Commentary

Optimizing Care for People Experiencing Homelessness and Serious Mental Illness amidst COVID-19: A Street Outreach Perspective

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Running head: Street outreach during COVID-19
Abstract: The COVID-19 pandemic has disproportionately affected marginalized individuals with multiple vulnerabilities, including those experiencing serious mental illness and homelessness. This population is adversely affected by the pandemic due to loss of opportunities for social connection and support, decreased engagement with community services, and increased risk of mental and physical health deterioration. Multidisciplinary street outreach teams have employed an instrumental service model in the provision of community-based, comprehensive care for individuals experiencing homelessness, often with concurrent challenges with mental illness and addictions. However, during this period of unprecedented and additional vulnerability, street outreach teams must adapt their existing practices to meet the evolving needs of their client population. This article aims to highlight the impact of COVID-19 on people with serious mental illness experiencing homelessness, and then share lessons learned and recommendations for action to optimize care and support to this vulnerable population amidst COVID-19.

Key words: COVID-19, serious mental illness, homelessness, street outreach.

Abbreviations: personal protective equipment (PPE), serious mental illness (SMI)
While the COVID-19 pandemic has profoundly affected all of society, marginalized groups have been disproportionately affected, both by the pandemic itself as well as by public health policies enacted to reduce transmission.\textsuperscript{1,2} This negative impact is exacerbated in individuals experiencing multiple vulnerabilities, such as those experiencing a serious mental illness (SMI, such as schizophrenia, bipolar disorder, and major depressive disorder) and homelessness. Although widespread data on the prevalence of COVID-19 in the homeless population remains scarce, geographic variability must be considered. In a study of 16 homeless shelters across four cities in the United States, residents testing positive for COVID-19 varied between 4\% in Atlanta to 66\% in San Francisco.\textsuperscript{3} Furthermore, the high prevalence of SMI among people experiencing homelessness has been well documented.\textsuperscript{4} The high prevalence of SMI among people experiencing homelessness has been well documented.\textsuperscript{4} This population faces particular challenges, including, but not limited to, loss of opportunities for social connection and supports, decreased engagement with community and outreach services, and increased risk of mental and physical health deterioration.\textsuperscript{5} Although the welfare of vulnerable populations should always be a key consideration for health and social systems striving for health equity, it assumes new urgency amidst the current pandemic, as the harms of inaction could be catastrophic.

Multidisciplinary street outreach offers community-based, comprehensive social and health supports to individuals experiencing homelessness, often accompanied by other health challenges, including mental illness and addictions. The overarching goal of street outreach is to support individuals living precariously (e.g., street living, temporary shelter) in accessing more
permanent housing arrangements and concurrently address their complex psychosocial needs. As many individuals with SMI experiencing homelessness are less likely to engage with traditional community health services, either due to lack of care coordination between health and social services, mistrust in health professionals, or illness-related factors, street outreach has a key role to play in identifying these individuals and maintaining ongoing connection and support. Street outreach teams typically include case managers and other health and social providers, as well as access to or direct involvement of nursing, psychiatry, and primary care. Teams are mobile, having the capacity to meet individuals in their preferred locations, supporting their transport to various in-person appointments, and providing resources for survival outdoors (e.g., bringing food, clothing, and medications). Numerous studies have demonstrated the benefits of outreach services for individuals with SMI experiencing homelessness, such as reduced hospital admissions, quicker access to and retention in independent permanent housing, increased trust-building between clients and service providers, and greater facilitation of supplemental services (e.g. obtaining identification, applying for income support, connecting to employment assistance services). As street outreach can effectively engage and support individuals who are seriously ill and difficult to engage in other services, it plays an instrumental role in the care of a vulnerable population who may not otherwise receive support.

In the midst of the COVID-19 pandemic, street outreach teams are learning and adapting to meet the evolving needs of this population safely, while maintaining their own staff safety. With little to guide such teams at this time, this article aims first to highlight the impact of COVID-19 on people with SMI experiencing homelessness and then to voice recommendations to optimize care and support to this vulnerable population at this extraordinary time. These insights can inform street outreach teams across multiple settings to
better serve people with SMI experiencing homelessness during this current pandemic and in future periods of unprecedented and additional vulnerability.

**Challenges for People with SMI Experiencing Homelessness during COVID-19**

Since the early stages of the pandemic, numerous concerns have been raised about the implications of COVID-19 for those living with SMI.\(^5,13\) Having a SMI elevates one's risk of COVID-19 transmission for a number of reasons. On an individual level, due to the symptoms associated with serious mental disorders affecting cognition, some individuals may have challenges with understanding, retaining, or using information and decreased capacity to make fully informed decisions, leading to greater difficulty adhering to infection prevention and control practices (e.g., mandatory mask-wearing, hand washing, social distancing). These concerns can be further exacerbated if individuals with SMI have concurrent substance use disorders or severe physical illness, such as traumatic brain injury, that may further impair insight and cognition.\(^14\) At the environmental level, during the COVID-19 pandemic, a number of shelters have had to limit capacity to support greater social distancing among residents, while individuals living in rental properties have been subjected to eviction due to inability to pay rent as a result of job or income loss.\(^15,16\) As a result, many individuals have been displaced to the streets, encampments, or other precarious living arrangements that may increase the risk of COVID-19 transmission and outbreaks in this population.\(^17\)

Furthermore, both SMI and homelessness are associated with increased medical comorbidities, such as smoking, lung disease, cardiovascular disease, diabetes, and obesity.\(^18,19\) These pre-existing medical conditions can raise one’s vulnerability to morbidity and mortality due to COVID-19, at a time when access to outreach supports is limited.\(^4\) As seen from the
experience of psychiatric hospitals in China, the risks of nosocomial transmission are also elevated in people with SMI experiencing a period of acute mental health decompensation requiring psychiatric admission, since these spaces often do not have the same capacity for infection prevention and control, leading to large outbreaks in some settings.\(^{20}\)

Another important consideration in the care of people with SMI experiencing homelessness is the interplay between the novel COVID-19 virus and psychotropic medications. Although knowledge on the exact mechanisms of interaction is still evolving, numerous preliminary safety concerns have been postulated.\(^{21}\) A group of clinicians in New York have conducted a structured literature review on potential safety considerations for psychotropic use in the context of COVID-19.\(^{21}\) Individuals with COVID-19 on Clozapine may be at increased risk of pneumonia, Clozapine toxicity, white blood cell abnormalities and increased risk of seizures. Individuals with COVID-19 on other antipsychotics or antidepressants may be susceptible to exacerbated risks of tachyarrhythmias and cardiac dysfunction. COVID-19 has also been associated with acute liver injury, which may be exacerbated by chronic antipsychotic or antiepileptic use, as well as acute renal injury, raising the potential for reduced Lithium clearance and nephrotoxicity.\(^{21}\) In a time of clinical uncertainty, treating clinicians face the added challenge of having to reconsider the risk of initiating, continuing, or titrating psychotropic medications with which they are otherwise familiar.

Lastly, the adverse impact of COVID-19 on mental health is significantly exacerbated among those experiencing SMI and homelessness due to the breakdown in regular routines related to widespread closure of community spaces and services and social isolation as a result of policies encouraging physical distancing and avoidance of group gatherings. These changes may lead to significant illness deterioration and ability to function independently.\(^{5,22}\) Studies have demonstrated that social connection serves as a protective factor, promoting a greater
sense of independence, reduction in stress, physical wellbeing, increased engagement with supports, and improved quality of life. At a time when many clinical and social services have shifted to virtual formats, many people with SMI experiencing homelessness are left further disadvantaged if they do not have access to technology or physical infrastructure required to engage with virtual meetings with their support providers.

**Lessons Learned, Recommendations for Action**

Based on the complex health and social challenges faced by people experiencing SMI and homelessness, and early lessons learned by street outreach teams during the COVID-19 pandemic, a number of practical recommendations can be shared, keeping in mind the need for adaptations in different service contexts given variations in street outreach models, regional infection prevention protocols, and population characteristics.

1. **Housing Security and Income Support**

It is recommended that multidisciplinary street outreach teams adopt and maintain the principles of *Housing First*, an evidence-based, recovery-oriented approach that connects people experiencing homelessness to independent housing and mental health supports with no preconditions. The underlying rationale for this approach is that housing is a human right and a precondition for successful recovery; people are more likely to engage in subsequent treatment and services if first housed. This differs from traditional housing program models, requiring service users to engage in psychiatric and substance use treatment before securing housing. *Housing First* models, in addition to ending chronic homelessness, have been shown to have a number of benefits compared with traditional housing programs. A randomized
control trial from Vancouver demonstrates that *Housing First* resulted in a significant increase in adherence to antipsychotic medication in formerly homeless adults, compared with traditional services.\(^{25}\) Additionally, a systematic review on the effectiveness of permanent supportive housing intervention for people experiencing homelessness showed increased long-term (six-year) housing stability for participants with moderate to high support needs, compared with traditional housing models.\(^{26}\)

As COVID-19 has added an additional strain on both tenants and landlords in managing rent payments, street outreach teams should strive to ensure that once housing is secured, housing is sustainable, before transitioning care to longer-term community mental health supports (such as an Assertive Community Treatment teams).\(^{27}\) This includes ensuring tenants are aware of their rights, negotiating contracts with landlords, aiding applications for housing subsidies, and seeking out legal support if there is a risk of early eviction. Resource compilations are available in certain jurisdictions to assist outreach workers in advocating for housing security for their clients, such as the *COVIDHelpTO* website by *Social Planning Toronto*.\(^{28,29}\)

Due to COVID-19, people with SMI experiencing homelessness may also suffer from loss of opportunities for employment and income. In addition to securing housing, it would be beneficial for outreach teams to simultaneously explore additional social and income supports to improve community integration and quality of life.\(^{23,29}\) Studies have shown that rent supplementation and income assistance help reduce homelessness and promote long-term housing stability.\(^{26,29}\) Thus, it is imperative that outreach teams inform themselves of newly available public income support (e.g., provincial emergency assistance) and rent supplement programs, and assist individuals in successfully accessing these benefits.\(^{30}\) People with SMI may already qualify for disability income or unemployment support; these streams of potential
income should be used.

2. **Socialization and Behavioural Activation**

Despite COVID-19 prevention measures encouraging physical distancing and reduction to in-person encounters, opportunities for socialization and behavioural activation are still possible. It is recommended that street outreach teams dedicate funding to the purchase or subsidization of smartphones, phone cards, and Internet access for individuals at highest risk of loss to follow up. This investment not only improves communication channels between homeless individuals and their support team but can also facilitate phone encounters with primary care providers, other service providers, family members and companions.\(^{30,31}\) Once established, teams can conduct phone visits instead of in-person visits. This can be dually beneficial in terms of reducing in-person exposure risks, as well as efficiency (e.g. reduced travel time and cost, increased encounter frequency). By empowering individuals with technological means, barriers to virtual therapy and group programs may also be reduced, further promoting access to care.\(^{31,32}\)

For individuals at high risk of poor outcomes, it may be beneficial for street outreach teams to advocate for in-person meetings with service providers. Encouraging scheduled plans to collect their income assistance and prescription medications, attend primary care appointments, and meet with vocational coaches can restore a sense of purpose and independence, while also developing social skills to challenge the negative symptoms associated with SMI, such as apathy, anhedonia, social withdrawal and inattention.\(^{33}\) It is important that when street outreach teams advocate for in-person socialization, they carefully assess capacity for understanding and appreciating protocols for safety (e.g., mandatory masking) and also
have the means to provide necessary personal protective equipment (PPE) for individuals to pursue safe socialization.

3. Psychotropic Treatment and Monitoring

It is also pertinent for outreach clinicians to stay up to date with rapidly changing treatment and monitoring guidelines for psychotropic medications, especially as the evidence base for the interplay between SMI and COVID-19 continues to evolve. Outreach clinicians should be aware of the potential for decline in medication adherence and interruption in medications prescribed by other mental health and substance use services due to COVID-19, which has been found in other settings such as primary care.\textsuperscript{34,35} They should also consider and address additional challenges to accessing medications, such as travel required to pick up medications from pharmacies and medication costs in a time of increased financial instability.

It is recommended that outreach teams consider the benefits and risks of treatment stability and infection prevention. If an individual with a psychotic disorder has yet to be stabilized on a medication regimen, it may be worthwhile initiating long-acting injectable (LAI) formulations. This allows for prolonged medication effects while reducing the number of administration events and exposure to clinical staff.\textsuperscript{36} For those stable on an oral regimen, they may continue at their usual therapeutic dose to minimize the potential for treatment interruption and decompensation. As outlined in guidelines for specific medications requiring regular monitoring (e.g., Lithium and Clozapine), consistent blood work at the appropriate intervals should be used to continue to monitor for hematologic, metabolic, cardiac, or other complications of common psychotropic medications. However, in select low-risk individuals who have been stabilized for a sustained period of time and are physically well, decreased monitoring frequency may be considered; this recommendation should be followed on a case-
by-case basis, considering each individual’s risk level, duration of stability on medication, and medical comorbidities.37,38

4. Physical Health Promotion and Infection Prevention

Given the increased susceptibility to COVID-19 transmission and poor outcomes among people experiencing homelessness and SMI, it is recommended that street outreach teams vigilantly screen for COVID-19 symptoms in this population (ideally by phone, prior to in-person visit) and connect individuals to nearby COVID assessment centres if screening positive. If hospital care is needed, outreach case managers should be prepared to escort individuals in the emergency department, as often people with SMI experiencing homelessness may not be able to fully advocate for themselves during a time of extraordinary vulnerability.39 Street outreach teams are also advised to make every effort to ensure that individuals are connected to primary care services to ensure continuing care for pre-existing and emerging physical health concerns.40 This may require advocating for rapid enrollment in a primary care practice, connecting to primary care services in shelters or drop-in centres, or hiring primary care clinicians to directly join the outreach team. Additionally, both street outreach teams and primary care services should be aware of emerging evidence concerning long-term sequelae of COVID-19; some reported complications include ongoing symptoms of dyspnea, cough and chest pain, as well as rare but serious complications such as myocardial inflammation, pulmonary function abnormalities, acute kidney injury, olfactory and gustatory dysfunction, and psychiatric manifestations.41 All clinicians involved in the care of previously infected individuals should remain vigilant in monitoring for potential chronic health consequences related to COVID-19.

Successful prevention of COVID-19 spread amongst this population largely begins with sufficient adherence to precautions from the outreach team itself. Since outreach workers
commonly travel across numerous environments, the potential for transmission is high. Thus, all outreach team members need access to appropriate PPE and training in its proper use. Depending on the individual service user’s needs, virtual encounters should be considered where possible, to reduce bidirectional transmission risks. Furthermore, it is important for teams to avoid physically aggregating for team meetings in common spaces and to work remotely if feasible and appropriate. In keeping with recommendations to form small social circles to limit the number of in-person contacts in regions with high community spread, the formation of dedicated multidisciplinary sub-teams should be considered. Only members within one sub-team should do outreach trips together, to avoid cross-contamination with other sub-teams and their client populations.

5. Supportive Interventions for COVID-19 Infected Service Users

As mentioned, individuals experiencing homelessness and SMI may face increased challenges adhering to public health measures, including self-isolating if positive for COVID-19. It is likely that many street-involved individuals may be unwilling or unable to partake in prevention measures, due to lack of understanding and awareness of related risks or lack of physical space and support to self-isolate. In a time when nonadherent behaviour can potentiate COVID-19 transmission and pose an increased risk to the affected individual and the general public, the threshold for street outreach teams to intervene is lowered. For clients experiencing homelessness with suspected or confirmed COVID-19, placement in low-barrier isolation facilities should be actively sought, including shelter hotels and other dedicated isolation centers where symptoms can be continually evaluated. In the scenario where psychiatric decompensation is affecting one’s ability to engage with testing or accessing such low-barrier isolation facilities, a short voluntary hospitalization may be considered for homeless
COVID-19-positive service users with SMI who are at high risk for poor outcomes, by allowing for brief psychiatric stabilization with the additional benefit of providing a dedicated space for self-isolation and ongoing monitoring of COVID-19 symptoms. It is important to note that voluntary hospitalization should only be considered in the context of acute psychiatric presentation or decompensation, and bed availability, as hospital bed capacity is limited in most settings and admissions primarily for self-isolation are not considered appropriate.

In addition to relevant public health regulations available to practitioners and public health authorities, mental health legislation further allows for the judicious use of certification for involuntary admission to a hospital under extraordinary circumstances. The decision to detain involuntarily in hospital is complex and should never be taken lightly. When deterioration in an individual’s mental health condition leads to high risk of physical impairment, or risks of harm to the individual or others, the right to individual autonomy may be forfeited, in favour of individual and public safety and provision of necessary psychiatric care. Involuntary hospitalization could be considered in exceptional circumstances, for individuals experiencing psychiatric decompensation interfering with their ability to care for themselves in the context of COVID-19, increasing their risk for negative outcomes, keeping in mind that such admission can feel dehumanizing, and result in negative views towards mental health care, which may in turn impair future treatment adherence.

As it is not advised that outreach physicians consider restrictive certification for involuntary admission for COVID-19-infected individuals with SMI experiencing homelessness except under extraordinary circumstances, every effort should be made to educate, coach, and support individuals to adhere to infection control precautions to minimize the risk of spread and to recognise COVID-19-related symptoms that may necessitate urgent medical attention.
Workers should also provide supplemental assistance (e.g., delivery of face masks, food, medications) to reduce the individual’s interactions with the community.

**Conclusion**

The COVID-19 pandemic presents specific challenges for individuals experiencing homelessness and mental illness, including difficulty adhering to precautions, increased social isolation, breakdown of routines, displacement, complications of medication management, and increased vulnerability to severe physical illness. To support appropriate care and supports to this population through street outreach, this article shares key insights and suggestions, including prioritizing housing first and income support services, promoting safe socialization, modifying psychotropic prescribing and monitoring practices, supporting health promotion and infection prevention service user practices, and offering supportive interventions for individuals who are suspected or confirmed COVID-positive. These insights and lessons learned during this pandemic may serve to optimize current outreach practice as well as inform future preparedness and program planning at times of pervasive social uncertainty and disruption.
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