Homeless people deserve a COVID-19 plan

Updated March 13, 2020 Cathy Crowe for SHJN

If there is any place in Canada that should have been first off the mark with a COVID-19 plan for homeless people that would be Toronto.

Yet we wait, amidst a multi-year long homelessness emergency.

Across the country, public health officials have neglected to address homelessness in their daily media messaging.

It is critical that a COVID-19 plan for homelessness is developed. The widespread public health advice to self-isolate is simply not possible in shelters where sleeping areas, washrooms and dining areas are shared, and residents do not have access to their own space and amenities. Furthermore, across the country, shelters are full and outdoor encampments are the norm.

Lessons not learned from SARS (2003) or H1N1 (2009-10)

While Canadian public health officials deserve some praise for improvements made post SARS and H1N1 they have not trickled down to the community level.

Health providers and advocates who work with homeless people are still waiting for measures to minimize potential deadly disease transmission. It's in part why they came together to advocate for Toronto to declare homelessness an emergency.

It is well known that people who are homeless are at increased risk during communicable disease outbreaks due to:

- Crowded, congregate overnight shelter conditions.
- Crowded daytime drop-ins.
- Frequent forced migration that is necessary for survival (such as seeking shelter, food or healthcare).
- Fragmented and reduced access to health care.
- An aging population.
- A high incidence of chronic illness.

Knowing this, the City of Toronto post SARS/H1N1 should have:

1) Ensured that the shelter system met the city council mandate that they not exceed 90% capacity. That target has never been met, not one night.

2) Ensured that any new emergency shelter model such as 24-hour respite sites, 24-hour overnight drop-ins for women, warming centres, cooling centres (cancelled in 2019), the Peter Street Assessment and Referral Centre would at least meet the City's Shelter Standards, including the 90% capacity guideline.

3) Developed a plan to phase out, over a number of years, its reliance on the volunteer and faith-based Out of the Cold (OOTC) program. In the OOTC program each participating church or synagogue is open one night per week, necessitating a forced migration of an individual to seven sites in seven days. In total the OOTC program provides approximately 700 'bed nights' per week.

4) Ensured that all emergency shelter models have health care options on site or as a partnership/resource available to them.

5) Improved communication. Communication issues were highlighted in the 2006 SARS Commission as a serious issue. There has not been significant improvement in communication to health providers, shelter or drop-in workers, OOTC volunteers or homeless people with respect to acute disease outbreaks. Of note, Toronto Public Health (TPH) withheld information on the 2017 Group A Streptococcus outbreak at Seaton House until frontline health providers went to the media. The outbreak ultimately lasted over 19 months and involved hospitalizations and closure of beds at the shelter.

Recommendations for a COVID-19 homelessness plan

1. Communication

TPH should implement a communications plan specific to the homeless population. They should designate coordinators, who would inform the broader network of shelter, health and outreach workers of occurrences or incidences of disease (including coronavirus, TB, influenza, Strep A).

TPH should publicize their hotline to assist with triage.

TPH should provide educational materials to workers and volunteers to help manage their facility during these health crises.

SSHA should also implement a communications plan and designate coordinators for clear and speedy communication.

SSHA should hold frequent, well-publicized webinars for people who work or volunteer in this sector on specific updates and topics related to COVID-19.

Particular attention should be paid to provide support and education for families including refugee families, who are placed in motels, should they become symptomatic.

TPH and Shelter Support and Housing Administration (SSHA) should develop signage for locations advising people entering they will be screened for symptoms.

2. Standards, social distancing, staffing

SSHA should immediately upgrade the standards in the 24-hr respite sites, overnight drop-ins for women and OOTCs (none currently meet the city's Shelter Standards). In particular that means enhancing staffing and cleaning, decreasing capacity and crowding. To compensate for bed/mat loss they must open additional new shelter sites.

SSHA should direct the volunteer, faith-based Out of the Cold program to cease operation for the remainder of their season. This would reduce nightly movement, risk of disease transmission and challenges for contact tracing. The Red Cross should be asked to operate one 24/7 location to replace mat loss.

SSHA and TPH should immediately direct all shelter sites including drop-ins to implement measures for ‘social distancing’ that include space requirements between sleeping areas, overnight and daytime capacity reductions per site. New York City Health recommends 3-6 feet and the use of barriers between beds/cots. They also recommend staggered meal sittings. However, according to the Centers for Disease Control and Prevention (CDC), COVID-19 is most likely to be transmitted between people if someone is within six feet of an infected person. Bunk beds do not provide adequate social distancing.

SSHA make sure all shelters remove length of stay restrictions at shelters.

SSHA should upgrade cleaning protocols to extreme cleaning and communicate this to all day and overnight shelters and programs. Personal protective equipment (PPE), specifically masks and gloves should be provided with guidelines for use. TPH inspectors should visit locations to provide education and ensure compliance.

In addition, TPH should provide travel size hand sanitizers or alcohol-based hand wipes to give out.

The city should create a funding stream for smaller organizations, including ones not funded by the city (drop-ins, food programs etc.), for enhanced cleaning, and additional operational costs such as transit support.

In the event of staff shortages due to illness, quarantine or work refusal, the city should develop a business continuity plan to ensure that shelters are considered a top priority, even if it means that staff from other city programs need to be redeployed.

Any indication of decline in shelter use should trigger enhanced funding for street outreach.

3. Screening and isolation

TPH and SSHA should develop a clear protocol for when people are screened on the phone, in person or by Central Intake if symptomatic including how the individual is transported to hospital or isolation/quarantine.

TPH should provide the secondment of public health nurses or funding for nurses for a minimum of four hours a day to every shelter, respite, 24-hour overnight drop-in and OOTC to help staff handle symptom identification and referral. Sites should have a pre-identified location for separation of an individual with suspected symptoms until TPH triage can take place.

TPH and SSHA should develop a plan for single room 'home' isolation for homeless people who are being isolated because they are symptomatic and for people who have had a high-risk exposure. During SARS that meant use of motel rooms but there has to be outreach support and a food program attached to that option.

TPH and SSHA should develop a clear protocol for moving people to motel rooms if isolation is needed.

Isolation and quarantine plans should include details plan for people who use drugs including access to harm reduction supplies, health supports. etc.

The city should fast track modular housing options on city land as they will offer better quality living spaces during isolation or quarantine and ensure permanent housing in the long term.

TPH and SSH should explore the use of incentives for testing, isolation, quarantine.

4. Protection of vulnerable

The city should declare a moratorium on evictions and mortgage non-payments.

The city should enhance funding for outreach workers and harm reduction teams.

The city should declare a moratorium on displacing people from encampments as it isolates them and moves them further from screening options and health care options.

The city should remove the moratorium on rules that disallow distribution of survival supplies (such as food and sleeping bags).

SSH should remove length of stay restrictions in shelters, where they exist, and direct shelters to allow people to stay in during the day if feeling ill.

SSHA should immediately prioritize moving people who are over 60, or with serious chronic illness into housing with rent supplements.

SSHA should immediately work to ensure people who are eligible for Ontario Disability Support Program (ODSP) are fast-tracked.

The City should develop emergency plans for the provision of the basic necessities of life such as shelter, food, health care, harm reduction programs should the closure of existing programs and agencies place people at risk.

5. Health care sector

The provincial Medical Officer of Health and Long-Term Care should direct hospitals that they cannot discharge homeless people back to a shelter or the street if they are still symptomatic or under investigation for COVID-19.

Public Health should ensure that ‘Don’t Ask Don’t Tell’ applies to screening centres and all health facilities.

Health care workers in community settings such as drop-ins and shelters must be prioritized for PPE.

6. Future protection of homeless population

Post COVID-19 TPH should resume vaccination clinics (flu shot, pneumonia vaccine) in all congregate settings where homeless people spend time.

Public health officials should advocate to the province and federal government for prioritization of the homeless population, and those who work with them, for the Corona virus vaccine when it is available

7. Declaration of emergency

Mayor Tory and City Council should hold an emergency meeting to declare a state of emergency.

In 1998 the Big Cities Mayors' Caucus of the Federation of Canadian Municipalities endorsed Toronto Disaster Relief Committee's declaration that homelessness was a national disaster. This resulted in billions of dollars of emergency funding for homelessness. This advocacy is necessary again with respect to COVID-19.

Declaration of an emergency at the provincial level would also ensure job protection for people who are asked to self-isolate or ordered to quarantine.

Numerous American cities have declared civic emergencies with respect to COVID-19. The Shelter and Housing Justice Network (SHJN) has advocated for 15 months to Mayor Tory and City Council to issue a declaration that homelessness is an emergency. The exact circumstances that put homeless people at risk for COVID-19 are the crux of that demand.

Declaration of emergency allows officials to take speedy and necessary steps. It allows city silos to work together. It permits mayors and public health officials to call for provincial and federal emergency funding.

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