Response to the Covid-19 epidemic for socially excluded groups in the community and in congregated settings

Paper presented to National Public Health Emergency Team

Drugs Policy and Social Inclusion Unit
Department of Health

Contents

1. Introduction

The National Public Health Emergency Team (NPHET) established a Subgroup on Vulnerable People to provide oversight and assurance with regard to the specific preparedness, measures and actions that need to be taken to protect vulnerable groups and individuals in society in response to Covid-19. The subgroup encourages an integrated cross Government approach.

Included within the vulnerable people categorisation are groups accessing social inclusion services in the community as well as congregated settings. These include people who use drugs, people who are homeless, people applying for international protection, Travellers and Roma, and undocumented migrants.[1] Collectively, these groups are referred to as 'socially excluded', as they are unable to participate in activities considered the norm in society due to inadequate income and resources, including housing, education and health resources.[2]

The Department of Health (through the Drugs Policy & Social Policy Unit) has oversight responsibility for the health needs of people who use drugs and other socially excluded groups. Responsibility for the provision of health service falls under the HSE National Office for Social Inclusion, which works to improve access to mainstream health services, as well as providing targeted measures.

Policy responsibility for the provision of accommodation for certain socially excluded groups rests with two line government departments: the Department of Justice and Equality (DJE) for applicants for international protection and refugees and the Department of Housing, Planning and Local Government (DHPLG) for Travellers and individuals and families who are homeless. These departments work with state agencies, local authorities, voluntary bodies and the private sector to provide housing services.

In the case of the Roma community who live in the community, there is a shared responsibility among government departments for providing services to this group under the auspices of the *National Traveller and Roma Inclusion Strategy*. For undocumented migrants, there is no lead government department responsible for their welfare or accommodation.

[1] Prisoners have not been included in this analysis as they exclusively fall within the remit of the Department of Justice and Equality and the Irish Prison Service.
[2] Official Government definition of poverty and social exclusion

The risks identified for socially excluded groups, and the significant safety and welfare issues which have arisen on an ongoing basis during the pandemic, have necessitated a high degree of cooperation between the Department of Health (DoH), the HSE (National Office for Social Inclusion, Communications Unit and Department of Public Health) and lead government departments (and associated agencies). This has taken place under the aegis of the NPHET Vulnerable People Subgroup. In addition, there have been extensive informal bilateral contacts and meetings between the DoH, the HSE and lead departments/agencies.

The purpose of this paper is to update NPHET on the response to the Covid-19 pandemic risks among socially excluded groups. The paper

- describes socially excluded groups and their risks from Covid-19,
- reports on the data on Covid-19 outbreaks and cases,
- details the preventative and ameliorative measures to contain Covid-19,
- outlines the structures and communications to manage the response, and
- highlights some policy lessons emerging.

2. Overview of socially excluded groups and their risks from Covid-19

The socially excluded groups comprehended by this report, the community and congregated settings, and the lead government departments are summarised in the table below.

Social excluded group	*Community*	*Congregated setting*	*Lead Govt Department*
Individuals & families who are homeless	Rough sleepers	Homeless services (emergency and long-term accommodation)	Department of Housing, Planning and Local Govt
Applicants for international protection and refugees on a government programme		Direct provision centres & emergency reception and orientation centres	Department of Justice and Equality
Members of Traveller community	Private & social housing	Halting sites	Department of Housing, Planning and Local Govt
Members of Roma community	Private rented and social housing		Shared under NTRIS
Undocumented migrants	Private rented housing		None
People who use drugs or have alcohol dependency	Private, rented and social housing	Homeless services and residential rehab centres	Dept of Health

The risks facing the socially excluded groups are qualitatively different to that of other individuals/groups within the remit of the NPHET Vulnerable People subgroup. They arise from the following factors:

- Low income and lack of resources, such as food poverty, lack of social networks, low education, inadequate accommodation or unemployment;
- Underlying health issues, such as long-term illnesses and weak immune systems. However, unlike the health needs linked with ageing, for example, their health issues usually reflect health inequalities linked to the social determinants of health;
- Many of these groups are in emergency or temporary accommodation, usually sharing accommodation with other individuals or with extended family members. This can make social distancing difficult and limit the capacity to cocoon or self-isolate;
- Lack of access to health services and low health literacy. Individuals may experience difficulties in accessing GP services or lack information on their entitlements. Low health literacy can stem from lack of confidence in dealing with health services, language or cultural issues, and poor communication and understanding of the needs of socially excluded groups by providers of health services.

Policy responsibility for responses to address the needs of these vulnerable groups rests across a number of different departments, necessitating whole of Government responses under various policy headings, including: the national drug strategy, *Reducing Harm Supporting Recovery*, the health-led response to drug and alcohol use; homeless policy under *Rebuilding Ireland* (DHPLG) and DJE-led policy responses in a number of areas, in particular the *National Traveller and Roma Integration Strategy*, the *Migrant Integration Strategy* and policies for international protection. In addition, the HSE *Intercultural Health Strategy* provides a comprehensive and integrated approach to addressing the health and support needs of service users from diverse ethnic and cultural backgrounds in Ireland.

Individuals and families who are homeless

The DHPLG's Homelessness Report for April 2020 reported 6,262 adults using local authority managed emergency accommodation, including 1,339 families and 3,073 children. The most recent winter rough sleeper count for Dublin, conducted in November 2019, identified 90 people sleeping rough in Dublin on the night in question. In Dublin, there are approximately 3,000 single people accessing emergency accommodation, many of whom have complex health support needs relating to mental health and addiction.

Applicants for international protection and programme refugees

In relation to international protection applicants and programme refugees, there are currently, some 8,000 persons being provided with accommodation services in 83 locations nationwide.

Members of the Traveller community

Census 2016 reported the total number of Travellers, usually resident in Ireland in April 2016, as 30,987, and recorded 8,717 households.[3] The majority of Travellers households were living in private dwellings; 2123 in detached houses, 2597 in semi-detached houses, 1919 in terraced houses, 678 in flats/apartments/ bedsits and 1015 in caravans or other mobile temporary structures. A small number, 639, were enumerated in communal establishments. The number of Travellers recorded as homeless in Census 2016 was 517.

Members of the Roma community

The report *Roma in Ireland – A National Needs Assessment* estimated the population of Roma at between 4,000 and 5,000.[4] The research found that one-fifth of Roma people in Ireland are completely marginalised from State services and supports. In the context of the Covid-19 pandemic, HSE estimated 300 individuals (plus children) who are most vulnerable in the Roma community.

People who use drugs or have alcohol dependency

People who use drugs or have alcohol dependency are a risk group given lifestyle, medical comorbidities and compromised immune system. There are approximately 10,000 individuals on opioid substitution treatment (OST). These are considered the most vulnerable people who use drugs. Around 1,000 of these are registered as homeless.

There are no official data on undocumented migrants.

3. Data on Covid-19 outbreaks and cases

The HPSC reports on an ongoing basis on cases of Covid-19 in the population and is the official source of data in relation to cases, deaths and clusters based on confirmed figures.

[3] The ethnic question in the 2016 Census was through self-identification. Traveller representative groups estimate there is in excess of 60,000 Travellers in Ireland.

[4] Pavee Point Traveller and Roma Centre & Department of Justice and Equality (2018) *Roma in Ireland – A National Needs Assessment*

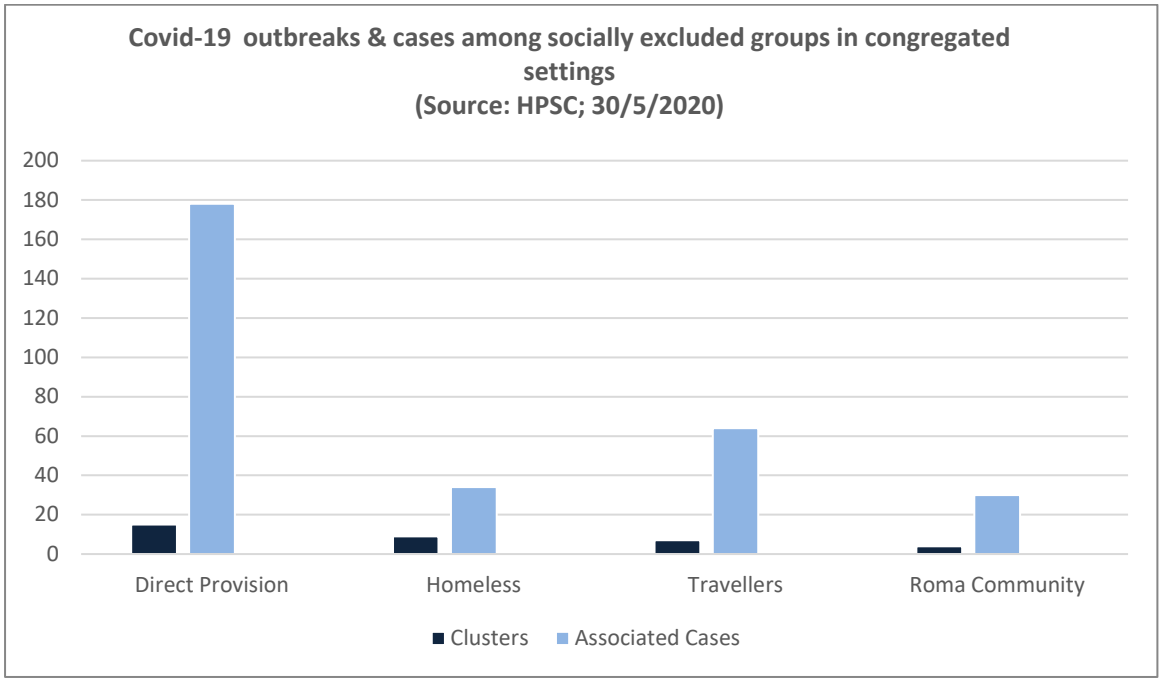
Routine HPSC data collection does not include information on risk factors such as addiction, socially exclusion, etc. However, data are provided on outbreaks in congregated settings. A cluster/outbreak is defined as:

- Two or more cases of laboratory confirmed COVID-19 infections regardless of symptom status - including cases with symptoms and cases who are asymptomatic

  OR

- two or more cases of illness with symptoms consistent with COVID-19 infection (as per the COVID-19 case definition), and at least one person is a confirmed case of COVID-19.

The HPSC data are reported on a weekly basis and represent a snapshot of outbreaks at this date and may not represent the complete picture. The data for outbreaks and associated cases for the week ending 30th May, 2020 are presented in the diagram below.



The data show a total of 35 outbreaks for socially excluded groups in congregated settings, with a total to 306 associated cases. The details of these outbreaks are as follows:

- direct provision centres: 15 clusters associated with 178 cases, 13 cases have been hospitalised, 0 cases were admitted to ICU and 0 cases have died;
- residential facilities for the homeless: 9 clusters associated with 34 cases. 7 cases were hospitalised, 2 cases were admitted to ICU and 0 cases died;

- Traveller Community: 7 clusters associated with 64 cases. 3 cases were hospitalised and 2 cases were admitted to ICU and 0 cases died;
- Roma Community: 4 outbreaks involving 30 cases. 9 cases were hospitalised, 5 cases were admitted to ICU and 4 cases died.

Among socially excluded groups in congregated settings, the highest numbers of outbreaks were in direct provision centres (15), the smallest numbers of detected clusters were in the Roma community (4).[5] Direct provision centres account for the largest number of cases associated with clusters (178), while homeless services and the Roma have the lowest (34 and 30 respectively). There is a variation in the number of cases associated with outbreaks for different vulnerable groups. Direct provision centres record the highest number of cases per outbreak at 12. Traveller halting sites are next highest at 9, while Roma have 7.5. Homeless services have the lowest number of cases per outbreak at 4. Overall, direct provision centres account for 43 per cent of all outbreaks and 58 per cent of associated cases.[6]

The severity of cases varies considerably by vulnerable group. While the highest number of outbreaks are in direct provision centres, the morbidity was relatively low with a high proportion of asymptomatic cases found during mass testing. The HSE indicate that a relatively high rate of mild and asymptomatic cases in direct provision centres may be related to the relative youth of residents and their overall health status.

The Roma community, though affected by only 4 outbreaks, the morbidity and mortality was significant. Infected individuals from the Roma community were more likely to be hospitalised and to be admitted to ICU. There are also four deaths recorded among Roma, while no deaths are recorded among any other of the vulnerable groups.[7]

HPSC data on the Covid-19 cases among socially excluded groups in the community are not currently available.[8] As such, the above data may not reflect the total number of cases for

[5] In the initial stages not all clusters in the Roma community were identified as these communities are scattered and may not be detected

[6] An outbreak of COVID-19 in a vulnerable group congregated setting can be declared over when there have been no new cases of infection (resident or staff) which meet the case definition for a period of 28 days (two incubation periods).

[7] More recent data (mid June) indicate two deaths among the homeless services.

[8] HSE National Social Inclusion Office receives anecdotal information about cases among socially excluded groups in the community.

individual groups. However, it is understood that a wider analysis of all cases by socio-economic status is being undertaken by HPSC and others.

In overall terms, the number of outbreaks and associated cases among socially excluded groups in congregated settings is quite low. Far greater impacts are recorded in residential care facilities, especially those catering for older people.

4. Public health guidance for socially excluded groups

In all matters related to the Covid-19 pandemic, public health advice from the HSE and the National Public Health Emergency Team was followed.

The HSE produced Covid-19 Guidance for Homeless and Vulnerable Groups, which is available on the HPSC website. This guidance document, which is constantly updated, gives general advice about preventing the spread of Covid-19 in Homeless settings and other vulnerable group settings including Direct Provision settings. These can be applied in hostels, hubs or residential settings including those without clinic or in-house nursing, medical or healthcare support.

The guidelines set out measures to prevent the spread of Covid-19, including cocooning for extremely medically vulnerable people, triage and testing (case finding) of vulnerable people as a priority group, adapted clinical criteria for testing, self-isolation/quarantine, clinical case management, communications and outbreak response. The guidelines recognise that congregated settings such as those outlined above pose specific challenges in the pandemic.

Advice notice has been prepared for **Homeless settings** based on updated public health guidance – including advice on containment, testing (procedure for suspected case & waiting for test results), isolation/treatment (confirmed case and unwell/confirmed case and not unwell) and cocooning. This advice notice continues to be updated.

5. Preventative measures in congregated settings

At the beginning of the Covid-19 pandemic, preventative measures were introduced in congregated settings. These included public health advice on personal hygiene and social distancing. In addition, as part of contingency planning, measures were taken to reduce the density of individuals in congregated settings (also referred to as thinning) and to transfer

individuals with underlying health conditions into separate accommodation (also referred to as cocooning).

Across **homeless services,** a range of precautions were introduced aimed at minimising the risk of infection among service users and staff, including hygiene arrangements and limiting the need for travel and movement between services. This planning was undertaken by the housing authorities in consultation with the relevant HSE regional offices.

DJE and the HSE have worked closely together to ensure that, to the best of their ability, the health and welfare of international protection applicants living in **direct provision,** and programme refugees living in EROCs availing of the State's accommodation services, are protected.

In the context of contingency planning, DJE and IPAS made contact with all of their centres, relaying all national public health messages and requesting the centres to complete contingency plans for Covid-19 and to generate "a self-isolation capability."

In the housing sector, local authorities put in place significant additional emergency accommodation to allow for the necessary social distancing in facilities. In Dublin, this involved the coordinating body for the four Dublin local authorities, the Dublin Regional Homeless Executive (DRHE) introducing over 500 additional beds for single adults. Approximately 550 beds were put in place in the Dublin region to allow individuals to self-isolate where required and for 'cocooning'. In relation to cocooning, the HSE had identified a significant number of individuals in emergency accommodation as being vulnerable and who were required to be 'cocooned'. While a number of these individuals have moved to supported housing, there are currently over 250 individuals 'cocooning' in short-term facilities established by the DRHE. The numbers requiring to self-isolate have remained very low and the DRHE are examining the current arrangements.

Local authorities have also worked with their service delivery partners to exit households from emergency accommodation and a significant number of families and individuals have moved from emergency accommodation to a home. Housing First tenancies have also been established for individuals who had been rough sleeping or had been long-term users of emergency accommodation. This work has led to a reduction in the numbers of people

accessing homeless emergency accommodation. The recently published DHPLG Monthly Homeless Report for April showed that there were 572 less people in emergency accommodation compared to the previous month.

At the outset of the COVID-19 response, DHPLG engaged with local authorities to examine the measures required to ensure the protection of **homeless individuals**. Local authorities have worked with the HSE regional offices to put in place measures to allow for the necessary social distancing and to provide capacity for individuals to self-isolate when required to do so. Additional accommodation for single persons provides for reducing the concentration of individuals sharing in existing hostels that will enable improved safe distancing options.

DJE procured a substantial amount of additional accommodation for **residents in direct provision centres**. This increased capacity forms a critical part of the overall strategy to protect its clients by:

- helping with social distancing measures through density reduction,
- supporting the measures required for vulnerable residents (cocooning), and
- providing offsite accommodation for self-isolation.

Over 600 residents in direct provision centres have been relocated to support social distancing in centres, and cocooning measures for the most vulnerable. All residents aged 65 or over have now been cocooned due to their particular vulnerability to this virus. Upon receipt of information from the HSE about residents with medical vulnerabilities requiring cocooning, these residents are cocooned on site or, where necessary, are moved to new accommodation to facilitate same.

A number of international protection applicants work as healthcare workers (deemed to be essential workers), especially those working in hospitals and/or nursing homes. On 10 April, the HSE issued its National Guidance Document on Temporary Accommodation for Healthcare Workers during the COVID-19 crisis. Healthcare workers living in direct provision are eligible to apply for accommodation under the scheme via a referral form to the HSE. DJE are encouraging all healthcare workers living in centres to apply for this temporary accommodation for their protection and that of other centre residents and staff. However, a relatively low number (41 individuals) have taken up this offer to date.

6. Preventative measures for people who use drugs and have alcohol dependency

The HSE prioritised access to OST services for people who use drugs. The aim was to ensure people on a waiting list commenced appropriate treatment. By the end of May 2020 there were an additional 650 individuals in receipt of OST compared with January 2020.

Separately, the HSE has put in place measures to maximise access to OST for **homeless people who use drugs**. Over 70 new homeless clients have signed up for treatment. For new and existing clients, special arrangements are being put in place to ensure continuity of supply during the crisis.

Additional harm reduction measures were introduced for people who use drugs or have alcohol-dependency. Major concern was the risk of overdose for people who use drugs during the pandemic. To minimise this risk, guidance was issued on overdose prevention, naloxone and needle exchange. A number of drug-related deaths have been reported in the Midlands and the Dublin inner city. A full analysis of the number of drug-related deaths during Covid-19 as compared to previous years using the HRB database will be possible in due course.

DoH worked with the HSE and Drug and Alcohol Task Forces to ensure that services and supports continue to be provided for those with problem drug and alcohol use. Task forces have been asked to prioritise the continuity of services and supports to vulnerable groups and individuals in their areas during the pandemic. HSE community-based drug and alcohol services continue to operate on an outreach basis. Services are also provided via telephone and video platforms.

The Department and the HSE have produced a number of harm reduction posters for people who use drugs, people with alcohol-related problems, and people at risk of overdose. There has also been a regular on-going collaboration with UISCE, the representative group for PWUD. The HSE drugs website, drugs.ie and the HSE Social Inclusion microsite are regularly updated with guidance on addiction issues.

Extensive guidance was developed for services for **people who use drugs** including:

- Contingency Planning for People who use drugs
- Medicines Management for Isolation Units

- Dispensing medication for people in isolation
- Safe supply of medicines during the Covid-19 pandemic
- Methadone take home leaflet
- Opioid Substitution Treatment Guidelines for Acute Hospital Setting

7. Testing

NPHET has set out criteria for testing suspect cases for Covid-19. At the outset of the pandemic, socially excluded groups (people who are homeless, Travellers, Roma, international protection applicants) were included as a priority group in the case definition.

A process has been developed between the HSE and the DRHE for testing in Dublin homeless services. Safetynet Primary Care is a registered charity funded by the HSE to offer a comprehensive primary healthcare service targeted at **people who are homeless**. The programme makes services more accessible by locating medical and social support services in the agencies and services where homeless people attend for support. Safetynet, working closely with HSE Local Public Health Dept in East Region and with National Public Health Specialist in HSE Social Inclusion, is carrying out testing in hostels where the most vulnerable are prioritised.

A bespoke Covid-19 community assessment hub for homeless and vulnerable groups in Dublin city centre was established. The hub is provided by Safetynet and the Mater Hospital and supported by the HSE. Safetynet doctors and nurses together with public health staff collaborate in relation to contact tracing and testing on close contacts on day 0 and day 7. This collaboration has extended to collaboration on CRM and CPM.

Where cases of COVID occur in a **Direct Provision** centre, testing strategies are determined in conjunction with the Local Public Health Directorate based on a comprehensive risk assessment. The risk assessment includes consideration of factors including the size and configuration of the Direct Provision Centre (e.g. are all services communal or are there separate living and catering facilities for each family). Testing strategies include testing of all residents and staff, or testing of contacts of cases only.

The HSE has developed a protocol for testing within the **Traveller** community. The approach to testing in particular sites is determined by public health officials following a risk assessment.

8. Outbreak control and self-isolation

Outbreak control incident teams were convened by local and sometimes national Public Health for the management of clusters across the vulnerable group settings. The Directors of Public Health with Social Inclusion support lead the investigation and management in terms of dedicated contact tracing enhanced testing, infection control measures and referral to dedicated self-isolation facilities for vulnerable groups. A process map for testing and self-isolation was developed along with standard operating procedures for self-isolation.

Homeless service providers implemented a range of measures to firstly reduce the spread of COVID 19 and thereafter to deal with persons who need to quarantine, self-isolate or positive cases who need separate accommodation.

A range of measures are in place in **direct provision centres** to address any cases of COVID-19 if or when they arise. This includes provision for self-isolation facilities in centres and a number of offsite self-isolation centres throughout the State. In all matters related to the COVID-19 pandemic, DJE work collaboratively with the HSE to implement the public health advice. Centres have been used extensively over the period up to early June and at this stage there is only a very small number using the facilities.

The established procedure across all direct provision centres where a person is suspected of having the virus or is confirmed as having the virus, is that, where advised by HSE Public Health, they are moved to a dedicated offsite self-isolation facility where supports are available for the duration of their period of quarantine until such time as the HSE considers that they can return to their centre with no risk to other residents or staff.

DJE established dedicated self-isolation facilities for residents in Dublin, Cork, Limerick and Dundalk, with a total capacity of 299 rooms. Residents in these facilities have their own bedroom and bathroom. Health care supports are provided onsite by the HSE and social care and support for residents provided by a non-profit Section 39 organisation. With the

reduction in the need for these facilities, the Department is working with the HSE on future needs and/or alternative utilisation.

The HSE has put in place specific measures for the **Roma community** where self-isolation is required. It recently acquired a 40 bed self-isolation facility for Roma in Dublin city centre. Residents entering the facility may be symptomatic and waiting test results, COVID positive, close contact of someone who is symptomatic or COVID positive. It is planned that each resident will have a 14-day stay.

There has been less than expected use of the HSE self-isolation and step-down facility established at the Citywest Hotel and convention centre in Dublin to ease pressure on hospitals in Dublin and surrounding areas. The facility was available to those who can self-manage.

9. Inter-agency coordination and communication

The HSE has worked with Pavee Point and Traveller Health Units to enhance information and awareness about hygiene, and other public health measures around social distance, restricted movements etc. Advocacy in reduction of overcrowding where possible, is also supported including co-operative working with Local Authorities and Department of Housing. Where self-isolation is required, the HSE works in conjunction with the local authority to find most appropriate solution including extra trailers on site or access to alternative accommodation including utilising HSE facilities such as the facility for Roma in the city centre and HSE Citywest facility.

The HSE's public health response to target the **Traveller community** includes a national helpline operated by Midlands Traveller Organisations, supported by HSE THU Midlands. Specific resources have been developed, (including translations of public health messaging), at Traveller Health Covid-19 sharing resources.

DJE has provided additional financial supports for the production of public health information materials specific to the **Traveller** community. Additional funding is also being supplied to provide interpretation support to **Roma** health activities and for other practical

measures. In addition, DJE has promoted public health advice widely to Traveller and Roma organisations throughout the country.

The HSE has worked with NGO representatives and established a public health initiative to target the **Roma community**, which includes:

- A national helpline up and running since Friday 27th March, HSE receiving details of call volume and queries and assisting where needed.
- GP available for Roma 7 days, 8am-8pm via Capuchin Clinic and Safetynet
- Translated materials in both Romanian and Slovak available
- All Emergency Departments contacted with detail of translated materials and details of interpreters.
- Specific resources developed and translated to Romanian, Czech and Slovak and a website resource page for Roma created, see Roma Covid-19 resource sharing page.

In relation to communications with those living in **direct provision** centres, IPAS in partnership with the HSE have put in place a national support telephone service. It provides public health advice to support staff managing IPAS accommodation. It is also being used to advise, support and work with IPAS sites, and locations where vulnerable groups are present. Specific resources have been developed, including guidance for international protection accommodation, and resources (including translations of public health messaging) are available at Migrant Health COVID 19 sharing resources.

IPAS has established a Contact Centre and communications unit providing a dedicated response to centre managers. The Call Centre makes contact with each of the 83 centres each day, compiling a management report with both quantitative and qualitative data to guide planning and decision making.

DJE continues to support the provision of the most recent public health instructions and guidance to residents. Additionally, that department is partnering with an NGO to provide a telephone helpline support to residents to respond to general concerns of residents at this time. The provision of hand sanitiser to centres for the use of residents and staff is in place with other PPE available to centres to be used in accordance with HSE advice.

The scope for NGO engagement for residents in direct provision was limited, with the main relationship being between the DJE and centre management.

Regular newsletters are issued to centres with information relating to social distancing, public health advice, supports for residents and children. Newsletters are also being tailored directly to residents' queries and communicated to them through Friends of the Centre structures and through Centre managers.

HSE and DHPLG hosted two online workshops for service providers working with homeless and addiction services.

- 15/04/20 : 'COVID19 Web session for homeless service providers in Dublin', 130 attendees
- 29/04/20: National COVID19 web session for homeless & addiction service providers- 250 attendees

The HSE has established a **cross-functional Covid-19 Dublin homeless response team** which included the appointment of an HSE clinical lead for the Dublin COVID19 Homeless response. There are 9 staff on the team made up of personnel from the HSE, the Dublin Regional Homeless Executive and NGO service providers. This team covers the three CHO areas in Dublin. The HSE also established an internal Covid-19 homeless coordination group, chaired by the National Social Inclusion Office, to monitor and respond to arising issues and coordinate priority actions across the three Dublin CHO areas.[9] Finally, local helplines were established for homeless service providers and service users in CHO areas.

During the peak periods, the HSE strengthened communication links within the organisation through Public Health and CHO Social inclusion groups, and with lead government depts and NGOs. Two or three times a week teleconferences were needed for some groups such as IPAS/ homeless and Roma / traveller groups. These were used to provide guidance on infection prevention and control and practical advice for incident management. The HSE

[9] Membership of the group includes HSE Social Inclusion operations managers, the HSE clinical lead for the Dublin COVID19 response, HSE Public Health and the NSIO. It included a number of operational workstreams including prevention, triage and testing, self-isolation and cocooning, clinical case management, staff training and support, and communications.

also worked with Capuchin and Safetynet to enhance the supports to Roma community with a designated Covid-19 helpline as well as weekly teleconferences.

10. Supporting measures

Access to primary healthcare services

HSE Social Inclusion and Primary Care provide support to a range of primary care projects and other initiatives for **Travellers** e.g. Traveller Health Units (THU) and Primary Health Care for Travellers Projects (PHCTPs). In PHCTPS Travellers work as community health workers, and this allows primary health care to be developed based on the Traveller community's own values and perceptions.

Sanitation and other services

DHPLG has acknowledged the constraints facing people who live in halting sites in adhering to public health advice. Additional accommodation and emergency provision of sanitary relief such as water tanks, extra toilet facilities and hand sanitisers have been provided to support **Travellers** living in halting sites.

Access to financial and related supports

DEASP have put in place simplified arrangements for PPSN applications during the Covid period – details here: https://www.gov.ie/en/service/12e6de-get-a-personal-public-service-pps-number. DEASP are working with Pavee Point and other organisations dealing with **Roma**, to promote and share information regarding simplified arrangements.

Furthermore, income support may be available under the DEASP Exceptional Needs Payments and the Urgent Needs Payment schemes for those experiencing financial hardship who may not qualify for support under other social welfare schemes. These payments are not subject to the habitual residence condition. These payments are provided by the Community Welfare Service of the Department.

Protection of tenants in private rented accommodation

The Emergency Measures in the Public Interest (Covid-19) Act 2020 was enacted on 27 March 2020 and provides for the operation of the Residential Tenancies Act 2004 during the Covid-19 emergency period to better protect tenants by prohibiting rent increases in all cases,

and tenancy terminations in all but limited and exceptional cases. The Act further provides that the emergency period, which terminates on the 27th June 2020, can be extended by a Government order. Such an extension is under consideration at present.

In addition, short-term income support can be provided under the DEASP Rent Supplement scheme, to ensure that tenants who have experienced loss of employment can continue to meet their rental commitments.

Access to public services

DoH is developing posters for Roma and other undocumented migrants on access to public services, in collaboration with HSE and DEASP.

11. Conclusions

NPHET recognised the potential impact from Covid-19 for vulnerable groups by establishing a specific subgroup to oversee the government and civil society response. Included in the remit of the group were a number of social excluded groups, including people who use drugs and those living in congregated settings. Under the auspices of the NHPET subgroup, preventative and responsive actions were developed by government departments responsible for the accommodation and welfare of these socially excluded groups.

Official HPSC data capture outbreaks among socially excluded groups in congregated settings, with little information available on those living in the community. A total of 35 outbreaks were recorded by the end of May, with a total of 306 associated cases. Approximately half of all outbreaks and cases were in direct provision centres, though these cases were associated with low morbidity. The most severe impact from Covid-19 was in the Roma community, with nine hospital admissions and four deaths from 30 cases.

Overall, the impact of Covid-19 was greatly minimised by an intensive and collaborative response from government, the HSE and civil society. This is especially evident in congregated settings, where the risk of outbreaks was much greater. Socially excluded groups were prioritised both individually as complex cases and also as part of congregated settings. They received priority action in terms of detection, case management and contact tracing. A fast track flexible approach was used for complex cases in these communities. This enabled fast action and minimised further spread.

It is difficult to assess the impact of Covid-19 among socially excluded groups in the community, due to the lack of data. While some data capture will improve in terms of ethnicity and risk factors it is unlikely that the sporadic case notification will be able to deliver the data needs. Also a challenge is that when mass testing is done the minimum dataset will be used. There is some evidence that the impact was greater among some groups, especially for the Roma community.

There are reports of drug-related deaths, which may be linked with wider societal impact of Covid-19. Further analysis is required to examine Covid-related issues such as mental health and stigma among social excluded groups.

Data reporting on Covid-19 for socially excluded groups has scope for further improvement, including use of ethnic identifier, as part of better analysis of the impact of Covid-19 on social-economic groups.

Key to the government response to Covid-19 among vulnerable groups is the enhanced cooperation between departments, agencies and NGOs. This is most apparent in homeless services and reflects existing relationships and contacts. The engagement with NGOs and advocacy groups has also supported the development and implementation of the necessary measures for vulnerable groups.

There are some aspects where collaboration could be enhanced. One example is the arrangements relating to access to HSE self-isolation facilities. These could be examined to reduce the cost of operating parallel facilities for social excluded groups.

Within the HSE, collaborative networks were developed between public health and social inclusion services. It is important that these networks are retained and strengthened in Dublin and across CHO areas, especially for primary care and community health.

It is important that the additional health and housing services provided to people who are homeless continue after Covid-19.

Greater focus on health care of socially excluded groups is needed with stronger clinical leadership especially in relation to migrant health. Ensuring access to basic health care such as immunisations; health screening as well as GP services for all marginalised groups should be a priority and mainstreamed across primary care and acute hospitals.

Access to primary care is also a challenge for many in DP and this needs to be examined and addressed in coming weeks. It is also recognised that further public health clinical supports are required in direct provision centres.

Finally, socially excluded groups experience underlying health inequalities. These reflect the wider social determinants of health, in regard to accommodation, income supports and risky behaviours. Long-term measures are required to address these social determinants. Access to health services for socially excluded groups must also be improved upon.