COVID-19 & Homelessness

what do we know, what are the risks, what can we do?

Webinar. 25 March 2020

Associate Professor Lisa Wood, UWA
Dr Andrew Davies, Homeless Healthcare
Acknowledgement of Traditional Custodians

The University of Western Australia and Homeless Healthcare acknowledge that we are situated on Noongar land, and that Noongar people remain the spiritual and cultural custodians of their land, and continue to practise their values, languages, beliefs and knowledge. We pay our respects to their elders past present and future.
COVID-19 Pandemic

What we know about Transmission and Risks
What is COVID-19?

**Coronaviruses**

- Large group of viruses
- Envelope
- Genetic material
- Protein spikes
  - Crown = "corona"

**Different types**
- Respiratory
- Gastrointestinal

**Common cold**, generally mild disease
- Some cause severe disease
- SARS-CoV China - 2003
- MERS-CoV Saudi Arabia - 2012
- 2019n-CoV China - 2019
How is COVID-19 transmitted?

- Mainly person to person transmission
- Through droplets when a person infected with coronavirus coughs or sneezes
- Surfaces that become contaminated with droplets – touching surfaces after coughing/sneezing
- Sharing food/drink/cigarettes/other objects that have been in mouth with someone who is infected with COVID-19
Symptoms of COVID-19

Symptoms can occur between 2-14 days after exposure

**People can have COVID-19 but be asymptomatic**

Most people get a mild to moderate illness

- Fever
- Dry cough
- Sore Throat
- Shortness of breath
- Muscle pain
- Tiredness

Some get a more severe illness
<table>
<thead>
<tr>
<th>SYMPTOM</th>
<th>COVID-19</th>
<th>COMMON COLD</th>
<th>FLU</th>
<th>ALLERGIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>Common</td>
<td>Rare</td>
<td>Common</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Dry cough</td>
<td>Common</td>
<td>Mild</td>
<td>Common</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>Common</td>
<td>No</td>
<td>No</td>
<td>Common</td>
</tr>
<tr>
<td>Headaches</td>
<td>Sometimes</td>
<td>Rare</td>
<td>Common</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Aches and pains</td>
<td>Sometimes</td>
<td>Common</td>
<td>Common</td>
<td>No</td>
</tr>
<tr>
<td>Sore throat</td>
<td>Sometimes</td>
<td>Common</td>
<td>Common</td>
<td>No</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Sometimes</td>
<td>Sometimes</td>
<td>Common</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Rare</td>
<td>No</td>
<td>Sometimes*</td>
<td>No</td>
</tr>
<tr>
<td>Runny nose</td>
<td>Rare</td>
<td>Common</td>
<td>Sometimes</td>
<td>Common</td>
</tr>
<tr>
<td>Sneezing</td>
<td>No</td>
<td>Common</td>
<td>No</td>
<td>Common</td>
</tr>
</tbody>
</table>

*Sometimes for children

Sources: CDC, WHO, American College of Allergy, Asthma and Immunology
How Severe?

80% Mild Symptoms
14% have severe disease,
6% are critically ill

Case fatality proportion  - 0.3-1%

Lancet 11/03/2020
Complications of COVID-19 in hospitalised patients

- Sepsis - 59%
- Respiratory failure – 54%
- Heart Failure – 23%
- Secondary infection – 15%
- Septic shock – 20%
- Acute cardiac damage – 17%

Mortality
Case fatality

1918 Flu - ≥ 2% 20-50 million deaths
1957 Asian Flu - 0.1-0.2% - 33,000 deaths
1968 Hong Kong Flu - 0.2-0.4% - 1-4 million deaths
2009 Swine Flu - < 0.025% - 18,000 deaths
2012 MERS – CoV - > 30% - 861 deaths
2002 SARS - < 10% 774 deaths
2019 COVID-19 - 0.3-1% - High level of uncertainty

Lancet 11/03/2020
UK Coronavirus action plan
80% of the deaths are people over 60

60% of people infected are 40 - 69, although fatality rate is higher among elderly

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Cases</th>
<th>Deaths</th>
<th>Fatality rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–9</td>
<td>416</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10–19</td>
<td>549</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>20–29</td>
<td>3,619</td>
<td>7</td>
<td>0.2</td>
</tr>
<tr>
<td>30–39</td>
<td>7,600</td>
<td>18</td>
<td>0.2</td>
</tr>
<tr>
<td>40–49</td>
<td>8,571</td>
<td>38</td>
<td>0.4</td>
</tr>
<tr>
<td>50–59</td>
<td>10,008</td>
<td>130</td>
<td>1.3</td>
</tr>
<tr>
<td>60–69</td>
<td>8,583</td>
<td>309</td>
<td>3.6</td>
</tr>
<tr>
<td>70–79</td>
<td>3,918</td>
<td>312</td>
<td>8</td>
</tr>
<tr>
<td>≥80</td>
<td>1,408</td>
<td>208</td>
<td>14.8</td>
</tr>
</tbody>
</table>

44,672 confirmed COVID-19 cases in Mainland China as of February 11, 2020.
Source: The Epidemiological Characteristics of an Outbreak of 2019 Novel Coronavirus Diseases (COVID-19)
Who is most at risk of COVID-19 mortality?

Older people
- aged 70+ in general population
- 50+ in homeless population

People with existing health conditions
- Hypertension – 45%
- Heart disease – 87%
- Respiratory conditions (Asthma, Chronic Obstructive Pulmonary Disease – 66%, Emphysema)
- Diabetes – 47%
- Suppressed immunity (eg if having chemotherapy, auto-immune disease, on immune suppressant medications)
- People who smoke tobacco

Who is most at risk in our WA homeless population?

High risk co-morbidities common amongst people experiencing homelessness

Among 4000 patients seen by Homeless Healthcare in last 3 years, high prevalence of chronic health conditions

- 13% have chronic respiratory conditions
- 8% have diabetes (associated with suppressed immunity)
- 79% smoke (associated with poorer lung health)
- Often have low immunity due to poor diet, food insecurity and drug use

+ in data just analysed:

20.5% of Homeless Healthcare patients who had an ED presentation or inpatient admission (2017-2019) were recorded in hospital data as having a primary diagnosis of one or more chronic conditions associated with COVID-19 mortality risk, e.g., hypertension, diabetes, cardiovascular disease, and chronic respiratory disease.

Other co-morbidities in Perth homeless population affecting health, immunity and coping

Also, trauma, family and domestic violence high

n=182 patients

*HODDS Patient Data

Wood L, Hickey J, Werner M, Davies A, Stafford A. “if you have mental health, alcohol and drug use issues you often fall through the cracks of the health system”: Tackling This Challenge Through a Novel Dual Diagnosis Outreach Service for People Experiencing Homelessness. Parity. 2020;In press.
In seasonal coronavirus washing hands regularly after coughing or sneezing reduces risk of passing on to household members by two thirds.

Spending more than five minutes in a room with someone with symptoms of a cold (other than a household member) – doubles your likelihood of infection.
The following activities are more common in week before respiratory infection onset

Bus, Train
Café, Restaurant, Party
Supermarket, Small shops
Going to place of worship
Residential accommodation checklist

Patient well enough?
Capacity to understand instructions?
Working phone?
< 60 minutes from hospital?
Can exposure of other residents be minimised sufficiently?
Can the patient be accommodated elsewhere?
Can their housemates be accommodated elsewhere?
If more than one patient can they be cohort?
Are any housemates particularly vulnerable e.g. chronic illness?
Can advice be issued to reduce transmission?
Residential accommodation checklist

Single occupancy room?

Handwashing facilities – soap, water, paper towels?

Can the patient have their own toilet or can shared facilities be adequately cleaned between use?

Sufficient cutlery and crockery to not need to share?

Sufficient face masks, paper towels, waste disposal bags, cleaning products?

Area to temporarily and securely store waste or laundry?

Support for getting groceries, prescriptions & other “personal needs”
COVID-19 infection control training

This 30-minute online training module is for health care workers in all settings. It covers the fundamentals of infection prevention and control for COVID-19.

Unknowns...

- Scientists and Health researchers (once thought of as nerdy, now seen as vital) working around the clock collaboratively to solve unknowns and develop a vaccine

- How long are people contagious? (around 10 days after testing positive but virus can linger)

- How long can virus survive on different surfaces?

- Different impacts by age group – evidence changing, WHO stresses ‘young not invincible’

- When will we have a vaccine? – it’s a scientific race but awhile away

- What do we know about cases of COVID-19 among homeless people in other countries? (data on this hard to get, at least one rough sleeper death USA, positive cases in UK and US)
The need for more tailored advice COVID-19 advice for people experiencing homelessness
The need for more tailored advice

**Problematic to follow the recommendations to general public**

- Limited access to bathrooms, taps, hand sanitiser, soap
- Harder to maintain ‘social-distancing’ – need to access essential services eg food relief, day centres
- Congregating with others to sleep safely at night is common – social distancing versus safety risk?
- No where to self-isolate to!
- If self-isolating or in lock down, how to access things like methadone, depot for psychosis
- Nowhere to quarantine or be in isolation
- Fewer support networks if need essential provisions and are isolated
Getting tailored advice out there quickly

Other areas of advice/info being requested in WA re COVID-19 and homelessness:

**Anxiety and worry among clients:** mainstream resources don’t reflect circumstances *(eg spend time in the garden, do online yoga)*

**Staff wellbeing, stress and risks**

**Risk management for services** and what to do if have a suspected case

**Sifting facts from fiction**

**Other?**
The value of more tailored advice

“Messages that say Stay Home are meaningless when you are on the streets – So we need something ‘like yesterday’ that explains factually how to stay safe if on the streets from COVID 19 and how to safely gain the support of others... honest practical advice that covers the sharing of food, drinks, needles bedding or clothes that may be unique to the homeless population

We need to get these message out there to those who don’t have TV or Social media, let alone hand sanitiser, regular food or toilet paper”

Melody Birrell | Community Development Officer
Service 3, Royal Perth Bentley Group 24/3

“We have some isolated rough sleepers in the Royal National Park who aren’t connected to any services and are very isolated- and whilst this might work in their favour for now, we do want to ensure we have some information for them that we can adapt for our purposes and saves us re-inventing the wheel”

Stephanie Macfarlane
Homelessness Health Program Manager
South East Sydney Local Health Service 24/3
What do we need to reduce risk and save lives?
What do we need?

a clear health strategy to reduce spread of COVID-19 and fatalities among people homeless

5 key elements*:

- Protect the most vulnerable - i.e. those with clinical risk criteria eg chronic health conditions, aged ≥ 55
- Reduce transmission risk
- Prevent explosive transmission spread (higher risk in residential services, settings where congregate)
- Minimise impact on public health system and essential services - reduce the need for ED presentation and hospital admission through effective supportive primary healthcare care in the community
- Prevent high mortality

What do we need?

For all people homeless, and those hope to accommodate rapidly

Access to COVID testing (mobile is being trialled in Boston and UK with homeless)

places where people can quarantine or self-isolate – will require health staff to monitor/ treat

Continuity of primary healthcare access for the range of other health conditions highly prevalent in this population

Access to AOD support (unplanned withdrawal risks, continuity of treatment, dispensing)

Mental health support for those housed as part of COVID-19 strategy will need to include access to GPs, mental healthcare plans and ideally the Homeless Outreach Dual Diagnosis service

health sector input into identifying those at greatest risk and triaging of accommodation allocation to reduce risk of disease spread
What do we need?

Accommodation and housing to reduce risk

Urgently need to provide people who are rough sleeping suitable accommodation (suitable in COVID-19 context means access to bathroom, minimal shared areas, access to food supplies)

A process for prioritising accommodating those most at risk fastest  The risk factors for COVID mortality/complications form an evidence based (non subjective) strategy for this

Once people are in accommodation, clear strategies and resourcing for ensuring continuity of essential support

What to do about social isolation and social support? Going to be a massive issue, with high vulnerability to worsening mental health and social isolation

* (case workers for those who have them wrap around supports, AOD/mental health support, access to primary care (GP/nurse).
What do we need?

Strategies to manage COVID anxiety in Homeless People

Acknowledge that anxiety is a normal response to the COVID-19 pandemic

Let people debrief, talk, make sense of the situation

Filter key information provide credible, evidence informed updates

Check in for heightened mental health symptoms - refer to psychological services where possible and appropriate

Be aware of language associated with COVID that may be triggering eg ‘lock down’ if been in mental health or justice institution

Encourage people to:

• follow good hygiene to reduce risk and fear of contracting it

• engage in things that distract them/make them feel good (e.g. sitting in sun, listening to music, talk to friends)

• avoid meth and other stimulants including caffeine (can increase anxiety)

• reframe concerns e.g. over 80% do not get sick at all, the vast majority fully recover
What do we need?

Strategies to manage COVID anxiety for Staff in Services

Mental Health First Aid principles- ensuring staff are aware of mental health symptoms in themselves and others

Accurate information available around risks to staff and issues that may arise

Ensure staff feel - line management, supervision, buddies

Connecting with others and debriefing – COVID is unchartered waters for all

Awareness of risks of physical and compassion fatigue

Model behaviours for people they support

Self care and exercise

Take breaks from watching, reading, or listening to news stories, and balance ‘bad news’ with the positive e.g. endless social media of people rallying to help others, and cute dogs and kittens!

distraction is good

focus on things you can do to make a difference

Dr James Hickey, Homeless Healthcare
Important to remember most people who get it recover!

What do we need?
Evidence led advocacy for fast action

Coronavirus is revealing how badly the UK has failed its most vulnerable

COVID-19 precautions – easier said than done when patients are homeless
Lisa Wood, Andrew Davies and Zana Khan
Med J Aust
Published online: 16 March 2020

Concerns for Australia's homeless community as coronavirus continues to spread
Questions?

(bearing in mind what is known is changing rapidly and some things unknown!)

Further info:


Faculty for Inclusion health website UK has up to date information and links to other sources -
https://www.pathway.org.uk/blog/

Shelter WA website has COVID-19 information and links for the social and affordable housing and homelessness sector
https://www.shelterwa.org.au/covid-19/