COVID-19 precautions: easier said than done when patients are homeless

Editor's note: This is an update of a Letter to the editor originally published as a preprint on 16 March 2020 (https://www.mja.com.au/journal/2020/212/8/covid-19-precautions-easier-said-done-when-patients-are-homeless).

To the Editor: Implementation of advice to the public and general practitioners on minimising the risk of COVID-19 exposure and transmission is immensely difficult for people experiencing homelessness and for the health services working with them. Yet this is a population group more vulnerable to infection than most.[1] The elevated risk factors for COVID-19 are substantial, as people experiencing homelessness have a much higher prevalence of comorbidity and chronic disease compared with people of the same age who are housed.[2] To illustrate further, among the 4000 active patients seen by Homeless Healthcare (Australia's largest specialist homelessness GP practice based in Perth), nearly all patients have comorbidities, 13% have chronic respiratory conditions, 79% smoke (associated with poorer lung health and risk) and 8% have diabetes (associated with supressed immunity). There are parallel calls in Australia and the United Kingdom for clearer government guidance as to how the precautionary measures can be applied in homeless populations. There are a myriad of challenges to this, both for people who are homeless themselves and for those providing health care to this vulnerable population group. These challenges include:

- Regular hand washing and hygiene (and accessing soap or sanitiser and bathrooms in order to do this) is extremely problematic if living on the street.
- Self-isolation by staying at home if you feel unwell and suspect having symptoms is impossible if you do not have a home to live in.
- Reducing face-to-face health service contact is being advocated to GPs and health services in Australia and the UK. The Australian Government has just announced Medicare rebates for b ulk-billed telephone consultation s,[3] but this is problematic for people who are homeless without a phone. Similarly, technological solutions such as video or virtual consultations are digitally prohibitive for people without a home let alone a computer.
- Outreach health services are among the most effective ways of enabling people who are rough sleeping to access health care.[4] Homeless Healthcare, for example, runs clinics at drop-in centres and crisis accommodation settings and has nurses out on the streets each day and doing home visits to those recently housed. However, implementing the use of personal protective equipment is difficult in these settings, and in the absence of primary care outreach, emergency department presentations are likely to escalate.
- Cancelling outreach GP clinics and other outreach services for this population to reduce exposure risks would have severe unintended consequences. If risk factors for COVID-19 or patients with COVID-19 are untreated in this highly susceptible population, the mortality risk is high.[1] Moreover, many people will not receive critical treatment for other medical conditions, such as depot medications for psychotic illness and, as articulated in a recently published article, "lockdowns and disease containment procedures might also be deleterious to the mental health of people experiencing homelessness, many of whom have fears around involuntary hospitalisation and incarceration".[1]

The higher risks of COVID-19 for people experiencing homelessness and, consequently, for those working closely with them present an enormous challenge that has no easy answers. As new precautionary measures are being announced daily, it is critical that further marginalisation for this group is not an unintended consequence.

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