Canadian Network for the Health and Housing of People Experiencing Homelessness

Briefing and Recommendations: Isolation and Quarantine
COVID-19 in the Homelessness Service Sector
v.1.0 - 11 March 2020

Purpose: To identify issues arising from emerging Federal guidance on COVID-19 management in the homelessness service sector, and offer alternate recommendations.

Issue summary: There are roughly 35,000 people in shelters in Canada on any given night, and roughly 200,000 people access shelters in Canada each year. Shelters, drop-ins, out-of-the-cold programs and other such services provide an essential health protection function for the people they serve. There are no national standards for outbreak management or pandemic response in the homeless service sector in Canada. It is difficult — if not impossible — to directly apply standards designed for health care settings (such as long-term care or hospitals) or congregate living settings (such as supportive housing facilities, group homes or military barracks) to homeless shelters.

Experience with previous epidemics, including SARS and H1N1, as well as recurrent outbreaks of influenza, meningococcal disease, tuberculosis and Hepatitis A show that COVID-19 is a significant threat for people experiencing homelessness in Canada. Roughly 30% of people experiencing homelessness report a cough at baseline, and 40% report shortness of breath with exertion, making screening and assessment particularly challenging in this group. Inadequate and inappropriate care, planning, and management strategies in this population raises critical individual health, public health, and bioethical concerns for people experiencing homelessness, personnel involved in their care, and the wider community.

On March 3, 2020, Health Canada issued the first COVID-19-related guidance that makes specific mention of shelters or people experiencing homelessness. This guidance concerns the adaptation of provisions for the isolation of a Person Under Investigation (PUI) for COVID-19, or a confirmed case of COVID-19 in a shelter setting or overcrowded housing. The Health Canada guidance calls for people living in shelters to adapt self-isolation procedures to single rooms or cohorted settings within shelters. The recommendation text is pasted below and available at this link: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/interim-guidance-cases-contacts.html

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.

Public health management of cases and contacts associated with novel coronavirus disease 2019 (COVID-19)

March 3, 2020

- **Cohorting cases/PUIs in co-living settings (e.g. those living in university dormitories, shelters, overcrowded housing).** Special consideration is needed to support cases/PUIs in these settings when self-isolating. If it is not possible to provide the case/PUI with a single room and a private bathroom, efforts should be made to cohort ill persons together. If there are two cases/PUIs who reside in a co-living setting and single rooms are not available, they could share a double room.

Analysis

CNH3 has conducted an analysis of the operational issues that would cascade from this approach to isolation and the quarantine of individuals within shelter settings. Specifically, we have assessed what would be required to implement this guidance in a way that achieves:

- A minimum standard of health and wellbeing for the individual in quarantine/isolation.
- An appropriate balance between the public interest in quarantine and the respectful and compassionate treatment of people experiencing homelessness, given their limited options and resources.
- A minimum standard of health protection from communicable disease for other shelter residents, while maintaining a safe, welcoming and open shelter environment.
- A minimum occupational health standard for shelter staff and volunteers.

We have limited this analysis to shelters, acknowledging that implementing this guidance in drop-ins and other homeless service settings would introduce other complexities. CNH3 acknowledges that isolation among people experiencing homelessness cannot be reasonably referred to as “self-isolation” because living spaces and resources are assigned to the individual. A homeless person cannot isolate in their own home.

In order to be able to implement current Federal guidance on isolation to a minimum standard, the shelter would need to be able to provide:

- A single private bedroom for the isolated or quarantined individual, or a space for cohorted individuals separate from the remainder of the shelter population.
- A single private bathroom and from bedroom to bathroom in isolation.
- If cohorting individuals, those individuals would need bedroom space and space to move separate from other non-quarantined individuals — similar to the other space that housed individuals would be able to access if they were in self-isolation at home.
- PPE for the isolated or quarantined individual as needed to get to bathroom or outside.
- Food delivery to the isolated or quarantined individual(s).
- PPE, and training to don and doff PPE, for shelter staff who have any interaction with the isolated or quarantined individual, as well as appropriate occupational health structures to maintain this standard, recognizing that PPE for droplet precautions are difficult to maintain even for trained health care workers.
- Mechanisms to provide ongoing physical and mental health care to quarantined or isolated individuals.

- Systems as recommended to prevent severe social isolation, including telephone and internet access, mechanisms to socialize to prevent mental health consequences.
- Harm reduction and addictions services, including for smoking, alcohol and illicit drugs when applicable, and the health care services to manage withdrawal or cravings.
- All of the above services for clients who presently receive assistance with their activities of daily living in shelter settings (mobility issues, toileting issues, feeding issues, cognitive impairments) but are not eligible for long-term care (mostly because of behavioural or addictions concerns).

Based on our experience providing healthcare services in shelters nationwide, these minimum operational needs fundamentally exceed the capacity of the vast majority of shelters in Canada, and therefore do not provide the necessary and practicable guidance needed for effective implementation or to ensure the equitable protection of the health of people experiencing homelessness and the prevention of the social and epidemiological implications of uncontrolled spread of COVID-19 in this population. Alternate approaches are required that will necessitate intersectoral collaboration to implement these solutions.

Recommendations

CNH3 recommends that Health Canada move forward with the following items.

- Form a small national working group on COVID-19 and Homelessness, tasked with developing practicable guidance for the homelessness services sector.
- Revised guidance on isolation/quarantine in shelters should include the following recommendations: “In the event that shelters and homeless service facilities do not have suitable designated space, Personal Protective Equipment (PPE), or staffing for appropriate isolation or quarantine, alternative isolation and quarantine supplies, staffing and/or facilities should instead be identified, resourced and overseen under the primary jurisdiction of public health agencies. Where regional networks of shelters are in place, specific facilities may be designated for this purpose. In other settings, isolation or quarantine for people experiencing homelessness may require temporary housing (eg: in motels/hotels) or placement in collaboration with long-term care or hospital settings. In specific circumstances where shelter facilities, design and architecture permits appropriate and effective isolation, quarantine or cohorting, these practices may be considered in shelters. Strategies could include a combination of the above and should include escalation and surge capacity preparedness as requirements increase over the course of an outbreak.**”**

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