National COVID-19 Homeless Service User Experience Survey

The National Social Inclusion Office

Report of Findings

October 2020

HSE Social Inclusion

Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

Foreword

People who experience homelessness in Ireland often have complex and multiple health needs including mental health and addiction needs, have higher mortality rates compared to the general population and use hospital inpatient and emergency services significantly more than housed people. Due to stigma associated with homelessness and the overlapping physical, mental health and drug & alcohol problems often experienced by persons who are homeless, the homeless population will often experience significant barriers to accessing appropriate healthcare services and using these optimally.

The majority of people experiencing homelessness in Ireland live in emergency and temporary accommodation where accessing appropriate supports and information, social distancing and appropriate hygiene can be a challenge. Due to these vulnerabilities, a greater number of risk factors faced the homeless population during the COVID-19 outbreak.

These known risk factors led to a proactive and preventative response by the health and housing sectors since March 2020. In the housing sector, local authorities put in place significant additional emergency accommodation to allow for the necessary social distancing in facilities and shielding/cocooning for the most vulnerable. The HSE, HPSC and voluntary service providers introduced a range of precautions aimed at minimising the risk of infection among service users and staff, including hygiene arrangements, limiting the need for travel and movement between services and the provision of additional supports to monitor and manage the health of those in shielding/cocooning and self-isolation facilities.

Given rapid changes to service delivery during the COVID-19 pandemic, the HSE National Social Inclusion Office (NSIO) along with the HSE Homeless Advisory Governance Group (HAGG) coordinated a National COVID19 Homeless Service User Experience survey between March and June 2020.

Service users have a right to be heard and listened to and it is especially important that our service users, who are often the most vulnerable and underrepresented population/s in our society, are consulted and involved in matters and decisions that may affect their lives. We were pleased to get a positive response to the survey with over 400 service users completing the survey. These responses provide the HSE with valuable information about the service users' health & well-being and experience using healthcare services during the outbreak, particularly those who were residing in isolation or cocooning/shielding beds.

Results from this survey gives a voice to our service users and will support evidence-based care and improve the quality and safety of care to the service user. Findings will not only help to inform service planning throughout the ongoing pandemic but will also provide guidance in relation to ongoing HSE service planning and quality service improvement in order to achieve an integrated and person-centred health service system for those experiencing homelessness across Ireland.

I would like to thank Marieke Altena from the National Social Inclusion Office for leading out on this project and writing this report. We would also like to thank everyone who contributed to and supported this project including members of the HSE Social Inclusion Homeless Advisory Governance Group (HAGG), HSE Social Inclusion colleagues, homeless service providers and peer workers who helped to facilitate administration of the surveys. Most importantly, we would like to sincerely thank each and every individual who took the time to respond to the survey and share their health experiences with us.

Joe Doyle
National Lead, Social Inclusion

Contents

1. Background and purpose

The Department of Housing, Planning & Local Government Homelessness Report May 2020[1] reported that 6,089 homeless adults were using local authority managed emergency accommodation during the week of 25th- 31st May 2020. Approximately 3,300 adults were accessing emergency accommodation. At the time of writing, the most recent winter rough sleeper count for Dublin, conducted in November 2019, identified 90 people sleeping rough[2]. Many rough sleepers and those accessing homeless accommodation have complex health support needs relating to mental health and addiction concerns and other chronic health conditions. Due to increased vulnerabilities, including their health and housing status, a greater number of risk factors faced the homeless population during the COVID-19 outbreak. This led to a proactive and preventative response by the health and housing sectors which were guided by advice from the National Public Health Team (NPHET), Health Protection and Surveillance Centre (HPSC) and the Health Service Executive (HSE).

In the housing sector, local authorities put in place significant additional emergency accommodation to allow for necessary social distancing in facilities. In Dublin, this involved the Dublin Regional Homeless Executive (DRHE) introducing over 500 additional beds for single adults. In addition, approximately 550 beds were put in place in the Dublin region to allow individuals to self-isolate where required and for cocooning and shielding[3]. A range of other precautions were introduced aimed at minimising the risk of infection among service users and staff, including infection prevention and control measures, limiting the need for travel and movement between services and the provision of additional supports to monitor and manage the health of those in shielding, cocooning and self-isolation facilities.

Given rapid changes to service delivery during the COVID-19 pandemic, The National Social Inclusion Office (NSIO) coordinated a National COVID-19 Homeless Service User Experience survey.

Specifically, the purpose of the survey was to:

- Provide an understanding of service-users' health and wellbeing while staying in COVID-19 accommodation for shielding, cocooning or self-isolation
- Provide an understanding of service users' experience of using health and support services while in COVID-19 units
- Inform national and local health service planning and resource allocation
- Identify areas for quality improvement in services
- Include the perspective of service users in service planning and delivery

Health Service Provision for People Experiencing Homelessness

In line with Rebuilding Ireland actions, the HSE, together with local authorities, has a joint responsibility and commitment to provide a long-term, coordinated and integrated response to delivering homeless services to a growing group of people experiencing homelessness. This involves the provision of suitable housing together with a set of appropriate health supports that assist the service user in maintaining a tenancy together with ensuring optimal physical and mental health. Currently, health services for the homeless population are delivered by multiple providers including Statutory Services, Non-Government Organisations (NGOs) and charitable organisations.

Social Inclusion in the HSE holds a remit for improving health outcomes and access to health services for vulnerable groups, including health service users experiencing homelessness. The National Social Inclusion Office (NSIO) is responsible for overseeing and managing a range of services and supports to address homelessness in line with the Rebuilding Ireland action plan. These are provided through inreach and outreach specialist services, multi-disciplinary homeless health teams and case management supports, care staff to support the health needs of residents in supported temporary and long term temporary accommodation and other specialised teams and individuals.

1 Department of Housing, Planning & Local Government Homelessness Report May 2020, Retrieved 17/09/20: https://www.housing.gov.ie/housing/homelessness/homelessness-report-may-2020

2 Dublin Region Homeless Executive (DRHE) Winter 2019 Rough Sleeper Count, Retrieved 17/09/20: https://www.homelessdublin.ie/content/files/Winter-2019-Rough-Sleeping-Count.pdf

3 Cocooning and Shielding is a measure implemented to protect those with medical vulnerabilities who are at greatest risk of COVID-19 infection by minimising their interaction with others.

National priorities and commitments of the HSE Social Inclusion are identified and agreed within HSE planning processes and documented in the National Service Plan, Primary Care. Priorities include:

- Providing appropriate primary care and specialist addiction / mental health services for homeless people in line with Rebuilding Ireland Action Plan for Housing and Homelessness, 2016; Reducing Harm, Supporting Recovery – A health led response to drug and alcohol use in Ireland 2017- 2025; and Sharing the Vision: A mental health policy for everyone, which supports a stepped care approach for the provision of mental health services
- Enhancing integrated multi-disciplinary homeless health teams to develop partnerships with relevant service providers, provide case management to people living in homelessness and support access to appropriate health and social care services
- Further strengthening integrated pathways through enhancing continuity of care for people experiencing homelessness who are leaving hospital, in partnership with the local authority and community service providers
- Enhancing in-reach primary care and mobile health units to support people living in emergency accommodation and supported temporary accommodation to access health services including GP and nursing clinics and mental health case management
- Providing multi-disciplinary wrap around health supports, including mental health and addiction supports, for housing first tenants, in line with targets in the Housing First National Implementation Plan 2018-2021.

Mental Health Service Provision

HSE Mental Health Services have local Community Mental Health Teams, Acute Mental Health Units and established Specialist Homeless Mental Health Teams. Specialist Homeless Mental Health Teams are dedicated to meeting the mental health needs of the homeless population and to providing education and support to staff working in the homeless sector. There are two Specialist Homeless Mental Health Teams located in Dublin; the Assertive Community Care Evaluation Service (ACCES Team) and the Programme for the Homeless, The Adult Homeless Integrated Care Team is located in Cork and a dedicated mental health homeless team is currently being developed in Kerry. For service users who present with substance misuse issues, Mental Health Services operate a shared care approach with the Addiction Services.

Counselling is available to homeless persons through a national service, Counselling in Primary Care (CIPC). Counselling is also available through the HSE Addiction Services and by HSE funded NGOs. In 2018 the National Office of Suicide Prevention (NOSP) provided additional funding for a homeless specific Out of Hours Counselling Service. Primary Care Open Access services are also delivered through HSE funded NGOs and primary care inreach teams that provide GP and Nursing clinics onsite in emergency accommodations which have been expanded with additional mental health nursing clinics.

The YourMentalHealth Information Line, operates on a 24/7 basis. It provides information to the public about mental health supports and services that are provided by the HSE and funded partners nationally, locally, online and by phone/text. The team can advise how and when these services can be accessed. In addition, for those who may need immediate support, HSE Mental Health in collaboration with partners SpunOut.ie launched the 24/7 text-based active listening service Text 50808. This is a free service which provides immediate support for people going through a mental health or emotional crisis.

2. Methodology

2.1 Data collection

Between 21st May and 12th June 2020 the HSE NSIO coordinated a service user experience survey to inform HSE service planning, resource allocation and to identify areas for quality improvement for the delivery of coordinated and person-centred health services for people experiencing homelessness.

A memo, participant information sheet and questionnaire were circulated by the NSIO to all Community Health Organisation (CHO) social inclusion managers who disseminated information about the survey to relevant local service providers.

The National COVID-19 Homeless Service User Experience Survey was adapted from the questionnaire developed for The Partnership for Health Equity Study[4] and was approved by the HSE Social Inclusion Homeless Advisory Governance Group (HAGG) to review the self-reported health status and health care experiences of people who were living in homelessness and those who were temporarily receiving supports in COVID-19 shielding, cocooning or isolation units.

A HSE memo on the implementation of the survey was circulated to relevant service providers. This included instructions on how to facilitate the collection of survey responses, either via online self-completion of the survey or through facilitating completion of the survey with residents when required and/or requested.

Informed consent

A participant information sheet was circulated in which service users were informed that they were under no obligation to undertake or complete the survey and that participation in the survey was voluntary. By participating in the survey, implied consent was provided for their anonymous responses to be shared with the HSE and relevant service providers to inform future service planning. Staff were instructed to take participants through the details on the participant information sheet and ensure they were fully-informed before participating. They were also instructed to support the participant in completing the survey if required.

Public health considerations

Service providers were encouraged to adhere to all Health Protection Surveillance Centre (HPSC) and HSE public health guidelines on infection control measures including appropriate hygiene and social distancing measures at all times. Services were advised to maintain social distance when supporting someone to complete the survey and adhere to appropriate infection control measures when sharing questionnaires and tools to administer the survey.

2.2 Data Analysis

508 responses were submitted to and stored on Smart Survey, an online survey tool. All survey data and raw response data is password protected and only accessible by the HSE NSIO. All participant data will remain anonymous and be shared by the NSIO in national and/or local report/s for HSE service providers and planners.

Of the 508 responses received, 430 survey responses were complete and therefore included in the overall analysis. Data was also broken down by region and by services specifically set up for COVID-19 shielding/ cocooning and self-isolation.

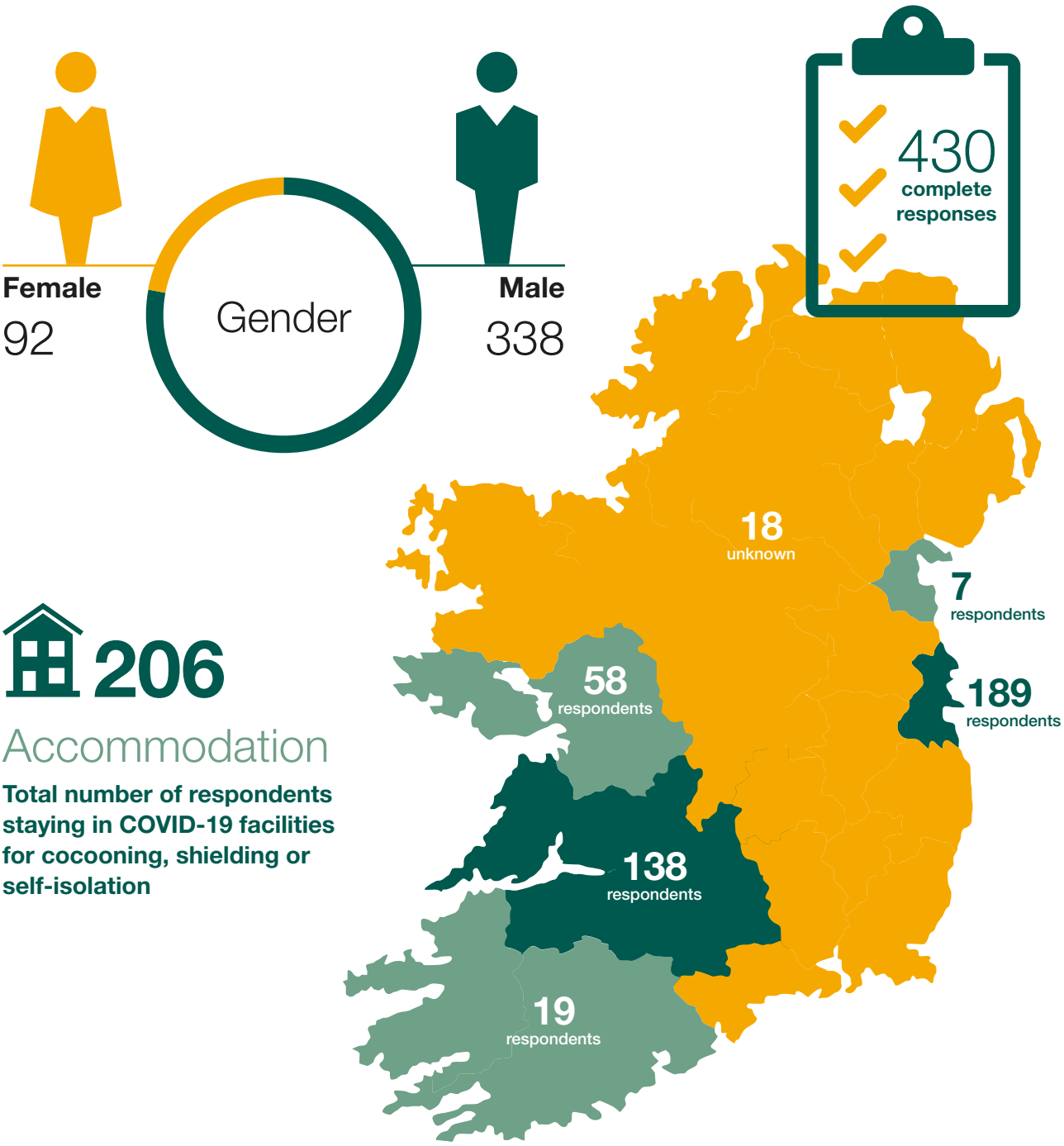
A thematic analysis was undertaken to systematically analyse qualitative responses provided in Questions 24 and 31 of the questionnaire. Common themes are visually presented in word clouds, in which the size of each theme indicates its frequency or importance. Quantitative survey data is visually presented in pie charts and bar graphs.

This report summarises results from the total number of responses (N=430) as well as any significant findings from aggregated data including the data sets listed in the below table (Table 2.1).

4 O'Reilly, F., Barror, S., Hannigan, A., Scriver, S., Ruane, L., MacFarlane, A. and O'Carroll, A. (2015). Homelessness: An unhealthy state. Health status, risk behaviours and service utilisation among homeless people in two Irish cities. Dublin: The Partnership for Health Equity

Table 2.1: Data sets by gender, region and accommodation

Data aggregated by:	No. of respondents
Gender (Female)	92
Region - Dublin (CHO 6, 7, 9)	189
Region - Limerick, Clare, Tipperary (CHO 3)	138
Region - Galway (CHO 2)	58
Accommodation - Total number of respondents staying in COVID-19 facilities for cocooning, shielding or self-isolation	206
Accommodation - Number of respondents staying in COVID-19 facilities for cocooning, shielding or self-isolation in Dublin (CHO 6,7,9)	128
Accommodation - Number of respondents staying in COVID-19 facilities for cocooning, shielding or self-isolation in Limerick/Clare/Tipperary (CHO3)	26
Total number of complete responses	**430**



3. Limitations

While the purpose of the survey was to specifically gather information on health experiences of those living in cocooning, shielding or self-isolation facilities, a number of responses were also received from other homeless services and individuals who were not staying in a COVID-19 facility or facility that had been reconfigured specifically to support cocooning or self-isolation. While the total number of responses (n=430) provides useful information on the health experiences of those who were living in homelessness during the outbreak, the total number of responses may not be representative of the intended target population.

Data has been aggregated by accommodation to include only those living in COVID-19 cocooning, shielding or self-isolation facilities and these responses were compared with the total data set, however the smaller sample size may not be representative of the intended target population.

Respondent bias and participation may have been impacted by the type and level of support offered by service providers to service users to complete the survey. This may have also had an impact on how representative the data is of the target population.

4. Results

4.1 Place of residence

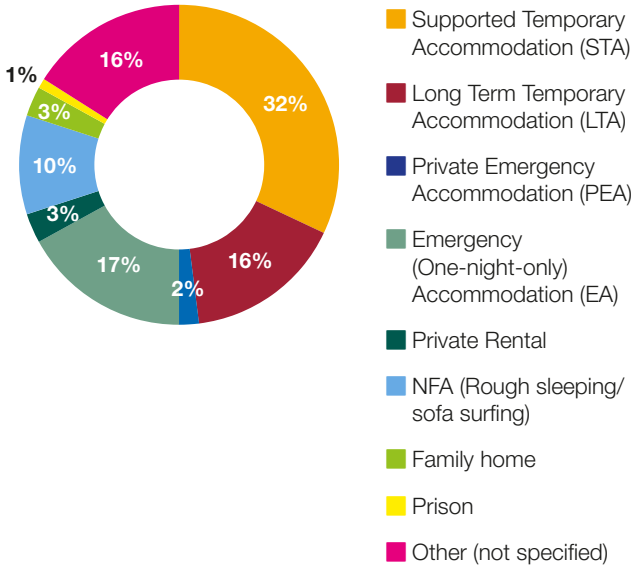
Out of 429 respondents to Question 3 of the survey, 44% or 189 respondents came from Dublin (CHO area 6, 7 or 9) and 32% or 138 respondents came from Limerick, Clare and Tipperary counties (CHO area 3) (see Figure 4.1.1 below).

Figure 4.1.1: County where the respondent currently resides (n=429):

CHO 2 (Galway)	58
CHO 3 (Limerick, Clare, Tipperary)	138
CHO 4 (Cork, Kerry)	19
CHO 6, 7, 9 (Dublin)	189
CHO 8 (Louth)	7
Unknown	18

Of 232 respondents to Question 3 (see Figure 4.1.2 below), 32% reported that they were previously staying in Support Temporary Accommodation (STA). 17% said they were previously staying in Emergency Accommodation (EA), 16% were staying in Long Term Temporary Accommodation (LTA) and 10% reported that they were previously rough sleeping or sofa surfing.

Figure 4.1.2: Previous type of accommodation (n=232):



4.2 Demographics

The majority of survey respondents were male (74%) between the ages of 25-45 years (47%) 45 – 65 years of age (37%). There was very little variation across regions in relation to age and gender breakdown.

Figure 4.2.1: Q4 - Gender (n=369):

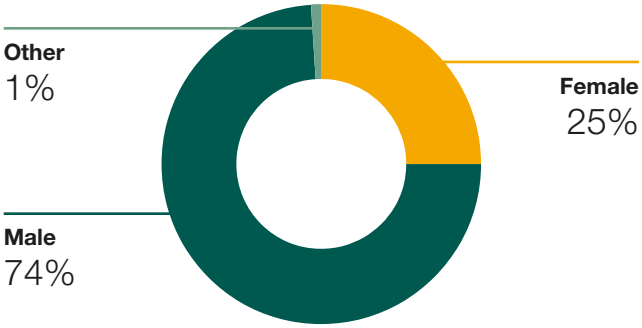
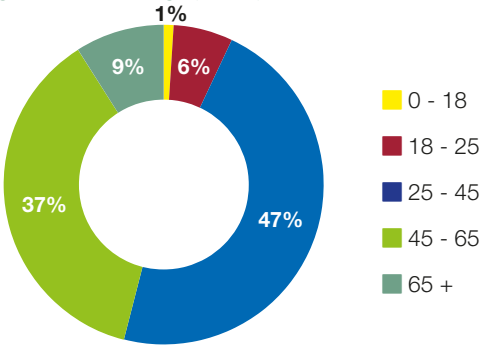


Figure 4.2.2: Q5 - Age (n=396):



349 (88%) out of 395 respondents indicated that they held Irish citizenship. The majority of respondents were born in Ireland (81%) and identified as Irish (84%) or Irish Traveller (7%). 395 out of 402 respondents said that they spoke English (see figures 4.2.3, 4.2.4 and 4.2.5 below). Country of birth, language and cultural or ethnic identity did not vary significantly across regions, however, in Galway, 11 respondents out of 54 (or 20%) reported that they identify as 'Irish Traveller' compared with 7% of all survey respondents.

Figure 4.2.3: Country of Birth (n=382):

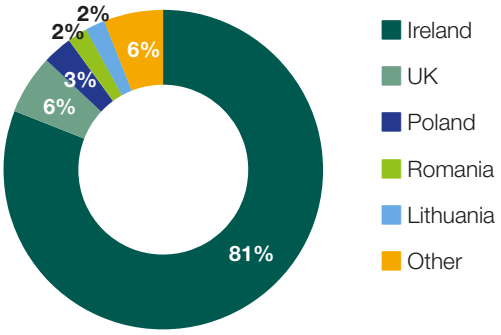


Figure 4.2.4: Cultural or Ethnic Identity (n=393):

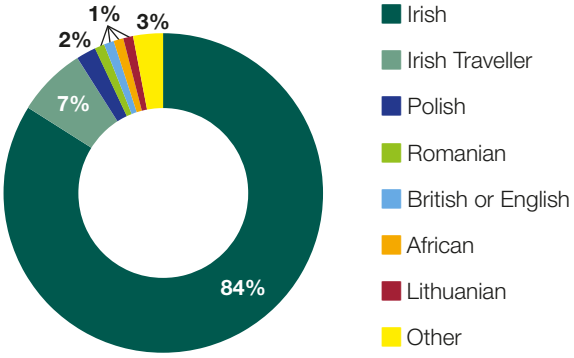
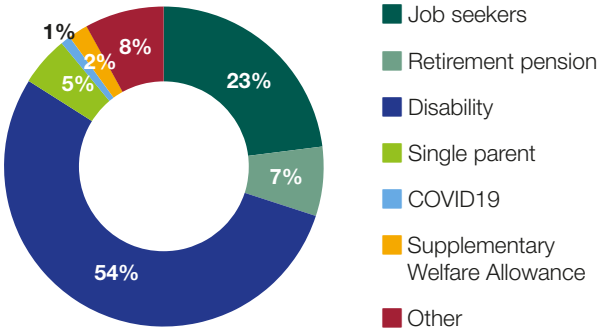


Figure 4.2.5: Language/s spoken (n=402):

English	395	
Irish	32	
French	15	
Polish	12	
Russian	10	
German	7	
Other	35	

390 out of 408 (96%) of respondents were in receipt of social welfare payment. Of these, 54% reported that they were receiving a Disability payment and 23% were receiving a Job Seekers payment (see Figure 4.2.6)

Figure 4.2.6: Type of welfare payment (n=390):



4.3 Health, Well-Being and Quality of Life

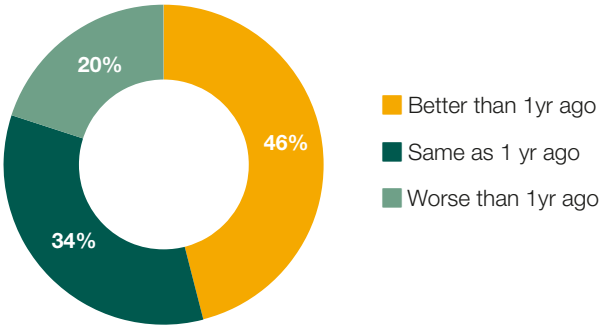
General health status

Over 60% of respondents reported that their general health was 'good' or 'fair' at the time of completing the questionnaire (see Figure 4.3.1). 46% said that their general health was much better or somewhat better than one year ago (see Figure 4.3.2).

Figure 4.3.1: Self-reported current general health status (n=414):

Excellent	6%	
Very good	15%	
Good	34%	
Fair	28%	
Poor	12%	
Very poor	5%	

Figure 4.3.2: Self-reported general health status compared with one year ago (n=413):



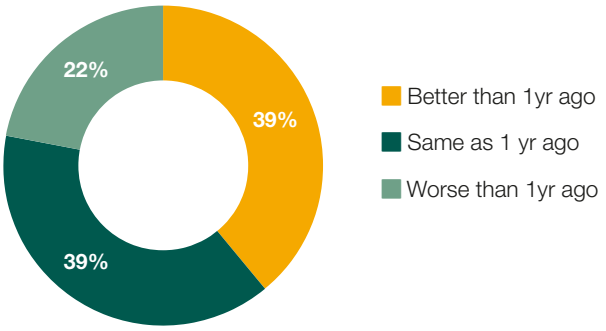
Mental Health and Suicide

Over 60% of respondents reported that their mental health was 'good' or 'fair' at the time of completing the questionnaire (see Figure 4.3.3). Almost 40% said that their mental health was much better or somewhat better than one year ago (see Figure 4.3.4).

Figure 4.3.3: Self-reported current mental health status (n=415):

Excellent	7%	
Very good	13%	
Good	34%	
Fair	27%	
Poor	15%	
Very poor	4%	

Figure 4.3.4: Self-reported mental health status compared with one year ago (n=410):



21% (or 82 out of 400 respondents) stated that they had experienced self-harm, attempted suicide or had suicidal thoughts in the last month (see Figure 4.3.5). 69 out of 400 respondents (or 17% of total respondents) experienced suicidal ideation in the last month. There was significant variation in this data when summarised by region and accommodation type. Respondents in Dublin report experiencing suicidal ideation more than respondents in other regions. Of respondents living in county Dublin (n=180), 21% report experiencing suicidal ideation compared with just 13% of respondents living in Galway, Limerick, Clare and Tipperary counties. 24% of those living in shielding /isolation facilities in Dublin report experiencing suicidal ideation (see Figure 4.3.6).

Figure 4.3.5: Self-reported suicide and self-harm from total number of respondents, in the last month (n=400)

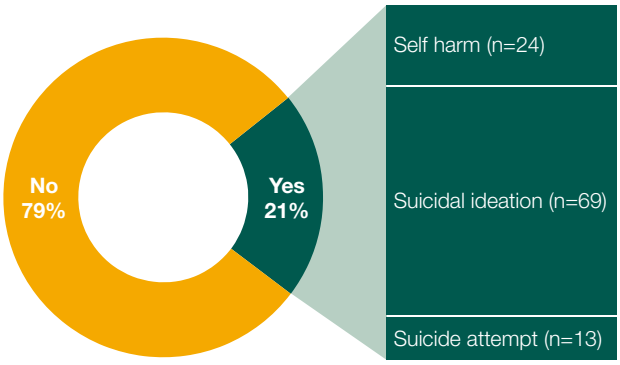
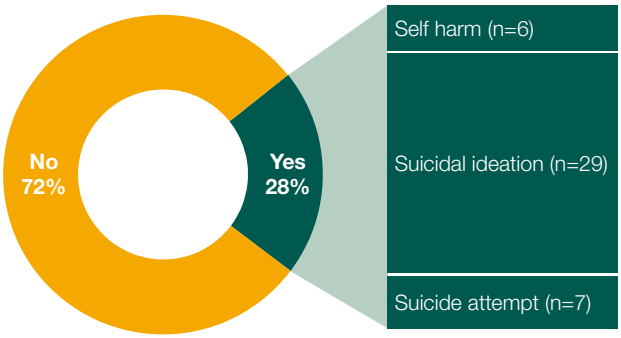


Figure 4.3.6: Self-reported suicide and self-harm from respondents living Dublin COVID-19 facilities, in the last month (n=123)



Drug and Alcohol use

226 out of 408 respondents (or 55%) report that they use drugs and/or alcohol.

Of these 47% said that their drug or alcohol use in the last year impacted their activities of daily living (ADLs), compared with just 35% who said that drugs or alcohol impacted their ADL's in the last month (see Figures 4.3.7 and 4.3.8 below).

Figure 4.3.7: % of respondents whose normal daily activities were impacted by drug and/or alcohol use in the last year (n=237):

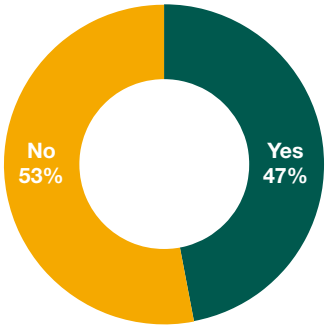
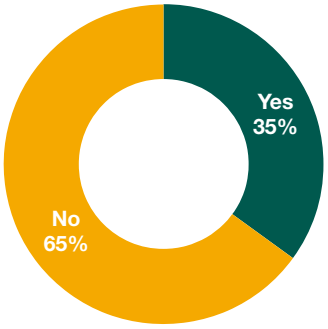


Figure 4.3.8: % of respondents whose normal daily activities were impacted by drug and/or alcohol use in the last month (n=220)



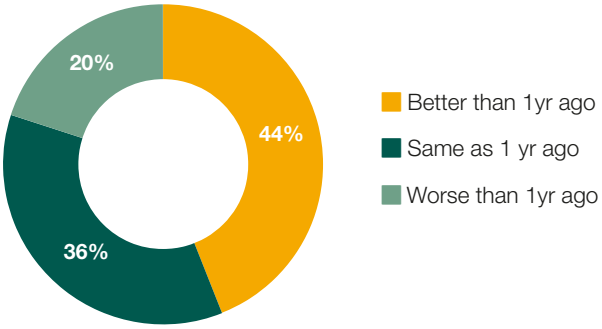
Quality of Life

Over 60% of respondents reported that their quality of life was 'good' or 'fair' at the time of completing the questionnaire (see Figure 4.3.9). 44% said that their quality of life was much better or somewhat better than one year ago (see Figure 4.3.10).

Figure 4.3.9: Q20 – Self-reported current Quality of Life (n=411)

Excellent	4%
Very good	15%
Good	35%
Fair	28%
Poor	14%
Very poor	4%

Figure 4.3.10: Q21 – Self-reported Quality of Life compared with one year ago (n=406)



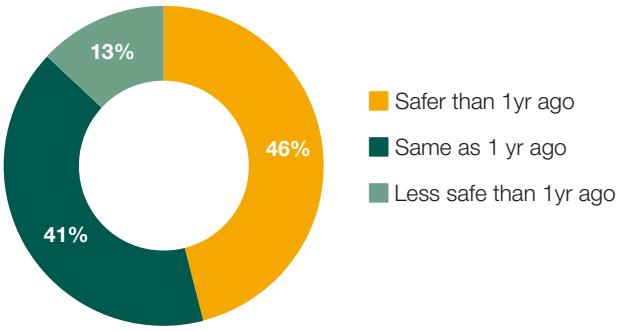
Safety

Over 70% of respondents reported that they felt 'very safe' or 'safe' at the time of completing the questionnaire (see Figure 4.3.11). 46% said that they felt much safer or somewhat safer than one year ago (see Figure 4.3.12).

Figure 4.3.11: Self-reported current sense of safety (n=411):

Very safe	34%
Safe	37%
Somewhat safe	18%
Not very safe	8%
Not safe at all	3%

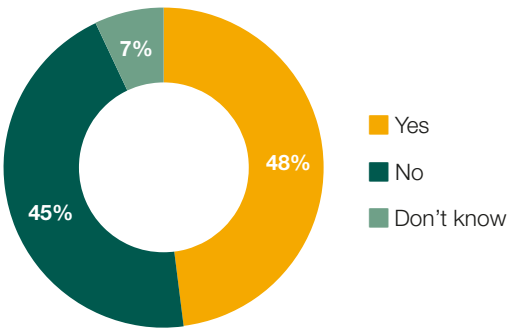
Figure 4.3.12: Self-reported sense of safety compared with one year ago (n=406):



Overall health and well-being

Overall, 48% (or 187 out of 393 respondents) said that they experienced changes to their overall health and wellbeing (including mental wellbeing) since they began 'cocooning' or self-isolating (see Figure 4.3.13).

Figure 4.3.13: % of respondents who reported changes to overall health and well-being since cocooning/isolating (n=393):



Of these, 56% (104 respondents) described a negative change to their health and 37% described positive changes (70 respondents).

Positive changes to health and well-being:

The most common themes (see Figure 4.3.14 below) described by respondents who indicated a positive change to their overall health, included an increased sense of safety and improvement in their living situation, which they described as having an impact on their overall health. They described that having their own room has had an impact on their sense of safety, mental health, drug use and relationships:

> "Being here has improved me, having my own room is the main factor, sharing a room I can't handle, if I am having a panic attack it's not good sharing when others are using and attempting suicide. All I want is my own room."

> "It has improved since cocooning because I feel safe. For example I can take off my runners without fear that they will be robbed."

> "My mental health has improved because I feel safe."

> "Cocooning has helped reduce my drug use. Knowing I can close my bedroom door at the end of a day is a big thing, safety is huge."

> "I can do what I want in my own room, (I have) privacy to speak with my family and children."

Other themes that were frequently described were improvements in drug and alcohol use, mental health, relationships and daily functioning:

> "I have mostly stayed off drugs and have been able to make more contact with my family because they see that I am getting better."

> "I have begun to read more and appreciate limited exercise more."

> "I am a wheelchair user. There is a lift here which has helped my joints i.e. i don't have to hobble up a stairs. Having my own room has improved my mental health. I could only grieve properly since I came here as I was sharing a room before."

Figure 4.3.14: Common themes in relation to overall positive changes to health and wellbeing since cocooning/isolating:

Negative changes to health and well-being

The most common theme (see Figure 4.3.15 below) described by respondents, who indicated a negative change to their overall health, was a deterioration in mental health. Respondents described experiencing a lower mood and an increase in anxiety, isolation, negative thinking, loneliness and stress during the outbreak:

> "I am more depressed and unsure of the future. Feeling more negative about life."

> "Wellbeing has got worse, the situation has caused suicidal thoughts and feelings."

> "Feeling more alone, anxiety getting worse due to too much time to overthink."

> "Too much time to think. Head will explode. Too much anxiety."

Respondents also described worry and uncertainty about the future:

> "I am always nervous because I don't know if I'm going to be moved."

> "Stressed not knowing where I could be in next few months."

> "I worry about going back to hostels as they are full of addicts and my last hostel I shared with 3 drug users and smoked heroin and crack day and night."

Respondents also frequently complained of physical health problems, less social connection, negative changes to their daily routine and activities, sleep disturbances, boredom and less supports and services available during the outbreak:

> "I smoke so I find it difficult to walk and I have put on a lot of weight."

> "No cooking facilities to cook proper meals for myself resulting in weight loss."

> "Mental health has deteriorated as I haven't seen psychiatrist and no AA meetings to go to."

> "No Gym, No College, No Mass, No Family Visits."

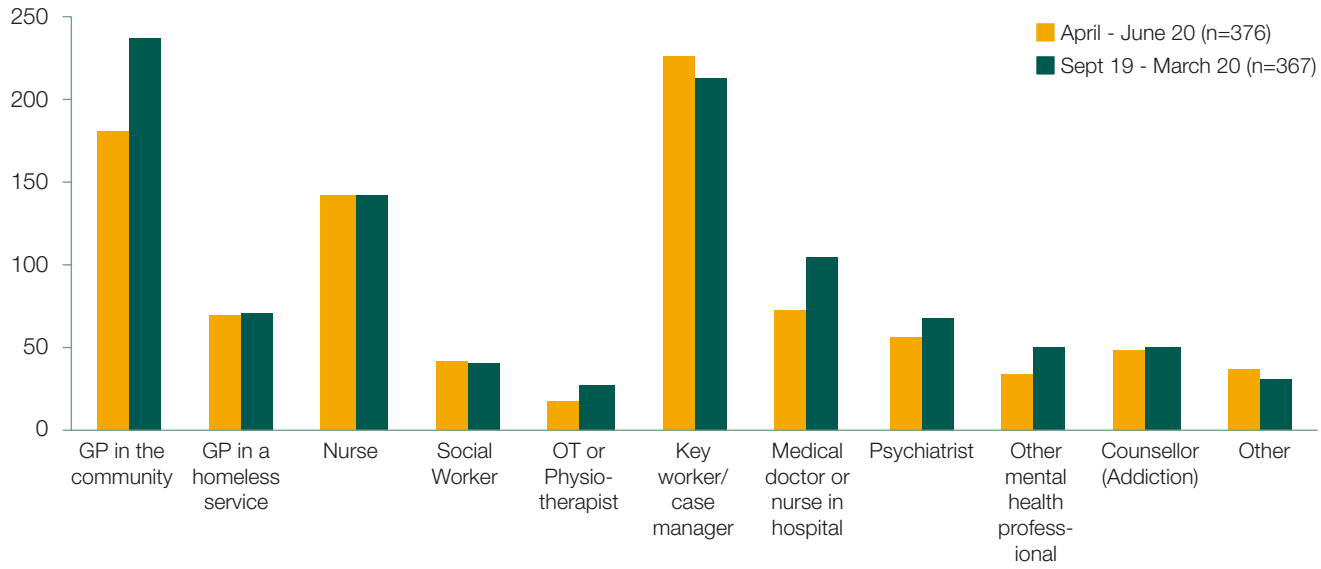
> "Feel isolated from family and friends especially my mother."

Figure 4.3.15: Common themes in relation to overall negative changes to health and wellbeing since cocooning/isolating:

4.4 Healthcare Utilisation

The overall number of health professionals seen throughout the COVID-19 outbreak period (April – June 2020) was comparable with the number of professionals seen in the six months before the outbreak (September 2019 – March 2020). The only exception was respondents engagement with a key worker or case manager, which increased during the COVID-19 outbreak period (see Figure 4.4.1). In Dublin, during the outbreak period, there was also a slight increase in the number of respondents who saw a nurse.

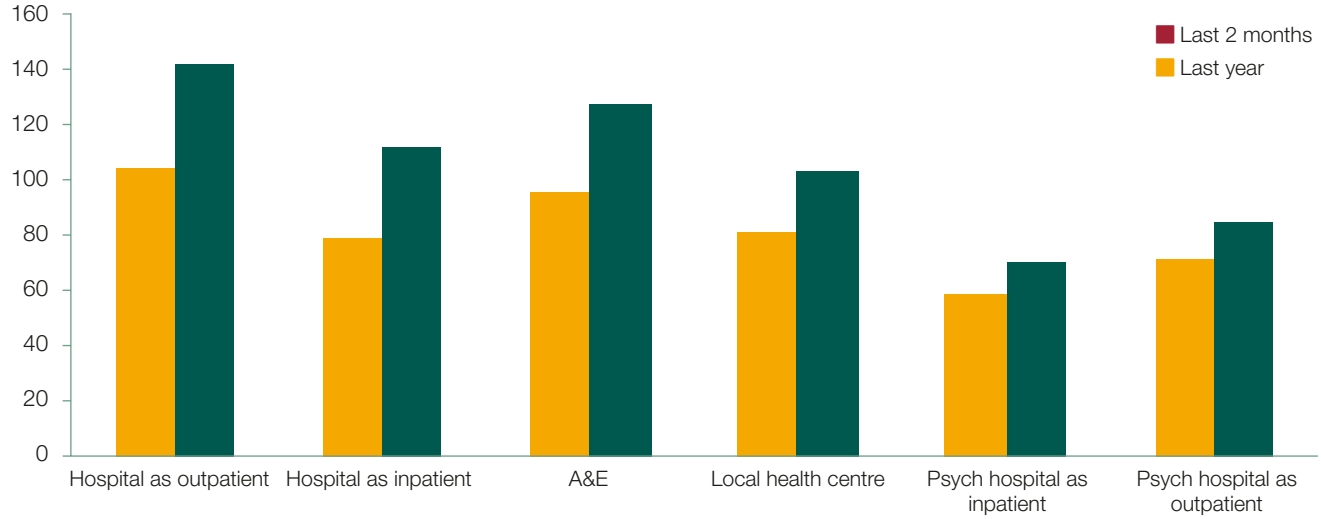
Figure 4.4.1: Health professionals seen between April – June 2020 and September 2019 – March 2020:



In most regions, access visits to secondary healthcare services, including visits to hospital inpatient and outpatient services as well as the Emergency Department (ED) were lower during the COVID-19 outbreak period (see Figure 4.4.2). However, in Galway, there was a 17% rise in the number of visits to EDduring the COVID-19 outbreak period. In Dublin, there was no change in the number of visits to psychiatric inpatient and outpatient hospital services in both periods.

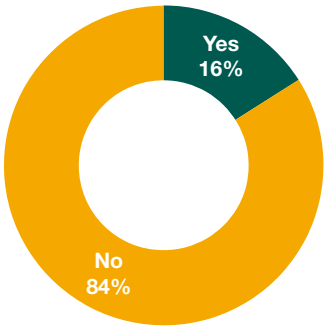
During the outbreak period, visits to local health centres were lower and in county Limerick, Tipperary and Clare access visits to all services reduced by over a half during this period.

Figure 4.4.2: Number of service visits in the last two months and last year (n=264):



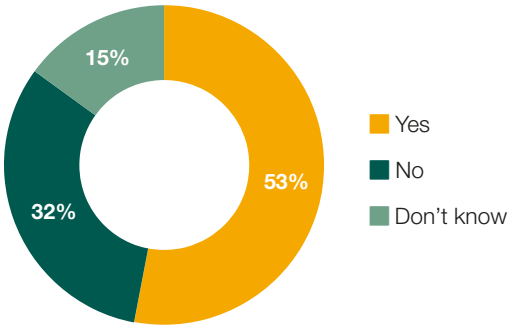
64 out of 397 survey respondents (or 16%) said that they had accessed new health supports since the start of the COVID-19 outbreak. This compares with 24% of respondents who were living in COVID-19 isolation or cocooning facilities at the time of the survey. Of all respondents who said they had accessed new supports, the majority said that they accessed drug and alcohol services and mental health services, including online and phone supports. Other new supports received included GP/primary care services, on-site nursing, housing support and project worker support.

Figure 4.4.4: Percentage of respondents who accessed new health supports since the start of the COVID-19 outbreak (n=397):



Just over 50% of all survey respondents said that they had an up-to-date care plan and 15% said they did not know if they had an up-to-date care plan (see Figure 4.4.3 below). This differed across regions, with 70% of respondents in counties Galway, Limerick, Tipperary and Clare reporting that they had an up to date care plan, compared with 35% in Dublin.

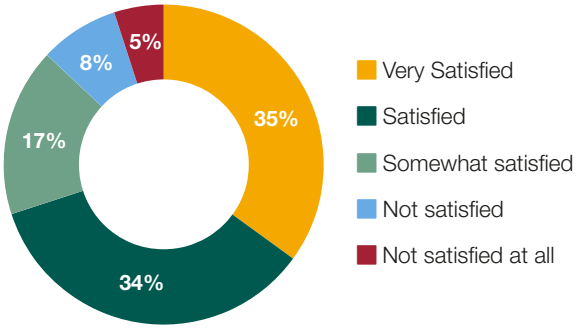
Figure 4.4.3: Percentage of respondents with an up-to-date care plan (n=388):



4.5 Service Satisfaction

Overall, respondents reported that they were satisfied with the health and/or support services that they were receiving during the reporting period. 70% of all survey respondents said that they felt satisfied or very satisfied with services they were receiving (see Figure 4.5.1).

Figure 4.5.1: Satisfaction with health services and/or supports during the COVID-19 outbreak (n=404):



> "I have had horrendous experiences since becoming homeless; I have been burnt out of a tent, and treated really badly by many. Since Covid-19 my experience has been very different, I have felt heard and understood, the staff have done everything they can for me, I am very grateful, they are all stars."

> "Meals coming to the hotel is a blessing, very appreciated, and a great relief for parents with vulnerable children who can't get to the shops."

> "I think there should be more places like this cocooning centre opened. So that people can move on to better places, their own privacy. It's a base where you can deal with issues you have."

Suggestions for service improvement

Suggestions from respondents on how health services and supports can be improved are listed below, from most commonly suggested to least commonly suggested:

- More consistent and accessible supports. Respondents particularly suggested greater availability and access to key workers and mental health services. Other suggested supports included outreach Public Health Nursing, GP and community health supports, supports in all hostels, harm reduction supports, drop-in-centres, activities, individual support work and hospital carers.

> "There seems to be some crossover between services provision and who accesses it, some people receiving a lot of outside supports from different services, and some not so much depending on who knows what's available"

> "(I have a) great key worker, she's the only one linking in at the moment. Would like to know if there are any other supports"

- Stable, safe and private accommodation. A large number of respondents suggested that single room accommodation or less crowded accommodation with own toilet, washing and cooking facilities will support transition to independent living, drug and/or alcohol detox, safety and mental health. Several respondents suggested that their own accommodation with supports would significantly improve health outcomes.

> "Health would be a lot better and no supports would be needed if we had our own house. I do not want to be sent back to a hostel where I will go backwards and be on the streets in a few months. I really do believe sharing with other people will be harmful. Its dangerous some have weapons on them and this makes my anxiety worse, I'm not able to stand up for myself. I want to make something of my life now and show them I've turned over a new leaf."

> "A hostel is so hard to live in cos of all the drugs i can't get clean. Here I feel better and can manage more."

> "I can't stress enough how having my own room has improved my mental health and peace of mind."

> "Being sent around different hostels has been upsetting and affected my mental health. I can't cope with it."

> "If you take someone from here and put them back into a place with sharing that would knock them back a lot. I would like my own place with more support. It would be great to have a staff that you could ring and ask to come for tea and a chat once I get my own place."

- Increased patience, respect and time from staff to listen to respondents.
- Better staff communication and support. A number of respondents would like more frequent engagement and contact with support staff and felt that communication about their care and next steps could be clearer.

> "I am not being listened to at all. It is very important that professionals listen to residents."

> "Staff should be friendly and trusting. Staff should be supportive. Please be more clear with communication, please don't use complicated words. I am too embarrassed to say I don't understand especially with doctors."

> "GPs and health centre staff could be more compassionate, feels like they are overworked and don't have time."

- Improved care planning and follow-up. It was suggested by a number of respondents that follow-up care could be improved such as following through with referrals and appointments and providing a care plan based on the assessments they completed.

> "More follow-up on assessments. I feel like I have been promised things that have not happened."

- Improvements in mental health services and access to mental health services. Respondents suggested that more and better mental health services were required including dual diagnosis services and therapies. They would also like more affordable and accessible mental health appointments, reduced waiting lists and for services to take them more seriously.

> "Better mental health services. 24 hour services. Separate mental health crisis. Education in A&E."

> "I feel mental health services and addiction services should be combined."

- Improved quality and frequency of meals provided in COVID-19 shielding/cocooning and isolation units.
- Other suggestions included increased funding/ resources, housing support, more encouragement from services to live independently, gym/sport facilities, better knowledge of supports available and involving clients in service delivery and care.

> "Ask residents what can be done to make life better!"

5. Summary of findings

Below is a summary of key findings to inform both national and local service planning and development:

- 70% of survey respondents were satisfied with the health services and/or supports that they were receiving during the COVID-19 outbreak period.
- In general, about 45% of respondents reported that their health, mental health and quality of life was better during the time of survey completion compared with one year earlier.
- Respondent's drug and alcohol use has had less impact on normal daily activities in the month prior to completing the survey compared with the previous year.
- Almost 50% of respondents say they felt much safer at the time of survey completion compared to one year earlier.
- Less than 60% report that they have an up-to-date care plan or key worker/case manager.
- More than 50% of respondents who reported changes to their overall health and well-being, reported increased isolation, anxiety, low mood and other mental health difficulties during the COVID-19 outbreak. Others reported feelings of uncertainty, worry and fear about the future.
- 24% of respondents who were living in COVID-19 isolation or shielding/cocooning facilities reported that they had accessed new health services or supports since the start of the COVID-19 outbreak.
- Respondents provided a wide range of suggestions to improve health services and supports including improved access to more health supports, key workers and mental health services and the provision of stable, private and safe accommodation that allows for improvement in health and well-being.
- A number of key regional differences were found, including:
  - » In Dublin COVID-19 shielding and isolation units, 24% of respondents experienced suicidal ideation in the last month compared with 13% of respondents in Galway, Limerick, Clare and Tipperary.
  - » In Galway, there was a 17% rise in the number of visits to ED during the COVID-19 outbreak period compared with a reduction in visits to ED in other areas.
  - » In Dublin, 35% reported that they have an up-to-date care plan compared with 70% who said they have an up-to-date care plan in Galway, Limerick, Clare and Tipperary.

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