Providing people experiencing homelessness with individual accommodation increases their chances of moving on to independent housing.

Dublin, Ireland: individual accommodation for people experiencing homelessness during the COVID-19 pandemic

Interview with
Dr Austin O'Carroll,
Clinical lead for the COVID-19 response to homelessness, Dublin, Ireland.

KEY POINTS

At the onset of the COVID-19 pandemic in March, the city of Dublin (Ireland) offered individual instead of collective accommodation to homeless people at higher risk of severe illness from COVID-19. The aim was twofold: to protect them from the virus and to house them while providing access to care and social assistance. First lessons from this experiment.

La Santé en action : ***How has Ireland facilitated access to housing for people experiencing homelessness?***

Austin O'Carroll: Ireland has taken a number of initiatives in recent years to provide housing for the homeless, including the Housing First programme. However, due to high rents, the process is slow and many homeless people continue to be housed in temporary accommodation centres. Prior to COVID, most people were housed in these centres for at least six months, but a significant minority were housed in shelters and had to seek new accommodation every night. Some were using these overnight shelters for over a year. During the initial COVID-19 lockdowns, we managed to systemize offers of stable accommodation and propose housing for a minimum of six months to all people using night shelters.

S. A.: ***How did you protect the most vulnerable people experiencing homelessness during the COVID pandemic?***

A. O'C. The initiative came from two scientists, Professors Al Story and Andrew Hayward, who, confronted by the pandemic, made a new proposal to the British authorities concerning emergency accommodation for homeless people who are at risk of getting severely ill from COVID-19. It consisted of offering them individual rather than collective housing, which would better protect them against the virus. We adapted their model to Ireland and named these spaces "protection units". The Dublin Regional Homeless Executive, the authority responsible for housing the homeless, opened 240 individual units located either in hotels or in privately rented flats that were vacant due to the health crisis and the collapse of the tourism industry. We also called on humanitarian organizations and their volunteers to find staff to run the units. The criteria for including homeless people in these protection units – mainly age and health status – were developed and then regularly updated using the emerging evidence that people with certain medical conditions were more vulnerable to COVID infection. We then asked each homeless shelter to assess the individual situation of their residents using a vulnerability grid. All residents who already had a single room and access to their own bathroom or a bathroom shared with no more than one other person were considered protected. We arranged for food to be delivered to the rooms of these people. The remaining residents at risk and exposed – those deemed most vulnerable according to the same assessment grid – were given an appointment with the clinical coordinator of the scheme and placed in protection units. Throughout the pandemic, new arrivals to homeless shelters had their situation assessed and the most vulnerable individuals were safeguarded via the protection units. Our street outreach teams carried out the same assessment on rough sleepers, and the most vulnerable were also placed in protection units.

S. A.: ***What do the protection units provide for homeless people?***

A. O'C. We had to make sure that people in isolation would stay in isolation. To ensure this happened, we implemented various measures. Food was delivered directly to secure rooms and in the case of spacious canteens, use was staggered to avoid crowding. Medication, including methadone/buprenorphine, was delivered directly to rooms. For those on opiate substitution therapy, this involved daily distribution. Nursing care for high-risk individuals was provided by a team from the Health Service Executive. Medical care was provided by Safetynet, a specialist service for the homeless funded by the Health Service Executive. Social support was offered by teams specialized in helping the homeless, while counselling services were offered via telephone by the charity Suresteps. Initiation of opiate substitution treatment


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was proposed to those using illicit opiates who were not already on a programme. Initiation of benzodiazepine detoxification or maintenance therapy was available to those who were dependent on street benzodiazepines. Specific assistance was offered to alcoholics and users of crack cocaine. Awareness schemes concerning phone scams were also organized.

S. A.: ***What are the strengths and weaknesses of the protection units?***

A. O'C. The strengths of the protection units are multiple. For example, they allow people experiencing homelessness to isolate during the COVID pandemic. A number of organizations lend support to solving this problem. For example, the teams of nurses and doctors provided effective support and good care for addiction management. Many of those placed in protective units went on to obtain their own accommodation, leaving of their own accord. It is believed that the one-on-one support given to them in the protection units provided an opportunity to deal with drug addiction or other problems that previously prevented them from benefiting from independent housing. There was also good atmosphere in many of the protection units. Finally, in January 2021, while the infection rate in the general population of Dublin was 5.5%, it was around 4% among the population of single homeless people in hostels and less than 1% in protection units [1]. The main weakness of this approach proved to be the psychological difficulties experienced by certain residents due to isolation. To combat this, we sometimes allowed "bubbles" where two or three residents could meet. The protection units were specifically intended to safeguard people who were vulnerable to complex coronavirus infection because of their age or health status. At the time, we did not consider extending it to non-vulnerable groups. However, we are currently examining the effects of this COVID policy in terms of the outcomes among those who received individual housing with associated health and social support. Increasing the availability of individual housing for people experiencing homelessness could be recommended in this context and beyond. ■

Interview by Jalpa Shah.

REFERENCE

[1] O'Carroll A., Duffin T., Collins J. Harm reduction in the time of COVID-19: Case study of homelessness and drug use in Dublin, Ireland. *The International Journal on Drug Policy*, 2021, vol. 87: 102966. DOI: https://doi.org/10.1016/j.drugpo.2020.102966

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