December 2020

Dear Readers,

We are pleased to share with you the latest edition of the FEANTSA Health & Homelessness newsletter, This is a publication that aims to bring you news about cutting edge research into the health issues of homeless people.
In this issue, you will read an excellent article from Dr Austion O'Caroll on the homeless sector's response to COVID 19 in Dublin. It is a great example of a well co-ordinated service system response which also highlights how health is contingent on housing and other support needs as well as on access to good quality health care. You will also find some of the latest research and reports into health and homelessness under the Resources section.

We would like to thank the author for their valued contribution to this edition of the newsletter.

Please do not hesitate to send your comments, questions and contributions to Dalma Fabian

---

Article

THE DUBLIN RESPONSE TO THE COVID-19 PANDEMIC IN THE HOMELESS SECTOR

by Dr Austin O'Caroll

Al Story describes the worsening health profile as one transgresses from affluence to poverty as a slope that rises the deeper one travels into deprivation. When we reach the margins, where homeless people inhabit, he describes the sharp increase in mortality and morbidity as a cliff face. We know homeless people have appalling life expectancy and ill health indices. (1-3) Then we take this same population, and we crowd them into hostels, dormitories and bunk beds. (4) The last ingredient one needed to create a disastrous recipe of contagion, overcrowded intensive care units filled with homeless people, and premature death was a pandemic. This was the prospect facing all practitioners working with homeless communities throughout the globe.

Dr Michael Ryan, Director of the World Health Organization advised early on *"If you need to be right before you move you will never win. Perfection is the enemy of the good when it comes to emergency management. Speed trumps perfection and the problem in society we have at the moment is everyone is afraid of making a mistake, everyone is afraid of the consequence of error. But the greatest error is not to move, the greatest error is to be paralysed by the fear of failure."* [5]

The homeless sector in Dublin responded with a frantic series of teleconferences across the Homeless health sector as well as the accommodation providers. A critical decision was made early on to develop a coordination team that brought together the Health Service Executive (HSE) Social Inclusion (SI) Directorate which oversaw

both homeless heath and addiction services and the Dublin Regional Homeless Executive (DRHE) which coordinated accommodation for homeless people via voluntary homeless charitable agencies. They immediately appointed an Operational and a Clinical Lead for the Covid Homeless Response. This coordinating team immediately sought to bring order to the frenetic activity within the sector by creating a coordinated plan and assigning key roles and responsibilities to homeless health, addiction and accommodation providers (see Figure 1):

Triage, Testing and Medical Monitoring: Safetynet Primary Care Service for homeless people already operated a mobile screening unit. This was adapted .

Isolation of Covid Suspect and Covid Positive Patients: Isolation centres were set up by PMVT and Depaul homeless voluntary agencies in newly acquired accommodation for people awaiting test results or who were diagnosed as positive. Safetynet provided medical support for patients who were diagnosed as positive.

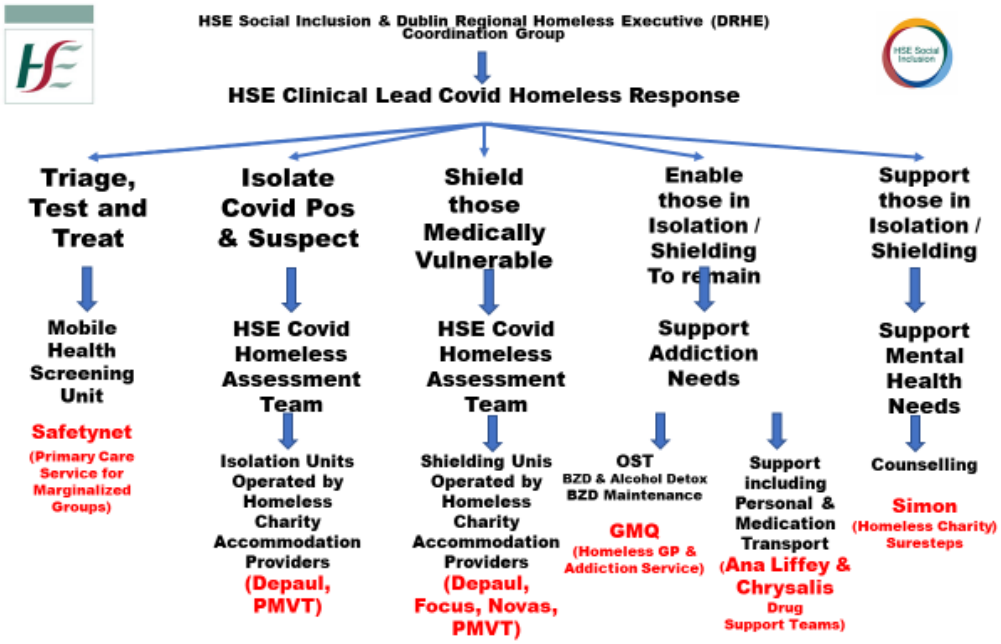
Shielding Units: A scoring system was developed based on age and comorbidities that was applied to all in single homeless accommodation. All those identified as vulnerable were placed in shielding i.e. they had their own apartment and had meals and medication delivered to them. These units were funded by DRHE and operated by voluntary agencies.

Addiction Treatment: Clients with untreated addiction needs were identified as being very unlikely to remain in isolation or shielding units. The HSE Addiction need issued new guidance. HSE Addiction clinics and GMQ Primary Care and Addiction Service for Homeless People provided rapid access to Opiate Substitute Treatment (OST) as well as Benzodiazepine and Alcohol Detoxes and on occasions Benzodiazepine maintenance treatment. GMQ and PMVT developed an inpatient OST initiation unit in one of the isolation centres.

Reduction of Number of Residents: A number of hostels were identified that had dormitories with bunk beds. It was decided to decant residents to newly created hostels so as to have only one person per bunk bed and two metres between each bed in dormitories.

Support for Clients: Two addiction harm reduction services (ALDP and Chrysalis) provided support for those in shielding or isolation, including transport of Covid Suspect/Positive cases; delivery of medication; harm reduction and social interventions. Another voluntary agency Simon Communities made its Sure Steps counselling service available to all by phone.

Figure 1: Division of Roles & Responsibilities



Communication was key to the smooth operation. Regular weekly meeting took place between the HSE and

DRHE; the Clinical Lead and Homeless Health Service Providers; the Operational and Clinical Leads and the Accommodation Providers; and the Operational and Clinical Leads with Addiction Services for homeless people. Regular liaison was also maintained with colleagues in the UK in particular with Profs Al Storey and Andrew Hayward of University College London.
The results of this coordinated response surpassed our expectations.

Table 1: Outcomes of Response to Covid Pandemic in Homeless Population Dublin March to September 2020.	
Mortality	A predictive model provided by our colleagues at University College London suggested that we would have, at worst, 36 and, at best, 12 Covid-related-deaths. We had only two deaths.
Positivity Rate	We tested over 1000 symptomatic patients of whom just over 70 were positive. We further screened 450 asymptomatic residents and 165 staff in hostels to estimate the level of asymptomatic infection in the sector. 10 residents (2%) and 5 staff (3%) were found to be positive.
Isolation	Over 700 people were placed in isolation.
Shielding	Over 550 people were shielded of who 340 were given new accommodation to shield in.
Reduction in Numbers in Hostels	We relocated over 120 clients to reduce numbers in dormitories in certain hostels.
Rough Sleepers	All rough sleepers were offered accommodation of whom 40% took up the offer.
Addiction Treatment	Waiting times for Addiction were reduced from 12-14 weeks to 3 days with over 200 people started on OST, over 80 given benzodiazepine or alcohol detoxes and 70 benzodiazepine dependant clients given benzodiazepine maintenance treatment.

Of note local Emergency Departments reported not only a low level of presentations with Covid infection amongst homeless attendees but also much lower presentations for non Covid issues. Further research is being pursued in this area.
There are several possible reasons for these outcomes. Ireland as a nation reacted early with a lockdown which did bring numbers in the community down by June 2020 to low levels. However, compared to other homeless populations internationally [6] and other marginalized groups in Ireland the level of infection was remarkably low in the homeless sector. The shielding units seemed to have achieved their objective with no person in shielding having a positive test.

The coordination between the HSE and DRHE was very successful in identifying new properties that had become vacant in the Airbnb and Hotel sector and staffing them as isolation and shielding units. The level of collaboration achieved between homeless health, housing and addiction had never been attained before with many homeless accommodation and addiction services redeployed to new units to work alongside each other. Based on a recognition of this success, the Ministers for Health, Housing and Addiction issued a statement committing to future coordination in addressing homelessness.

The presence of a strong homeless health primary care sector (Safetynet GP & Nursing Services; GMQ GP & Addiction Services; Depaul, HSE Healthlink, PMVT and Simon Nursing Services) with strong working relationships across the homeless sector was a key factor enabling a rapid response. Many of the necessary mechanisms required for the response were already in place e.g. Mobile Health Screening Unit; GP and Nursing Services; Homeless Addiction Services etc.)

A key factor that enabled this collaboration was the sharing of a common vision and mission at all levels in the

various health, housing and addiction bodies (policy makers/ CEOs/managers/health professionals/community workers). Vision is how one wants to see the world (in this instance we wanted a world whereby homeless people had the level of protection against Covid-19 warranted by their health status). Mission is what one decides to do to help achieve that vision. The sharing of a vision and mission empowers teams to collaborate effectively.

Finally, the presence of a social inclusion directorate in the Irish Health Services Executive (see Fig 1) was crucial to the success of this operation. Social Inclusion's brief is *"to reduce inequalities in health and improve access to mainstream and targeted health services for vulnerable and excluded groups in Ireland".* Every Community Health Organization (CHO) has a social inclusion officer who reports to the National Social Inclusion Office who report to the HSE CEO. The presence of social inclusion ensured that addressing health inequities for marginalized groups was institutionalised at policy level and enabled the development of collaboration across the various sectors.

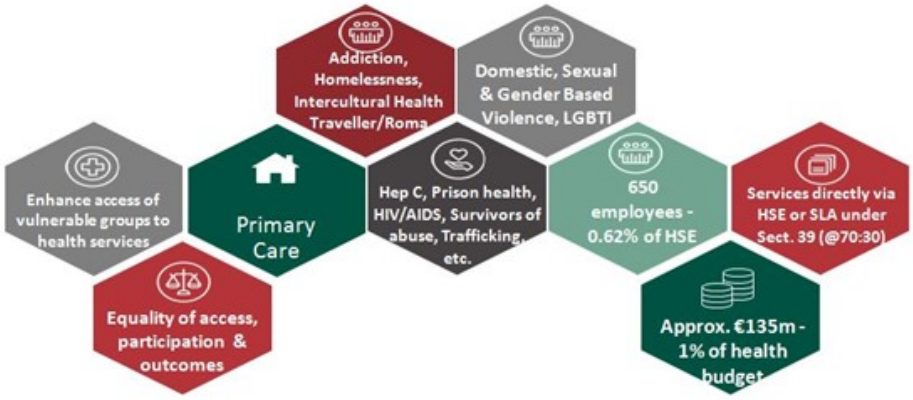


Figure 2: HSE Social Inclusion [7]

The Dublin response to the Covid-19 demonstrates the value of a holistic coordinated response that recognises health is determined not purely by biomedical factors but is socially determined. Health is contingent on housing and other social supports as well as access to quality medical care. While all of us working in homeless services instinctively believe housing is a key pre-requisite for health, the evidence base remains depressingly sparse and incomplete.[8] The Dublin response provides further support for the necessity of addressing health both through access to health services and housing.

1. Story A. Slopes and cliffs in health inequalities: comparative morbidity of housed and homeless people 2013:382(s93) doi: https://doi.org/10.1016/S0140-6736(13)62518-0
2. O'Carroll A, O'Reilly F. (2008) Health of the homeless in Dublin: has anything changed in the context of Ireland's economic boom? *European Journal of Public Health.* Oct;18(5):448–53. doi: 10.1093/eurpub/ckn038. Epub 2008 Jun 25
3. O'Carroll A, Wainwright D. Making sense of street chaos: an ethnographic exploration of homeless people's health service utilization. *Int J Equity Health*. 2019;18(1):113. Published 2019 Jul 23. doi:10.1186/s12939-019-1002-6
4. https://www.rte.ie/news/ireland/2018/0125/935886-a-state-of-emergency/
5. https://www.who.int/docs/default-source/coronaviruse/transcripts/who-transcript-emergencies-coronavirus-press-conference-full-13mar2020848c48d2065143bd8d07a1647c863d6b.pdf?sfvrsn=23dd0b04_2
6. Baggett, T. P., Racine, M. W., Lewis, E., De Las Nueces, D., O'Connell, J. J., Bock, B., & Gaeta, J. M. (2020). Addressing COVID-19 Among People Experiencing Homelessness: Description, Adaptation, and Early Findings of a Multiagency Response in Boston. *Public Health Reports (1974)*, *135*(4), 435–441. https://doi.org/10.1177/0033354920936227
7. https://www.hse.ie/eng/about/who/primarycare/socialinclusion/about-social-inclusion/#:~:text=HSE%20Social%20inclusion%20aims%20to%20reduce%20inequalities%20in,to%20sup

port%20the%20following%20vulnerable%20groups%3A%20addiction%3B%20homelessness

8. Baxter AJ, Tweed EJ, Katikireddi SV, Thomson H. Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomised controlled trials. J Epidemiol Community Health. 2019 May;73(5):379-387. doi: 10.1136/jech-2018-210981. Epub 2019 Feb 18. PMID: 30777888; PMCID: PMC6581117.

Resources

Groundswell Benefits for Health report

Benefits for Health is a research study exploring how health and welfare systems are experienced by people who are homeless and how these two systems intersect and impact on their lives.

The study, conducted by Groundswell, was led by researchers with experience of homelessness' and engaged 242 people who are currently experiencing homelessness in London, whose stories were collected using focus groups, case studies and one-to-one survey-based interviews.

The Benefits for Health study shows how the relationship between health and welfare benefits for people who are homeless is complicated. Due to a tightening of eligibility criteria and conditionality, the process of applying, receiving and maintaining benefits has a significant impact on the health and well-being of claimants. Additionally, the challenges of navigating the complex benefits system by people experiencing homelessness were common, and individual health factors often played a significant part in exacerbating these challenges. Despite the significant health challenges faced by participants and the health-related benefits and easements that exist to support them, those who are homeless are often excluded from these protections. Due to a lack of flexibility in administrative systems to support the needs of people who are homeless, expectations set do not adequately take into account multiple and complex health and social care needs that may affect the ability to engage with the welfare system. However, for those who were able to claim and maintain welfare benefits successfully, this had a positive impact on their health and wellbeing. This illustrates there is space for health and welfare systems to improve joined-up working to improve the lives of people facing homelessness.

You can access the full report here: https://groundswell.org.uk/wp-content/uploads/2020/12/Benefits-for-Health-full-report.pdf

Multimorbidity and emergency department visits by a homeless population: a database study in specialist general practice

Background: Estimating healthcare needs of the homeless is associated with challenges in identifying the eligible population.
Aim: To explore the demographic characteristics, disease prevalence, multimorbidity, and emergency department visits of the homeless population.
Design and setting: EMIS electronic database of patient medical records and Quality and Outcomes Framework (QOF) data of all 928 patients registered with a major specialist homeless primary healthcare centre based in the West Midlands in England, from the period of October 2016 to 11 October 2017.
Method: Prevalence data on 21 health conditions, multimorbidity, and visits to emergency departments were explored and compared with the general population datasets.
Results: Most homeless people identified were male (89.5%), with a mean age of 38.3 (SD = 11.5) years, and of white British origin (22.1%). Prevalence of substance (13.5%) and alcohol dependence (21.3%), hepatitis C (6.3%), and multimorbidity (21.3%) were markedly higher than in the general population. A third (32.5%) had visited the emergency department in the preceding 12 months. Emergency department visits were associated

with a patient history of substance (odds ratio [OR] = 2.69) and alcohol dependence (OR = 3.14).
Conclusion: A high prevalence of substance and alcohol dependence, and hepatitis C, exists among the homeless population. Their emergency department visit rate is 60 times that of the general population and the extent of multimorbidity, despite their lower mean age, is comparable with that of 60–69-year-olds in the general population. Because of multimorbidity, homeless people are at risk of fragmentation of care. Diversification of services under one roof, preventive services, and multidisciplinary care are imperative.
More info: https://bjgp.org/content/69/685/e515

Provision and accessibility of primary healthcare services for people who are homeless: a qualitative study of patient perspectives in the UK

Background: Anecdotal reports of people who are homeless being denied access and facing negative experiences of primary health care have often emerged. However, there is a dearth of research exploring this population's views and experiences of such services.
Aim: To explore the perspectives of individuals who are homeless on the provision and accessibility of primary healthcare services.
Design and setting: A qualitative study with individuals who are homeless recruited from three homeless shelters and a specialist primary healthcare centre for the homeless in the West Midlands, England.
Method: Semi-structured interviews were audiorecorded, transcribed verbatim, and analysed using a thematic framework approach. The Theoretical Domains Framework (TDF) was used to map the identified barriers in framework analysis.
Results: A total of 22 people who were homeless were recruited. Although some participants described facing no barriers, accounts of being denied registration at general practices and being discharged from hospital onto the streets with no access or referral to primary care providers were described. Services offering support to those with substance misuse issues and mental health problems were deemed to be excluding those with the greatest need. A participant described committing crimes with the intention of going to prison to access health care. High satisfaction was expressed by participants about their experiences at the specialist primary healthcare centre for people who are homeless (SPHCPH).
Conclusion: Participants perceived inequality in access, and mostly faced negative experiences, in their use of mainstream services. Changes are imperative to facilitate access to primary health care, improve patient experiences of mainstream services, and to share best practices identified by participants at the SPHCPH.

More info: https://bjgp.org/content/69/685/e526

Build Back Fairer: The COVID-19 Marmot Review

As the UK emerges from the COVID-19 pandemic 'Build Back Better' has become the mantra. Important, but we need to Build Back Fairer. The levels of social, environmental and economic inequality in society are damaging health and wellbeing.
It was the principles of fairness and the need to do things differently that animated the concrete recommendations that were set out in the February 10 Years On Review, just before the pandemic hit with such devastating intensity. Inequalities in mortality from COVID-19 and rising health inequalities as a result of social and economic impacts, have made such action even more important.

The aim of this report is three-fold:

- To examine inequalities in COVID-19 mortality. Focus is on inequalities in mortality among members of BAME groups and among certain occupations, alongside continued attention to the socioeconomic gradient in health – the more deprived the area, the worse COVID-19 mortality tends to be
- To show the effects that the pandemic, and the societal response to contain the pandemic, have had on social and economic inequalities, their effects on mental and physical health, and their likely effects on health inequalities in the future

- To make recommendations on what needs to be done

You can access the full report here: http://www.instituteofhealthequity.org/resources-reports/build-back-fairer-the-covid-19-marmot-review

Guidance on the provision of support for medically and socially vulnerable populations in EU/EEA countries and the United Kingdom during the COVID-19 pandemic

Key messages

- The COVID-19 pandemic has had a huge and unprecedented impact on the EU/EEA and the UK, both in terms of morbidity and mortality, but also in social and economic terms.
- Some individuals are much more vulnerable than the rest of the population, whether to COVID-19 itself, insofar as they are at elevated risk of severe disease and death, or to the consequences of the public health measures that have been imposed in order to control the spread of the virus, which have exacerbated their already challenging life situations. These people could be described as medically or socially vulnerable, respectively.
- Many people have experienced both medical and social vulnerabilities during the COVID-19 pandemic, while others have faced a particularly extensive set of challenges due to their belonging to two or more recognised categories of social vulnerability. These challenges have included the need for targeted information, problems accessing services, de-prioritisation of routine services, stigma/discrimination, and legal as well as financial barriers.
- Civil society and other organisations have worked to provide essential services throughout the pandemic to support these people. An ECDC survey has identified a range of cross-cutting good practices that underpin the successes that have been achieved in spite of the considerable financial and logistical challenges faced. These include flexibility and an ability to adapt services to the emerging situation, thereby ensuring the continued provision of material and social support; creative use of online technologies; and a foundation for the work based on the principles of community engagement.
- National and regional authorities have facilitated civil society groups in many areas through provision of financial support; working to ensure good communication, collaboration and coordination with them; and facilitating a wider framework for action based on equity and human rights.
- However, coordination between civil society organisations and the authorities has not always been ideal. There have also been cases where the rights of vulnerable populations have not been upheld, as detailed in this document.
- The efforts of civil society support organisations over the course of the pandemic to date have been remarkable, but they may not be sustainable over the longer term, and they do not replace states' obligations to ensure access to care and support for people on their territory.
- Financial and political support from national and regional authorities along with collaborative efforts to coordinate and streamline services may be essential if the support organisations are to survive and continue to serve the most vulnerable populations in the EU/EEA.

Full guidance is available here: https://www.ecdc.europa.eu/sites/default/files/documents/Medically-and-socially-vulnerable-populations-COVID-19.pdf

This publication has received financial support from the European Union Programme for Employment and Social Innovation "EaSi" (2014-2020)