Moving homeless from the street/communal shelters to self-contained accommodation

The immediate aim of this toolkit is to help communities ensure that people who are sleeping rough, and those who are in inadequate temporary accommodation, have the resources/ policies needed to protect themselves during the COVID-19 pandemic. This includes taking action to ensure the group can access facilities that enable them to adhere to public health guidance on hygiene or isolation, and mitigation of infection risk and ensure they are able to self-isolate as appropriate in line with public health guidance, in order to lower the risk of transmission to others.

The key components are:

- Centralised coordination cell led by local authority to ensure efficient deployment of resources of all partners.
- Cohort homeless people based on those who have symptoms of COVID-19 and those who are asymptomatic.
- Appropriate Care, accommodation and access to support for those who are symptomatic and those who are asymptomatic.
- Rapid identification of clinical deterioration and escalation.

A list of partners who need to be involved in this strategy includes Local Authorities, Health Care, Voluntary Sector and Accommodation and Service. It is recommended that protocols should be implemented by local staff (e.g. outreach workers, hostel staff) following guidance and instruction from health care professionals either in-person or remotely (i.e. over the phone).

Count who is on the street and who is in communal shelters

Practically, the first steps here are to 1) get the most updated data on numbers on the street and the number of people currently using communal shelters, as they cannot self-isolate; and 2) map the current capacity in the system for hostels / homeless accommodation. This will give you an idea of how many hotel spaces required to meet the needs of the population during the pandemic.

It will be worth understanding 3 key cohorts:

- Those that will engage
- Those that will engage but with whom there are challenges to maintaining that support
- Those that require additional intensive support to engage

Irrespective of cohort, communities must remember the importance of a trauma-informed and psychologically-informed approach to engaging with people who are experiencing homelessness and are rough sleeping. Homeless and substance misuse services support people with some of the most complex needs who may face very significant challenges during the current emergency. Frontline staff will know their service users well and should wherever possible tailor support to meet the needs of individuals. In many cases staff will have well developed relationships and be in a position of trust. Services should work to prioritise both their services and staff to support the most vulnerable, including where possible providing outreach to those who are most disengaged.

Identify the key priority areas

Cities are encouraged to start with protecting the most vulnerable people to prevent deaths in a public health emergency. Leaders need to identify key priority areas where the strategies should be implemented. For example, areas with high levels or hotpots of rough sleepers. Data is needed to feed into identifying these areas and groups and needs to be constantly updated in real-time to capture how many are being successfully moved into self-contained accommodation.

While the aim should be to develop a nationwide response, consider starting in one priority-need city and expanding this approach to other cities. Once the most vulnerable cohort has been identified and moved into accommodation, the strategy can expand to address the needs of others at risk (e.g. overcrowded hostels, overcrowded temporary accommodation, etc).

Develop a triage strategy, with infrastructures, to move people from communal shelters or the street to self-contained accommodation

Cities are still in the process of developing strategies to triage the homeless population from the street and communal shelters and build pathways/systems to get people into self-contained accommodation - hotels, student accommodation, and hostels with self-contained accommodation (ie, rooms with bathrooms). This focus is particularly on moving people from the streets and encampments, night shelters, hostels without single rooms. But this process can be complex.

Ultimately, any strategy must seek to:

- ensure that people who are, or are at risk of, sleeping rough, and those who are in inadequate temporary accommodation have the support, resources and policies needed to protect themselves,
- Ensure that this population has access to the facilities that enable them to adhere to public health guidance on hygiene or isolation,
- mitigate their risk of infection and to ensure they are able to self-isolate as appropriate in line with public health guidance, in order to lower the risk of transmission to others, and
- utilise alternative powers and funding to assist those with no recourse to public funds who require shelter and other forms of support due to the COVID-19 pandemic

Triage First

It may be worth offering different approaches for the symptomatic/asymptomatic. For example, in England, they have established COVID PROTECT for those with chronic illness but no new symptoms and COVID CARE for those with symptoms and confirmed cases (more details offered below). It is also worth looking at the possibility of separating people who have significant drug and alcohol needs from those who don't.

More broadly, the strategy should include **stopping homeless people from congregating in facilities such as day centres and street encampment and getting the social care basics such as food, and clinician care to people who need it in self-contained accommodation.** There is a need to consider how individuals can contact people while in isolation (e.g. phone).

Governance is key: any strategy requires a massive amount of coordination across different partners - and needs leadership /a steering group regularly communicating and coordinating a cross-government, cross-society strategy. Be aware that some departments may start working in silos, but you need to open communication and joint-work across government departments (e.g. both the Health Department and Housing Department).

Assessment and organization

Cities should consider a public health approach to triaging, assessing and accommodating people. This involves assessing and organising people into three groups:

1. Symptomatic (new persistent dry cough and fever/temperature over 37.8C) individuals will receive COVID treatment-forward interventions (eg., COVID-CARE)
2. Asymptomatic high clinical risk (over 55 or those eligible flu vaccination) individuals will receive COVID-avoidance interventions (eg.,COVID-PROTECT)
3. Asymptomatic and non-risk patients will continue to use current service provisions, or be placed in accommodation where needed to meet current guidance on self-isolation

Current guidelines for suitable accommodation for successful self-isolation include:

- Single rooms with en-suite and catering facilities, or alternative food provision
- Accessible accommodation for people with disabilities
- Protocols to respond appropriately to on-site alcohol and potential drug use (using the existing risk management protocol but further guidelines to follow)

Substance guidance

Where necessary, local protocols should be agreed for prescribing, needle exchange and the provision of naloxone. There is no evidence that people who are homeless or people who have substance misuse issues are at heightened risk from COVID-19. However, they may be more vulnerable due to pre-existing or untreated physical health conditions or subject to additional barriers to prevention of infection.

Consideration should be given to sustainable and clinically appropriate alternatives to existing opioid substitution therapy services. If such a model is to be introduced, all relevant substance misuse services and the Substance Misuse Area Planning Board need to ensure appropriate and timely arrangements including clinical governance arrangements are in place prior to implementation. It will be vital to ensure that regular contact is maintained with all service users to provide relevant support and to check on physical and mental health and wellbeing regardless of treatment regime.

For more complete guidance, see the [Coronavirus guidance for substance misuse and homelessness services](#) from Wales.

Secure hotels and partners willing to work with the local government

Any effective strategy will require active and cooperative partnership. This includes the charitable and private sectors. Most cities have unutilized or underutilized resources in the private sphere that can be tapped into in times of crisis, and must work to establish partnerships in support of the immediate crisis.

In the UK, for example, the Mayor's Office and Government are identifying suitable hotels that can be utilized to put homeless people into single room ensuite accommodation, alongside identifying support workers to work in the hotels with this cohort. **Note: this may take time and initial conversations should be started as soon as possible.** Given the chaotic nature of the cohort, and the need to provide support workers, private sector businesses may be hesitant to get involved and will want to begin with small test sites. This may include local government making routes to allow for hotels serving the homeless to remain open, despite the new rules on social distancing and lock-downs elsewhere.

Leading charities should be tapped where possible to mobilize their logistics and volunteers to rise to the challenges and support individuals in self-contained accommodation.

Another important part of this strategy is securing Personal Protection Equipment - as well as the equipment to test the homeless population for COVID-19. This requires much-needed equipment, which everyone in every sector is naturally competing for, and will again require creative partnerships with local businesses, shops, and/or manufacturers depending on the scale of the problem and the population.

There are other layers around this strategy that need to be considered: security, getting the police involved by sharing hotel location information, legal enforcement, help transporting people from support services to hotels, and personal protection equipment for staff involved in transport, etc.

Examples of arguments to support hotel rooms for the homeless population

The current arguments being used to provide hotel spaces and to direct some Personal Protection Equipment to this area:

- People experiencing homelessness, particularly those who are rough sleeping, are especially vulnerable in this outbreak - they are three times more likely to experience a chronic health condition including asthma and chronic obstructive pulmonary disease (COPD),
- UK modelling suggests that at least 61% of the population are clinically vulnerable,

- Hard to predict the total number of the homeless population who may be symptomatic given the transience of the population,
- Shelter environments are very high risk in terms of transmission to other rough sleepers, who are generally are in very poor health already, and also the wider public,
- Outreach and hostel workers will be unable to cope without additional support,
- Some hostel workers refuse to work with symptomatic people - lack of support in the community puts a high risk of mortality within this population,
- The health care argument (can be replicated in the US). People who are homeless and symptomatic are currently turning up to A&E in the UK at the moment, in increasing numbers, because there is not the support in the community for them anymore. This is increasing risk in A&E and they are also turning people away.