Public Health Responses to Homelessness During COVID-19 in Ireland: Implications for Health Reform

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Introduction

It is well-established that housing is a key determinant of health since stable housing makes it easier to become and remain healthy, just as being healthy makes it easier to become and remain stably housed (Marmot, 2005; Rolfe et al., 2020; Whitehead & Dahlgren, 2006). Likewise, the relationship between health and homelessness (that is, the absence of secure, appropriate housing) is complex; the causal ‘arrow’ is bi-directional since the latter can be both a driver and a consequence of poor health or indeed poor access to healthcare (Wright, 1990). For example, poor health can precipitate homelessness if it “interferes with employment, reduces income, or ruptures social ties” (Lee et al., 2010, p. 506) while at the same time, poor health outcomes amongst those experiencing ‘chronic’ or long-term homelessness can be exacerbated by prolonged stays in homelessness environments where they are exposed to high levels of stress, health risks in overcrowded facilities and dietary or hygienic shortcomings (Kushel et al., 2001; Wright, 1990). Moreover, the nature of an individual’s interaction with health systems can either hinder
or enable their exit from homelessness depending on how it is designed in terms of access, eligibility and its approach to healthcare delivery (Siersbaek et al., 2021).

What this inextricable relationship between health and homelessness means, however, is that any investment in housing stability is correspondingly an investment in health and vice versa. The critical implications of this policy intersection are even clearer since the onset of COVID-19. Indeed, it is increasingly recognised that: 1) those experiencing chronic or entrenched homelessness, including rough sleeping, often have high rates of comorbid conditions that make them extremely susceptible to hospitalisation and death related to COVID-19 (Baggett et al., 2020; Perri et al., 2020); 2) communal or congregate shelter facilities - the dominant homelessness response in the Global North - are not conducive to minimising the spread of infectious diseases (Mohsenpour et al., 2021); and 3) those experiencing homelessness may face barriers to vaccination (Fu et al., 2021) or have poor access to emerging forms of e-health and telemedicine due to a lack of resources (e.g. technology, private living quarters) that would enable them to engage in these new healthcare pathways (Zhai, 2021).

Parsell et al. point out that since the pandemic began, homelessness has also in many countries been (re)framed as a public health issue rather than one that simply affects ‘the individual’; and this, they argue, has had a “profound impact” on how some Governments have sought to address it (Parsell et al., 2020, P. 1). In Canada, for example, an additional 157.5 million (CAD) was allocated to their Homelessness Strategy (Lord & Saad, 2020) while in the US, 4 billion (USD) was pledged to mitigate the impacts of COVID-19 on homelessness populations, with further preventative measures put in place, including emergency rental assistance and time-limited eviction moratoriums in areas of substantial and high transmission (Acosta et al., 2020). In other jurisdictions – including the UK, France, New Zealand, and Australia – unprecedented funding arrangements were announced to temporarily house rough sleepers and those in congregate homelessness facilities in motels or other ‘self-contained’ accommodation to reduce the risk of exposure to the virus (Pawson et al., 2022; Pleace et al., 2021). Similar measures were observed across the rental sector in Ireland (Ahern & Roy, 2020), alongside a coordinated effort led by the Health Service Executive’s (HSE) Social Inclusion Unit that combined housing, health, and addiction approaches - with initiatives including provision of single occupancy housing and streamlined treatment for drug dependence - to enable homelessness service users to isolate (Corey et al., 2022; Crowley & Hughes, 2021; O’Carroll et al., 2021).

Yet, in both the Irish and international context, questions remain about the immediate and longer-term outcomes of newly implemented public health interventions for homeless populations and whether they - along with greater financial investment and apparent shifts in policy direction towards a housing-led approach as opposed to a shelter-led response - will be sustained. Such considerations are critical and timely in countries such as Ireland, where we are currently progressing a reform agenda that seeks to transition to a universal health system that is based solely on need rather than ability to pay (Department of Health, 2019; Houses of the Oireachtas Committee on the Future of Healthcare, 2017). One of the key deliverables of the reform roadmap - called Sláintecare- is to “develop plans for the provision of accessible and safe care that meets the needs of the homeless population and reduces dependency on emergency departments and acute services” (Department of Health, 2021, p. 21). With evidence suggesting that the pandemic has led to increased use of emergency services amongst certain homeless populations (Brien et al., 2022; Corey et al., 2022), it is important that dedicated research and policy attention is paid to advancing understanding of how this can be meaningfully achieved in the COVID-19 context.

The Health and Homelessness Policy Context

Ireland remains one of the few high-income countries where citizens do not have universal access to public healthcare; rather, a complex set

1 ‘Housing-led’ as referred to here, is a broad philosophy that takes the position that responses to homelessness should start with a house and that those experiencing homelessness should have their agency and preferences respected (Busch-Geertsema et al., 2010).
of eligibility arrangements based on age, health, and socioeconomic status continue to be in place, many of which have been critiqued as antiquated and not fit-for-purpose (Organisation for Economic Cooperation and Development/European Commission, 2019). Additionally, just under half of the population purchases voluntary health insurance for faster access to private health services, which are generally oriented towards elective acute hospital-based care. Thus, although individuals have access to acute hospital-based care that is free or with low-cost user charges, many face extensive and often prohibitive charges for access to primary and community services as well as extremely long waiting lists to access diagnostics, assessment treatment, and care in public hospitals; all of which contributes to high levels of unmet need and health inequity (Houses of the Oireachtas Committee on the Future of Healthcare, 2017).

Acknowledging the inherent issues associated with the complex and shifting eligibilities and different degrees of access to care, the Irish Parliament established a committee in 2016 to develop a plan to reorientate the Irish health system towards universalism. The Committee on the Future of Healthcare produced a report called Sláintecare (‘sláinte’ being the Irish word for health) which was published in June of 2017 (Houses of the Oireachtas Committee on the Future of Healthcare, 2017). The report details a ten-year phased, costed plan for implementing universal healthcare free at the point of use in Ireland (Burke et al., 2018). Implementation has since begun, but progress is slow, and significant delays have been reported (Thomas et al., 2021). Most recently, the implementation process was boosted in 2020 and 2021 through significant investment in policy changes as part of the Irish health system’s COVID-19 response (Burke et al., 2021). That said, the impact of this boost may be ebbing following the resignations of the most senior people responsible for Sláintecare and a lack of clarity on reform governance and accountability since September 2021 (Department of Health, 2022).

Similarly, despite Ireland’s policy commitment to a housing-led approach, the rapid growth in homelessness rates since 2014 has seen emergency-based responses to homelessness gradually return as the modus operandi of policy action including the expansion of emergency infrastructure - including congregate facilities with shared living or sleeping spaces - to accommodate the steady stream of individuals presenting as homeless to local authorities (O'Sullivan, 2016, 2020; Sheridan and Parker, 2023). Ireland’s homelessness policy response has also been critiqued for its reliance on the private rental market to meet a sizeable proportion of social housing need (Hearne & Murphy, 2018; Lima, 2018). Notably, since 2018, an average of 55% of social housing expenditure per annum is spent on capital expenditure. At the same time, there has been a shift towards a more neoliberal model in which social housing is delivered through the private rented sector (PRS) via the provision of rental subsidies, such as the Housing Assistance Payment (HAP) and the Homeless HAP2 (HHAP) (Hearne & Murphy, 2018; Norris, 2013). Coupled with historically low levels of purpose-built social housing during 2012-2017 - where social housing expenditure fluctuated between 20-30% - these developments have meant that since 2016, (H)HAP has become the “primary mechanism for preventing homelessness and for assisting people to exit emergency accommodation” (Hearne and Murphy, 2018, p. 14).

**Study Aims and Objectives**

In this paper, we use Ireland as a case study to explore whether and how public health responses to homelessness during the COVID-19 pandemic hold important insights for the development of effective health policy. A secondary analysis of publicly available data was undertaken to examine homelessness COVID-19 infection rates as well as trends in emergency infection rates as well as trends in emergency

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2 HAP is a form of ‘social housing support’ in Ireland that, subject to rent limits and conditions, allows qualified applicants to source rental accommodation in the private market; the homeless HAP increases the basic HAP payment by up to 20% (outside of Dublin) and 50% (in the Dublin region) for those at risk of homelessness and local authorities may also pay rental deposits and advance rental payments, if required (O’Sullivan, 2020). It is worth noting that private landlords can legally terminate a tenancy and demand vacant possession in certain circumstances (such as when they wish to sell, refurbish or give the property to a family member), even when the tenant is receiving social housing supports (O’Sullivan, 2016).
accommodation usage between 2020 and 2021. Focusing specifically on public health emergency measures implemented via the health and housing systems, respectively, we discuss how such interventions may have impacted these homelessness figures in both intended and unexpected ways. We conclude by teasing out and unpacking what lessons, if any, may be relevant for Irish health reform via Sláintecare implementation.

Methods

This study forms one work package within the Health Research Board (HRB)-funded Foundations’ research project that aims to harness key learnings from Ireland’s health system response to COVID-19, with a view to informing the implementation of Ireland’s ten-year health reform plan, Sláintecare (Barry et al., 2021; Burke et al., 2021; Burke et al., 2020; Johnston et al., 2021; Marron et al., 2021; McGlacken-Byrne et al., 2021; Parker et al., 2023). Ethical approval was granted by the Research Ethics Committee of the Centre for Health Policy and Management and Centre for Global Health at Trinity College Dublin (Burke et al., 2020). This component of the research was divided into two phases:

Phase One: Desk-Based Research to Compile Homelessness-Related COVID-19 Public Health Measures

Published academic and grey literature as well as official Government documents were reviewed to identify and describe key homelessness-related public health measures implemented in response to COVID-19 in the Irish context that occurred between the first lockdown in March 2020 and December 2021. The responses selected do not represent an exhaustive list; however, they nevertheless demonstrate the broad range of public health interventions developed and enacted at speed during the crisis and provide an important foundation for discussion and debate about whether and how key learnings could be relevant for health reform.

Moreover, while the measures outlined may not all be explicitly linked to public health, it could be reasonably argued that any intervention that prevents an individual or family from experiencing homelessness, or reduces prolonged exposure to homelessness service settings, would likely have a significantly positive impact on health status.

In fact, the Irish government itself has pointed out the direct link between providing secure housing and limiting the spread of COVID-19. As Ahern and Roy point out, the Minister for Housing’s request to extend the measures relating to rental housing, in particular, was framed as being in the public interest due to: 1) the threat to public health presented by COVID-19; 2) the highly contagious nature of that disease; and 3) the need to restrict the movement of persons in order to prevent the spread of the disease among the population. For this reason, they contend that the retention of these measures “depended on a public health rationale, in particular on the need for restricted movement of persons” (Ahern & Roy, 2020, p. 10). As such, we frame emergency COVID-19 measures implemented in the private rental sector via the housing system as important public health responses to homelessness for the purposes of this analysis.

Phase Two: A Secondary Analysis of Publicly Available Administrative Data on COVID-19 Infection Rates and Emergency Accommodation Trends

A secondary analysis of publicly available administrative data - that is, data derived from the operation of administrative systems and collected by government agencies for the purposes of record-keeping - was undertaken to demonstrate the extent to which these measures may have impacted homelessness infection rates and emergency accommodation usage. Hakim defines secondary analysis as “any further analysis of an existing data set which presents interpretations, conclusion of knowledge additional to, or different from, those presented in the first report on the enquiry” (Hakim, 1982,

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3 Notably, the use of a public health rationale to circumvent the right to private property in the Irish Constitution - that restricts the ability of Government to strengthen security of tenure in the PRS - was a short-lived measure that was only enacted during the initial waves of the COVID-19 outbreak.
In short, secondary analysis refers to a process where data collected by one researcher, is re-analysed by another to pursue an alternative perspective on the same research topic, or a new research interest entirely.

Secondary analysis is beneficial since it: 1) allows for the generation of new knowledge and new hypotheses or provides support for existing theories; 2) aids sensitive research by reducing respondent burden and minimising the recruitment of additional participants; and 3) gives greater access to rich, detailed data collected from ‘hard to reach’ populations (Cheng & Phillips, 2014). Once selected data were extracted, cleaned, and prepared for analysis, descriptive statistics were computed using Microsoft Excel 2016. Data were drawn from the following three sources:

1. **The Health Service Executive (HSE) Health Protection Surveillance Centre, Reports on the Epidemiology of COVID-19 Outbreaks / Clusters in Ireland**. These weekly reports include data extracted from Computerised Infectious Disease Reporting (CIDR) - an information system developed to manage the surveillance and control of infectious diseases in Ireland. Data is compiled on reported COVID-19 outbreaks in settings involving vulnerable populations, including ‘facilities for the homeless’ as well as ‘laboratory confirmed cases’ linked to these outbreaks.

2. **Department of Housing, Local Government and Heritage, Homeless Reports**. Derived from the national electronic case management system called Pathway Accommodation & Support System (PASS), these reports compile monthly ‘point in time’ data on the number of adults and accompanying children residing in State-funded emergency accommodation in Ireland.

3. **Department of Housing, Local Government and Heritage (DHLGH), Local Authority Regional Performance Reports: Homeless Quarterly Progress Reports**. Derived from PASS, Local Authority Performance Reports are submitted to the DHLGH through the regional lead authorities. Each includes quarterly ‘flow’ data on the numbers of households exiting emergency accommodation into tenancies and the duration of shelter stays in Ireland. The Homeless Quarterly Progress Reports summarise these data and also include details on the number of Housing First tenancies created during each quarter of the year and the total number of such tenancies in place at the end of each quarter.

A common limitation of the use of administrative data for research purposes is that researchers have to ‘make do’ with what is available (or what they are given) rather than generating tailored data that includes specific variables of conceptual interest to address the study aims(s) (Connelly et al., 2016; Culhane, 2016). In this instance, for example, it was not possible to infer some statistics that would have been useful for context, such as the total number of laboratory-confirmed COVID-19 cases linked to outbreaks within which to situate the number of those reported in ‘facilities for the homeless’. Similarly, the data available at the time of writing did not include the first four months of the pandemic (i.e., from March-July 2020). Moreover, while PASS data provide universal coverage and a full consensus of all State-funded homelessness services in the region, it is important to note that they do not provide a complete enumeration of family homelessness in Ireland. PASS statistics do not include, for example, data on individuals and families living in homelessness services that are not publicly funded; those living in Direct Provision centres; those residing in situations of hidden homelessness or sleeping rough; and those accommodated in refuges or domestic violence services (O’Sullivan, 2020).

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4 In the Republic of Ireland, the Department of Health is responsible for health policy development and the Health Service Executive (HSE), established under the Health Act 2004, has statutory responsibility for the management and delivery of health and personal social services.


Despite these limitations, PASS nevertheless provides the most “timely, detailed, reliable and consistent” minimum estimate of the extent of homelessness in the country (O’Sullivan, 2016, p. 17) and “allows for an exploration of [homelessness] trends with a degree of accuracy that is uncommon” in a European comparative context (O’Sullivan, 2020, p. 53). Additionally, the use of existing, publicly available administrative data is in keeping with the nature and rationale of the broader study within which this research is situated. More specifically, within the rapidly changing and emerging context of the pandemic, the primary goal of the study is to produce research evidence at speed that can be fed directly into the health system in real-time to inform the implementation of health reform.

**Table 1:**

<table>
<thead>
<tr>
<th>Year</th>
<th>Week ending</th>
<th>cases notified that week</th>
<th>Cases notified that week for all vulnerable groups</th>
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<tbody>
<tr>
<td>2020</td>
<td>29-Aug</td>
<td>&lt;5</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>05-Sep</td>
<td>&lt;5</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>12-Sep</td>
<td>&lt;5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>19-Sep</td>
<td>&lt;1</td>
<td>&lt;1</td>
</tr>
<tr>
<td></td>
<td>26-Sep</td>
<td>&lt;5</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>03-Oct</td>
<td>&lt;5</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>10-Oct</td>
<td>0</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>17-Oct</td>
<td>5</td>
<td>263</td>
</tr>
<tr>
<td></td>
<td>24-Oct</td>
<td>9</td>
<td>58</td>
</tr>
<tr>
<td></td>
<td>07-Nov</td>
<td>&lt;5</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>14-Nov</td>
<td>&lt;5</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>21-Nov</td>
<td>&lt;5</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>28-Nov</td>
<td>&lt;5</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>05-Dec</td>
<td>&lt;5</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>19-Dec</td>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>26-Dec</td>
<td>&lt;5</td>
<td>41</td>
</tr>
<tr>
<td>2021</td>
<td>02-Jan</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>09-Jan</td>
<td>&lt;5</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>16-Jan</td>
<td>&lt;5</td>
<td>81</td>
</tr>
<tr>
<td></td>
<td>23-Jan</td>
<td>&lt;5</td>
<td>120</td>
</tr>
<tr>
<td></td>
<td>30-Jan</td>
<td>&lt;5</td>
<td>94</td>
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<tr>
<td></td>
<td>06-Feb</td>
<td>8</td>
<td>91</td>
</tr>
<tr>
<td></td>
<td>13-Feb</td>
<td>&lt;5</td>
<td>97</td>
</tr>
<tr>
<td></td>
<td>20-Feb</td>
<td>5</td>
<td>89</td>
</tr>
<tr>
<td></td>
<td>27-Feb</td>
<td>&lt;5</td>
<td>86</td>
</tr>
</tbody>
</table>

8 For a more detailed discussion of the strengths and weaknesses of PASS data, see Parker (2021).

9 Between 29 August 2020 and 5 December 2020 these data also included cases recorded in facilities for those with addiction issues. From 19 December 2020 onwards, these data refer to cases reported in homelessness facilities only. It should also be noted that due to the cyber-attack on the HSE IT systems on 14 May 2021, there was a gap in the reporting of COVID-19 outbreaks.
As can be seen, the infection rate remained low between 29 August 2021 and 4 December 2021. Almost all weeks (85%) recorded zero or less than five new cases linked to outbreaks in homelessness services, with those in homelessness settings representing a notably small proportion of all weekly reported cases amongst vulnerable groups. By far the highest number of cases (n = 43) was reported during the week ending 6 March 2021 - reflecting overall trends of high rates in the community - yet this only accounted for 25% of the total number of cases amongst other populations deemed to be particularly ‘at risk’ during this period.

Data from the Health Protection Surveillance Centre (HPSC) indicate that there were 39 reported COVID-19 outbreaks in homelessness facilities between 1 March 2020 and 16 March 2021, a majority of which (n = 28) were recorded during the third wave of the pandemic (Lima, 2021). A total of 222 confirmed COVID-19 cases and four COVID-related deaths were linked to these outbreaks between 1 December 2020 and 16 March 2021 (Lima, 2021), which stands in stark contrast to the estimated 19 deaths that were predicted to have occurred if services and practices in the homelessness sector had remained unchanged in the COVID-19 context (O’Carroll et al., 2021).

These figures are likely explained by the fact that a number of public health and health system measures were quickly undertaken at the outset of the COVID-19 pandemic in Ireland, starting in March 2020. Following the appointment of a clinical lead to steer the homelessness COVID-19 response, and due to the high risk of transmission in congregate emergency accommodation, a set of guidelines and recommendations were developed by the HSE Social Inclusion Division and sent to local authorities. This resulted in: 1) a reduction of beds - primarily for adults unaccompanied by children - to provide more space for service users and staff; 2) the transfer of individuals from supported temporary accommodation to private emergency accommodation; and 3) the closure of three facilities to comply with public health advice (Kelleher & Norris, 2020).

In response, approximately 450 new emergency beds in hostels and a further 670 in hotels and single occupancy accommodation were sourced (Kelleher & Norris, 2020). Accommodation to allow isolation of positive and suspected cases was rapidly obtained by the Dublin Region Homeless Executive (DRHE) and staff were funded by the HSE (Corey et al., 2022). The extent and nature of this extra capacity facilitated both ‘shielding’ (or ‘cocooning’) for those who were identified as vulnerable due to age or medical condition as well as isolation for positive and suspected cases. Close contacts of COVID-positive cases were placed in quarantine and the immediate identification and testing of symptomatic homeless people was implemented.

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The spike amongst those residing in homelessness services that occurred on 6th March 2021 is likely a direct reflection of a significant rise in infections that occurred in the general population during this period.

It is the authors’ understanding that these individuals were/are not considered ‘housed’ and still feature as ‘homeless’ in official statistics for the duration spent in these newly sourced accommodations.
(Lima, 2021). It was reported, for example, that 750 service users (out of a total of 4173 accessing emergency accommodation in Dublin) were tested by early June 2020 (Corey et al., 2022; O’Carroll et al., 2021).12

Other measures put in place to protect adults and children in emergency accommodation included visitor restrictions in homelessness services and all ‘one-night-only’ bookings being replaced with long-term bookings to prevent frequent movement between facilities. All emergency beds in the Dublin Region were also provided on a 24-hour basis, with no requirement for service users to vacate the premises during the day, and those experiencing rooflessness or ‘street’ homelessness were offered emergency accommodation via outreach teams (Kelleher & Norris, 2020).

The HSE provided ‘enhanced and priority access’ to COVID-19 vaccines for those experiencing homelessness and it was planned that by the end of June 2021, those affected by addiction or living in direct provision centres would be prioritised irrespective of age or medical conditions (HPSC, 2022). In Dublin, people with substance dependencies were also ‘fast tracked’ in terms of being enrolled in methadone maintenance programmes or opiate substitution therapy (OST) along with voluntary agency staff being authorised to collect treatment on the behalf of those isolating or shielding (Corey et al., 2022). Notably, as a result, the wait to commence OST reduced from 12-14 weeks to 2-3 days and among the small number of service users engaging in OST, greater provision of Benzodiazepine and availability of Naloxone was also reported (O’Carroll et al., 2021).

The homelessness public health response to COVID-19 enacted and steered via the health system moved quickly. In doing so, previously existing barriers to speedy placement in secure, single-occupancy emergency accommodation as well as OST were removed and ultimately the incidence of COVID-19 among individuals experiencing homelessness was much lower than expected.

### Emergency Accommodation Trends in the COVID-19 Context: The Impact of Public Health Measures Enacted via the Housing System

Alongside Ireland’s COVID-19 response in health and homelessness service settings, emergency measures also contained provisions related to rental housing. This primarily included moratoriums on rent increases and terminating tenancies in private rental, local authority or AHB accommodation.13 These measures were introduced for a three-month period on 27 March 2020 under The Emergency Measures in the Public Interest (Covid-19) Act 2020 and were subsequently extended until 1 August 2020, following which the Residential Tenancies and Valuation Act 2020 came into effect. This new legislation prohibited rent increases for tenants who had not been financially impacted by COVID-19 and protected against eviction only in cases where tenants were experiencing rent arrears due to COVID-19 (e.g., loss of employment). The rent freeze ran until 12 January 2022, following extensions brought in under subsequent legislation.

Additional measures under the Residential Tenancies Act 2021 were introduced on foot of Ireland’s second and most extensive lockdown in October 2020, during which time restrictions were placed on travel outside of a five-kilometre radius of one’s residence. This legislation - which ended on 13 April 2021 but will automatically apply in any and all future level 5 lockdowns - stipulated that tenants in private rented and AHB housing were not required to vacate their property during the emergency period, with the exception of specific breaches of tenant obligations (e.g., anti-social behaviour). Local Authorities were similarly asked by the Department of Housing not to terminate long leases who passed the six-month threshold in rental housing were able to acquire security of tenure under the Residential Tenancies Act 2004 during this time.

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12 COVID-19 testing policies were determined by the HSE and HSP under the guidance of NPHET and were consistent across vulnerable groups and settings. For example, in September 2020, in line with the recommendations of NPHET, a comprehensive programme of COVID-19 testing started across all accommodation centres housing asylum seekers and refugees in Ireland.

13 ‘One-night-only’ accommodation requires individuals and families to find new accommodation every day but only after they have demonstrated to their local authority that they are still ‘homeless’.

14 Ahern and Roy (2020) note that it remains somewhat unclear whether tenants in year-long leases who passed the six-month threshold in rental housing were able to acquire security of tenure under the Residential Tenancies Act 2004 during this time.
tenancies except in cases of ‘severe’ anti-social behaviour on the part of tenant(s).

Figure 1 presents the total number of adults accessing State-funded emergency accommodation in Ireland between April 2014 and December 2021, by region. The data demonstrate that the number of adults accessing emergency accommodation had been increasing almost every month since April 2014 before peaking at 6697 in January 2020; that is, immediately before the first wave of COVID-19 began in March. From this point on, an initially sharp and subsequently steady reduction in the number of those residing in homelessness services is observed. By May 2021, the total number had fallen to 5843 - its lowest level since July 2018 - representing an overall decrease of 7% since emergency measures were put in place.

Figure 1
Total Number of Adults Accessing State-funded Emergency Accommodation in Ireland (April 2014 – December 2021), by Region.

Apart from a slight uptick that coincides with more limited protections for tenants being implemented in August 2020, the downward trend continued following the reintroduction of enhanced measures for renters during the second lockdown in October and remained relatively steady until April 2021, when the eviction ban was lifted. In the following 5-month period between May 2021 (n = 5843) and October 2021 (n = 6317), the number of adults accessing EA increased by 8%, or 474 individuals, almost returning to pre-COVID levels.

Figure 2 presents these data by household composition. As seen, adults with and without accompanying children followed a relatively similar trajectory from December 2014 until mid-2018, when the number of families in emergency accommodation appeared to slow and stabilise (albeit remaining at very high levels upwards of 2000), while adults unaccompanied by children remained on their upward trend. Most strikingly, however, is the divergence that occurred between the two groups following the introduction of emergency measures in March 2020.

These data show that the number of families accessing emergency accommodation plummeted, dropping sharply from 2322 in February 2020 to 1334 in March 2021; a decrease of almost half (42%) in just over a year. By contrast, the number of adult-only households continued to rise during this period, reaching an all-time high of 4763 in November 2021 and representing an increase of 69% since these data

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15 It is worth noting that these emergency accommodation patterns may have been further impacted by migration with a significant number of singles and families entering the country and moving immediately into homelessness services, hence the presentation of new households into emergency accommodation even during the period of enhanced tenancy protections. Dedicated research and analysis in this area would be of interest.
were first collected in December 2014 (n = 2310). Critically, adults with children recorded their first monthly increase since February 2020 in April 2021 - directly following the eviction ban being lifted - and have been steadily rising ever since, standing at 1788 in November 2021.

Figure 2

*Total Number of Adults Accessing State-funded Emergency Accommodation in Ireland (December 2014 – December 2021), by Household Composition*

It is likely that these trends are partially explained by the enhanced rates of exits via social housing tenancy offers and greater availability of HAP and the homeless HAP. Citing DRHE reports, Lima (2021) notes that 264 new HAP tenancies were created in 2019 for those exiting emergency accommodation, while 640 were created in 2020, representing an increase of just under 150%. In relation to social housing, it was reported at the September Housing Strategic Policy Committee Meeting that Dublin City Council had ‘front-loaded’ homeless lettings for the year to protect vulnerable households and older people experiencing homelessness and that lettings would have to be subsequently ‘rebalanced’ later in the year (Reidy, 2021). This suggests that a majority of all housing allocations available to those experiencing homelessness were made in the first half of 2020.

Figure 3 presents data on the number of net new entries to emergency accommodation and exits to tenancies amongst adults with children in Dublin. The apparent impact of emergency measures is evident. A notable decrease in the number of new presentations occurred at the outset of the pandemic, falling from 80 in February 2020 to 14 in April 2020. However, by August 2020, these numbers had almost returned to levels observed immediately prior the pandemic (n = 78) before once again demonstrating a gradual and mostly downward trend. This may be due, in part, to the fact that Ireland experienced a brief reduction in rent inflation at the beginning of the pandemic, followed by rapidly accelerating advertised rents during 2021; by late 2021, market rents for available properties were escalating at more than 8% (Pawson et al., 2022).

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16 This increase may be partly influenced by an upgrade of the PASS system from July 2021 onwards, which recategorised children in families over the age of 18. It is also important to note that seasonal decreases are often evident during the Christmas period when families tend to exit emergency accommodation to spend this time with family members or friends.
This period also saw three ‘spikes’ in exit patterns throughout 2020 - including February (n = 146), May (n = 140) and November (n = 116) - potentially aligning with ad hoc social housing allocation ‘boosts’. On the other hand, there was a marked increase in the number of new presentations in April 2021 when the eviction ban was lifted, that was immediately followed by a marked decrease in the number of exits in May 2021 (when it is possible that the pattern of social housing lettings reverted to type). This has resulted in the number of new entries surpassing those leaving emergency accommodation for the first time during the pandemic as of September 2021.

Discussion

The analysis presented here indicates the significant public health impact of emergency COVID-19 measures from both a health and homelessness perspective. Public health interventions implemented in the housing and homelessness systems, such as eviction bans and the relocation of those accessing emergency accommodation into single occupancy housing with key health-related supports, appears to have helped to protect against the spread of the virus amongst homelessness populations while also contributing to the reduction of homelessness presentations during COVID-19. This holds critical policy implications since it supports the prioritisation of housing-led solutions to address both homelessness and its health-related consequences. Moreover, it is clear that existing networks between Government, the HSE, voluntary homelessness organisations and local authorities also enabled the “rapid, effective response” that prevented widespread outbreaks and deaths in homelessness services and settings (Crowley & Hughes, 2021, p. 4). International evidence on the success of housing-led programmes such as Housing First\(^\text{17}\) indicates that this kind of synergistic multi-agency approach to address homelessness via the provision of both housing and health-related supports, can reduce non-routine health service use and improve the health and housing status of those at the most extreme end of marginalisation; that is, individuals experiencing long-term homelessness with severe mental ill-health, substance dependencies and/or chronic health problems (Baxter et al., 2019). A key component of the HSE National Social Inclusion Office’s plan to address the health needs of those experiencing long-term homelessness, for example, is to

\(^{17}\) Housing First provides early access to housing in conjunction with intensive health and social care supports as needed amongst those experiencing long-term and recurrent homelessness. Within the Housing First approach, as originally developed by Sam Tsemberis (2010), housing is viewed as a human right, not a privilege that must be earned through demonstrating ‘housing readiness’.
provide health services to support the national implementation of Housing First, with long-term funding of 4 million (EUR) also being allocated to improve these programmes as well as mental health services and integrated care plans (Government of Ireland, 2021).

This represents some important progress; however, the findings suggest that the public health measures implemented during the pandemic in Ireland also seem to have had a significant impact on macro-level homelessness trends. Different ‘layers’ to Ireland’s COVID-19 homelessness response were revealed, suggesting that while homelessness interventions enacted via the health system successfully protected against spread of infection in congregate settings and addiction services, broader measures enacted via the housing system - such as increased tenancy protections and social housing allocations - impacted different populations in different ways. Most strikingly, the data show that although these interventions led to an overall reduction in the number of adults in emergency accommodation, this downward trend was driven by fewer families residing in homelessness services while the number of adult-only households continued to rise.

These observations dovetail with a substantial evidence base that locates the causes of family homelessness in structural forces linked to dysfunctional public and private housing systems (Long et al., 2019; Walsh & Harvey, 2015) as well recent research that suggests that approximately 90% of family homelessness in the Irish context would be quickly resolved with immediate access to secure housing with or without supports (Parker, 2021). That the number of adult-only households did not experience the same downward trend following the introduction of public health measures for renters suggests that these individuals may have been ‘couch surfing’ and living in situations of ‘hidden’ homelessness that broke down, perhaps due to people seeking to reduce their social contacts during the pandemic. Moreover, since the eviction ban did not include those who were evicted on the grounds of anti-social behaviour, it could be the case that those entering emergency accommodation under such circumstances could have had high and complex needs - associated with domestic violence, substance dependencies or mental ill-health, for example - and/or be experiencing the long-lasting effects of complex trauma (Hopper et al., 2010). Which is to say, that those in the most vulnerable living situations may not have enjoyed the protections afforded by the public health measures implemented in the rental sector.

It is perhaps unsurprising that COVID-19 has unearthed many inequalities in health and housing systems across countries and exposed weaknesses “that continue to marginalize the already vulnerable” (Desjarlais-deKlerk, 2021, p. 80). However, when it comes to homelessness specifically, the pandemic has arguably brought “into clearer focus an already existing problem with already existing solutions” (Owen & Matthiessen, 2021, p. 156). It could be argued that the pandemic has highlighted our ‘poverty of ambition’ when it comes to dominant and prevailing shelter-led policy responses (Parsell et al., 2021) which can, in fact, cause greater harm - both in terms of one’s physical and mental wellbeing - as well as prolonged experiences of homelessness, in some cases (Parker, 2021). As such, Ireland’s pandemic response has provided compelling evidence, if more were needed, that the solution to most homelessness (and its health-related consequences) is housing, whether this comes in the form of prevention (including increased tenancy protections), rapid re-housing solutions or Housing First approaches (Keenan et al., 2020). Affordable, appropriate and secure housing that is widely accessible not only limits the transmission of COVID-19, but also bolsters the health and well-being of entire communities.

All of this suggests that any large-scale health system reform that aims to target those experiencing homelessness in the COVID-19 context must ensure that interventions and models of care address key determinants of health and health inequalities, including housing and effective responses to homelessness, alongside social distancing and social isolation measures to reduce exposure to health risks (Desjarlais-deKlerk, 2020). Even more significantly, the findings highlight the need to bring homelessness, housing and health solutions ‘into conversation’ with each other to ensure that the combined impact of these policy interventions is greater than the sum of its parts (Ranmal et al., 2021). From this perspective, the ongoing design and roll-out of health reform
underpinned by public health responses in the Irish case represents a unique window of opportunity for health decision-makers to develop shared policy goals and processes with those in the homelessness and housing sectors (Department of Health, 2021). This is because Sláintecare provides an opportunity to implement reforms that can cut across all these fields to not only promote stability post-COVID-19, but to also ‘future-proof’ for crisis-events thereafter. As Desjarlais-deKlerk (2020: 80) points out “even once COVID-19 becomes less of a concern, global society remains vulnerable to pandemics and widespread illness”. By fostering interaction between these policy areas by way of “bidirectional communication and active collaboration”, there is potential to integrate services and systems in a way that reduces health inequalities and improves health outcomes for those experiencing homelessness in the longer-term (Doran & Tinson, 2021, p. 53).

As Ireland moves out of the management phase of the COVID-19 crisis into the recovery and preparation stage, attempts should be made to incorporate this way of ‘thinking’ about how health intersects with housing into policy discourse more broadly in order to fully align with public policy aims and the key tenets of Sláintecare, specifically. In other words, one could argue that the policy goals of Sláintecare should not simply refer to the provision of accessible care to those experiencing homelessness, but also acknowledge that residential stability will be necessary to enable them to access (and receive) care effectively and to ensure health equity is both achieved and sustained over time.

**Conclusion**

Ireland’s pandemic response has demonstrated that governments can, in fact, implement the broad-brush policy responses necessary to stem exponentially rising homelessness rates and reduce blockages in homelessness service systems, even if only temporarily. Moreover, despite a low rate of infection occurring in homelessness service settings, pragmatic responses - alongside well-coordinated actions by health services, homelessness organisations, and local authorities - saved lives and ensured that those without a secure place to live were protected from the virus (Corey et al., 2022; Crowley & Hughes, 2021; O’Carroll et al., 2021). These successes merit recognition in their own right; however, the long-term impact and continuation of these interventions after the pandemic remains unclear.

Health practitioners as well as homelessness organisations and service providers have recommended that the public health responses to homelessness implemented during COVID-19 should be retained. This argument is strengthened by the fact that we are already starting to see regression in the gains made as the housing system, in particular, reverts to type. Yet insofar as safe, affordable housing protects the public health and well-being of all citizens, “only politics and political will can make that level of inclusion and physical protection a reality” (Desjarlais-deKlerk, 2020: 80). Parsell et al. (2021: 11) suggest that this requires the reframing of homelessness as an issue intrinsic to public health rather than individual actions or ‘shortcomings’. This research, however, presents another potential route for countries undergoing large-scale health reform: to reframe access to housing as being fundamental to public health and universal health systems that seek to meaningfully tackle health inequalities.

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