COVID-19: opportunity to improve crisis responses to homelessness?

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Public Health

Background COVID-19 struck when, despite plans to support the homeless population in Scotland, sustainable arrangements seemed beyond reach without a change of mindset by all providing support.

Methods Four case studies describe the experience of individuals who received support during the COVID-19 pandemic. Late in 2020 support workers selected individuals whose support would have been different without the pandemic; sought their permission; and collected information from case notes and those engaged.

Two other case studies describe new models addressing homelessness in response to the pandemic. During December 2020 the author interviewed managers who had contributed to the design and delivery of those models, and accessed data collected for other purposes.

These six studies are tested against the five core principles of the Plan to End Homelessness, the basis of current homelessness policy in Scotland.

Results COVID-19 stimulated new forms of support for Edinburgh's homeless people, and a new culture of working together to solve urgent problems in ways that are person-centred and relationship-based.

Discussion Tackling homelessness in these ways highlighted resistant structural problems, notably how to ensure sufficient affordable housing. Plans to prevent homelessness must address such problems.

Conclusion This new approach marks a cultural change in multi-agency services support for homeless people. The challenge is to sustain these improvements, and learn lessons for the future.

Keywords: COVID-19; Scotland; homelessness; housing; healthcare; social care; public health; social policy; case studies; interpersonal relations

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Introduction

In the two years before the pandemic, there was a change in national policy approaches to homelessness. This stemmed from the work of the Homelessness and Rough Sleeping Action Group[1] and the resulting Scottish Government's Plan to End Homelessness,[2] published in 2018 and revised during the pandemic in September 2020. The key principles of the policy are:

- Taking a person-centred approach.
- Preventing homelessness from happening in the first place.
- Joining up planning and resources to tackle homelessness.
- Responding quickly and effectively where homelessness happens.
- Prioritising settled homes for all.

In essence, the policy aims, by doing everything through the lens of these five principles, to end homelessness. To do this requires a massive culture change and a real shift in attitude of those responding to homelessness. Fundamental to this shift is not just responding to lack of housing, but also addressing the health of the public.[3]

The COVID-19 pandemic required a public health response including rapid cross-sector collaborations and quick decisions to provide safe new solutions for those who were rough sleeping or in other insecure or temporary accommodation where staying safe from transmission was much more difficult. This necessity had the unexpected benefit of creating a context for those engaged in homelessness service across third, public, and sometimes business, sectors to experience this shift. This paper offers an early qualitative review of the impact of those new solutions using the framework of the key

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principles of the Plan to End Homelessness. It uses evidence from case studies of the pandemic to test the efficacy of the policy against practice.

This paper focuses on a narrow range of crisis responses to homelessness, driven by the COVID-19 pandemic and building on pre-existing plans; these are not long-term, sustainable solutions to homelessness. Those solutions require recognition of, and engagement with, the much deeper systemic structural issues which drive people into homelessness. In particular long-term solutions to homelessness need to deal with issues that crisis responses cannot – notably the impact of poverty, especially childhood poverty, lack of access to affordable housing and secure, properly paid work;[4] and the overlap between homelessness and outcomes like chronic offending and substance misuse.[5]

Thus this paper shows how the crisis highlighted the importance of trusted relationships and a person-centred approach in the journey of support. It evidences how the pandemic changed the way services were offered, which in turn changed how those needing support changed their engagement with the support on offer. We provide evidence of how introducing prevention into the spiral of homelessness can happen even at a point of crisis. We also show how the rapid nature of cross-sector decision-making required by the pandemic stimulated new understanding in decision makers, which encouraged them to think differently about the system and experience the cultural changes needed to realise the vision of the Plan to End Homelessness.

Homelessness in Edinburgh

Edinburgh has had a systemic homelessness problem, both hidden and exposed, for many years. It has around 11% of the total number of homelessness presentations in Scotland. This is driven by several interconnected structural issues including poverty levels,[6] shortages of temporary and long-term affordable social accommodation, the use of short-term lets and welfare reform. Only 14% of Edinburgh's stock is social housing compared with closer to 25% in other major cities.[7] An economy significantly dependent on tourism[8] puts additional pressure on accommodation provision throughout the year and drives private rented accommodation out of the reach of people on low incomes.[9] The waiting time for social housing is often two years or longer and the number waiting is growing as the city continues to expand. Before the COVID-19 pandemic, much of the accommodation used to house people in crisis had been 'congregated' with shared facilities, for example bed and breakfast accommodation, often of poor quality, purchased from the private sector, hostels, and night shelters in church halls, all with little private space.

The number of homeless presentations in Edinburgh fell from 4,016 in 2014/15 to 3,188 in 2018/19, although this figure grew again in 2019/20 to 3,355.[10] The number of people rough sleeping in Edinburgh is less clear, as any count is only a snapshot; however recent evidence gathered by third-sector organisations suggest an average of 120 to 150 people sleep rough most nights in Edinburgh. Over 1,112 unique individuals presented at the Edinburgh Night Shelter, run and funded by Bethany Christian Trust in the period from its opening in September 2019 to the closing of the hotel-based accommodation in July 2020; 95% of these individuals indicated their only alternative would have been sleeping rough.[11]

Daytime homelessness crisis response is provided through the City of Edinburgh Council's (CEC) Access Point (the team that assesses whether someone meets the criteria to be classed as homeless), supplemented by the work of a variety of third-sector services,[12] some of which, but not all, are commissioned by CEC. The night-time offer is primarily the night shelter, the care van, street teams and some other food-based provisions, with CEC's out-of-hours service providing access to emergency accommodation. Supporting this are several hostels, and rapid-access accommodation including private sector bed and breakfast accommodation which is purchased as required.

Despite the best efforts of many organisations, from both the third and public sectors, to provide high-quality person-centred, relationship-based services which could respond quickly to need, systems were slow and often unable to respond to crises smoothly and quickly. For example, in 2019/20, 49% of those who presented at the night shelter did so because no suitable accommodation was available.[13] Where a place in bed and breakfast accommodation could be found, the average length of stay was 14-18 months.[14] The impact on mental health of staying in bed and breakfast accommodation is enormous, and the likelihood of people returning to homelessness is high.[15]

Those who are homeless or at risk of homelessness are over-represented amongst those presenting with drug-related infections, trauma and harm. In 2016 audit of the Edinburgh Access Practice (GP surgery for people with past or present experience of homelessness) found:[16]

- 87% of patients have a long-term physical health problem, with an average of three conditions per person.
- 70% have the triple morbidity of physical, mental and substance use problems.
- The average age of death was 47 for men and 41 for women.[17]
- The health of those presenting was comparable to that of a general population cohort in their 80s, despite the vast majority being under 60 years of age.

All of these factors have a huge impact on the health of those experiencing homelessness. There were already many barriers to homeless people accessing healthcare. Some of these are related to services, for example GP registration, rigid appointment systems with loss of access for failure to attend, and availability of the required documentation. Some factors are about the individual's own circumstances,

e.g. literacy skills, access to the internet, trauma, mental health, previous negative experiences of services, and mistrust of state support. These barriers exacerbate existing vulnerabilities and, in a pandemic, make those experiencing homelessness even more vulnerable.

Methods

The case study approach places complex subjects, in this case homelessness policy, into a real, living context where the lives of those affected by the policy decisions are the lens through which the efficacy of those policies can be assessed. The cases chosen cannot cover every aspect of a given policy but should offer insight into the human impact of a policy and bring to light different phenomena and influences that policies in the field need to address.

Cyrenians have worked to tackle the causes and consequences of homelessness for over 50 years. Cyrenians have 50 projects,[18] local and national, working right across the spectrum from crisis responses to very early interventions. From the very outset Cyrenians have believed in the importance of putting lived experience at the heart of policy making; and then listening, reflecting, testing and reaching conclusions. Cyrenians also believe that individual solutions to homelessness lie in values-led, relationship-based approaches which place respect and compassion at the heart of the support being offered; with 'successful outcome' being defined by the person being supported.

This paper lives this belief, presenting data from two sources: four case studies of individual people who were experiencing homelessness when the pandemic began; and two interviews with the managers of projects – Milestone House Intermediary Care Unit (MHICU) led by Cyrenians and the Welcome Hub led by Bethany Christian Trust – which radically changed their method of delivery on seeing the experiences of the pandemic by those facing homelessness.

These six pieces of evidence are tested against the five core policy principles of the Plan to End Homelessness, which will drive homelessness policy in Scotland over the coming years. These are generally accepted by those in the homelessness sector as the key principles to address and test proposed changes in support, not least because they were shaped and influenced by people with lived experience.

If the Plan is to end homelessness, its core principles need not just to define system change required but also to be effective in reducing homelessness. The pandemic created an opportunity to test the validity of these principles against practice in the very different circumstances in which decisions were made – quickly, across sectors and with little immediate focus on cost.

Each case study includes a brief review by one of the Cyrenians or Bethany support workers of the specific impact on the individual's welfare of decisions made because of the pandemic about their support, and their engagement in the decision-making. These reviews are necessarily subjective as the supporters were engaged in those decisions and, more importantly, working with the subjects of the case studies. The trust already existing in those relationships leads to an openness which outweighs any dangers in inconsistency of inquiry which a first-hand account method might risk. The individuals were selected for review in response to a specific request to Cyrenians and Bethany staff for this paper but those conducting the reviews received no other guidance other than to provide information about pandemic-driven decisions with individuals experiencing homelessness. The information for the reviews was taken from case notes, and the personal knowledge of staff engaged in the events and decisions.

Individuals were chosen for review because decisions about the support they received would have been very different without the pandemic. Those individuals gave permission for their support worker to use the review in the paper but the narratives have been anonymised. The reviews were conducted during November and December 2020. In the view of the staff and the author, these cases are good examples of the impact of the pandemic on decisions about support for those experiencing homelessness – typical examples of an atypical context. The author has edited these studies for stylistic consistency and to test them against the five core principles of the Plan to End Homelessness.

The project-based case studies are new models of responding to homelessness which have emerged from decisions driven by the pandemic. The author drew the information for these studies from interviews with the managers of the projects. The data were collected during December 2020 in separate interviews face to face with each manager, who provided further data collected for other purposes. Both managers were engaged in the design and delivery of the projects from which these new models arose. Their evidence provides first-hand accounts of the journey from idea to implementation, as well as comparisons with what came before. The two projects were chosen as good examples of emerging new models of work needing cross-sector decision-making driven by the needs of the pandemic. Both created opportunities for participants to experience the cultural and mindset changes required for the success of the Plan to End Homelessness.

All six case studies are illustrated by evidence from studies in homelessness before COVID-19 and analysed through the lens of the five principles underpinning the Scottish Government's Ending Homelessness Together Action Plan.[19]

Results

This section presents findings from personal experiences of being homeless in the pandemic through four individual case studies and two interviews with managers of projects that radically changed their method of delivery in response to tough experiences of homelessness in the pandemic.

Individual case studies

Box 1 Individual A

Situation

A was referred to Cyrenians Hospital Inreach Team (CHIT) by the ward staff at Edinburgh Royal Infirmary (ERI) in November 2020. A had been living in a camper van and had no permanent home. In the previous months his health had deteriorated quickly since heart surgery in July 2020, and he had had multiple admissions to Emergency Departments and cardiac wards. Because he was living in his van during the pandemic, and subject to rules around mixing with other households, A had become very isolated and was not seeing anyone regularly. This had had an additional adverse effect on his recovery.

Response

A had never accessed homelessness services before being in hospital. The CHIT team were able to guide him through the system and work with him over four weeks to look at his housing options. Medical staff all agreed that his accommodation was exacerbating his deteriorating health, evidenced by two further admissions to hospital during these weeks. A was referred with continued support to the Private Rented Sector (PRS) project, a joint pilot project as another response to the pandemic set up by a partnership between Cyrenians, Crisis and the Simon Community and funded by the Scottish Government to access the much-increased availability of private rented accommodation due to the pandemic.

Outcome

Within two weeks of being referred to the PRS project, and whilst continuing to receive support from CHIT, A was able to access a new tenancy close to his family and spend Christmas with them. The joint working between NHS and Cyrenians and the access to new resources in the form of the PRS pilot mean this whole process took only six weeks. Before the pandemic, this would have taken much longer and included a stay in temporary accommodation, which would not have helped his recovery.

Box 2 Individual P

Situation

P was a long-term rough sleeper who had been a regular user of the Edinburgh Night Shelter. Although he was in a Housing First tenancy, he continued a chaotic lifestyle due to significant alcohol addiction arising from previous trauma and post-traumatic stress disorder (PTSD). This had been confirmed by medical assessment but P had not been able to engage with any treatment offered. P had had multiple admissions to Emergency Departments over several years only to discharge himself and return to his drinking which was usually spirits. His capacity to sustain engagement in any support offered was limited. P had regularly ended previously accessed support because of episodes of binge drinking triggered by the PTSD. P had lost several tenancies and other accommodation over several years through alcohol abuse and challenging behaviour, and was in danger of losing his present tenancy.

Response

P presented to, and was offered a place at, the Old Waverley Hotel in Edinburgh (alternative to the Night Shelter) early in the first lockdown. He soon began to engage with the support being offered in a way which staff noted as different from previous attempts to draw him into housing. Though the conversations were not radically different from many with P in the Night Shelter and elsewhere, the hotel context seemed to make the difference. He was finally able to articulate where he wanted to be in the future rather than simply deal with the immediate situation. In the two weeks P was in the hotel he displayed no difficult behaviour and continued to show real engagement with support being offered. P stopped drinking spirits and accepted support from the GP for alcohol craving. He was eating well and regularly, and showed much physical improvement. P was offered a supported accommodation place in Bethany House Hostel, which he accepted.

Outcome

P is still resident in Bethany House Hostel. He continues to engage with support staff who have known him for several years and see a marked difference in his physical wellbeing with very different and much more positive behaviour patterns. Asked why he had engaged differently, P said the hotel felt calmer. He said it provided a different type of stability and comfort, because he could stay all day and knew when meals would be available; and he did not have to worry what would happen once he had to leave in the morning. Unlike the Night Shelter, he could stay there during the day, and the support he needed came to him rather than him seeking it out. This meant he could meet the different services he needed to talk to, without retelling his story several times; he could rely on communication between support services, which made him feel confident that the support was working.

Box 3 Individual W

Situation

W was admitted to hospital just before lockdown with infected injection sites in his left leg. He had been homeless in Edinburgh for nine years with multiple admissions to the Emergency Department, and was sleeping rough when admitted. W had no family support and was very wary of engaging with agencies or support services. He was withdrawing from heroin and wanted to discharge himself against medical advice, as in previous admissions. The Drug Liaison Nurse was able to start W on methadone, which enabled him to choose to stay in hospital.

Response

W was due to stay in hospital for at least a week. He was nervous of this but the Cyrenians team visited him every day, building up trust to explore what kind of accommodation he would like to access. During these conversations W was helped to realise he would not be able to look after his wounds if he returned to the street and being on crutches while rough sleeping would put him at even greater risk. The pandemic created a level of engagement with W which enabled the Cyrenians team to discuss self-care decisions with him, previously impossible. He finally agreed that we could seek temporary supported accommodation for him. Although W had been homeless for nine years, his fear of statutory services meant he did not have homeless status with the Council. Cyrenians liaised with the Council Housing Officer at ERI and W was immediately given homeless priority status and allocated a Housing Officer.

However, the situation changed quickly when ward staff advised Cyrenians on the third day of W's admission that he was being discharged that afternoon, owing to pressure on beds. Cyrenians worked with the ERI to secure him hospital accommodation for a further night and then focused on accessing accommodation for his discharge. Before the pandemic, a major challenge was helping health staff under pressure understand that discharging someone to an appointment with the Council's Access Point was not discharge to accommodation suitable for recovery, or even to accommodation at all. However, the pandemic meant the need for people to be in safe accommodation where they could isolate created common purpose, so things happen much more quickly, with organisations being much more flexible. As a result, Cyrenians managed to secure W a space at supported accommodation on his discharge the next day.

Outcome

One year later W remains drug free and still lives in the supported accommodation. He has not had any hospital admissions since moving in. He is fully engaged in the 12-step drug rehabilitation process, now volunteers with Crossreach and spent Christmas with his family this year for the first time in nearly a decade.

W is clear that his health improved dramatically during the pandemic. He has somewhere to stay, where he can recover from his infection, receive regular support and food, and access his methadone easily. Both W and the team judge that one extra night in hospital which, without the added pressure of the pandemic would have been difficult to achieve, changed the trajectory of his life. Speaking of his admission to hospital and the work he and Cyrenians had done together he said; 'If I hadn't met you guys, I would have left straight away. We both know I'd probably be dead or overdosed in a doorway somewhere'.

Box 4 Individual M

Situation

M had lived rough on the streets of Edinburgh for over ten years. Seen as a local 'character', he occupied the same spot and regularly received food, clothing and money from the public. But the statutory agencies and third sector knew little about him or the precipitating factors for his homelessness. Cyrenians had been engaging with M for three years using the relationship-based approach, accepting they might never know his full story, but instead getting to know him as much as he would allow. However, we provided regular contact by visiting him on the street every day without challenging him to change his life until he was ready. Until the start of the pandemic the work progressed slowly: other professionals were introduced and M started engaging with health services, social work and other street-based service providers. We also established a relationship with a local accommodation service who allowed M to use their facility while on the street. We saw this service as a potential long-term plan should M ever decide he was ready to get off the street.

The pandemic changed this as it required M to leave the street as safely and appropriately as possible. This was a concern as it was enforced change rather than giving him any choice. There was a real prospect that M would refuse to move indoors. That could lead to criminal charges, reducing his capacity to access services.

Response

The trigger that persuaded M to move indoors came from an unexpected event building on the relationship-based approach that Cyrenians had pursued. The Cyrenians worker whom M knew best had to isolate on returning from Spain because of the pandemic. When M heard why the worker had been away for so long, this experience of someone whom he trusted persuaded him to concede reluctantly that moving indoors was probably a good idea, despite resisting that

before the pandemic. The service who knew M offered him accommodation. As M had not engaged with the benefits system for years, however, a new claim was urgently needed. To their credit the Access Point social work team achieved that quickly, again because the pandemic demanded that and enabled them to do it.

Outcome

M still resides in the same place, working with support staff on site. He is physically better through access to healthy food and engaging with those around him. Initially M only wanted to be there temporarily, but now states two years would be a 'good length of time to stay there', and has finally spoken a little about re-establishing contact with his family. Thus the pandemic ended a slow-paced conversation about ending long-term rough sleeping, and gave M a new start based on trust in a relationship that convinced him the pandemic was real and needed a response from him. Without the relationship built up over years, M would have been much less able to decide to end his rough sleeping. The pandemic meant the funding required through the benefits system and access to accommodation happened quickly so the momentum created by the pandemic-driven decision to move was not lost.

Case studies of service change

Box 5 Milestone House Intermediary Care Unit (MHICU)

Need

Homeless people spend longer recovering in secondary care, as home care and rehabilitation is very difficult in insecure accommodation. They often discharge themselves, leading to re-admission, and increased morbidity and risk of death. Even if they do stay for the time required, outpatient management is difficult through lack of funds for travel, access to transport, and managing appointments within a chaotic lifestyle. Thus we identified the need for safe places for discharge where this vulnerable group with complex needs could isolate whilst recovering, avoiding temporary accommodation where the chance of contracting COVID-19 was greater.

Response

Together NHS Lothian primary and secondary care, CHIT, Waverley Care and City of Edinburgh Council Social Work and Housing Departments jointly established Milestone House Intermediary Care Unit (MHICU) within six weeks of lockdown in March 2020. The project created a safe space where relationships could form between third-sector support staff and patients using the CHIT model, while providing safe multi-disciplinary care to finish recovery from acute illness. MHICU assisted hospital flow, managed comorbidity, and provided opportunity to assess and address chronic health issues alongside social and housing needs. The pandemic focused minds and ensured that the decision to progress and fund took three weeks. Normally a cross-sector project of this scale takes at least a year to plan, design, fund and agree governance. Instead those responsible agreed to manage issues raised by the collaboration as the project progressed.

Surprisingly there were and are very low levels of COVID-19 in the homeless population of Edinburgh and many other, but not all, cities across the world.[20] MHICU took patients similar to those CHIT would have taken, but for whom supporting at home or similar would have been much more difficult in lockdown. This 'step-down' model has proven a very effective addition to the CHIT model. It reduces the challenge of managing difficult accommodation and regular outpatient appointments, which can be difficult for those with challenging underlying conditions.

Outcome

Between April and December 2020 there were 50 admissions to MHICU: 29 from hospital, 14 from the community to avoid hospital admission, and 7 following failed discharge. Average stay in MICU was 25 days, ranging from 3 to 98 days. At admission all patients had addiction issues; 13 had no fixed abode, 16 were in temporary accommodation, 16 had a tenancy, 2 were in a tenancy awaiting repairs and 3 were awaiting transfer to more suitable tenancy. At audit 28 had achieved planned discharge to suitable accommodation, 14 had discharged unplanned, and 8 were ongoing. There was substantial renewed engagement with healthcare:

- **Primary care engagement**
  Sixteen patients re-engaged with primary care: nine registered with a GP, five accessed community physiotherapy, one undertook cognitive assessment to improve access to welfare support, and one accessed social work and substance misuse services. All had previously been unable to access primary care services.
- **Hepatitis C treatment**
  Four patients began hepatitis C treatment, three re-engaged with treatment and two were supported to complete treatment.
- **Hospital outpatient management**
  Sixteen patients were supported to attend hospital outpatient appointments. Another nine were supported through treatment for chronic health conditions where the alternative would have been hospital admission – including cancer, severe rheumatoid arthritis, and drug-related infection.

- **Prevention of hospital admission**
  In six patients admission to MHICU prevented acute hospital attendance or admission, and in another nine MHICU reduced time in hospital.
- **Housing**
  Nine patients moved from no fixed abode to appropriate accommodation. Seven moved to more appropriate accommodation. One returned to an altered tenancy.
- **Community support**
  Ten individuals re-engaged with community support services. Four were newly referred to addiction services, 15 for housing support and two for homecare support.

The MHICU was created to ameliorate the potential impact of COVID-19 on the homeless population. Decisions were taken very rapidly in a cross-sector collaboration which was able to bypass the usual barriers. Though the initial assumption about need was pessimistic, medical and social outcomes for users been so good that MHICU has been funded until August 2021, and there is a concerted effort to fund it in the long term.

Box 6 Welcome Hub

Need

The Scottish Government and CEC reacted quickly to the pandemic and, in partnership with several third-sector organisations, arranged the provision of hotels and other suitable accommodations to ensure that everyone would have a safe space to stay and isolate if necessary. A wide variety of partners came together to provide staffing, healthcare, housing and food; and redeployed their efforts to the locations where people were being housed. Street Outreach teams and drop-in centres targeted individuals who were sleeping rough to offer them a place indoors. Very soon almost all in need had somewhere safe to stay.

Response

In April 2020, as part of this programme, the Old Waverley Hotel was booked to act as a full-time alternative to the traditional Night Shelter. Run by Bethany Christian Trust, supported by CEC and a team of charities, the Old Waverley welcomed over 700 people though its doors in its six months of operation. About half of these were accessing homelessness services for the first time. The previous Night Shelter had opened nightly from 9pm to 7am and provided a hot meal and the use of a camp bed. It had hosted around 1,000 distinct individuals in the previous 12 months.

Outcome

Using hotel-based resources as a response to rough sleeping during the first lockdown showed some clear advantages. People do not have to leave the next morning as the building provided 24-hour support. There is increased dignity for people to use a bedroom with facilities, change and wash in their own space without simply staying in their own clothes and sleeping in a shared room. Many had previously found the congregated model intimidating, especially those who were escaping from violence or mental health problems; sometimes they had experienced violence from others in the Night Shelter. Those using the hotel facilities had more space to settle, and more time to come to terms with losing their home (and often their relationships) than in a congregated setting. They were more willing to engage with support services and often became healthier. Many using the hotel, who had previously not engaged with support services, began to take up offers of help and moved from the hotels into temporary accommodation, or even permanent. Partnership working, developed over many years with many services across many types of need, was much more effective because there were another 14 hours a day for partners to interface with those they support.

As a direct result of this experience, a decision was taken no longer to run a Night Shelter as a congregated model. Instead, a new Welcome Hub opened in October 2020 using 65 beds in a hotel, booked until May 2021 in the first instance, and paid for by CEC and Scottish Government. Previously the full costs of the Night Shelter had been met by Bethany Christian Trust. In this new model several other charities partner with CEC staff, who provide both concierge and housing staff, and NHS public health and primary care staff. Early evidence suggests this model, formed in a crisis, continues to have a positive impact. Between October and January, 583 distinct individuals had used the Hub, 83% of whom later found suitable alternative accommodation.[21]

Testing the evidence against the five core principles of the Scottish Government's Ending Homelessness Together Action Plan

1. Taking a person-centred approach

The clearest example of the benefit of a person-centred approach is individual M. The opportunity to leave the streets after ten years presented because of the relationship which had built over several years. His lifestyle meant he had little awareness of the pandemic and he was suspicious of anyone telling him he was 'in danger'. But hearing the Cyrenians worker's story gave M a new perspective, and enabled him to feel he was choosing for himself to move indoors, thus improving his health.

The value of being at close hand cannot be underestimated. For A and W the presence of CHIT members on the hospital ward and in the MHICU facilitated conversations which felt more natural and personal, unbounded by appointments, travel and formality. A had never previously accessed homelessness services. The team was able to find a quick solution because they could accompany him through a strange system when he was seriously ill.

Facing immediate discharge from hospital, W overcame fears, and benefitted from the advocacy of CHIT. With safe accommodation, regular relationship-based support, good food and easy access to a methadone prescription, his health greatly improved during the pandemic because the CHIT team had time and opportunity to discuss his options. The creation of the MHICU during the pandemic removed the threat of sudden discharge and built relationships with homeless patients, helping them to take the right next step and thus their recovery.

Feedback from P about using the hotel highlights the importance of dignity, access to washing facilities, three meals a day, and not having to leave at 7am every morning. Being able to access housing, social work, health and social support all in one place without a myriad of appointments was described as helping people feel they are 'finally in charge of their own destiny'. As one person put it: 'The Link Worker changed my whole outlook on assistance: I was helped to get a social worker, GP, Housing Officer and accommodation, with moral support and kindness shown throughout.'

2. Preventing homelessness in the first place

For W and P, MHICU and the Welcome Hub broke the cycle of homelessness and loss of support. For A, CHIT prevented long-term homelessness. By supporting people to complete their treatment, the MHICU enabled W to get better and move to somewhere where he was more likely to recover and get support to access permanent accommodation.

On average, 25 of the people accommodated at the Welcome Hub each week have not previously accessed homeless services and would otherwise be sleeping rough. Catching them at this key moment and providing well-rounded support mean that they are less likely to suffer the health consequences of long-term homelessness. Though this model does not work for everyone,[22] it makes enough difference to provide a strong case for continuation, though not in isolation.

3. Joining up planning and resources to tackle homelessness

In all four individual case studies, quick collaboration achieved better and more sustainable outcomes. Someone like M moving into accommodation after over a decade on the streets and then engaging in support to maintain that accommodation exemplifies collaborative working. Thus COVID-19 helped decision makers see the impact of quick, collaborative decision making on the experiences of homeless people like A, M, P, and W rather than assessing impact theoretically through a risk-averse lens driven by inappropriate accountability models. It showed that bypassing barriers and fear of 'getting it wrong' put good outcomes within their grasp, and the grasp of those in need.

4. Responding quickly and effectively when homelessness happens

Both the MHICU and the Welcome Hub increase the potential for a quick and effective response to homelessness. The Welcome Hub can prevent people in the early stages of homelessness from becoming trapped in a cycle which can potentially lead to much poorer health outcomes. The MHICU allows interventions at the point of illness, with potential to break the cycle of homelessness and ill-health. P and W provide good examples of new arrivals who move on quickly.

Both services provide a place of stability, informality, dignity and compassion for building the trusted relationships which underpin increased engagement with services – even when there has been previous resistance. This engagement is even more likely when those supported can access the full range of services in one place, because the services are either all present as in the Welcome Hub, or all accessible by advocacy and accompaniment, as with the CHIT service linked to the MHICU. A, W and P all illustrate this, and they are not unusual.

5. Prioritise settled homes for all

The lack of affordable housing in Edinburgh is the biggest barrier to these initiatives achieving their full potential. The need for affordable housing across Scotland is well documented. The housing charity Shelter Scotland recently called for 53,000 new affordable homes to be built in the next five years, 60% of them in Edinburgh.[23] In response, Edinburgh Council has committed to building 20,000 affordable houses over the next ten years.[24] But the biggest challenge to achieving this is land costs.

The cost of temporary accommodation continues to grow. Over the last three years the cost to the Council of using bed and breakfast accommodation was approximately £14m a year.[25] There are around 10,000 homes advertised in Edinburgh for short-term lets which is around 31% of the total in Scotland.[26] Furthermore new regulations which restrict how long one can be in 'unsuitable accommodation' will add

significant pressures, as a lot of the present accommodation will no longer be legally useable as temporary accommodation for longer than seven days.

The connection between stable affordable housing and good health is clear.[27-29] The experiences of A, P, W and M show how new services and faster collaborative decision-making can achieve stable accommodation for some people experiencing homelessness. MHICU and the new Welcome Hub create the kind of relational environments that enable some in the crisis of homelessness to access the support they need. But access to those opportunities is not universal, and other homelessness services struggle to achieve stable housing for those they support. On 30 September 2020 the number of open homelessness cases in Edinburgh was 27,332, a 20% increase over a year; and 14,151 households were in temporary accommodation, a 24% increase over a year.[30]

Discussion

The four case studies show how the COVID-19 pandemic led to faster, more collaborative cross-sector decision making. This was driven largely by the imperative to reduce the likelihood of homeless people contracting COVID-19, but had the effect of improving their recovery from illness and ability to manage their general health. Thus a relational, person-centred approach can benefit people experiencing homelessness. The pandemic enabled services that previously could not make quick decisions because of restrictions driven by laborious decision-making protocols and funding limitations, to take radical approaches which led to good health and other outcomes for all four individuals. The combination of a person-centred approach, collaborative services and the need for safety in a pandemic led to good decisions which do not need a pandemic before we repeat them.

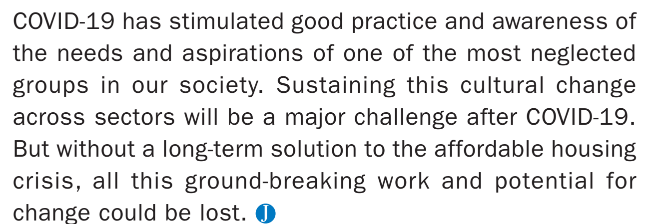
This is further evidenced by the successes of MHICU and the Welcome Hub, both of which grew out of the imperative to enable homeless people to isolate because of COVID-19. The decisions to create them were very rapid and culturally different from the usual process of service design and cross-sector collaboration. The danger of COVID-19 in this vulnerable group allowed decision makers to take a different view of the constraints which usually shape such discussion, including budgets, models of accountability, competing political objectives, and professional protectionism. The focus was on the risk to the individuals experiencing homelessness rather than to those taking decisions. These decisions could not have been achieved in the same time frame outside a pandemic.

The impact went further. The Welcome Hub grew out of the experience of getting those sleeping rough into a safe place. The clear benefits triggered another cross-sector decision to change the congregated night shelter provision, including introducing public funding. As a result, more people experiencing homelessness will get support at the right time in the right way. The MHICU was also driven by a public health response – to patients testing positive for COVID-19 and discharged from hospital with mild symptoms, but without appropriate accommodation. This decision also quickly overrode the usual barriers including funding. Though fewer patients tested positive for COVID-19 than expected, the pandemic encouraged rapid adjustment to meet the public health needs of the homeless in general – with excellent health and other outcomes.

Conclusion

The pandemic has encouraged both public and third-sector services to take culturally radical decisions focusing on the key principles of the Plan to End Homelessness. It created a context in which services could quickly experience the benefits of responses to homelessness which have dignity and compassion at their core. These stimulated quick, personalised steps where the individual receiving support was at the heart of decisions.

COVID-19 has stimulated good practice and awareness of the needs and aspirations of one of the most neglected groups in our society. Sustaining this cultural change across sectors will be a major challenge after COVID-19. But without a long-term solution to the affordable housing crisis, all this ground-breaking work and potential for change could be lost.



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