Palliative Care in the COVID-19 Pandemic

Briefing Note

Palliative Care for those Experiencing Homelessness in the Time of COVID-19

Issue

High rates of chronic disease among people experiencing homelessness (PEH) places them at a higher risk of death from COVID-19 infection. The pandemic poses new physical, psychological, and social threats, compounding their vulnerability and complicating their access to palliative care (PC) services, which were already inadequate prior to COVID-19.

Background

Groups at high risk of COVID-19 are disproportionately represented among PEH[1,2] (e.g. older persons, immunocompromised, those with chronic illness etc.). The homeless population is comprised of individuals who often experience social and health inequities including, but not limited to, sex workers, people living with mental illness, older persons, women, sexual and gender minorities, persons with disabilities, people who use drugs (PWUD), street children, people living in poverty, displaced persons e.g. due to a humanitarian crisis, persons who have been abandoned, and those unable to go home. Heath care systems' capacities to effectively mitigate COVID-19 outbreaks among homeless populations is limited.

Key Facts

- Due to their vulnerability, the burden of Serious Health-related Suffering (SHS) requiring PC is high amongst the homeless population and is expected to rise during the COVID-19 pandemic.

- Individuals with mental health issues who are also homeless face unique additional vulnerabilities (e.g. psychosis, cognitive decline). They also experience higher rates of physical illness, which puts them at risk of becoming seriously ill with COVID-19[1].

- PWUD are disproportionately represented among PEH and face additional risks from COVID-19, linked to drug use behaviours and related healthcare needs[3].

- In many countries' PEH are highly stigmatised, despite underlying circumstances related to structural, economic and social inequities.

- PEH have limited access to basic health and social care, including PC, medicines, and essential equipment to support patients with COVID-19.

- In some countries, attention and resources have centered on the pandemic – 'bringing people in,' closing shelters and finding individual rooms. Those already identified with PC needs have been overlooked as a result. Professionals in some health and social care settings are restricted by their own organisations from visiting/supporting PEH, further compounding limited support.

- Where PEH remain on the street, their 'living' environments make it impossible to follow infection control measures such as handwashing and self-isolation.

- Hostels, where existent, may not fall under the remit of either health or social care, and this various by country. This can complicate hostel access (especially in non-urban settings) to PPE.

Current Status

- Increasing numbers of PEH as shelter capacity is decreased due to COVID-19 and clients are fearful of living in more confined quarters[1].
- Income from begging/panhandling is falling as the public is more reluctant to engage in contact - exacerbating economic vulnerability (e.g. quality/quantity of food/medications that can be purchased).
- PEH have limited access to phones/internet, compounding social isolation, and limiting ability to access help and up to date information, including public health messaging.
- Supervised consumption services for PWUD are reduced and clients may avoid accessing services to lower COVID-19 exposure risk; they may be at higher risk of death from drug use in isolation[1].
- Resources for health assessments of those housed in hostels/hotels are limited and maintain the invisibility of the homeless health crisis.
- Congregate living environments (e.g. shelters) render it extremely difficult to follow infection prevention and control measures, such as frequent handwashing, physical distancing, and self-isolation. Shared living facilities heighten contraction and transmission risk.
- In some countries, funds have been allocated to buy tablets for hostels/shelters/shared houses so PC coordinators can liaise more efficiently with service users and staff to provide PC support.

Recommendations to UN member states and civil society organisations

- Recognise PEH as a high-risk group for COVID-19. Hospitals, primary health care and community-based services need to prioritise this population for ensuring PC support through an effective referral system.

- Integrate PC into public health systems, including public health measures being sensitive to the needs of PEH and taking a human rights approach.

- Integrate the principles of PC to the homeless into the COVID-19 response i.e. flexibility, low barrier services, trusting relationships, trauma informed and person-centred care[4].

- Estimate and plan for adequate PC support throughout the pandemic among homeless populations (e.g. segregated accommodations, staffing considerations)[5]. Ensure PC access for individuals who are deteriorating (COVID-19 and non-COVID-19 related) and for whom acute care is not an option.

- Where possible provide safe accommodation options for people with nowhere to isolate "at home"[6]. In contexts where it is not possible to do this, it is necessary to maintain access to basic sanitary supplies for both hygiene and infection prevention purposes (e.g. hand washing, masks, toilets)[7].

- Expand, rather than postpone addiction care [8], and integrate harm reduction measures into the COVID-19 response to help PWUD follow public health recommendations.

- Promote advanced care planning (ACP) with PEH and explore how they might want to be cared for if they become unwell[1].

- Ensure a social assessment on admission to identify whether the PEH has a family/street family and determine if connection can be facilitated.

- Recognise grief and loss during COVID-19 and beyond and provide grief and bereavement support mechanisms for PEH, shelter communities, and staff supporting their care.

- Provide emotional support and PC training for people working with PEH, NGOs and FBOs caring for the PEH through PC teams.

- Enhance chaplaincy and social work collaboration to meet psychosocial, spiritual, religious, and/or existential needs, particularly for homeless populations who may be socially isolated.

- Ensure health systems and PC teams integrate social histories upon initial assessment to evaluate economic status of individuals and families at risk for, recovering from, or currently experiencing homelessness in the context of COVID-19.

- Provide a dignified burial/cremation for PEH who die ensuring those who are unidentified are treated with the utmost respect and in accordance with congruent religious/cultural practices.

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