April 12, 2021

To The Board of Health re **HL72.1 Response to COVID-19**

I am a registered nurse and member of the Street Nurses Network and have been working with people experiencing homelessness for over 5 years. There has never been a day, COVID or pre-COVID, when all of our clients have been able to access a space in a shelter site. In addition to the lack of capacity within the system, there is very little mobility afforded those who rely on the emergency shelters. More often than not, to access a different type or bed or shelter or to move to a location closer to existing service providers and supports a client must give up their current spot, spend time on the street and begin again trying to access a bed.

We have continued to support and provide care for our homeless clients since the onset of the COVID-19 pandemic in March 2020. We have seen the impact of the city's response to COVID on our homeless clients. We've seen successes including the rapid opening of the Recovery site providing support to people who contract COVID and their close contacts and the implementation of many health and harm reduction supports to individuals isolating there. Additionally the expansion of the shelter hotel program to create many single-room occupancy shelter spaces.

Our clients need permanent, affordable housing in their communities. In the interim, shelter-hotels are a welcome addition to the city's emergency shelter offerings. Unlike shelters or respites, shelter-hotels provide private space which allow people to isolate and significantly reduce their risk of contracting COVID. The new single room sites provide greater privacy and security than shelters and respites which significantly supports people's mental health. Additionally, the city has partnered with community agencies to provide health, harm reduction and case management supports at many of these sites. There have been outbreaks at these hotels and there is room to support shelter-hotel operators to improve infection prevention and control there, but the physical design of the space supports clients who want to physically distance to reduce their risk of acquiring or transmitting COVID.

What we see in the drop-ins, the encampments, the safe injection sites and on the streets is that the people who most need these private and physically distanced spaces in the shelter hotels cannot access them. There are not yet enough emergency shelter beds within the system to meet demand nevermind enough single-occupancy spaces. Additionally, those which have been created in response to COVID are not being utilized fully, and not being accessed equitably. We are concerned that the city has not done everything in its power to protect the health of those most at risk of severe morbidity and mortality from COVID.

An example: a 70+ year old individual with medical conditions which put them at higher risk of a poor outcome if they were to contract COVID, but who otherwise has no support needs or risk factors related to more private accommodation is staying in a congregate shelter -- sleeping in a shared room with other individuals. This individual has called central intake and has been told that they are ineligible to be considered for other spaces within the system via central intake as they are already in a program. They were redirected to speak with staff of the congregate site they are currently in to request a transfer. The staff are unable or unwilling to do this, leaving the client with the impossible options of staying in the high-risk of COVID shelter accommodation or to leave their shelter, spend the night on the street and hope to be able to access a different, safer shelter accommodation though central intake over the next several days.

It is hopefully clear why, in the absence of access to shelter hotels, many homeless individuals are spending more of their time in public spaces - parks and transit. The shelters and the respites are exactly the settings we have been told to avoid to reduce our risk of COVID -- they are dangerous. People with the physical stamina to do so are living in parks instead of respites to reduce their risk of COVID. Unfortunately, many of those left behind in the few physically accessible congregate shelters and respites are the more medically complex and vulnerable individuals who can't spend days at a time on the move or on the streets.

While we've seen how the shelter hotels can be supportive and stabilizing from a physical and mental health perspective, generally, and safer from the perspective of COVID transmission there are many empty shelter-hotel rooms in the system. Some of these rooms are being held because of COVID cases within the facility resulting in a declared outbreak which halts new admissions for at least 14 days. While well-intentioned, this is a counter-productive intervention in a time when individuals are being kept in congregate settings with known outbreaks. Additionally, many of the hotel rooms are being held, we're told, for individuals staying in encampment sites prioritized for clearing.

One downtown hotel is staffed and yet approximately half empty-- over 100 empty rooms empty!-- due to a combination of outbreak and preservation of rooms for future encampment clearings. As healthcare providers operating in a pandemic we must prioritize getting those most at risk of harm to safety--this means giving those who wish to leave congregate settings an opportunity to move out, especially those who are medically at risk.

COVID has highlighted issues within the emergency shelter system we have long known to negatively impact our clients' mental and physical health. The population of people experiencing homelessness is heterogeneous and individuals have different needs. The system has some variety of supports offered -- shelter, respites, transitional housing, and shelter-hotels all offering a varying level of support and different barriers to accessing services. Yet, the system is designed to prevent movement within the system. Individuals are offered the first available space and once they have accepted have little if any ability to move within the system to a location/program which would better support their needs-- even when there are spaces available.

We know there are empty rooms in the shelter hotels right now and yet my client in their 70s can't leave the congregate shelter where they are at increased risk of COVID. We call Central Intake for people we meet on the street, exhausted and in crisis, and told there is no space. Unbelievably, even hospitals and the recovery site are similarly stuck with individuals ready to be discharged from acute care or who have completed their isolation period-- they call central intake and are also told there are no beds.

This situation is absurd:

An individual with frostbite being discharged back to the street - to shuffle around in the snow when the hospital calls and there is no bed. If, however, this individual is staying in a priority site, they may return to their tent only to meet a Streets2Homes worker and find they are indeed eligible to move into one of the empty shelter hotel rooms.

A person, fearful of contracting COVID, chooses to stay in a park when they are repeatedly unable to access a private room. In order to have access to food, water and basic sanitation they choose to set up their tent near a respite site where they can access some of the services--inevitably, the respite has an

outbreak and the individual is exposed to COVID due to needing to access meals at the respite site. Long delays in public reporting of cases and outbreaks contributes to these exposures.

This crisis necessitates we act. What ask that you

- Increase the capacity of the emergency shelter system, specifically single-room occupancy sites which promote physical distancing and ventilation.
- Toronto Public Health to increase IPAC support to all emergency shelter programs and to account for the differences between shelter, shelter-hotel and respite sites. Tailor IPAC recommendations and specifically outbreak management to each program with the goal of safely preserving shelter space.
- Create a pathway for hospital discharge planners and social workers to have expedited access to shelter-hotel spaces. In the context of a surge of COVID cases individuals must be discharged to the street when there are no beds available through central intake. We see every day how people are at risk of losing whatever gains they made in terms of their health and stabilization when they are discharged to the street.
- Transparent, accessible, timely communication with individuals who utilize emergency shelters related to case counts and outbreaks in as much detail possible while maintaining confidentiality.

Thank you for your time and consideration on these important matters. I look forward to seeing your actions.

Sincerely,

Megan Lowry, RN and the Street Nurses Network (SNN)

I am unable to depute in person due to the demands of the 3rd wave of COVID on the homeless population and have requested that my colleague and member of the Street Nurses Network, Elizabeth Harrison share my deputation on my behalf.