Review of Crisis Mental Health Support within Inclusion Health

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IRISH RESEARCH COUNCIL
An Chomhairle um Thaighde in Éirinn

A DEDICATION TO CHRIS O'DONNELL

This research report is dedicated to Chris O'Donnell RIP who sadly passed away before the end of the project. Chris was a peer support worker with Safetynet Primary Care and a vital member of the advisory group. A fearless advocate and activist for improving access and experiences of health care for the most marginalised the memory of Chris should act as a motivation for all to keep fighting for equity and justice.

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INTRODUCTION AND OVERVIEW

This report presents the findings of a collaborative research project between SafetyNet Primary Care and the UCD School of Nursing, Midwifery, and Health Systems, aimed at exploring and improving crisis mental health support for individuals experiencing homelessness in Ireland. The project emerged from a partnership-driven approach to addressing complex healthcare challenges, ensuring that research is directly informed by clinical experience and service needs. For SafetyNet clinical teams, support workers and leadership, the issue of providing crisis mental health support was becoming an ever more challenging issue.

The study was funded by the New Foundations Grant from the Irish Research Council (now Research Ireland), supporting applied research that translates into tangible improvements in service provision.

Mental health crises are disproportionately prevalent among people experiencing homelessness, yet access to appropriate care remains fragmented and inadequate. Despite growing recognition of the relationship between homelessness, mental illness, and social exclusion, mental health services often operate within rigid frameworks that do not accommodate the realities of homelessness. Many individuals struggle to access timely, appropriate support, leading to reliance on emergency departments, law enforcement interventions, and temporary crisis responses rather than sustained mental health care.

This report builds upon an extensive literature review and qualitative research to examine the barriers and enablers in delivering mental health interventions for people experiencing homelessness. It is structured around four Initial Programme Theories developed in consultation with clinicians, service leaders, and experts with lived experience. These theories explore:

- **The role of trust in engagement with mental health services**
- **The impact of clinician training on service delivery**
- **The influence of social determinants, particularly housing, on mental health outcomes**
- **The need for flexible service models to sustain engagement**

To investigate these themes, two interlinked studies were conducted:

- Semi-structured interviews with clinicians and service leaders to explore their experiences of delivering crisis mental health care to homeless populations.
- A focus group with clinicians working in SafetyNet Primary Care, discussing the barriers and enablers to implementing effective mental health interventions.

The findings from this research offer valuable insights into systemic and policy-level failures while also identifying promising practices and areas for reform. By combining theoretical analysis, frontline expertise, and service-user perspectives, this report contributes to evidence-based solutions for improving crisis mental health responses in homelessness services. The recommendations put forward aim to inform policy, enhance service design, and ultimately improve mental health outcomes for some of the most marginalised individuals in society.

ABOUT SAFETYNET PRIMARY CARE

SafetyNet Primary Care is a healthcare organisation dedicated to improving access to primary care services for people experiencing homelessness and other vulnerable groups in Ireland. Originally founded as 'SafetyNet Ireland', the organisation began as a network for health professionals and organisations working to enhance healthcare access for homeless populations. In 2009, it was officially incorporated and later granted charity status.

In 2015, SafetyNet expanded its mandate beyond networking and advocacy to become a direct provider of primary healthcare services, reflecting the growing need for accessible, community-based health interventions. This shift was accompanied by a name change to SafetyNet Primary Care, signalling its commitment to delivering frontline services alongside its original coordination role.

By 2017, SafetyNet further strengthened its role in coordinating care through the introduction of a shared electronic patient record system, enabling continuity of care across different service providers. Today, SafetyNet employs General Practitioners (GPs), nurses, and support workers to deliver essential healthcare services to individuals who might otherwise face barriers to mainstream healthcare access.

A core aspect of SafetyNet's work is its proactive approach to identifying service gaps and developing new healthcare initiatives to meet emerging needs. By working in collaboration with the Health Service Executive (HSE) and voluntary donors, the organisation ensures that marginalised populations receive equitable and high-quality healthcare. SafetyNet Primary Care remains a key advocate and service provider in Ireland's response to health inequalities, continuing to support those who are often excluded from traditional healthcare systems.

It is within the remit of Safetynet Primary Care to advocate for our patients, especially in relation to identifying gaps that impact on access to mainstream healthcare. It is important to us that patients with lived experience have a voice in the development and shaping of services that meet their needs.

Research Team

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BACKGROUND LITERATURE

In order to explore how crisis mental health support can be effectively provided for people experiencing homelessness, four theories (or Initial Programme Theories, IPTs) were developed. These theories emerged from an initial literature review and consultation with the project advisory group, which included clinical experts, service leaders, methodological specialists, and individuals with lived experience.

One of the main challenges identified in the literature was the lack of dedicated research focusing specifically on homelessness as an independent factor. Many studies examined homelessness only in connection with other issues such as substance use or veteran status, limiting their relevance to a broader homeless population. Additionally, causation-mechanism-outcome chains were often not well established, meaning that while some interventions showed benefits, the reasons behind their success were not always clear.

Another key limitation was the difficulty of applying international research to the Irish context. Even in countries with similar or lower GDP per capita, the specific economic and social policies governing housing, public expenditure, and mental health care vary significantly. The ongoing Irish housing crisis presents a unique backdrop, making it essential to validate theories with data from Irish community services.

There were also gaps in research methodology, including poor dropout analysis, lack of co-production with homeless stakeholders, and limited ethical considerations regarding participant compensation. Addressing these issues is crucial for developing meaningful, evidence-based interventions.

Theory 1: The Role of Trust in Healthcare Engagement

Theory:

If a trusting relationship is developed between people experiencing homelessness and their healthcare providers, they are more likely to engage with healthcare services, leading to better health outcomes.

Literature Reflections:

Trust was identified as a key factor influencing whether homeless individuals engage with healthcare interventions. Studies showed that when trust was established, individuals were more likely to adhere to care plans and reduce their use of emergency services (James et al., 2023). However, research did not always demonstrate causal links between trust and positive health outcomes.

Service user perspectives highlighted the importance of stability in services and clear access criteria. One study found that homeless individuals struggled to access care unless they were seen as being in either “too much” or “too little” crisis, leading to inconsistent engagement (Manson & Fast, 2023). Another study showed that homeless-specific service design improved primary care experiences, particularly for individuals with severe psychiatric symptoms (Chrystal et al., 2015).

Bias from healthcare providers was another major barrier to trust. Research found that homeless individuals felt that clinicians often viewed their pain, addiction, and mental health needs with suspicion, which led to care disengagement and poorer outcomes (Gilmer & Buccieri, 2020). This suggests that training for all frontline healthcare providers–not just those working in specialist homeless services–could improve engagement and trust.

Theory 2: The Impact of Training on Service Delivery

Theory:

If healthcare providers receive appropriate training on the complexities of homelessness, they will be able to deliver more specific and effective care, leading to better health outcomes.

Literature Reflections:

There is no standardised training programme for healthcare providers on homelessness, and existing studies are largely exploratory or retrospective rather than interventional. Some international research has proposed "population-tailored care" models (O'Toole et al., 2018), but these have primarily been tested in veteran populations rather than the general homeless population.

A Canadian study on the CATCH (Coordinated Access to Care for the Homeless) programme found that a 4- to 6-month interdisciplinary intervention improved mental health and substance use outcomes. However, it also led to an increase in emergency department visits, reinforcing the idea that better access to care does not always reduce crisis presentations but may indicate more proactive help-seeking (Stergiopoulos et al., 2018).

Additionally, racial and gender disparities were found in healthcare access. Studies showed that white, cisgender males were more likely to receive crisis interventions, while women, Black individuals, and those with multimorbid illnesses had lower access to psychiatric care (Bailey et al., 2021; Moczygemba et al., 2014). Similar disparities exist in Ireland, where ethnic minority and LGBTQ+ homeless individuals face additional barriers in accessing care (Moloney et al., 2022). This highlights the need for inclusive, intersectional training programmes that go beyond treating homelessness as a monolithic experience.

Theory 3: The Role of Social Determinants in Mental Health Outcomes

Theory:

Healthcare interventions for people experiencing homelessness are heavily influenced by broader social determinants of health, particularly the availability of stable housing.

Literature Reflections:

While many studies called for greater attention to social determinants, few tested interventional approaches to address them. Research in Australia found that housing-first models improved mental health outcomes for those with severe mental illness (Burton et al., 2021). However, other studies suggested that housing alone was not enough–without additional mental health and social support, health improvements were often temporary (Malte, Cox, & Saxon, 2017).

A quality-of-life survey on homeless individuals with severe mental illness found that certain demographic factors influenced perceptions of care. For example, cisgender males and stimulant users reported better experiences, while transgender individuals and those using depressant substances (such as inhalants) had worse experiences (Presnall et al., 2023). This highlights the need for services tailored to diverse experiences, rather than a one-size-fits-all approach.

Theory 4: The Need for Flexible Service Infrastructure

Theory:

To sustain engagement and improve mental health outcomes, service infrastructure must be flexible enough to meet the diverse and evolving needs of individuals experiencing homelessness.

Literature Reflections:

Many mental health and addiction services operate with rigid structures, making it difficult for people experiencing homelessness to engage consistently. Studies in the UK found that homeless individuals referred to police custody for mental health reasons were less likely to be referred onward for clinical care (Hopkin et al., 2020). Similarly, research in France highlighted that psychiatric outreach teams were sometimes perceived as more coercive than law enforcement, creating further barriers to engagement (Girard et al 2014).

The need for greater flexibility in crisis services is reinforced by evidence that homeless individuals often cycle between different service providers without a stable point of contact. Low-barrier, drop-in mental health services could provide a more accessible entry point into care, particularly for those who struggle with appointment-based models.

Conclusion

The literature highlights significant gaps in evidence and intervention design when addressing crisis mental health care for individuals experiencing homelessness. While research supports the importance of trust-building, tailored training, social determinants, and flexible service design, much of the existing data is retrospective, focused on specific subpopulations (e.g., veterans), or lacks long-term follow-up.

For services to be effective and equitable, future research should focus on validating these theories within the Irish context, using realist methodologies and participatory approaches that include the voices of people with lived experience. Addressing the gaps in evidence will help inform policy changes, service improvements, and training programmes that move beyond crisis management toward long-term, sustainable support for individuals experiencing homelessness.

RESEARCH STUDIES

Following the literature review, two interlinked studies were conducted to explore the experiences of clinicians and service leaders involved in delivering mental healthcare to homeless populations in Ireland. These studies aimed to provide real-world insights into the barriers and enablers of crisis mental health support for individuals experiencing homelessness.

Study 1: Semi-Structured Interviews with Clinicians and Service Leaders

Study 1: Semi-Structured Interviews with Clinicians and Service Leaders

The first study involved semi-structured interviews with 14 healthcare professionals who provide mental health support to homeless populations. Participants were asked to reflect on their experiences of caring for clients experiencing acute or crisis mental health deterioration.

Participants

The study included:

12 clinicians:

4 General Practitioners (GPs)

3 Specialist Nurses

3 Nurse Managers

1 Hospital Consultant

1 Psychotherapist

2 service leaders

Data Collection

Interviews were conducted between January and April 2024.

8 interviews took place online via Zoom, while 4 were conducted in person.

Each interview lasted between 30 and 60 minutes and was transcribed verbatim.

Analysis

The data was analysed using Reflexive Thematic Analysis (RTA) following the six-stage framework outlined by Braun & Clarke (2006; 2012). This approach allowed for a structured yet flexible exploration of emerging patterns and deeper thematic insights. Through this process, five key themes were generated from the interviews.

Findings Study 1

Barriers to Accessing Healthcare and Mental Health Services

One of the most pervasive issues highlighted across the interviews is the significant barriers individuals experiencing homelessness face when attempting to access healthcare and mental health services. These barriers stem from systemic issues such as restrictive eligibility criteria, poor service coordination, long waiting lists, and the transient nature of homelessness itself. Many of the professionals interviewed expressed frustration at the bureaucratic and fragmented nature of service provision, which often leaves the most vulnerable individuals without adequate care.

A major barrier identified is the inflexibility of the healthcare system, particularly in mental health services, where rigid criteria exclude individuals who do not fit into predefined categories. Several interviewees highlighted the issue of catchment areas, which prevent homeless individuals from accessing mental health services unless they have a registered address in the area.

> *"Psychiatric services often refuse to admit homeless individuals, citing various reasons, such as catchment area restrictions." (Service Leader)*

> *"The mental health system's strict reliance on catchment areas makes it incredibly difficult to access care. Homeless people don't fit into these boundaries, and as a result, many don't receive any support." (Hospital consultant)*

Another significant barrier is the exclusion of individuals with dual diagnoses (both a mental health condition and substance use disorder) from many mainstream mental health services. This exclusion leads to a cycle where individuals with substance use disorders are denied psychiatric care because of their addiction, and their mental health continues to deteriorate.

> *"Many clients with clear signs of mental illness struggle to obtain a diagnosis because they also have an addiction, leaving them in a continuous cycle of exclusion from mental health care." (Nursing Manager)*

> *"Unless somebody is at the point of needing to be sectioned, they're not engaged with ongoing mental health support. That's a huge gap." (Service Leader)*

Waiting times for psychiatric care were also identified as a major issue. Many individuals who are experiencing acute distress are often turned away because they do not meet the threshold for immediate intervention. Instead of early support, individuals are forced to wait until their condition deteriorates to a crisis point, at which stage law enforcement often becomes involved.

> *"Emergency mental health services often turn people away, claiming they are 'not unwell enough' for intervention. This sends a devastating message to individuals who have finally built up the courage to seek help." (Psychotherapist)*

> *"I often section people not because they are an immediate risk to themselves or others, but because their inability to access care means their health will deteriorate. The new Mental Health Act changes will restrict this further." (General Practitioner)*

Healthcare settings themselves also pose significant barriers, as many individuals experiencing homelessness report negative past experiences with professionals, which deter them from seeking care in the future. Stigma and discrimination from healthcare workers can reinforce existing distrust in the system.

> *"Many of my clients report feeling judged or dismissed when seeking medical care, especially if they have a history of addiction." (Psychotherapist)*

> *"We did a piece of research around people living with HIV, and their really appalling*

experiences at diagnosis–the way they were treated, dismissed, and belittled. It's no wonder people don't engage with healthcare services." (Service Leader)

Finally, practical barriers such as the lack of a fixed address, phone number, or necessary documentation make it difficult for individuals experiencing homelessness to access follow-up care, medication, and referrals.

"Patients are sent letters asking them to call to confirm appointments, or else the appointment is cancelled. This doesn't work for homeless people who may not have a phone, fixed address, or the literacy skills to understand the letter." (Specialist Nurse)

"To receive medication like Aranesp after discharge, asylum seekers need a PPS number and either a medical card or a drug payment scheme card. If they don't have these, they can't get the medication and therefore can't be discharged. These logistical barriers delay care and put additional strain on the system." (Specialist Nurse)

The cumulative effect of these barriers is that individuals experiencing homelessness are often excluded from the very services designed to support them, leading to worsening health outcomes, increased reliance on emergency departments, and ultimately higher rates of crisis situations that could have been prevented with earlier intervention. Many of those interviewed emphasised the need for systemic change, including more flexible and inclusive mental health services, better coordination between agencies, and proactive outreach models to engage individuals before they reach a crisis point.

The Importance of Building Trust and Therapeutic Relationships

A recurring theme across the interviews was the fundamental role of trust in providing healthcare and mental health support to individuals experiencing homelessness. Many of the professionals highlighted how previous negative experiences with healthcare services, social services, and even law enforcement have led to deep mistrust among this population. Without a strong therapeutic relationship, many individuals are unwilling or unable to engage in care, making trust-building a crucial aspect of service provision.

One of the key challenges in building trust is that many individuals experiencing homelessness have faced systemic failures, abandonment, and stigma. They often come into contact with services only when in crisis, and their past encounters with healthcare professionals have frequently been negative.

> *"Many homeless people have trust issues due to a lifetime of being let down by family and professionals, so trust has to be earned." (Specialist Nurse)*

> *"Relationship-building is crucial in therapy, but it can take longer with clients experiencing homelessness because many have endured significant trauma. These individuals have often been let down by services, social systems, and sometimes their own families." (Psychotherapist)*

Another major barrier to trust-building is the high turnover of staff in homeless services, which makes it difficult for individuals to establish stable, long-term relationships with professionals.

> *"Every time somebody comes into one of our services, they see a whole new set of faces, and I think that can be very unsettling. It means you have to start building that relationship all over again." (Service Leader)*

> *"A major challenge is that homelessness services often experience high staff turnover, leading to inconsistent support. Clients have frequently developed relationships with key workers or other professionals, only to have those individuals leave. This can reinforce feelings of abandonment and distrust." (Psychotherapist)*

Flexibility in service provision was identified as a key enabler of trust-building. Many professionals emphasised the need to meet people where they are, rather than expecting individuals to engage with rigid or highly structured services.

> *"If a service is structured, time-restricted, and feels impersonal—like in a traditional health centre—then forming a strong therapeutic relationship is more challenging." (Service Leader)*

> *"Within hostels, relationship-building is easier because I see people regularly. They might come in with respiratory issues or looking for sleep medication, and while I may not prescribe what they're looking for, I use those interactions as opportunities to talk about their general health and mental health." (General Practitioner)*

Consistency and follow-through were also highlighted as critical aspects of trust-building. Many individuals experiencing homelessness have been repeatedly let down by professionals who promise support but fail to deliver.

> *"If I tell a patient I'll see them tomorrow, I make sure to follow through. If I can't, I ensure they get a message. Many homeless people have trust issues due to a lifetime of being let down by family and professionals, so trust has to be earned." (Specialist Nurse)*

> *"One woman I worked with had severe health issues. Over time, we built a strong relationship because I kept my word and supported her consistently. Even when she left the hospital, staff would call me and put her on the phone so I could encourage her to come back." (Hospital consultant)*

Humour and informal engagement were also cited as useful strategies for breaking down initial barriers and helping individuals feel more at ease.

"Humour helps as well. If someone is demanding sleeping tablets, I might joke, 'Sure, will I throw in a few diazepam, some Lyrica, and whatever else while I'm at it?' and they'll laugh, realising that's not going to work with me. But from there, I can steer the conversation toward what support they actually need." (General Practitioner)

Despite these strategies, some professionals noted that trust cannot always be established, particularly when individuals are dealing with severe trauma, mental illness, or are in an active crisis state.

"There have been times where I simply could not build a relationship, no matter how much effort I put in. Some people are too unwell, too traumatised, or too distrustful to engage with services. In those cases, all we can do is be consistent and ensure they know the door is open when they are ready." (Psychotherapist)

"If someone is paranoid or floridly psychotic, it's very difficult to build a relationship. Often, I visit them multiple times, just getting them used to my face and my presence. Over time, they might begin to engage." (General Practitioner)

Ultimately, the professionals agreed that trust is built over time, through consistency, flexibility, and understanding. Establishing strong therapeutic relationships can mean the difference between an individual accessing long-term care or disengaging completely from the system. While trust-building is difficult, and sometimes impossible in certain cases, a person-centred, trauma-informed approach that prioritises respect, flexibility, and continuity was seen as the most effective way to engage individuals experiencing homelessness in healthcare and mental health support.

Trauma-Informed Care and Holistic Approaches to Mental Health

A consistent theme across the interviews was the need for trauma-informed care when working with individuals experiencing homelessness. Many of the professionals interviewed emphasised that homelessness is rarely an isolated experience; rather, it is deeply intertwined with past trauma, mental health struggles, substance use, and systemic failures. A trauma-informed approach acknowledges these complexities and ensures that services are designed to be flexible, non-judgemental, and responsive to the needs of individuals with histories of trauma.

Many professionals noted that a traditional, medicalised approach to mental health care often fails to meet the needs of this population. Instead, care needs to be person-centred and adapted to individuals who may struggle with engaging in structured services due to their past experiences of trauma and instability.

> *"Trauma-informed care is absolutely essential for anyone working with people experiencing homelessness. The majority of these individuals have endured severe trauma, often beginning in childhood." (Psychotherapist)*

> *"If we can't acknowledge somebody's pre-existing trauma and their life experiences before and when they come to us, I think we're at nothing." (Service Leader)*

One of the key principles of trauma-informed care is understanding behaviour as a response to trauma, rather than simply seeing it as 'difficult' or 'non-compliant'. Many interviewees pointed out that traditional healthcare models tend to focus on diagnosis and treatment plans without considering the broader context of an individual's life. This approach often alienates individuals experiencing homelessness, many of whom have had previous negative encounters with healthcare professionals, social services, and law enforcement.

> *"Sometimes it's easier for staff to deal with aggressive behaviour if they know that client A has had a very traumatic background and maybe hasn't had the opportunities to learn how to react and socialise in a normal way." (Service Leader)*

> *"Understanding the deep connection between trauma, physical illness, and mental health would have completely changed my approach to nursing. Even a half-day training session on trauma-informed care would be eye-opening for many professionals." (Specialist Nurse)*

Another key component of trauma-informed care is recognising the importance of autonomy and choice in healthcare interactions. Many individuals experiencing homelessness have lived through experiences where they have had little to no control over their circumstances, and forcing them to engage with services in a rigid, structured way often leads to disengagement.

> *"Assuming we can walk into someone's life and offer help without consent is a mistake. Respecting autonomy is critical." (Service Leader)*

> *"When someone has been traumatised repeatedly—by their family, by the system, by healthcare professionals—telling them 'you have to do this' is the fastest way to make them walk away." (Hospital consultant)*

In addition to being trauma-informed, several professionals advocated for a holistic approach to mental health care, which takes into account a person's housing situation, substance use, physical health, and social support networks rather than treating mental health issues in isolation. Many interviewees criticised the way mainstream mental health services expect individuals to be abstinent from substances before receiving care, arguing that this creates a significant barrier for those who use substances as a way to manage trauma.

> *"The vast majority of our clients have a dual diagnosis—whether formally diagnosed or not. Many have severe mental health conditions and substance use disorders, but the system still operates as though these need to be treated separately." (Service Leader)*

> *"If we're not going to acknowledge that people self-medicate as a way of managing trauma, then we're not really treating them. We're just setting them up to fail." (General Practitioner)*

Many professionals called for greater integration of peer support and lived-experience workers into mental health services. Several interviewees noted that individuals experiencing homelessness often relate more to peer support workers than to highly trained professionals because they see them as people who truly understand their experiences.

> *"Often, individuals who have struggled in traditional mental health services benefit more from support workers with lived experience rather than highly trained professionals." (Service Leader)*

> *"A peer support worker can sometimes achieve in five minutes what a psychiatrist can't do in five weeks–because the person trusts them." (Specialist Nurse)*

Finally, interviewees highlighted the need to prioritise basic needs–such as housing, food, and safety–before attempting to engage individuals in mental health treatment. Without addressing these fundamental concerns, it is nearly impossible for individuals to fully engage in therapy, medication adherence, or long-term recovery plans.

> *"Mental well-being is vital, but it's nearly impossible to achieve while someone is homeless. You can't talk about coping strategies when someone doesn't even know where they'll be sleeping tonight." (Service Leader)*

> *"The assumption that people can focus on mental health while living in crisis is completely misguided. Stability in housing, stability in substance use–these have to come first." (Service Leader)*

The Need for Stability in Housing, Healthcare, and Substance Use

A recurring theme across the interviews was the fundamental role of stability in housing, healthcare, and substance use as a prerequisite for meaningful engagement with mental health services. Many professionals emphasised that without stable accommodation, consistent healthcare access, and support in managing substance use, individuals experiencing homelessness face significant barriers to improving their mental well-being. Without a foundation of stability, mental health interventions often fail to have lasting impacts, as individuals remain trapped in cycles of crisis and instability.

One of the most pressing issues raised was the disconnect between housing policies and mental health services. Many interviewees criticised the assumption that simply providing housing would be enough to support people in recovering from homelessness. Instead, they argued that housing must be accompanied by ongoing, structured support, particularly for individuals with complex mental health and addiction needs.

> *"Housing alone isn't enough–it needs to be supported housing. Some people thrive in a structured environment, and taking them out of that and putting them into isolated settings can strip them of their social support system." (General Practitioner)*

> *"The second somebody leaves a six-month bed and moves to another hostel, everything becomes uprooted–their routine of accessing appointments, taking medication, going to their local shop. Everything is disrupted." (Service Leader)*

For many individuals experiencing homelessness, the lack of stability in housing leads to a breakdown in mental health and medical care. Many interviewees highlighted the challenges of maintaining treatment plans, taking medication consistently, and attending appointments when housing is unpredictable.

> *"We can prescribe medication, but if someone has no fridge to store insulin, no regular access to food, and no safe place to sleep, then the prescription is pointless." (Specialist Nurse)*

> *"Even when someone is engaged in services, if they get moved from one hostel to another or end up rough sleeping again, they often disengage completely. Stability is everything." (Nursing Manager)*

Another key challenge identified was the instability in substance use patterns and the unrealistic expectations placed on individuals to achieve abstinence before accessing mental health care. Many professionals expressed frustration that services often refuse to support individuals unless they commit to complete sobriety, despite the fact that substance use is often a coping mechanism for trauma and mental illness.

> *"We, as a society, are very fixated on abstinence–people have to stop taking drugs, and unless they stop, they can't achieve anything. But we've actually seen clients who reduce their substance use to a less chaotic amount, and that in itself is progress." (Service Leader)*

> *"There's no point in addressing substances if we're not going to address mental health at the same time. It's not realistic to expect someone to stop using when their mental health is completely unstable." (Service Leader)*

The rigid structures of many treatment programmes were also identified as a barrier to stability. Many individuals experiencing homelessness struggle to comply with strict rules and schedules due to the unpredictability of their daily lives, leading to high dropout rates from structured addiction and mental health services.

> *"Many addiction services have rules that simply don't work for homeless individuals. If someone misses three appointments, they're discharged from the programme. But these are people who don't always know where they'll be sleeping that night–how can we expect them to show up every time?" (General Practitioner)*

"People assume that once you provide housing, everything else falls into place. But the reality is that a lot of our clients need intensive, long-term support to stabilise their substance use and mental health." (Nursing Manager)

Interviewees also highlighted the failure of current systems to provide long-term support, noting that many services are designed for short-term crisis intervention rather than sustained engagement. When individuals transition out of homelessness, they often lose access to key supports, leading to relapse and re-entry into homelessness.

"We see it all the time–someone stabilises in supported accommodation, then they move into independent housing with no supports, and within months, their mental health deteriorates, and they're back on the streets." (General Practitioner)

"There are people who actually do better in structured environments like hostels or residential services. When they're moved into independent living without support, they feel isolated, struggle to maintain routines, and their mental health collapses." (Specialist Nurse)

Many professionals argued for a shift towards a harm-reduction approach rather than an abstinence-focused model, as well as greater investment in long-term, integrated support services. Instead of expecting individuals to become completely stable before receiving care, services should focus on meeting people where they are, supporting gradual reductions in harm, and providing care that adapts to the realities of homelessness and addiction.

"We need to move away from an all-or-nothing approach. Even small steps–like reducing alcohol use, stabilising on methadone, or attending therapy once a month–can be life-changing for people." (Service Leader)

"The most important thing is consistency. People need to know that even if they relapse, even if they miss appointments, the support will still be there when they're ready." (Specialist Nurse)

Systemic and Policy Failures in Addressing Homelessness and Mental Health

One of the strongest themes emerging from the interviews was the systemic failures and policy shortcomings that prevent individuals experiencing homelessness from accessing appropriate mental health care. Many of the professionals highlighted that current systems are not designed to accommodate the complex, intersecting needs of people who are homeless, particularly those with dual diagnoses (mental illness and substance use disorder), unstable housing, or ongoing trauma histories.

A key issue raised was the fragmentation of services, where housing, healthcare, mental health, and addiction services operate in silos rather than providing integrated care. Many interviewees noted that the current system places unrealistic expectations on service users to navigate multiple bureaucratic processes, which can be overwhelming and unachievable for people experiencing homelessness.

> *"We have a very disjointed healthcare system. Clients go all around the city to get a wound dressed here, meds there, and methadone over there. It would be impossible for somebody who's housed, working, and fully educated to keep up with that level of access to care." (Service Leader)*

> *"Homeless services are stuck between a rock and a hard place. We don't provide mental health care; we're not funded to provide mental health care. Yet, the vast majority of our clients have mental health needs and some kind of mental health diagnosis." (Service Leader)*

A major policy failure identified by multiple professionals was the exclusion of people with dual diagnoses from mental health services. Many mental health services refuse to treat individuals who are actively using substances, while addiction services often require mental health stabilisation before providing support. This leads to a cycle of exclusion where individuals are denied care from both systems.

> *"The vast majority of our clients have a dual diagnosis–whether formally diagnosed or not. But unless they're completely sober, they can't access mental health care, and without mental health support, they struggle to stabilise their substance use." (Service Leader)*

> *"Many clients with clear signs of mental illness struggle to obtain a diagnosis because they also have an addiction, leaving them in a continuous cycle of exclusion from mental health care." (Nursing Manager)*

Another significant challenge is the reliance on crisis-driven interventions rather than preventative care. Many professionals expressed frustration that individuals often cannot access mental health services until they reach a crisis point, at which stage police or emergency services become involved.

> *"The system isn't built for prevention–it's built for crisis. People can be floridly psychotic, but unless they are an immediate risk to themselves or others, they won't get help. Instead, they are left to deteriorate until the police are called." (General Practitioner)*

> *"Emergency mental health services often turn people away, claiming they are 'not unwell enough' for intervention. This sends a devastating message to individuals who have finally built up the courage to seek help." (Psychotherapist)*

Many interviewees also highlighted the failures in the discharge process from hospitals and psychiatric units, where individuals experiencing homelessness are often sent back onto the streets with no follow-up care.

> *"If someone is homeless and being discharged from hospital, there's no guarantee that we'll even be informed. There is no systematic follow-up, and many people just disappear back into the streets." (Specialist Nurse)*

> *"Discharge planning from hospitals is shocking. Some services, like the Peter McVerry*

Trust, have mental health nurses working within homeless services. That model should be expanded." (General Practitioner)

Additionally, proposed changes to the Mental Health Act were widely seen as a policy failure that would further restrict access to psychiatric care. Many professionals warned that the new legislation would make it even harder to admit individuals for treatment, even when it was clear they needed urgent care.

"The revision of the Mental Health Act is a huge concern. If I see someone who is floridly psychotic but not an immediate risk, I won't be able to intervene. Instead, they will be left to deteriorate until they reach the point where the police are called." (General Practitioner)

"One major policy concern is the proposed changes to the Mental Health Act. These changes may make it harder to admit individuals for treatment, even when it is clear they would benefit." (Service Leader)

The criminalisation of homelessness was also identified as a growing concern, particularly as law enforcement is often used to manage individuals experiencing mental health crises instead of healthcare professionals. Many interviewees stressed that homelessness should be treated as a public health issue, not a criminal justice issue.

"Crisis intervention should not rely on law enforcement. We need trained professionals who can intervene compassionately and effectively, ensuring that people in crisis receive the care they need before their situation escalates." (Service Leader)

"Right now, people see prison as a place of respite because at least they have structure, food, and shelter. That tells you everything you need to know about how badly the system is failing them." (Psychotherapist)

Finally, several professionals criticised the lack of long-term planning in policy responses to homelessness and mental health, noting that the focus tends to be on short-term solutions rather than addressing the root causes of the issue.

"We need a coordinated system to identify and respond to mental health crises among people experiencing homelessness. Currently, there is no clear pathway, meaning access to care is inconsistent and often dependent on location." (Service Leader)

"There needs to be more community-based crisis mental health supports and forensic community assessments. Different services often do not communicate effectively, which results in clients falling through the cracks." (Nursing Manager)

The interview findings provide a comprehensive insight into the challenges faced by individuals experiencing homelessness when attempting to access mental health care and broader health services from a clinician perspective. Across all perspectives–service leaders, general practitioners, specialist nurses, nursing managers, and psychotherapists–a clear picture emerges of a fragmented, crisis-driven system that often fails to meet the needs of the people it is designed to serve.

Study 2: Focus Group with Clinicians in SafetyNet

Study 2: Focus Group with Clinicians in SafetyNet

The second study consisted of a one-hour focus group with 12 clinicians working within SafetyNet, including:

- **4 Nurses**
- **8 General Practitioners (GPs)**

Data Collection

The focus group was held during an in-service training day within the organisation.

The session was facilitated by a research assistant (SK).

Participants were split into three smaller groups of four, each prompted to discuss the enablers and barriers related to the four Initial Programme Theories (IPTs) identified in the literature review.

Notes were taken within each group, and observations were recorded by the facilitator.

Analysis

The focus group data was analysed using Reflexive Thematic Analysis (RTA) to identify shared perspectives and differences in how clinicians engage with and experience the challenges outlined in the IPTs.

Findings

Barriers to Effective Mental Health Care

1. Unmet Basic Needs Affect Clinical Care

Many individuals experiencing homelessness face severe deprivation, including lack of access to stable housing, food, and supportive relationships. These unmet needs significantly impact their ability to engage with mental health services. Without secure accommodation, consistent nutrition, and social support, individuals may struggle to prioritise their mental health, adhere to treatment, or attend appointments.

2. Undignified and Inaccessible Care Settings

Care is often provided in inappropriate or undignified environments, such as hostels, mobile health units, or directly on the streets. These settings can lack privacy, safety, and basic amenities, making it difficult to deliver compassionate, patient-centred care. Some hostel accommodations were described as unsafe or chaotic, further discouraging engagement with healthcare services.

3. Cultural and Language Barriers

Participants highlighted cultural differences and language barriers as major obstacles to effective care. Many clients struggle to communicate their needs, and without interpreters or culturally competent care, misunderstandings can arise, leading to poor engagement and misdiagnoses.

4. Lack of Time and Workforce Pressures

Clinicians frequently experience significant time constraints, making it difficult to provide comprehensive care. Many service users are also impatient with long waiting times, leading to missed opportunities for care. In addition, a high prevalence of substance use among clients can further complicate interactions, requiring more time for engagement and intervention.

5. Hierarchical and Siloed Services

Clinicians expressed frustration with hierarchies within the healthcare system, which create barriers to effective collaboration and referrals. These hierarchies exist at multiple levels:

Between healthcare providers and clients, impacting trust and engagement.

Between different levels of healthcare professionals, where formal mental health services often only accept doctor-led referrals, despite the fact that nurse-led services may be more effective for this population.

Between fragmented service providers, where mental health, addiction, and primary care services operate in silos, making coordination difficult.

6. Inconsistency and Re-Traumatisation

A lack of continuity in care leads to individuals having to retell their stories repeatedly, which can be deeply re-traumatising. The frequent turnover of healthcare providers and lack of long-term engagement create instability and mistrust, reducing the likelihood of sustained engagement in care.

7. Structural and Geographic Barriers

Practical barriers such as transport difficulties, territoriality among clients over different areas of the city, and inaccessible clinic designs make it harder for individuals to attend appointments. The need for clients to travel across multiple services to receive different aspects of care further discourages engagement.

8. Negative Past Healthcare Experiences

Many individuals experiencing homelessness have had poor past experiences with healthcare providers, leading to mistrust and reluctance to engage with services. Overcoming these negative perceptions requires significant relationship-building efforts.

Enablers of Effective Mental Health Care

1. Consistency in Care Teams

Participants emphasised the importance of continuity in staffing, as familiarity with healthcare providers builds trust and facilitates long-term engagement. When clients see the same clinicians over time, they are more likely to open up, adhere to treatment, and seek care proactively.

2. Clear Communication and Realistic Expectations

Setting clear expectations from the outset–about treatment options, service limitations, and realistic outcomes–helps to build trust and engagement. Clinicians need to communicate honestly and transparently to avoid creating false hope or disengagement when services cannot meet every need.

3. Trauma-Aware, Non-Judgmental Care

Clinicians must be trauma-informed and non-judgmental, recognising that mental health challenges, substance use, and difficult behaviours often stem from past trauma and structural disadvantages. A compassionate, person-centred approach is essential to fostering engagement.

4. Meeting Clients Where They Are

Mental health interventions should be flexible and adapted to the realities of homelessness. This includes:

- Providing care in settings that are accessible and comfortable for clients.
- Understanding that not all clients are ready for structured treatment and working within their current needs and capabilities.
- Recognising that mental health needs often overlap with addiction, trauma, and social instability, requiring a holistic, rather than rigidly medicalised approach.

5. Reliable and Accessible Services

Participants noted that for homeless clients to engage with services, those services must be seen as reliable. Services that offer low-barrier, easily accessible, and timely care tend to have higher engagement rates. SafetyNet was praised for its ability to see people relatively quickly, reducing the frustration of long waiting times.

6. Clinicians with a Commitment to Social Justice

Healthcare providers working in this space need to be motivated by a commitment to social justice, not just clinical expertise. This requires a deep understanding of the systemic inequities faced by people experiencing homelessness and a willingness to advocate for their needs.

7. Flexibility in Roles and Organisational Structure

Being outside of the formal HSE system allows services like SafetyNet to operate with greater flexibility, tailoring care to client needs rather than being bound by bureaucratic constraints. Within the organisation, fluidity between roles–such as nurses and doctors working collaboratively rather than in rigidly defined hierarchies–was seen as a major strength.

8. Interpreters and Culturally Competent Care

Having access to trained interpreters was identified as a key enabler in overcoming language barriers and improving communication. Ensuring that services are culturally responsive helps to enhance engagement with diverse client groups.

9. Staff Dedication and Energy

Finally, participants noted that the commitment and energy of staff plays a crucial role in delivering high-quality care. The ability to work creatively within limited resources, build relationships with clients, and advocate for better services is essential to improving outcomes for homeless populations.

The focus group discussions provided a detailed understanding of the real-world challenges and success factors in delivering crisis mental health care to homeless populations. While systemic barriers–including service fragmentation, workforce pressures, and hierarchical referral structures–continue to impede access, flexibility, trust-building, and a commitment to social justice were identified as key enablers of effective care.

These findings reinforce the need for holistic, trauma-informed, and accessible mental health services that adapt to the needs of people experiencing homelessness rather than expecting individuals to fit into rigid care models. Moving forward, addressing systemic issues, investing in service continuity, and expanding interdisciplinary, flexible models of care will be critical to improving mental health outcomes in this vulnerable population.

CONCLUSION AND RECOMMENDATIONS

This report highlights the significant challenges and potential solutions for providing effective crisis mental health support to individuals experiencing homelessness in Ireland. The findings from both the semi-structured interviews and the focus group discussions illustrate a healthcare system that is fragmented, inflexible, and often inaccessible to those who need it most. The barriers to accessing care–ranging from rigid eligibility criteria and long waiting times to negative past experiences and the lack of trauma-informed services–create significant obstacles for homeless individuals seeking mental health support.

A recurring theme throughout the research is the critical role of trust in engagement with healthcare services. Many individuals experiencing homelessness have been let down by institutions in the past, making relationship-building and continuity of care essential to improving outcomes. However, the high turnover of staff, hierarchical referral structures, and systemic gaps in follow-up care further erode trust and reduce long-term engagement.

The need for a trauma-informed, holistic approach to care was also strongly emphasised. Homelessness, mental illness, substance use, and past trauma are deeply interconnected, yet mainstream mental health services often operate in silos, failing to accommodate the complex needs of this population. Without stability in housing, healthcare access, and harm-reduction support, meaningful mental health interventions are often unsustainable.

Additionally, systemic failures in policy and service design–such as the exclusion of individuals with dual diagnoses, the reliance on emergency crisis-driven interventions, and the proposed changes to the Mental Health Act–further perpetuate cycles of crisis and disengagement.

Despite these barriers, the report also identifies key enablers that contribute to successful engagement with mental health services for people experiencing homelessness. These include consistent and flexible care teams, non-judgmental trauma-aware clinicians, interdisciplinary collaboration, and harm-reduction approaches that prioritise stability over rigid abstinence models. Services that are reliable, easily accessible, and tailored to the needs of homeless populations see far higher rates of engagement and better health outcomes.

Ultimately, the findings of this report underscore the urgent need for systemic reform. Improving mental health support for people experiencing homelessness requires more than just additional resources–it demands a fundamental shift in how services are structured, delivered, and integrated. A coordinated, person-centred, and equity-focused approach is essential to addressing these longstanding gaps and ensuring that mental health care is accessible, effective, and inclusive for Ireland's most vulnerable populations.

RECOMMENDATIONS

1. Integrate Mental Health, Addiction, and Housing Services

Services must move away from working in silos and adopt a coordinated, multi-agency approach. Mental health, addiction treatment, and housing services should be fully integrated to provide holistic, wraparound support rather than requiring individuals to navigate multiple disconnected systems.

2. End the Exclusion of Individuals with Dual Diagnoses

Mental health and addiction services must remove the barrier that prevents individuals from accessing psychiatric care due to ongoing substance use. A harm reduction approach should be prioritised, allowing individuals to receive mental health support regardless of their substance use status.

3. Expand Trauma-Informed Care Training Across All Frontline Services

All professionals working with individuals experiencing homelessness–including healthcare workers, social care staff, and Gardaí–should receive mandatory training in trauma-informed care. This would help staff better understand the impact of trauma and avoid reinforcing cycles of mistrust and disengagement.

4. Reform the Mental Health Act to Improve Access to Care

The changes to the Mental Health Act that further restrict involuntary admissions should be reconsidered. Legislation must ensure that clinicians have the ability to intervene early before individuals experiencing homelessness and severe mental illness reach a crisis point.

5. Prioritise Housing with Support, Not Just Housing Alone

Housing policies must move away from short-term, unstable accommodation and towards long-term, supported housing models. Simply providing housing is insufficient–many individuals need ongoing mental health, addiction, and social support to sustain independent living and prevent re-entry into homelessness.

6. Increase Funding for Community-Based Crisis Mental Health Services

Community-based drop-in crisis mental health services should be expanded to provide accessible, flexible, and low-barrier care options. Many individuals experiencing homelessness do not engage with traditional appointment-based services, meaning outreach models and walk-in clinics should be prioritised.

7. Reduce the Reliance on Law Enforcement for Mental Health Crises

Mental health crises should be managed by trained healthcare professionals rather than police. Investment should be made in specialist crisis intervention teams that can respond to emergencies with a focus on de-escalation and providing appropriate mental health care.

8. Improve Discharge Planning from Hospitals and Psychiatric Units

Individuals experiencing homelessness should never be discharged from hospitals or psychiatric units without a clear, coordinated follow-up plan. Dedicated hospital-to-housing pathways should be established, ensuring that people do not return to rough sleeping or unstable housing immediately after discharge.

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Bailey, K., Lee, G., Victor, G., Sightes, E., Comartin, E., Grommon, E., & Ray, B. (2021). Crisis event dispositions following a crisis response team intervention. Psychiatric rehabilitation journal, 44(4), 310-317. https://doi.org/10.1037/prj0000501

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative research in psychology, 3(2), 77-101.

Braun V. & Clarke V. Thematic Analysis: A Practical Guide. Los Angeles: SAGE; 2021

Burton, D., Jones, S., Carlisle, T., & Holmes, A. (2021). Homeless men with psychosis are spending more time shelterless. Australasian psychiatry : bulletin of Royal Australian and New Zealand College of Psychiatrists, 29(2), 145-148. https://doi.org/10.1177/1039856220928860

Chrystal, J. G., Glover, D. L., Young, A. S., Whelan, F., Austin, E. L., Johnson, N. K., Pollio, D. E., Holt, C. L., Stringfellow, E., Gordon, A. J., Kim, T. A., Daigle, S. G., Steward, J. L., & Kertesz, S. G. (2015). Experience of primary care among homeless individuals with mental health conditions. PloS one, 10(2), e0117395. https://doi.org/10.1371/journal.pone.0117395

Gilmer, C., & Buccieri, K. (2020). Homeless Patients Associate Clinician Bias With Suboptimal Care for Mental Illness, Addictions, and Chronic Pain. Journal of primary care & community health, 11, 2150132720910289. https://doi.org/10.1177/2150132720910289

Girard, V., Bonin, J. P., Tinland, A., Farnarier, C., Pelletier, J. F., Delphin, M., Rowe, M., & Simeoni, M. C. (2014). Mental health outreach and street policing in the downtown of a large French city. International journal of law and psychiatry, 37(4), 376-382. https://doi.org/10.1016/j.ijlp.2014.02.008

Hopkin, G., Chaplin, L., Slade, K., Craster, L., Valmaggia, L., Samele, C., & Forrester, A. (2020). Differences between homeless and non-homeless people in a matched sample referred for mental health reasons in police custody. The International journal of social psychiatry, 66(6), 576-583. https://doi.org/10.1177/0020764020920904

James, M., Greenhill, M., & Sullivan, D. (2023). Introduction of a homeless health outreach team in Northern New South Wales: is acute service usage reduced?. Australasian psychiatry : bulletin of Royal Australian and New Zealand College of Psychiatrists, 31(4), 441-444. https://doi.org/10.1177/10398562231164869

Malte, C. A., Cox, K., & Saxon, A. J. (2017). Providing intensive addiction/housing case management to homeless veterans enrolled in addictions treatment: A randomized controlled trial. Psychology of addictive behaviors : journal of the Society of Psychologists in Addictive Behaviors, 31(3), 231-241. https://doi.org/10.1037/adb0000273

Manson, D., & Fast, D. (2023). "They are always focusing on the person who is doing the worst": Exploring how crisis shapes young people's pathways in and out of supportive housing in Vancouver, Canada. Social science & medicine (1982), 331, 116091. https://doi.org/10.1016/j.socscimed.2023.116091

Moczygemba, L. R., Osborn, R. D., & Lapane, K. L. (2014). Adherence to behavioral therapy and psychiatry visits in a safety-net setting in Virginia, USA. Health & social care in the community, 22(5), 469-478. https://doi.org/10.1111/hsc.12102

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, 191(1), 321-326. https://doi.org/10.1007/s11845-021-02546-x

O'Toole, T. P., Johnson, E. E., Borgia, M., Noack, A., Yoon, J., Gehlert, E., & Lo, J. (2018). Population-Tailored Care for Homeless Veterans and Acute Care Use, Cost, and Satisfaction: A Prospective Quasi-Experimental Trial. Preventing chronic disease, 15, E23. https://doi.org/10.5888/pcd15.170311

Presnall, L., Suchting, R., Hicks, G., & Hamilton, J. (2023). Predictors of self-reported general health status in people experiencing homelessness with serious mental illness. Quality of life research : an international journal of quality of life aspects of treatment, care and rehabilitation, 32(7), 2003-2011. https://doi.org/10.1007/s11136-023-03370-9

Stergiopoulos, V., Gozdzik, A., Nisenbaum, R., Durbin, J., Hwang, S. W., O'Campo, P., Tepper, J., & Wasylenki, D. (2018). Bridging Hospital and Community Care for Homeless Adults with Mental Health Needs: Outcomes of a Brief Interdisciplinary Intervention. Canadian journal of psychiatry. Revue canadienne de psychiatrie, 63(11), 774-784. https://doi.org/10.1177/0706743718772539

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