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European Homelessness and COVID 19

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The report also draws on a range of other resources, including FEANTSA’s own data collection, analysis by the Deputy Director, Ruth Owen, and inputs from the Director, Freek Spinnewijn. As always, the work of EoH presented here benefits from Mike Allen’s (Focus Ireland) input and comments. Sources from outside Europe are also used in trying to understand and consider the possible long-term effects of COVID-19 on homelessness and housing exclusion as the pandemic continues to unfold.

People working in homelessness services across Europe also supported the research at an extremely challenging time. Our sincere thanks are due to all those who contributed both directly and indirectly to this report.

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March 2021.

¹ Pleace, N., Baptista, I., Benjaminsen, L. and V. Busch-Geertsema (2020) *Staffing Homelessness Services in Europe* (Brussels: FEANTSA). https://www.feantsaresearch.org/public/user/Observatory/2020/comparative_studies/Feantsa-Studies_10_v02.pdf

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Foreword

The Corona crisis is a difficult period for everyone, but especially for people who are homeless, who are amongst the most vulnerable in European society. People experiencing homelessness can be more at risk because some groups, especially those experiencing long-term and repeated homelessness, often have underlying health conditions. People experiencing street homelessness and in emergency shelters can experience difficulties in self-isolating, entering lock down, and following other recommended preventative measures to keep safe. People living in temporary accommodation may face challenges around overcrowding.

There are insufficient facts and figures available for in-depth research on the impact of the Coronavirus on homelessness. However, data are now emerging, and because of the urgency of the situation, we still wanted the European Observatory to do an initial analysis of how the pandemic affects people experiencing homelessness, the services they use, and the policies to support them. We also asked the Observatory to explore possible future scenarios. You can read the results of this work in this report.

The analysis focuses on the initial wave of the pandemic but also takes account of more recent developments. There are many reasons to be concerned about the current state of homelessness policies, especially in light of a pandemic. But there are also reasons to be hopeful. Several European countries have managed to get most people experiencing street homelessness off the street into safe accommodation in record time. In many countries, night-only shelters transformed into 24/7 shelters and more single occupancy rooms have been made available. It will be important to sustain these small steps of progress after the pandemic. We also see a momentum to transition to housing-led and Housing First approaches to homelessness. The Corona-crisis made abundantly clear that access to adequate and affordable housing is the best protection against the virus, and that housing people experiencing homelessness is the most logical public health intervention.

We hope that this paper will help policy makers at local, national, and European level to rethink the way they address homelessness, and to be prepared when the next pandemic hits Europe.

I would like to thank the members of the Observatory for their input and Nicholas Pleace for coordinating this piece of research and drafting the paper.

I wish you all an interesting read.

Kjell Larsson.

President of FEANTSA

March 2021

Summary

- The COVID-19 pandemic has been causing modifications in responses to homelessness across Europe for just under one year at the time of writing. The situation is fluid, with levels of infection shifting and being met by alterations in plans, policy, and practice. This report describes a situation in which the pandemic is ongoing and the extent and nature of any long-term effects on European homelessness remains uncertain.
- The information presented here is the result of a rapid review, drawing on the experience, contacts, and knowledge of the authors and the other relevant data and reports that could be found. This report should be read as an attempt to bring together what is currently known about the still emergent consequences for homelessness from the pandemic.
- In common with OECD countries, almost all European Member States have introduced some form of eviction ban in response to the pandemic. Various policies, including furlough arrangements and enhancements to social protection, are also enabling people who might otherwise lose housing as a result of unemployment to retain their homes. These policies are temporary.
- Some emergency shelter services have been closed because they were ‘shared air’ services in which people lived and slept in communal areas. Others have been modified. One response has been to change shelters into a ‘quarantined’ services to prevent external infection. This has involved changing shelters from overnight to 24-hour operation, only allowing residents out under strict rules, and not allowing in new residents who exhibit potential symptoms and/or have a positive test. Expansion of existing shelter provision, allowing existing services to enact social distancing (e.g. halving bedspaces), and enabling people experiencing street homelessness to move off the street has also been widespread.
- When the virus has taken hold in a ‘shared air’ service the effects have sometimes been severe, with extremely high infection rates. However, several Member States, including Denmark, Germany, Hungary, Ireland, and Portugal, were initially successful in containing infection rates among people experiencing homelessness. In some cases, the nature of service provision, for example a tendency to provide people experiencing homelessness with their own rooms rather than use shared sleeping areas, facilitated containment of the virus. During the first wave, the UK was also largely successful in containing the virus

among people experiencing homelessness, closing a relatively small number of ‘shared air’ services in a context in which many services offered people their own rooms and there was relatively high use of housing-led/Housing First services using ordinary housing.

- The pandemic led to a number of interventions, sometimes using hotels or additional emergency accommodation and temporary accommodation – or some combination of arrangements – that took significant numbers of people experiencing street homelessness off the streets. On a temporary basis, the ‘complex’ problem of street homelessness was largely and rapidly stopped. While there were still operational problems and, sometimes, an ongoing absence of a clear strategy to prevent an eventual return to the streets, there were also reports of gains in wellbeing and health as people who had been experiencing street homelessness were moved into hotels.
- Countries using temporary supported accommodation that offers people their own rooms/apartments and homelessness strategies that lean towards, or are focused on, housing-led/Housing First responses to homelessness appear to have been inherently more resilient in their capacity to manage the pandemic, because those systems meant self-isolation and maintaining lockdown was less complex. This said, there was also evidence of innovative, flexible, and imaginative thinking, alongside strong personal dedication from staff in ‘shared air’ services, that kept these systems up and running – and infection rates among people experiencing homelessness down – in extremely challenging circumstances across several EU Member States.
- The viability of ‘shared air’ services has been brought into further question by the ongoing effects of the pandemic. Following a lead from the highly successful Finnish strategy, several Member States are moving toward increasingly housing-led/Housing First strategies, Ireland and Portugal being among the examples. Some comparisons between the UK, which has moved away from the provision of emergency shelters using a ‘shared air’ approach, and the USA, where ‘shared air’ services are in widespread use, have shown the UK has markedly lower levels of infection.
- In the UK, Australia, and elsewhere, commentators have drawn attention to public health concerns, rather than concerns about homelessness, driving new and significant, albeit generally temporary, interventions that have significantly reduced the number of people experiencing street homelessness and emergency shelter use. Effectively reclassifying homelessness as a public health issue has provided momentum for policy change that has reduced levels.

- The impacts of the pandemic on women's homelessness remain uncertain at the time of writing. There is global, alongside pan-European evidence, of an increase in domestic abuse, which acts as a major trigger of homelessness among women and family homelessness, the latter disproportionately involving lone women parents with dependent children, across Europe. This is an area where policy responses have lagged behind those for people experiencing street homelessness and using emergency shelter.
- It is uncertain how far and how fast homelessness might rise following the lifting of various emergency and temporary measures introduced in response to the pandemic. There is the possibility that some EU Member States and other European countries will simply 'switch off' specific measures at a given point, ending eviction bans and extra support for people experiencing street homelessness in an unplanned way, leading to sudden, perhaps significant, spikes in homelessness. However, much depends on how these policies are wound down and, as appears to be the case for a few EU Member States, whether the pandemic has prompted a wider re-think of homelessness policy, prompting reorientation towards more integrated housing-led/Housing First strategies that are likely to produce sustained falls in homelessness.
- The pandemic has highlighted wider questions of housing exclusion across Europe. Beyond homelessness, it is clear that people who are badly housed, often within socially and environmentally degraded built environments, are at significantly higher risk from the virus.

Introduction

In the Spring and Summer of 2020, when some of the initial work on this publication was being done, the immediate crisis arising from the SARS-CoV-2 virus and coronavirus disease (COVID-19) seemed to be lessening. Lockdowns across much of Europe had reduced the infection rate and containment through modification and regulation of public behaviour, until the point at which vaccines arrived, was looking feasible. The situation had changed rapidly by the end of 2020, a combination of increasingly relaxed social controls and more infectious mutations of the original virus led to new lockdowns. At the time of writing, mass vaccination is underway, but these programmes are unevenly distributed and the extent and speed at which they may contain the virus is unclear. The economic and social effects of COVID-19 look set to be profound, but as the crisis is ongoing, assessing the nature and extent of these impacts and other new challenges, including the treatment and support needs of people experiencing ‘long-COVID’,¹ is not yet possible.

COVID-19 has acted as a lens that has highlighted the nature and extent of housing exclusion and homelessness in Europe. The spatial concentration of both infection and death in areas of social and economic disadvantage – in which people are badly housed – experiencing overcrowded homes and overcrowded environments, without the living space, gardens, and green space that more affluent Europeans take for granted, has been repeatedly shown.² Within this, it is also clear that ethnic and cultural minorities who are more likely to live in socially, environmentally, and economically degraded places in Europe, which again meant poor, overcrowded, housing conditions, were also more likely to catch COVID-19 and to die from it. Those parts of the European population who are badly housed, in areas experiencing multiple forms of deprivation, are most at risk from the virus.³

¹ “Long covid” is a term being used to describe illness in people who have either recovered from covid-19 but are still report lasting effects of the infection or have had the usual symptoms for far longer than would be expected. See Mahase, E. (2020) Covid-19: What do we know about “long COVID”?, *BMJ* 370: m2815

² Bambra, C., Riordan, R., Ford, J. and F. Matthews (2020) The COVID-19 pandemic and health inequalities, *Journal of Epidemiology and Community Health* pp.1–5. doi: 10.1136/jech-2020-214401

³ Marmot, M. and Allen, J. (2020) COVID-19: exposing and amplifying inequalities, *Journal of Epidemiology and Community Health* 74(9) pp.681-682.

COVID-19 has had a devastating effect on some people experiencing homelessness, but has also seen some European countries put a new level of resources and political will into preventing new homelessness and attempts to end living on the street. Evidence from around the World has shown that when the virus entered communal homelessness services – that is emergency shelters and other facilities with shared sleeping space and living space, which exist in different forms but are characterised by ‘shared air’ – the effects are frightening, with examples of massive levels of infection. In France, infection rates in some ‘shared air’ emergency shelters have been reported to be between 23% and 62%, while rates of 17%, 36%, and 66% have been reported in some US emergency shelters.⁴ By contrast, Europe has also seen eviction bans designed to help stop new homelessness from occurring and, through the use of hotels and other emergency accommodation, to ensure people were not living on the street, and thus not able to create a safe space. In some countries, these interventions have come close to getting almost everyone living on the streets in sheltered accommodation, with some evidence of wider benefits to their wellbeing, health, and chances of exiting homelessness.⁵

As the effects of the virus continue, questions are arising about the extent, duration, and end results of what were originally thought of as relatively short-term, emergency interventions to prevent and reduce homelessness. A major aspect of homelessness and housing exclusion, people living in situations of extreme overcrowding, such as two families and/or two or more other households occupying living space designed for a smaller group of people, has continued unabated in Europe.⁶ Debates about what exactly constitutes ‘hidden’ homelessness continue⁷, but it is evident that less attention has been paid to people living within housing without privacy, legal security, physical security, or control over their own living space, than to people experiencing

⁴ Pleace, N. (2021) *Minimising the impact of COVID-19 on people sleeping rough: an overview of UK and global responses* (blog) <https://covidandsociety.com/minimising-impact-covid-19-people-sleeping-rough-overview-uk-global-responses/>

⁵ Lewer, D., Braithwaite, I., Bullock, M., Eyre, M.T., Aldridge, R.W., Story, A. and A. Hayward (2020) *COVID-19 and homelessness in England: a modelling study of the COVID-19 pandemic among people experiencing homelessness, and the impact of a residential intervention to isolate vulnerable people and care for people with symptoms* (medRxiv) <https://www.medrxiv.org/content/10.1101/2020.05.04.20079301v1.abstract>; Harrison, J. (2020) *Manchester Emergency Accommodation Evaluation: Interim Report* (Riverside) https://www.riverside.org.uk/wp-content/uploads/2020/06/Riverside_MCREmergency_Accommodation_FINAL.pdf

⁶ Foundation Abbé Pierre – FEANTSA (2020) *Fifth Overview of Housing Exclusion In Europe 2020* FAP/FEANTSA https://www.feantsa.org/public/user/Resources/resources/Rapport_Europe_2020_GB.pdf

⁷ Pleace, N. and Hermans, K. (2020) Counting All Homelessness in Europe: The Case for Ending Separate Enumeration of ‘Hidden Homelessness’ *European Journal of Homelessness* 14(3) pp.35-62.

street homelessness. This is despite the ever increasing evidence that overcrowding, and within that, a lack of control over living space, is strongly associated with greater rates of COVID-19 morbidity and mortality.

The long-term effects of the pandemic on homelessness are uncertain. Much of the OECD, alongside EU Member States, has introduced eviction bans, provided additional emergency shelter, and increased welfare payments on a temporary basis.⁸ Some of these interventions, depending on how they are structured and also on how long they last, could have a lasting effect on levels of homelessness. However, basic structural problems linked to homelessness, particularly lack of adequate, affordable homes with reasonable security of tenure, cannot be rapidly addressed. The Netherlands is investing €200 million in new accommodation, providing some 10 000 supported housing units⁹ moving to a housing-led/Housing First approach, which is similar to Finnish strategies. England has also announced significant extra spending, some €270 million¹⁰, but having successfully cleared the streets of people living on the street, using hotels, and other temporary accommodation with the 'Everyone In' programme, there is evidence that it has not yet put in place the infrastructure, nor the affordable, secure homes to provide a properly supported route out of living on the streets.¹¹ In some other European countries, as this report describes, emergency responses around shelters and other service provision for people experiencing street homelessness remain in place. Short-term measures that were designed on the assumption there would be a fairly rapid 'reset' to existing practice are becoming longer term interventions.

As vaccination accelerates, questions about access for people experiencing homelessness are starting to be asked. Some countries are prioritising some people experiencing homelessness at the highest risk for vaccination, i.e. living on the street or in emergency accommodation, one example being Denmark.¹² Hungary has also prioritised social workers working with people experiencing homelessness. After many months of variations in practice, a UK risk assessment algorithm for the National Health Service used to prioritise access to vaccines included people experiencing homelessness.¹³ Some other European countries, at the time

⁸ Pleace, N. (2021). op.cit.

⁹ https://www.feantsa.org/public/user/Observatory/2020/conference/COVID19_OBS_FINAL.pdf

¹⁰ <https://www.gov.uk/government/news/extra-covid-protections-for-rough-sleepers-and-renters>

¹¹ Neale, J. (2021) *Experiences of Being Housed in A London Hotel as Part of the 'Everyone In' initiative Part 2: Life in The Month After Leaving the Hotel* (London: KCL). <https://osf.io/x73am/>

¹² <https://www.bloomberg.com/news/articles/2021-01-19/homeless-danes-to-get-early-vaccination-in-eu-s-fastest-program>

¹³ <https://digital.nhs.uk/coronavirus/risk-assessment>

of writing, are prioritising other groups, such as older people and those with pre-existing conditions, without yet announcing any specific provisions for people experiencing homelessness.

Despite widespread, evidence broadly linking housing exclusion, overcrowding, and degraded built environments with higher COVID-19 morbidity and mortality, poorly housed populations do not, as yet, appear to be being prioritised by any European country. The European Region of the World Health Organisation took the view that people experiencing homelessness were at heightened risk from the virus in the Summer of 2020, noting that:

People experiencing homelessness are medically high-risk and frequently have poorer physical and mental health than the general population. People experiencing homelessness are often exposed to substandard environmental conditions; experience problems accessing health care and basic services, and may live close to environmental or contamination hotspots and/or in dwellings made from nondurable materials.¹⁴

WHO Europe argued that access to test and trace systems, treatment, vaccination, and basic support should be organised on the basis that people experiencing homelessness were a group at heightened risk. This is in common with many national level strategic responses in Europe, and a wider tendency within health policy and research to equate ‘homelessness’ with people living on the street, in emergency shelters, and/or in encampments, rather than the wider definition that encompasses people experiencing homelessness, such as extreme overcrowding and highly precarious living situations, within housing.

Questions around how quickly people experiencing homelessness will be vaccinated and how specific challenges, such as ensuring second injections for people whose homelessness is associated with high and complex needs, including severe mental illness and addiction, are still open at the time of writing. As this report notes, earlier experience at the beginning of the pandemic saw some homelessness service providers struggling to access the personal protective equipment (PPE)¹⁵ they needed and having to improvise their own responses to COVID-19. The degree to which homelessness strategies will be developed, modified and integrated with the public health strategies to stop the virus will be crucial in deter-

¹⁴ https://www.euro.who.int/__data/assets/pdf_file/0005/458780/homelessness-COVID-19-factsheet-eng.pdf

¹⁵ Masks, sanitiser, physical barriers, and other support/material to reduce the risk of transmission and create/modify facilities to enable self-isolation where needed.

mining how effectively Europe is able to prevent and reduce homelessness and reduce the dangers of mass contagion among people experiencing, or at risk of, homelessness.

This report is a mixture of some rapid research conducted within the home countries of the members of the European Observatory on Homelessness, FEANTSA's data collection on COVID-19, news from both mass and social media, and new research being produced by academics, policy researchers, and other analysts. Unlike other reports produced by the European Observatory on Homelessness, it is not based on a single data gathering exercise using standardised research instruments and a shared conceptual framework. An attempt has been made to cover as much ground as possible, to include the most recent sources, and to consider what we know about the challenges and opportunities for preventing and reducing European homelessness that will arise as Europe and the wider World try to bring the pandemic under control and then to understand and manage the economic and social consequences. The report does not constitute research in the orthodox sense, nor is it presented as such, it is an attempt to capture the state of play around COVID-19 and homelessness at a European level and to try to make some informed guesses about what the challenges ahead will look like and how we might best meet them.

The first section of the report looks at the management of COVID-19 by the homelessness sector, detailing some of the challenges and the ways in which they have been met and the problems that have arisen when the risks could not be fully addressed. The second section looks at new policies and practices that have resulted from COVID-19, including eviction bans and attempts to greatly reduce or end sleeping on the street. The third section examines prevalence, impact on public health systems, and arrangements for access to treatment and vaccination. Finally, the fourth section looks at some of the emergent issues in homelessness linked to the pandemic and considers what the key lessons for preventing and reducing homelessness might be.

1. Adapting Homelessness Services

1.1 Introduction

This first section explores how homelessness services responded to COVID-19. As with other sections in this report, it is assembled from multiple exercises which took place at different points during the pandemic. The section begins with an overview of how emergency shelters responded to the pandemic and the challenges they faced, this is followed by sub-sections on fixed-site supported housing and housing-led/Housing First programmes, concluding with what could be gathered on other forms of homelessness services.

1.2 Emergency shelters

The design, operation, and support of emergency shelter services varies across Europe. European countries tend to all have at least some service provision that offers shared sleeping areas, food, and access to varying types and levels of support. It is common for these sorts of services to be available overnight, but not during the day. However, the term ‘emergency shelter’ can encompass services with markedly different forms of operation and resource levels.¹⁶

In some countries, one example being Slovenia, emergency shelters are part of the social care and welfare system, run and regulated by municipal social services. In other examples, such as Greece and Italy, emergency shelter is often run by charitable organisations, including major faith-based charities, that operate in several European countries. In some countries, such as Denmark, emergency accommodation and temporary accommodation can be contained within the same service. In Denmark, these forms of homeless accommodation form the majority of services (except for some very low threshold emergency services with communal sleeping spaces) and usually provide relatively intensive support, in most cases also offering someone their own private bedroom and being open all day. By contrast, in much

¹⁶ Pleace, N., Baptista, I., Benjaminsen, L. and V. Busch-Geertsema (2018) *Homelessness Services in Europe* (Brussels: FEANTSA). https://www.feantsaresearch.org/public/user/Observatory/Feantsa-Studies_08_v02%5B1%5D.pdf

of Central, Eastern, and Southern Europe, emergency shelters form the bulk of service provision; these services are more likely to take the form of ‘shared air’ services with communal sleeping space and to be closed during daylight hours.¹⁷

The available evidence indicates four main responses to COVID-19 from emergency shelter services:

- Quarantining of ‘shared air’ services, closing the provision to new residents, and/or screening new residents before admission while allowing services that usually open only at night to remain open all day.
- Partial closure of some areas, e.g. communal spaces within emergency shelter offering people their own bedrooms and/or modification of internal space; e.g. creating one-way systems to avoid ‘pinch points’ where people would usually pass each other in corridors or on staircases.
- Reducing resident numbers in ‘shared air’ services to enable people to self-isolate and observe local lockdown protocols. This is generally combined with physical modifications to reduce risk within existing services and the creation of additional, temporary, shelter capacity and keeping emergency shelters that usually only operate in the winter months open all year, allowing resident numbers to be reduced.
- Shutdown and replacement of ‘shared air’ services with alternative arrangements that enable residents to self-isolate and observe local lockdown protocols, for example shutting down an emergency shelter with shared sleeping areas and moving residents into individual hotel rooms.

Taking Budapest, where the bulk of service provision is emergency accommodation with shared areas, as an example, several tactics have been employed to try to manage COVID-19. Initially, the main strategic responses were:

- Keeping some of the winter-only emergency shelter services open.
- Opening further temporary emergency shelter provision.
- Internal rearrangement of services to reduce risks, for example bringing the number of bedspaces down. The number of admitted people was reduced to a maximum of approximately 60% of usual numbers and the positioning of beds was changed. Other measures included creating ‘boxes’ or small clusters of residents who lived together in a shared space, who do not mix with other groups of residents.

¹⁷ As above.

- Changes to administrative practices, as there are usually both referrals to emergency shelters and the option for people living on the street (or at risk of doing so) to queue up outside services, which then provide beds on a first come, first served basis. This was modified so that emergency shelters shifted to working through referral only.
- Emergency shelters entered a state of quarantine, not allowing new admissions and/or monitoring new admissions carefully and asking people staying in emergency shelters to minimise the frequency with which they left the building (with someone being asked to leave the service if they kept going in and out).

While additional emergency shelter capacity was opened in Budapest, outreach/ street social workers were requested not to bring people experiencing street homelessness to emergency shelters and to concentrate on ensuring people experiencing street homelessness were clothed and fed. The daycentres used by people experiencing street homelessness, that is daytime services that provided food, shelter from the weather, and services, were also closed, because all used large communal spaces. There have been attempts to manage this, offering take away/ take-out food and trying to modify operations to stay open.

German homelessness service provision is more often in the form of supported housing in which residents have their own rooms or small apartments. Emergency shelter provision was however extended in some cities, with Berlin renting additional hostel space containing 200 beds, with rooms containing no more than two people. As in Budapest, some existing emergency shelter provision that usually operates only at night have remained open throughout the day. There were examples of shelters that closed their doors to people with no local connection¹⁸ to an area, which is illegal in Germany, while others reduced bed spaces and turned people away. Larger cities were most likely to provide additional emergency shelter beds.

Similar provisions were made in Denmark, with winter-only emergency shelters remaining open and additional capacity being made available. In March 2020, central government organised extra accommodation for people experiencing homelessness by prolonging existing winter emergency accommodation to the end of April, keeping open approximately 120 beds. The winter emergency accommodation could also be accessed by migrants, including people with no permanent residence in Denmark.

¹⁸ See: Baptista, I., Benjaminsen, L. and N. Pleace (2015) *Local Connection Rules and Homelessness in Europe* (Brussels: FEANTSA). https://www.feantsaresearch.org/download/feantsa-studies_05_web7437249621511918755.pdf

Danish practice broadly mirrored that reported in Hungary with regard to emergency shelters. ‘Shared air’ services in Copenhagen were remodelled to reduce the risk of close interaction between people using them, spaces between beds were increased, and physical barriers were introduced. This was in addition to providing additional, temporary shelter beds to enable shelters to reduce the number of people they were accommodating.

In Portugal, the main response to the pandemic was to significantly increase emergency shelter provision, within the context of a National Homelessness Strategy that aims to work toward a more housing-led response to homelessness (see Section 2). Emergency shelters remained open, with guidance on operational practice during the pandemic being issued by the National Health Authorities, which in summary, covered the following:

- Promoting frequent symptom screening;
- Ensuring physical distance;
- Ensuring that people’s basic needs are met;
- Ensuring frequent cleaning and disinfection of spaces;
- Promoting regular ventilation of indoor areas;
- Promote training and self-care among users;
- Promoting awareness on the need for isolation;
- Creating adequate spaces for isolation/quarantine situations; and
- Promoting the reduction of contacts to essential activities only.

Modifications have also been made to Irish emergency shelters that have ‘shared air’ spaces. Communal areas within services where people in residence had their own bedrooms have been modified or closed, and services in which sleeping areas were shared also focused on reducing physical proximity. People who were in higher risk groups, for example because of being over 60 and/or due to the presence of underlying conditions, were moved into single occupancy accommodation so that they could be shielded/cocooned from infection. As in Hungary, ‘shared air’ services had their capacity reduced, with some residents being moved elsewhere, in order to facilitate social distancing.

Test and trace systems were used to identify and isolate anyone who had been in close contact with someone infected with COVID-19. In Dublin, a number of congregate services were also closed when social distancing measures were not practical to implement or adaptation would take too long, this was alongside the reduction

in bedspaces in services that remained open. Dublin lost some existing 500 beds, mainly in services for adult-only households, with the provision of alternative arrangements in private facilities to counteract this loss of beds.

The UK has relatively few 'shared air' services. As for the last three decades, municipal commissioning of homelessness services has shifted to smaller scale supported housing provision, working by referral, offering residents their own rooms, and greater use of housing-led approaches.¹⁹ Emergency shelters, provided via the No Second Night Out programme²⁰ in England and through local, charitable, faith-based organisations, using shared sleeping areas are still in use. They are designed with a triage function, i.e. to provide immediate shelter for people experiencing street homelessness, but with an ultimate goal to move them onto supported housing or housing-led/Housing First services. However, these 'shared air' services were all closed, with the 'Everyone In' programme using self-contained temporary accommodation and (mainly) hotel rooms being brought in as an alternative for people experiencing street homelessness and/or at risk of doing so (see Section 2).

Questions were raised by some parts of the homelessness sector about the sustainability of keeping all the 'shared air' emergency services closed. One concern was that the No-Second Night Out infrastructure of emergency shelters has been replaced with the COVID-19 response in England. This means those becoming newly homeless and ending up on the streets do not have those services available, which might sometimes mean worse outcomes. There is also the question around sustainability, as while positive outcomes have been achieved through the 'Everyone In' programme, it is heavily reliant on hotel rooms being available and a more sustainable, COVID-19 resilient, approach is needed.

The earlier 2020 research from the European Observatory on Homelessness (EoH) on staffing and homelessness services in Europe²¹ showed similar patterns of response in Belgium, where in Brussels emergency shelters remained open but with this testing in place and operating at a reduced capacity to try to manage the risk of infection. The Czech Republic created additional shelter capacity to facilitate social distancing and Italian service providers also introduced social

¹⁹ Blood, I., Pleace, N., Alden, S. and S. Dulson (2020) *A Traumatised System: Research into the commissioning of homelessness services in the last 10 years* (Leicester: Riverside). https://eprints.whiterose.ac.uk/165214/1/A_Traumatised_System_FULL_REPORT_v8_webFINAL.pdf

²⁰ <https://www.homeless.org.uk/our-work/campaigns/policy-and-lobbying-priorities/no-second-night-out-campaign>

²¹ Pleace, N., Baptista, I., Benjaminsen, L. and V. Busch-Geertsema (2020) *Staffing Homelessness Services in Europe* (Brussels: FEANTSA). https://www.feantsaresearch.org/public/user/Observatory/2020/comparative_studies/Feantsa-Studies_10_v02.pdf

distancing measures within existing emergency shelters. The Netherlands also closed ‘shared air’ services where distancing could not be introduced and expanded provision, as did Spain.

1.3 Fixed site supported housing

As noted, there is not an exact line between what constitutes an emergency shelter and what is defined as supported housing in Europe. Broadly speaking, fixed site supported housing, in which at least several people are resident in the same building which also has on-site staffing, either all day and night, or during part of the day, is designed to be longer term and, for people experiencing homelessness, is usually designed to make someone ready for living in independent housing.²²

As these forms of homelessness services tend to offer individual bedrooms to residents and, in the North West of Europe, including the UK, can also offer small, self-contained apartments, they have tended to remain open. Modifications like those reported for emergency shelters have been introduced, such as closure or alteration of communal areas and shared spaces, like corridors and staircases, to avoid close contact were developed, alongside systems for isolating someone who was thought to be infected and their close contacts (see Section 3). This was the case in Denmark, Germany, Ireland, and Portugal.

In the UK, some major homelessness sector providers of supported housing, usually operating multiple types of services under commission from several municipalities and tending to work on a regional and/or national basis, reported that physical modification of services had been practical. These organisations were large enough that concerns about staffing – when support and administrative staff were in ‘at risk’ groups and had to be sent home or to work from home – could be handled by moving staff between services. Support was moved to telephones and online, with services buying phones when someone did not have one and providing other support, e.g. televisions and computer games if someone had to self-isolate in their room/apartment in a supported housing project. Smaller and mid-size supported housing providers, with lower financial reserves and smaller staff pools, found this kind of adaptation more difficult.

Where residents were in communal apartments within supported housing, e.g. 3-5 bedrooms organised around a shared bathroom and kitchen, service providers created ‘social bubbles’, which like the ‘box’ arrangements in Hungarian emergency

²² Pleace, N., Baptista, I., Benjaminsen, L. and V. Busch-Geertsema (2018) *Homelessness Services in Europe* (Brussels: FEANTSA). https://www.feantsaresearch.org/public/user/Observatory/Feantsa-Studies_08_v02%5B1%5D.pdf

shelters, did not mix with people from outside that group. Some closures, for example when supported housing had some shared bedrooms, have also occurred. This was handled through the use of hotels and other temporary accommodation; there were also cases of supported housing projects which had partially shut, closing down those elements of the service where social distancing was not possible. Admissions and departures were reported as being much more carefully managed than usual.

Earlier 2020 research from EoH on staffing and homelessness services in Europe²³ showed similar patterns elsewhere in Europe. In Finland, supported housing services went into quarantine. This included restricting visits to a congregate Housing First services where residents have their own self-contained apartments in one apartment block, but this was described as a radical decision.

1.4 Housing-led and Housing First services

Social distancing questions did not arise for housing-led and Housing First services that use a combination of mobile support and ordinary housing scattered across communities. The two challenges that have been widely identified are:

- Providing support when someone using housing-led/Housing First services has to self-isolate and to stay at home.
- Finding safe ways to provide one-to-one support.

This experience was similar across several countries, with most reporting a shift to support by telephone and, to a lesser extent, online communication through social media and teleconferencing software. Services were in different positions with regard to the extent to which they could supply telephones/smartphones or tablets/computers to someone who did not have one. In Denmark, for example, telephone-based support in many cases replaced face-to-face support in floating support services, provided to people in their own housing, during the lockdown period.

In Portugal, Housing First services have been modified in various ways. One change has been to facilitate people at heightened risk from the virus staying at home, for example by providing food parcels. When taking on new service users, Housing First also had to ensure that everything in a new home was in place at once, because someone, once moving in, needed to be able to stay at home on a sustained basis.

²³ Pleace, N., Baptista, I., Benjaminsen, L. and V. Busch-Geertsema (2020) *Staffing Homelessness Services in Europe* (Brussels: FEANTSA). https://www.feantsaresearch.org/public/user/Observatory/2020/comparative_studies/Feantsa-Studies_10_v02.pdf

Both Portugal and Germany have modified practice for housing-led/Housing First by allowing meetings between support workers and people using the services to take place outside and in other socially distanced forms, rather than moving support entirely to the telephone and/or online. In Portugal, visits to people at home, with workers and the people being visited being equipped with PPE were still being used, but at a reduced frequency. In both countries, meetings are more carefully planned than was usual prior to the pandemic to ensure that the right social distancing and other precautionary measures were in place. Irish practice has again been similar, modifying working practices to enable social distancing and support isolation and remaining at home where needed.

In the UK, larger providers of Housing First services are able to manage pressures on staffing by redeploying people from other services when gaps in staffing appeared. As in Denmark, support has been largely shifted to telephone communication, though there is also use of social media and teleconferencing apps. One major provider reported that a high proportion of people using Housing First were without a telephone and had to be provided with one. As in Portugal, food parcels and other support are provided to encourage people to stay at home or when they have to self-isolate.

The earlier 2020 research from EoH on staffing and homelessness services in Europe²⁴ showed similar patterns elsewhere. Italian services included examples of support, designed around a therapeutic community model of residents and staff using the same service, that were shifted online.

1.5 Daycentres and other services

Information on food distribution and other services for people experiencing homelessness, such as daycentres, which provide shelter, food, and varying levels of support during the day was more limited. Sometimes these services are not part of a formal homelessness strategy or commissioning and are run by small organisations, including local community and faith-based groups.

In England, there are reports that some smaller, voluntary, community and faith-based services that operated with very low budgets and even lower margins, have collapsed, while others have gone into suspension, as anything that works in using a 'shared air' space, such as one or more large rooms, cannot operate. The Hungarian experience, in relation to Budapest, was also that day centres were

²⁴ Pleace, N., Baptista, I., Benjaminsen, L. and V. Busch-Geertsema (2020) *Staffing Homelessness Services in Europe* (Brussels: FEANTSA). https://www.feantsaresearch.org/public/user/Observatory/2020/comparative_studies/Feantsa-Studies_10_v02.pdf

typically closed for the same reason. At the same time, as night-shelters were operated on 24 hour basis, with residents not being allowed to pursue their regular daily activities outside the shelters, such as going to work or to soup kitchens for meals, shelters had to organise in-facility food provision for clients. As all schools and kindergartens were also locked down, the public kitchen capacity of the municipality of Budapest, which normally serves education and childcare facilities, was available to provide all shelters with cooked meals, and further resources were also drawn upon to cover all food needs.

The situation with food distribution is uncertain. Some groups that supply food on the street may still be able to function, dependent on local regulations and the degree to which they are able to protect staff, volunteers, and the people approaching them for help. In other cases, as in England, much of the street-using population has been temporarily accommodated in places, particularly hotels, in which meals or food parcels are being provided, removing much (though not necessarily all) of the immediate need for these activities.

2. New Services and Policies

2.1 Introduction

This section looks at the development of new homelessness services and policies in direct response to homelessness. The first subsection looks at eviction bans and other preventative services, the second explores interventions designed to end, or greatly curtail, street homelessness. The third subsection examines initiatives intended to reduce homelessness, including systems being built to stop a return to previous levels of homelessness when COVID-19 emergency interventions, which are temporary in nature, come to an end.

2.2 Eviction ‘bans’

The different administrative areas of the UK have all introduced measures around eviction. The Government in England reports that the applications to the courts for possession (eviction) by private and social landlords were down by 86% between July and September 2020, compared to the same period in 2019. No repossessions of owner occupied housing were recorded between April and the end of September 2020 in England, compared to 14 847 in the same period last year.²⁵ Like England, Wales has introduced extended timelines around eviction. Eviction orders were banned at the start of the first lockdown in March 2020 and the notice period landlords must give extended from three to six months.²⁶ Scotland has introduced a temporary ban on eviction orders, which at the time of writing, has just been extended.²⁷ Northern Ireland, like Wales, has extended the timelines around eviction procedures, passing legislation that will apply while the pandemic continues.²⁸ The Financial Conduct Authority (FCA), which regulates the financial sector operating in the UK, has ordered that homeowners whose income has been affected by the pandemic have until 31 March 2021 to apply for a payment break on their mortgage, with existing payment deferrals to run until

²⁵ <https://www.gov.uk/government/news/extra-covid-protections-for-rough-sleepers-and-renters>

²⁶ <https://gov.wales/eviction-during-coronavirus-pandemic>

²⁷ <https://www.gov.scot/news/eviction-ban-extended/>

²⁸ <https://www.communities-ni.gov.uk/news/minister-hargey-strengthen-protections-private-renters>

31 July 2021.²⁹ By some estimates, hundreds of thousands of people will be at risk of losing their homes when these bans are lifted as the economic effects of mass unemployment linked to COVID-19 are felt.³⁰

In Portugal, data collected in 2018 by the Institute for Housing and Urban Rehabilitation (IRHU) showed that there were about 25 000 families struggling to meet housing costs, concentrated in the Lisbon and Porto regions, which had the highest rents in the country. Mass unemployment from the pandemic is generally expected to increase the number of families in this position, thus increasing the number of people at risk of losing their homes. Legislation was introduced in March 2020 to minimise some of the housing related consequences of the pandemic. These include Article 8 of Law no. 1-A/2020 which introduced a *de facto* suspension of evictions, originally scheduled to end on 30 September 2020 and later extended to the end of June 2021.

Article 4 of Decree-Law 10-J/2020 introduced a moratorium allowing the suspension of the payment of instalments on bank loans, particular home loans. By the end of April, the banks had received almost 570 000 requests for a moratorium, 90% of which were approved. As in the UK, these arrangements are a break or pause in mortgage payments, i.e. a postponement rather than cancellation of payments. It is also the case in both Portugal and the UK that any suspension of rent paid to a social or private landlord is also a postponement, not a cancellation of housing debt. In Portugal, rather than the use of individual agreements, a specific law sets the parameters around when rent arrears might be permitted (Law no. 4-C/2020), which applies when a household loses 20% or more of its income compared to the same period in the previous year. Financial support is also provided to landlords who have lost significant income due to rent arrears, in the form of interest free loans, which are also available to tenants in need of financial help. Initial reports are that these mechanisms have not been widely used.

In Ireland, the 'Emergency Measures in the Public Interest (COVID-19)' Act, 2020 came into force at the end of March 2020. This legislation prohibited evictions from either social or private rented housing and also allowed tenants to stay in their housing even if an eviction notice had been served prior to the period covered by the law. A rent freeze was also introduced, and the initial eviction moratorium was extended in July 2020. At the time of writing, The Residential Tenancies and Valuation, Act 2020, which came into effect on 1 August 2020 had been protecting tenants experiencing rent arrears due to COVID-19 from eviction and rent increases

²⁹ <https://www.fca.org.uk>

³⁰ https://england.shelter.org.uk/media/press_release/230000_renters_at_risk_of_covid-eviction_when_government_ban_lifts

until 10 January 2021. The protection was specific, eviction was only banned for that reason, while eviction for other reasons could still go ahead.

When a second lockdown was imposed in Ireland in October 2020, another act, the Residential Tenancies Act, 2020 put in place temporary restrictions which meant tenants in the private rented and social rented sectors were not required to vacate their rental properties during an ‘Emergency Period’ (from 21 October to 1 December 2020), except for anti-social behaviour or damage/risk to the housing they are renting. These provisions are automatically extended alongside any extension of lockdown arrangements. Local Authorities, which also provide social housing, were asked by the Department of Housing not to terminate any of their tenancies for any reason, other than severe cases of anti-social behaviour. It has been reported that the initial ban on terminating tenancies and the rent freeze contributed to a sharp decrease in the number of new presentations to emergency accommodation, particularly for families.

Looking across experience in the UK, Portugal, and Ireland, the latter have issued more qualifications and limitations on eviction ‘bans’ while the UK introduced broader – albeit also temporary – measures. Experience in Denmark has been rather different. There has not been a freeze on evictions during the pandemic. The National Government has urged public housing organisations to avoid evicting people due to rent arrears during the pandemic where possible and to work on finding realistic solutions and repayment agreements with households in arrears. However, in practice the extent to which these measures are adopted has been determined by public housing organisations.

Germany initially ‘froze’ court cases for evictions for rent arrears if they were caused by a tenant’s income loss due to the pandemic. The freeze was only from April to June 2020 and gave the tenants a long period to repay rent arrears caused by the pandemic in that period, but the extent of rent arrears due to the pandemic was not reported as being very high.

In Hungary, one of the first responses was the prolongation of the eviction moratorium, which had been running since March 2020. In addition, there is a repayment moratorium on housing loans, upon individual request, with broad availability during the first wave of the pandemic in early 2020, and which continued to be available with some minor restrictions in the second wave from Autumn 2020. Further, municipal rents have been frozen, or reduced, in order to minimise tenant rent arrears.

Research looking at the global response to the pandemic, published in the Spring of 2020, suggests that the use of eviction ‘bans’ of various sorts was very widespread in Europe and beyond. Another widespread measure was the use of financial

support to owner occupiers who were still paying a mortgage but had lost income or employment due to the pandemic.³¹ At the time of writing, it is not clear how widespread these interventions were or how many are still in place, recent spikes in infection has caused many temporary interventions to be renewed or extended.

2.3 Ending street based homelessness

The reaction to people experiencing street homelessness in some European countries, as the true nature and extent of the pandemic rapidly became apparent, was unprecedented. There were sudden, resource-intensive attempts to clear the streets of people living there.

One example was the English ‘Everyone In’ policy, which came close to – temporarily – ending a large element of people experiencing street homelessness with 72 hours, by using hotels and temporary accommodation, which was presented as compassionate, but was driven by other concerns.³² The potential risks from a mobile, highly infected, population who, when they had been experiencing street homelessness for some time or on a repeated basis were very likely to have underlying medical conditions that placed them at greater risk of death, to each other, to the public health system, and to the general population, were seen as too high.

With the English ‘Everyone In’ policy, some 15 000 people were placed into emergency accommodation, mainly in hotels, with approximately 5 000 being accommodated in London alone. Within the hotels, a tier system was put in place³³:

- COVID Care hotels (accommodating people testing positive for, or displaying and reporting symptoms of, the disease).
- COVID Protect hotels (accommodating people who were asymptomatic but considered most vulnerable to the disease because of their age or underlying health conditions).
- COVID Prevent hotels (accommodating people who were asymptomatic and deemed less vulnerable to COVID-19).

³¹ Kholodilin, K. A. (2020) *Housing policies worldwide during coronavirus crisis: Challenges and solutions*, DIW focus, No. 2, Deutsches Institut für Wirtschaftsforschung (DIW), Berlin

³² Lago, C. (2020) The fleeting ambition of “Everyone In” exposes England’s rough sleeping blindspot *New Statesman* 22 December 2020 <https://www.newstatesman.com/politics/uk/2020/12/ fleeting-ambition-everyone-exposes-england-s-rough-sleeping-homeless-blindspot>

³³ Neale, J. (2021) *Experiences of Being Housed in A London Hotel as Part of the ‘Everyone In’ initiative Part 2: Life in The Month After Leaving the Hotel* (London: KCL). <https://osf.io/x73am/> https://kclpure.kcl.ac.uk/portal/files/136655170/Neale_et_al_Homeless_Hotel_Study_part_1_October_2020.pdf

The tier structure did not really come into play as the clearance of the streets and the emptying of ‘shared air’ services seems to have happened rapidly enough to mean that almost all the people who had been experiencing street based homelessness, or who were at risk of it, were not infected. It has been estimated that, alongside other measures, ‘Everyone In’ may have reduced the potential for infection, hospitalisation, and mortality among people experiencing street homelessness and experiencing other forms of homelessness significantly (see Section 3).³⁴

Initial reports have shown benefits to health and wellbeing, as people who had been experiencing street based homelessness benefitted from having a stable environment where it was comparatively easy for health and support services to reach them.³⁵ Anecdotal evidence from the homelessness sector has supported the findings of this initial research, with reports of improvements in wellbeing linked to access to regular, healthy food, sanitation, and private living spaces. Mental health and drug and alcohol services were easier to reach for some people once they were visiting groups who had been placed in hotels. One recent report from a major London service provider notes the following³⁶:

- *Gains associated with safe, secure and clean accommodation, with meals provided. The use of self-contained accommodation reduced the risk of transmission of Covid-19 and helped ensure people could self-isolate if needed.*
- *Having support workers on site to help people follow public health guidance, manage any issues with their accommodation and cope with complex problems related to their homelessness, such as drug and alcohol and mental health problems.*

³⁴ Lewer, D., Braithwaite, I., Bullock, M., Eyre, M.T., White, P.J., Aldridge, R.W., Story, A. and Hayward, A.C. (2020). COVID-19 among people experiencing homelessness in England: a modelling study. *The Lancet Respiratory Medicine* 8(12) pp.1181-1191. <https://www.thelancet.com/action/showPdf?pii=S2213-2600%2820%2930396-9>

³⁵ Harrison, J. (2020) *Manchester Emergency Accommodation Evaluation: Interim Report* (Riverside) https://www.riverside.org.uk/wpcontent/uploads/2020/06/Riverside_MCREmergency_Accommodation_FINAL.pdf; Neale, J. *et al.* (2020) Experiences of Being Housed in a London Hotel as Part of the ‘Everyone In’ Initiative Part 1: Life In The Hotel London: KCL: https://www.researchgate.net/publication/346931657_EXPERIENCES_OF_BEING_HOUSED_IN_A_LONDON_HOTEL_AS_PART_OF_THE_%27EVERYONE_IN%27_INITIATIVE_PART_1_LIFE_IN_THE_HOTEL

³⁶ St Mungo’s (2021) *Housing and health: Working together to respond to rough sleeping during Covid-19* (London: St Mungo’s). <https://www.mungos.org/publication/housing-and-health-working-together-to-respond-to-rough-sleeping-during-covid-19/>

- *The close involvement of health services to provide support and healthcare in the emergency accommodation where people were staying. This support has been provided regularly and consistently, and from a position of understanding the full extent of an individual's support needs, rather than trying to treat related problems separately.*
- *The triage, assess and cohort model which ensured people were grouped on the basis of their clinical vulnerabilities and medical needs, including separate accommodation for people with Covid-19 symptoms. This reduced the risk of infection and allowed focused medical support to be provided – the benefits of which extended beyond maintaining people's immediate welfare during the pandemic. Stretched health services could be targeted at concentrated populations of people who needed them the most.*

There are, however, also reports of anxiety about what will happen when these temporary arrangements come to an end and, as time went on, breakdowns in the hotel arrangements are being reported for small numbers of individuals with high and complex needs. Boredom has also been reported as an issue, reflecting the general experience of the UK population, in being largely confined indoors for long periods during the pandemic. Underlying risk factors for people experiencing street homelessness remain an issue, in a context in which 'Everyone In' did not, entirely, clear the streets³⁷, while people experiencing homelessness who live on the streets on a repeated or sustained basis, tend to have very high rates of underlying conditions that place them at greater risk from COVID-19.³⁸

Responses from the homelessness sector to 'Everyone In' were positive, because a very rapidly introduced policy greatly reduced people experiencing street based homelessness with near-immediate effect, and because it combined a sudden, positive shift in environment, often with clearer and easier access to support. It also generated gains in health and wellbeing. The concerns were centred on sustainability and building effective pathways from the hotels and other temporary accommodation into settled housing, minimising the risk that a 'reset' when the hotels ceased to be available, returned many people to the street. However, the concerns about basic structural problems, including deep cuts to homelessness sector budgets over the last decade, alongside the marked and chronic shortfalls in affordable housing supply across much of the UK, were not being addressed. This is seen as inherently limiting the capacity to move people who had been experi-

³⁷ <https://www.gov.uk/government/statistics/rough-sleeping-snapshot-in-england-autumn-2020/rough-sleeping-snapshot-in-england-autumn-2020>

³⁸ St Mungo's (2021) *Housing and health: Working together to respond to rough sleeping during Covid-19* (London: St Mungo's). <https://www.mungos.org/publication/housing-and-health-working-together-to-respond-to-rough-sleeping-during-covid-19/>

encing street based homelessness, or at risk of it, who were now staying in hotels, into a settled home. The longer the ‘temporary’ solution of using hotels was employed, the greater the risk, so some homelessness service providers thought that progress made by some people with high and complex needs might start to be lost (see below). The Government, by contrast, has presented the policy as a considerable success, claiming ‘Everyone In’ had, by November 2020, supported some 33 000 people with nearly 10 000 in emergency accommodation and over 23 000 already moved on into ‘longer-term’ accommodation.³⁹

‘Everyone In’ was seen by some homelessness service providers as facilitating support at levels that were not always possible within ordinary services. One reason for this was that comparatively large groups of people experiencing street homelessness or at risk of doing so were grouped together in ways that made them easier to reach than usual for services like mental health and addiction support. Another reason was that the hotels continued to function with their existing staff handling day to day operation, this meant most of the logistics of physically running shelters or fixed site services were already being handled, freeing up staff time to focus on support.

Another response was cynicism. Some people in the homelessness sector viewed the presentation of a ‘humanitarian’ policy towards people experiencing street homelessness in the mass media as concealing a reality in which ‘Everyone In’ was primarily motivated by public health concerns, rather than a sudden Damascene conversion to ending street based homelessness. The contagion risk from people experiencing homelessness and the probability that some of them would be at greater risk of hospitalisation and death because of underlying conditions, increased potential pressures on an already underfunded and overstretched public health system.

Denmark also reacted to COVID-19 among people experiencing homelessness at a national level. Additional financial support was made available to provide additional emergency shelter capacity (see Section 1), alongside making use of hotel rooms that were empty because of the pandemic. As in England, hotels were attracted by the possibility of retaining an income from accommodating people experiencing homelessness while normal business was not possible.

In Germany, regional and city governments varied in whether or not there was an effort to end street based homelessness in response to the first outbreaks of the virus. Some Länder (regional governments), such as Baden Württemberg and Schleswig-Holstein, provided additional funding for municipal governments to finance additional temporary accommodation, alongside other services such as

³⁹ <https://www.gov.uk/government/news/extra-covid-protections-for-rough-sleepers-and-renters>

food provision. In Hamburg, the private sector gave a large amount of money (almost €450 000) to a voluntary organisation to rent hotel rooms for people experiencing street homelessness. About 170 persons were accommodated in single hotel rooms between April and June 2020, but this initial intervention was temporary as they had to leave when the hotels (temporarily) reopened for touristic purposes and the money was spent. A few other large cities have also rented hotel rooms, but to a minor extent, including Frankfurt and Düsseldorf.

Hungarian responses centred on modifications to emergency shelters and some additional provision of services as noted in the last section. There was not a major policy initiative within any area to end street based homelessness in response to the pandemic, although there were some exceptions in Budapest (see below).

Portuguese responses centred on providing additional emergency accommodation at some scale: 21 emergency accommodation services for people experiencing homelessness were opened across the country in Almada, Cascais, Braga, Espinho, Lisboa, Loures, Oeiras, Porto, Seixal, Setúbal, and Tavira. This often involved conversion of existing buildings, including sports halls. Shared apartments were also used in Oeiras (Lisbon region) and Tavira (Algarve region), alongside some use of tents in a campsite in Espinho (Northern Portugal). While this is an expansion of an existing model of shelter provision improvising services using existing buildings and sites, this is a national strategy with the intention of ensuring that emergency accommodation be available throughout the pandemic. Over 500 people were accommodated in emergency facilities almost overnight.

In late November 2020, in a week-long count, 139 unique individuals were encountered in Dublin by the statutory funded Dublin Simon Community Street Housing First Outreach Team. Data from Dublin shows that the majority of those experiencing street based homelessness also use emergency shelters. The number of unique individuals who were experiencing literal homelessness over the period of three-months and in contact with the Housing First Outreach Team increased slightly from 698 in quarter one (Q1) to 709 in Q2 and to 723 in Q3 2020. Those adults who were also accessing emergency accommodation dropped from over 80% in Q2 and Q3 2019 to 70% in Q2 and Q3 2020, suggesting that there were a not insignificant number of individuals who were experiencing street homelessness *only* during the first 3 months of the emergency measures to restrict the spread of COVID-19 and in the following quarter following the end of the first emergency period.

2.3.1 New policy responses to COVID-19

Some European countries are pursuing specific modifications to homelessness services and strategies to prevent and reduce homelessness as a direct result of COVID-19. This is distinct from temporarily adapting to the pandemic with the expectation that homelessness services and strategies will simply reset to their pre-pandemic form, assuming the virus is brought under control and/or ceases to be a widespread danger.

Denmark and Germany are not, as yet, taking a position in which fundamental reform to homelessness services and strategy is being envisaged as a result of COVID-19. It is important to contextualise these policy decisions, as both countries have relatively extensive, well-resourced homelessness services in overall terms (allowing that there is variation between regions and municipalities).⁴⁰ While there is still some use of ‘shared air’ services under normal circumstances, homelessness services quite often provide people with experience of homelessness with self-contained bedrooms or apartments and, although it is more the case in Denmark than Germany, housing-led and Housing First models; using ordinary or other self-contained housing are widespread. This meant that homelessness services and systems were, comparatively, resilient in the face of the pandemic, because social distancing could be handled by a homelessness sector in which ‘shared air’ services were not predominant.

Irish homelessness policy is undergoing a sustained process of moving toward a greater use of prevention and housing-led/Housing First services, meaning that reductions in ‘shared air’ services and some forms of congregate supported housing are already part of the national strategy.⁴¹ As in Denmark and Germany, the combination of specific, temporary interventions, as a direct result of the pandemic, plus a homelessness sector in which many services were not ‘shared air’, meant that existing systems were, again, relatively resilient in the face of the pandemic. As yet, there is no indication that medium to long term policy in relation to homelessness will be modified as a result of the pandemic.

In Ireland, the pandemic has the potential to act as an accelerant to shifts in policy and practice that are already underway. As is discussed in Section 4, the pandemic has also highlighted the barriers to strategic change and their consequences in a quite unprecedented way. The need for continuing in an already

⁴⁰ Pleace, N., Baptista, I., Benjaminsen, L. and V. Busch-Geertsema (2018) *Homelessness Services in Europe* (Brussels: FEANTSA). https://www.feantsaresearch.org/public/user/Observatory/Feantsa-Studies_08_v02%5B1%5D.pdf

⁴¹ Allen, M.; Benjaminsen, L.; O’Sullivan, E. and Pleace, N. (2020) *Ending Homelessness in Denmark, Finland and Ireland* (Bristol: Policy Press).

established policy direction being further highlighted by the pandemic does not, in itself, address various structural and political barriers that can slow down or impede homelessness strategy.⁴²

Portugal provides another example of a strategic response that will, over time, make homelessness systems and strategies more resilient to the risks of pandemic, but like Ireland, this strategy was in place before COVID-19 appeared. Strategic development around homelessness was moving towards Housing First programmes and other housing-led approaches, the effectiveness of which was increasingly recognised, and was already attracting new policy interest and public investment. The Portuguese Presidency for the Council of the European Union in 2021 is paying particular attention to designing common policies for the homelessness sector at EU level, reflecting the strategic intention to place the European Pillar of Social Rights, with a particular emphasis on Principle 19, on the European agenda:

Housing and assistance for the homeless:

- a) *Access to social housing or housing assistance of good quality shall be provided for those in need.*
- b) *Vulnerable people have the right to appropriate assistance and protection against forced eviction.*
- c) *Adequate shelter and services shall be provided to the homeless in order to promote their social inclusion.*⁴³

The Portuguese response has been a shift in public discourse towards accelerating the planned changes to strategy. An existing goal to end homelessness by 2023 has been reaffirmed, despite the additional challenges and costs resulting from the pandemic. Expansion of Housing First services and shared housing models at a national level are alongside plans to expand services and enhance homelessness support in Lisbon and other cities.

Modifications to homelessness policy as a result of COVID-19 have not necessarily occurred at a large scale. Taking the example of Budapest, an expansion of social housing provision for people with experience of homelessness was one result of the pandemic, securing 71 apartments that enabled older people in 'shared air' services to move to a less risky living environment. This created space in emergency shelters that, because they were operating in a modified form to facilitate social distancing, were already struggling to accommodate new people experiencing street homelessness. This kind of relatively small, but locally significant, modifica-

⁴² As above.

⁴³ https://ec.europa.eu/commission/priorities/deeper-and-fairer-economic-and-monetary-union/european-pillar-social-rights/european-pillar-social-rights-20-principles_en

tion in policy and practice is difficult to map at the time of writing, not least because the situation around the pandemic remains fluid, so that the ways in which individual service providers, municipalities, and regional governments are reacting remain in flux. In time, these kind of smaller adaptations and modifications to policies and procedures might turn out to be one of the main legacies of the response to COVID-19, many responses to homelessness at local level may change, and potentially change for the better, but it is not possible to guess at the nature or extent of any such change at present.

In England, there had been a sudden shift in policy. The problem of people experiencing street homelessness, so often presented as ‘complex’ and hence ‘difficult’ to resolve, using a very longstanding political narrative of ‘high and complex’ individual needs needing to be met, while the effects of multiple systemic failures across economy, society, and the State were downplayed⁴⁴ was suddenly addressed through increased public spending. ‘Everyone In’ very rapidly cleared the streets of people experiencing street homelessness and, for the most part, appears to have kept them in the hotels and temporary accommodation that was employed for the purpose. The specialist taskforce, set up to orchestrate the next phase, has been working with local authorities and the homelessness sector to ensure those accommodated through ‘Everyone In’ are helped into longer-term accommodation, with a stated goal that as few people as possible return to life on the streets.⁴⁵ This policy is radical because it undermines earlier government narratives that street based homelessness was a ‘complex’ social problem which was used to explain why levels were increasing, drawing attention away from expenditure cuts and other systemic drivers of street based homelessness and because the Government itself claims that it appears to be working⁴⁶.

The recipients of ‘Everyone In’ are receiving a mix of housing-led/Housing First support and access to adequate, affordable housing that would ensure that they did not, for the most part, return to the streets. Early results appear to have been mixed, in that while there has been an active attempt to provide settled housing, outcomes have not always been good.⁴⁷ Nevertheless, it is the case that extra spending has been made available, not just to provide emergency shelter in hotels and other temporary accommodation, but with the specific goal of stopping a return to street based homelessness.

⁴⁴ Anderson, I. (1993) Housing policy and street homelessness in Britain *Housing Studies* 8(1) pp.17-28.

⁴⁵ Cromarty, H. (2021) *Coronavirus: Support for rough sleepers (England)* House of Commons Briefing Paper Number 09057.

⁴⁶ <https://www.gov.uk/government/news/extra-covid-protections-for-rough-sleepers-and-renters>

⁴⁷ Neale, J. (2021) *Experiences of Being Housed in A London Hotel as Part of the ‘Everyone In’ initiative Part 2: Life in The Month After Leaving the Hotel* (London: KCL). <https://osf.io/x73am/>

Several concerns have been raised by the homelessness sector⁴⁸:

- That the arrangements under 'Everyone In' are temporary and that a return to lower levels of support for people experiencing street homelessness following the pandemic will mean that new people experiencing street homelessness, who will not be helped by 'Everyone In', will not see the same level of support, causing street based homelessness to again become recurrent and sustained in some cases and the potential for levels to rise again.
- That arrangements for undocumented migrants experiencing street based homelessness, who have been supported under 'Everyone In' are ambiguous.
- That sustained public spending cuts since 2010 have weakened the homelessness sector, undermining capacity in terms of the number of people it can support and the range of help that can be provided.
- That the deep, sustained shortage of adequate and affordable housing in much of the UK inherently limits capacity to provide sustainable routes away from street based homelessness and other forms of homelessness and also limits the effectiveness of preventative services.

England has been through a similar experience before. Sustained efforts and significant additional public spending from central government were directed at rising levels of people experiencing street homelessness from 1990 onwards. An intensification of resources saw levels of people experiencing street homelessness fall by 75% between 1998-2005.⁴⁹ This was followed, from 2010 onwards, by sustained and deep cuts to local authority budgets, which meant that significant cuts happened across the homelessness sector, which combined with reductions in welfare spending and other social protection, has been broadly associated with a spike in street based homelessness levels since that period.

⁴⁸ Cromarty, H. (2021) *Coronavirus: Support for rough sleepers (England)* House of Commons Briefing Paper Number 09057.

⁴⁹ Wilson, W. and Barton, C. (2020) *Rough Sleeping (England)* House of Commons Briefing Paper Number 02007, 9 April 2020.

3. Infection Management and Access to Health Care

3.1 Introduction

This section of the report explores the experience of managing COVID-19 infection among people experiencing homelessness across Europe, also looking at access to health care services. The first subsection briefly reviews evidence on morbidity and mortality, this is followed by a review of the management of health and wellbeing within homelessness services. Test and trace systems, access to health care, and vaccination are then discussed.

3.2 Prevalence

The prevalence of the virus can shift rapidly. Policy mistakes such as dropping lockdown conditions too fast or issuing unclear and partially contradictory sets of rules around when social mixing is allowed, have been associated with spikes in cases, as has an increased risk from the potentially more infectious variants that emerged in late 2020 and early 2021. Generally high prevalence might start to be reflected in levels of infection among people experiencing homelessness, but at the time of writing levels among people with lived experience seemed comparatively low in many European countries.

In Denmark, rates of infection among people experiencing homelessness were low during the first wave of the pandemic, within a context of what was also a quite low general infection rate across the general population. Yet, at the time of writing, there have been reports of local outbreaks of infection among people at risk of homelessness during a second wave of COVID-19 infections in early 2021.

In Hungary, very few deaths among people with experience of homelessness were reported during the first wave of COVID-19, with the situation unclear as a second wave began in November at a higher prevalence across the general population. The situation among people experiencing homelessness in Germany was unclear at the time of writing, but anecdotal evidence suggests that infection rates are comparatively low. Portugal too reported low prevalence of COVID-19 infection during the

first wave, but there were also concerns reported among some service providers that the *potential* for infection among people experiencing homelessness, using some services, was seen as high.⁵⁰

In Ireland, outbreaks of COVID-19 were not being reported in homelessness services toward the end 2020. There had been 14 outbreaks in total documented throughout 2020, which had involved 77 cases from January to November 2020, of whom less than five had required intensive care unit (ICU) hospital beds. Of the cases that had been documented, most were in Dublin.⁵¹ Anecdotal evidence in the UK indicated that the prevalence of COVID-19 was relatively low, which has been ascribed to quite rapid introduction of social distancing within services, a quite high proportion of which offered self-contained studio apartments or bedrooms or were housing-led/Housing First models. Three major homelessness providers, working at regional and national level, each reported a handful of cases among services that provided accommodation and support to several thousand people. Ongoing issues with the effectiveness and reach of ‘test and trace’ systems have meant that both prevalence within the general population and among people experiencing homelessness in the UK have been hard to assess with a high degree of accuracy. Recent, robust, statistical estimates at the time of writing do strongly indicate high prevalence across the whole UK population.⁵²

This picture was not a universal one. Within Europe and internationally, there is evidence that when the COVID-19 virus gets a foothold in ‘shared air’ homelessness services, in which social distancing either has not been introduced or can only be implemented in limited ways, or reaches other homeless populations in which social distancing is not possible, rates of COVID-19 infection can be astronomical.

Recent French research, which is yet to be peer reviewed, reports a prevalence of 426 infected people among a group of 818, who were using food distribution sites, emergency shelters, and workers’ residences (hostels) supported by Médecins sans Frontières (MSF) in Paris and Seine-Saint-Denis, which is an overall infection rate of 52%. Rates of infection were reported as being much higher on some sites than others, near-universal in workers’ residences (88.7%), while just over half of people (50.5%) living in emergency shelters were also infected, with much lower,

⁵⁰ Responses to questionnaires sent to the Local Homelessness Units (NPISA) coordinators.

⁵¹ Source: Health Service Executive (HSE) Health Protection Surveillance Centre <https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/surveillance/covid-19outbreaksclustersinireland/> cited in O’Sullivan, E. (2020) Op.cit.

⁵² <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/coronaviruscovid19infectionsurveypilot/8january2021>

but still high, rates among people using food distribution centres (27.8%).⁵³ Recent reports from Italy suggest that access to emergency shelter has fallen with the need to close some services and create social distancing in others and that mortality among people living on the street, from all causes, has increased.⁵⁴

Internationally, work in the US has reported very high rates in some emergency shelters, where, as in some parts of Europe, ‘shared air’ services are comparatively common. Infection rates have been reported as variable ranging between very few infections, to between almost one fifth (17%), over one third (36%), and a majority of people using homelessness services (66%).⁵⁵ An early analysis of the potential impact of COVID-19 estimated that very significant expenditure would be needed to provide the modifications and extra bedspaces needed to create sufficient social distancing within the ‘shared air’ emergency shelters and other services in the homelessness sector. Some 400 000 additional units to manage the COVID-19 pandemic for the estimated homeless population were thought to be required, at an annual cost of some €9.58 billion.⁵⁶ Australian researchers have also identified a need to remodel services if the threats presented by the virus to people experiencing homelessness are to be contained, alongside the dangers of infection from people with lived experience to the general population⁵⁷, which has directly motivated policy interventions like the English ‘Everyone In’ initiative (see Section 2). Where infection has not been detected at high prevalence at the time of writing, epidemiologists and health scientists are warning that any homeless service with ‘shared air’ presents a serious risk of COVID-19 infection.⁵⁸

⁵³ Roederer, T., Mollo, B., Vincent, C., Nikolay, B., Llosa, A., Nesbitt, R., Vanhomwegen, J., Thierry, R.O.S.E., Francois, A.N.N.A., Torre, C. and Fourrey, E. (2020) High seroprevalence of SARS-CoV-2 antibodies among people living in precarious situations in Ile de France (*MedRxiv*). <https://www.medrxiv.org/content/medrxiv/early/2020/10/09/2020.10.07.20207795.full.pdf>

⁵⁴ <https://www.theguardian.com/world/2021/feb/01/rome-covid-rough-sleeper-deaths-italy>

⁵⁵ Mosites, E., Parker, E.M., Clarke, K.E., Gaeta, J.M., Baggett, T.P., Imbert, E., Sankaran, M., Scarborough, A., Huster, K., Hanson, M. and Gonzales, E. (2020). Assessment of SARS-CoV-2 infection prevalence in homeless shelters—four US cities, March 27–April 15, 2020 *Morbidity and Mortality Weekly Report* 69(17) p.521.

⁵⁶ Culhane, D.P., Treglia, D., Steif, K., Kuhn, R. and T. Byrne (2020) Estimated Emergency and Observational/Quarantine Capacity Need for the US Homeless Population Related to COVID-19 Exposure by County; Projected Hospitalizations, Intensive Care Units and Mortality http://works.bepress.com/dennis_culhane/237/

⁵⁷ Parsell, C., Clarke, A. and Kuskoff, E. (2020) Understanding responses to homelessness during COVID-19: an examination of Australia *Housing Studies* (online first). DOI: 10.1080/02673037.2020.1829564

⁵⁸ Lima, N.N.R., de Souza, R.I., Feitosa, P.W.G., de Sousa Moreira, J.L., da Silva, C.G.L. and Neto, M.L.R. (2020) People experiencing homelessness: Their potential exposure to COVID-19, *Psychiatry Research* 288 p.112945; Barbieri, A., (2020) CoViD-19 in Italy: Homeless population needs protection *Recenti progressi in medicina* 111(5) pp.295-296.

The point that people experiencing homelessness might be at higher risk of dying from COVID-19 has been repeatedly asserted.⁵⁹ However, this is based on a particular idea of who people experiencing homelessness are, which stems from medical research often tending to equate homelessness only with people who are experiencing street homelessness or living in emergency shelters. Within some of this research, there has also been a tendency to collect data only at one point in time, which means people whose high and complex treatment and support needs – such as those who have both a severe mental illness and issues with addiction, who are more likely to be long-term or repeatedly homeless – can be over-sampled.⁶⁰

Both the focus on people experiencing street homelessness and in emergency shelters and the tendency to only collect data at one point in time, can make lone people experiencing homelessness appear more ill, with more pre-existing/underlying medical conditions, and thus more at risk from COVID-19, than is actually the case. Moreover, a tendency focus on individuals, rather than families⁶¹ and other households containing more than one member, also tends to skew the data collected on homelessness by some medical research.

However, this is not to suggest that there are not people experiencing homelessness at heightened risk from COVID-19. There are examples of European countries where people experiencing homelessness appear significantly more likely than the general population to have multiple, underlying conditions, such as Denmark⁶² or Finland⁶³. In addition, there is evidence that, even if actually a minority among

⁵⁹ Parsell, C., Clarke, A. and Kuskoff, E. (2020) Understanding responses to homelessness during COVID-19: an examination of Australia *Housing Studies (online first)*. DOI: 10.1080/02673037.2020.1829564

⁶⁰ O'Sullivan, E., Pleace, N., Bush-Geertsema, V. and Filipovič Hrast, M. (2020) Distorting tendencies in understanding homelessness in Europe: Methodologies, medicine and mental illness *European Journal of Homelessness* 14(3) pp.1-21.

⁶¹ Baptista, I., Benjaminsen, L., Busch-Geertsema, V. and Pleace, N. (2017) *Family Homelessness in Europe* (Brussels: FEANTSA). https://www.feantsaresearch.org/download/feantsa-studies_07_web3386127540064828685.pdf

⁶² Benjaminsen, L. and Birkelund, J.F. (2020) Explaining excess morbidity amongst homeless shelter users: A multivariate analysis for the Danish adult population, *Scandinavian Journal of Public Health* 48(4) pp.412-421.

⁶³ Y Foundation (2017) *A Home of Your Own: Housing First and ending homelessness in Finland* https://ysaatio.fi/assets/files/2018/01/A_Home_of_Your_Own_lowres_spreads.pdf

people experiencing homelessness, a group of repeatedly and long-term people experiencing homelessness with multiple morbidities are present in many European countries and, indeed, throughout the Global North.⁶⁴

Three other points are worth briefly noting:

- The evidence that the COVID-19 virus causes both more morbidity and mortality in populations characterised by socio-economic disadvantage is becoming very strong.⁶⁵ In particular, people living in situations of housing exclusion⁶⁶, i.e. overcrowding, insecurity, and poor conditions and in degraded environments, lacking green space and with crowded external space, are at a significantly greater risk from the virus. As is discussed in Section 4, these effects are so pronounced, alongside other evidence on other negative effects of degraded built environments and housing exclusion on health and wellbeing, as to raise questions about how ‘homelessness’ – in the sense of inadequate housing causing direct risks to wellbeing – should be defined in the wake of the pandemic.
- There is strong evidence that all services and environments which have ‘shared air’ represent a heightened risk of COVID-19 infection. Alongside some homelessness services, retirement communities, residential care, and other residential services for vulnerable and frail older people, in addition to other people with limiting illness and disabilities, expose people who are at a greater risk of dying and becoming seriously ill from COVID-19 to ‘shared air’ environments in which the virus will spread more quickly.⁶⁷

⁶⁴ Aldridge, R.W., Story, A., Hwang, S.W., Nordentoft, M., Luchenski, S.A., Hartwell, G., Tweed, E.J., Lewer, D., Katikireddi, S.V. and Hayward, A.C. (2018) Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis, *The Lancet* 391(10117) pp.241-250.

⁶⁵ In England, age-standardised mortality rate of deaths involving COVID-19 was 3.1 deaths per 100 000 population for the most deprived areas in July 2020; this was significantly higher than the 1.4 deaths per 100 000 population in the least deprived areas. Source: ONS <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19bylocalareasanddeprivation/deathsoccurringbetween1marchand31july2020> Similar results have been reported in Spain, see: Bambra, C., Riordan, R., Ford, J. and Matthews, F. (2020) The COVID-19 pandemic and health inequalities, *Journal of Epidemiology and Community Health* 74(11) pp.964-968 and the United States e.g. Hatef, E., Chang, H.Y., Kitchen, C., Weiner, J.P. and Kharrazi, H. (2020) Assessing the impact of neighborhood socioeconomic characteristics on COVID-19 prevalence across seven states in the United States, *Frontiers in Public Health* 8.

⁶⁶ <https://www.feantsa.org/en/news/2020/07/23/fifth-overview-of-housing-exclusion-in-europe-2020?bcParent=27>

⁶⁷ Gordon, A.L., Goodman, C., Achterberg, W., Barker, R.O., Burns, E., Hanratty, B., Martin, F.C., Meyer, J., O'Neill, D., Schols, J. and Spilsbury, K. (2020) Commentary: COVID in care homes—challenges and dilemmas in healthcare delivery, *Age and Ageing* 49(5) pp.701-705.

- The pandemic is fluid, there have been rapid shifts in how infectious the virus is and how easily it can spread. Risks have changed quickly and may do so again, meaning that some existing safety measures that have kept infection rates low among people experiencing homelessness may lose effectiveness. The virulence of COVID-19 cannot be overstated and there have been a great many instances in which populations with low infection rates of COVID-19 have seen very rapid transition to high morbidity and mortality.

3.3 Potential pressure on public health systems

There have been some early attempts at estimating the extent to which social distancing interventions have reduced infections among people experiencing homelessness. Focusing on the lone adult homeless population in England, using administrative data and estimates, one exercise reported that (for February to May 2020):

*In this first wave of SARS-CoV-2 infections in England, we estimated that the preventive measures imposed might have avoided 21 092 infections (19 777–22 147), 266 deaths (226–301), 1 164 hospital admissions (1 079–1 254), and 338 ICU admissions (305–374) among the homeless population.*⁶⁸

Another relatively early estimate, arguing for the immediate introduction of social distancing and other measures in the USA, reported in April 2020:

*We estimate that 21 295 people experiencing homelessness, or 4.3% of the U.S. homeless population, could require hospitalization at the peak infection rate of 40%, with a potential range from 2.4% to 10.3% hospitalizations.*⁶⁹

Another study suggests that, as of August 2020, New York had 25 times more laboratory confirmed cases of COVID-19 among people who would normally be living on the street or in emergency shelters than was the case in London.⁷⁰

⁶⁸ Lewer, D., Braithwaite, I., Bullock, M., Eyre, M.T., White, P.J., Aldridge, R.W., Story, A. and Hayward, A.C. (2020) COVID-19 among people experiencing homelessness in England: a modelling study, *The Lancet Respiratory Medicine* 8(12) pp.1181. Numbers shown in brackets are the range of estimates.

⁶⁹ Culhane, D.P., Treglia, D., Steif, K., Kuhn, R. and T. Byrne (2020) Estimated Emergency and Observational/Quarantine Capacity Need for the US Homeless Population Related to COVID-19 Exposure by County; Projected Hospitalizations, Intensive Care Units and Mortality. http://works.bepress.com/dennis_culhane/237/

⁷⁰ Hayward, A., Story, A. (2020) *Public Health rationale for not opening/re-opening communal airspace sleeping facilities for homeless people during the SARS-CoV-2 pandemic* <https://www.pathway.org.uk/wp-content/uploads/UCL-CCIH-Faculty-Position-Statement-Aug-2020-Communal-Airspace-Sleeping-Facilities-AS-AH.pdf> cited in St Mungo's (2021) Op.cit.

Australian researchers have interpreted a sudden policy shift toward homelessness in the same way as elements within the UK homelessness sector has interpreted 'Everyone In' (see above), with a supposed policy response to 'homelessness' being seen as actually driven by public health concerns.

In relation to the homelessness response, it would be a mistake to think that these interventions arise primarily from a concern for the impact of COVID-19 on the health of the homeless. As we showed above, the evidence has long demonstrated the negative health impacts of shared homeless accommodation and rough sleeping, along with the housing solutions available to address them. Despite this, governments have been reluctant to act on this evidence and make the necessary investments required to address the health (and moral) crisis that homelessness constitutes. As our Australian analysis illustrates, what has driven the recent response has rather been the reframing of homelessness from an individual to a public health crisis, where the vulnerabilities experienced by the homeless are identified as a threat, not only to their own health, but also to that of the public more broadly.⁷¹

The emergence of certain new variants of the virus, which appear to cause COVID-19 infection at higher rates because they are more virulent, has generated further public health concern. A recent position statement with medical professionals involved in delivering healthcare to people experiencing homelessness has summarised some of these concerns in relation to the UK, which called for additional resources.⁷²

The new variant is >50% more transmissible and has rapidly become the dominant circulating strain in all worst affected areas. The increase in virus transmissibility is projected to cause a large and rapid increase in incidence with levels of hospitalisations and deaths in 2021... In March 2020, the Government's 'Everyone In' strategy provided emergency single room accommodation to almost 15 000 highly vulnerable homeless people nationally. These unprecedented measures, coupled with enhanced disease surveillance, infection prevention and control (IPC) measures, outreach COVID-19 testing, clinical triage and support for people needing to self-isolate, saved hundreds of lives and prevented thousands of hospitalisations.

⁷¹ Parsell, C., Clarke, A. and Kuskoff, E. (2020) Understanding responses to homelessness during COVID-19: an examination of Australia *Housing Studies* (online first). DOI: 10.1080/02673037.2020.1829564

⁷² *Urgent need for a step change in homeless sector response due to new variant SARS-CoV-2* (VOC 202012/01) – Dr Al Story and Prof Andrew Hayward (UCL) – 24 December 2020 <https://www.pathway.org.uk/wp-content/uploads/New-variant-SARS-CoV-2-B.1.1.7.-Homeless-sector-response---24-December-2020-final.pdf>

Among other measures it was argued that:

Government must provide resources to local authorities for additional safe self-contained emergency accommodation to protect lives and enable people who are homeless to follow national Tier 4 guidance [remain at 'home']... Current projections indicate that safe self-contained emergency accommodation will be required for at least the first quarter of 2021 and probably beyond.

Fear of high prevalence, high rates of hospitalisation, and high mortality from COVID-19 among people experiencing homelessness has been a major motivation for shifts in European homelessness policy and for homelessness policy across the Global North. Some discussion about the possibility that interventions primarily designed to protect public health can become the mechanism by which at least some forms of homelessness are brought to an end, have already begun (see Section 4).

3.4 Infection management within homelessness services

3.4.1 Test and trace

Testing and tracing varies, some have integrated people experiencing homelessness into mainstream systems, meaning that access, quality, and speed of results from testing are determined by how well population-level test and trace is working. Others have made specific arrangements to ensure that people experiencing homelessness and people working in services to support them have access to tests.

Management of COVID-19 infection through testing alone has proven logistically challenging. Questions have been raised about the efficacy of rapid results testing, while the delays in getting back tests from laboratories creates logistical challenges. Effectively, testing would have to be continual and perpetual before it could come close to providing a higher degree of safety, and even then, the fact that infection can happen at any point means that it can never work as a response on its own, creating the need for both PPE and social distancing. The advantage of frequent and rapid testing and tracing is that known risks can be found and managed, reducing infection and helping ensure that someone who is infected gets access to treatment and support as soon as possible.

In Budapest, homelessness services initially had to watch and react as if someone were infected, should they present with possible symptoms. This means that all services were obliged to operate a screening-upon-entry, based on a protocol developed by service providers, watching for the obvious (potential) symptoms, such as frequent coughing, reports of loss of a sense of smell and taste, and measuring what can be measured by using infrared thermometers to measure temperatures.

A 24-hour hotline to the GP network run for people experiencing homelessness was also created. The limits and risks of having to take this approach are obvious in the context of reports that a significant proportion of people with COVID-19 infection are asymptomatic. While some of the most recent work in this area suggests initial reports of very large numbers of asymptomatic infections, a conservative estimate on available data still suggest a rate of (at least) one in six infected people presenting as asymptomatic.⁷³ The situation has since improved with the Budapest municipality securing funding from the Soros Foundation to cover testing costs in all social services, including homelessness services. Quarantine-beds, or isolated rooms in shelter services, were installed to make sure identified cases and people moving out from hospitals are safely placed with sufficient time for recovery, before being allowed to use any further shelter-based provision. Local municipalities applied varying policies, depending on their financial capacity, including testing front-line staff in residential social services and street outreach teams.

Responses to a questionnaire sent to the coordinators of the Local Homelessness Units (NPISA) in Portugal showed that almost all fixed-site services had the ability to screen new admissions and isolate infected people experiencing homelessness. However, testing capacity was reported as being uneven, only half of the NPISA coordinators declared that services could test everyone, while one third reported they still lacked the equipment to test effectively.

The situation in the UK is uneven. At the time of writing, national test and trace systems have not been successfully implemented⁷⁴ and there are currently doubts about the efficacy of the rapid result test that had been intended to form the backbone of a national network.⁷⁵ Access to these tests, as with wider healthcare provision, is universal, using a mix of drive-through and walk-through test sites, alongside some mobile testing units. Nationally, current guidance is that testing available for the general population should be used by people experiencing homelessness and those working in homelessness services, rather than specific provision being made.⁷⁶

⁷³ Byambasuren, O., Cardona, M., Bell, K., Clark, J., McLaws, M.L. and Glasziou, P. (2020) Estimating the extent of asymptomatic COVID-19 and its potential for community transmission: Systematic review and meta-analysis, *Official Journal of the Association of Medical Microbiology and Infectious Disease Canada* 5(4) pp.223-234.

⁷⁴ Rajan, S., D. Cylus, J. and McKee, M. (2020) What do countries need to do to implement effective 'find, test, trace, isolate and support' systems?, *Journal of the Royal Society of Medicine* 113(7) pp.245-250.

⁷⁵ <https://www.theguardian.com/world/2020/dec/22/plans-for-30-minute-covid-lateral-flow-tests-in-england-halted-over-accuracy-fears>

⁷⁶ <https://www.homeless.org.uk/sites/default/files/site-attachments/COVID19%20HomelessnessResources%20v15%20Sept20.pdf>

Reports from the homelessness sector in the UK report a mixed picture. In some areas, testing prioritised people experiencing homelessness and people working in homelessness services from the start of the pandemic, in others, no specific arrangements have been made. In the earlier stages of the pandemic, some services reported no access to testing and that they did not have a clear picture of what to look for in terms of infection, making it difficult to know when to act. The incubation period and the speed at which results from laboratory testing were available, often taking several days, alongside the constant risk of infection and possible reinfection, meant that some service providers took the view that testing could not happen at sufficient speed and frequency to make much operational difference on its own.

Ireland has pursued systematic testing of people experiencing homelessness and has data on COVID-19 prevalence.⁷⁷ During the early stages of the pandemic a national Clinical Lead for the COVID-19 Homeless Response was appointed and protocols for identification and immediate testing of people experiencing homelessness with symptoms were developed and implemented. This was combined with the various initiatives and interventions designed to enable social distancing within services described in Section 1.

Inconsistencies and challenges around test and trace systems must be seen in the context of an ongoing global challenge in getting the right systems fully operational. Different countries are building systems in very different contexts and with varying levels of resources. Building successful test and trace systems has been described as requiring the following⁷⁸:

- Producing and procuring enough testing materials;
- Developing sufficient skills and facilities to meet testing needs;
- Strengthening laboratory capacity to rapidly analyse samples and immediately report the results;
- Building a large, well-trained workforce to conduct contact tracing (even in countries using digital technologies);
- Supporting people in isolation; and

⁷⁷ O'Carroll, A., Duffin, T. and Collins, J. (2020) *Saving lives in the time of COVID-19. Case study of harm reduction, homelessness and drug use in Dublin, Ireland*. (London: LSE). <https://www.drugsandalcohol.ie/32291/1/Harm-Reduction-in-the-time-of-COVID19.pdf>

⁷⁸ Rajan, S., D. Cylus, J. and McKee, M. (2020) What do countries need to do to implement effective 'find, test, trace, isolate and support' systems?, *Journal of the Royal Society of Medicine* 113(7) pp.245-250.

- Recognising that successful ‘test, trace, isolate’ depends on having adequate capacity in many areas of the public health system.

Effectiveness in test and trace for people experiencing homelessness and for people working in homelessness services is ultimately dependent on the robustness of what is developed at national level in each EU Member State and in other European countries. Where wider national systems are weaker, the probability is that capacity to effectively test and trace people experiencing homelessness and those working with them will also be weaker.

3.4.2 PPE and wider risk management

Access to PPE was reported as being problematic for many homelessness services during the early stages of the pandemic. In Denmark, services reported widespread shortages during the initial stages of the pandemic. At the time of writing, the situation had improved and PPE was generally accessible to homelessness services. The German experience was very similar, initial PPE shortages being fairly rapidly addressed. Likewise in Budapest, initial reliance on private and NGO resources shifted to more effective government-managed provision around Summer 2020. In Portugal, a new programme has been launched by central government called ‘Adapt Social+’, aimed at specifically supporting the costs of adapting the activity of social services, within which homelessness services are included, to COVID-19, this supports:

- Personal protective equipment for workers and users;
- Hygiene equipment;
- Disinfection contracts;
- Costs of training support workers;
- Reorganisation of workplaces; and
- Changes in service layout.

UK homelessness service providers reported confusing and limited guidance being issued on how to respond to infection during the initial phases of the pandemic being issued from multiple sources. PPE was not widely available for several weeks, with shortages being reported across the public health system and homelessness services often being unable to secure sufficient supply. Some services worked with support from public health services, which provided supplies as the logistics began to improve, while some larger homelessness service providers simply purchased PPE on the open market. Operationally, the shortage of PPE caused some problems for homelessness services, with some staff either being unable to come into work

because they were, themselves, in groups at heightened risk, for example because of an underlying condition, while some others refused to come into work until PPE was available. In some instances, people experiencing homelessness with complex needs showed low compliance with social distancing and PPE use, linked to a high degree of distrust in government. This added to the sense of danger some staff felt. However, low compliance with PPE use and social distancing was not reported as widespread. This considered, the resistance to science and government guidance also exists in the wider UK population. Most people experiencing homelessness were reported as being worried about the virus, with people experiencing street homelessness generally taking the opportunity to take the hotel rooms offered through 'Everyone In', while those already within services followed social distancing measures and used PPE when requested.

The experience of managing the pandemic was described in terms of having to re-build protocols and systems very quickly. Many contingencies were anticipated, particularly by the largest homelessness services providers, but a situation in which everything had to be modified – because situations when people experiencing homelessness and people providing them with support would have to constantly think about masks, social distance, and the constant risk of serious infection from sharing indoor air – had not been planned for.

3.4.3 Addiction

Issues around management of drug use were also reported. In Ireland, modification of existing rules to ease access to therapeutic drugs to manage addiction across the homelessness sector has been credited with successful management of addiction and a wider reduction of potential mortality among people experiencing homelessness. As noted, the 'high cost, high risk' experience of homelessness, as long-term or recurrent and as associated with multiple morbidities, including severe mental illness, disability, and drug and alcohol addiction, while it does exist, should not be taken as representing what is actually a much wider and diverse social problem.⁷⁹ For people experiencing homelessness who had addiction issues however, the following provisions made in Ireland⁸⁰ were reported as beneficial:

⁷⁹ O'Sullivan, E., Pleace, N., Bush-Geertsema, V. and Filipović Hrast, M. (2020) Distorting tendencies in understanding homelessness in Europe: Methodologies, medicine and mental illness *European Journal of Homelessness* 14(3) pp.1-21.

⁸⁰ O'Carroll, A., Duffin, T. and Collins, J. (2020) *Saving lives in the time of COVID-19. Case study of harm reduction, homelessness and drug use in Dublin, Ireland*. (London: LSE). <https://www.drugsandalcohol.ie/32291/1/Harm-Reduction-in-the-time-of-COVID19.pdf>

- As addiction was a potential barrier to compliance with social distancing and isolation where required, access to Opiate Substitution Therapy (OST), i.e. management of heroin addiction using Methadone, was quickly widened.
- Benzodiazepine (BZD/tranquiliser) addiction is also an issue in Ireland and again, it was rapidly recognised that people experiencing homelessness with high dose BZD dependence were unlikely to remain in their accommodation. BZD maintenance treatment was organised to minimise this risk.
- Access to the drug Naloxone which is used when someone has an opioid overdose was eased and simplified compared to arrangements prior to the pandemic.

In England, arrangements around access to Methadone were also simplified. Larger prescriptions of the drug were made available, as practice had been to administer daily doses in controlled environment, which was seen by some homelessness service providers as simplifying the challenges around managing opiate addiction, but by others as creating new management issues, i.e. having sometimes large quantities of methadone present in fixed site services. Challenges were reported in ensuring access to support from addiction services via telephone or social media and around the nature and intensity of help that could be provided. The role of homelessness services as case managers/service brokers, facilitating access to public health, and addiction services was challenging in contexts where the full or usual staff team was not available because of the impacts of the virus. Access to addiction services did improve in some cases, for example there was some evidence that people experiencing street homelessness accommodated under 'Everyone In' arrangements in hotels found support with addiction easier to access.⁸¹ Access to prescriptions, alongside food and other essentials, was arranged for people having to self-isolate. Some new challenges were reported. Patterns of addiction had sometimes changed, as the virus disrupted (illegal) supply chains, which could present new sets of challenges.

Denmark also issued national directives around access to addiction treatment for people experiencing homelessness. In particular, the Ministry for Social Affairs and the Interior together with the Ministry of Health issued a letter to municipalities directing them to ensure that addiction treatment was maintained as a critical function. As in Ireland and the UK, Danish attention was again focused on the effective management of opioid addiction to enable people experiencing homelessness to self-isolate should they need to do so. However, 'shared air' services, including drug consumption rooms, were closed.

⁸¹ Harrison, J. (2020) *Manchester Emergency Accommodation Evaluation: Interim Report* (Riverside) https://www.riverside.org.uk/wpcontent/uploads/2020/06/Riverside_MCREmergency_Accommodation_FINAL.pdf

Again, capacity to manage addiction will depend on context. Ireland and the UK are both countries in which resources for homelessness services and for public health are comparatively high. Where both the resources available to homelessness services and to addiction services are more limited, capacity to successfully manage addiction among those people experiencing homelessness for whom it is an issue is likely to be more limited.

3.4.4 Access to health care

Consistent barriers to health care for people experiencing homelessness have been repeatedly identified for decades across Europe. There is considerable evidence that attempts to ‘treat in place’, without addressing homelessness, ranging from mental health interventions and attempts to end or reduce addiction, alongside other forms of attempted treatment of tuberculous, HIV, and hepatitis, are generally relatively ineffective.⁸² Multiple barriers to health care for people experiencing homelessness have been identified by past research⁸³:

- Public health systems tend to work on the basis of someone having a fixed address and varying in their capacity to support people who lack settled housing.
- Attitudinal barriers can exist to public health services for people experiencing homelessness, including cultural, historical, and mass media images of homelessness, e.g. people experiencing street homelessness can be assumed to be disruptive because they are seen as ‘addicts’ or ‘criminals’ or as likely to present with challenging behaviour linked severe mental illness.
- Logistical barriers to effective treatment for people experiencing homelessness. This can include problems in travelling to general practitioner (GP)/family doctor services and to hospital outpatient appointments, e.g. if they lack money for public transport and the lack of adequate, secure housing in which to recover from illness. Alongside this, people experiencing homelessness may move or be required to move across administrative boundaries for public health systems, disrupting continuity of care. People experiencing homelessness who move between different public health administrative regions may not have accessible, comprehensive medical records, depending on how those systems are organised.

⁸² Pleace, N. (2008) *Effective Services for Substance Misuse and Homelessness in Scotland: Evidence from an international review* (Edinburgh: Scottish Government). <https://www.york.ac.uk/media/chp/documents/2008/substancemisuse.pdf>

⁸³ Pleace, N. and Bretherton, J. (2020) *Health and Care Services for People Sleeping Rough: the views of people with lived experience* (The Partnership for Responsive Policy Analysis and Research (PREPARE)). <https://www.york.ac.uk/media/spsw/documents/research-and-publications/HealthandCareServicesforPeopleSleepingRough.pdf>

- The need for multidisciplinary and specialist teams for people experiencing homelessness with high and complex needs, for example services that can treat and support people with both issues around addiction and severe mental illness, rather than separate addiction services that cannot work with people with severe mental illness and mental health services that cannot work with people with addiction issues.
- Attitudinal barriers among people experiencing homelessness and people experiencing street homelessness, including an *expectation* of rejection when seeking help from public health services, creating a psychological barrier to seeking treatment. This has been linked to late presentation to medical services by people experiencing homelessness, when symptoms of serious illness have become severe.
- Problems with maintaining continuity of care when people experiencing homelessness were mobile, both in the sense of moving between administrative areas while on the street, and in the sense of being moved between areas by local authorities and homelessness services when they sought help.

As in other policy areas, the effectiveness and availability of health services for people experiencing homelessness tends to reflect wider policy. Countries with extensive and relatively well funded public health systems may be more likely to make specific provision of people experiencing homelessness and to integrate public health services into a wider homelessness strategy. Conversely, where public health systems are either not universally accessible and/or have comparatively limited resources, access may be difficult, e.g. relying on charitable activity that may be restricted to a few areas such as major cities.

Access to emergency health care, for example when someone requires an ICU bed due to COVID-19, would not usually be impeded outside a context where there was general pressure across a public health system that means it is more difficult for anyone to get a bed. However, without universally accessible systems or public arrangements to enable access to free/highly subsidised health insurance for people experiencing homelessness and other low income groups, access to longer term treatment may be limited, depending on how health policy is designed. For people experiencing homelessness, any difficulties in accessing long-term treatment could be an issue around the impacts of ‘long-COVID’, where limiting illness, disability, and a higher risk of overall mortality can follow a ‘recovery’ from COVID-19, which looks like it might become quite widespread.⁸⁴

⁸⁴ Mahase, E. (2020) Covid-19: What do we know about “long COVID”?, *BMJ* 370: m2815

Danish health services that are specifically designed for people experiencing homelessness continued to function, with modifications to practice to ensure social distancing and outreach services were extended. Appointments with outreach nurses are handled remotely, with support workers in homelessness services providing access to any drugs that are prescribed.⁸⁵ Specific provision for people experiencing homelessness who needed to self-isolate was also made, initially using a smaller unit and then moving to a larger facility with 60 rooms. During the first wave of the pandemic these facilities were not widely used, reflecting a generally low prevalence of COVID-19 among people experiencing homelessness, however, localised outbreaks were being reported among people experiencing homelessness in the early part of 2021. Emergency accommodation cannot reject people experiencing homelessness with signs of possible infections, but are expected to contact public health authorities which then assess any need for treatment or quarantine. Local authorities (municipalities) are also obliged to ensure quarantine facilities are available to people experiencing homelessness who require them.

Some German voluntary/charitable medical services, used by people experiencing homelessness, have had to close down because they are run by retired doctors who are at potentially higher risk from the virus. Additional provision for people experiencing homelessness had not been developed at the time of writing, although this is in the context of a highly developed public health system.

In Budapest, people experiencing homelessness receive medical services from a specialist GP network, combined with some specifically allocated hospital beds. During the first wave of the pandemic, GP support moved to telephone services. If someone is diagnosed with COVID-19, there is access to space for self-isolation and, if required, they use the same hospital services as the general population. Across Hungary, testing upon releases from hospitals proved ineffective in the first wave of the pandemic, which meant that quarantine arrangements within shelter services had to be set up in order to prevent infections coming from hospitals, which was then identified as a driving pandemic spread in residential facilities for older people.

Portuguese medical services for people experiencing street homelessness centre on outreach teams, which include both specialist addiction services and medical professionals, with medical outreach being largely focused on Lisbon. A psychiatric hospital in Lisbon also supports outreach services. Shelters, which remained open in a socially distanced form, alongside the provision of additional services (see Section 1), continued to be supported by these services. In Germany and

⁸⁵ In some countries there are distinctions between nursing staff and nurse practitioners, the latter having the authority to prescribe medication and deliver other treatments that were traditionally handled by a doctor.

Hungary, however, people experiencing homelessness were broadly expected to access mainstream public health services, rather than new, separate health services being set up.

All UK public health services (National Health Service, NHS) are theoretically available to people experiencing homelessness, including people experiencing street homelessness, but there is a longstanding recognition that various logistical and attitudinal barriers, both among some health professionals and among people experiencing homelessness themselves, can impede access to treatment. Provision of specialist publicly funded health services for people experiencing homelessness is widespread, with a mixture of specialist GP clinics, addiction services and, probably most frequently, psychiatric teams for people experiencing homelessness being present in most cities and larger towns.⁸⁶ As elsewhere, services that were ‘shared air’ were either modified or shut down; mainstream NHS services were used if people experiencing homelessness required hospitalisation.

3.5 Vaccination

Vaccination is underway at the time of writing, but progress is uneven and there are logistical challenges around distribution and vaccine supply. In some instances, vaccination of people experiencing homelessness and people working in homelessness services has been prioritised, but at the time of writing mass vaccination of both higher risk groups and the general population has only just begun.

The European Commission has issued a list of key steps in relation to vaccination across the 27 Member States⁸⁷ which broadly identifies, without actually spelling it out, people experiencing homelessness as within priority groups (i.e. people who cannot socially distance and more disadvantaged socioeconomic groups):

All Member States will have access to COVID-19 vaccines at the same time on the basis of population size. The overall number of vaccine doses will be limited during the initial stages of deployment and before production can be ramped up. The Communication therefore provides examples of unranked priority groups to be considered by countries once COVID-19 vaccines become available, including:

⁸⁶ Pleace, N. and Bretherton, J. (2020) *Health and Care Services for People Sleeping Rough: the views of people with lived experience* (The Partnership for Responsive Policy Analysis and Research (PREPARE)).

⁸⁷ European Commission (2020) *Coronavirus: Commission lists key steps for effective vaccination strategies and vaccines deployment* (Press Release) Brussels, 15 October 2020



- *Healthcare and long-term care facility workers;*
- *Persons over 60 years of age;*
- *Persons whose state of health makes them particularly at risk; essential workers;*
- *Persons who cannot socially distance;*
- *More disadvantaged socio-economic groups.*

The Council of Europe Committee on Bioethics has also emphasised that vaccination strategy must be adapted to the needs of “persons who are systematically disadvantaged in accessing healthcare”, which again, should theoretically include people experiencing homelessness.⁸⁸ However, the term ‘homelessness’ is not employed in the statements around equal and ethical access to vaccination.

Within the UK, people experiencing homelessness have been explicitly identified as a high vulnerability group requiring priority access to vaccination⁸⁹ in a risk assessment algorithm developed for the NHS. As in the rest of Europe, populations with shared characteristics with people experiencing homelessness, such as experiencing extremes of social and economic marginalisation, are being prioritised. Across the UK, much of the homelessness sector has called for priority access to vaccination for people experiencing homelessness. Within certain areas, public health authorities have prioritised people experiencing homelessness, at the time of writing the City of Liverpool had given an initial vaccine dose to 500 people with a history of homelessness and living on the street, placing them among the first people to receive immunisation.⁹⁰ As this report is being written, more local public health authorities are deciding to prioritise people experiencing homelessness as they implement vaccination, including Oldham and Oxfordshire.

The Danish Government has recently announced that people experiencing homelessness will receive priority access to vaccination.⁹¹ In Germany, people staying in homelessness services are also being prioritised, alongside migrant populations in asylum seeker facilities, where there have been COVID-19 outbreaks.⁹² In Portugal,

⁸⁸ <https://www.coe.int/en/web/portal/-/covid-19-and-vaccines-equitable-access-to-vaccination-must-be-ensured>

⁸⁹ <https://digital.nhs.uk/coronavirus/risk-assessment>

⁹⁰ <https://www.bigissue.com/latest/proud-of-this-city-500-homeless-people-vaccinated-in-liverpool/>

⁹¹ <https://www.thelocal.dk/20210120/denmark-makes-homeless-a-priority-in-vaccine-rollout>

⁹² <https://www.infomigrants.net/en/post/29327/germany-asylum-seekers-second-in-line-for-coronavirus-vaccine>

people experiencing homelessness living in ‘shared air’ services have not been included in the priority groups for vaccination, unlike older people living in residential facilities and support staff in those facilities.

In Hungary, frontline social workers seem to be prioritised, but there were uncertainties in actual access to vaccination as the vaccination plan is being updated and modified according to the availability of the vaccines at the time of writing. SOTE, the Semmelweis University for Medicine and Health Sciences (a state university) has also volunteered to vaccinate all people experiencing homelessness and those working in service provision in Budapest and beyond, offering 70 000 vaccine doses from its own supply. However, this is an initiative from the University, not part of official policy.

Outside Europe, the Canadian Government has identified people experiencing homelessness as among the priority groups for vaccination, noting the following:

*... marginalized populations in Canada have been disproportionately affected by COVID-19, and that systemic barriers to accessing necessary supportive care for COVID-19 also exist in urban settings related to factors such as poverty, systemic racism and homelessness.*⁹³

There are major policy challenges. Governments are in the midst of a pandemic where the situation can and has shifted very rapidly, from apparently gaining control to suddenly losing it again, in part because the virus itself is changing, and in part due to mismanaged attempts to balance public health against minimising severe economic and social damage from sustained lockdowns. Nevertheless, maintaining a focus on people experiencing homelessness as a group who are inherently vulnerable, sometimes because of their general health and *always* because of their situation, is vital.

⁹³ Government of Canada (2020) *Guidance on the prioritization of initial doses of COVID-19 vaccine(s)* <https://www.canada.ca/en/public-health/services/immunization/national-advisory-committee-on-immunization-naci/guidance-prioritization-initial-doses-covid-19-vaccines.html>

4. Challenges and Opportunities

4.1 Introduction

This final section looks at emergent issues around COVID-19. This material is necessarily speculative as the pandemic is still in progress and there have been recent, significant, changes that show that mapping the course of the virus and its consequences is difficult. The issues highlighted are women's homelessness, what are currently anticipated as being likely increases in overall homelessness, and some of the debates around changes in practice that are emerging during the pandemic.

4.2 Women's homelessness

The United Nations has highlighted global evidence of an increase in violence against women and girls, citing national reports from Europe and beyond of rising reports of domestic abuse.⁹⁴ One issue identified in these reports is the impact of lockdowns, which appear to increase risks, especially when combined with increasing levels of economic and social hardship stemming from the impact of the virus. A 60% increase in emergency calls from women subjected to violence by their intimate partner has been reported in the World Health Organization Europe Member States.⁹⁵

The interrelationships between domestic abuse and women's homelessness and between family homelessness, which disproportionately involves lone women parents with dependent children across Europe, are well established.⁹⁶ There are multiple distinctions between women's and men's homelessness, just as there also similarities, but a consistent difference is the rate at which women's homelessness is a result of domestic abuse, the rate at which women – and children – experience trauma and the challenges that can arise in providing routes to settled housing for

⁹⁴ <https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/issue-brief-covid-19-and-ending-violence-against-women-and-girls-en.pdf?la=en&vs=5006>

⁹⁵ Mahase, E. (2020) COVID-19 EU states report 60% rise in emergency calls about domestic violence, *BMJ* 369: m1872.

⁹⁶ Mayock, P., Bretherton, J. and Baptista, I. (2016) Women's Homelessness and Domestic Violence: (In)visible Interactions, in: Mayock, P. and Bretherton, J. (Eds.) *Women's Homelessness in Europe*, pp.127-154. (London: Palgrave Macmillian).

women who are still at risk from a former partner.⁹⁷ While domestic abuse can be an issue for men, it is the major cause of women's homelessness and among the most frequent causes of family homelessness in Europe.

Data on the extent to which new homelessness may be being generated by higher levels of domestic abuse are not available at a pan-European level, nor in individual Member States, and globally, it is more a question of anticipating a new wave of women's and family homelessness because of the rising levels of domestic abuse. Whether, and to what extent, this will be the case is uncertain at the time of writing, but the possibility exists and it is anticipated. Portuguese data suggest that apparently falling levels of domestic abuse, in terms of formal criminal complaints, may be associated with the pandemic making it more difficult to report the crime, while other indicators, including the use of a COVID-19/domestic abuse hotline, have increased rapidly.

Women's homelessness almost certainly exists at a scale that has not really been recognised, in part because women's trajectories through homelessness are harder to see than is the case for lone men, and in part because what is actually very often women's homelessness involving lone women parents with dependent children, is classified as 'family' homelessness. Administrative processes and labels, alongside separate funding and policy processes, have also tended to mean that women's homelessness that is caused by domestic abuse is not always counted as such, women who are homeless and who use refuges and other domestic abuse are often counted as experiencing 'domestic abuse' rather than homelessness.⁹⁸

As it is less visible, women's homelessness has received less attention, but rather than fewer services being made available than is the case for lone homeless men, there has been a tendency to provide very few services for women, on the basis that it is supposed to be a highly unusual phenomenon, which is an increasingly dubious looking assumption.⁹⁹

⁹⁷ Bretherton, J. (2020) Women's Experiences of Homelessness: A Longitudinal Study, *Social Policy and Society* 19(2) pp.255–270. DOI: <https://doi.org/10.1017/S1474746419000423>

⁹⁸ Baptista, I., Benjaminsen, L., Busch-Geertsema, V. and Pleace, N. (2017) *Family Homelessness in Europe* (Brussels: FEANTSA). https://www.feantsaresearch.org/download/feantsa-studies_07_web3386127540064828685.pdf; Busch-Geertsema, V., Benjaminsen, L., Filipović Hrast, M. and Pleace, N. (2014) *The Extent and Profile of Homelessness in European Member States: A Statistical Update* (Brussels: FEANTSA).

⁹⁹ Bretherton, J. (2020) Women's Experiences of Homelessness: A Longitudinal Study, *Social Policy and Society* 19(2) pp.255 – 270. DOI: <https://doi.org/10.1017/S1474746419000423>; Bretherton, J. (2017) Reconsidering gender in homelessness, *European Journal of Homelessness* 11(1) pp.1-21.

In Budapest, it has been reported that women experiencing street homelessness, for whom there was already relatively limited dedicated provision, found the range and extent of emergency shelter services greatly restricted as services were quarantined and modified. There were some attempts to address the situation, such as the creation of additional women-only emergency shelter space, but the perception was that access to services had been reduced. Women experiencing street homelessness were especially affected by the restrictions as there are only very few shelter places, and new clients were not admitted to either of these. One shelter created an extra wing for women and intends to keep this service running.

Reports from the UK were that the response to the pandemic was shaped by stereotypical images of homelessness, as essentially a social problem experienced by lone adult men, rather than reflecting the more complex gender dynamics of homelessness. This was in spite of growing attention, including at a pan-European level as well as within the UK itself, of the realities and needs associated with women's homelessness. For example, when hotel accommodation was made available to people experiencing street homelessness, no consideration was given in most areas to whether or not there should be separate provision for women, despite the provision of women-only services being standard pattern in the planning and commissioning of homelessness services across the UK. Equally, at strategic level, little thought was initially given to the possibility that domestic abuse might occur within locked down homelessness services at a higher rate, involving both women and men. Refuge services that have a 'shared air' design are unusual, but there is longstanding evidence that existing provision does not have sufficient capacity under normal circumstances, meaning that services have been quickly overwhelmed, especially when running at reduced capacity. One reported experiment with using a hotel as an improvised refuge was quickly overwhelmed.

4.3 Expected increases in homelessness

The expectation is that there will be increases in homelessness. Two potential drivers are the effect of ending various forms of eviction bans being combined with massive surges in unemployment. By some predictions, whole economic sectors, including tourism, travel, restaurants, retail, and the creative arts – anything that relies on people gathering together and travelling together – will be damaged. The rate and nature of economic recovery and the possibility that existing changes like the large scale replacement of physical with online shopping, will be greatly accelerated by the pandemic, are all being discussed. An evicted household which has limited, or no financial resources, nowhere else to go, and no support mechanisms, either formal or informal, is likely to become homeless. If evictions increase, there will be some increases in homelessness that are related, but, as has always been

the case, most evicted households will not simply become homeless households.¹⁰⁰ Much depends on how severe the recession or depression resulting from the pandemic is, how long it lasts, and the rapidity, disposition, and nature of any economic recovery. In some EU Member States, restricted public funding for preventing evictions and offering affordable social housing or rental support may further exacerbate and prolong the economic vulnerabilities of households who were previously employed in the most heavily damaged sectors of the European economy, including tourism and the wider leisure industries.

The other potential driver, which would cause homelessness on a smaller scale, but with a high human cost, is the possibility that street based homelessness will increase. The most immediate perceived risk here is that the various temporary and interim measures designed to end or reduce street based homelessness will cease to be supported. Both the people assisted by these services and people who enter street based homelessness after they have ceased to be supported will have fewer options available to them, potentially causing levels to rise.

In essence, the concerns centre on the idea that both specific policies to prevent and reduce homelessness and other provisions, such as economic support for people who have lost employment or who are being held on furlough through support from European governments, represents a significant level of ‘stored up’ homelessness. The concern is that this stored up homelessness will appear once the extraordinary measures taken in response to the pandemic cease to be used. However, at the time of writing, the level and the nature of any such rises is something that remains to be seen and, for a surge in stored up homelessness to occur, governments would have to switch off all the pandemic related supports at once, which is something at least some may not choose to do.

4.4 Reconsidering existing systems and services

Some sudden and pronounced policy shifts occurred as the true nature and meaning of the pandemic was understood. Evictions were ‘banned’, or at least widely restricted, and many European countries took measures that reduced the overall levels of street based homelessness. Sudden, rapid reductions in homelessness resulted. While they did not resolve underlying issues ranging from shortfalls in affordable, adequate, and social housing supply, alongside funding gaps and other issues with homelessness services and the degree to which health, welfare,

¹⁰⁰ Kenna, P., Nasarre-Aznar, S., Sparkes, P. and Schmid, U.C. (Eds.) (2018) *Loss of Homes and Evictions Across Europe: A Comparative Legal and Policy Examination* (Edward Elgar Publishing).

and social protection systems helped prevent homelessness and facilitated exits, nevertheless they brought what were characterised as complex social problems to an apparent, sudden stop.

Homelessness is often presented as a complex policy area. However, as the pandemic took hold, new levels of resources were, for example, quickly directed at people experiencing street homelessness and, very quickly, there were a lot less of them. That Europe has the capacity to end homelessness, through governments enabling a well-resourced, integrated homelessness strategy with the right mix of preventative services, social and affordable housing supply, housing-led/Housing First, and other supported housing services has been repeatedly – indeed exhaustively – demonstrated by Finnish policy and practice.¹⁰¹ Outside Finland, during the pandemic, it became apparent that a sudden direction of more resources at homelessness could significantly reduce levels and achieve other positive benefits, such as enabling some people to exit on a sustainable basis, while others saw gains in wellbeing. These rapidly built policies were not perfect, but, as with Finnish policy and practice, achieving sudden reductions in levels of homelessness raised questions about the idea that homelessness was a ‘complex’ problem to solve.¹⁰²

For some in the homeless sector, the danger zones in the post-COVID-19 world centre on what has been called the ‘cultural gravity’ distorting explanations of homelessness in Europe.¹⁰³ This is the longstanding tendency to explain homelessness in terms of individual pathology: the choices, actions, needs, characteristics, and experiences of each individual; homelessness as a matter of ‘sin’ and ‘sickness’ rather than ‘systems’.¹⁰⁴ Evidence that social protection systems, welfare regimes, GDP, or the level of inequality in a society influences the level and nature of homelessness gets downplayed, or largely ignored¹⁰⁵, despite evidence that homelessness and poverty are deeply intertwined.¹⁰⁶

¹⁰¹ Allen, M.; Benjaminsen, L.; O’Sullivan, E. and Pleace, N. (2020) *Ending Homelessness in Denmark, Finland and Ireland* (Bristol: Policy Press).

¹⁰² Harrison, J. (2020) *Manchester Emergency Accommodation Evaluation: Interim Report* (Riverside) <https://www.riverside.org.uk/wp->; Neale, J. (2021) *Experiences of Being Housed in A London Hotel as Part of the ‘Everyone In’ initiative Part 2: Life in The Month After Leaving the Hotel* (London: KCL). <https://osf.io/x73am/>

¹⁰³ Pleace, N. (2016) Researching homelessness in Europe: Theoretical perspectives, *European Journal of Homelessness* 10(3) pp.19-44.; O’Sullivan, E., Pleace, N., Bush-Geertsema, V. and Filipović Hrast, M. (2020) Distorting tendencies in understanding homelessness in Europe: Methodologies, medicine and mental illness *European Journal of Homelessness* 14(3) pp.1-21.

¹⁰⁴ Gowan, T. (2010) *Hobos, Hustlers and Backsliders: Homeless in San Francisco* (University of Minnesota Press: Minnesota).

¹⁰⁵ Parsell, C. (2018) *The Homeless Person in Contemporary Society* (London: Routledge).

¹⁰⁶ Bramley, G. and Fitzpatrick, S. (2018) Homelessness in the UK: who is most at risk?, *Housing Studies* 33(1) pp.96-116.

Homelessness services and systems, as has been noted elsewhere¹⁰⁷, are shaped by images of who and what people experiencing homelessness are, images that can centre on the idea of ‘underserving’ poor who have caused their own plight. Responses to homelessness that, for example, focus on emergency shelter rather than providing settled homes and support, are influenced by these ideas and by tradition, because this is what a ‘homeless service’ looks like. The pandemic has raised deep questions about the viability of ‘shared air’ services that could act as an accelerant to change that was already underway, towards more progressive services for which there is better evidence base, such as Housing First and innovations around prevention.

The low resilience of some aspects of the European homelessness sector, ranging from ‘shared air’ emergency shelters through to daycentres and other services that do not, directly, provide a settled home or necessarily a clear route to one, further highlighted by the pandemic, shows us that, across Europe as a whole, homelessness is not being solved. The policy response to homelessness, as has been noted elsewhere¹⁰⁸, needs to be reimagined. A recent review of responses to COVID-19 in Ireland produced by one of the authors of this report, noted that:

*The measures put in place to protect adults in emergency accommodation, particularly congregate shelter settings, mitigated their extreme vulnerability to contracting COVID-19, but also implicitly acknowledged that the provision of emergency congregate accommodation as currently structured is inherently problematic. The limitations of the provision of congregate emergency accommodation as a response to residential instability are long-standing, comprehensive and compelling, and the high risk of contracting COVID-19 demonstrates the vulnerability of shelter users to injurious infection, is further evidence of the limitations of a Shelter-led response to homelessness.*¹⁰⁹

Alongside this, however, are examples of remarkable innovation, flexibility, and dedication, of a homelessness sector that, in several countries, jumped just as it needed to and was instrumental in stopping the initial impact of the pandemic on people experiencing homelessness being far worse than it was. Lives were saved because the homelessness sector rearranged itself, creating social distancing, facilitating isolation and quarantine, hacking together rudimentary test and trace systems when it needed to, and finding ways to keep congregate fixed site services and housing-led and Housing First services open. That innovation was not confined

¹⁰⁷ Gowan, T. (2010) *Hobos, Hustlers and Backsliders: Homeless in San Francisco* (University of Minnesota Press: Minnesota).

¹⁰⁸ O’Sullivan, E. (2020) *Reimagining Homelessness* (Bristol: Policy Press).

¹⁰⁹ O’Sullivan, E. (2020) *COVID-19, Congregate Emergency Facilities and Responses to Homelessness in Ireland: Report for the Irish Human Rights and Equality Commission*, Dublin p.1.

to the newer models of service either, traditional, 'shared air' emergency shelters found ways to stay open, to try to keep residents safe and, across the homelessness sector as a whole, improvisation ranging from taking over hotels to campsites reduced street based homelessness and came close to clearing the streets of people in several countries.

The challenge centres on maintaining the possibilities for positive change illustrated by the virus, that more resources can make a sudden, marked difference in homelessness and that the flaws in 'shared air' models of service provision, which effectively had no resilience in the face of the pandemic, might also hint at other problems. Beyond the evidence of people becoming 'stuck' in emergency shelters and that people with high and complex needs do not get the right mix of support, which includes settled, adequate housing, needed to exit homelessness in these services, questions might be raised around the fundamental nature of services that increased the risk of COVID-19 by nature of their very design and operation.

There is a need to extract the positives from the experience of the pandemic and build on them, looking at innovation and improvisation and seeing what lessons can be learned, alongside taking a long, critical look at what the pandemic can tell us about the strengths of existing homelessness services and strategies. Changing existing responses to homelessness in Europe has been difficult, a great deal of progress has been made and there is a lot of good practice, but the most innovative thinking is not always as far reaching as it should be. Real progress has been made in promoting Housing First, but it is not yet mainstream practice¹¹⁰ in much of Europe. In talking to some people from the homelessness sector for this report, the concern that, should levels of overall homelessness and people experiencing street homelessness spike in the wake of the pandemic, the response will be to fall back on what has always been done before and build more emergency shelters and spend more on temporary accommodation. The more effective solutions to homelessness, prevention, housing-led services, Housing First, and the examples of effective practice in fixed site supported housing tend to take more time to establish and, to work well, need the coherence and orchestration that can only be delivered through an integrated national homelessness strategy.

The importance of thinking critically remains. While there is much to recommend Housing First when it is implemented in the right way, it is becoming evident that it is not a perfect self-contained solution and that it works best within an integrated strategy. This is because it is not designed for all forms of homelessness, the original model being a mental health intervention for people with high and complex

¹¹⁰ Pleace, N., Baptista, I. and Knutagård, M. (2019) *Housing First in Europe: An Overview of Implementation, Strategy and Fidelity* (Brussels: Housing First Hub Europe). <https://housingfirsteurope.eu/research/2019-housing-first-in-europe-an-overview-of-implementation-strategy-and-fidelity/>

needs, and because it is not the case that it is the only thing needed for an effective homelessness strategy. In addition, it has become clear that a single intervention like Housing First cannot necessarily meet all needs, questions about the wellbeing, social integration, and health of some long-term users of Housing First services remain and, as one of the key advocates of Housing First has argued, to be in favour of the idea and support it does not mean never being critical of aspects of it.¹¹¹ At the same time, it seems obvious based on current evidence that the overarching principle of Housing First, that housing is a human right and that any solution to homelessness has to begin with a settled, affordable, adequate home, is, as Finnish practice again shows us, the core to an effective homelessness strategy, which uses a whole range of different types of homeless and preventative service.¹¹²

4.5 Wider questions around housing exclusion

Debates about creating a shared definition of homelessness that can be measured in a consistent and comparable way across Europe, which have involved some of the authors of this report for many years and which continued in the recent COST action CA15218 – *Measuring homelessness in Europe*¹¹³ the subject of a special issue of the *European Journal of Homelessness*¹¹⁴ have centred on when someone is in a physical and legal situation that crosses the line between having a home and not having one.

Considerable progress has been made over the last 20 years, not least with the creation of the *European Typology of Homelessness* (ETHOS)¹¹⁵, which is advocated and used by FEANTSA and which has been instrumental in moving the debates about counting homelessness away from seeing the problem just in terms of people experiencing street homelessness and in emergency shelters. Alongside the questions around how to better define, measure, and respond to European homelessness, there are related questions around other forms of acute housing need. ETHOS describes multiple forms of housing exclusion, where housing is inadequate,

¹¹¹ Aubry, T. (2020) Analysis of housing first as a practical and policy relevant intervention: The current state of knowledge and future directions for research, *European Journal of Homelessness* 14(1) pp.13-26. https://www.feantsaresearch.org/public/user/Observatory/2020/EJH/EJH_14_1-A1-Web%5B2%5D.pdf

¹¹² Allen, M.; Benjaminsen, L.; O'Sullivan, E. and Pleace, N. (2020) *Ending Homelessness in Denmark, Finland and Ireland* (Bristol: Policy Press).

¹¹³ <https://www.cost.eu/actions/CA15218/#tabs|Name:overview>

¹¹⁴ Volume 3, 2020 see: <https://www.feantsaresearch.org/en/publications/european-journal-of-homelessness?journalYear=2020#tab0>

¹¹⁵ <https://www.feantsa.org/en/toolkit/2005/04/01/ethos-typology-on-homelessness-and-housing-exclusion>

but someone is not experiencing homelessness, while the analysis in the annual FEANTSA and FAP reports also describes housing exclusion as an interrelated social problem, existing alongside homelessness, across all of Europe.¹¹⁶

COVID-19 has much higher morbidity and mortality rates in areas characterised by spatial concentration of poverty within degraded built environments. Areas where there is little physical space between homes, an absence of parks and green areas, narrow streets, shared stairwells and corridors, and in which the housing is overcrowded, are those in which COVID-19 infection and death have been most widespread. The effect is not simply about the nature of housing or the built environment, as poorer people tend to have lower quality health and will, for example, be more likely to have underlying conditions or other characteristics, like obesity, that increase the risk that a COVID-19 infection will become fatal. Nevertheless, an independent, significant effect is observable at global level. In the UK, the Office for National Statistics has reported that:

*Looking at deaths involving the coronavirus (COVID-19), the mortality rate in the least deprived areas (decile 10) in England was less than half of the mortality rate in the most deprived areas across April to July. The age-standardised mortality rate of deaths involving COVID-19 was 3.1 deaths per 100 000 population for the most deprived areas in England in July; this was statistically significantly higher than the 1.4 deaths per 100 000 population in the least deprived areas.*¹¹⁷

When poor housing, which means overcrowded dwellings in poor conditions in degraded environments, a pan-European issue¹¹⁸ and a global issue, places people at heightened risk in this way, the need to prioritise wider housing exclusion alongside homelessness is highlighted. Interventions around people experiencing street homelessness were centred on their incapacity to self-isolate, but, just as people experiencing homelessness in other situations, such as ‘hidden’ homelessness or staying in temporary accommodation, heightened risks also exist for people experiencing housing exclusion. The line between homeless and ‘hidden homeless’ has always been ambiguous and disputed, the pandemic gives us another opportunity to reconsider how we are thinking about both homelessness and the wider dimensions of housing exclusion.

¹¹⁶ <https://www.feantsa.org/en/news/2020/07/23/fifth-overview-of-housing-exclusion-in-europe-2020?bcParent=26>

¹¹⁷ <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19bylocalareasanddeprivation/deathsoccurringbetween1marchand31july2020>

¹¹⁸ Foundation Abbé Pierre – FEANTSA (2020) *Fifth Overview of Housing Exclusion In Europe 2020* FAP/FEANTSA https://www.feantsa.org/public/user/Resources/resources/Rapport_Europe_2020_GB.pdf

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European Homelessness and COVID 19

Coronavirus has put a spotlight on homelessness across Europe. The pandemic has shown both the dedication of European homelessness service providers and the dangers when the virus gets into homelessness services that are not designed to manage an airborne infection. The human cost of homelessness, including living rough and in shared-air services has also been underlined by the pandemic, making it clear that a homeless life cannot, of necessity, be a healthy one. This report pulls together the available evidence, seeking to present the best available picture of what is still an ongoing European public health emergency as it relates to homelessness. The emerging lessons and opportunities presented by the pandemic are also discussed.

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