SYSTEMS ACCELERANT?

THE RESPONSES OF SIMON COMMUNITIES TO 'FIRST WAVE' COVID-19

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EXECUTIVE SUMMARY

This research evaluates the responses of the eight Simon Communities in the Irish Republic to the challenges posed by COVID-19 from the point of view of the Simon Communities and of key statutory (Local Authority and Health Service Executive) respondents, across the eight regions in which Simon operates, during the 'first wave' or early phase of the pandemic in the period March – August 2020. While responses to the challenges posed by COVID-19 varied across the eight Simon Communities with their different mix and scale of services, the focus of the research is to arrive at an overall evaluation of these responses, rather than providing a detailed evaluation for each region. Although reflecting the Simon Communities context, the findings are likely to be indicative of the experiences of other homelessness NGOs oriented towards single homeless persons during this period.

On the basis of the interviews conducted, the eight Simon Communities have responded well overall to the challenges posed by first-wave COVID-19 across a range of services. Steps were successfully taken to decrease the number of people in any given emergency hostel, move residents to other services and facilities and ensure that cocooning/ isolation sites were established, engage with rough sleepers, and to develop innovative responses to the needs of methadone users. A more mixed picture emerges in relation to adjustments to food and health services and long-term supported accommodation, and in relation to staffing, in the face of the multiple challenges presented by the pandemic. The successful responses in relation to emergency accommodation and self-isolation, engaging with rough sleepers, and innovative responses to drug use, have emerged through enhanced co-operation with local authorities and the Health Service Executive.

Overall, the very low levels of infection and fatality amongst rough sleepers and users of emergency shelters during the first wave of the pandemic was due in no small part to their early recognition as a high-risk group for COVID-19, and the expansion and acceleration of services put in place by homelessness NGOs working together with statutory bodies.

Responses to the pandemic by the Simon Communities- working in cooperation with Local Authorities and the regional Health Service Executive – may provisionally be characterized as a 'systems accelerant'. The term 'system accelerant' draws attention to the strengthened implementation of principles already espoused at policy level (the elimination of involuntary rough sleeping and long-term use of emergency accommodation and moves towards the provision of independent accommodation with appropriate supports).

However, ongoing research is required to monitor whether the gains achieved by Simon services during COVID-19 will be maintained post-pandemic. This crucially depends on the continued and increased supply of suitable accommodation for single persons exiting homelessness, with appropriate health and other supports as required.

CHAPTER 1 – INTRODUCTION

Single homeless persons are vulnerable to infectious diseases due to inadequate shelter and, in many cases, poor health. Ironically, general public health measures, such as stay-at-home rules, restriction of services, and social distancing requirements which restrict access to accommodation, to health and other supports, to friends and family, and to public spaces, potentially worsens the vulnerability of this already marginal population. Homeless services potentially play a key role in mitigating their heightened vulnerability. The present report is a study of one of the leading Irish homeless NGOs, viz. the Simon Community, which comprises of a network of organisations across eight regions of the country, in its responses to the challenges posed by the first wave of the COVID-19 pandemic[1] from March through August 2020.

1.1 Research aim and objectives

This research aims to evaluate the responses of the eight Simon Communities in the Irish Republic to the challenges posed by COVID-19 from the point of view of the Simon Communities and of key statutory (Local Authority and Health Service Executive) respondents, across the eight regions in which Simon operates, during the 'first wave' or early phase of the pandemic in the period March – August 2020. While responses to the challenges posed by COVID-19 varied across the eight Simon Communities with their different mix and scale of services, the focus of the research is to arrive at an overall evaluation of these responses, rather than providing a detailed evaluation for each region.

The objectives of this research are as follows:

- Explore the research and policy context in which Simon Communities operate
- Describe the views and experience of key service providers concerning the responses of Simon Communities during the first wave of covid-19
- Evaluate the responses of the Simon Communities, drawing on a prescriptive, analytical and explanatory framework

The research forms part of a larger study, which will involve interviews with service users (Spring 2021) and follow-up interviews with Simon Communities and statutory respondents (Summer 2021). Although the focus in on the Simon Communities, the research findings are likely to be indicative of the experiences of other homelessness NGOs oriented towards single homeless persons during this period.

1 COVID-19 is the name of the coronavirus disease caused by SARS-CoV-2. Following standard usage, COVID-19 is the term used throughout the report.

1.2 Research Methods

Semi-structured interviews were undertaken with Simon Communities and with statutory stakeholders across the eight Simon regions, exploring the impact of, and responses to COVID-19 on their services during the 'first wave' of the pandemic in the period March – August 2020. Themes addressed in these interviews covered: emergency and long-term supported accommodation; rough sleepers and outreach / drop-In services; housing supports and Housing First tenancy sustainment; health and food services; staffing; and planning and cooperation between the Simon Communities and statutory bodies.

Interviews were conducted with key respondents in each of the eight Simon Community areas from mid-August to early October 2020. These respondents comprised managers within the Simon Communities, and Local Authority and Health Service Executive personnel with responsibility for homelessness and social inclusion services in each area. Findings from these interviews with eight Simon Communities managers, five managers from the HSE[2], and six managers from the local authorities[3], are presented in chapter 4. To provide a strategic policy overview, an interview was unsuccessfully sought with a representative from the Homeless Section of the Department of Housing, Planning and Local Government.

The online semi-structured interviews were recorded and transcribed. Thematic analysis was then carried out on the transcribed data.

Research interviews were conducted in conformity with Simon Community codes of ethical best practice in relation to informed consent. An information sheet was supplied to respondents and written consent was obtained. Respondents were assured of anonymity in relation to use of their interview material. Consequently, neither respondents from the Simon Communities nor respondents from the local authority or the HSE are identified by name or region.

1.3 Interpretive Framework

The interpretive framework employed in this report to inform interview themes and to understand and explain the research findings comprises three aspects: prescriptive, analytical, and explanatory.

The UN Special Rapporteur on Housing provided, in the early stages of the pandemic, a prescriptive checklist of actions that states must take to fulfil their human rights obligations to homeless persons (Farha, 2020). The recommendations relevant to Simon Community services were:

- Rough sleeping
    - urgently provide accommodation to rough sleepers, as a stepping stone to eventual permanent accommodation;
    - guarantee access to public toilets, showers, and handwashing facilities and products for homeless persons who remain living on the street;
    - ensure that homeless people are not criminalized, fined or punished in the enforcement of containment measures;

2 The HSE respondents covered seven of the Simon Community regions.

3 The local authority respondents covered seven of the Simon Community regions.

- Emergency accommodation
    - facilitate pandemic health guidelines around physical distancing, self-isolation, and quarantine;
    - ensure access to privacy, water/sanitation, food, social and psychological supports, health services and testing;
- COVID-19 testing
    - provide homeless persons exhibiting virus symptoms, those who test positive for coronavirus, with a safe place to stay, immediate medical attention, access to food, and any necessary medical and other supports to ensure they can manage quarantine or self-isolation;
- Food and other services
    - ensure that food banks, and other support services for homeless people, are included in the list of essential service providers and are allowed to continue their services;
    - a more decentralised delivery of services, including on-site support or "home" delivery should be considered;
- Supports for service providers
    - governments must ensure that service providers can have access to up-to-date health information, masks, hand sanitizers and any other necessary personal protective equipment required to safely continue providing support services.

This prescriptive framework was used in drawing up the themes to be explored in interviews with the Simon Communities and statutory bodies (see chapter 3).

Analytically, Seeley (2020b) provides a five-fold typology in her review of how homeless services and systems in 21 cities across the globe have responded to COVID-19. This typology distinguishes between:

- 'weakened' systems which have resulted in contraction of or closure of services such as shelters, day services and food provision, and in some cities an increase in punitive measures;
- 'no change' services where few if any changes were made, apart from observing general social distancing and sanitation guidelines and the use by staff of PPE, with no 'homeless-specific' guidance
- 'expanded normal' services which have increased the quantum of services (e.g. number of emergency beds), increased funding, with 'homeless-specific' guidance
- 'broadened normal' services which have increased the quantum of services (e.g. number of emergency beds), increased funding, with 'homeless-specific' guidance, and added elements such as street medical services and better access to temporary and single-person accommodation

- services which have undergone a 'systems acceleration', with a focus on bringing in all rough sleepers and offering own-room or independent-living accommodation. "These cities benefitted from a special committee or taskforce charged with a COVID-19 homelessness-specific strategy, and while congregate services like day centers and soup kitchens may have closed as part of quarantine measures, alternate services in the shape of single-person accommodation with social support replaced them " (Seeley, 2020b: 7). In some cases, this meant widening the eligibility criteria to include some who were in insecure or inadequate housing (see section 2.1 below for an explanation of these terms).

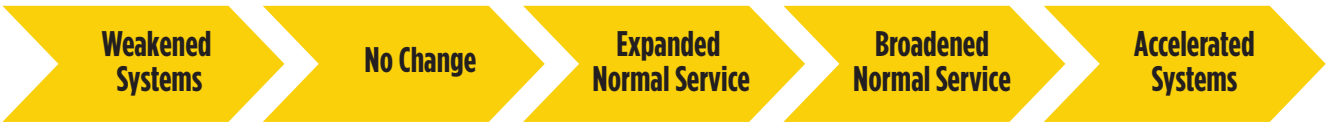

Fig. 1 A FRAMEWORK FOR HOMELESSNESS SERVICES SYSTEM RESPONSES TO COVID-19 (adapted from Seeley, 2020b)

The present report has adapted Seeley's city-wide framework to focus on the services of the eight Simon Communities delivered in conjunction with two key statutory bodies, viz. the local authorities and the HSE, in these regions.

To *explain* which of these options predominated, the social science concept of 'path dependency' is employed (Anderson, Dyb and Finnerty, 2016; Clapham, 2019). In a path dependency approach, the decisions made at one point in a policy pathway are likely to narrow the choices at a later point. However, while the main institutions in society may be solid and only change slowly, at a particular moment striking turns may occur or be activated, for example public health crises such as the COVID-19 pandemic. These possible turns or developments are, however, dependent on and limited by former developments and structures. 'Path dependence' would suggest a preliminary hypothesis that policy and practice responses would reflect both prior policy arrangements and some degree of institutional inertia.

It may be hypothesized that homeless systems which have undergone a 'systems acceleration' are those which, as in the Irish case, had already embraced, at least in principle, housing first and rapid re-housing approaches, and were more likely to accelerate and deepen these efforts in the face of the challenges posed by COVID-19. As Seeley (2020b: 41) suggests, "For systems whose homelessness system was already calibrated to a housing-led methodology, therefore, the COVID-19 crisis may have acted as an accelerant for minimizing use of congregate shelters without requiring a major mindset change". A more agent-inflected version of path dependence would suggest that 'political will' broadly construed (to include the values, commitment, and behaviour of NGO and statutory actors) plays a key role in translating these potentialities into actual policies and practices.

1.4 Research scope and limitations

In terms of the scope and limitations of the research, the following points should be borne in mind:

- The study period is the first wave of the pandemic (the second and third waves will be included in future research)
- The focus is on that section of the homeless population predominantly served by the Simon Communities, viz. the single homeless person with complex needs.
- While there were a plurality of responses to the challenges posed by COVID-19 varied across the eight Simon Communities with their different mix and scale of services and degree of collaborative working with statutory bodies, the research aims to arrive at an overall evaluation of these responses, rather than providing a detailed evaluation for each region.
- The study does not attempt to quantify the health impacts of the pandemic on the homeless population.
- The perspectives of the different agencies were captured via interviews at managerial, rather than rank-and-file, levels.
- The report does not address issues around the quality and sustainability of the accommodation and support measures adopted, nor is it more broadly an evaluation of policy responses to homelessness tout court (though it does tentatively suggest an optimistic interpretation of these responses in section 4.1)
- The perspectives of service users will be captured in fieldwork in Spring 2021.

1.5 Report Structure

Following on from this introductory chapter's discussion of research aim, methods, framework, and limitations, Chapter 2 explores current understandings of homelessness and reviews Irish homelessness policy, with a focus on single homeless persons using emergency shelters or sleeping rough. It also includes a profile of the eight Simon Communities nationally. Chapter 3 presents research findings based on interviews with managers of Simon services and with local authority and Health Service Executive personnel with responsibility for homelessness. Chapter 4 presents the report's conclusions and outlines future research activities.

CHAPTER 2 – UNDERSTANDING AND RESPONDING TO HOMELESSNESS

This chapter provides an overview of theory and practice in relation to contemporary homelessness. It begins, in section 2.1, with an account of four key research findings that have shaped homelessness policy and practice. There follows, in section 2.2 a discussion of homelessness policy and trends in homelessness in Ireland. The challenges that COVID-19 poses to the homeless population is outlined in section 2.3. An overview of the services provided by the eight Simon Communities is supplied in section 2.4.

2. 1 Homelessness theory, research and policy

The widely-accepted European Typology of Homelessness and Housing Exclusion (ETHOS) distinguishes between four broad situations of homelessness and being at risk of homelessness: rooflessness (rough sleeping); houselessness (residing in emergency accommodation); insecure housing; and physically inadequate housing (Edgar and Meert, 2005). In Ireland, the official definition remains that of Section 2 of the Housing Act 1988, where a person is regarded as homeless if the local authority assesses that they have no accommodation that they can 'reasonably occupy', or they are living in some form of emergency accommodation, and are judged to have insufficient resources to secure reasonable accommodation. While this could encompass a wide range of housing need, in practice the definition is interpreted narrowly to focus on those sleeping rough and those living in emergency and transitional accommodation (Daly, 2019).

Four key research findings have shaped homelessness policy and practice in Ireland and in many other countries. Firstly, a consensus on the causes of homelessness ('rooflessness' and 'houselessness') has emerged from work by scholars such as Wright, Rubin and Devine (1998), Fitzpatrick (2005), Busch-Geertsema, Edgar, O'Sullivan, and Pleace (2010), and Bramley and Fitzpatrick (2018). Broadly speaking, this framework sees the causes of homelessness as lying in some combination of structural, familial and individual level factors, with the prevailing combination a matter of empirical investigation. In this complex mix of poverty, adverse childhood experience, low levels of educational attainment, labour and housing market precarity, and mental health and addiction and behavioural issues, homelessness emerges as "the outcome of a dynamic interaction between individual characteristics and actions and structural change" (Busch-Geertsema et al. 2010, p.5). Overall, the risk of homelessness is high amongst poor households impacted by one or more of these additional risk factors (Lambert, 2017; Bramley et al., 2018).

The second key research finding relates to a differentiation amongst the homeless population according to the length of time the person is homeless. Pioneering studies by Kuhn and Culhane (1998) and replicated for the Dublin region (Waldron, O' Donoghue-Hynes, and Redmond, 2019) have demonstrated varying patterns of emergency shelter use, distinguishing long-term or 'chronic' shelter residents with addiction and mental health issues, occasional or episodic shelter users, and one-off or transitional users. As discussed in section 2.4 below, it is the 'episodic' and 'chronic' single homeless person, many of whom may alternate between sleeping rough, using emergency

accommodation, with some spells in insecure and inadequate accommodation, that comprise the bulk of the Simon service users.

A variety of social and economic policies and services may seek to address homelessness, in terms of prevention, emergency response and resettlement measures. At the core of current policy responses to chronic and episodic homeless persons in many countries is the Housing First, or more generally, the 'housing-led' approach to homelessness, and this relates to the third key research finding viz. that chronic and episodic homeless persons can attain residential stability in independent living with appropriate floating supports (Allen et al., 2020). In this housing first approach, housing is itself a form of health care (Parvensky, 2004).

Additional impetus to move to a 'housing first' model of service response, apart from the benefits that independent living provides to formerly homeless person, and the many negative features of emergency congregate settings (Finnerty, 2018; McMordie, 2020), has come from a fourth key research finding, namely the high cost of emergency responses to homelessness, when the cost of emergency health care, policing and other services is added to the costs of shelter provision (Parsell et al., 2016).[4]

Overall, then, current research - and policy in many countries - emphasizes the importance of early intervention and resettlement with appropriate supports for episodic and chronic homeless populations, rather than relying principally on emergency responses to homelessness in the form of shelters and hostels.

2.2 Homelessness in Ireland: Policy and Trends

Homelessness policy in Ireland, in line with the evidence-based policy trends discussed above, has broadly shifted towards a housing-led model (O'Sullivan, 2020). *The Way Home*, published in 2008 just as the global financial crisis was puncturing the Irish housing bubble, had as its key target the elimination of long-term homelessness and involuntary rough sleeping by end 2010 (DEHLG, 2008). A 2013 homelessness policy statement re-iterated this goal (with 2016 as the revised target year for ending homelessness) as well as providing an explicit commitment to a housing-led approach (involving, inter alia, rapid re-housing, ensuring that the time spent in hostel accommodation was kept to a minimum and that rental housing units would be available to homeless households (DECLG, 2013). This housing-led approach to homelessness is sustained in Rebuilding Ireland, the current national homelessness strategy (Government of Ireland, 2016). *The National Housing First Implementation Plan* identified approximately 660 single individuals, who were long-term homeless with complex needs, as suitable for enrolment in a housing first program.[5]

Most recently, the *Program for Government* (Department of the Taoiseach, 2020: 53-4) re-iterates a number of these established objectives in relation to homelessness, including helping rough sleepers into sustainable accommodation, moving away from dormitory-style accommodation, provision of suitable tenancies in the private rented and social housing sectors, continued expansion of Housing First, and ensuring dedicated HSE funding for homeless health services.

4 To these wider social costs might now be added the public health costs during the pandemic. Pawson et al. (2020: 61) suggest that, in a review of Australian policy, "[w]hen reporting on the benefits to people experiencing homelessness that many important COVID-19 measures represent for them, we must acknowledge that these policy and practice measures were motivated to benefit society, not the homeless." See also Parsell et al. (2020).

5 There are of course a wide range of other statutory and voluntary agencies involved in aspects of homelessness services: for details, see Homelessness Inter-Agency Group (2018), MAZARS (2015).

The organizational and administrative infrastructure through which prevention, emergency and resettlement policies[6] could be addressed were also developed during these decades.

In terms of communication and cooperation between the individual Simon Communities and the local authority[7] and health services[8] in their region, these potentially built on the existing relationships through the creation of regional homeless fora[9] (and the setting up of what would eventually become the Dublin Region Homeless Executive), Service Level Agreements and homeless action teams (Anderson et al, 2016).

Despite the pivot towards a housing-led approach, however, the official measure of homelessness (excluding rough sleepers) has registered rapid increases up to early 2020, with an increase of 150% in the numbers of homeless households between 2014 and 2019 (O'Sullivan, 2020; DHPLG, monthly).[10] While the most notable feature of this increase has been the growing proportion of families, single homeless persons – the client group principally served by the eight Simon Communities, as discussed in section 2.4 below – make up the bulk of adults who are 'houseless' i.e. residing in emergency accommodation. Single persons who are 'episodically' or 'chronically' homeless may alternately sleep rough and reside in emergency shelters, and have high levels of addiction and poor health compared to the domiciled population (Finnerty, 2014; O'Reilly, Barror, Hannigan, Scriver, Ruane, MacFarlane, and O'Carroll, 2015; Glynn, 2016; Finnerty, 2018).

Irish homelessness policy has been subject to extensive negative evaluation, particularly in relation to the rise of family homelessness (Daly, 2019; Hearne, 2020). In relation to the current or former 'chronic' and 'episodic' homeless populations that comprise the bulk of the Simon service users, reductions in their number have been identified as depending on the degree of person-centred support and choice, speedy responses, assertive outreach leading to a suitable accommodation offer, services that address wider support needs, and effective collaboration between agencies and across sectors (see section 1.4 above). Conversely, Mackie, Johnsen, and Wood (2019) explore the barriers to delivering these key factors that address street homelessness: "the lack of settled accommodation, funding challenges, ineffective collaboration and commissioning, the needs of different subgroups, ineligibility of some people for publicly funded support, overly bureaucratic processes, and the need for stronger political will". This is echoed in an Irish context by Allen et al. (2020), who note the puzzling gap between housing-led aspirations and the actual outcomes for homeless people, and stress the relative lack of focus and ambition in providing settled accommodation for single homeless people with complex needs.

6 Or 'prevention, protection, and progression' (DRHE, 2019).

7 The Department of Housing, Local Government and Heritage provides an overall legislative, policy and funding framework for homeless services; the provision of these services is the legal responsibility of local authorities (Browne, 2020).

8 The Department of Health and HSE are responsible for the delivery of a range of health-related services and supports to homeless persons. According to the HSE National Social Inclusion Office (2020), key components of such services and supports are to "Provide health services to support the national implementation of Housing First programmes. Enhance mental health and addiction supports, by enhancing supports and services within homeless accommodation and inreach specialty supports and prioritising homeless actions outlined in the National Drugs Strategy. Enhance inreach primary care within homeless accommodation and outreach services for hard to reach people in homelessness with complex needs".

9 These fora were restructured and placed on a statutory basis by the 2009 Housing Act (Allen et al., 2020). These fora are required to produce action plans, the most detailed of which are produced by the Dublin Region Homeless Executive – see Dublin Region Homeless Executive (2019).

10 Persons in domestic violence refuges, in direct accommodation, and those sleeping rough or in 'inadequate' and 'insecure' settings, are not included in this measure (Daly, 2019; Hearne, 2020).

2.3 COVID-19 and Homelessness

The emergency public health measures announced by then-Taoiseach Leo Varadkar in March 2020 was a dramatic response to the threats posed by COVID-19 (see Appendix 1 for a select timeline). However, as Abrams and Szefler (2020:) note, "Pandemics rarely affect all people in a uniform way". This observation is particularly true of episodic and chronic single homeless persons, who typically are highly vulnerable to infectious disease due to inadequate shelter and existing poor health, and in the absence of concerted and targeted public policies, have the fewest resources to mitigate this vulnerability. (Wood, Davies and Khan, 2020).

Responses to pandemics also rarely have a uniform impact, as ironically, general public health measures, such as stay-at-home and shutdown requirements, may impact most adversely on this already marginal population: "Restrictions implemented to reduce the risks of COVID-19 have been inequitable in their impact, with homeless populations struggling to access the food relief, crisis shelter and social supports that they had available to them just… months ago" (Cumming, Wood and Davies, 2020: 1). It is also the case that prevention (social distancing and hygiene, shielding) and containment (self-isolation) requirements may be difficult or impossible to observe for those who are sleeping rough, while the closure of public and 'third' spaces, the curtailment of 'sofa surfing', and the requirement to stay indoors in congregate settings, the traditional and staple form of assistance offered to homeless populations internationally, may now ironically increase their risk of infection (Abrams et al., 2020). As noted by Perri, Dosani, and Hwang (2020: E716), emergency shelters are "an ideal environment for transmission of SARS-CoV-2 because of shared living spaces, crowding, difficulty achieving physical distancing and high population turn-over".

In relation to planning for responses to first-wave COVID-19 in the homeless sector, Ireland did not assemble a special national committee or taskforce or publish a national plan. This contrasts with the situation in England, where a COVID-19 Homeless Sector Plan was drawn up in March 2020 (Kirby, 2020; Lewer, Braithwaite, Bullock, Eyre, White, Aldridge, Story, and Hayward, 2020). In particular, there was no official policy statement in relation to getting rough sleepers off the street - by contrast with e.g. several states in Australia (Pawson et al., 2020) or England (Kirby, 2020), and no detailed information/announcements on additional funding for Local Authorities or the HSE throughout the 'first wave'.[11]

However, guidance circulated by the Dublin Region Homeless Executive (though authored by the HSE Social Inclusion) in early March 2020 (and most likely sent to all local authorities) advised on "general advice about preventing the spread of COVID-19 in Homeless settings and for migrants/ refugees and vulnerable groups. These can be applied in hostels, hubs or residential settings including those without clinic or in-house nursing, medical or healthcare support." (HSE, 2020a). This early March circular was updated several times, throughout the first wave, to reflect growing knowledge about the virus (HSE, 2020b).

11 The Minister did announce, in a 21st March press release, that "…earlier this week I guaranteed our NGOs any additional funding that is needed to take the necessary actions to keep users of their services safe, as well as their own staff."(Department of Housing, Local Government and Heritage, 2020c). Subsequently, the October 2020 Budget announced a 30% increase in spending on homelessness for 2021 (DoHLGH, 2020a).

In general, temporary mitigation measures proposed by the HSE to address the pandemic challenges amongst the homeless population comprise:

- prevention (hygiene, social distancing),
- testing – both outreach (on the streets) and inreach (in homeless accommodation)
- provision of dedicated accommodation for self-isolation/quarantine, a decreasing of density in existing emergency hostels (so that 1 person per room would be the norm), provision of extra emergency accommodation and an enhanced effort to get rough sleepers into such accommodation.
- Special provision for people who use drugs or are on drug maintenance programs: a fast tracking of enrolment in methadone programs, and 'home delivery' of methadone for those in isolation / shielding.

These proposed measures are in line with many of the UN Special Rapporteur's prescriptions on how homeless services should be adapted consistent with a human rights-based response to COVID-19 challenges (see section 1.3 above).

More generally, as discussed in section 1.3, the response of homeless services in different cities and countries display very wide variation. Seeley (2020b) in her study of 21 cities internationally, found that the response of homeless services during the first wave of the pandemic ran a spectrum from a 'weakening' of services through to a systems 'acceleration'. This typology distinguishes between:

- **'Weakened' services** which have resulted in the diminution in services such as shelters, day services and food provision, and in some cities an increase in legal sanctions against rough sleepers. Cities in this category were Rome (Italy) and Moscow (Russia).
- **'No change' services** where few changes were made, apart from containment measures such as social distancing and sanitation guidelines. Cities in this category were Rijeka (Croatia), Brussels (Belgium), and Tokyo (Japan).
- **'Expanded normal' services** which have increased service capacity (e.g. number of shelter beds), increased funding, along with containment guidelines specifically for homelessness settings. Cities in this category were Bratislava (Slovakia), Budapest (Hungary), Helsinki (Finland), Buenos Aires (Argentina), Berlin (Germany), Glasgow (Scotland), São Paulo (Brazil), and Barcelona(Spain).
- **'Broadened normal' services** which have increased service capacity (e.g. number of shelter beds), increased funding, along with containment guidelines specifically for homelessness settings, with the addition of street medical services and better access to temporary and single-person accommodation. Cities in this category were Santiago (Chile), New York City and Los Angeles (USA), Athens (Greece), and Vienna (Austria).

- **Services which have undergone a 'systems acceleration'**, with a focus on bringing in all rough sleepers and offering own-room or independent-living accommodation[12]. Additionally, "while congregate services like day centers and soup kitchens may have closed as part of quarantine measures, alternate services in the shape of single-person accommodation with social support replaced them" (Seeley, 2020b: 7). In some cases, this meant widening the eligibility criteria to include some who were in insecure or inadequate housing. Cities in this category were Adelaide and Sydney (Australia), London (England), and Edinburgh (Scotland).[13]

  Seeley also notes that few cities fell precisely into any one category and may have had elements from several of the categories.

2.4 Profile of the Simon Communities in Ireland

Front-line homeless services in the Irish Republic are predominantly provided by non-governmental non-profit organisations, reflecting both their origins in delivering services that statutory bodies were not providing, and more recently as part of the Irish 'mixed economy of welfare', whereby homeless NGOs work in a coordinated or partnership fashion with health and local government to deliver a range of services. (Anderson et al, 2016; O'Sullivan, 2020).

The eight Simon Communities in Ireland provided services to approximately 18,000 people in 2020. They had an expenditure of €39 million in 2018[14], and are one of the leading charities providing services to homeless persons in Ireland. They are funded from both statutory sources (primarily the Health Service Executive and the Department of Housing, Planning and Local Government / Local Authorities, typically through Service Level Agreements) and from fundraising. As with other NGOs in the homelessness sector, staffing in the Simons moved from being predominantly volunteer-based up to the 1990s to being currently composed of a mix of paid staff and volunteers, in line with the policy developments described in section 2.2 above. These volunteers in turn comprise part-time volunteers, and full-time volunteers.

12 Seeley (2020) employs the term 'system overhaul'. The present research has substituted the term 'systems acceleration' to clarify that what is involved is the strengthened implementation of principles already espoused at policy level (i.e. a housing-led approach which aims to eliminate both involuntary rough sleeping and long-term use of emergency accommodation).

13 Seeley did not include any Irish cities in her sample.

14 Data collated from the websites of the eight Simon Communities. These website details may be found on the website of Simon Communities of Ireland: www.simon.ie

The geographical distribution of the eight Simon Communities is illustrated in Fig. 1 below.

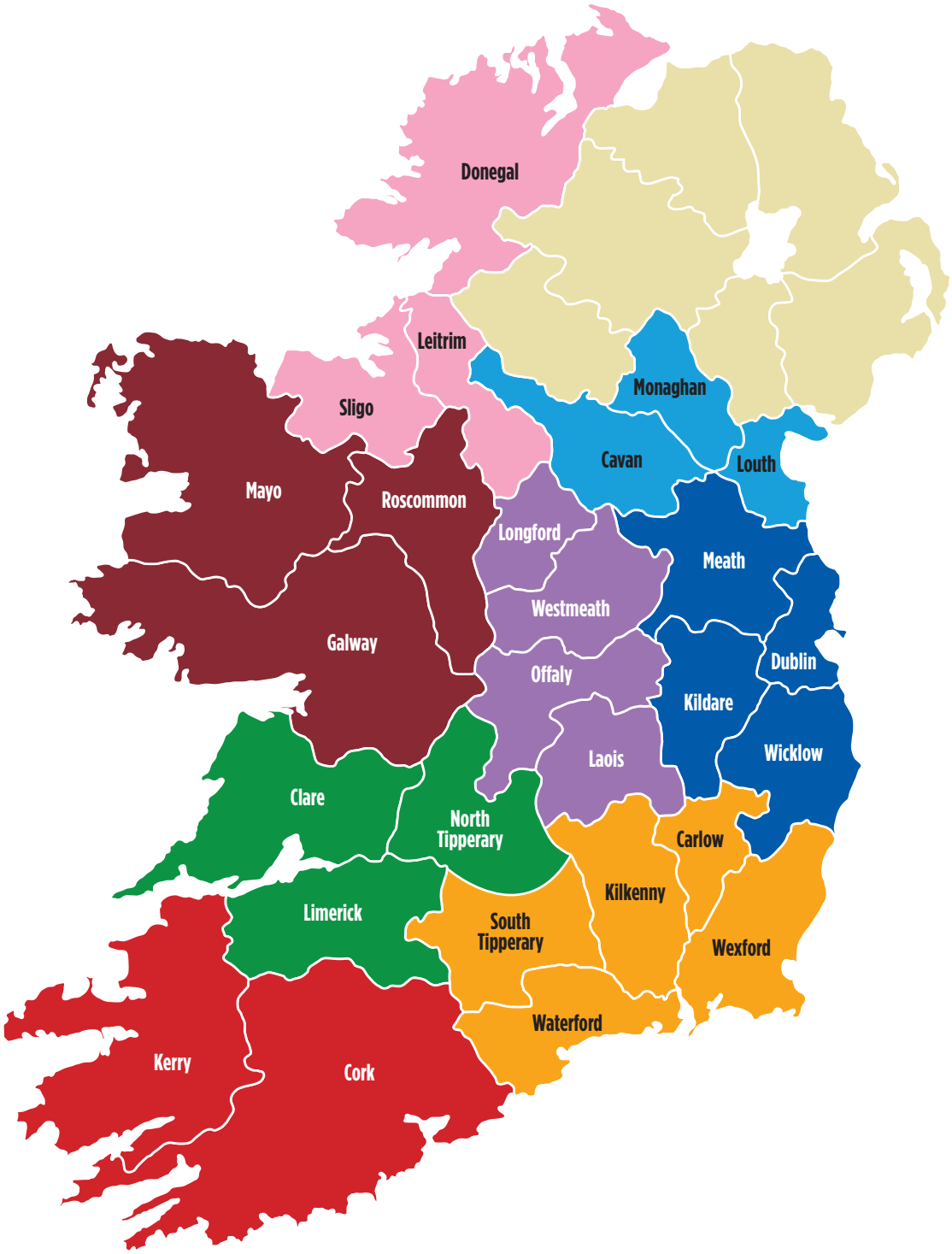

Fig. 1 COUNTY DISTRIBUTION OF THE EIGHT SIMON COMMUNITIES IN THE REPUBLIC OF IRELAND

Dublin – **Dark Blue** | Cork – **Red** | Mid-West – **Green** | South East – **Orange**
Galway – **Maroon** | Midlands – **Light Purple** | North West – **Pink** | Dundalk – **Light Blue**

The wide range of, and variation in, the homeless services provided in the eight Simon areas is captured in Fig. 2 below, and spans preventative, emergency and resettlement services. However, while Simon resettlement services cover floating supports in independent accommodation, and the provision of long-term supported accommodation, Simon does not directly supply independent accommodation to clients.

With some few exceptions, the homeless sub-population served by these Simon Communities comprises single adults, both rough sleepers and in emergency accommodation in the first instances, many of whom would experience 'episodic' or 'chronic' homelessness (see section 2.1) and then in transitional (single unit or congregate) or long-term accommodation (so that the accommodation offered is predominantly for single persons, rather than couples or adults with children) (Finnerty, 2018).

Emergency Accomodation	Cork Simon Dublin Simon	Midlands Simon Galway Simon	Dundalk Simon
Housing Supports & Independent Living	Cork Simon Dublin Simon Midlands Simon	Galway Simon Dundalk Simon Mid West Simon	North West Simon South East Simon
Rough Sleeper Outreach	Cork Simon Dublin Simon	Midlands Simon Galway Simon	
Advice Clinic	Dublin Simon South East Simon	Galway Simon Dundalk Simon	North West Simon
Long-Term Housing Support	Cork Simon Dublin Simon	Galway Simon Midlands Simon	
Tenancy Sustainment Prevention & Resettlement	South East Simon North West Simon	Dublin Simon Galway Simon	Midlands Simon
Family Hub	Mid West Simon		
Housing First	Cork Simon Galway Simon	South East Simon Mid West Simon	Midlands Simon
Health Clinic & Referrals	Cork Simon Dublin Simon	Galway Simon Dundalk Simon	
Food Bank and/or Soup Run	Cork Simon Dublin Simon	Mid West Simon	
Personal Development & Activities	Cork Simon Dublin Simon	Galway Simon Dundalk Simon	
Residential Treatment Services	Dublin Simon		

Fig. 2 RANGE OF SIMON COMMUNITY SERVICES

2.5 Conclusion

Homelessness policy in Ireland has shifted away from a reliance on emergency accommodation and towards a housing-led model with supports as required to sustain independent living. However, while there are policy commitments to ending involuntary rough sleeping and the long-term use of emergency accommodation, and to a housing-led approach, only sluggish progress had been made in implementing these commitments and in reducing the size of the single homeless population. Single homeless people are highly vulnerable to infectious diseases such as COVID-19, making the accelerated implementation of these policy commitments – and the role of homeless services such as Simon - particularly critical. The next chapter presents findings arising from interviews with managers from the Simon Communities and from the local authorities and the HSE, exploring the challenges posed to clients and services by the first phase of the COVID-19 pandemic from March through August 2020.

Chapter 3 – Findings

This chapter presents the findings from online interviews conducted with key respondents in the eight Simon Community areas about the challenges posed by COVID-19. The eight Simon Communities provide a wide range of services spanning the preventative, emergency, and resettlement categories (see section 2.4 above), and COVID-19 posed challenges in each of these services. This was in the context of an expanding knowledge base about the virus during the first phase of the pandemic from March to August 2020.These respondents comprised managers within the Simon Communities, and Local Authority and Health Service Executive personnel with responsibility for homelessness and social inclusion services in each Simon community area. The respondents (eight from Simon Communities, alphabetically denoted A to H; five from the HSE, alphabetically denoted A to E; and six from the local authorities, alphabetically denoted A to F) were assured of anonymity in relation to use of their interview material (see section 1.2): consequently no respondents are identified by name or region.

Interview findings are presented under the following headings: emergency accommodation; long-term supported accommodation and a family hub; rough sleepers and outreach / drop-in services; tenancy sustainment, Housing First and housing supports; health services; food services; staffing; COVID-19 planning; and interagency cooperation (with some overlap between these themes). The UN Special Rapporteur on Housing's prescriptive framework (see section 1.3 above) is employed, where applicable, as a point of reference throughout these sections.

3.1 Emergency Accommodation

As noted in section 2.3 above, emergency shelters provide an ideal environment for transmission of infectious diseases because of shared living spaces, crowding, difficulty achieving physical distancing and high population turn-over. Several challenges thus faced the Simon Communities (Cork, Midlands, Galway, Dublin and Dundalk) providing emergency accommodation. The main challenges identified in the interviews revolved around decreasing density, decanting existing residents, ensuring appropriate accommodation and arranging pre-test isolation, testing and then transfer and supports re isolation and cocooning/shielding facilities. There was broad agreement amongst respondents that the Simon Communities had considerable success in addressing these shelter management challenges.

3.1.1 Containment and mitigation

A big concern for us in terms of the service user was their health…a lot of them have health issues so..we felt they were at high risk if they were to get COVID. We were very worried we were going to lose a lot of people.

Simon Respondent H

In the first wave of panic, trying to find somewhere for everybody and simultaneously we took a room back in every service and we made it an isolation room. So, we had to set those up, take all the stuff out of them, make them extremely clinical, train staff - what to do if somebody came to the office saying 'I have a sore throat' or something. Getting themselves into PPE, get the person in the isolation room.

Simon Respondent C

The early challenges in sourcing protective equipment is illustrated in this comment:

There was some difficulty initially. We were trying to source them from anywhere we could. We were on to the HSE…at the time they had a little bit of supply…that was a challenge, we were getting bits here and there from different pharmacies, but nothing substantial. That was a big worry at the start. After a time the HSE were able to source a lot of PPE but we were into the first couple of months of it…Sanitisers the same – we were getting them from anywhere we could.

Simon Respondent H

The general point is echoed by a local authority respondent:

….but no-one really knew what to do…now there's loads of guidance and loads of best practice but at that time in March -I don't think anyone knew what to do!

Local Authority Respondent E

3.1.2 Decreasing density

A priority for shelter management was to decrease density and move existing residents into other services. The oversubscription of services in ordinary times meant that decreasing the number of residents was a considerable challenge.

> *The immediate thing was how you create distance in services that are oversubscribed. The shelter is always over capacity, and the normal practice would have been to try and bring as many people in as possible even if that meant having to put people on mattresses on the floor next to each other…or even if it meant having to offer the couch in the rec room and somebody else on a mattress on the floor in the rec room.*
>
> **Simon Respondent G**

As a result of high numbers of people in emergency services, space was a real issue in attempting to de-congregate emergency accommodation. As well as alternate arrangements being devised and implemented, new referrals needed to be suspended.

> *We had still the same people in the services, but we were trying to de-congregate a little bit and reduce the number of clients in the service because people were sharing two to three beds, four bed rooms, you know. Then at the same time, we were expected to have an isolation room. But like, we didn't have the space for the people, never mind the isolation room!*
>
> **Simon Respondent A**

> *They started to take over some of the private hostels and stuff at that stage and we stopped taking referrals, so we reduced down then, we still have two people in a room in our services, but they're a distance apart, you know.*
>
> **Simon Respondent C**

In terms of the existing hostel residents:

> *We were doing a lot of work in terms of just talking to people…reminding them of the basic things – the hand-washing, the coughing and the sneezing, the distancing…and to raise the awareness, we were putting information up on posters, stuff like that…letting them know the risks and how they could protect themselves….that was a big piece of work.*
>
> **Simon Respondent H**

In spite of all of the upheaval, quantity of tasks and time involved, Simon Communities appear to have responded well to the task of decreasing the number of people in emergency accommodation.

> *We did well on de-congregating, with huge support from the HSE… and the testing has been really efficient. That provides us a lot of reassurance and relief for staff that they aren't going to be left with somebody with symptoms on sites within an inappropriate setting.*
>
> **Simon Respondent C**

Moving existing residents to other services or facilities required detailed organisation and planning work on the part of staff in Simon Communities, in partnership with statutory bodies.

> *There was a big piece of work between ourselves and the City Council around identifying people within the shelter who could move to other options…like, repurposed B&Bs, hotel rooms, other emergency service providers, and identifying who the people that would be able to cope with that would be.*
>
> **Simon Respondent G**

> *I think it is fair to say that there was a high level of cooperation between all the agencies in the [region] to cater for at risk groups, notwithstanding the shortage of emergency accommodation… Officials are generally proactive and sympathetic to the difficulty of dealing with hard to place clients, so there wasn't any exceptional provisions required to speed up services but having said that they did their best to ensure everyone's case was treated with urgency. [one county council] in particular have reported using the allocation of LA Housing to vulnerable clients as a way to respond to the needs of long term hostel users that would find it difficult to manage social distancing in a congregated setting. [Another] County Council made an arrangement to block book a bed and breakfast for its own use when some of their regular providers shut down.*
>
> **Simon Respondent E**

For some residents, the proposed changes in accommodation made them nervous of moving to unfamiliar surroundings or different services. In relation to moving to cocooning or isolation facilities, one Simon respondent reported that:

> *Mostly they didn't want to go, didn't get the support. The support wasn't there, onsite, the way it was in an STA. They were, you know, afraid to go, afraid of being lonely, afraid of being locked in somewhere where there was nobody else there.*
>
> **Simon Respondent C**

An alternative perspective on this process is offered by a local authority respondent:

> *There were times when I actually did have a battle on my hands… to actually decant the services because I understand that some of these service users don't see [it] as an emergency shelter…they see it as their home, they've been there that long. And I guess in our current role it's changing that mindset – that's not the case, we shouldn't have people consecutively in those beds for longer periods of time than what they should be.*
>
> **Local Authority Respondent E**

To address the loneliness and boredom faced by people who needed to isolate, creative methods were employed. This ranged from ensuring that people had access to a phone and television, to having some games to play to pass the time.

> *We were setting people up in their pod. So, ensuring that people had stuff to do. We had different bits and pieces, like cards, Netflix, stuff like that. You know, I had to go purchase phones, all that kind of stuff for people who were referred in. Providing food, personal care items, basically whatever the individual needed, and the whole purpose of this was to ensure that those individuals stayed in isolation. We supported them to do that, and as comfortably as possible.*
>
> **Simon Respondent D**

This links to the wider role played by emergency hostels in the overall response to homeless services:

> *One of the big learnings for us – and in this we are supported by the HSE and (named) Council, that the congregate settings are not ideal…If a good thing has come out of it, it has given the HSE and the Council more focus…that we need to move away from congregate settings like big shelters… where people are sleeping next to each other….so we're working on something with the [local authority] to source external places.*
>
> **Simon Respondent H**

Based on these interviews, the kind of measures in relation to emergency accommodation proposed by the UN Special Rapporteur discussed in section 1.3 above were, overall, successfully implemented in those Simon Communities which provided emergency accommodation. However, further research is required to explore 'suppressed' demand for emergency accommodation, the movement of long-term residents out of hostels and the experience of service users in this process.

3.2 Other congregate settings: Long-term supported accommodation and a Family Hub

Challenges of containment and mitigation likewise confronted other congregate settings. In terms of encouraging residents to comply with distancing and hygiene guidelines, one respondent noted:

> *we found what was most useful for ensuring compliance or getting people to isolate and stay at home, or getting people to use the sanitiser or increase their hygiene practices…is the relationship they already have with the staff they know…and the relationship they have with the other residents in the house, and their sense of it being their home and their sense of community and responsibility within the neighbourhood.*
>
> **Simon Respondent G**

However, practical difficulties in securing compliance meant certain restrictions had to be put in place:

> *We had to change the use of the kitchen and that was disappointing across the houses because we have really tried over the years to de-institutionalise those places as much as possible and to encourage people to think of themselves as living in a kind of supported house-share: it's their house, its where they live, they can go make themselves a cup of tea at one in the morning if they want.*
>
> **Simon Respondent G**

In one region a number of families were fast-tracked from a family hub into social housing or approved housing bodies housing.

> *So, within, I'd say about two weeks we moved 10 families out. Some went to local authority housing, some went to other AHB housing, some went back to hotel or B&B accommodation. I think there was only two families, that that happened to, it was while they were waiting for accommodation to be ready for them, but it wasn't a very long period. So, literally, it was a really fast turnaround for all of those families…*
>
> **Simon Respondent D**

Based on these interviews, the kind of measures in relation to long-term accommodation proposed by the UN Special Rapporteur discussed in section 1.3 above were, overall, successfully implemented, albeit with increased restrictions leading to a loss of 'homeliness' in some long-stay houses.

3.3 Rough Sleepers and Outreach / Drop-In Services

Rough sleepers, though a small proportion of the homeless population (see section 2.2 above) face particular risks in coping with COVID-19: preventing against infection (social distancing and hygiene, shielding), containment (self-isolation), and accessing the food relief, crisis shelter and social supports that they had previously been available to them (see section 2.3 above). This is in the policy context of aiming to end involuntary rough sleeping. The COVID-19 risks in turn poses challenges for the Cork, Dublin, Galway and Midlands Simon Communities that provide services to rough sleepers. Overall, these Communities had to cut back on certain drop-in services for health protection reasons, while nonetheless maintaining restricted drop-in essential services such as health and food services, and showers and washing facilities. However, outreach teams continued to distribute sandwiches and water throughout, and to direct people to available services.

During the peak of the first phase of the pandemic, the number of rough sleepers decreased, principally as a result of their accepting accommodation. The changing nature of the accommodation 'offer' was pivotal in this regard:

> *…clients having their own space is paramount to sustainability in a placement and also recovery. So sharing facilities – 2 to a room or 3 to a room – is really not productive and that's something we've seen in relation to rough sleepers. …Simon outreach were able to get a number of rough sleepers they had low engagement with because they couldn't offer them anything, they could only offer them a bed in a 4-bed dorm, and they wouldn't take it. But when they were able to get a cocooning facility which was a self-contained unit people came off the streets, they felt much safer…[in relation to accommodation] going forward, service providers need to reflect on what they would provide and we need to look at what we want from service providers….during COVID we had a low amount of rough sleepers - people did choose to come in, they had their own space and they felt safe. ..That's something that needs to go forward, instead of shared facilities…"*
>
> **Local Authority Respondent D**

The drop in facility was ended, but we continued with any rough sleepers or people who would need access for showers or washing facilities or to get food, it was all done on an appointment basis so that staff could then manage social distancing in it. We were trying to regulate it because otherwise people would have been dropping in and hanging out for cups of tea and stuff.

Simon Respondent F

Outreach continued. The outreach team did continue. Again, I suppose they were quite worried about how they were going to operate, but we came in with protocols for them and how they were going to operate, and they continued.

Simon Respondent A

From the start for the outreach team, it was different, obviously. That whole phase of identifying the vulnerable clients and getting people into accommodation and stuff. A couple of people the outreach team were working with did access some of the hotels or the cocooning places. So, at one stage, we were kind of feeling like a lot of people were off the streets, you know?

Simon Respondent C

Another local authority respondent insisted that no rough sleeper who had been discharged from an isolation facility was sent back onto the streets:

[the named] Simon would have gone out and brought these people back in – either back in to services or referred them for isolation, and the isolation was then provided through the HSE Social Inclusion Team, and our services... And once we had someone isolated within a two-week period, they would not have been exited back onto rough sleeping. .... So we had a 14-day window to figure out an exit plan for this client, so where were they going to go: were they going to be suitable for B&B, were they going to be suitable for a bed in [an emergency hostel]. We were able to get an exit plan for them – for just emergency beds, not an exit from homeless services.

Local Authority Respondent E

In a similar vein, a HSE respondent noted:

Nobody who comes into self-isolation from rough sleeping is going to be exiting rough sleeping ...We worked very very closely with the local authority around exit planning...exiting people into more stable accommodation... Some exited to B&Bs, others to the Shelter, others to Housing First.

HSE Respondent E

Based on these interviews, the kind of measures in relation to rough sleepers proposed by the UN Special Rapporteur discussed in section 1.3 above were successfully implemented in those Simon Communities which provided services to existing rough sleepers. They represent an acceleration of existing policy to end involuntary rough sleeping. For those who remained on the streets, a variety of sanitary facilities were provided, again as per the Special Rapporteur's recommendation. There seems to have been a more mixed outcome in relation to outreach and drop-in services, as these were curtailed to some extent (see also discussion of Food and Health services below).

3.4 Housing Support and Housing First, and Tenancy Sustainment

The term 'tenancy sustainment', in the sense employed by the eight Simon Communities, covers housing support services to persons in their own accommodation who have previously been homeless and need continued assistance in maintaining their tenancy. As noted in section 2.2 above, housing supports (including Housing First supports) now feature as a key part of homelessness policy, especially in relation to single homeless persons who have been chronically or episodically homeless.

Although some of the work continued in-person, much of the work in tenancy sustainment during the first wave of COVID-19 was moved to telephone support only, to comply with public health guidelines.

> *All the visiting teams turned into telephone support only. We knew who we needed to contact and who we needed to support during that timeframe. But what was closed down was the clinics, which is where people would drop in and that part of the work was a bit of a pressure point because where would people go then? So, while we were available for visiting support by telephone, we had to make sure that we told the council that they could refer people to that way. So, we would have gotten referrals from the council during that time. We just dealt with people on a one to one as they came through to us.*
>
> **Simon Respondent B**

Moving to telephone support was difficult for both staff and clients, due to the lack of face-to-face conversation and the difficulty in maintaining links with clients.

> *I think it was a challenge from the service user's perspective, in the sense of they just wanted people around and it's come up a lot, that the frustrations were there – 'why are you going again? Sure, you're just in the door. Would you not bring me such a place or could you not do whatever.' There was that kind of frustration. It was the kind of fear that when you were going from one house to another that you could be the super transmitter.*
>
> **Local Authority Respondent B**

> *We did arrange visits and deliveries of medicine and shopping by the Community Garda in [named town], and kept in touch with people by phone*
>
> **Simon Respondent E**

Despite these difficulties, Housing First services were expanded in some instances:

> *…intensive support was maintained throughout, and not just maintained but the service actually developed in that more and more tenancies were filled as they came along… Throughout the pandemic the service managed to support the people involved and it didn't press pause on more people coming into the service.*
>
> **HSE Respondent E**

As the first wave of COVID-19 infection receded towards the end of the summer, housing supports and visiting supports have resumed. Although, policies needed to be developed around home visits in order to ensure both staff and clients continued to be kept safe.

> *Visiting support services, then I mean, a lot of that was done over the phone, and there were no visits for a number of months. They've recently went back to visiting support and like the Sli, Support to Live Independently, and we've developed and approved a policy around how they work, you know, the checks they need to do before they go to visit. They only visit if it's really necessary. So that helps them to feel safe, and also for the clients they're meeting who might be vulnerable, for them to feel safe.*
>
> **Simon Respondent A**

In one region, a co-living[15] project was established in conjunction with the local authority to house homeless single men. Simon have tried to house friends together in order to improve the likelihood of success in this project. Support workers visit on a daily basis.

> *A lot of these gentlemen wouldn't necessarily have strong relationships with family or friends. Some of them have become quite isolated throughout the years, being in homeless services and stuff like that. So, recognition of, 'OK, something different might work here', besides giving these individuals a property, and 'there you go, you're on your own now and manage away'. They had bonded quite well with some other men of their own age group within these services, and we started noticing the really strong relationships. We put a proposal in to the local authority for the co-living project, and this is where the men have been moving into now. For now, we're certainly getting positive responses from the men, you know. They're not isolated, their support workers are going in on a daily basis to those that need it.*
>
> **Simon Respondent D**

Based on these interviews, though not specifically addressed by the UN Special Rapporteur (but broadly speaking coming under the umbrella of 'maintaining existing services') there seems to have been a somewhat mixed outcome in relation to housing supports and tenancy sustainment. A shift from house-calls to phone contacts quite understandably occurred. However, this is a clear instance of services' compliance with public health measures impacting adversely on service users, or at least the balance struck between keeping clients and staff virus-free reduced the nature of the service available.

15 This is not to be confused with 'co-living' rental developments which are now to be restricted under new planning guidelines: see Department of Housing, Local Government and Heritage (2020b).

3.5 Health Services

In relation to the single homeless person who episodically or chronically sleeps rough and/or resides in emergency shelters, or has moved into some form of resettlement programme, high levels of addiction and poor health are often evident and a range of services have developed to address these issues (see section 2.2 and 2.3 above). Given the nature of the COVID-19 crisis, the health and wellbeing of these clients assumed particular significance.

In relation to emergency accommodation:

> *We had the [medical team] with us on-site.... It was certainly very good having a medical team. Initially when we had to get people tested, there were long delays in getting the results...so the medical team were great in being able to chase up the test centres...Then after a while the medical team started doing the testing themselves...the tests were done on site, so if somebody presented with symptoms, they would see them, they'd get the test done that morning, straight away, and get it off.*
>
> **Simon Respondent H**

In relation to rough sleepers, one respondent noted that:

> *Many of the people, they have multiple issues going on. Mental health issues, drugs and alcohol and having nowhere to stay. Once the basic need of a person is facilitated and in a safe environment - they can clean themselves, food readily available and the chance of them being robbed, attacked and all these kinds of things de-escalate. So, they become a little just a little bit happier in themselves. So, their outcomes are slightly better.*
>
> **HSE Respondent A**

The availability of methadone was expedited in some areas, which meant that people with addiction issues did not have to wait for long periods to be included in the programme.

> *Another area where red tape was able to be cut, was being able to initiate methadone for people at short notice compared to having to 10 days and longer to get into a programme and all the red tape around that. This way, people could be initiated on methadone and stabilised very, very quickly.*
>
> **Simon Respondent A**

> *So, I mean, people were just instantly put on methadone that needed it rather than, you know, a nine month wait or something.*
>
> **Simon Respondent C**

There were both positive and negative outcomes for people with addictions as a result of the COVID-19 crisis. Methadone being made more widely available, coupled with people being accommodated in suitable accommodation resulted in some people's addictions becoming more manageable. Unfortunately, the reduced availability of some drugs meant that some people turned to other substances and there were a number of overdoses as a result.

> *What happened for some people, not all people, but some people, was that their drugs and alcohol use de-escalated on a number of grounds. Some people actually stopped drinking through the support of a GP and detox support.*
>
> **HSE Respondent A**

> *But also, with the access to drugs being greatly reduced, there was struggles there because some people obviously couldn't find their drug of choice and consequently shifted to another drug, and we had a few issues of obviously people overdosing simply because you gave me what you had, and then suddenly I took it and I had a bad reaction. I overdosed. So, there was a few issues of people getting taken to hospital because of overdose.*
>
> **HSE Respondent A**

Counselling services continued online or over the telephone throughout. Some clients appear to have preferred this arrangement.

> *Some of our counselling service went to video platforms and you know, telephone conversations. It's only recently we're back in face-to-face in terms of the counselling. Surprisingly enough, clients took to it, the non-face-to-face, which was not what we anticipated. We got good traction with people we wouldn't have normally got traction with. They liked the non-face-to-face.*
>
> **Simon Respondent A**

However, other respondents reported negative results from the curtailment of services, and that mental health issues have increased as a result of the COVID-19 crisis.

> *The support for mental health and addictions, you know, has really sat with us, and that's been very hard on staff, and the team needed to kind of, you know, troubleshoot everything coming up every day with people when their normal services have been closed. Their mental health is worse than it's ever been. So, I think that's the bit that, you know, we didn't do so well.*
>
> **Simon Respondent C**

Based on these interviews, the kind of measures in relation to health needs of the homeless population proposed by the UN Special Rapporteur discussed in section 1.3 above were successfully implemented in Simon Communities, though with quite mixed outcomes in terms of client experience.

3.6 Food Services

The food bank provided by some of the Simon Communities regionally is an important service in addressing the problem of food poverty in Ireland. The number of people availing of the service appears to grown significantly in the first quarter of 2020, in one region growing by more than 20 per cent:

> *The amount of people who needed to access supports around food, clothes, just your basics, you know? Life's necessities to keep your family ticking over. Last year, we served 7,000 people in our food bank services and as far as the end of April this year, those figures had increased to nearly eight and a half thousand.*
>
> **Simon Respondent D**

The traditional 'Soup Run' model involves volunteers and staff of Simon Communities going out onto the streets and offering tea, sandwiches and soup to those who need it. It also offers blankets, clothing and non-judgemental conversation with people experiencing homelessness.

Unfortunately, it was not possible to continue to organise soup runs, whether on the street or on a sit down basis, in many regions during the COVID-19 crisis, due to the challenges posed in ensuring the safety of staff, volunteers and clients. However, some Outreach teams undertook the role of distributing food and water:

> *We called off the soup run in early March. It wasn't possible to run safely, we haven't returned to the soup run yet. So, the job of giving out the sandwiches and the bottled water and the chocolate fell to the Outreach team… which they're still doing.*
>
> **Simon Respondent C**

> *The soup run had to be done as a take-away service…dinners were prepared and given to people at the back gate.*
>
> **Simon Respondent H**

Based on these interviews, though not specifically addressed by the UN Special Rapporteur but broadly speaking coming under the umbrella of 'maintaining existing services', there seems to have been a somewhat mixed outcome in the early months of the pandemic. The curtailment of some food services due to health concerns for staff and clients quite understandably occurred. This is a clear instance of services' compliance with public health measures reduced the nature of the service available.

3.7 Staffing

Simon Communities typically are staffed by a mix of paid staff, part-time volunteers, and full-time volunteers, though with a preponderance of paid staff in recent decades (see section 2.4 above). Interviews across the eight Communities reveal the impact that the pandemic had on staffing arrangements.

Potential staffing challenges clearly loomed large for Simon managers, particularly of emergency accommodation:

> *…from a practical point of view, we were looking at supplementing staffing levels from the casual panel, to make sure that we had enough people there…we were aware that if someone was identified as a close contact in the shelter, it could take several people out. That was a big anxiety.*
>
> **Simon Respondent H**

Neither full or part-time volunteers were generally available, due to public health guidelines or concerns, particularly in relation to emergency and long-term supported accommodation, requiring paid staff needed to assume their roles.

> *The full-time volunteers couldn't come, and many of those we had opted to return to their home countries before flights were stopped, understandably. So, people we expected to have who were built into the rota and were our cover for the next 9 or 6 months or however long they had left in their contracts were suddenly leaving. And, again, entirely understandably. And then the new cohort of volunteers who were due to come in to support our staffing levels, couldn't come. So, we lost all those people.*
>
> **Simon Respondent G**

From the perspective of some statutory respondents, these staffing issues were initially the source of some frustration:

> *There were times …when I had to remind agencies like [named] Simon what their funding purposes were. If I had all outreach teams isolating, what was the contingency for that. And there was struggles within organisations as to what they were going to do. Staff weren't available, relief panels weren't available…*
>
> **Local Authority Respondent E**

In relation to Simon clients moving to self-isolation facilities, one HSE respondent reported:

> *the support would primarily follow from the lead organisations so a support worker from Simon would be working with somebody. That person moves off site from Simon to our self-isolation and we expected that the level of support [from Simon] would follow. That fell down quite a lot…The support didn't travel quite as much as we had hoped. We had our own self-isolation support team that did all the heavy lifting there, basically.*[16]
>
> **Local Authority Respondent E**

16 This respondent noted that two HSE-funded Simon support workers were subsequently recruited for this purpose.

However, staffing systems managed to adapt to the Covid challenges:

> *Obviously everyone thought of the hospital or the frontline staff.... I do think the staff in services like [named] Simon didn't get the merit at the time for what they had to deal with – it was quite commendable – it was a hard one!*
>
> **Local Authority Respondent E**

Many staff needed to be redeployed to ensure that appropriate numbers were always available on site.

> *So, there was a fair amount of planning around staffing and nobody took leave during that time because obviously we needed our front-line workers. We transferred some of my visiting support team across to the front line during that timeframe because they needed them in emergency services.*
>
> **Simon Respondent B**

> *You know, obviously there was a struggle to, you know, to have all your staff on site. So that was another side of it, you know. But that meant we had to deploy people into different positions and into frontline positions if they were working in offices and that, just to make sure there was enough staff onsite still.*
>
> **Simon Respondent A**

Staff were re-trained very quickly in order to work in areas that they may have been unfamiliar with. Staff needed to familiarise themselves very quickly with the new policies and procedures in place.

> *It was a complete shift in programming, I guess. I guess we had staff working there since 2017, and I suppose they applied for a job as working with families, and now here you are with the older gentlemen, who, you know, a whole set of different needs and everything. So, it was a huge shift, I guess, for all of the staff at the time. It really, really has worked well.*
>
> **Simon Respondent D**

> *We're trying to avoid having to bring in an agency, because we don't want the scenario where maybe agency staffers are moving from one service to another. That's why we put a ban on it completely and no temporary staff coming in. So that there was no risk that they were carrying anything into this service.*
>
> **Simon Respondent A**

Based on these interviews, the Simon Communities broadly complied, despite some initial challenges, with the UN Special Rapporteur's recommendations in relation to staffing arrangements so that they could safely continue providing support services.

3.8 Planning for COVID-19

While the appearance of COVID-19 in Ireland had been reported earlier, it was not until mid-March that restrictions and guidelines in relation to homeless services materialised, with a number of updated versions produced (see section 2.3 above, and Appendix 1). The restrictions on movement, social distancing, hygiene and the use of personal protective equipment came into effect quite suddenly, with policies and procedures around accommodation and health services – in collaboration with the local authorities and HSE – apparently developing somewhat more gradually.[17] This communication and cooperation between the individual Simon Communities and the local authority and health services in their region potentially built on the existing relationships through Service Level Agreements, the regional homeless fora, and homeless action teams (see section 2.3 above).

This sudden implementation of restrictions and guidelines associated with COVID-19, resulted in an intensification of activity and preparation works by staff in the Simon Communities as people tried to ensure that procedures, facilities and services were appropriate to both public health guidelines and in keeping people safe.

> *The first month was crazy. Absolutely crazy. It just all seemed to kick off overnight, so there was a lot of scurrying of activity.*
>
> **Simon Respondent A**

> *My role was to identify what was required by the Homeless Service Providers. Identify source for PPE and arrange supply and delivery of same through all the channels available…[and] to support the RGN and GP who work in homeless services in [the region] in accessing testing and also in assisting RGN in getting trained for testing.*
>
> **HSE Respondent C**

The disparate nature of some of the information released during the initial phase of lockdown in March 2020 caused some uncertainty as to what was appropriate for the services. There was also a lack of information specific to homeless services, which required an interpretation of the public health guidelines to ensure that they were adhered to as much as possible.

> *You just had information coming from all directions, and then the next day all the information would change, and then you're trying to communicate that to staff.*
>
> **Simon Respondent A**

> *The problem was the changing goalposts. Are we supposed to wear a mask, are we not? Who wears masks, who doesn't? What is a clinical environment? Where do homeless services fit within these different types of residential services that the HSE were giving guidelines on?*
>
> **Simon Respondent B**

17 Note that the lack of participation by a representative of the DHLGH (see section 2.3 above) has meant that a more strategic insight into these developments is not possible in this report.

Notwithstanding the lack of specific guidelines and information, staff in the Simon Communities adapted well. Policies and procedures to guide and inform staff members were completed and speedily put in place:

> *We came out very quickly with a policy and I visually looked at every single site in the organisation to see was the policy being implemented because, at that stage, we didn't have time, we didn't have the resources to even train people to audit.*
>
> **Simon Respondent A**

> *From an organisational perspective, [...] would have led on providing us with documentation very early on that got created into a policy and procedure, COVID protocols and policy, and that was kind of our solid document and everything else sort of fell out of that over the timeframe, with obviously education to staff and light changes happening on projects. Our guiding documents would've been led mainly by the information from HSE and DCC.*
>
> **Simon Respondent B**

Based on these interviews, supports from statutory bodies for service providers in relation access to up-to-date health information, masks, hand sanitizers and any other necessary personal protective equipment required in responding to covid-19 complied, after some initial challenges, with the UN Special Rapporteur's recommendations.

3.9 Interagency working

While there has always been a degree of joint working in delivering services for people experiencing homelessness, the nature of the COVID-19 crisis and the threat it posed to the homeless population appears to have, in the main, resulted in enhanced inter-agency collaboration. Collaboration between Simon Communities, local authorities, the Health Service Executive and other non-governmental organisations and charities resulted in the adaptation of services, acceleration of certain projects and the formation of stronger lines of communication.

> *One of the things across the board...was the interagency work: everybody was able to see... the most important person, which is the client, and what was the best for them.... That really worked well, that coordination piece which we try to practice every day, but when COVID came, people were really able to drill down to 'what does the person need?'*
>
> **Local Authority Respondent D**

> *It was incredible. It was it is an open forum of a conversation as well. Very defined roles within the project, no overlapping, no stepping on anyone's toes. Very clear definition of whose role what was, and yeah, it was just fantastic. A really positive experience.*
>
> **Simon Respondent D**

This [coordination with Simon Community and local authority] was done on a needs basis – initially looked at the more vulnerable (Rough Sleepers) and then worked in partnership with all other stakeholders in managing all the other homeless accommodation. Meetings were called as required to address the immediate and potential issues. There are good relations between all stakeholders in [the region] so informal and formal work well.

HSE Respondent C

There were regular meetings with the HSE and with the Council…The Council were sourcing extra B&Bs for people…because we had to cut our numbers back. That became easier after a while because there were no tourists as such, there was more access for the Council to get B&Bs for [30] people…There was a constant liaising with the CC: if they saw our numbers going up…they could get spaces in one of the other NGOs or spaces in the B&Bs…working together, it gave us more of a focus, I think.

Simon Respondent H

At the start, we had very frequent communication…we had twice a week call with residential services and service managers where we tried to address issues, we updated and address issues as they were coming up…in my own role I would have been in contact quite regularly – daily – from [named Simon Director] – there would have been ongoing daily issues around particularly self-isolation for the people in the different services

HSE Respondent E

These positive experiences of teamwork between Simon Communities, local authorities, statutory bodies and other NGOs has resulted in not only helping to keep people experiencing homelessness safe during the first wave of COVID-19, but also the possibility of further collaboration.

We are in conversations with the HSE at the moment and the local authority around maybe managing it, you know, as more of a partnership, kind of holistic approach.

Simon Respondent D

However, not all of the experiences of interagency working were positive.[18] In one region, for example, there were issues in attempting to access, supported temporary accommodation.

It was quite disjointed. Again, there was a group of people working together and you were left out of the loop and it didn't matter how much we tried to get access to some of the accommodation, we just didn't.

Simon Respondent A

18 See other comments expressed in relation to staffing.

However, the positive experiences of collaboration clearly outweigh the negative. Individuals in each of the agencies clearly worked very hard to expedite resources, to adapt services and to ensure the safety of clients.

> *I do think it is down to key individuals and key people driving that kind of culture forward. It is a culture of practice.*
>
> *The stuff that we did here… I'm just very proud of it, from a humanitarian perspective.*
>
> **Local Authority Respondent B**

> *It was an example of good practice in exiting people into more stable living and a better quality of life. There's been some fantastic successes around that, to the point that we're now providing policy and developing a system with the Local Authority around the learning from our self-isolation experiences and what can actually be achieved with proper support for people and proper structured exit planning.*
>
> **HSE Respondent E**

Though not an issue addressed by the UN Special Rapporteur in her prescriptive framework, but drawing rather on the evolution of the collaborative machinery at regional level (discussed in section 2.2) and the important role identified played by city-level fora in many cities internationally (Seeley, 2020b), a greater role for the various fora would have been expected. This did not appear to be the case outside of the special case of Dublin. While such informal contacts can make for speedier communication and decision-making, a potential disadvantage is that they are overly dependent on personal contacts.

3.10 Conclusion

On the basis of the interviews conducted, the eight Simon Communities have responded well overall to the challenges posed by COVID-19 across a range of services in relation to the prescriptive human rights framework. Steps were successfully taken to decrease the number of people in any given emergency hostel, move residents to other services and facilities and ensure that cocooning/ isolation sites were established, engage with rough sleepers, and to develop innovative responses to the needs of methadone users. A more mixed picture emerges in relation to adjustments to food and health services and long-term supported accommodation, and in relation to staffing, in the face of the multiple challenges presented by the pandemic. The successful responses in relation to emergency accommodation and self-isolation, engaging with rough sleepers, and innovative responses to drug use, have emerged through enhanced co-operation with local authorities and the Health Service Executive.

Chapter 4 – Conclusions and Future Research

4.1 'Systems accelerant' or 'broadened normal services'?

As noted in section 2.3 above, certain sections of the homeless population – in particular the single person sleeping rough or resident in an emergency shelter - are highly susceptible to viruses such as COVID-19, due to existing poor health and lack of a home, in the absence of concerted and targeted public health and housing policies. Responses to pandemics also rarely have a uniform impact, as general public health measures, such as lockdown requirements, may impact most adversely on this already marginal population in relation to access to food relief, emergency accommodation and social supports. Social distancing requirements may be difficult or impossible to observe for rough sleepers, while the closure of public and 'third' spaces, and the requirement to stay indoors in congregate settings, may increase the risk of infection for those staying in emergency accommodation.

This research set out to describe and understand the impacts of and responses to the first wave of COVID-19 in the eight Simon Communities, from the point of view of managers in these Communities and of key statutory respondents across these regions.

On the basis of the interviews conducted, the eight Simon Communities have responded well overall to the challenges posed by COVID-19 across a range of services in relation to the prescriptive human rights framework. Steps were successfully taken to decrease the number of people in any given emergency hostel, move residents to other services and facilities and ensure that cocooning/ isolation sites were established, engage with rough sleepers, and to develop innovative responses to the needs of methadone users. A more mixed picture emerges in relation to adjustments to food and health services and long-term supported accommodation, and in relation to staffing, in the face of the multiple challenges presented by the pandemic. The successful responses in relation to emergency accommodation, engaging with rough sleepers, and innovative responses to drug use, have emerged through enhanced co-operation with local authorities and the Health Service Executive.

Overall, the very low levels of infection and fatality amongst rough sleepers and users of emergency shelters during the first wave of the pandemic, was due in no small part, to their early recognition as a high-risk group for COVID-19, and the expansion and acceleration of services put in place by homelessness NGOs working together with statutory bodies. The Dublin region had the clearest (written) policy response, in terms of the guidelines circulated by the DRHE (section 2.3 above); in other regions it appears that more informal liaison between NGOs, LAs and the regional HSE were developed specifically to deal with COVID-19 challenges. However, this is in the context of quite a developed homelessness services infrastructure in the main cities, which was successfully mobilised to meet the COVID challenges.

In relation to explaining this recognition of rough sleepers and emergency shelter residents as a high-risk group, the policy and research literature stresses the importance of the degree of person-centred support and choice, speedy responses, assertive outreach leading to a suitable accommodation offer, services that address wider support needs, 'political' will, and effective collaboration between agencies and across sectors (see sections 1.4 and 2.2 above). Some of the

same factors (particularly speedy responses, suitable accommodation offers, services addressing wider support needs, and effective collaboration) were clearly operative in moving residents from crowded emergency shelters, and rough sleepers into a variety of more private and sometimes self-contained accommodation, and in innovative responses to the needs of methadone users.

In general, changes to practice were within the envelope of existing policy aspirations to the housing first, and more broadly, the housing-led model discussed in section 2.2. Employing Seeley's analytic framework set out in section 1.4, responses to the pandemic by the Simon Communities working in cooperation with Local Authorities and the regional Health Service Executive, can tentatively be characterized as a 'systems accelerant' in relation to rough sleeping and emergency accommodation, and to innovative health services around drug use (though not in relation to centralized response planning or to bringing in those in inadequate housing). The term 'system accelerant' draws attention to the strengthened implementation of principles already espoused at policy level (the elimination of involuntary rough sleeping and long-term use of emergency accommodation, and the provision of independent accommodation with appropriate supports).

In terms of the path dependency explanatory framework (section 1.3), the hypothesis that homeless systems which had already embraced, at least to some extent, housing first and rapid re-housing approaches, were thus more likely to accelerate and deepen these efforts in the face of the challenges posed by COVID-19, is provisionally borne out by the findings of the present report. This is clearly the case in relation to repurposing emergency shelters and efforts to eliminate rough sleeping undertaken by some Simon services in collaboration with local authorities and the HSE.

A less sanguine interpretation of the research findings would place these responses in a 'broadened normal service' category based on the continued reliance on emergency accommodation (however 'thinned-out'), and a predicted return to 'business as usual' after the pandemic (for an Australian example of this approach, see Parsell, 2020). This more sceptical evaluation would still be consistent with a path dependency approach, except that the 'continuity' would be with policy shortcomings rather than policy aspirations.

Nevertheless, the broadly positive outcomes registered across a wide range of Simon services has been mirrored in some other jurisdictions e.g. Pawson et al. (2020: 88) in relation to four of the five mainland Australian states note that "COVID-19 has clearly shown that society can temporarily (virtually) end rough sleeping and overcrowded occupancy of shared homelessness accommodation. Australia's challenge — and opportunity — is to take the successes achieved during COVID-19 and integrate them into mainstream systems". This exhortation applies equally to the Irish case, and crucially in relation to the supply of suitable accommodation for single persons exiting homelessness, with appropriate health and other supports as required.

4.2 Future Research

Clearly, in the context of second and third waves of the pandemic, the responses of the eight Simon Communities to the challenges for clients, staff and services require ongoing research, in order to arrive at a more definitive evaluation. As noted in Chapter 1, the present report forms part of a larger study, which will involve interviews with service users (Spring 2021) and follow-up interviews with Simon Communities and statutory respondents (Summer 2021). Of particular importance is whether the positive developments identified in this report are sustained, justifying the characterisation of responses to the first wave of COVID-19 as a 'systems accelerant' rather than an 'expanded normal service'. This crucially depends on the continued and increased supply of suitable accommodation for single persons exiting homelessness, with appropriate health and other supports as required.

Appendix A – Select Timeline of Covid-19 in the First Wave[19]

29th February 2020	The Health Protection Surveillance Centre is informed of the first confirmed case of Covid-19 in Ireland.
6th March 2020	The number of Covid-19 in the Republic of Ireland rises to 18 after five new were identified. One of these new cases is that of a healthcare worker who was in contact with a confirmed case.
9th March 2020	The Government decides to cancel all St Patrick's Day parades on the advice of health officials.
11th March 2020	The first death due to coronavirus in Ireland is confirmed.
12th March 2020	Taoiseach Leo Varadkar announces that schools, colleges and childcare facilities will close until 29 March because of Covid-19, and that indoor gatherings of more than 100 people and outdoor mass gatherings of more than 500 should be cancelled.
16th March 2020	The government established the pandemic unemployment payment at an initial rate of €203 a week. This later rose to €350. By the end of March, almost 400,000 people had applied for the payment.
17th March 2020	In a special Ministerial Briefing broadcast, Taoiseach Leo Varadkar says coronavirus emergency is likely to go on well beyond 29 March.
21st March 2020	Press release from the Minister for Housing guaranteeing NGOs any required funding, secure facilities across the country for self-isolation, and announcing that local authorities are working closely with their HSE counterparts at the local level. Department of Housing, Local Government and Heritage (2020c). DRHE issues guidance prepared by the HSE to local authorities who are engaging with their service providers on the necessary measures.
24th March 2020	The Taoiseach announces stringent news measures designed to curb the spread of Covid-19, including asking people to stay home, unless they could not work from home, with schools and childcare facilities to remain closed until 19 April. All non-essential shops are to close.

19 This timeline draws on a number of sources, including:
https://www.citizensinformation.ie/en/health/covid19/public_health_measures_for_covid19.html#
https://www.rte.ie/news/2020/0320/1124382-covid-19-ireland-timeline/

28th March 2020	A mandatory order for everyone to stay at home for a two-week period until 12 April, apart from certain exceptions, comes into effect across the country. The measures include people only being allowed to leave home for essential work, to buy food, or for certain vital reasons such as attending medical appointments. staff working in homeless NGOs providing emergency accommodation to homeless households are deemed essential personnel, as are staff involved in the provision of private emergency accommodation (Hotels and B&Bs).
29th March 2020	A second press release from the Minister for Housing (Department of Housing, Local Government and Heritage, 2020d) confirming that staff working in homeless NGOs providing emergency accommodation to homeless households are deemed essential personnel, and announcing the supply of additional accommodation for self-isolation and to meet social distancing requirements.
18th April 2020	The stay at home measures are to continue until the 5th May 2020 (on 1st May, they were further extended to the 18th May).
15th May 2020	The Government proposes a 5-stage exit plan, with successive loosening of restriction through to August 2020.
29th July 2020	The Minister of State with responsibility for Public Health, Wellbeing and National Drugs Strategy, Frank Feighan, notes the number of outbreaks of COVID-19 in homeless services has been minimised, with only 15 cases associated with 4 clusters (Departments of Health and of Housing, Local Government and Heritage, 2020).

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