CHIRN

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Research Report: Observations from the front lines of service provision for people experiencing homelessness during the first wave of Covid-19

This report is based on ethnographic fieldwork at a local service provider (in the form of volunteering shifts) as well as over a dozen short interviews with management, staff and residents during the first wave of Covid-19 (spring and summer 2020). It was prepared by Dr Johannes Lenhard and Eana Meng and supported by a small Covid-response UKRI grant and a Cambridge Impact grant.

I Implications for people experiencing homelessness and rough sleeping

1. **There was an increased number of vulnerable people in situations of homelessness in need of housing, support and care.**

Stay-at-home orders meant that an increased number of people needed to be housed and cared for (e.g. releases from prison, people vulnerably housed loosing accomodation). Additionally, the pandemic and the rules put in place to govern it increased support needs for individuals due to increased stress, anxiety and issues around substance abuse (e.g. methadone script not or less easily available).

2. **People with dual diagnoses (mental health and substance use conditions) were particularly in need of support and care which was often not accessible in the first phase of lockdowns.**

As a product of the pandemic directly and indirectly, those with dual diagnoses in mental health and substance use conditions were particularly vulnerable. The virus and the circumstances it procued (e.g. isolation) exacerbates mental conditions, and those with addiction are also more at risk of harm due to compromised immune systems and weaker pulmonary systems. Furthermore, as an indirect consequence, stay-at-home orders interrupted these resident's need to buy drugs; where some residents relapsed, others suffered from withdrawal symptoms. External providers of care were less available (temporarily), leading to over-burdened staff members at service providers not able to supply the (specialised) care needed.

3. **Telephone and virtual support are helpful but were overall an inadequate replacement.**

Members of staff that stayed at home and continued to provide support resorted to using telephone contact. There was a significant difference in how residents responded to staff over telephone. Staff reported how residents did not like the phone conversations and prefered face-to-face contact. In addition, the face-to-face appointments allowed for drug testing which many residents relied on to stay substance free. In the absence of the drug testing in the initial lockdown period, some residents relapsed. This issue was mitigated once more staff were trained to conduct drug tests.

II Implications for staff and management at the service provider

1. **There was an increased burden of care on service providers and the members of staff who continued to work. These were often not equipped to adequately respond to residents' needs.**

Partly due to safety reasons or self-isolation of vulnerable staff, there was a decrease in the number of staff and volunteers available. As such, there was an increased burden on those who remained to manage a number of novel and overlapping issues: maintaining physical distancing, providing novel activities for residents, and providing care for residents experiencing withdrawal symptoms unable to leave the premises (including for specialised support). Mostly, staff were not trained for this type of support leading to increased stress and anxiety also among staff members.

2. **The institution adjusted well despite the complexity and novelty of the issues faced.**

The pandemic's stay-at-home order fundamentally challenged how service providers operated as an institution rooted in providing a place to sleep but encouraging residents to spend their days outside. From the increased burden on staff to the decreased number of residents housed (elimination of communal sleeping quarters) as well as evictions of possibly the most vulnerable residents, the process of adaptation was a difficult one. Howevever, the service provider was still able to deliver on its purpose of providing day-to-day activities and essential support (e.g. planning for housing, applying for benefits, finding medical help).

3. **Due to inadequate and vague government guidance on policies, management was forced to adapt new rules in real-time.**

Though a surprising 3.2 million was made available for (housing) rough sleepers, (central) government support and guidance beyond monetary measures was sparse. As a result, management and staff were forced to experiment, e.g. around stay-at-home orders. Staff worked together with residents to discover what worked, such as relaxing rules around television and alcohol use. As government rules changed (e.g. allowing for 'unlimited exercise'), experimentations continued. This process of real-time adaptation caused uncertainty and again increased stress among staff and management as well as residents.

4. **Management prioritized decisions to provide safety for the majority over the individual.**

Management and staff accomodated the needs of the residents and did not always enforce strict rules (e.g. number of outings and time spent outside). However, frequent and serious violations were sanctioned for the sake of keeping the institution as a whole safe. This led to the eviction of residents possibly compromising the safety of other residents with their behaviour. The evicted residents tended to be the ones that were most in need of urgent and specialized care (that, again, was not accessible easily during that period).

5. **The pandemic posed a large financial burden on the institution – decreasing the amount of income for an increased amount of work.**

Despite the opportunity for additional (charity) funding, the service provider faced increased financial burdens throughout the pandemic. On the one hand, there was less income from housing support as less residents were housed. On the other hand, the usual fundraising events stopped generating income. Furthermore, it is unclear how much government support the institution will receive. In addition, more pressure was placed on fewer members of the staff (see #1).

6. **Very positively, the service provider was able to keep Covid out completely during this phase.**

Despite the challenges and changes the institution underwent, the precautions and efforts proved successful in terms of preventing the virus from entering the institution. There were some reports from residents about presenting symptoms and precautiously self-isolated, but no residents (or staff) tested positive. All in all, the staff and residents were safe throughout the first phase of the pandemic.

III Ongoing questions

1. **In the latter phase of the pandemic, new and functioning normals were established.**

Despite initial challenges, within a few weeks of the pandemic, new normals were put into place that allowed the institution to function adequately. While many issues remained and the staff continued to have to adjust to new government guidelines, all in all, staff and residents coped exceptionally well. Particularly with the overall reopening and specifically of the specialized care services, the situation markedly relaxed.

2. **The biggest concern of residents and staff remained continuing uncertainty about the next phase of rules and order. Housing remained a key question mark.**

Nearly all residents frequently asked staff members how their lives will change after regulations are lifted, and the most common concern is whether or not they will have accommodation after. Management will need to address a number of other issues, such as unpaid rent. The uncertainty was a cause of stress for both groups.

IV Recommendations and learnings

1. ***Inclusive communication*: Involve staff and residents more directly in decision making and communicate more effectively. Conduct regular surveys / feedback loops.**

Given the readjustments the pandemic posed to everyone in the institution(s) and the fact that rules had to be made up in real time, a more inclusive communication throughout the pandemic including staff and residents frontline experiences could have strengthened the response (and its acceptance) even further. Now retrospectively, there seems to be an opportunity to learn (internally) about the service provider's crisis response by conducting a survey: Were you happy with how things were dealt with? How did staff morale hold up? Did residents feel that the day activities kept them busy? What was inefficient? What are areas of improvement? What was missing that they needed? How well was communitication between staff, or between staff and residents? For the employees and volunteers that stayed at home, it would be good to ask what their experiences were like – were they happy with the telephone support? Answers to these questions will help design a more resilient organisation going forward.

2. ***Staff training*: All members of staff would benefit from additional training.**

The crisis situation caused by the pandemic is not unique and to be able to respond to future incidents even better, members of staff would benefit from specialised training in, among others: drug testing, developing contingency plans (e.g. employee absentia), stress management, specific virus-related training

3. ***Specialised dual diagnosis support*: One of the core vulnerabilities exposed by the pandemic that is of ongoing importance is specialised dual diagnosis support.**

There are several options on providing this going forward. The preferred one would be to hire a speciliased nurse available to residents regularly; alternatively existing staff members could be trained.

V Recommended reading

1. Homeless People Are Among the Most Vulnerable to the Coronavirus. (Yale Medicine)

2. Interim Guidance on Unsheltered Homelessness and Coronavirus Disease 2019 (COVID-19) for Homeless Service Providers and Local Officials (Center for Disease Control and Prevention)

3. COVID-19 & Addiction: Risk of Going Untrested (American Addiction Center)

4. Guidance for People Who Use Substances on COVID-19 (Yale Program in Addiction Medicine)

5. COVID-19 and Homelessness (Homeless Link)

6. Homelessness and the Response to Emerging Infectious Disease Outbreaks: Lessons from SARS (Journal of Urban Health)