing somebody's going to be on site on certain set days, but if something comes up in the meantime, you have the option of asking somebody to come in, or you can take somebody out to an appointment."*

The success of Housing First initiatives in improving outcomes by addressing multiple needs holistically was given as an example of the positive impact on mental health, addiction service engagement, and the reduction of emergency attendances and arrests. The participant also critiqued the systemic barriers that PEH face, emphasising the importance of a supportive and person-centred approach.

Figure 11. Ways to Improve Service Integration (N=89) – Source: TASC, 2024



Discussion

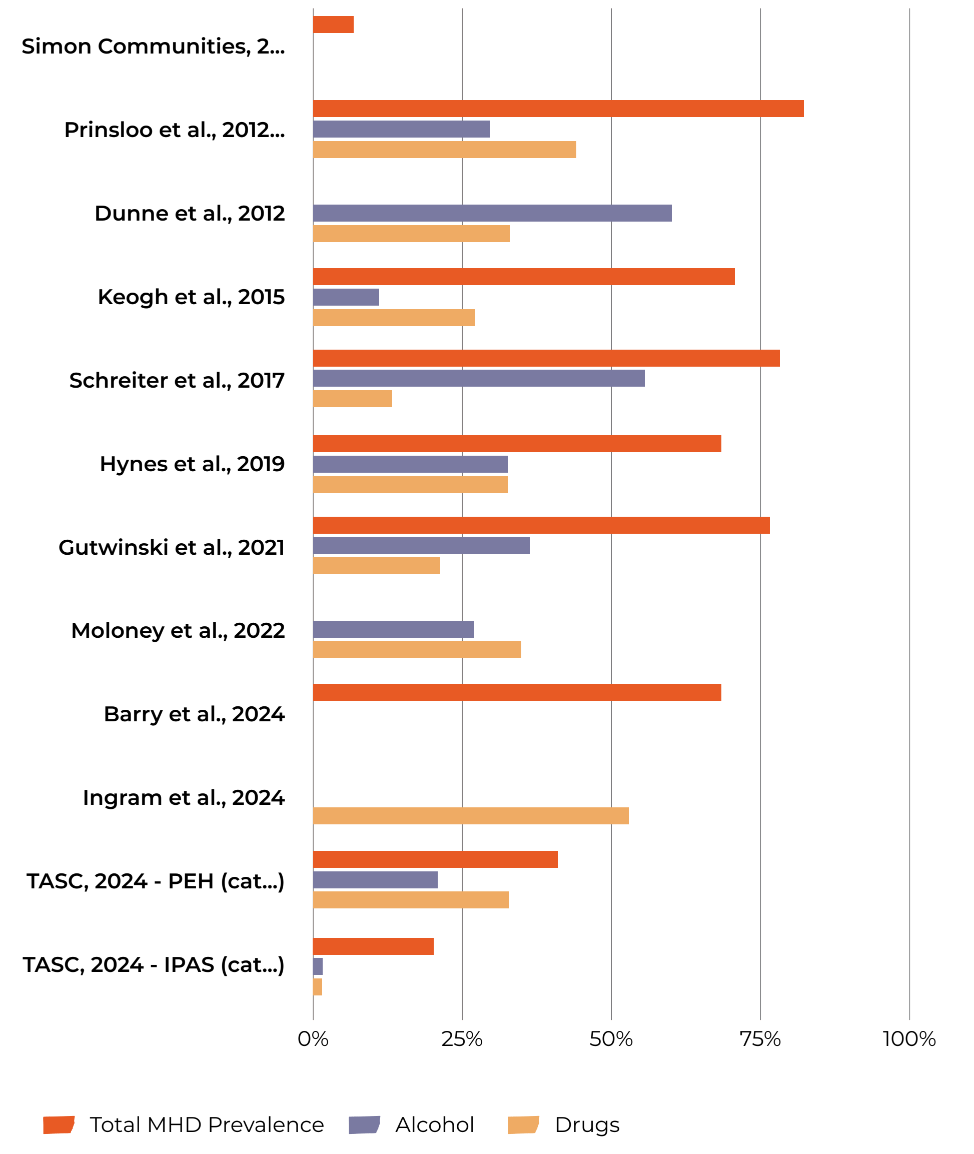
Depaul Residents Compared to the Published Literature

The MHD and substance misuse prevalence data from Depaul residents was lower than expected based on the published literature. The proportion of Depaul residents living in emergency and homeless accommodation with alcohol and drug difficulties is notably low, with 21.6% reporting alcohol misuse and 30.7% reporting drug misuse.[10] These figures are generally lower than those in the published literature (Figure 12; see Table A2 for details). The lower rates found in the Depaul data may reflect methodological variations in data collection compared to earlier studies, service context or differences in population demographics. As the data used for assessing MHD prevalence in Depaul data were collected by staff when individuals first presented at the service, it may be that individuals were concerned about their housing placement being impacted by answers to questions around alcohol and drug misuse in particular. In addition, immigrants living in IPAS accommodation may have language and other cultural barriers which may further serve to reduce the possibility of such disclosures occurring.

The lower reports of MHDs for individuals resident in Depaul supported IPAS accommodation, in comparison to the general PEH population, is not surprising, as residents in IPAS accommodation have less contact with Depaul staff. Due to the differences in the way that these data are collected for the two different populations there is no evidence that MHDs are actually more prevalent among IPAS residents. Although lower than the general population, the figure of 19.5% of those IPAS residents who reported having a MHD, is closer to those for the international literature than the substance misuse figures (Figure 12).

However, the Depaul data does not allow for looking specifically at PTSD and trauma, which are MHDs that have been repeatedly attributed to the asylum seeker experience. One Depaul resident living in IPAS accommodation was interviewed for this research, during the interview they mentioned depression, PTSD and trauma as MHDs that they and their family were currently facing. In a French study, Roze and colleagues (2020) used the Mini International Neuropsychiatric Interview to assess the prevalence of PTSD in 691 migrant mothers experiencing homelessness in homelessness shelters in the Paris region.

Figure 12. Comparison of Mental Health and Substance Use Difficulties Across Studies – Source: TASC, 2024



10 PEH figures presented here and in Figure 12 for Depaul excludes those individuals living in IPAS accommodation. Data for IPAS residents is identified separately.

A total of 112 (16.2%) met the diagnostic criteria for PTSD, and 431 (62.4%) had experienced trauma in their lives.

The underreporting of MHDs among PEH, as indicated by administrative data, presents a significant discrepancy when compared to the lived experiences of service providers and residents. Service providers spoke about often encountering high rates of MHDs among PEH, including conditions like depression, anxiety, PTSD, and substance misuse, which are frequently intertwined with their housing instability. Similarly, residents themselves report struggles with mental health that are not always captured in formal data collection processes. This gap may stem from barriers such as stigma, lack of access to mental health assessments, or inconsistent reporting practices within administrative systems. As a result, the prevalence rates reflected in official records likely underestimate the true scope of MHDs within the two populations explored here, highlighting the need for more comprehensive and inclusive data collection methods to inform policy and service provision.

Specific MHD Prevalence

Depaul data does not allow for a detailed breakdown of MHDs. However, published findings indicate varying prevalence rates for different MHDs among homeless populations across studies. Depression was consistently reported, ranging from 11.6% (Schreiter et al., 2017) to 49.5% (Keogh et al., 2015), with larger reviews (e.g., Barry et al., 2024) reporting a moderate 19%. Schizophrenia varied widely, from 7% (Barry et al., 2024) to 53.3% (Moloney et al., 2022), with smaller studies often showing higher rates. Post-Traumatic Stress Disorder (PTSD) prevalence was reported in fewer studies but reached up to 47.6% (Armstrong et al., 2020). Alcohol misuse ranged from 10.5% (Keogh et al., 2015) to 61.1% (Dunne et al., 2012), while drug misuse was prevalent in 13.9% to 44.7% across studies. Self-harm rates ranged between 13.8% and 22.2%, and suicidal ideation varied widely, peaking at 18.1% (Keogh et al., 2015). Suicide attempts had inconsistent reporting, with rates up to 15.2% (Schreiter et al., 2017). Bipolar disorder was less common, generally below 5.7%, except in some smaller samples. Anxiety prevalence varied significantly (11.7% to 36.2%), while personality disorders were infrequently measured but reached 66.6% (Gentil et al., 2019) in smaller studies. (Additional details are located in the summary table located in Table A3.)

High MHD Rates in Ireland and Potentially Higher for PEHs

Research suggests a higher prevalence of MHDs among the general population of people living in Ireland in comparison to other countries in Europe. As part of their Health at a Glance report, the Organisation for Economic Co-operation and Development (2016) reported that Ireland had the third highest prevalence rates for MHDs in Europe, with 19% of the Irish population recorded as currently experiencing MHDs.

In their most recent Mental State of the World report, Sapien Labs (2024) ranked Ireland as having the 8th poorest mental wellbeing score of the 64 countries included in their survey in 2023. Irish respondents had an average Mental Health Quotient score of 55, on a scale ranging between -100 and 200. Ireland had the 6th highest percentage of respondents (31%) who were distressed or struggling. The respondents for Sapien Labs' study were unlikely to include many PEH, as the survey was delivered online and recruitment was carried out through digital advertising. However, this work suggests that Irish people may be relatively more at risk to experience MHDs when compared to people living in other countries.

In a survey requested by the European Commission, Directorate-General for Health and Food Safety, Ipsos European Public Affairs (IEPA, 2023) found that Irish respondents were the most likely in Europe to have themselves or have a family member that has encountered one or more issues accessing mental health services. 44% of Irish respondents had faced issues accessing mental health services while the EU average was 25%. Irish people are some of the most likely to experience MHDs and are most likely to encounter issues accessing mental health services.

Those experiencing homelessness often face difficulties in accessing care for MHDs (Kerman et al., 2019), with service eligibility being the most common barrier to access. Kerman and colleagues found that service bans and refusals were common for PEH in their sample, and that the decision to ban or refuse service often appeared to be one-sided, unfair, or discriminatory, based on their interviews with PEH.[11] Other common barriers to access for care for MHDs for those experiencing homelessness in their sample included programme capacity, the proximity of the programme, and the affordability of the programme.

11 Kerman and colleagues (2019) identified lacking any ID as one barrier, but did not provide specific examples of a ban/refusal that was one-sided, unfair, or discriminatory.

Limits of Literature on MHDs in PEH

There are significant limitations common among much of the academic literature on the prevalence of MHDs among PEH. For long-term rough sleeping PEH, a small but particularly vulnerable sub-group, there are significant barriers to MHD research recruitment that need to be considered. These barriers chiefly include lifestyle instability, contacting/locating participants, illness and prioritisation of needs (Prinsloo et al. 2012, Hynes et al. 2019, Mcloughlin et al. 2021).

Mcloughlin and colleagues (2021) argue that the energy required to navigate the instability of life as a PEH often forces individuals to prioritise immediate survival, shelter, and sustenance over health assessments. This effect may be compounded for longitudinal work where participating PEH may need to contribute several times. There is a well-established literature base discussing how PEH with MHDs can face challenges maintaining contact with healthcare providers (e.g., Marshall et al., 1994). Also, others have discussed difficulties they faced maintaining contact with PEH in the context of their research (Hynes et al., 2019), suggesting that PEH with MHDs may face challenges when attempting to contribute to long term research projects. The resources required to either commit to a long-term health improvement plan or to repeatedly contribute to a piece of research may not be available to all PEH with MHDs. To improve healthcare outcomes and participation rates for PEH with MHDs, healthcare plans and research methodologies must be developed with these unique needs in mind.

MHDs may exhibit an episodic nature, where individuals experience periods of remission interspersed with episodes of heightened intensity (Sabharwal et al., 2021). The episodic nature of MHDs may be demonstrated by the difference in current and lifetime prevalence rates reported by the authors of several of the studies, reviews, and reports included in this review. The episodic nature of these MHDs can be influenced by a variety of factors, including stress and medication adherence. Thus, environmental factors can affect the timing and occurrence of MHDs and may also have an influence on housing stability for PEH or people experiencing housing insecurity.

Conclusion

This data highlights the complex and interconnected factors contributing to the challenges faced by PEH with MHDs. It underscores the importance of holistic support systems to address these issues effectively. Stakeholders emphasised the intricate relationships they have with medication, the critical need for counselling and therapeutic supports, and the importance of a stable and empathetic environment for recovery and well-being.

Despite differences in research methodology making direct comparisons challenging for some MHDs, the published literature from Ireland and internationally strongly indicate that PEH in Ireland have a higher rate of MHDs than the general population. This raises various concerns, including around accommodation support provided to PEH and the availability of associated mental health support.

MHDs are complex and can vary greatly in how they affect individuals. It's important for service providers, policymakers, and society as a whole to recognize the unique challenges that people with MHDs face. This understanding goes beyond mere awareness and includes in-depth knowledge of how these difficulties manifest, the symptoms they produce, and how they impact an individual's ability to maintain stable housing. Many mental health difficulties are not constant; they can be episodic, meaning that individuals might experience periods of stability followed by episodes of severe symptoms. These episodes can disrupt an individual's ability to manage daily life, including maintaining housing.

More specifically, the availability and accessibility of mental health services for PEH come into question. If the current support systems are not adequately equipped to handle the higher rates of MHDs among PEH, there is a real risk that their mental health difficulties could worsen, further complicating efforts to stabilise their housing situations. This underscores the need for a holistic approach that not only provides shelter, but also ensures that mental health care is an integral part of the support offered to this vulnerable population.

Recommendations

This report primarily focuses on accommodation for PEH and some residents in IPAS accommodation. However, during interviews with Depaul residents, the evidence highlights inconsistencies in Ireland's approaches to addressing MHDs and alcohol and drug difficulties among PEH. While some individuals have access to multidisciplinary supports, the majority face significant barriers to obtaining adequate assistance. The following section outlines recommendations to improve support systems for PEH.

In order for Depaul to meet these recommendations at an organisational level is through adequate and sustained funding, ensuring that mental health and housing supports are properly resourced to meet the needs of PEH.

Organisational Level

Administrative Data Collection and Monitoring

- Where possible, align the administrative database to systematically record the MHDs of residents (e.g. include diagnostic information in individual records).
- Develop a system of monitoring staff inputs associated with MHD at a site level.

Staff Training

- Provide additional training for non-clinical staff to enhance their ability to support clients with MHDs.
- Deliver training for healthcare and social welfare staff to improve their understanding of barriers faced by PEH and the effects of trauma, enhancing client experiences.

On-Site Supports

- Make access to mental health and addiction services more convenient by bringing these supports directly on-site in homeless accommodation settings.

Peer Support Programmes

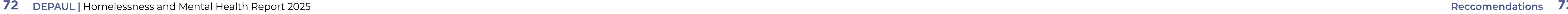
- Establish peer support initiatives to encourage engagement and reduce stigma, particularly among individuals who use drugs and pregnant women. These programmes can foster solidarity, understanding, and inclusivity across diverse groups.

Flexible Service Models

- Adopt a hybrid approach that allows for scheduled onsite support on set days, with flexibility to address urgent needs through additional appointments or referrals.

Adopt a Case Management Approach

- Introduce case management practices to improve collaboration between services, strengthen communication, and provide more effective advocacy for clients.
- Assign dedicated case managers to oversee individual cases, ensuring continuity and consistency in care.



Regional Level

Expand Collaborative Efforts

- Strengthen collaborations between homelessness services and MH services through formal partnerships, co-located services, and shared protocols to facilitate seamless care.
- Develop multidisciplinary teams (MDTs) in all regions, incorporating MH professionals, addiction specialists, housing providers, and other key stakeholders to address complex needs efficiently.

Develop Outreach and In-Reach Programmes

- Implement outreach initiatives to identify and engage PEH who may not access traditional services.
- Establish in-reach teams from community MH services to provide onsite support at shelters or homeless accommodations, ensuring immediate and flexible access to care.
- Extend sufficient MH supports and access to key workers to those living in direct provision.

Co-Location of Services

- Promote the co-location of homelessness, MH, and addiction services to streamline referrals and improve access to holistic care.
- Use the Longford model as an example of good practice, where community alcohol and drug services are available alongside outpatient psychiatric care, enabling faster referrals and comprehensive support.

Leverage Good Practices from Dublin and Longford

- Replicate successful examples of MDT inclusion health teams in Dublin and integrated service models in Longford to improve responsiveness and outcomes nationwide.

National Level

Full Legislative Reform

- Legislative reform of the Mental Health Act (2001), including alignment with the United Nations Convention on the Rights of Persons with Disabilities, to protect the rights of all persons with MHDs.

Fully Adopt the Dual Diagnosis Model of Care

- Prioritise the implementation of the Dual Diagnosis Model of Care (2022), which focuses on integrated treatment for individuals with co-occurring mental health difficulties and substance misuse difficulties.

Adequate Funding and Infrastructure

- Allocate sustained funding to enhance the integration of homelessness and MH services, ensuring resources are sufficient to meet demand across all regions.
- Provide funding to support the delivery of dual-diagnosis services, emphasising trauma-informed care, flexibility, and accessibility.

Expand Housing First Initiatives

- Scale up Housing First programmes, which address housing, mental health, and addiction needs holistically, demonstrating positive outcomes such as increased service engagement and reduced emergency attendances and arrests.

Support Family Unification

- Address systemic barriers to family reunification, particularly for mothers seeking to regain custody of their children.
- Increase the availability of family-friendly hostels to reduce stress and support family stability.

Increase Single Bedroom Availability

- Expand the number of single bedrooms in homeless accommodations to promote dignity, privacy, and personal security for individuals experiencing homelessness.

Address Systemic Barriers

- Tackle systemic issues that prevent PEH from accessing timely and adequate care, focusing on reducing administrative hurdles and improving person-centred support across services.

References

Armstrong, R., Phillips, L., Alkemade, N., & Louise O'Donnell, M. (2020). Using latent class analysis to support the ICD-11 complex posttraumatic stress disorder diagnosis in a sample of homeless adults. Journal of Traumatic Stress, 33(5), 677-687. https://doi.org/10.1002/jts.22554

Ayano, G., Solomon, M., Tsegay, L., Yohannes, K., & Abraha, M. (2020). A systematic review and meta-analysis of the prevalence of post-traumatic stress disorder among homeless people. Psychiatric Quarterly, 91(4), 949-963. https://doi.org/10.1007/s11126-020-09746-1

Barry, R., Anderson, J., Tran, L., Bahji, A., Dimitropoulos, G., Ghosh, S. M., ... & Seitz, D. (2024). Prevalence of Mental Health Disorders Among Individuals Experiencing Homelessness: A Systematic Review and Meta-Analysis. JAMA Psychiatry. https://doi.org/10.1001/jamapsychiatry.2024.0426

Canavan, R., Barry, M. M., Matanov, A., Barros, H., Gabor, E., Greacen, T., ... & Priebe, S. (2012). Service provision and barriers to care for homeless people with mental health problems across 14 European capital cities. BMC health services research, 12, 1-9.

Carmichael, C., Schiffler, T., Smith, L., Moudatsou, M., Tabaki, I., Doñate-Martínez, A., ... & Grabovac, I. (2023). Barriers and facilitators to health care access for people experiencing homelessness in four European countries: an exploratory qualitative study. International Journal for Equity in Health, 22(1), 206.

Central Statistics Office (2022). Census of population 2022. https://www.cso.ie/en/statistics/population/censusofpopulation2022/

CHNI (2017, December). A Picture of Health. https://www.publichealth.hscni.net/sites/default/files/A%20Picture%20of%20Health%20Dec%202017_0.pdf

Department of Health. (2024). Ministers for Health announce Government approval to publish Mental Health Bill 2024. Government of Ireland. Retrieved January 18, 2025, from https://www.gov.ie/en/press-release/fdbbb-ministers-for-health-announce-government-approval-to-publish-mental-health-bill-2024/

Department of Health. (2020). Sharing the Vision: A mental health policy for everyone. Government of Ireland. https://assets.gov.ie/76770/b142b216-f2ca-48e6-a551-79c208f1a247.pdf

Department of Housing, Local Government, and Heritage (2024, May). Department of Housing, Local Government and Heritage Monthly Homelessness Report May 2024. https://www.gov.ie/pdf/?file=https://assets.gov.ie/297403/eabd7b85-e9ba-4a31-95d6-415f741cee1e.pdf#page=null

Depaul Ireland. Mental Health & Homelessness. https://ie.depaulcharity.org/wp-content/uploads/sites/2/2023/01/Mental-Health-Homelessness-Report-2022.pdf

Dunne, E., Duggan, M., & O'Mahony, J. (2012). Mental health services for homeless: patient profile and factors associated with suicide and homicide. Irish Medical Journal, 105(3), 71.

English, Eoin (2025, January 10). Homelessness peer support initiative to expand. Irish Examiner. https://www.irishexaminer.com/news/munster/arid-41425663.html

European Commission. (2023). State of Health in the EU: Ireland Country Health Profile 2023. Retrieved from https://health.ec.europa.eu/document/download/20f96f89-7286-4e4f-8a2c-bea12cf97576_en

Fazel, S., Geddes, J. R., & Kushel, M. (2014). The health of homeless people in high-income countries: Descriptive epidemiology, health consequences, and clinical and policy recommendations. The Lancet, 384(9953), 1529–1540. https://doi.org/10.1016/S0140-6736(14)61132-6

FEANTSA (2005, April 1). ETHOS – European Typology on Homelessness and Housing Exclusion. https://www.feantsa.org/download/ethos2484215748748239888.pdf

Halpin, Padraic (2024, November 27). Irish voters angry as cash windfall fails to fix poor public services. Reuters. Retrieved January 18, 2025, from https://www.reuters.com/world/europe/irish-voters-angry-cash-windfall-fails-fix-poor-public-services-2024-11-27/

Gentil, L., Grenier, G., Bamvita, J. M., Dorvil, H., & Fleury, M. J. (2019). Profiles of quality of life in a homeless population. Frontiers in Psychiatry, 10, 10. https://doi.org/10.3389/fpsyt.2019.00010

Gleeson, C. (2024, June 1). Number of homeless is a record the Government does not want – Dara Calleary. The Irish Times. https://www.irishtimes.com/ireland/social-affairs/2024/06/01/number-of-homeless-is-a-record-the-government-does-not-want-dara-calleary/

Gulati, G., Keating, N., O'Neill, A., Delaunois, I., Meagher, D., & Dunne, C. (2018). The prevalence of major mental illness, substance misuse and homelessness in Irish prisoners: systematic review and meta-analyses. Irish Journal of Psychological Medicine, 36(1), 35-45. https://doi.org/10.1017/ipm.2018.15

Gutwinski, S., Schreiter, S., Deutscher, K., & Fazel, S. (2021). The prevalence of mental disorders among homeless people in high-income countries: an updated systematic review and meta-regression analysis. PLoS medicine, 18(8), e1003750. https://doi.org/10.1371/journal.pmed.1003750

Hyland, P., Vallières, F., Shevlin, M., Bentall, R. P., Butter, S., Hartman, T. K., Karatzias, T., Martinez, A. P., McBride, O., Murphy, J., & Fox, R. (2022). State of Ireland's mental health: Findings from a nationally representative survey. Epidemiology and Psychiatric Sciences, 31, e57. https://doi.org/10.1017/S2045796022000312

Hynes, F., Kilbride, K., & Fenton, J. (2019). A survey of mental disorder in the long-term, rough sleeping, homeless population of inner Dublin. Irish Journal of Psychological Medicine, 36(1), 19-22. https://doi.org/10.1017/ipm.2018.23

IEPA (2023, October). Flash Eurobarometer 530 – Mental health: Summary. https://europa.eu/eurobarometer/surveys/detail/3032

IMHE (n.d.) Health risks and issues – mental health. https://www.healthdata.org/research-analysis/health-risks-issues/mental-health

Ingram, C., Buggy, C., Elabbasy, D., & Perrotta, C. (2023). Homelessness and health-related outcomes in the Republic of Ireland: a systematic review, meta-analysis and evidence map. Journal of Public Health, 1-22. https://doi.org/10.1007/s10389-023-01934-0

Ingram, C., Buggy, C., MacNamara, I., & Perrotta, C. (2024). "Just a knife wound this week, nothing too painful": An ethnographic exploration of how primary care patients experiencing homelessness view their own health and healthcare. Plos one, 19(7), e0299761. https://doi.org/10.1371/journal.pone.0299761

Irish Prison Service (2024, July). Prisoner Population on Monday 1st July 2024. https://www.irishprisons.ie/wp-content/uploads/documents_pdf/01-July-2024.pdf

Keogh, C., O'Brien, K. K., Hoban, A., O'Carroll, A., & Fahey, T. (2015). Health and use of health services of people who are homeless and at risk of homelessness who receive free primary health care in Dublin. BMC Health Services Research, 15, 1-8. https://doi.org/10.1186/s12913-015-0716-4

Kerman, N., Gran-Ruaz, S., Lawrence, M., & Sylvestre, J. (2019). Perceptions of service use among currently and formerly homeless adults with mental health problems. Community Mental Health Journal, 55, 777-783. https://doi.org/10.1007/s10597-019-00382-z

Kim, Y., Bender, K., Ferguson, K. M., Begun, S., & DiNitto, D. M. (2018). Trauma and posttraumatic stress disorder among homeless young adults: The importance of victimization experiences in childhood and once homeless. Journal of Emotional and Behavioral Disorders, 26(3), 131-142. https://doi.org/10.1177/1063426617710239

Marshall, M., Nehring, J., Taylor, C., & Gath, D. (1994). Characteristics of homeless mentally ill people who lose contact with caring agencies. Irish Journal of Psychological Medicine, 11(4), 160-163.

McLoughlin, A., Feeney, A., & Cooney, J. (2021). Homelessness, emergency care and mental health. Inner-city emergency department psychiatry referrals: a retrospective descriptive analysis. Irish Journal of Medical Science (1971-), 190, 1201-1204. https://doi.org/10.1007/s11845-020-02392-3

McLoughlin, C., McLoughlin, A., Jain, S., Abdalla, A., Cooney, J., & MacHale, S. (2021a). The suburban-city divide: an evaluation of emergency department mental health presentations across two centres. Irish Journal of Medical Science (1971-), 190, 1523-1528. https://doi.org/10.1007/s11845-020-02496-w

McQuillan, K., Hyland, P., & Vallières, F. (2022). Prevalence, correlates, and the mitigation of ICD-11 CPTSD among homeless adults: The role of self-compassion. Child Abuse & Neglect, 127, 105569. https://doi.org/10.1016/j.chiabu.2022.105569

Mental Health Reform. (2024). Historic funding allocated for mental health services in Budget 2025. Retrieved from https://mentalhealthreform.ie/news/historic-funding-allocated-for-mental-health-services-in-budget-2025/

Moloney, N., O'Donnell, P., Elzain, M., Bashir, A., Dunne, C. P., Kelly, B. D., & Gulati, G. (2022). Homelessness amongst psychiatric Inpatients: a cross-sectional study in the mid-west of Ireland. Irish Journal of Medical Science (1971-), 1-6. https://doi.org/10.1007/s11845-021-02546-x

National Academies of Sciences, Engineering, and Medicine. (2018). Permanent supportive housing: Evaluating the evidence for improving health outcomes among people experiencing chronic homelessness. Washington, DC: The National Academies Press. https://doi.org/10.17226/25133

National Institute of Mental Health (2023, July). Mental Health Information - Major Depression Statistics. https://www.nimh.nih.gov/health/statistics/major-depression

Organisation for Economic Co-operation and Development (2016). Health at a Glance: Europe 2016: State of Health in the EU Cycle. OECD Publishing, Paris. https://doi.org/10.1787/9789264265592-en

O'Brien, K. K., Schuttke, A., Alhakeem, A., Donnelly-Swift, E., Keogh, C., O'Carroll, A., ... & Fahey, T. (2015). Health, perceived quality of life and health services use among homeless illicit drug users. Drug and Alcohol Dependence, 154, 139-145. https://doi.org/10.1016/j.drugalcdep.2015.06.033

Oireachtas. (2024a). Written answers: Mental health funding. Retrieved from https://www.oireachtas.ie/en/debates/question/2024-07-23/2414/

Oireachtas. (2024b). Written answers: National mental health policy implementation. Retrieved from https://www.oireachtas.ie/en/debates/question/2024-10-09/222/

Pleace, N., Teller, N., & Quilgars, D. J. (2011). Social housing allocation and homelessness: EOH comparative studies on homelessness. Prinsloo, B., Parr, C., & Fenton, J. (2012). Mental illness among the homeless: prevalence study in a Dublin homeless hostel. Irish Journal of Psychological Medicine, 29(1), 22-26. https://doi.org/10.1017/s0790966700017560

Roze, M., Melchior, M., Vuillermoz, C., Rezzoug, D., Baubet, T., & Vandentorren, S. (2020). Post-traumatic stress disorder in homeless migrant mothers of the Paris region shelters. International Journal of Environmental Research and Public Health, 17(13), 4908. https://doi.org/10.3390/ijerph17134908

Sabharwal, A., & Grover, G. (2021).Prediction of inter-episodic time for recurring mental illness using order statistics. Malaysian Journal of Public Health Medicine, 21(2), 52-60.

Sapien Labs (2024). The Mental State of the World Report 2022: A Perspective on Internet-Enabled Populations, A Publication of the Global Mind Project. https://sapienlabs.org/wp-content/uploads/2024/03/4th-Annual-Mental-State-of-the-World-Report.pdf

Schreiter, S., Bermpohl, F., Krausz, M., Leucht, S., Rössler, W., Schouler-Ocak, M., & Gutwinski, S. (2017). The prevalence of mental illness in homeless people in Germany: a systematic review and meta-analysis. Deutsches Aerzteblatt International, 114(40), 665. https://doi.org/10.3238/arztebl.2017.0665

Simon Communities of Ireland (2010). Health and homelessness - Health snapshot study of people using Simon services and projects in Ireland. https://www.simon.ie/wp-content/uploads/2021/04/Health-and-Homelessness-Health-Snapshot-Study-of-People-using-Simon-Projects-and-Services-In-Ireland-Dec-2010.pdf

Tsai, J., Mares, A. S., & Rosenheck, R. A. (2017). A multi-site comparison of supported housing for chronically homeless adults: "Housing First" versus "Residential Treatment First". Psychological Services, 7(4), 219–232. World Health Organisation (2022, January 10). Schizophrenia fact sheet. https://www.who.int/news-room/fact-sheets/detail/schizophrenia

World Health Organisation (2022, June 8). Mental disorders fact sheet. https://www.who.int/news-room/fact-sheets/detail/mental-disorders

World Health Organisation (2022, March 31). Depressive disorder (depression) fact sheet. https://www.who.int/news-room/fact-sheets/detail/depression

Appendices

Table A1. ETHOS Categories and Definitions of Homelessness and Housing Exclusion

Conceptual Category		Operational Category	Living Situation	Living Situation
Conceptual Category	Roofless	1. People living rough	1.1 Public space or exernal space	Living in the streets or public spaces, without a shelter that can be defined as living quarters
		2. People in emergency accomodation	2.1 Night shelter	People with no usual place of residence who make use of overnight shelter, low threshold shelter
	Houselessness	3. People in accomodation for the homeless	3.1 Homeless hostel	Where the period of stay is intended to be short term
			3.2 Temporary accommodation	
			3.3 Transitional supported accommodation	
		4. People in Women's shelter	4.1 Womens shelter accommodation	Women accommodated to experience of domestic violence and where the period of stay is intended to be short term
		5. People in accommodation for immigrants	5.1 Temporary accommodation/ reception centres	Immigrants in reception or short-term accommodation due to their immigrant status
			5.2 Migrant workers accomodation	
		6. People due to be released from institutions	6.1 Penal institutions	No housing available prior to release Stay longer than needed due to lack of housing No housing identified (e.g. by 18th birthday)
			6.2 Medical Institutions	
			6.3 Children's institutions/homes	
		7. People receiving long-term support (due to homelessness)	7.1 Residential care for older homeless people	Long stay accommodation with care for formerly homeless people: (normally more than one year)
			7.2 Supported accommodation for formerfy homeless peple	
	Insecure	8. People living in insure accomodations	8.1 Temporarily with family/friends	Living in conventional housing but not the usual place of residence due to lack of housing Occupation of dwelling with no legal tenancy illegal occupation of a dwelling
			8.2 No legal (sub)tenancy	
			8.3 Illegal occupation of land	
		9. People under threat of eviction	9.1 Legal orders enforcod (rented)	Where orders for eviction are operative Where mortgagee has legal order to repossess
			9.2 Repossession orders (owned)	
		10. People living under threat of violence	10.1. Police recorded incidents	Where police action is taken to ensure place of safety for victims of domestic violence
	Inadequate	11. People living in temporarnon-conventional structures	11.1 Mobile homes	Not intended as place of usual residence Makeshift shelter, shack, or shanty Semi-permanent structure, hut, or cabin
			11.2 Non-conventional buildings	
			11.3 Temporary structure	
		12. People living in unfit housing	12.1 Occupied dwellings unfit for habitation	Defined as unfit for habitation by national legislation or building regulations
		13. People living in extreme over-crowding	13.1 Highest national norm of overcrowding	Defined as exceeding national density standard for floor-spaceor useable rooms

Original source: FEANTSA, 2024

Table A2. Specific MHD Prevalence and Comorbidities:

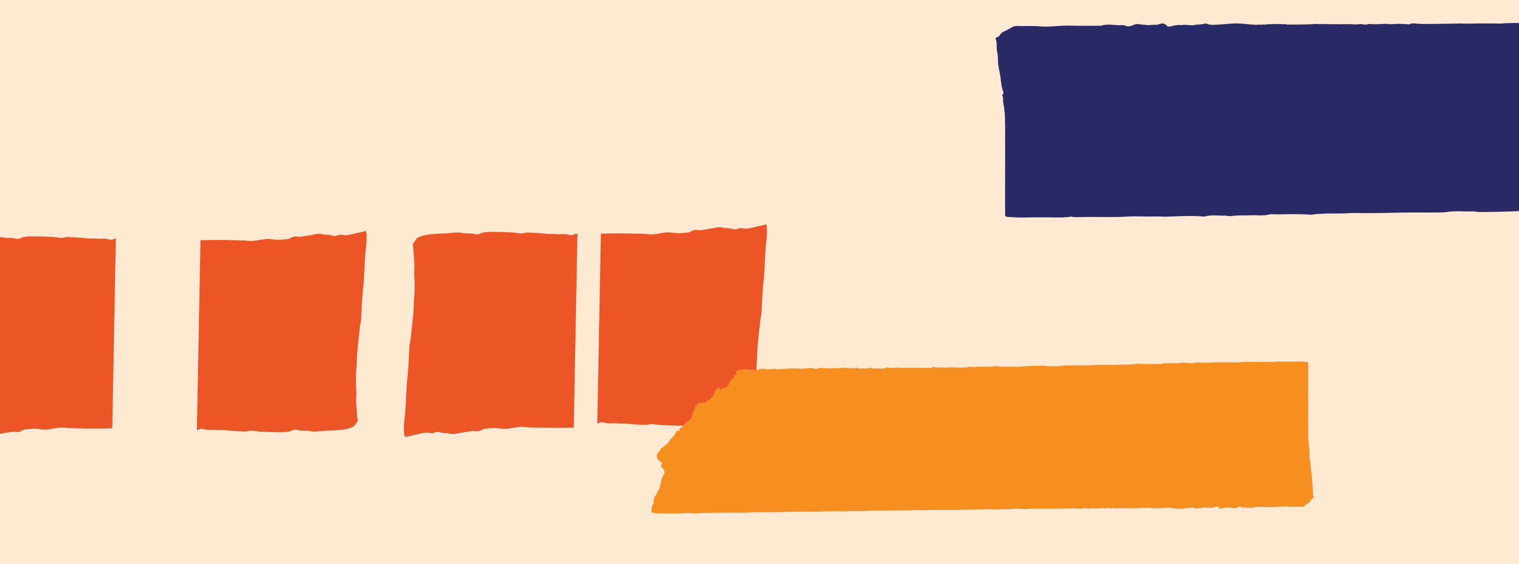
Source	Country	N	Prevalence	Comorbidities
Simon Communities, 2010	Ireland	788	52.0%	
Dunne et al., 2012	Ireland	54		70.4%
Prinsloo et al., 2012	Ireland	38	81.6%	57.9%
Keogh et al., 2015	Ireland	105	69.5%	
Schreiter et al., 2017	Germany	1220	77.4%	
Hynes et al., 2019	Ireland	16	68.8%	12.5%
Gutwinski et al., 2021	High-income countries	8049	76.2%	
Barry et al., 2024	International	48414	67.0%	

Source: TASC, 2024

Table A3. Specific MHD Prevalence: Schizophrenia, PTSDs, Depression, Anxiety, Suicidal Ideation, Suicide Attempt, Self-harm, Personality Disorder, Alcohol and Drugs

Source	Country	N	Depression	Schizophrenia	PTSDs	Alcohol Misuse	Drug Misuse	Selfharm	Suicidal Ideation	Suicide Attempt	Bipolar	Anxiety	Personality Disorder
Simon Communities, 2010	Ireland	788	28.8%	8.5%	1.0%			13.8%	7.1%		3.3%	11.7%	
Dunne et al., 2012	Ireland	54	25.9%	50.0%		61.1%	31.5%				7.4%	18.5%	37.0%
Prinsloo et al., 2012	Ireland	38	34.2%		5.3%	28.9%	44.7%				5.2%	18.4%	
Keogh et al., 2015	Ireland	105	49.5%	13.3%		10.5%	26.7%		18.1%	8.6%	5.7%	36.2%	
O'Brien et al., 2015	Ireland	105	41.0%	13.3%					18.1%	8.6%	5.7%	46.7%	
CHNI, 2017	Northern Ireland	261	45.2%		4.6%							26.4%	
Schreiter et al., 2017	Germany	1,220	11.6%	8.3%		55.4%	13.9%				15.2%	17.6%	29.1%
Kim et al., 2018	USA	601			22.3%								
Gentil et al., 2019	Canada	455							22.2%				66.6%
Hynes et al., 2019	Ireland	16		25.0%		31.3%	31.3%				6.3%		
Armstrong et al., 2020	Australia	206			47.6%								
Ayano et al., 2020	International	20,634			27.4%								
Gutwinski et al., 2021	High-income countries	8,049	12.6%	12.4%		36.7%	21.7%				4.1%		25.4%
McQuillan et al., 2022	Ireland	56			37.5%								
Moloney et al., 2022	Ireland	15	20.0%	53.3%		26.7%	33.3%				13.3%		
Barry et al., 2024	International	48,414	19.0%	7.0%							8.0%		
Ingram et al., 2024	Ireland	74					52.7%						

Source: TASC, 2024



Dublin
18 Nicholas Street,
Dublin 8, D08 VCP7
+353 1 4537111
depaul@depaulcharity.net

www.depaul.ie

Belfast
449 Antrim Road,
Belfast, BT15 3BJ
+44 28 9064 7755
depaulni@depaulcharity.net