Canadian Network for the Health and Housing of People Experiencing Homelessness

Commentary on Health Canada's "Guidance for providers of services for people experiencing homelessness (in the context of COVID-19)"

On March 24, 2020, Health Canada released its guidance for providers of services for people experiencing homelessness in the context of COVID-19. Although recommendations from March 3, 2020 did make mention of shelter settings, this is the first Federal COVID-19 guidance concerning this sector.

Guidance for this sector is desperately needed, and people experiencing homelessness are likely to be affected severely and disproportionately by the COVID-19 pandemic. **In that context, CNH3 celebrates the release of a guidance from Health Canada facilitating the direction of practice and preparation nationwide. Here, we summarize perspectives that may guide the implementation of these guidelines and future revisions**

Overall, CNH3 believes that it is the responsibility of public health agencies to secure a minimum standard of health protection for people experiencing homelessness in Canada in the context of a COVID-19 pandemic. Homeless service providers are to be engaged as collaborators in that effort, but cannot assume the fiduciary or regulatory responsibility for minimum health protection standards including isolation and communicable disease control.

Offering safe, affordable, appropriate and permanent housing on an emergency basis is likely the single best approach for protecting the health of people experiencing homelessness in the context of COVID-19. This is feasible in all Canadian centers, and has been implemented as a response to COVID-19 in other settings globally. Also essential in all planning for this population — but absent from the existing recommendations — is the ongoing provision of harm reduction services, trauma-informed care practices, and culturally safe care.

Passage	Comment
Consider specialist services that may be required e.g. mental health services, drug and addictions support/programming, social workers.	Mental health, drug and addictions services are critical. Consider revising to "Ensure that appropriate mental health, substance use and harm reduction services, trauma-informed care practices and culturally safe systems of care are supported throughout planning and implementation."

This document was prepared by the Population and Public Health Community of Practice of the Canadian Network for the Health and Housing of People Experiencing Homelessness (PPHC-CNH3), a national collaboration of providers with joint expertise in public health, shelter medicine, and homeless service sector operations. This is a living document, and subject to revision and further development based on feedback from partners and policymakers.

Work with community networks (such as community leaders, PHA, and faith-based organizations) in advance to secure additional shelter spaces in order to accommodate the requirements of social distancing (e.g. recreation facilities, community centres, hotels or modular units).	Public health agencies bear the responsibility to deliver minimally acceptable space for health protection. This could be made more explicit. Suggest "PHAs should ensure that homeless service sector providers have access to adequate shelter spaces to accommodate the requirements of social distancing, including in partnership with community leaders and faith-based agencies."
Coordinate with affiliated shelters or congregate living facilities in the community to plan to cohort those who have mild cases of COVID-19 together, recognizing that those with severe symptoms (see below) should be transported via emergency medical services (EMS) to a healthcare facility.	Public health agencies bear the responsibility to deliver minimally acceptable health protection in the context of an outbreak. This could be made more explicit. Suggest "PHAs should coordinate with local agencies to ensure that people with mild COVID-19 cases are placed in settings where non-infected residents can be protected from infection and where infected individuals can receive adequate supports, recognizing that those with severe symptoms (see below) should be transported via emergency medical services (EMS) to a healthcare facility. This may require collaboration with other congregate living facilities."
Plan to have appropriate supplies on hand, such as personal protective equipment for those who are providing care to ill clients (e.g. gloves and gowns).	With national shortages of supplies, this guidance could be explicit about what homeless service providers should do if adequate supplies are not available.
Identify if alternate care sites are available for clients with suspected or confirmed COVID-19 or if service providers should plan to isolate cases within their facility.	Public health agencies bear the responsibility to deliver minimally acceptable health protection in the context of an outbreak, not shelter providers. Suggest "Public health agencies should ensure that all people experiencing homelessness and who are suspected or confirmed with COVID-19 have access to appropriate isolation facilities for personal and community health protection."
Anticipate an increase in absenteeism among homeless service provider staff. Develop flexible attendance and sick-leave policies. Staff (and volunteers) may need to stay home when they are sick, caring for a sick household member, or caring for their children in the event of school dismissals. Identify	Guidance should be explicit about what homeless service sector agencies should do if staff shortages result in staffing levels below minimum standards. Shelters and drop-ins should have emergency demobilization strategies and plans for emergency closure or continuity of operations.

critical job functions and positions, and plan for alternative coverage by cross-training staff members.	
If staff and volunteers are not able to maintain a 2 meter distance between themselves and those who are symptomatic, contact the PHA for advice in implementing measures within the shelter to minimize the opportunity for close unprotected contact.	The situation described here is the rule rather than the exception. Strategies for managing this to a minimum health and occupational standard should be made explicit.
Assign clients with mild respiratory symptoms consistent with COVID-19 infection to individual rooms.	This recommendation may benefit from some assertion that individuals confined to rooms require access to toileting, hygiene, medical and mental health care, medications, behavioural support and harm reduction services as required.
If individual rooms for sick clients are not available, consider using a large, well-ventilated room to cohort symptomatic patients together.	This approach is only safe if all symptomatic individuals are confirmed to have COVID-19. Unless COVID-10 is confirmed, this approach will propagate outbreaks, and will specifically transmit COVID-19 to individuals at the highest risk of severe clinical outcomes (ie: people who have respiratory symptoms but do not yet have COVID-19). Suggest replacing “sick clients” with “clients who are confirmed to have COVID-19”.
In general, sleeping areas (for those who are not experiencing respiratory symptoms) should have beds/mats placed at least 6 feet apart, and request that all clients sleep head-to-toe.	The head-to-toe recommendation may not be socially acceptable and lacks an evidentiary foundation. Suggest removing this. Guidance should be explicit about not using the top bunk of bunk beds, because droplet spread to those sleeping below likely extends beyond 6 feet and is difficult to control.

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