HOMELESSNESS SERVICE SYSTEMS RESPONSES TO COVID-19

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ABSTRACT

This paper seeks to uncover what factors account for differing homelessness sector responses to COVID-19 in twenty-two cities. Information on each city's response and implementation process was collected from cities in the form of surveys with follow-up interviews alongside supplemental information provided by the cities themselves or gathered via secondary research. The study lays out a framework for responses: weakened systems, no change systems, expanded normal services, broadened normal services, and system overhaul. Expectations are that a city's welfare regime, its enshrinement of housing rights, pre-crisis homelessness management policies, resource availability, and homeless population size will be the determining factors in its response type. However, results suggest that welfare regimes, population size, and housing rights had minimal impact on shaping city response; lack of resource availability, pre-crisis homelessness management policies, and clear direction from a provider-inclusive leadership team showed stronger impact.

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CONTEXT: HOMELESSNESS AND COVID-19

Pandemics have never been experienced equally by all people. Throughout history, infectious diseases have again and again been felt more heavily and experienced more fatally by people "experiencing poverty, marginalization, stigmatization and discrimination" (Perri, Dosani, and Hwang 2020). The Black Death killed a third of the world's population by 1351, but the highest number of deaths occurred within the poorest populations (Ahmed et al. 2020); the 1918 influenza struck the poor first, and worst (Mamelund 2018); the waves of typhus throughout the 1800s, which saw notably high death rates among upper classes, killed a far higher number of the lower classes (Hays 2005). This disparity is rooted in a host of causes, from living conditions and housing density to lack of access to reliable information channels, leaving vulnerable populations unaware of or unable to practice protective measures.

The COVID-19 crisis no different: it is "increasingly demonstrable that social inequalities in health are profoundly, and unevenly, impacting COVID-19 morbidity and mortality" (Abrams and Szefler 2020). Caused by novel coronavirus SARS-CoV-2 and belonging to a highly contagious viral family, COVID-19 is "primarily transmitted between people through respiratory droplets and contact routes" (Public Health England 2020). Symptoms vary in severity, from asymptomatic infection to acute respiratory distress, pulmonary embolisms, delirium, and stroke, and severity seems to be tied to certain co-occurring health factors, such as asthma, old age, and other immunodeficiencies. Early data shows that these features have rendered the virus both more prevalent and more dangerous to already-marginalized populations, with risk of severe disease and death higher among people from "deprived areas or

from certain non-white ethnicities" (Public Health England 2020). What this suggests is that while rich and poor may be equally susceptible to viral transmission, they are not at equal *risk*.

Government advice with regard to prevention and viral containment has emphasized self-quarantine and isolation, stringent hygienic and sanitation practices, implementation of regulations around face masks and shields, and closure of congregate public spaces (Okonkwo et al. 2020). This can be problematic for people in lower socio-economic groups broadly; it is impossible for people experiencing homelessness, who live at the crossroads of multiple disadvantages and vulnerabilities. Dr. Jim O'Connell notes that the "pillars of viral containment and treatment—physical distancing, frequent handwashing, quarantine, isolation, and sheltering-in-place—are rendered futile, if not impossible, when viewed from the lobby of a crowded shelter" (O'Connell 2020). The Culhane, Treglia, and Steif model estimates that, given no change in system services, people experiencing homelessness in the United States[1] would be twice as likely to be hospitalized over the course of the crisis period, two to four times as likely to require critical care, and two to three times as likely to die, with as many as 21,000 total hospitalizations and 3400 deaths:

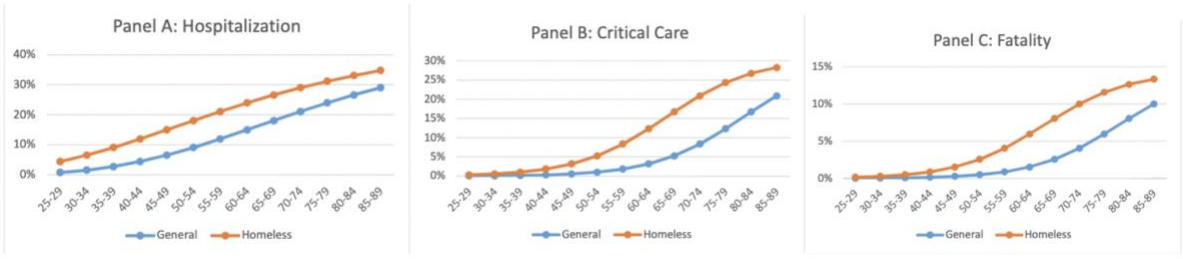

FIG. 1: ESTIMATED IMPACT OF COVID-19 ON U.S. HOMELESS POPULATIONS (CULHANE, TREGLIA, AND STEIF 2020)

[1] Testing in the United States has been at best unequally distributed, and difficult for many homelessness service providers to access; it is possible, if not likely, that the true impact of COVID-19 on homeless populations will never be known.

Rough sleepers are more likely to suffer from lowered immune response due to malnutrition, exposure, stress, and lack of sleep (Abrams and Szefler 2020); more likely to belong to marginalized ethnicities, genders, classes and castes; more likely to lack access to hygiene facilities, sanitizing agents, and protective gear; and, of course, more likely to be unable to self-isolate while living and sleeping in public, makeshift, or communal spaces. It is a population for whom viral exposure is probable, prevention difficult, and mortality rates likely to be high. Additionally, both COVID-19 and homelessness are in a sense *urban* crises; although cases of both do exist in rural communities, their impact has been felt overwhelmingly in cities: over 90% of COVID-19 cases have been recorded in urban environments (United Nations 2020) and the majority of people experiencing homelessness are likely doing so in cities.[2]

Homelessness is a phenomenon which primarily takes place in public and communal spaces, and as a result, rough sleepers in some homelessness systems during lockdowns found themselves with no safe place to self-isolate or quarantine. Outside, they were at increased risk of fines and arrest, while emergency shelters were "an ideal environment for transmission of SARS-CoV-2 because of shared living spaces, crowding, difficulty achieving physical distancing and high population turn-over" (Perri, Dosani, and Hwang 2020). These challenges rendered individuals more susceptible to transmission and potentially increased the severity of their symptoms while the service system grappled with the reality that existing processes reinforced—rather than relieved—these harms.

[2] It is admittedly difficult to quantify percentage of homelessness taking place in rural rather than urban environments, as rural homelessness tends to be of a "hidden" nature.

Most homelessness service systems take a broadly similar shape: congregate emergency shelters, day centers, meal services, and outreach teams form the bulk of services, complemented by smaller (and often strained) prevention and housing support services:

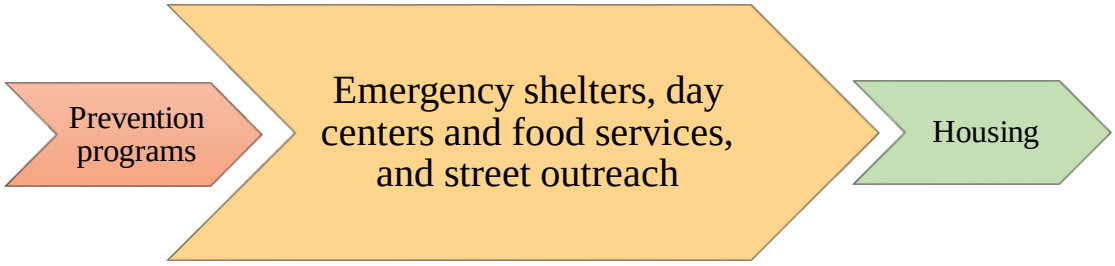

FIG. 2: TYPICAL HOMELESSNESS SERVICES SYSTEMS SET-UP

These congregate spaces were the ideal environment for transmission of SARS-CoV-2, and as governments introduced measures to contain and combat COVID-19, the homelessness sector was faced with the challenge of adapting service systems which often operated in direct conflict with the best guidance around viral suppression.

A FRAMEWORK FOR SYSTEM RESPONSES

Homelessness sectors responded to COVID-19 with varying degrees of change and at varying speeds. Some systems were able to manage near-complete service redesigns almost overnight, while others made few, if any, adjustments. Responses have fallen along a spectrum, with restricted access to existing services on one end and moving exclusively to single-person accommodation on the other.[3]

[3] I first proposed a version of this spectrum in a report on homelessness and COVID-19 for the Centre for Catholic Social Thought and Practice, but will develop it more thoroughly here, and explore what may have influenced cities to develop certain types of strategies.

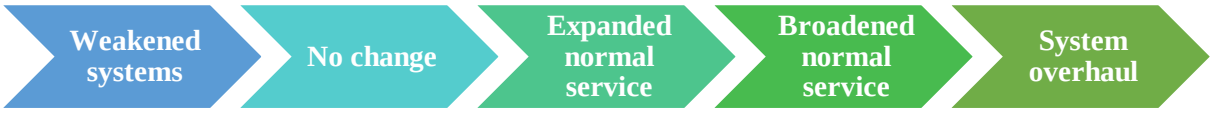

FIG. 3: A FRAMEWORK FOR HOMELESSNESS SERVICES SYSTEM RESPONSES TO COVID-19

Weakened Systems. A "weakened system" in this paper is defined as a system which restricted access to typical supports and services, typically while increasing criminalization measures against homelessness. Restrictions included closing day centers, food kitchens, and night shelters without providing alternative housing or shelter options, while criminalization included increased fines and threat of arrest, either for being in public spaces while stay-at-home orders were in place and/or for failure to wear masks or face shields. Cities in this category are Rome, Italy and Moscow, Russia.

No Change. This paper defines systems which saw "no change" as those which implemented no special measures, received minor if any additional resources, and followed no homelessness-specific guidance, although they may have followed broad citywide guidance around increased handwashing, frequent sanitation, and encouraging or requiring staff to wear personal protective equipment (PPE). Cities in this category are Rijeka, Croatia; Brussels, Belgium; and Tokyo, Japan.

Expanded Normal Service. "Expanded normal service" describes systems which may have received increased financial resources alongside protective gear, tailored guidance, and usually an influx of space for congregate shelter, typically repurposed buildings or additional bed space in existing shelters. It includes cities that accomplished this by extending the dates of their winter programs, which increase the number of beds and services available during the winter months when cold weather can render sleeping outside more deadly. Cities in this category are

Bratislava, Slovakia; Budapest, Hungary; Helsinki, Finland; Buenos Aires, Argentina; Berlin, Germany; Glasgow, Scotland; São Paulo, Brazil; and Barcelona, Spain.

Broadened Normal Service. This paper defines "broadened normal service" as expanded normal services *plus* special measures, such as medical street teams, alongside increased access to temporary housing and single-person accommodation. The foundational shape of the system did not change significantly, but services received an influx of financial resources, protective gear, mobile testing and health screenings, and were able to access a significantly higher amount of single-person accommodation through partnership with hotels, hostels, and community centers. Additionally, services were linked to quarantine shelters or other accommodation specifically for people experiencing homelessness who tested positive for COVID-19. Cities in this category are Santiago, Chile; New York City, USA; Athens, Greece; Los Angeles, USA; and Vienna, Austria.

System Overhaul. A "system overhaul" describes cities which sought explicitly to bring all rough sleepers inside and into single-person accommodation, typically through partnerships with hostels, hotels, and other businesses. 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:

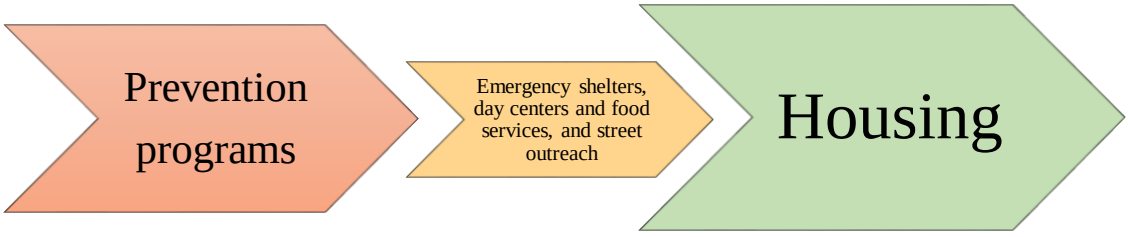

FIG. 4: A MODEL FOR REORIENTATION OF HOMELESSNESS SERVICES TOWARD HOUSING

In some cases, this shift meant broadening who was considered eligible to receive homelessness services—while some programs may have previously required individuals to have been rough sleeping, some cities permitted individuals in unstable, overcrowded, or inadequate lodging to access those services as a prevention measure. Prevention measures are therefore included in the chart above, but as prevention programs often form their own service ecosystem (including services like rent support and landlord mediation, which are not applicable to rough sleepers) they will not be discussed in this paper other than to acknowledge that building out prevention services has been part of many cities' strategy. Cities in this category are Adelaide, Australia; Sydney, Australia; London, England; and Edinburgh, Scotland.

Cites broke down into groups as below, although it should be noted that few cities fell perfectly into any one category and may have had elements from several:

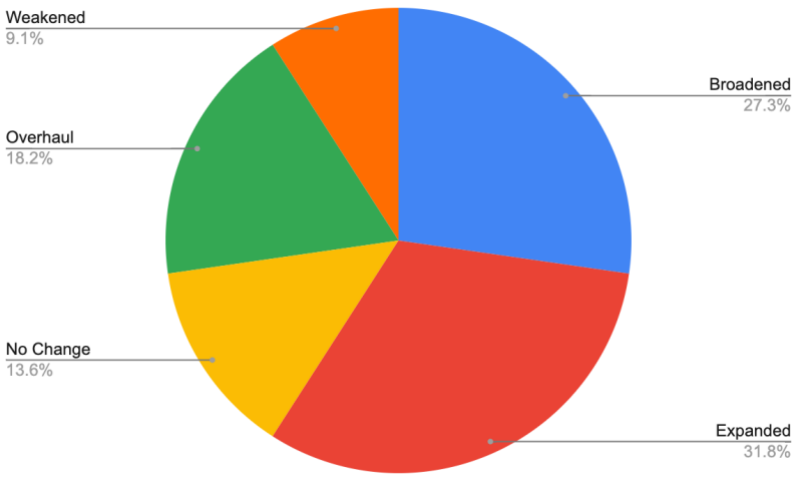

FIG. 5 BREAKDOWN OF CITIES INTO SYSTEM RESPONSE TYPE

The most common responses to the crisis were expanding or broadening homelessness systems, with slightly more cities expanding rather than broadening services. The most common measures taken were provision of PPE (63.64% of cities), lowered capacity in emergency shelters to enable social distancing (45.45%),

the opening of new congregate shelter space (45.45%), and increased single-person housing availability (71.43%):

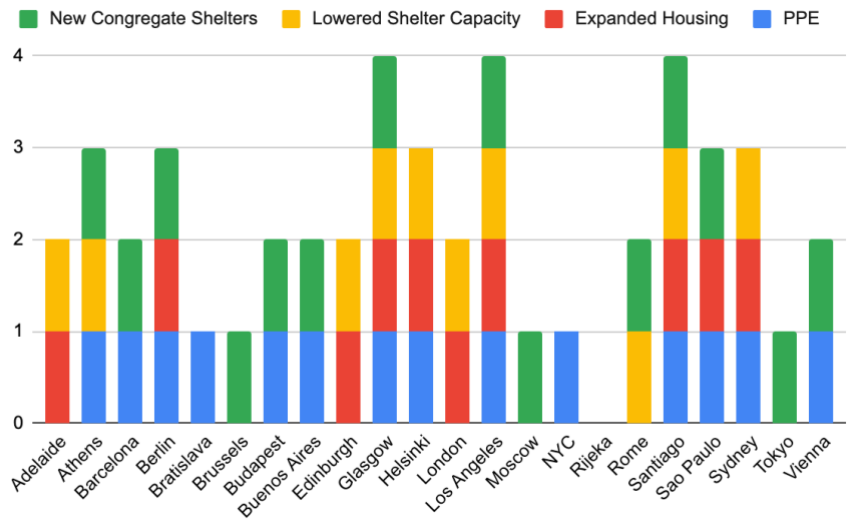

FIG. 6: MOST COMMON COVID-19 PROTECTION MEASURES IN HOMELESSNESS SERVICES

METHODOLOGY

This dissertation will seek uncover what accounts for differences in policy responses to COVID-19 in the homelessness sector, using original qualitative research from survey and interview data collected from twenty-two cities alongside secondary research via publicly available information from cities and local media. The paper will focus on city, rather than national, responses, as typically homelessness services are designed and run by municipal governments and NGOs, although they may align with national guidance or strategies, sometimes in order to receive funding. The paper will use the terms “homelessness sector,” and “homelessness services system” interchangeably to mean the official or sanctioned ecosystem of services through which people experiencing homelessness in a given city may access housing and crisis support, which may include both government programs and cooperative NGOs. Given the still-developing status of the crisis, this

thesis will be time-bound, looking specifically at the period between February and June 2020, when global lockdown measures were at their peak (Aura Vision 2020).

As this paper focuses on government response, independent services offered by NGOs (that is, services not offered at least in partnership with local government) will not be considered as part of the city's "official" response even if those services did not run counter to government guidance. In areas where coordination levels between NGOs and local government are low, this admittedly leaves out a significant piece with regard to the experience of people experiencing homelessness. However, in cities where NGOs operated without partnership with, or in direct opposition to, local government measures, these services were not part of the city government response and therefore will not be "counted." The paper will also not evaluate system responses in terms of "effectiveness," as it is too early to appropriately evaluate how "well" systems performed, particularly as many places have been unwilling or unable to perform appropriate levels of testing.

The cities selected for this paper were chosen based on two criteria: (1) similar normal service set-ups, where 'normal' indicates a status quo and not a normative judgement on quality or kind of service availability and (2) similar or overlapping definitions of homelessness, as defined using the Institute of Global Homelessness (IGH) Global Framework. Homelessness as an international phenomenon has no standardized definition, so survey respondents were asked to use the IGH Global Framework to identify how homelessness manifests in their city. The framework "captures three broad categories of people who may be considered homeless, defined as 'lacking access to minimally adequate housing,'" (Busch-Geertsema, Culhane, and Fitzpatrick 2016) and has been selected in place of other

frameworks for its specifically global perspective:

FIG. 7: THE IGH GLOBAL FRAMEWORK FOR DEFINING HOMELESSNESS (BUSCH-GEERTSEMA, CULHANE, AND FITZPATRICK 2016)

It is notoriously difficult to accurately enumerate people experiencing homelessness, and not all cities do so on a regular basis; this paper has taken the reported numbers at face value, though they are contested in some places. Figures used are from the most recent available count, which may not all be from the same year (and certainly have not all used the same methodology). For this reason, the numbers should be considered for the impact within their own context but not necessarily for direct comparison to one another. For example, Rome's data comes from a count conducted in 2014, and more recent numbers are not available.

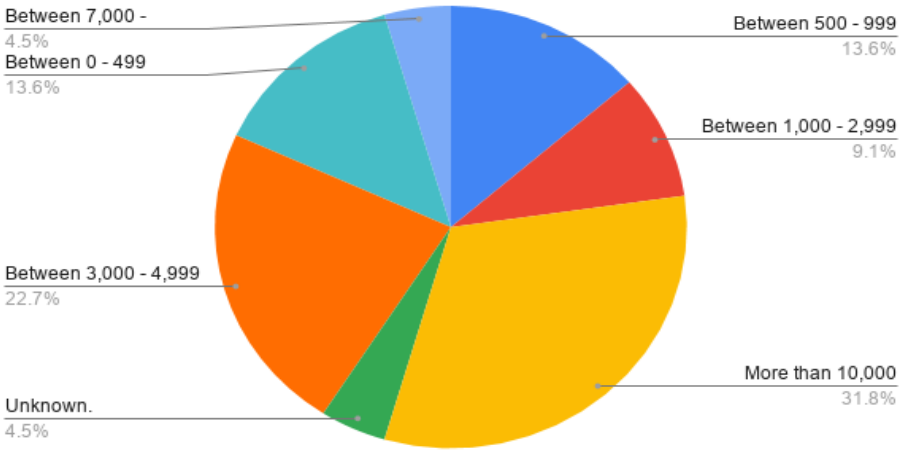

FIG. 8: HOMELESSNESS DATA FROM PARTICIPATING CITIES

The size of cities' homelessness population was not a qualifying or disqualifying criteria, as to some degree the type of response could be expected to relate to the size of the problem.

EXPECTATIONS

This paper uses data collected from twenty-two cities to identify common factors that may have shaped COVID-19 homelessness policy responses, hypothesizing that the type of national welfare regime, the city's position on housing as a commodity or a social right, the size and scope of the problem, resource availability, and pre-crisis homelessness management frameworks will have the largest impact. This first hypothesis draws on Esping-Anderson's framework of liberal, conservative/corporatist, and social democratic welfare regime types but also includes the subsequent additions of mixed and developing regimes (Steurer and Hametner 2010). Cities have been sorted per those literatures, and per the work of Bizberg (São Paulo, Buenos Aires, Santiago) and Jakobson, Rudnik, and Toepler (Moscow)[4]:

[4] See Appendix.

Welfare Regime	Cities
Liberal	Glasgow, Los Angeles, NYC, Adelaide, Edinburgh, London, Sydney
Conservative/Corporatist	Vienna, Berlin, Brussels, Tokyo, Rome, Moscow
Social Democratic	Helsinki
Mixed	Athens, Barcelona, Santiago, Buenos Aires, São Paulo
Developing	Bratislava, Budapest, Rijeka

TABLE 1: WELFARE REGIMES IN PARTICIPATING CITIES

The more liberal a welfare state that a city belongs to, the weaker its homelessness services system response to COVID-19 is expected to be. In economies where workers are highly commodified, "markets become universal and hegemonic … [and] the welfare of individuals comes to depend entirely on the cash nexus" (Esping-Andersen 1990). But for people experiencing homelessness, the cash nexus tends to be both low-paying and informal, thereby shutting them out of many social benefits; this could extend to COVID-19 lockdown measures, which often needed to be accessed through one's employer or at one's registered address (for example, furlough schemes and one-time payment benefits). Historically speaking, homelessness service systems have utilized a "staircase" structure of homelessness services:

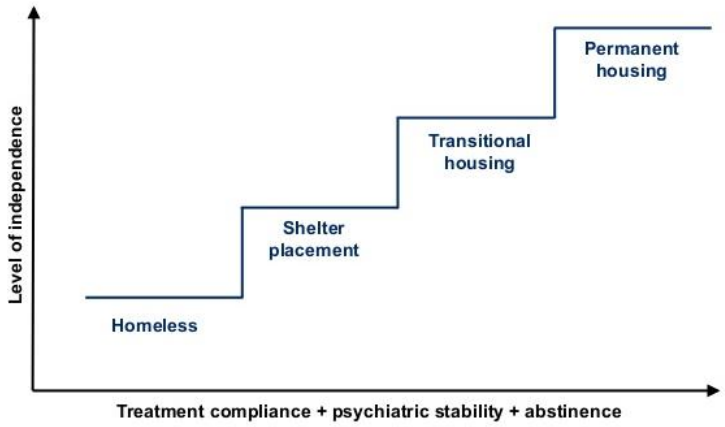

FIG. 9: THE STAIRCASE MODEL OF HOUSING INDEPENDENCE (HENWOOD 2014)

Some social democratic welfare states, however, have in recent years put heavier focus on housing and services, rather than requirements around "earning"

benefits through compliance. (Some, but very few, cities in liberal states have done this, on a citywide rather than national basis.) The expectation, therefore, is that the more 'liberal' a welfare state, the less likely a city would be to deliver a comprehensive and housing-based response in its homelessness services, and more likely to deploy mitigation strategies like medical services and extra shelter beds.

Some of this relates to normative ideas around whether housing is viewed as a human right or as a commodity, and by extension, to what extent governments are responsible for providing it. Harloe points out in *The People's Home? Social Rented Housing in Europe* that "housing has always had an ambiguous and shifting status on the margins of the welfare state, the least de-commodified and the most market-determined of the conventionally accepted constituent elements of such states" (Harloe 1995). But within service provision best practice, the idea of immediate housing—rather than a staircase of earned independence—as the most effective method of combating homelessness has spread significantly in the last twenty years, an approach called interchangeably "housing first" or "housing-led":

> The Housing-Led approach is increasingly being recognized as an effective intervention for reducing homelessness. Its main features are access to stable housing solutions as soon as possible, targeted interventions for households that are at risk of becoming homeless, and the provision of personalized solutions based on each individual's needs. Such support addresses issues such as tenancy maintenance, social inclusion, employment, health and well-being for people who are living in housing, rather than at a stage prior to re-housing. Moreover, it is delivered on a "floating" basis rather than in an institutional setting.
>
> (Kourachanis 2017)

For cities where housing is already considered part of a government's remit, a robust, housing-led crisis response seems obvious. For cities where housing is viewed strictly as a commodity, we would expect to see alternative sheltering routes

pursued. In other words, in cities with housing-led attitudes already entrenched in their homelessness crisis management structures, we would expect to see a housing-led crisis response.

The third hypothesis relates to the size and shape of a city's homelessness problem. In some places, homelessness numbers have reached crisis levels; in others, targeted campaigns have reduced numbers dramatically. A smaller homeless population would likely be easier to quickly house, treat, or quarantine as necessary, and would require fewer additional resources to do so. Tied to this, the availability of resources for the homelessness sector is expected to impact the scale of a city's response; those which received more additional resources (either financial or via bed space or new housing pathways) would likely have been able to make more sweeping changes.

Finally, while it is important to draw a distinction between ongoing crisis management (as rising levels of homelessness have been categorized) and sudden crisis management (such as immediate responses to COVID-19), the ideals behind both are intimately connected, as responses to new and immediate crises are layered on top of pre-existing, ongoing crisis management structures. Put another way, "the character of the measures appears to be the product of models for … management of the social crisis" (Kourachanis 2017). We would therefore expect cities with pre-crisis commitments to reducing or ending homelessness to produce a more robust, housing-led response than those cities which did not, as the policy structures and political will to bring rough sleepers inside would already be in place.

RESPONSES

All information recorded here comes from collected survey and interview data, unless otherwise cited.

WEAKENED SYSTEMS

In cities where homelessness services were weakened, the ability of service providers to adapt their services for COVID-19 were scattershot at best. The face-to-face nature of homelessness services limited providers as lack of available PPE, caps on grouping went into place, non-essential staff were required or advised to stay home. Without receiving exceptions on congregating from the government, and without support to replace a cratering volunteer base, many services were forced to close.

This proved problematic for people experiencing homelessness, particularly in systems where services were restricted in conjunction with increased criminalization, such as fines and arrests for individuals found out-of-doors after curfew or without cause. Some cities implemented punitive measures to keep public spaces empty, despite significant data showing that fines and move-along policies fall short as a strategy to address homelessness, and in fact often traps people in cycles of incarceration and rough sleeping: “criminalization not only fails to reduce homelessness in public space, but also perpetuates homelessness, racial and gender inequality, and poverty even once one has exited homelessness” (Herring and Yarbrough 2015). Cities categorized as showing “weakened systems” during the lockdown period are Rome, Italy and Moscow, Russia. Both these cities increased criminalization (measured here by raised fines for loitering and/or associated prison time), lowered shelter and service availability, and had no homelessness-focused strategy, but instead folded guidelines or requirements for services into guidance for other services. In contrast to no change systems, however, cities may have ultimately received some resources, though it is difficult to quantify whether these qualify as *additions* to the system or simply reconfigurations pre-existing services.

In Rome, initial criminalization methods burdened individuals found to be loitering in public spaces with fines of up to USD 220, with associated prison time of up to three months, while simultaneously restricting emergency shelter availability and offering no new single-accommodation housing options (Povoledo 2020). Those seeking special permits or seeking help were unable to receive the necessary documents as many government departments closed and those without a regular GP to visit in the event of developing COVID-19 symptoms struggled to access the National Health System, as clinics were available only in the case of emergency (INTERSOS 2020). Furthermore, individuals who had been staying in city shelters but left them for any reason were not accepted back inside, and after stay-at-home orders most soup kitchens and other volunteer-run organizations closed due to lack of volunteers. These decisions were made by the Municipality, as part of the larger COVID-19 response strategy, as the city did not have a dedicated homelessness response strategy or work in collaboration with local service providers in the formation of the broader response.

After significant pushback from local and international advocates, the Municipality of Rome reached an agreement with local NGOs to deliver a new strategy which included mobile medical teams and the activation of new shelter bed space. However, it should be noted that the medical teams represented a *conversion* of services, rather than implementation of *additional* services: INTERSOS, the NGO responsible for delivering the mobile team, did so by closing its main reception center and outpatient clinic. Beginning in April, the Municipality opened a new crisis-specific shelter, for those without symptoms or at low-risk for COVID-19, but this shelter closed in early June—without re-opening of previously closed reception

centers. Some hotel rooms were said to be made available for self-isolation, but this number fell far below the need and did not come into play for some time.

Moscow's response played out differently. The city does not receive national funding specifically targeted to homelessness, although some NGOs receive federal grants and state social services are financed regionally. The budget for all social services, through 2022, was published prior to lockdown measures going into place, and the city has not announced plans to alter it, although there will be grants given out to address consequences of COVID-19. In Moscow, no special strategy was implemented by the local or national government aside from broad requisite guidelines around temperature monitoring and mandatory masks for staff. Although state-run shelters closed on May 3, they did not evict those staying in them; instead, those in the shelters were confined for the duration of quarantine, with medical services being delivered on-site.[5] NGOs were not permitted to deliver food services, and existing soup kitchens or distribution sites were shut down; where NGOs continued delivering food, they faced fines and confrontations with police. Providers received no additional financial or human resources from the city government, offers for collaboration between NGOs and government agencies were rebuffed, and none of the guidelines released by local government were homelessness specific.

In both Rome and Moscow, service providers were not brought into the strategy-making process, and guidance or requirements weren't tailored to homelessness services, leaving them with few options even when they were allowed to stay open. Implementation problems arose as a result of poor guidance and lack of additional resources as service providers were asked to change their processes

[5] These shelters are for people experiencing homelessness who are Russian residents, registered in Moscow; migrants or those registered in another area are not eligible to receive services.

without being given help to do so. The relationship between legislative bodies and the service providers they were guiding was often fractious, and this hindered the development and implementation of a comprehensive response. Where additive homelessness-specific interventions were applied (e.g., guidance for safely running a reception center), they were voluntary; where subtractive interventions were applied (e.g., closing reception centers or quarantining those already in them), they were required. Decisions were made unilaterally by bureaucrats without homelessness expertise, but implemented by service providers, who struggled to adapt and fought back against government advice, slowing their response time and often resulting in a *volte-face* of tactics in the middle of the crisis. Additionally, in weakened systems there was no single person, organization, or government department in charge of the homelessness strategy; rather, all departments which intersected with homelessness services were left to make their own decisions.

NO CHANGE SYSTEMS

There weren't any cities who made literally no changes to their systems during the lockdown period, if only because stay-at-home orders required existing services to adjust their work due to more limited staffing and a dearth of volunteers. Cities classified as having "no change" are therefore those for whom changes made were as a result of changes to other systems, to capture an intersecting population (such as migrants), or in an effort to maintain their status quo. For these cities, however, guidance was voluntary, and services received no additional support or "reward" for adhering to government guidelines. Some cities did implement measures which *included* people experiencing homelessness, but these benefits were made without clear understanding of how those people would receive them, and the implementation process suffered. Japan's financial benefit of JPY 100,000

for each citizen included people experiencing homelessness, but in order to receive it, individuals needed to go to the municipality in which they were registered. This proved problematic for people experiencing homelessness, who may have left that municipality long ago with no means to return or documentation to prove their registry or indeed not be registered anywhere.

In Tokyo, local government announced a plan to spend 1.2 billion yen on hotel rentals for those who had been sleeping in internet cafés; however, this captured mostly individuals who were newly homeless, and left out long-term rough sleepers. Tokyo reports roughly 4,000 individuals sleep in internet cafés; of those, between 700-1,000 were housed in a hotel room. However, given that no other measures were put in place within the homelessness services system and that this subpopulation tends to represent individuals in an immediate crisis, rather than individuals who are considered “part of” Japan’s homeless population insofar as they define homelessness, it would be difficult to justify this as a “homelessness system” change.

Japan’s definition of homelessness is strictly confined to rough sleepers, although conflicting enumeration data exists on how many of these there are. The Tokyo Metropolitan Government’s official homelessness count reported 890 rough sleepers, but local NGOs have contested this number, citing poor methodology, and report that their own counts suggest that number is closer to 1,540. This might complicate the picture of who was and was not housed by the internet café scheme, as the city lacks data on where the ‘remaining’ 3,000 individuals sleeping in internet cafés went. Collecting this data was made more complicated by the fact that homelessness outreach services were limited during lockdown to protect outreach workers.

In contrast to cities with weakened systems, the majority of no change systems did not receive any kind of national funding for their services. Where changes to regular practice were enforced for services and businesses across the board, the homelessness sector implemented them, but none of this guidance was tailored to or indeed cognizant of the unique needs of homelessness providers and either limited additional resources were provided to the sector, or none at all. For these cities, a sector other than homelessness services was given charge of strategy for services, and the specificity of homeless populations' need was not built into the strategy. Services in Rijeka followed restrictions that applied to other, non-homelessness services, including guidance around face masks and minimizing physical contact, but no special measures were implemented for homelessness specifically. In Brussels, certain special measures were introduced for 'cross-populating' groups, such as migrants, for whom some socio-medical interventions were put into place. But although many individuals experiencing homelessness in Brussels are migrants (23.9% in 2018), these measures were not directed toward them in a homelessness services capacity (that is, 'normal services' for the homelessness sector, such as housing referrals and emergency shelter, were not expanded or offered as part of the response). Measures which were implemented for other services were voluntary, and no additional resources—human, financial, or in-kind—were given to the sector.

EXPANDED NORMAL SERVICE

Though the line between no change systems and expanded normal services is in some cases blurry, the two key differences between them are that systems which expanded their normal programming received contextually significant investment of resources, either financial or in-kind, and a higher degree of

involvement from service providers and NGOs in strategy development. The most common forms of expansion were availability of PPE for staff and expanded hours for day centers or emergency accommodation, alongside at least one shelter designated for people experiencing homelessness who displayed COVID-19 symptoms. All cities received additional financial resources, at varying levels, though some cities did not receive them until up to eight weeks after services were meant to implement new measures and in some cases the finances were restricted to staffing or overhead costs for things like PPE rather than going to programming. In others, funding was given as part of broader spending initiatives—for example, São Paulo's municipal government awarded extra funding for poverty measures, of which homelessness services are one of many recipients; it is therefore difficult therefore to say exactly how much funding went to the sector. Most cities also received in-kind donations of housing or space for new congregate emergency shelters.

In Budapest, government-owned buildings, flats, and container housing units[6] were committed to the sector for use as makeshift emergency shelter, including a quarantine site for those who had no homes to isolate in. Most new facilities went to people *already* utilizing services who had to be moved from night shelters to meet physical distancing guidance, although the municipality donated an empty building to make a congregate-style shelter for new arrivals. There was no injection of cash into the system, per se, but the municipality paid for state service providers' additional expenses. Social workers as well as clients were able to receive regular testing, alongside PPE, and distancing measures were implemented in congregate shelters. Notable in this case is Hungary's stringent 'anti-homelessness' laws, put in place in

[6] 'Container housing' describes housing units built either literally out of shipping containers or other (usually recycled) materials as an alternative form of housing. These typically follow the 'tiny home' trend, particularly when utilized by the homelessness sector.

2018, which effectively made homelessness illegal and drove many rough sleepers into hiding—in some ways, Budapest operating with expanded normal services (rather than a weakened system) might represent a significantly more liberally-minded approach than the national mood might predict. During the lockdown there were no known fines or arrests issued by the police to people experiencing homelessness.

In many cases, additional resources came only after heavy lobbying from service providers and NGOs, who were able to make specific requests around what resources would be most effective; in others, they were built into city-wide or nation-wide guidance for businesses broadly, but with input from service providers. This was not precisely the case in Budapest, where the city's largest service provider worked with government departments to design the city's guidance. São Paulo's municipal government issued some guidance and support measures, but these fell far below what NGOs and service providers needed, and only after pushback from shelter staff were resources like free PPE offered. Buenos Aires, which issued stricter lockdown measures than other cities throughout the country, at first failed to make special provisions for homelessness services, and only after a cooperative of services demanded support was the response adjusted. Although the city services received no COVID-19 specific additional cash funding that was not already budgeted for the winter months, the sector was able to expand its services in part due to an early-activated winter program which provided for an influx of additional housing resources, such as empty buildings to convert into congregate shelters. The government reported housing 700 rough sleepers as a result of the service expansion (Lorente 2020). Additionally, shelter staff were able to receive some training around caring for individuals displaying COVID-19 symptoms.

Barcelona's City Council released its homelessness strategy three days after the citywide lockdown after conversations with the government/NGO working group, though not all the proposals from the sector were taken up. In the early stages of lockdown, prior to the service expansion, people experiencing homelessness who remained outside were issued fines from local police, and often struggled to receive services as volunteer-run soup kitchens and hygiene stations closed to protect their volunteers, many of whom belonged to vulnerable demographics themselves. However, the city opened new bed space for 600 individuals across multiple congregate shelters, though current data suggests that many of these spaces were taken up by individuals newly pushed to the street as a result of hotel and hostel closures, rather than people who were rough sleeping prior to the COVID-19 crisis.

The initial service changes in Bratislava, Slovakia were slim, just PPE for staff of shelter services and service users, but as the lockdown went on, more measures to address the unique problems of people experiencing homelessness in the city were added. This was due in part to Bratislava's homelessness services working together to create a four-pronged strategy when initial government advice failed to materialize. This was then relayed up to the team in charge of the city-wide strategy, and incorporated into broader guidance, though not all of the suggestions were operationalized in full, on time, or at all. In Budapest, the city's initial release of guidance lacked clarity, and service providers struggled to implement appropriate measures; providers instead collaborated on a set of protocols until government efforts caught up.

What is interesting about systems which simply expanded their normal services, without broadening their remit or adding crisis-specific interventions, is that cities within this group tend to fall on two ends of a 'normal' service spectrum.

Bratislava's services are typically small, and under-funded; although perhaps significant investment would have been a stronger response from local government, the tendency to ignore homelessness persisted throughout the crisis. In cities like Helsinki, however, which had a more robust pre-crisis system and far fewer rough sleepers, significantly smaller investment may have been necessary. There, guidance for homeless services specifically was released alongside other guidance and was done in partnership with homeless service providers. Guidance was therefore more robust, including restrictions on the number of people in day centers; increased capacity in emergency housing, with special shelters just for those displaying COVID-19 symptoms; reinforced pre-existing outreach services; and ongoing cooperation and communication between municipal homeless services, service providers, and NGOs. Glasgow moved all its rough sleepers into short-term accommodation, but this was something that the system had already been working to do; the lockdown and its attendant release of new funding therefore provided a lever to hasten the opening of new housing units, but this was not a necessarily re-orientation of services.

While it is difficult to directly compare the size of cities' whole homeless populations due to differing methodologies and timelines, it is important to note that Bratislava's reported pre-crisis rough sleeper population was between 1500 and 2000 people, and Helsinki's between 30-70; ensuring therefore that Helsinki's individuals had places to stay and isolate if necessary was a much lighter lift. Berlin reported more than 10,000 people experiencing homelessness, with an unknown percentage representing individuals without any form of accommodation. It was therefore unknown how many rough sleepers remained outdoors during lockdown measures, although the city opened three new emergency congregate shelters, a

quarantine station for those with symptoms, and provided homelessness services providers with PPE. The broad guidelines for services did not change and adherence was voluntary other than the wearing of a mask, which was required to receive additional funding (more than EUR 3 million was added to the system to fund the shelters, quarantine station, and free PPE).

Cities which expanded their normal services are categorized by certain similarities: an influx of financial and/or in-kind resources, though typically limited in scope; guidelines for homelessness services were part of broader city-wide advice, and were largely voluntary, although services may have received some kind of reward (i.e., funding) for following them. Additionally, these guidelines tended to be *additive* rather than *subtractive*, such as adding mandatory PPE to the system, increasing food delivery mechanisms, adding beds to existing night shelters, and incorporating 24/7 care for shelters which traditionally emptied during the day. Some systems lowered barriers to shelter (that is, allowing those with addiction management issues to obtain shelter where they may have previously required sobriety tests) and created spaces for specific demographic targets; for example, São Paulo created special places for elderly people experiencing homelessness and those displaying COVID-19 symptoms. Equally important was the inclusion of service providers in the creation of city-wide guidance, although homelessness service providers were not in *charge* of generating the policy and in some cases had to lobby as a sector to involve local government and receive benefits. In contrast to weakened systems and no change systems, however, service providers and NGOs were part of the conversation which did ultimately include homelessness-specific guidance, even if this guidance was folded into a broader city-wide approach.

Broadened normal service

The key difference between a system which expanded its normal services and a system which broadened its normal services is that “broadened” services include the addition of entirely new *types* of service, alongside significant increase in the availability of single-person accommodation as a preferential intervention over the addition of congregate shelters (although these may also have been part of the approach). Where this differs from a “system overhaul” is that these new types of interventions took the shape of *impact mitigation* measures and did not seek to *replace* old ways of working. Congregate shelters remained open, though typically with new regulations around bed space and distancing, and new shelters may have been added to the system. In many of these cities, a robust temporary housing element was added or expanded within the system, but this was not intended to meaningfully displace congregate settings in the long-term.

All cities in this paper which have been categorized as “broadened normal service” cities had a homelessness services response which happened at the same time as all other COVID-19 suppression measures. In most cities these guidelines were required for organizations to follow, though this was not always the case. Vitally, each of these cities included homelessness service providers and NGOs in the initial effort to identify priority actions and advice, although services may have further developed cooperative strategies or plans. This latter example happened in Los Angeles, where homelessness service providers worked together to standardize language, operationalize staff trainings, and formulate strategies for post-COVID management to ensure that a sense of urgency was maintained after the initial crisis passed.

Rather than simply adding more of what would be considered ‘normal’ service provision, cities added new elements, with the financial resources to implement them

coming either immediately or promised in the form of post-COVID reimbursements, grants, or other payment forms. A crucial part of each city's strategy included expanding single-person housing opportunities—Los Angeles committed to a goal of housing 15,000 people experiencing homelessness, though they ultimately housed 3,387. In contrast, New York by July had roughly 13,000 homeless individuals residing in commercial hotels in order to ensure distancing in congregate settings. Vienna, Athens, Santiago, and Los Angeles added extensive testing capacity for service providers; Los Angeles created medical street teams to engage with people sleeping in homeless encampments, and Vienna created a service hotline to help service providers coordinate when an individual presented with symptoms or tested positive for COVID-19. Athens opened two new shelters with stringent requirements around physical distancing and shelter capacity, alongside disinfecting measures and specific strategies for outreach among those who remained outside.

An important element for most cities with broadened normal systems was the medical aspect—that is, a focus on treating and containing cases within populations experiencing homelessness, rather than shifting system design in order to *prevent* transmission of the virus. This is not to say that prevention measures, such as requirements around social distancing and PPE, were not implemented; only that significant resources and new services were devoted to addressing cases as they presented. New York City exemplifies this mitigation tactic: the city took a two-pronged approach to its strategy, one for sheltered individuals and one for unsheltered (terms which loosely correlate to categories one and two of the IGH Framework). For sheltered individuals, the Department of Social Services (DSS) worked in partnership with the Department of Housing Services (DHS) and the Department of Human Resources Administration (HRA) to codify a screening

protocol which connected those presenting symptoms to hospital care and isolation to quarantine potentially contagious individuals from others using the shelter system. Part of this strategy included adapting congregate shelters to increase social distancing and limit gatherings as well as relocation out of shelters—but this latter intervention was done on an individual basis, in relation to need. Overlaying this strategy were new services around testing, tracing, and treatment, coupled with enhanced medical oversight.

The strategy for unsheltered individuals focused on widening availability of screenings and hospital connections, as well as strengthening outreach services with new housing availability, expedited intake, and stringent case monitoring. But although service offerings were broadened to include new, COVID-specific measures designed to mitigate the effects of the virus on the population, they were not designed to *meaningfully disrupt* the status quo of how the city approaches homelessness; that is, unlike cities which I have categorized as experiencing a system overhaul, the system in NYC received an influx of resources to minimize the impact of COVID-19 on a vulnerable population, not to address homelessness itself. This is not necessarily a critique; these measures seem to have had a positive effect: the city has tracked a total of 1,342 total positive cases, with a 7.45% fatality rate, which is well below predictions from the Culhane, Treglia, and Streif model.

Santiago's guidance came in two waves: first, homelessness services worked together to create a sector-wide response during the first two weeks of lockdown; after a month, the government released its official response with guidelines that were mandatory for services to follow. The city's main approach was to extend and expand its winter program with added distancing, sanitation, and safety measures. The plan opened 92 additional congregate spaces, increased capacity for outreach,

generated additional housing options, and instituted medical teams. In addition, they created a homelessness COVID-19 phone line to allow for reporting of people exhibiting symptoms as well as resources for those who were particularly high risk and established stringent sanitation processes. The system received an injection of funds for new bed space and for its Rutas Protege Calle COVID-19, and PPE was provided to organizations receiving public money. The street routes operated in a similar manner as the ones in Los Angeles, designed to prevent and mitigate the effects of COVID-19 on the homeless population, with specific attention to older adults and those with chronic illnesses.

We see in this category a slightly different base trend than for cities which simply expanded normal services: those who broadened their services typically *already had* robust systems, working to actively manage homelessness as an issue. They were able to receive significant inflows of resources, and the result was interventions built onto existing structures. This may go some distance in explaining the "medicalized" approach to impact mitigation, which added services to address a new concern but did not adjust service offerings to address the underlying vulnerabilities that made the system so high-risk. Some of this may also be explained by simple urgency—it may be faster, and easier to implement, additional new services than to change the *modus operandi* of a large, complex system burdened by stringent regulations which may already render it difficult to navigate for clients and social workers. It should be noted too that the inclusion of service providers in planning and decision-making, while allowing for the important perspective of those 'doing the work on the ground,' opens the door to complexity around competition and conflicting ethos (for example, around barriers to housing—

in pre-crisis systems many people experiencing homelessness were ineligible to receive services if they were drinking or use drugs).

System overhaul

What differentiates cities described as undergoing a system overhaul from those which expanded or broadened their services is that these cities made significant changes to the *types* of services they were offering: that is, not simply adding new interventions, but shifting away from old ways of working, particularly with regard to congregate shelters and barriers to housing. Additionally, these cities showed three key similarities: first, the homelessness strategy was *specific* to homelessness, and not part of other city-wide guidance; second, the strategy was led by either an individual or small taskforce which included services or individuals with homelessness expertise; and third, the systems received a significant increase in financial resources *paired with* significant increase in single-person accommodation resources.

Strictly speaking, within this category there are two streams: those which eliminated congregate shelters entirely and those which significantly reduced their capacity while increasing single-person accommodation availability. While this difference *is* important, the qualifying feature of this category was the degree to which the system focused on new ways of addressing homelessness, indicating a shift away from old system set-ups. As such, some cities which maintained old types services but at reduced capacity have been classified as undergoing an overhaul.

Exemplary of this second category is Sydney, Australia, which underwent significant change but did not ultimately close its shelters.[7] Instead, Sydney assembled a Taskforce chaired by the NSW Department of Communities and Justice and populated by individuals from the health and homelessness services, alongside executive staff from the City of Sydney Council. The primary work of the Taskforce was the development and implementation of an Accommodation Plan which outlined stronger outreach strategies, single-person accommodation options, and decongestion of congregate emergency shelters. To finance these measures, Sydney received a large influx of financial resources: AUD 14 million for emergency accommodation which would allow for isolation and AUD 10 million for food relief. Additionally, two large national NGOs delivering services on government contracts were granted additional funding to expand capacity for their homelessness and outreach services. Although Sydney did not close its congregate shelters, it initiated a stringent policy of de-concentration, transitioning a proportion of those utilizing the services into alternative accommodation, largely hotels throughout the city. The system also implemented brand-new medical testing and isolation services for people experiencing homelessness, operating three pop-up testing clinics and developing immediate housing plans for those who tested positive for COVID-19 so as not to return them to congregate settings.

Adelaide's approach took a very similar shape. Night shelters were not closed (though their capacity was reduced to ensure physical distancing ability), and medical teams with mobile testing capacity were instated, but the city's focus was on

[7] A note: this paper will use "Sydney" to refer specifically to what is officially called the 'City of Sydney Local Government Area' but might be thought of as the central business district and surrounding suburbs, rather than the entirety of what can be technically counted as Sydney. This is because Greater Sydney is split into a complex web of thirty-five municipalities, each with their own response.

moving existing rough sleepers into single-person accommodation, including a specific COVID-19 quarantine hotel. Adelaide received an influx of financial resources that were tied to staffing and housing costs, and, like Sydney, instituted a taskforce comprised of both community and public providers alongside government and homelessness services to develop the city-wide strategy for the sector. Adelaide is somewhat unique in that its homelessness strategy went into effect *before* formal lockdown for the rest of the city, although there were already other measures in place (such as social distancing).

This is one approach to a system overhaul. While this approach is closer to the cities categorized as having broadened their normal services, Sydney and Adelaide are distinct in two important ways. First the approach was housing-led and *included* medical services but did not *depend* on them—that is, system changes were made to minimize the rate of infection by addressing the immediate vulnerability of houselessness, rather than mitigating the rate of infection through medical treatment. Second, the degree of post-crisis planning which was built into the strategy implies a significant mindset shift with regards to what is necessary to address homelessness.[8] Inherent to Sydney's COVID-19 strategy was ensuring that those housed on a temporary basis were provided with linkages and pathways to more stable, long-term housing. This includes long-term "responses through the social housing system, lease subsidies in the private sector, and government exit planning with specialist homelessness services and service system to transition eligible tenants to aged care facilities and disability support under the National Disability Insurance Scheme" (NSW Department of Communities and Justice 2020).

[8] Glasgow did not qualify as undergoing a system overhaul, though its process looks somewhat similar to Sydney and Adelaide, because it was re-orienting in this direction prior to COVID-19.

Cities which broadened their normal services may have done some planning around how to proceed post-crisis, but to a much lesser degree, and tied more to ensuring that those who received housing are offered opportunities to stay housed than focusing future services on prioritizing housing as a matter of course.

The other approach, taken by London and Edinburgh, is categorized by the closing of all congregate night shelters in favor of moving all rough sleepers into single-person accommodation. In London, activities considered to be “street activities” that might bring people experiencing homelessness out to receive, for example, food or clothes, were also closed. This was done off the back of recommendations from the UK Homelessness Taskforce on COVID-19; initially, plans had been drawn up for day centers and shelters, but changed tack under the leadership of the Taskforce, which instead suggested an ‘everyone in’ strategy: “The [Ministry of Housing, Communities, and Local Government (MHCLG)] worked with health experts and charities who were mobilized to help get London sleepers into different hotels. They set up a triage process: COVID PROTECT for those with chronic illness but no new symptoms, COVID CARE for those with symptoms and confirmed cases, and COVID PREVENT for all other rough sleepers” (Seeley 2020). To pay for these new services, the sector received GBP 433 million in funds to provide 6,000 new housing units. An additional GBP 105 million was released to keep rough sleepers safe and off the streets during the full run of the pandemic. These funds are comprised of 81% new revenue and 19% repackaged existing homelessness funding. The overarching goal of the strategy was to ensure that no rough sleepers remained on the street during the pandemic, and this was largely achieved—the city rigorously tracked its rough sleeping population, and ultimately housed 15,000 individuals. It should be noted that not all of those were rough

sleepers; prior to COVID-19, the rough sleeping population of London was 8,885 individuals, with an additional, significant population living in temporary accommodation.

Edinburgh followed a similar policy: night shelters were closed, with a view towards bringing all rough sleepers into single-person accommodation. The city received a healthy injection of resources of more than GBP 3 million, and the strategy was managed by a taskforce comprised of government and homelessness service providers. As in London, the city is working to ensure that every housed person has a plan to move out of the hotels without returning to the streets.

WHAT FACTORS SHAPED CITY RESPONSE?

WELFARE REGIMES

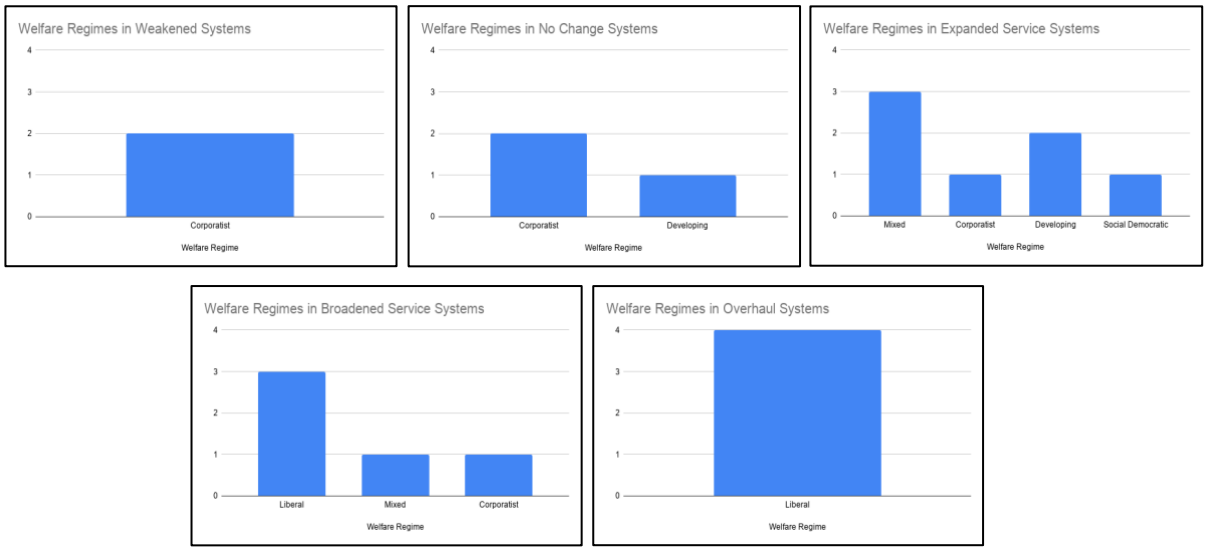

FIG. 10: WELFARE REGIMES WITHIN SYSTEM RESPONSE TYPES

Welfare regimes did not align neatly with system response type. Clusters took the form of "*only* X regimes did Y, but not *all* X regimes did Y." For example, both weakened systems were corporatist welfare regimes; all overhaul systems were liberal. But not all corporatist or liberal regimes weakened or overhauled their

systems. This may be due to the nature of homelessness services, which tend to be highly localized; cities whose services were not beholden to a strong national strategy may not precisely conform to the broader national welfare regime in their service delivery mechanisms, or the scale of the emergency may have triggered extraordinary responses. Harloe theorizes that “only when adequate [housing] provision in commodified form is not possible (even with state support) and when this situation has some broader significance for the dominant social and economic order, that recourse is made to large-scale, partially decommodified, state-subsidized and politically controlled mass social rented housing” (Harloe 1995). While Harloe is not discussing housing for people experiencing homelessness per se, but a broader policy of rented social housing, the impact of COVID-19 certainly meets all of these criteria; so while it is possible to say that perhaps an emergency of this scale was required to *trigger* housing initiatives from more liberal welfare regimes where they occurred (for example in London), evidence does not support the theory that a city’s welfare regime *decided* its response to the emergency. Corporatist welfare regimes had the largest spread of responses; this may be tied to the nature of conservative welfare, which relies heavily on traditional communities of care. The strength of these communities may have varied or been affected differently by lockdown measures (i.e., some places losing volunteers to stringent stay-at-home orders, as in Italy, and others not).

Although it is the case that systems which offered more limited services pre-lockdown tended to offer more limited crisis response, this occurred on something of a bell curve, where both the smallest and most robust systems showed the smallest responses, perhaps due on one end to inability and on the other end to lack of need. That is, in systems where prevention and housing first were already the primary

method of addressing rough sleeping, fewer adjustments were needed. Finland, internationally lauded for its steep reductions in homelessness, has done so through its national housing first program (Tainio and Fredriksson 2009). Accordingly, Helsinki's COVID-19 adjustments were minimal. For those cities whose problem was below crisis levels and whose housing-focused response systems were already robust, COVID-19 simply may not have presented enough of a crisis to trigger significant systemic changes.

Size of the homelessness problem

The number of people experiencing homelessness varied drastically not just overall but also within response types, suggesting that homelessness plays out very differently in each city, but this did not seem to have significant impact on the type of city response. Though it would be inaccurate to deny that cities with smaller homeless populations likely had an "easier" time housing people—or at the very least, protecting them from the COVID-19 spread—these cities did not uniformly decide to switch the overall strategy of their homelessness services from focusing on emergency services to focusing on housing and prevention. Both London, with a pre-crisis rough sleeper population of 8,855, and Glasgow, with a pre-crisis population of just 30, chose a housing-led strategy. Conversely, Helsinki (30-70 pre-crisis rough sleepers) expanded its shelter options but didn't explicitly pivot to single-person accommodation to bring them inside. London stands out as an overhaul city with regard to the scope of its pre-crisis homelessness population; the three other overhaul cities had fewer than two hundred rough sleepers.

In this sense it appears that the size may have impacted strategy more the higher the number was, but that influence diminished with the scale of the problem. 71.5% of cities with populations over 10,000 opted to broaden or expand their

services and pursued a mitigation approach rather than a housing one; that number grew to 76.9% when including cities with populations over 3,000. However, cities with population counts below 1,000 were much more evenly dispersed:

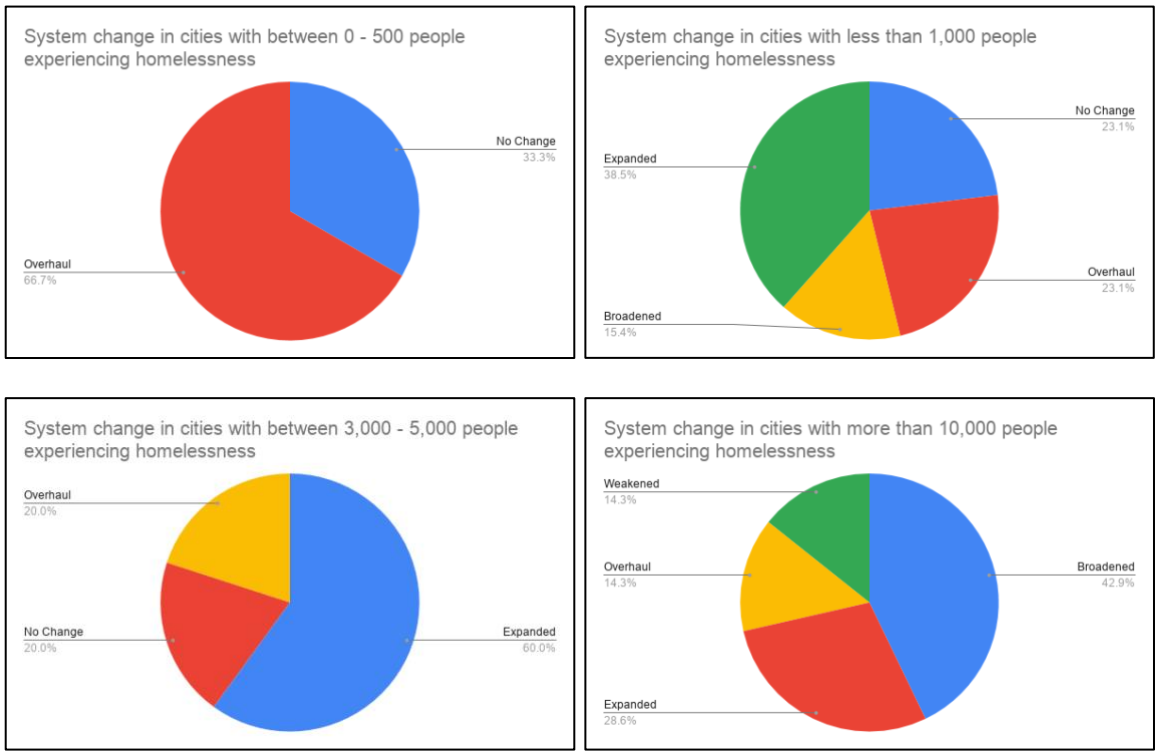

FIG. 11: SYSTEM RESPONSE TYPE BASED ON HOMELESSNESS POPULATION SIZE

Among the cities with the smallest homeless populations,[9] the system response fell on either end of the spectrum: either no changes were made, or a massive system shift occurred. This may be because small homeless populations were viewed as either easy to house or too small to worry about; but this is conjecture and would require further investigation.

RESOURCE AVAILABILITY

[9] This refers to the homeless population as a whole, and not exclusively to rough sleepers (for example, Helsinki reported between 30 and 70 rough sleepers, but an overall homeless population of between 1,000 and 3,000).

To some degree, almost all cities received *some* form of additional resources, though these were not always financial and, in some cases, came in the shape of as-yet-unclaimed reimbursement promises. Only four cities (Rijeka, Brussels, Moscow, and Budapest) reported receiving no direct financial aid, but these reports are complicated by how money is dispersed in each place; for example, in Budapest, city-funded service providers were permitted to make necessary purchases out of the city budget, but did not receive any designated cash inflow. Overhauled systems all received significant additional financial resources alongside in-kind resources such as new options for housing via partnerships with local businesses; but so did many cities who instead broadened or expanded their services. While *lack* of resources seems to have had a strong influence in preventing a city from meaningfully adapting their systems to address COVID-19, larger investments did not necessarily steer cities toward overhauling their systems.

HOUSING AS A HUMAN RIGHT

To categorize housing as a right would be to at least partially uncouple it from the market and complicate its value as capital; for many states, residential property sale is a crucial part of drawing investments (Farha 2020). It is slightly complex therefore to determine which countries "consider" housing a human right and which view it strictly as a commodity, as many places don't use this language directly, but refer to rights around dignity and standards of living while allowing for increased financialization of housing markets. For example, Japan has enshrined the right "to maintain the minimum standards of wholesome and cultured living" (O'leary 1994), which is broadly interpreted to include a right to housing, but does not specifically name it. Some countries enshrine the right to services or aid without explicitly guaranteeing a right to housing itself. In some places, city ordinances differ from

state: Berlin has a right to housing, but Germany does not. Housing in London is *highly* financialized, and does not espouse the right to housing, but the homelessness response was still housing-led.

On the other hand, every city except for Los Angeles and New York belong to states that ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR), of which Article 11 explicitly includes the right to adequate housing (Committee on Economic Social and Cultural Rights 1966). Yet not all non-USA cities followed a housing-led response. Considering this, despite expectations the rights framework did not seem to strongly impact a city's response to COVID-19 nor indeed its pre-crisis management strategies.

PRE-CRISIS HOMELESSNESS MANAGEMENT APPROACHES

Housing-led approaches as a way to not just manage but actually reduce and even end homelessness have been gaining traction, in rhetoric if not always in practice. It may be that homelessness systems whose crisis management rhetoric has taken aim at reducing or ending homelessness, particularly *vis-a-vis* housing first, had an easier time fully pivoting to an approach with heavier focus on single-person accommodation. This certainly rings true for system overhaul cities: Sydney, Adelaide, London, and Edinburgh have all recently committed to ending or sustainably reducing the size of their homelessness problems, as have many cities whose service scope broadened (including Chicago, Santiago, New York City, and Los Angeles; also including Glasgow and Helsinki,[10] whose systems qualified as only having expanded due to a prior orientation toward housing). But even those

[10] Helsinki as a city does not have its own commitment to reduce homelessness but is part of Finland's broader strategy to end homelessness nationally, so is being counted here.

broadened systems without explicit homelessness reduction targets (namely Vienna and Athens) have in recent years shifted toward a housing-led approach in their normal homeless services.

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. However, for cities whose systems still heavily rely on emergency shelter, switching exclusively to single-person accommodation was a heavier lift.

CLEAR DIRECTION FROM COLLABORATIVE LEADERSHIP

One common feature of systems which broadened or overhauled their systems was the presence of a collaborative taskforce with remit to produce and implement homelessness service responses, whatever those might be. An obstacle for systems which were unable to rally much response was lack of clarity, or lack of attention in broad guidance to homelessness services' unique needs, which led to implementation problems. But almost all those cities who were able to better target both interventions and resources did so off the back of clear guidance from a homelessness-specific taskforce that included perspectives of service providers.

Data is still being collected on rates of infection, hospitalization, and death among homeless populations, and we may never have the full picture due to lack of homelessness enumeration broadly and lack of COVID-19 testing availability specifically. Whether systems will return to their pre-COVID normal set-ups, or change meaningfully in approach, is impossible to predict. What is certain is that the COVID-19 crisis is not over; even as vaccines and treatments are developing, the reopening world may be headed for a second wave of infections, and what effect this will have on homelessness systems remains to be seen.

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APPENDIX

Extensive work has been done regarding the classification of non-European states' welfare regimes beyond Esping-Anderson's original work. Though there is no official consensus, I have classified cities based on that scholarship.

The classifications for the USA, UK, Australia, Austria, Belgium, Germany, Italy, Japan, and Finland come directly from Esping-Anderson's work, summarized in the table below by Clare Bambra:

Liberal	Conservative	Social Democratic
Australia	Austria	Denmark
Canada	Belgium	Finland
Ireland	France	Norway
New Zealand	Germany	Sweden
UK	Italy	
USA	Japan	
	Netherlands	
	Switzerland	

Source: Bambra, Clare. "Cash versus services: 'worlds of welfare' and the decommodification of cash benefits and health care services." *Journal of social policy.* 34, no. 2 (2005): 195-213.

Classifications for Croatia, Greece, Spain, Hungary, and Slovakia come from scholarship which builds on Esping-Anderson's work. Summarized by Steurer and Hametner in the table below, these states were not addressed in *Three Worlds of Welfare Capitalism*, and do not seem to fall neatly into the original ideal types. Italy, in brackets here, is somewhat contested; however, I have classified it per Esping-Anderson as within the homelessness sector there is a high degree of involvement of traditional systems of support, typified by church-run services and organizations:

Model	Countries†	Ideology	Key features of socioeconomic integration
Scandinavian	Sweden, Finland, Denmark (the Netherlands, Norway)	Social Democratic	• Aims to realize social *rights* for all its citizens • Promotes equality of high social standards • Social benefits are universal, i.e. independent of class and status • Strong support for working mothers
Continental	Germany, Austria (France, Belgium, Luxembourg, Switzerland)	Conservative	• Granting social rights considers existing class and status differentials (with a focus on work-related, insurance-based benefits) • Redistributive effects are limited • Social policies aim to preserve traditional family structures (limits emancipation of women)
Anglo-Saxon	UK (Ireland)	Liberal	• Dominated by market logic, i.e. the state encourages the private provision of welfare • Social benefits are modest, often means tested and stigmatizing
Mediterranean	Spain, Portugal, Greece (Italy, Cyprus, Malta)	Mixed	• Fragmented and 'clientellistic' support focusing on income maintenance (pensions) • Still under development, making older systems of social support (family, church) still necessary
Transitional	New EU Members from Central-Eastern Europe	Developing	• New social policies are developing, but with considerable variations

Source: Steurer, Reinhard and Markus Hametner. "Objectives and indicators in sustainable development strategies: similarities and variances across Europe." Sustainable Development 21, no. 4 (2013): 224-241.

The cities in Latin American contexts—São Paulo, Buenos Aires, and Santiago—have been classified based on the scholarship of Ilan Bizberg, who argues that "the economic structure and the socio-political conformation (the orientation of the economy, the role of the State and the wage relation (*rapport salarial*: comprising basically the industrial relations system and the welfare regime) are complementary enough to be able to point towards ideal types, although they might not be totally consolidated yet" (Bizberg 2014). Bizberg notes that the strength of labor forces is a critical factor in shaping the welfare regime, and that in Latin America these policies "contribute to the economic orientation led by the internal market through a wage led growth (Brazil and Argentina) or merely compensate market faults in a market-oriented economy based on foreign capital (Mexico and Chile)." That is, Argentina and Brazil have to some degree expanded their welfare regimes, while Chile's has become more liberal; but the nature of this process

means current regimes display properties of multiple ideal types, leading to their "mixed" classification.

Russia's welfare regime classification comes from the work of Jakobson, Rudnik and Toepler, who argue that "hampered by the economic hardships of the transition and the loss of philanthropic traditions after more than 70 years of communism, a liberal policy regime did not take firmly hold [in Russia] and has gradually been replaced by a new cultural policy consensus more akin to a conservative welfare regime, marked by a return of the state to a more dominant role with the support of core cultural policy constituencies." These arguments are based on a timeline beginning with the collapse of the Soviet Union, indicating that despite "laissez faire attitudes of the 1990s" (Jakobson, Rudnik, and Toepler 2018) Russia has seen a reintroduction of conservative ideals in cultural and welfare policies which have shifted it into a corporatist mode.

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