FACING FAQS:
H1N1 AND HOMELESSNESS IN TORONTO

Dr. Kristy Buccieri
Trent University
Department of Sociology
kristybuccieri@trentu.ca

Dr. Stephen Gaetz
York University
Faculty of Education
sgaetz@edu.yorku.ca

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EXECUTIVE SUMMARY

The homelessness sector of Toronto faced a public health threat from the H1N1 pandemic. This report shares the findings of research undertaken in 2010 and 2011, assessing the pandemic preparedness of the homelessness sector before, during, and after the outbreak. Interviews were conducted with 149 homeless individuals, fifteen social service providers, and five key stakeholders involved in the H1N1 response. This report is divided into five key sections, and uses a question and answer approach to examine the core issues. The first section, "Homelessness, Health and Infrastructure in Toronto" examines how the homelessness sector is organized, how well homeless individuals are faring mentally and physically within the city, and how the sector organizes health care services for its clients. The second section, "Preparing the Homelessness Sector for H1N1" explores the work that was done prior to the outbreak and the challenges that arose. The third section, "H1N1 and the Homelessness Sector Response" examines how the sector performed during the outbreak phase. Included in this section are discussions of operational changes, communication strategies, supplies, vaccination efforts, and infection control measures. The fourth section, "Learning from H1N1" offers a reflection on how prepared the sector is for another outbreak and what challenges would need to be overcome in the event of a more severe pandemic. Key findings in each of these sections are outlined below.

KEY FINDINGS

Homelessness, Health, and Infrastructure in Toronto

The homelessness sector in Toronto is under-funded and under-resourced. More than half the homeless respondents used shelters and nearly all of them used drop-in centres on a regular basis. Homeless individuals' reliance on these services – for food, shelter, and support – creates perpetually high capacity and a heavy demand for service.

Social service agencies are often congregate settings. Many homeless persons share bedrooms, sleep in close proximity to one another, and are often in touching distance of at least five other people at any given time. The congregate nature of these settings (combined with high demand), creates challenges to undertaking personal hygiene practices, like accessing bathing and laundry facilities.

Homeless individuals in Toronto are nutritionally vulnerable. Despite primarily depending on drop-in centres and shelters for food, many participants also reported getting food from dangerous sources, like strangers and garbage bins. On average only one-quarter of the homeless participants were able to eat breakfast, lunch, and dinner on a daily basis. More than half did not have daily access to fresh drinking water.

Homeless persons experience complex physical and mental health challenges. Homeless participants stated they were in good health overall, but also reported a range of health issues. Nearly half considered themselves to have a disability, which primarily involved mental health challenges, like depression and anxiety. Homelessness was an emotional experience, and many individuals reported low motivation and/or high rates of substance use.

Access to health care is a concerning issue for homeless persons. Only slightly more than half of the homeless participants had a regular health care practitioner, and many had concerns over how they were treated by mainstream health care facilities (like hospitals). Homeless persons largely relied on the homelessness sector for health care, including onsite care at shelters and drop-in centres.

Homelessness sector health care operates through networks and partnerships. Many social service agencies offer onsite health care, but often it is through the outreach services of another agency (such as a community health centre). Although some of these arrangements are formal partnerships, the sector also runs on informal networks of service workers who know one another and share a sense of responsibility for client health care.

Preparing the Homelessness Sector for H1N1

Toronto Public Health took the lead role in co-ordinating the homelessness sector response to H1N1. As an established health authority within the city, they relied on pre-existing relationships with hospitals, other city departments, and health agencies. Other key stakeholders that emerged as H1N1 leaders were Shelter, Support, and Housing, and the Inner City Health Associates.

Pandemic planning for homeless persons primarily followed the mainstream planning approach. Despite some special consideration for youth, pregnant women, and Aboriginal persons, homelessness was not considered to be a direct cause of being 'at-risk' during the pandemic. As a population, they received the same public health messages as the general public (such as to cover their mouths when coughing, wash their hands, and get the vaccine). Homeless persons were not consulted in sector planning initiatives.

Most social service agencies had pandemic plans, but were unfamiliar with the city's plan. Although some plans were more developed than others, the majority of agencies had emergency and/or pandemic plans stemming from the SARS outbreak. These plans were often created through consultation with officials from Toronto Public Health.

Pre-existing partnerships within the sector were a key source of pandemic planning support. Most agencies turned to their formal and informal partner agencies for guidance and advice on planning. Unfortunately, a general lack of funding meant that no concrete inter-agency plans of action were developed.

Three main challenges emerged for the homelessness sector in relation to preparing for H1N1. These challenges included a lack of funding (in general and for H1N1 related expenses), strained capacity as social service providers had to take on health care related duties that went beyond their regular work expectations, and system fragmentation within the sector.

H1N1 and the Homelessness Sector Response

During H1N1, homeless individuals continued to use shelters at a steady rate, but were less inclined than usual to use drop-in centres. It should be noted that while there was a decline in drop-in centre usage, more individuals still reported going to drop-in centres than to shelters.

Operational changes were observed within service agencies. Notably, there were some improvements, in relation to pandemic planning, higher levels of cleanliness, and enhanced communication between staff and clients. However, there were also some challenges. Staff members at many agencies had to undertake additional tasks without a reduction of existing duties, many services and programs were changed or adapted to accommodate H1N1, and some staff members were unable to undertake their regular duties due to illness.

As a whole, social service providers were well prepared to work through H1N1. Prior to the outbreak, many agencies hosted on-site training for their employees pertaining to infection control strategies, infection screening, the use of protective measures, quarantine protocols, and vaccinations. Staff expressed some concerns, primarily related to client welfare and staffing issues. The little resistance from staff (primarily related to the vaccine and its potential side-effects) was addressed through open-door policies.

Toronto Public Health communicated H1N1 information to agencies on an on-going basis. The communication strategy included posting information on their website, hosting sector-wide meetings, making a health professional available for questions, and holding a weekly open phone call for updates). This response had several strengths – it reached a broad audience of social service providers, established Toronto Public Health as the H1N1 authority, and allowed them to work closely with stakeholders. However, it also had several challenges – there was not enough time or resources to do one-on-one visits, the phone calls were underutilized, and they were unable to use social media.

Homeless individuals did not rely on social service providers for H1N1 information. Within social service agencies, information was distributed to clients through a variety of methods, such as posters, verbal communication, and information sessions. However, homeless individuals reported that health care professionals and the media were their best source of information (with social service providers being considerably lower on the list).

Social service agencies faced four main challenges in relation to H1N1 supplies. First, the cost of supplies was an issue as many agencies had to redistribute their existing budgets to pay for them. Second, the demand for supplies combined with the general lack of storage space meant that many agencies were perpetually running low – or completely out – of supplies. Third, some agencies had concerns that clients would drink the hand sanitizers, due to the alcohol, and had to supervise its use. Finally, in the initial stages there was confusion over the kinds of masks that were needed and the number that needed to be ordered to meet demand.

The strategy for vaccinating homeless persons was to hold outreach clinics in shelters and drop-in centres. Toronto Public Health ran a number of vaccine clinics in partnership with social service agencies. According to social service providers, the uptake by homeless clients was considered to be considerably high (with estimates ranging from 50-60%), but key stakeholders felt it was lower than desired due to agency relations, staff resistance, poor inter-governmental communication, distrust of health care providers, and the mobility of homeless persons. Nearly every homeless participant knew there was a vaccine, but a quarter did not know about the on-site clinics. Of the homeless individuals in this study, 36.9% were immunized.

Infection control was a priority for social service agencies. Nearly every agency had a plan for infection control, although some were more detailed than others. The most common approaches included screening for signs of illness, attempting to isolate infected clients, using protective coverings, and providing onsite medical treatment where possible. Some challenges that emerged for agencies in implementing infection control strategies included that they are often congregate settings, are generally not purpose-built as social service agencies (or with public health in mind), and many are impeded by small size and/or a lack of resources.

Learning from H1N1

Advanced, flexible, planning is key to being prepared for a pandemic. Within the homelessness sector, in particular, having flexible and accessible plans was considered to be the best approach for meeting the complex needs of the clients during the outbreak. It was also recognized that on-going planning was needed, and that Toronto Public Health could assist by having yearly meetings with agencies to review and refresh existing plans.

In the event of a future / more serious outbreak, five key challenges would need to be addressed. These challenges, as identified by key stakeholders include: sector preparedness and co-ordination, availability of staff, welfare of clients, further strains on already limited financial and spatial resources, and co-ordination with external bodies like hospitals and emergency services.

RECOMMENDATIONS

This report ends with a "Conclusion and Recommendations" section that pulls the key findings together and offers recommendations for creating a more integrated and interconnected sector. In its current state, the homelessness sector is fragmented due to under-funding and a lack of resources. Additionally, while social service providers are expected to take on health care duties (often in addition to their existing roles), they are not necessarily given the training, resources, and supports needed to do so. The following recommendations are put forth to address these gaps and ensure better sector-wide preparedness in both pandemic and non-emergency times.

The Homelessness Sector Needs More Resources and Discretionary Funding

1. More funding is needed for shelters and drop-in centres to cover the costs associated with operations, supplies, and staff salaries.
2. Funding and resources are needed to meet the nutritional needs of homeless individuals.
3. Funding and resources are needed to meet the physical health, mental health, and disability related needs of homeless individuals.

The Homelessness Sector needs to Systemically Integrate its Health Services

4. The health care needs of homeless individuals should be included in the curriculum of all medical / nursing education programs.
5. The homelessness sector should coordinate with medical / nursing programs to increase opportunities for practicums and placements within shelters and drop-in centres.
6. Health services within the homelessness sector should be organized as an interconnected network of formal partnerships and coordinated service delivery.
7. A new sector-wide position should be created to organize health service co-ordination across agencies.

Public Health must be a Daily Part of Homelessness Sector Operations

8. Homeless individuals require increased access to hygiene facilities, like laundering and bathing spaces, both inside and outside social service agencies.
9. Hygiene practices that increased during H1N1, such as hand-washing and disinfecting shared agency spaces, should continue to be enacted in non-emergency times.
10. New social service agencies should be purpose-built with public health considerations in mind.
11. To help decrease the spread of communicable diseases, ultraviolet germicidal irradiation (UVGI) air purification systems should be installed in all shelters, drop-in centres, and community health centres.
12. On-going public health training is needed for all staff working within the homelessness sector.
13. A new sector-wide position should be created to coordinate public health initiatives within and between agencies.

Pandemic Planning must regularly occur within and between Homelessness Sector Agencies

14. In the event of a pandemic, Toronto Public Health should be the recognized authority at the local level.
15. Pandemic planning for homeless individuals must involve persons with lived experience of homelessness, and take into consideration the unique challenges posed by homelessness.
16. Internal-agency pandemic planning should be a collaborative effort, but led by a designated public health staff member.
17. Sector-wide pandemic planning should be an on-going and collaborative effort, facilitated through yearly meetings.
18. Designated funding needs to be made available to allow homelessness sector agencies to enact public health initiatives.

Pandemic Outbreak requires a Systemic, Integrated Response from the Homelessness Sector

19. In the event of a pandemic, declining drop-in centre usage rates would need to be offset by increased outreach initiatives.
20. Flexible staffing plans may be needed in a pandemic situation, to facilitate the transfer of duties between staff members, and the reduction of regular work expectations.
21. The homelessness sector should develop a communal stockpile for pandemic supplies, to be rationed between agencies, determined by factors such as agency size, client need, and type of facility.
22. Alcohol-based hand wipes could be distributed to homeless individuals instead of liquid sanitizer, to reduce consumption.
23. Outreach vaccination clinics should be held in shelters and drop-in centres for seasonal influenza as well as for pandemic outbreaks.
24. A health-based agency should be designated as the homelessness sector infirmary in the event of a pandemic outbreak.

Pandemic Communication within the Homelessness Sector must Involve Multiple Approaches and the use of Clear Language

25. Toronto Public Health should communicate pandemic related information to the homelessness sector using clear-language and a variety of mediums.
26. To reach a broad audience and facilitate the rapid transmission of information, Toronto Public Health officials should utilize social media tools like Twitter and Facebook.
27. Toronto Public Health should meet with homeless individuals directly, to discuss pandemic related issues.

CONTENTS

INTRODUCTION

In the spring of 2009 Dr. Margaret Chan, Director-General of the World Health Organization, held a press conference to announce that the world was experiencing an influenza pandemic known as H1N1. In the speech Dr. Chan declared, "Above all, this is an opportunity for global solidarity as we look for responses and solutions that benefit all countries, all of humanity. After all, it really is all of humanity that is under threat during a pandemic" (Chan, 2009). While it may be true that all of humanity is at risk during a pandemic, some individuals carry the burden of this risk more than others. Social and structural inequities, woven into the fabric of our society, play a large role in determining how well (or how poorly) groups and individuals manage during a health crisis. As Appleyard (2009) has noted, the ways in which emergencies play out are directly rooted in pre-existing social patterns established during non-emergency times. This report examines the homelessness sector in Toronto and its response prior to, and during, the H1N1 pandemic.

Managing public health issues is not a new concern for the homelessness sector of Toronto, as outbreaks of tuberculosis, lice, and bedbugs have emerged within this context (Basrur, 2004; Tuberculosis Action Group, 2003). However, addressing large-scale pandemics that threaten society as a whole poses considerable challenges in relation to homelessness. First and foremost, the sector is comprised of a variety of agencies, professional roles, and mandates. Despite the offering of health services in many agencies, the homelessness sector is not itself a health sector. This reality raises a number of considerations for policy-makers, social service workers, health care providers, and homeless persons. How do public health officials plan and prepare for a pandemic, given the challenges associated with homelessness, such as high mobility, distrust of health care providers, and underlying complex health issues? How do individual agencies within the sector prepare for a pandemic, when their resources are already stretched thin? How do homeless persons cope with the threat of illness when they are dependent on a sector that is comprised largely of congregate settings? These questions are just a few of the Frequently Asked Questions (FAQs) that emerge in relation to homelessness and pandemic planning.

The H1N1 outbreak provided a unique case study in which these issues could be studied. The basis for this report is research conducted on pandemic preparedness in the homelessness sector of Toronto, funded through the Canadian Institutes of Health Research. Similar data was also collected by partner researchers in Calgary, Regina, and Victoria. However, this report focuses exclusively on the results of the Toronto-based study. It is recognized that each city operates its homelessness sector in different ways and, as such, there is no attempt to suggest that these findings are applicable across Canada. Instead, this report offers deeper insight into how the H1N1 response was carried out in Toronto.

ABOUT THE STUDY PARTICIPANTS

The Toronto study ran from 2010 to 2011, and included three key participant groups – homeless individuals, social service providers working in the homelessness sector, and key stakeholders (such as policy makers and health care professionals) working with homeless persons and/or service providers. A total of 149 homeless individuals were included in the study. Of these participants, the majority were self-identified males (64.4%), with a minority of female (30.2%) and transgender (2.7%) individuals. The average age of participants was 34, and the sample ranged from 16-75 (consisting of 45% street youth, aged 16-24). The homeless participants primarily self-identified as straight (72.5%), but a large minority reported being LGBTQ (18.9%). Ethnically, the homeless participants were a diverse sample, with 36.9% considering themselves to be a visible minority. While the majority were Canadian citizens (83.9%), only one-third were born in Toronto (33.6%). Aboriginal participants comprised one-quarter of the homeless respondents (24.8%).

Nearly every homeless participant stated that they had been homeless during the H1N1 outbreak (96%). Those who were not homeless at the time of H1N1, but were homeless at the time of the interview, were included in the study. The most common cited reason for their homelessness was conflict with a family member or roommate (45%), but other reasons also included the end of a relationship (7.4%), drug and/or alcohol addiction issues (6.7%), loss of employment (6.0%), death of a loved one (3.4%), running away from a group home (3.4%), relocation (2.0%), and not having any money (2.0%). The age at which the participants first experienced homelessness ranged from seven to sixty, with an average of 23 years. Most of the participants had been homeless only once in their life (32.9%), but others had been homeless two to five times (27.5%), on and off the streets since the first time (14.1%), or homeless six or more times (9.4%).

The majority of the homeless participants did not complete high school (63.0%), although a small minority had a high school diploma (11.4%), or college / university education (14.8%). A large number of participants did not have a paying job at the time of the study (81.2%). Those who did work, primarily held part-time sales and service positions. Financially, participants reported being supported by a number of sources over the preceding thirty days, through social assistance (61.1%), friends (32.9%), personal needs allowance (23.5%), paid work (22.1%), parents / family (22.1%), disability benefits

(20.1%), and/or by a partner (20.1%). Outside the formal economy, participants earned money through participating in research (46.9%), engaging in odd jobs (43.7%), selling drugs (34.2%), selling their belongings (32.2%), panhandling (29.6%), bottle picking (22.2%), selling stolen goods (20.2%), theft / B&E / jacking (15.4%), scamming (14.8%), sex trade work / street prostitution (14.7%), and squeegeeing (1.4%).

The homeless participants in this study resided in various accommodations. In the thirty days preceding the study, more than half had spent at least one night in a homeless shelter (59.0%). In the same period, nearly half had also couch-surfed / spent the night at a friend's (49.0%) and/or spent at least one night on the street (46.9%). Other common places where respondents resided for at least one night in the preceding thirty days included, their own apartment / house (36.8%), a park (34.9%), a hostel (23.5%), a motel / hotel (23.4%), jail (20.1%), a squat (11.4%), transitional housing (9.3%), and/or an out of the cold program (2.8%). A large number of participants reported that they regularly lived with someone else (36.2%), who was generally a friend or partner.

In addition to homeless individuals, a total of fifteen social service providers were interviewed as part of this study. Each of these participants worked in an agency that provided services for homeless, vulnerable, marginally-housed, and/or street-involved persons in Toronto. These participants included seven individuals who worked as managers of health care / nursing, three nurses and nurse practitioners, two directors, one executive director, one residential supervisor, and one chaplain. These individuals had served in their current positions between eight months and nineteen years, with the majority having been in their position for two to ten years at the time of the interview. Of these participants, seven had worked in other inter-agency positions prior to undertaking their current role. Most of these individuals began in non-managerial positions and were promoted. The participants had been working in their respective agencies between one and twenty years, with most being there for two to ten years.

The agencies where the interviews took place are not named in this report for reasons of participant anonymity. However, to provide a sense of context, some general descriptive data must be shared. The social service providers identified their agency's areas of expertise as housing and shelter (seven agencies), health and mental health (six), youth services (five), counseling (three), drop-in services (two), advocacy (two), LGBTQ services (one), outreach (one), and harm reduction (one). These agencies serve a diverse range of homeless individuals, describing their clients variously as women, men, youth, Aboriginal, LGBTQ, drug users, those with complex physical and/or mental health needs, people living in the inner city, and people trying to get away from the inner city.

Demographically, the clients who use these services were rather broad (and tended to vary by agency focus / mandate). For instance, those with a special focus, like youth, gender-specific, or LGBTQ had higher percentages of clients who met these criteria than other agencies. Data on the number of clients each agency served on a daily basis was not able to be collected. Many of the organizations operate multiple programs and were not able to provide specific figures. However, the clear message from service providers was that the agencies were busy and nearly always filled to capacity on a daily basis. The agencies reported upon in this study were funded through a number of organizations, government bodies, and programs. Most notably, ten agencies relied on community donations (from citizens, churches, and organizations like the United Way), nine agencies were funded through the City of Toronto, and seven agencies received funding through the Ministry of Health and Long-Term Care. Additional funding sources included various federal grants, the Ontario Trillium Foundation, and Human Resources and Skills Development Canada.

Finally, in addition to homeless individuals and social service providers, five key stakeholders were interviewed for this study. To protect their identities, their names and specific roles cannot be provided in this report. However, these five individuals served in key roles related to the homelessness sector, public health, homelessness sector policy, and homelessness sector service co-ordination within Toronto. Each of these five individuals were actively involved in key stakeholder roles during the H1N1 pandemic. During the interviews, they described their roles in terms of advocacy, liaising, health care, influencing planning and policy, and serving on the front-line during the H1N1 pandemic.

ABOUT THE REPORT

Facing FAQs examines H1N1 and homelessness in Toronto by posing and answering a series of questions. The report is divided into five key sections. The first section, "Homelessness, Health and Infrastructure in Toronto" examines how the homelessness sector is organized, how well homeless individuals are faring mentally and physically within the city, and how the sector organizes health care services for its clients. The second section, "Preparing the Homelessness Sector for H1N1" explores the work that was done prior to the outbreak and the challenges that arose. The third section, "H1N1 and the Homelessness Sector Response" examines how the sector performed during the outbreak phase. Included in this section are discussions of operational changes, communication strategies, supplies, vaccination efforts, and infection control measures. The fourth section, "Learning from H1N1" offers a reflection on how prepared the sector is for another outbreak and what challenges would need to be overcome in the event of a more severe pandemic. At the end of each of these four sections is a summary of take-away messages that highlight the key findings.

The report ends with a "Conclusion and Recommendations" section that pulls these key findings together and offers recommendations for creating a more integrated and interconnected sector. As this report shows, the homelessness sector performed well in response to the H1N1 outbreak, but there was considerable recognition that it was a mild pandemic. H1N1 put additional pressure on an already strained system. Emergency responses are only as strong as the foundations upon which they are built – the best way to ensure pandemic preparedness in the homelessness sector is to shore up its everyday operations. Homelessness is a public health issue, but addressing it will only be achieved if agencies have the finances and resources to make it a real priority. This report presents the FAQs as a call to action.

HOMELESSNESS, HEALTH, AND INFRASTRUCTURE IN TORONTO

Pandemic preparedness is best achieved when it is built upon a solid foundation. Constructing a strong and integrated homelessness sector is essential for promoting and protecting the health of homeless persons. This section reports on the current state of the homelessness sector in Toronto, and the health and wellness of homeless persons in the city during non-emergency times.

HOW IS THE HOMELESSNESS SECTOR ORGANIZED IN TORONTO?

The homelessness sector in Toronto is comprised of a broad range of services and supports that are intended to prevent / reduce homelessness, support those in crisis, and aid in transitioning off the streets and into stable and suitable housing. The kinds of supports that operate within the sector include, but are not limited to, emergency shelters, drop-in centres / day programs, community health centres, and food banks. This report focuses particularly on the operations of emergency shelters, drop-in centres, and community health centres.

According to one key stakeholder, Toronto has a "hybrid-model shelter system," in which there is a mix of city-run and otherwise operated shelters. More precisely, the City of Toronto division entitled, Shelter, Support and Housing, operates thirty to forty shelters, while the rest are operated through non-profit and community organizations. There are a disproportionate number of beds in each shelter. Figures presented by one key stakeholder suggested that at the time of the interview (in 2011), there were 1,500 beds in city-operated shelters and approximately 2,650 beds in purchase-of-service shelters, for a total of approximately 3,800 emergency shelter beds (not including violence against women shelters and domestic hostels). Statistics collected and reported upon by the City of Toronto (n.d.) indicate that in the same year as the study, the average nightly occupancy of emergency shelter beds was approximately 3,716 individuals. Given these figures, there was an average occupancy rate of 97.8% in emergency shelters in Toronto during 2011. Key stakeholders interviewed for this study indicated that there are many structural problems in the homelessness sector, but among the most pressing is the under-funded and under-resourced nature of essential services, like emergency shelters. Meeting the demand for service requires more funding and resources than are available to the shelter providers.

The homeless participants in this study made up a considerable portion of Toronto's shelter users. More than half (57.7%) indicated that they go to a homeless shelter at night. Of those who report using shelters, many did so every night (30.3%), at least once a week (13.8%), and whenever they needed a place to sleep (4.0%). Those who used emergency shelters tended to have specific preferences over which shelter they used (38.9%). The most commonly cited reasons for preferring certain shelters were for comfort / cleanliness (12.1%), the staff who worked there (10.1%), available services (8.7%), accessibility / convenience (4.0%), routine (3.4%), small size (2.7%), safety (2.0%), friends who also accessed the shelter (1.3%), health care provision (1.3%), and religious / cultural affiliations (1.3%). While the sleeping conditions at shelters varied, they were largely reported to be congregate settings, in which residents spent considerable time in close proximity to one another. When asked how many other people generally shared their room at night, the most common response was one to five other people (33.6%). Several participants reported sleeping in bunk beds (12.8%), and the distance between sleeping space was commonly described as being one to five feet apart (21.5%).

Emergency shelters provide more than just a bed, as half the homeless participants in this study, indicated they access other services there as well (50.3%). Among the most commonly utilized supports (besides sleeping accommodations) were food services (41.6%), support / case workers (21.5%), health care (13.4%), clothing and personal supplies (9.4%), laundry (9.4%), shower / hygiene (8.1%), workshops (5.4%), transit tokens (3.4%), social activities (2.0%), and computers / television (2.0%). Shelter staff were considered to be a particularly important reason participants chose to attend, or not attend, a particular shelter. Of those who reported using shelters, many felt that shelter staff provide them with the kind of information and support they need (40.9%), particularly in relation to housing.

Drop-in centres provide another crucial piece of homelessness sector infrastructure in the city of Toronto. According to one key stakeholder, there is a common misconception that all kinds of day programs and drop-in centres can be grouped together. In practice, this stakeholder noted, there are actually three models of service: faith-based, community development, and social service. Drop-in centres are not run through the City of Toronto (although some do receive municipal funding), but rather are more loosely operated with

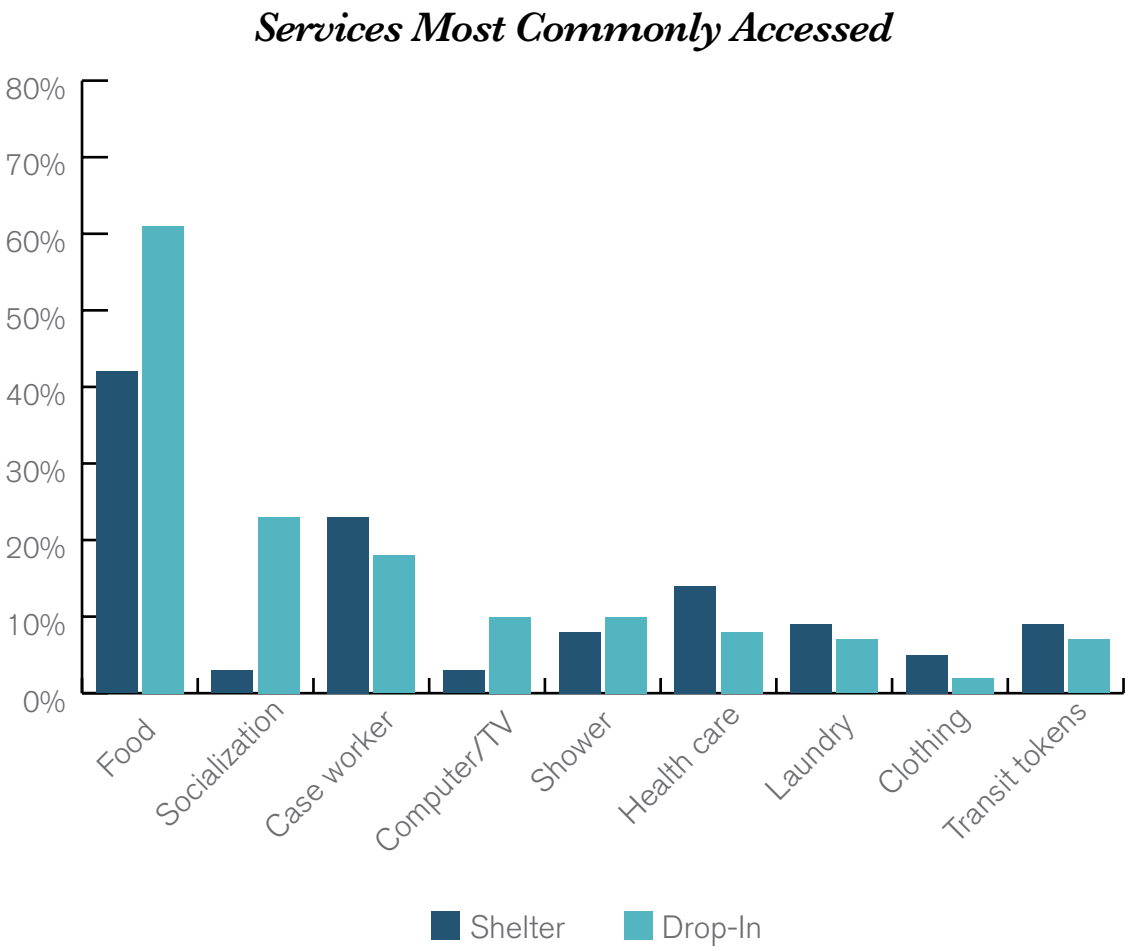
a broader diversity of programs than shelters. One stakeholder noted, "There is also a misconception that they are just soup kitchens. Drop-ins actually evolved in response to broader sector needs (particularly in relation to mental health and housing needs." Drop-in centres were seen as particularly important, for one stakeholder, at providing 'wrap around support' to help people move forward. They were seen as a source of low-threshold services (i.e. no pressure), a place of autonomy and power, and a place where clients are able to make choices on how to represent themselves.

While only slightly more than half the homeless participants in this study reported using shelters, the large majority used drop-in centres (84.6%). Almost half of these participants (48.3%) reported going to at least one drop-in centre a day, whereas others went several times a week (18.1%), twice a week (7.4%), or once a week (6.7%). On average, participants reported that when they went to a drop-in centre they stayed there for one to three hours (45.0%), more than five hours (14.1%), less than one hour (11.4%), four to five hours (8.1%), or for a variable amount of time (5.4%). More than half (59.1%) stated that they preferred some drop-in centres to others. Primary reasons for having a preference included that they liked the social environment (13.4%), choice of services and food (9.4%), staff members (7.4%), and convenience (6.7%).

Like shelters, drop-in centres are commonly congregate settings, in which clients are in close contact to one another. In this study, for instance, participants reported that while at their preferred drop-in centre there are often more than twenty (20.1%) or more than fifty (30.9%) other individuals in the room with them at any given time. It is also quite common to have at least five other people within touching distance when at a drop-in centre, as reported by a large number of participants (41.6%). When at a drop-in centre, participants were divided on how they spent their time, with many indicating they liked to engage with other people (39.6%) and a quarter preferring to be alone (25.5%).

By far the most commonly accessed service at drop-in centres was meal and food programs (61.7%). Other important reasons for attending these services included socialization (21.8%), support / case workers (18.1%), computer / television (10.1%), shower / hygiene (10.1%), health care (8.7%), laundry (7.4%), shelter from the elements (6.8%), clothing / personal supplies (6.8%), workshops (4.0%), sleep (2.0%), basic needs

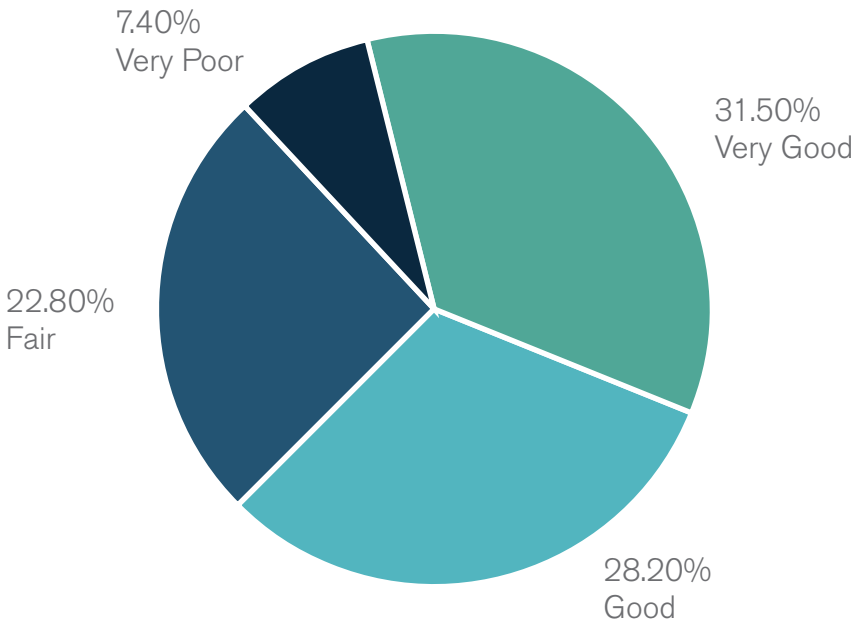
(2%), convenience of location (2%), to see staff (1.3%), to volunteer (1.3%), cultural and religious services (1.3%), education (1.3%), and transit tokens (1.3%). Staff members who work at these drop-in centres play an important role in supporting homeless individuals and keeping them connected. A large percentage of homeless respondents (69.1%) stated that the staff at their preferred drop-in centre give them the kind of information and support they need. Further, many stated that they trust the staff at drop-in centres completely (32.2%) or for the most part (25.5%). The most important factor that determined levels of trust was whether the client regularly attended the drop-in centre, and thus developed a sense of familiarity and/or rapport with staff members.



HOW PHYSICALLY HEALTHY ARE HOMELESS INDIVIDUALS IN TORONTO?

Homeless individuals often experience a range of physical health problems, including respiratory illness, fatigue, traumatic brain and other injuries, sexually transmitted infections, hepatitis, and HIV/AIDS (Daiski, 2007; Frankish, Hwang, & Quantz, 2005; Hwang, 2001; Hwang et al., 2008; Haldenby, Berman, & Forchuk, 2007; Topolovec-Vranic et al., 2012). In this study, the majority of homeless participants reported that they were in very good / excellent health (31.5%) or good health (28.2%) overall. Approximately one-quarter of respondents reported being in fair health (22.8%), and surprisingly only a few reported being in poor or very poor health (7.4%). Despite these reports of overall wellness, the participants did identify several health conditions they experienced in the preceding year. Among the most frequently listed conditions were fatigue / tiredness (59.7%), coughing up phlegm (51.7%), shortness of breath (36.9%), night-sweats (35.6%), chest pain (28.2%), unexplained weight changes (24.2%), chronic lung disease (21.5%), coughing up blood (16.8%), infection (16.2%), fever that persists (14.1%), and diabetes (8.1%). When asked about health conditions overall (not limited to the preceding year), participants also noted experiencing arthritis (13.4%), Hepatitis A, B, or C (12.8%), lung disease (7.4%), cancer (6.7%), HIV/AIDS (4%), tuberculosis (2%), and herpes (1.4%). The incongruent nature of homeless individuals reporting being in excellent health, yet having multiple health concerns, may be explained by the high percentage who reported that their health had not changed from the year prior (40.3%). This figure suggests that homeless individuals may become accustomed to having certain health conditions, and consequently perceive ill health as their regular state.

Overall Health



Engaging in self-care is an essential means of promoting and maintaining personal health. When asked about their regular hygiene practices, participants stated that at least once a day, they were able to wash their hands (87.2%), brush their teeth (72.5%), take a shower (64.4%), eat on a clean surface (62.6%), and wash their clothes (17.5%). These figures are alarming low, given the potential for disease transmission that accompanies not washing one's hands, body, or clothing, and not being able to eat from a clean / disinfected surface. Many homeless persons rely on social services like drop-in centres and shelters to meet basic needs like bathing and obtaining food (Sager, 2011). The congregate nature of these settings exposes homeless individuals to a range of potential bacteria and viruses (Ali, 2010; Hwang, Kiss, Gundlapalli, Ho, & Leung, 2008), while the high volume of clients creates barriers to accessing limited resources, like shower stalls and washing machines. Subsequently, Sasaki, Kobayashi, & Agui (2002) have written, "It is likely that factors such as overcrowding, malnutrition condition, and inadequate access to medical care affect the transmission and spread of louse-borne diseases among the homeless" (pg.429). The congregate nature of these social service agencies may pose additional challenges to the health and wellness of homeless individuals.

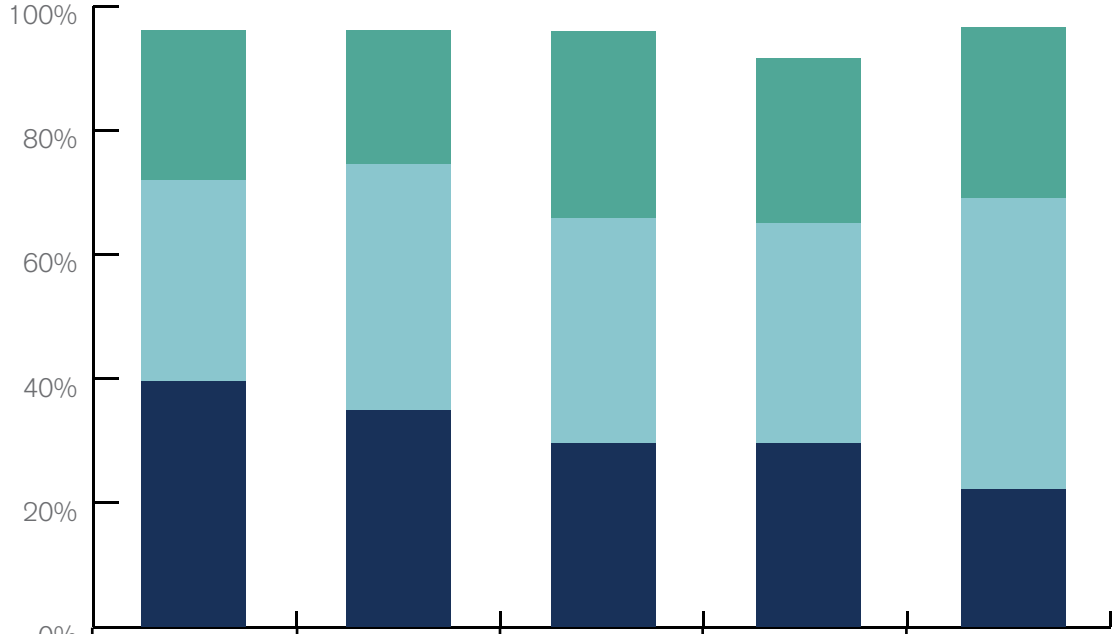
HOW MENTALLY HEALTHY ARE HOMELESS INDIVIDUALS IN TORONTO?

Homelessness is an experience that often leaves individuals disconnected from positive social support networks (Gaetz, O'Grady, & Buccieri, 2010). While some homeless persons may find sources of support in street communities (Kelly & Caputo, 2007) or social service workers (Thompson, McManus, Lantry, Windsor, & Flynn, 2006), homelessness is often described as being an experience of loneliness and isolation (Rokach, 2005). Consequently, research consistently finds that homeless persons are at higher risk of mental health conditions such as depression, anxiety, and post-traumatic stress disorder (Bender, Ferguson, Thompson, Komlo, & Pollio, 2010; Forchuk, Csiernik, & Jensen, 2011; Kirst, Frederick, & Erickson, 2011).

In this study, homeless participants were asked to reflect on the preceding thirty days and report on their feelings. The findings suggest that homelessness may be defined by a range of conflicting emotions. While the majority reported that in the preceding thirty days they felt happy (74.5%), enjoyed life (71.9%), and felt hopeful (65.8%) on a daily or weekly basis, the majority also reporting feeling depressed (69.1%) and lonely (65.1%) on a daily or weekly basis. Additionally, a large minority of participants reported in the preceding thirty days, rarely or never feeling hopeful (30.2%), enjoying life (24.2%), or feeling happy (21.6%). The findings suggest that these emotional states may have a negative impact on one's motivation, as nearly three-quarters of the participants (73.1%) reported that in the preceding thirty days they felt like doing nothing at all on a daily or weekly basis. Lacking this motivation is a large concern that may impeded one's ability to locate, obtain, and maintain employment, housing, and social supports.

Relatedly, the study also found that when asked about disabilities, nearly half of the homeless participants (47.0%) identified having at least one that limited what they could do, such as at work or school. The majority of the reported disabilities were related to mental health conditions (21.5%), such as depression, anxiety, and post-traumatic stress disorder. Other disabilities included pain and mobility issues (21.1%), learning disorders (8.7%), addictions (4.7%), and fetal alcohol spectrum disorder (1.3%). Experiencing disability-related barriers to moving off the street was a key concern that impacted nearly half the homeless individuals in this study.

Feelings in the Preceding 30 Days



	Enjoyed life	Felt happy	Felt hopeful	Felt lonely	Felt depressed
Rarely/Never	24.2%	21.6%	30.2%	28.2%	27.5%
Weekly	32.3%	39.6%	36.3%	35.6%	47.0%
Daily	39.6%	29.5%	29.5%	29.5%	22.1%

WHAT SUBSTANCE USE AND ADDICTION ISSUES DO HOMELESS INDIVIDUALS REPORT IN TORONTO?

Many homeless individuals use substances and/or have addiction-related issues, and these findings are particularly well documented in Toronto (Barnaby, Penn, & Erickson, 2010; Grinman et al., 2010; Hwang, 2006). Among this study's participants, the large majority reported smoking cigarettes (85.2%) and, of those who smoked, most did so every day (80.5%). Approximately two-thirds of the participants reported drinking alcohol (67.1%), with reported frequency rates of less than once a week (22.8%), every day (20.8%), several times a week (11.4%), once a week (10.7%), and an occasional binge (2.0%).

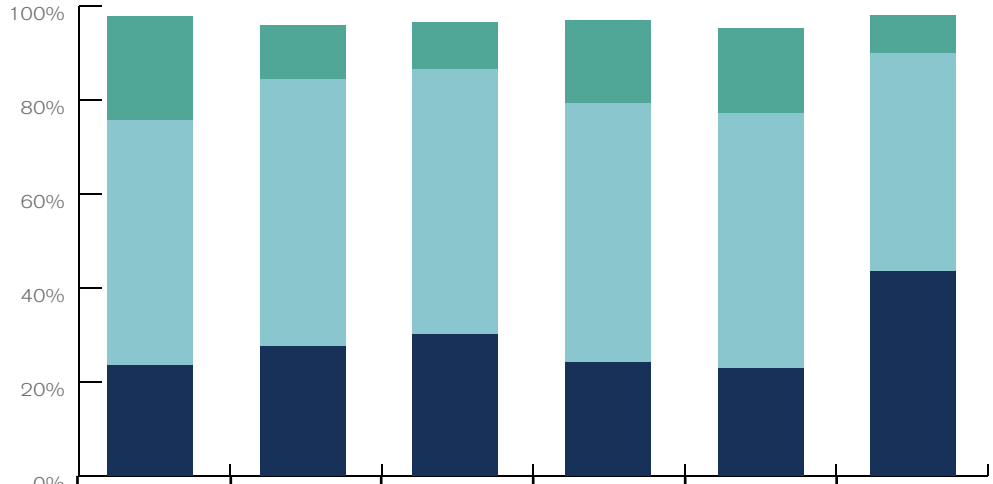
The majority of respondents reported using street drugs (61.7%), with the most commonly used being marijuana (42.3%), crack cocaine (25.5%), ecstasy (6.1%), methamphetamine (5.4%), prescription drugs that were not theirs (3.4%), and heroin (0.7%). Of those who reported using street drugs, most did so every day (28.9%), but other commonly reported frequencies were several times a week (14.8%), less than once a week (10.7%), once a week (4.7%), and an occasional binge (2.0%). Half of those who reported using street drugs said they did so with other people (49.7%), with the others most commonly being friends (28.9%). Only a small minority reported using with anyone who was around, whether known or not (6.7%), a partner (5.4%), or their street family (2.0%). When asked what proportion of their friends / peers use street drugs, respondents said that most (28.9%), all (28.2%), or some (19.5%) did, with only 14.8% saying that none did.

Participants were also asked about their gambling habits. A minority of participants reported gambling (21.5%), such as playing the lottery (7.4%), card games (7.4%), Proline (4.7%), online (3.4%), Casino (2.7%), scratch cards (2.1%), VLT slots (1.3%), and bingo (1.3%). Of those who reported gambling, the most commonly stated frequencies were less than once a week (12.8%), once a week (3.4%), every day (1.3%), and an occasional binge (1.3%).

HOW WELL ARE THE NUTRITIONAL NEEDS OF HOMELESS INDIVIDUALS BEING MET IN TORONTO?

Research clearly documents that homeless individuals are nutritionally vulnerable, and that this is a pressing issue in Toronto (Gaetz, Tarasuk, Dachner, & Kirkpatrick, 2006; Tarasuk, Dachner, Poland, & Gaetz, 2009, 2010). Among the study's homeless participants, over half (52.4%) stated that in the preceding thirty days they did not feel like eating on a daily or weekly basis. While this figure may initially seem high, it must be contextualized within the broader scope of food and water availability for homeless individuals within the city. First, we asked participants how regularly they were able to obtain food and clean water. The results indicated that while participants had access to food and water, they measured it on a weekly rather than daily basis. Accordingly, the statistics show that in the preceding thirty day period, only a small minority of participants had daily access to food for breakfast (23.5%), lunch (27.5%), supper (30.2%), daytime snacks (24.2%), evening snacks (22.8%), and daily access to clean drinking water (43.6%). The consequences of not having access to regular food and water are serious, and include a range of issues reported by participants in this study, such as poor physical and mental health, fatigue, and a lack of motivation.

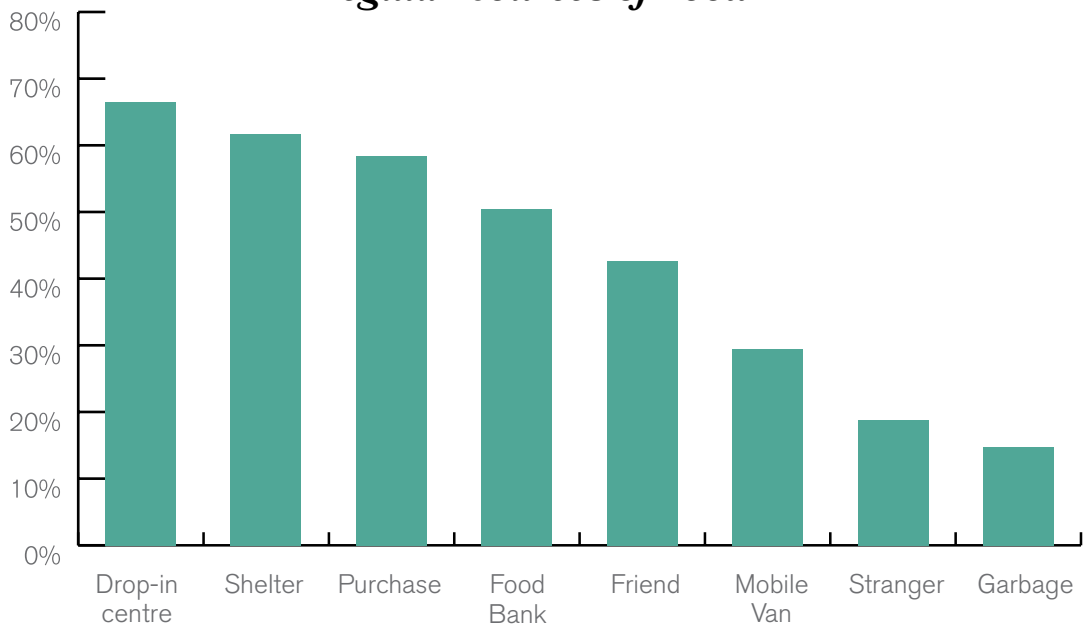
Access to Food and Water



	Breakfast	Lunch	Supper	Snack (day)	Snack (night)	Clean Water
Rarely/Never	22.1%	11.4%	10.0%	17.5%	18.2%	8.1%
Weekly	52.3%	57.0%	56.4%	55.2%	54.4%	46.3%
Daily	23.5%	27.5%	30.2%	24.2%	22.8%	43.6%

Further examination was conducted on the sources of food that homeless individuals regularly rely on in Toronto. Among the most commonly noted were drop-in centres (66.5%), shelters (61.7%), purchasing it oneself (58.4%), and soup kitchens / food banks (50.4%). Less commonly cited, but still notable sources, were regularly obtaining food from friends (42.7%) and mobile outreach vans (29.5%). Among the more alarming findings, was that participants reported regularly obtaining food from strangers (18.8%) and garbage bins / dumpsters behind restaurants (14.8%). Many of the sources of food are unreliable, and may pose considerable health risks if the food is spoiled or tainted. Relying on sources of food that are potentially hazardous, and not certain to be available, is a large concern that makes homeless individuals nutritionally vulnerable in the city of Toronto.

Regular Sources of Food



WHAT HEALTH CARE SUPPORTS DO HOMELESS PERSONS ACCESS IN TORONTO?

This study has shown that many homeless individuals experience complex health issues, such as physical and/or mental illness, substance abuse, and poor nutrition. Despite these concerns, only slightly more than half of the respondents (52.3%) reported having a regular doctor or nurse they could go to for medical assistance, although the majority (89.9%) stated that if they needed to see a doctor they would be able to. Those who had a regular doctor generally had appointments at least once a month (17.5%) or once a week (12.1%). Since becoming homeless, participants reported seeing a health professional for a range of concerns, including depression (43.6%), alcohol or substance use (39.6%), anxiety (34.2%), difficulties with relationships (31.5%), manic depression (20.1%), trauma / assault (18.8%), attempted suicide (13.4%), schizophrenia (8.1%), and brain injury (5.4%).

Most participants had an Ontario health card (81.9%), and more than half had been to the hospital for some form of treatment in the preceding year (51%). Many of these participants remained in the hospital for one night or longer (32.4%), while others stayed for a few hours (16.8%). Reasons for visiting the hospital in the previous year included acute injury or infection (18.8%), serious or chronic illness (6.7%), mental health care (5.4%), alcohol / drug abuse (4.7%), pain (3.4%), minor surgery (2%), giving birth (2%),

trauma care (1.3%), and seizures (1.3%). Although hospitals are a primary source of health care for many homeless individuals, several participants (22.8%) had concerns over the way they are generally treated, as was previously found by other researchers (Wen, Hudak, & Hwang, 2007). In particular, they were concerned that they would receive poor health care and that they feel stigmatized due to issues of homelessness, mental illness, and/or addictions.

As a result of these concerns, many homeless individuals rely on alternate means to meet their health needs. When asked about their main source for health care, the most commonly cited responses were community health centres (36.9%), physician (30.9%), walk-in clinics (24.8%), shelters / drop-in centres (22.8%), and only a few noted hospital emergency rooms (12.8%). Many of the health services accessed by homeless individuals are community-based and run out of the agencies they already access (such as shelters and drop-in centres). It should be noted as well, that although a number of individuals indicated they had a physician, it was not clear where these physicians worked (i.e. whether they held a private practice or operated within a community health centre or service agency).

WHAT DOES THE TORONTO HOMELESSNESS SECTOR DO TO MEET THE HEALTH NEEDS OF CLIENTS?

The homelessness sector plays a large role in offering services that meet the complex and varied health care needs of the homeless clients they serve. Yet, very few of the organizations within the sector are actually health-based. Many are social service agencies, such as shelters and drop-in centres that offer some form of health care on premises. On-site provision was offered through nine of the fifteen social service agencies represented in this study, as part of their daily operations. Another four agencies did not offer their own health services, but had external professionals come for regular outreach visits (often on a once-a-week basis). An important finding of this study is that many social service agencies provide health care to their clients, despite not having health mandates. The need for health and wellness supports among the homeless population is so high, that many organizations find ways to incorporate health care into their daily operations.

Providing health services poses many challenges for the under-funded and under-resourced agencies that make-up the homelessness sector in Toronto. For this reason, the model of health care provision offered within the sector is one best described as a network of partnerships. In this study, all but one agency reported having formal partnerships in delivering health care to their clients (although some were more formalized than others). A considerable amount of health care within the sector is offered through outreach services and mobile clinics, which operate through shelters and drop-in centres on various schedules. Several agencies were commonly mentioned as being primary health care providers. For instance, Sherbourne Health centre was commonly mentioned, as

it operates the Health Bus in partnership with other homeless service agencies. The Centre for Addiction and Mental Health (CAMH) provides mental health and addictions supports to several agencies. Shout Clinic was an important health partner for many of the youth-specific agencies and provided mobile outreach. Also commonly noted partners were Street Health, St. Michael's Hospital, Queen West Community Health Centre, Regent Park Community Health Centre, Seaton House, Toronto Public Health, and the 416 Community Support for Women. These constitute examples of formal partnerships, in which health clinics are organized and scheduled between agencies.

When health care is made available at shelters and drop-in centres, it is primarily operated through full-time nurses and/or nurse practitioners, with physicians, dentists, and mental health professionals working on an outreach / part-time basis. Many physicians who work with these agencies are part of the Inner City Health Associates (ICHA). According to one key stakeholder, this group is comprised of approximately 50-55 physicians working in various locations across Canada. In Ontario, provincial negotiation led to funding for 60 hours of population health work in 30-40 locations, much of which is done in co-ordination with other bodies, like harm reduction networks and the Street Nurses Association.

Utilizing a networked approach to health care is effective for reaching homeless persons, who are often marginalized and disconnected from more mainstream sources of health care. Through these networks of health professionals, who do outreach within the homelessness sector, individuals can access a range of health supports, including specialized services like registered dieticians, chiropractors, chiropodists, dentists, massage therapists, naturopaths, diabetes supports, FASD diagnosis and assessment, pre- and post-natal support, optometry, HIV/AIDS testing, harm reduction, and Aboriginal healers and elders. However, despite the benefits of this networked approach, the funding for these programs is limited. With such a high demand for health services, many organizations that offer outreach are over-burdened and forced to make difficult decisions on how to best utilize the limited resources they have available.

Where formal partnerships between social and health services were limited, or unavailable, social service providers reported engaging in less formal arrangements to help meet the needs of their clients. Whereas the formal partnerships were established through set clinic hours, these informal partnerships tended to occur through inter-staff relations between agencies. If a client at a shelter or drop-in centre was in need of health care (that was not available on site), staff members would likely call someone at another agency to connect with health supports. For instance, if a youth was in need of health care, their worker might call Covenant House, Evergreen, or Shout Clinic to notify the workers the client required an appointment. Although not formal agreements between agencies, these kinds of partnerships were seen as being a critical means through which social service workers provided health care to their clients. Thus, a combined system of on-site health care provision, reliance on outreach / partnerships, and informal co-ordination between agency staff constitutes the homelessness sector response.

Take-Away Messages

- The homelessness sector in Toronto is under-funded and under-resourced.
- Social service agencies are often congregate settings.
- Homeless individuals in Toronto are nutritionally vulnerable.
- Homeless persons experience complex physical and mental health challenges.
- Access to health care is a concerning issue for homeless persons.
- Homelessness sector health care operates through networks and partnerships.

PREPARING THE HOMELESSNESS SECTOR FOR H1N1

Pandemic planning and preparedness requires the involvement of many key stakeholders. This section reviews the work that was done, prior to the H1N1 outbreak, to prepare the homelessness sector. It examines who the key players were, how planning was approached, and the challenges that emerged in the process.

WHO WERE THE KEY STAKEHOLDERS INVOLVED IN PANDEMIC PLANNING FOR THE HOMELESSNESS SECTOR?

In Toronto, a number of key stakeholders were involved in helping to prepare the homelessness sector for H1N1. At the forefront of the planning and preparedness initiative was Toronto Public Health. Given their role as the municipal body overseeing the city's response to H1N1, Toronto Public Health took the lead in working with agencies and organizations to prepare for the outbreak. According to one key stakeholder, "It was good that Toronto Public Health stepped up with a specific identifiable group of people to deal with the homelessness sector. It worked very well in Toronto."

Toronto Public Health worked with a range of bodies, but some were more closely aligned than others. For instance, previous relationships existed with many health-based stakeholders – like St. Michael's Hospital, the Toronto Central Local Health Integration Network, and community health centres – making it an easy transition to discuss issues pertaining to homelessness and/or pandemic planning. Another relationship that Toronto Public Health had previously established with the Toronto Police Service allowed them to discuss pandemic planning issues, although the discussion did not extend to homelessness. Notably, Toronto Public Health had little engagement with the provincial government of Ontario and stakeholders interviewed for this study did not know of any collaboration around the homelessness sector.

Among the most important of the relationships, was that between Toronto Public Health and another city department, Shelter, Support and Housing. These two departments have a long history of working together on infection control and public health promotion within the homelessness sector of Toronto. More specifically, previous outbreaks of tuberculosis in shelters (Basrur, 2004; Tuberculosis Action Group, 2003) and SARS in the city (Svaboda et al., 2004; The SARS Commission, 2004, 2006a, 2006b, 2006c) have led to the creation of resources like *Breaking the Chain* (Toronto Public Health, 2006). This infection control document served as the precursor for the influenza planning guide for homeless and housing service providers (Toronto Public Health, 2009), which was published three years later at the start of H1N1.

In addition to working closely with public health officials, Shelter, Support and Housing played a key role in helping to prepare the city-operated shelters they oversee for the H1N1 outbreak. In the beginning stages of the pandemic, most of the work was done internally through e-mail correspondence, preparing the emergency system, and developing a fit-testing plan for 95-level respirators (which have been standard in Ontario since SARS). Within the department, they created a service disruption form, established a pandemic policy team, and found substitutes in the event that workers in essential positions became ill. According to one stakeholder, while they primarily played a supporting role during H1N1, had the pandemic been more severe, Shelter, Support and Housing would have taken on a bigger, leading role. During the outbreak, they worked closely with the Office of Emergency Management, Ministry of Children and Youth Services, Family Services, Ministry of Health and Long-Term Care, Toronto Police Service, and EMS. Reportedly, these relationships focused on core services and the need for continuity, such as keeping staff healthy and the possibility of redeploying workers from non-essential departments like Parks and Recreation.

The final group involved in helping prepare the sector for H1N1 was a group called the Inner City Health Associates (ICHA), who were primarily involved in advocacy and committee work alongside Toronto Public Health and Shelter, Support and Housing. This group is comprised of physicians and health care practitioners interested in public health issues. They do not have an official role / voice, but have been involved in different initiatives within the sector, such as assisting with tuberculosis outbreaks in shelters. As health care providers responding to a pandemic among the homeless, ICHA made an action plan to endorse and support the efforts of Toronto Public Health. According to one stakeholder, historically the relationship between ICHA and Toronto Public Health has been a positive and natural one, although some tension exists in their relationship with Shelter, Support and Housing given their activism and grassroots nature.

The ICHA response was described as being 'ad-hoc' and specifically for the purpose of advocating for the homeless during the H1N1 outbreak. They formed a group that held meetings and had an interactive website through Google. They quickly decided that anyone who wanted to be part of the group meetings and online forum was welcome. As individual health care providers, they struggled at times with issues of conflicting political agendas, establishing credibility, deep-rooted system issues like budgetary constraints, and liability issues for independently dispensing medical advice.

On October 13, 2009 the ICHA hosted an educational meeting at St. Michael's Hospital. At this meeting, health care workers and others in attendance created a list of advocacy requests which they presented to the Board of Health later the same month. The list of eleven recommendations included: housing for the severely immune-compromised, replacing out of the cold programs with secure beds, opening two new shelter sites to accommodate rough sleepers, increased shelter beds, providing service agencies with emergency pandemic supplies (like masks and alcohol-based hand sanitizer), reserving a team of health providers to work with the homeless, ensuring the continuation of essential support services during the outbreak, like cleaning and cooking staff, placing a moratorium on rules that disallow survival supplies (such as distributing take-away food and sleeping bags), removing shelter length of stay restrictions, allowing people who are ill to stay in the shelters during the daytime, and creating a place for convalescents. At the time of the stakeholder interviews, approximately six months later, it was noted that few of these recommendations had been implemented by the Board of Health.

HOW WAS PANDEMIC PLANNING APPROACHED FOR HOMELESSNESS PERSONS WITHIN THE SECTOR?

Pandemic planning for homeless persons requires thinking through a number of key challenges that might arise due to the unique circumstances that homelessness presents (such as high mobility, underlying health issues, and a lack of housing for convalescence). In general, the approach taken by city officials was to extend the mainstream approach to the margins, rather than adapting it to meet the needs of the specific population. According to one stakeholder, this is why it is important to have people who are knowledgeable about high-risks groups in the planning process. Overall, the approach was to utilize many of the same general public health strategies for homeless persons – such as infection control and vaccination – and take into consideration sub-populations where needed. According to one stakeholder, the city was focused on larger groups like 'the homeless' and did not plan in detail for striations or layers of homeless identities.

Yet, some considerations had to be made given the unique properties of H1N1 and the threat it posed to certain groups. For instance, youth and pregnant women were among the biggest concerns for social service providers because of the additional risks posed to them during the outbreak. Primarily, the special attention they received involved outreach on the part of service workers and stakeholders to ensure they were informed about the vaccine and knew about the potential risks of becoming infected. Those with underlying health problems were also at higher risk and some measures were taken to protect them as well. One stakeholder noted that special dietary programs were available for those who needed them but that, "the diet was not tasty, but would be effective." Families experiencing homelessness were not a special consideration during H1N1 planning, according to one key stakeholder although arguably should have been, given the health needs of children within them. Finally, the increased risk to Aboriginal homeless persons was given consideration by some service providers and stakeholders. Some of the key concerns were the proximity of individuals on small rural reservations, and the higher proportion of complicating health factors, like diabetes. Addressing these concerns meant that Toronto Public Health worked closely with First Nations representatives, and advocated for vaccine clinics in agencies that served Aboriginal clients.

HOW DID SOCIAL SERVICE AGENCIES ENGAGE IN PANDEMIC PLANNING AND PREPARATION?

Despite the City of Toronto having a pandemic plan (Toronto Public Health, 2011), most social service providers said that they were not very familiar with it. Although many were aware it existed, they did not know specific details of its contents or of its recommendations for best practices. When asked about internal agency plans, there was a clear discrepancy between the responses given by service providers and key stakeholders. While all but two service providers indicated that their respective agencies had a plan in place prior to H1N1, the stakeholders believed that most agencies did not have plans developed. As one stakeholder stated, "Living through H1N1, one of the biggest issues was that so many agencies had not even a generic emergency plan. So in dealing with H1N1, many were starting from scratch. However, I will say that this wasn't just a problem for small agencies. A lot of hospitals have that problem too."

According to service providers, the plans they had largely emerged as a result of the previous SARS outbreak in Toronto. Some agency staff noted that prior to H1N1 their plans had been more 'emergency based' and covered a range of situations, not only those that were health-based. However, the general consensus among service providers was that plans were updated to reflect the specific events of H1N1 and focused primarily on sanitization practices, how to screen for signs of illness, and contingency plans in the event of staffing shortages. The stakeholders were less confident that firm plans were in place and instead reported that it was the larger agencies who had completed planning, and that smaller ones tended to have only minimal plans, such as closing primary services in favour of outreach.

Thirteen of the fifteen service providers indicated that they had support from external bodies in relation to creating their pandemic plans. Primarily this support came from Toronto Public Health, in the form of in-house visits, hosting town hall meetings for shelter and drop-in centre operators, and through online / phone communication. Service providers as a whole believed that the support from Toronto Public Health was 'very helpful' and they had enough information to allow them to adequately plan for H1N1. Other sources of planning support included St. Michael's Hospital, the Ministry of Health and Long-Term Care, the Registered Nurses' Association of Ontario, the Local Health Integration Networks, Ontario Safety Alliance, the AIDS Bureau, and CATIE. Additionally, Shelter, Support and Housing offered planning support to the shelters they oversee by hosting scenario-based training, in which managers were able to meet for half a day and engage in role-playing with one another around issues of pandemic and emergency planning for homeless persons.

Within the sector itself, most service providers reached out to other agencies for guidance and advice on pandemic planning. Many took advantage of existing relationships, partnerships, and committee meetings to gain insight into how others were approaching the planning and preparation process. Notably, many service providers took advantage of the opportunity to connect with other agency staff by participating in sector-wide meetings, variously hosted by the Toronto Drop-In Network, Inner City Health Associates, Toronto Public Health, and Shelter, Support and Housing. Those who did reach out to other service providers, reported discussing a range of topics, including co-ordination in the event of a more serious outbreak, under what circumstances to close, the health status of clients at each agency in relation to H1N1, vaccination clinic times and locations, access to medical supplies, measures to take if clients became ill, and strategies for cancelling programs with as little disruption as possible. Unfortunately despite these conversations, very few action plans were developed through these interactions due to a lack of funding and resources.

WHAT CHALLENGES DID THE HOMELESSNESS SECTOR EXPERIENCE WHILE PLANNING FOR H1N1?

Interviews with social service providers and key stakeholders revealed three main challenges that the homelessness sector faced in trying to prepare for the H1N1 pandemic. Notably, none of these challenges – lacking funding, strained capacity, and system fragmentation – were exclusive to H1N1. These are the conditions under which the homelessness sector operates on a daily basis. The challenge created by the pandemic, was that it put further stress on infrastructure and resources that are already nearing a breaking point.

According to a key stakeholder, the general lack of funding available to social service agencies was a large inhibitor for pandemic planning. Many agencies had small operating budgets, with little to no recourse for discretionary spending. As a stakeholder noted, "Because the budgets of agencies were so small, they had almost no leeway to deal with these kinds of things [such as a health emergency] when they popped up." Many social service providers identified the lack of funding as a primary challenge that had to be overcome for undertaking planning and getting their agencies prepared for the outbreak. Although the limited funds proved to be challenging, one stakeholder mentioned witnessing a strong will by many agencies to find alternative ways to get what they needed. To this end, one service provider stated, "You can't always wait for others. Sometimes we have to go ahead and get things done ourselves."

The circumstances created by a lack of funding – under which agencies have to 'get things done' themselves – can be problematic when the capacity to meet challenges is also a limiting factor. Service providers and stakeholders argued that many agencies without health care mandates nonetheless held expectations that staff would undertake health-based responsibilities (like pandemic planning), for which they had no formal training. In the words of one stakeholder, "One of the things that struck me was the difficulty so many organizations had with organizational depth. They just didn't have the staff time to free up to think things through. They are funded in a very strict way that limits their mandate – this is really true in social services. The fact that health issues occur in the realm of social services becomes really difficult, and they are not always able to pick it up." This lack of capacity reflects a deeper systemic division between the practices of health care and social service provision within the sector. The ideology that separates health care as its own entity apart from social service provision perpetuates a system in which capacity for both becomes tied to limited and inflexible mandates.

Shoring up the homelessness sector in non-emergency times provides the best chance for meeting client needs during a health (or other) emergency. At present, "The city is very fragmented in terms of homeless services," according to one key stakeholder. There was a common belief among all the stakeholders that the homelessness sector is not only underfunded, but is "held together by big hearts and chewing gum." Co-ordination of infrastructure and resources is an important issue under normal circumstances, and one that becomes even more pressing when planning or preparing for a pandemic outbreak. Stakeholders in this study worried that because of the fragmentation in the sector, smaller agencies in particular may not know how to "hook into resources available to them" and consequently may not be as connected during an outbreak. This sentiment was shared by a few social service providers, who stated there was some confusion in understanding the intersections of different players involved and a lack of information on what other agencies were doing to prepare for H1N1.

Take-Away Messages

- Toronto Public Health took the lead role in co-ordinating the homelessness sector response to H1N1.
- Pandemic planning for homeless persons primarily followed the mainstream planning approach.
- Most social service agencies had pandemic plans, but were unfamiliar with the city's plan.
- Pre-existing partnerships within the sector were a key source of pandemic planning support.
- Three main challenges emerged for the homelessness sector in relation to preparing for H1N1 (lack of funding, strained capacity for health care, and system fragmentation).

H1N1 AND THE HOMELESSNESS SECTOR RESPONSE

The H1N1 outbreak was a relatively mild pandemic, with only 1.3% of homeless participants in this study indicating they had a confirmed diagnosis. This section examines the sector response during the outbreak, and the steps taken to protect homeless individuals. Key considerations include service operation, the experiences of social service workers, the experiences of those who were homeless, access to supplies, the immunization strategy, and infection control practices.

WHAT EFFECT DID H1N1 HAVE ON SERVICE USAGE AND OPERATION?

Participants interviewed as part of this study had considerably mixed opinions on whether or not the H1N1 pandemic had an impact on service usage and operation. According to one key stakeholder, the shelter occupancy levels remained stable during H1N1, with no drop-off in resident numbers. The findings of this study support this statement, as 62.4% of homeless participants reported going to shelters during the H1N1 outbreak (which is very close to the 57.7% who reported spending at least one night in a shelter in the thirty days preceding the interview). However, the usage rate of drop-in centres was considerably lower during H1N1 (71.8%, compared to the 84.6% who accessed them in the preceding thirty days). It is uncertain what accounts for this difference, but is likely due (at least in part) to concerns about the pandemic.

When homeless participants were asked whether they noticed a difference in the daily operations of homeless service agencies, some stated that there were changes in their preferred shelters (24.2%) and drop-in centres (20.1%). The largest, or most noticeable, of these changes was the increased emphasis on cleaning and hygiene practices. Yet, while several participants noted that there were changes in the daily operations of their service agencies, many more stated that they observed no operational changes in the shelters (34.2%) and drop-in centres (49.0%) they attended during H1N1. Social service providers were equally divided on whether the pandemic impacted the operation of their service agency (with eight stating there was an impact, and seven stating there was none).

Among the agencies that noted operational changes, four key themes emerged. First, H1N1 led to several improvements in service operation (such as through updated pandemic plans, increased hygiene practices, and increased communication between staff and clients). Second, the H1N1 pandemic created additional workloads for agency staff, causing added stress as existing work expectations were generally not reduced or adapted to account for the increased responsibilities. Third, several service providers noted that their agency's daily services were changed and/or restricted to accommodate provisions for H1N1. For instance, social service providers mentioned suspending some non-essential services, setting-up a screening centre, reassigning health care staff to different duties, and adapting screening and triage practices for potentially infected clients. Finally, some social service providers noted operational changes resulting from staff illness, such as one agency where a staff member became infected with H1N1 and had to conduct some duties over the phone from home.

HOW PREPARED WERE SOCIAL SERVICE PROVIDERS TO WORK WITHIN THE CONTEXT OF H1N1?

The majority of social service providers interviewed stated that their agency's staff underwent various types of training exercises prior to, and during, the H1N1 outbreak. Primarily this training consisted of infection control strategies (cleaning, mixing solutions, when/how to clean for best results, hand-washing), infection screening (how to identify someone with H1N1), protective measures (mask fit testing and use of protective clothing, such as gloves), quarantine (where to place a client who was ill), and vaccination information (what was in them, and the potential for allergic reaction). Training was generally provided in group settings on-site by the agency's own nursing or medical staff (where available). Where health care professionals were not available, many agencies relied on Toronto Public Health for training.

On-going communication with social service agencies about H1N1 was primarily the responsibility of Toronto Public Health. They employed a multi-approach strategy that included hosting sector-wide meetings, making health care professionals available for questions, posting information on their website, and holding a weekly open phone call in which agency staff could call and receive important updates. This strategy had several strengths, but also faced some logistical challenges. What Toronto Public Health did well was reach a broad audience of social service providers (by utilizing a variety of communication methods), establish themselves as the authority on H1N1 within the homelessness sector, and work closely with key stakeholders such as the city department Shelter, Support and Housing and the Toronto Drop-In Network to communicate with service agencies.

Many agencies reported that they received information from Toronto Public Health and held regular (sometimes daily) staff meetings to share the information. A consistent theme in the findings of this study was that agencies had an 'open door policy' for

staff, where they were able to speak with management at any time about questions or concerns they might have. In addition to verbal information, many agencies also had posters containing information about H1N1, and engaged in regular e-mail exchanges among the staff. As one key stakeholder mentioned, a survey of homelessness sector agency staff showed they were generally content with the information they received and felt it was reliable.

While the communication between Toronto Public Health and social service agencies was largely effective, some key learnings did emerge on how to improve it. First, the pressing nature of the H1N1 pandemic meant that Toronto Public Health did not have the time or resources to meet with agencies and offer planning / implementation support on a one-to-one basis. This meant that while agencies may have received the information, they may not have implemented it as well as they could have, had there been on-site assistance. Second, the weekly sector-wide conference call in which people could sign-on and get reports on H1N1, vaccine clinics, flu assessment centres, and confirmed cases was considered to be a very useful but underutilized communication tool. As one stakeholder noted, "The issue was of having enough infrastructure to keep people in the loop, but at the same time letting people self-regulate regarding the amount of time they devoted to it." Although easily accessible, very few individuals actually signed onto the weekly calls meaning that the core group of people who attended were then responsible for disseminating the (second-hand) information to their respective networks. The final shortcoming of the communication response was the lack of social media. Many governmental and social service agencies restrict access to social media sites (like Facebook and Twitter), missing a key opportunity for stakeholders to connect and communicate with one another in real time.

WHAT CONCERNS DID SOCIAL SERVICE PROVIDERS RAISE IN RELATION TO WORKING THROUGH H1N1?

As a whole, social service providers were well-prepared to work within the context of H1N1, but many also expressed concerns about their duties and obligations during the outbreak. The largest (or most vocalized) of these concerns related to staff themselves becoming infected with H1N1, and the fear that they would subsequently expose their family members to the illness. The initial uncertainty of the disease led to requests from staff members for gloves and masks be worn at all times (which was not advised by Toronto Public Health), and that agencies be closed as a precaution. This fear-based response was concerning, particularly to one key stakeholder who stated, "At the beginning, I was getting worried. People were calling saying, 'When should we shut down?' This was the wrong approach. These *are* emergency services – they need to stay open. They are the last resort. You shut down when you're the last man standing." It was noted that fear, more than resistance, was what drove the social service providers' requests for closures and additional health precautions.

Concerns over client welfare was a top priority for many social service providers during H1N1. Common themes emerging out of the social service provider interviews related to operational issues, such as how to best treat those who became ill, where to put them within the agency, and which doctors would accept patients without an Ontario health card (OHIP). Additional concerns were raised over staffing issues, such

as navigating unionized work environments, and what to do in the event one became ill and had exhausted their sick days. Several social service providers noted that within their particular agency, workers expressed concern over these issues but that they were dealt with using the 'open door policy' and that concerns rarely escalated into resistance.

In the few instances where staff resistance emerged, it tended to be in relation to the H1N1 vaccine, and its potential negative side-effects. According to one key stakeholder, the media coverage of H1N1 (and the vaccine) raised the level of fear, and likely resistance, around this issue. Overall, the vaccine resistance itself was relatively minimal and contained to certain individuals (although some staff at one agency were cited as intentionally providing incorrect information to clients as a form of resistance). Other mildly contentious issues that emerged at individual agencies pertained to male staff not wanting to shave their facial hair for mask fittings, actively not washing their hands as passive-aggressive resistance to hygiene warnings, and certain staff wanting to share H1N1 information from other sources beyond Toronto Public Health.

HOW WAS INFORMATION ABOUT H1N1 COMMUNICATED TO HOMELESS PERSONS?

Communication within the homelessness sector took a top-down approach during the H1N1 pandemic, in which policy makers and health care providers shared information with social service providers, who then shared it with homeless persons. According to the key stakeholders interviewed for this study, there was little to no direct interaction between themselves and the homeless clients of the agencies they worked with. Thus, it was largely the responsibility of social service workers and agency-based health care providers to ensure their clients received current and reliable information about H1N1. This is no small challenge, as client populations vary in demographics, comprehension levels, and agency attendance, meaning that multiple strategies were employed to connect with as many clients as possible.

Results of this study indicate that nearly every homeless participant (97.3%) remembered hearing about H1N1 during the outbreak. When asked to discuss more specifically what they knew about H1N1, more than half stated that it was like the flu (53.7%) and nearly half stated that it was a serious and deadly illness (45.6%). Other commonly reported known information about H1N1 included that there was a vaccine (20.8%), it was contagious (17.4%), it could be transmitted between people and animals (7.4%), serious outbreaks had occurred in other places (6.0%), there was a lot of media coverage / panic (4.7%), people were told to engage in hygiene practices like hand washing (4.0%), it was a viral disease (4.0%), certain groups were particularly vulnerable (2.7%), it was initially called swine flu (2.7%), and it was a conspiracy made up by the government (1.3%).

The homeless participants in this study reported turning to a number of sources for information on H1N1, although 26.8% reported there was not enough information available. Interestingly, while social service providers noted that keeping clients informed about the pandemic was a key part of their responsibilities, the homeless individuals did not consider social service agencies to be their primary source of information. When

asked where they received their best information about H1N1, participants stated that health care providers (76.5%), television news (76.5%), newspapers (74.5%), and posters / pamphlets (73.1%) ranked higher than shelters and drop-in centres (69.1%). Following these sources, were information letters (53.5%), family members (41.6%), and friends (39.6%). Half of the respondents (49.7%) said that health care providers were the most reliable source of H1N1 information, while only a small minority (10.7%) believed that shelter and drop-in staff were the most reliable source.

These findings are perhaps not surprising, given that many social service agencies are not mandated to be health care centres, and thus would not be the first choice for health information. However, these findings do point to some areas where communication may have been lacking. First, nearly one-fifth of the homeless participants surveyed (19.5%) stated that they did not receive any information about H1N1 from social service agencies. Second, when homeless persons did receive information from these sources, only 57.0% reported that the information was useful. Communication within shelters and drop-in centres was commonly done through a variety of strategies, such as informal conversations, group education sessions, posters, and other print materials. Several agencies noted that nursing students engaged clients in education sessions and often tried to present the information in novel ways, like an H1N1 trivia game. However, despite these strategies there were few mechanisms in place to ensure that homeless clients understood the messages they were receiving. Although one agency distributed a survey to clients to assess their level of comprehension, most relied on open-door policies and general observations made by staff.

While having an open-door policy worked well to address social service provider concerns, it did not prove to be as widely successful with homeless clients. A policy of this nature places responsibility on the homeless person to clarify any information that is misunderstood. For some clients, this was considerably problematic. Among

those most commonly noted by social service providers were persons for whom English was a second language, those with limited reading comprehension, those with addiction / substance abuse issues, and those with mental health concerns that limited comprehension. Because these challenges are present in daily work within the homeless sector, many service providers had worked out strategies for communicating with clients (such as providing translated pamphlets from Toronto Public Health), and did not see these issues as insurmountable hurdles. Rather, they provided additional barriers that had to be considered and addressed when communicating with clients.

Determining what information to share and from which sources were notable challenges for several social service providers. When asked what they spoke about with clients, the most commonly reported topics were hygiene practices and prevention tips (like social distancing, disinfecting, and hand-washing), the vaccine, where immunization clinics were being held, and the general symptoms of H1N1. However, service providers struggled over some issues, such as what information they should share from the media and whether they should intentionally limit information to avoid panic among their clients. Finding a balance was challenging for the social service providers, as many of them were expected to distribute public health information without a formal background in the field of health. Many homeless individuals recognized this limitation and turned to health care practitioners instead, to better understand H1N1.

WHAT CONCERNS DID HOMELESS INDIVIDUALS EXPRESS IN RELATION TO H1N1?

While many homeless individuals had questions about H1N1, the overall sense was that they exhibited very little resistance and generally remained calm. Three issues, in particular, emerged as being sources of concern or contemplation for homeless individuals in Toronto. The first issue was the risk of infection, as nearly half (47.7%) of the homeless participants surveyed indicated that they were concerned about becoming infected (while 49.0% were not concerned). Relatedly, the second concern pertained to the use of social service agencies and the practices they were enacting to help combat the spread of disease. Again, this issue was limited and rather mild. Whereas 26.8% stated they had concerns about staying at a shelter during H1N1, 40.3% stated they did not have concerns. Likewise, while 20.8% had concerns about going to a drop-in centre during H1N1, 57.0% were not concerned. Among those who were concerned, the most commonly stated reason for shelters and drop-in centres was the potential for the spread of germs.

The third issue of concern raised by homeless individuals was that of immunization. Some individuals had a lack of understanding and/or fear of the side-effects. This was most notably seen among the youth populations, as many had seen an online YouTube video that inaccurately depicted only being able to walk backwards as one of the adverse effects. As one key stakeholder noted, youth are not generally considered to be a high-risk population for seasonal influenza but they were for H1N1. Previous vaccine clinics were not geared to this population, and as such many were not used to getting vaccinated and had concerns. One additional concern was raised by a social service provider, whose agency served many Muslim clients – because the pandemic was initially called swine flu, some clients required confirmation that the vaccine did not contain any pork.

These three issues (infection, organizational practices, and vaccination) were the primary concerns raised among the homeless population. Others that were mentioned, but not as recurring themes, included some resistance to isolation measures (where clients wanted more space to move around), and difficulty with clients who wanted to drink the hand sanitizers that were offered in agencies. While many of these issues were not considered to be overly concerning to the homeless population, social service agencies attempted to address them through client meetings, open door policies, printed literature, and holding circles where residents could speak with life skills counselors. Overall, these methods appeared to be effective, as 71.1% of homeless participants believed that if they had concerns about H1N1 they could speak to a staff member of a shelter or drop-in centre, while only 5.4% believed they could not. As a whole, while homeless individuals had some concerns, they were relatively minor and limited in scope.

HOW WELL STOCKED WITH SUPPLIES WERE HOMELESSNESS SECTOR AGENCIES DURING H1N1?

The H1N1 outbreak required homelessness sector agencies to procure and store many supplies (such as cleaning products, hand sanitizer, masks, and gloves) that may have been outside or beyond their regular stock. Social service providers interviewed for this study were evenly divided on whether gaining access to supplies was a challenge for their respective agencies. Half of the providers stated that there were no problems with getting supplies, and/or that they already carried many of the items needed (this was particularly true for agencies that provided on-site health care). The other half – a mix of participants from shelters, drop-in centres, and community health centres – had trouble keeping supplies in stock and/or obtaining more. In particular, masks and syringes were consistently mentioned as being on back-order during the outbreak.

Despite the divided opinion of social service providers, one key stakeholder believed that access to supplies was not a major hurdle because, "champions of the cause emerged." In particular, this stakeholder identified four key players who were involved in getting supplies into homelessness sector agencies. The first, the Ministry of Health and Long-Term Care (MOHLTC) had a response unit, where people were willing to "run with the idea of getting Tamaflu pre-dispensed to homeless agencies." According to this stakeholder, the MOHLTC "signed on to make it happen and so it did." Two divisions within the City of Toronto (Shelter, Support and Housing, and Toronto Public Health) were also identified by this stakeholder as playing important roles in distributing supplies. As a stakeholder noted, "The City of Toronto doesn't have the money in the budget for [supplies]. Strictly speaking, they're not supposed to do that but they got some money and managed to make it happen." During the outbreak, Shelter, Support and Housing was directed by the Board of Health to get supplies for shelters and drop-in centres (despite not overseeing the latter), and were able to use an internal automatic tabulate spreadsheet with changeable parameters to determine what supplies could be

distributed. Accordingly, they were able to get masks, take-out food containers, Kleenex, hand sanitizer, and transit tokens to homelessness sector agencies. The fourth identified key player was the Toronto Drop-In Network, whose members distributed the supplies that were obtained by Shelter, Support and Housing.

Even with these identified champions of the cause, there were four main challenges that arose in relation to supplies. The first, and most commonly noted, was the cost associated with obtaining these supplies. Social service providers from several agencies noted that the cost of H1N1 supplies came out of their regular operating budgets (thus redirecting funds away from other resources). According to one stakeholder, "The homelessness sector is always short of supplies and resources." If gaining access to supplies in non-emergency times is a challenge, how can agencies reasonably be expected to meet this need when faced with the additional burden of managing an emergency outbreak?

When agencies were able to gain access to supplies, another challenge they faced was trying to keep them in stock. The high demand for supplies meant that agencies had difficulty maintaining the necessary levels. Thus, many social service providers faced situations in which supplies would be depleted as rapidly as they became available. Stockpiling supplies was not an option for several reasons. First and foremost, as one stakeholder noted, creating a stockpile does not work when an agency is already short of supplies. Not having enough room to store supplies was another reason that some social service providers identified as being a barrier. For one agency, having enough room was not an issue but they ordered emergency infection kits too far in advance and the contents had expired before the H1N1 outbreak occurred. Having a sector-wide communal stockpile was suggested as a potential solution to the shortage, but this idea poses several logistical challenges. Deciding how supplies are divided, where they would be stored, and who would provide funding are all important considerations. As one stakeholder noted, creating a communal stockpile would be difficult unless other mechanisms, like government fund matching programs, were put in place.

The third challenge that arose in relation to supplies pertained to hand sanitizer. While many agencies understood its importance, and wanted to distribute it to clients, there was a concern that some homeless clients might consume the contents of the bottles. This was noted as a concern that many agencies had, according to one key stakeholder. In one social service agency the issue of clients attempting to drink the hand sanitizer was so pressing that they had to tie the bottle to a staff member's desk to supervise its usage.

Finally, the issue of masks caused considerable confusion, particularly at the beginning of the outbreak. Among the most common questions were whether surgical masks were needed, what the fit-testing requirements were for different masks, and where the money would come from to pay consultants to do the fitting. At a meeting for shelter operators, hosted by the City of Toronto, public health officials told managers that they should not get the N95 masks (i.e. fitted masks), but that if they had extra money in their budgets, they could get surgical masks for people who were coughing and/or showing signs of illness. At another meeting, hosted at St. Michael's Hospital by the Ad-Hoc Pandemic Working Group, specifications were outlined for service providers on how to calculate the number of masks they would need. The general formula given was 40% of the number of clients + 10% for congregate settings + 25% for Influence-like Illness (ILI) wastage. This formula could then be adapted for various settings, such as shelter, drop-in centres, and health care settings. Despite the early confusion, not many agencies reported having challenges with masks (likely due to the low rates of illness among the homeless population).

WHAT IMMUNIZATION STRATEGY WAS USED TO REACH HOMELESS PERSONS?

Determining priority vaccine groups was a key factor in deciding how to approach vaccination among homeless populations. According to one key stakeholder, the staff at Toronto Public Health were the first to be vaccinated, and then resources were used where the need was high. Although it makes logistical sense that the public health officials managing the pandemic outbreak would receive immunizations first, one stakeholder did note that there were no estimates on how many staff at Toronto Public Health were immunized, and suggested that these figures should be made publicly available for future outbreaks.

Within the homelessness sector, vaccinations were largely provided through Toronto Public Health organized vaccine clinics within shelters and drop-in centres. Several agencies (such as community health centres) operated their own clinics independently, but much of the vaccine response was implemented by Toronto Public Health (Buccieri & Gaetz, 2013). On November 2 2009, representatives from Toronto Public Health and Shelter, Support and Housing jointly hosted a meeting at which they shared the vaccination strategy with shelter providers. The officials stated that homeless persons were not on the official 'at-risk' list, but that vaccine clinics were going to be established at shelters, even with the limited vaccine supply. The reasons for holding these clinics included that children may be present in the shelters, homeless persons often have underlying health issues, and that shelters are congregate settings. Shelter operators were given contact information for Toronto Public Health, if they wanted to host a vaccine clinic in their organization, for both their clients and their staff. At this meeting a public health official noted that staff members qualified as health care workers, making them eligible for priority vaccinations, because they provided 'at home' care to those living in the shelters.

Interestingly, the early vaccine strategy was to focus on shelters, rather than drop-in centres. One key stakeholder noted that initially drop-in centres were not on the list to host vaccine clinics, as an assumption was made that homeless persons could be reached through shelter clinics. At the meeting for shelter operators, a public health official noted that people living in shelters need the vaccines because it is their home, while those visiting drop-in centres may have a home where they can stay and avoid contact with people who are ill. Members of the Toronto Drop-In Network negotiated with Toronto Public Health to get clinics into their agencies, noting that their clients are in need, and may not be reached through shelter-only outreach. This negotiation resulted in the set-up of a test clinic, in which eight homeless individuals were present and six decided to get vaccinated. Following this test, Toronto Public Health agreed to include drop-in centres in their vaccination strategy for homeless populations.

The effort to roll-out vaccine clinics within homeless services was greatly facilitated through pre-existing relationships. For instance, the Toronto Drop-In Network played a key role in linking the organizations with Toronto Public Health, for the purpose of establishing vaccine clinics. Likewise, the close relationship between Toronto Public Health and Shelter, Support and Housing meant that operating clinics within city-run shelters was also easier to facilitate. In previous years, Toronto Public Health had run seasonal influenza vaccine clinics in certain agencies and were able to rely on those relationships to promote the H1N1 clinics. Implementing the vaccination strategy relied on a network of nurses and nurse practitioners, within Toronto Public Health and various social service agency settings. Among the agencies interviewed for this study, ten of the fifteen agencies had on-site clinics, and those that did not had strategies for assisting clients (such as taking them to agencies where the vaccine was offered). Although working within certain limitations, such as resource constraints, immunization efforts within the homelessness sector was initiated at the beginning of the outbreak, beginning between the spring and fall of 2009.

HOW EFFECTIVE WAS THE IMMUNIZATION STRATEGY FOR REACHING HOMELESS PERSONS?

Nearly every homeless individual interviewed knew that there was a vaccine for H1N1 (93.3%). Generally their information came from the media (43.6%), doctors (17.4%), drop-in centres or day programs (14.8%), general word of mouth (14.8%), shelters (10.1%), friends / family (8.1%), hospitals (2.0%), and jails (1.3%). When asked if they knew where to get the vaccine, a large majority (85.2%) indicated that if they wanted the vaccine they would have known where to get it. However, only three-quarters of respondents (75.8%) knew that H1N1 vaccine clinics were being held in shelters and drop-in centres. Further, of those who knew about the clinics, only 69.1% actually knew how to access them (such as when they were held, and at which agencies).

During the pandemic outbreak, many social service agencies requested on-site vaccine clinics to make immunization easier for their clients and staff. In the interviews, every service provider indicated that their clients were able to receive the H1N1 vaccine, with average estimates of client immunization in the 50-60% range. The client uptake reported by social service providers was actually higher than the reported immunization rates by homeless participants. In this study, 36.9% reported getting vaccinated and 61.1% reported not getting vaccinated. Those who chose to get vaccinated often did so in the fall of 2009. Key reasons for getting immunized included fear of getting sick (16.1%), recommended by a physician (4.0%), belonged to a high-risk medical or lifestyle group (3.4%), agency staff recommended it / were getting it themselves (2.7%), family or friend recommended it / were getting it themselves (2%), shelter conditions, such as crowding and close proximity to other users (2%), treatment of existing illness / improve immunity (2%), and regularly received seasonal vaccine (1.3%). Those who chose not to get vaccinated provided their main reasons as a lack of knowledge of where to get it (22.1%), not concerned with getting sick (14.8%), fear of needles (12.8%), opposed to the H1N1 vaccine due to side-effects (5.4%), and they had already received the seasonal influenza vaccine (1.3%).

Nearly every social service provider indicated that the vaccine strategy was very effective, as the H1N1 rate was low among their clients and they observed no real outbreak of the illness. Out of the fifteen agency staff interviewed, nine could not think of any changes they would have made to the vaccination process, with one stating it was

"quiet and easy." Those who did feel changes could be made to improve the vaccine strategy variously indicated that in the event of future pandemics, they would place themselves on the vaccine clinic list earlier, order less vaccines, keep better track of who within their agency received the vaccine, try to better understand the responsibilities of Toronto Public Health, better coordinate the physical space of the vaccine clinics to accommodate post-vaccine monitoring, and get more people involved in sharing and communicating information about the clinics.

According to one key stakeholder, although Toronto Public Health operated approximately twenty clinics, with thirty to sixty people vaccinated at each, the uptake was not as high as they had expected. The stakeholders interviewed for this study generally felt that the response to the vaccine clinics could have been better. Five key factors were attributed to the perceived low response. First, some organizations that hosted clinics had not previously distributed vaccines to clients. Those that regularly offered seasonal vaccine clinics were reported to be better prepared to host the clinics and more supportive of the initiative. Second, while many Executive Directors and management staff wanted vaccine clinics in their agencies, front line staff were not always as supportive. Despite key stakeholder concerns over their lack of interest, estimates suggest that in several agencies as many as 90% of staff members received the vaccine (often at the on-site clinics). Accordingly, staff perception was believed, by one stakeholder, to be the most important factor in client uptake.

The third factor that accounted for low client vaccine rates was a lack of clear communication and co-ordination between inter-governmental agencies. The official roll-out strategy was to have messages transmitted from federal, to provincial, to municipal governing health bodies, but often the media received and disseminated messages to the public before they were vetted at all levels. Consequently, the general public wanted access to the vaccine more quickly than it was available, resulting in anxiety and frustration when people could not be accommodated. Fourth, as indicated in the relationship between homeless individuals and health care providers, there is often a sense of distrust (that one will not receive adequate care and/or that they will be stigmatized). This general lack of trust, combined with fear over H1N1 vaccine side-effects, served as identifiable barriers. Finally, the highly mobile nature of many homeless individuals meant that some clients may have been missed in the roving outreach clinics. As one stakeholder noted, H1N1 vaccines were offered at a number of places, but it is unknown how much overlap there is in service usage. The lack of current data is detrimental to reaching the broadest range of individuals possible.

WHAT INFECTION CONTROL MEASURES DID SOCIAL SERVICE AGENCIES IMPLEMENT?

Every social service provider interviewed, with the exception of one, indicated that their agency had a procedure or strategy in place for identifying clients infected with H1N1, and for reducing the spread of disease. When asked to elaborate on how their agencies managed infection control among their clients, four key strategies emerged. The first, and most commonly noted, was screening for signs of illness, particularly when clients initially entered the agency. This screening took on different forms, with some engaging nurses and health care staff to conduct individual screening clinics, while others had assessment flow charts, client log-books, and an intake symptom screening questionnaire. At the meeting for shelter providers, jointly hosted by Toronto Public Health and Shelter, Support and Housing, a public health official stated that they were not recommending H1N1 screening in shelters. The rationale provided was that infected clients were at much greater risk if they were turned away and had nowhere else to go. While initially Toronto Public Health urged against keeping infected clients in shelters, over time they realized that the risk of transmission was unavoidable, and that an individual could become infected simply walking through public spaces, like Dundas Square.

The second infection control strategy employed by several agencies was to isolate clients who may be infected and encourage social distancing between clients. For many agencies this meant asking clients to return home (if this was an option) or keeping them in a separate room within the agency, such as a nurse's office. While most of these agencies had general policies that advised infected clients should be kept away from others, a few had established detailed quarantine procedures within their pandemic plans. For instance, one shelter's plan stated that infected clients would be isolated as quickly as possible and kept there until symptoms of fever were gone. This same agency also had clients lie head-to-toe beside each other to maximize the distance between their mouths / noses at night. Two other agencies stated they tried to isolate infected clients by having them use a secondary exit (i.e. not entering or leaving through the front door), while another used different floors for different purposes (such as one for assessment and one for vaccination) in order to reduce the chances infected clients would come into contact with others.

The most detailed plan for using isolation as a means of infection control was created by a shelter. According to their pandemic plan, if a client were to become ill and needed to remain in the shelter, they would section off part of the residence to serve as an isolation area. Operations staff would then construct a negative airflow area by building temporary barriers of wood and heavy plastic. Two parallel walls would be built, approximately three to four feet apart, with overlapping sheets of plastic at the openings. An identical third wall would be constructed several yards away to create an anti-chamber where staff could disrobe after leaving the isolation area. Negative air pressure would be created in the isolation area by blowing air out a window using a small fan. As the need to expand or decrease the size of the isolation area changed, the plastic barriers would be moved to accommodate. Thus, while many agencies utilized isolation and social distancing as a primary means of infection control, some had very detailed logistical plans established while others relied on general measures.

The third infection control strategy involved trying to combat the spread of illness through protective coverings (such as masks and gloves), and sanitizing areas where clients were present. According to one key stakeholder, the shelters were clean and had disinfection rules to follow making them relatively safe places to be during H1N1. As this stakeholder noted, "You are at no greater risk of acquiring H1N1 in a shelter than you are on a subway. My opinion is you may be better off." Finally, where possible, some agencies tried to provide onsite medical treatments to their patients as a way of reducing infection among their clients. Allowing residents to stay in bed, rather than forcing them out at a pre-determined curfew time, was proposed by an advocacy group at the beginning of the H1N1 outbreak. Toronto Public Health agreed with this measure and instituted a policy to allow people to remain in bed during the day if they were sick. Shelter providers were also strongly discouraged from transferring a person to another shelter if they were ill.

These four infection control strategies – screening, isolation, protective coverings, and onsite treatment – constituted the general measures taken by agencies within the homelessness sector. However, it was noted by one key stakeholder that there is nothing that can be done to completely eliminate the risk of disease transmission. Accordingly, this person stated, "But really, there is only so much you can do. If you truly don't want to have an infection, then live in the mountains. Infection control is important, but it should not rule our lives. One of the cautions about medicalizing social services is that you shouldn't go overboard. You've gotta keep things in perspective." Infection control is an important part of operating social services, but it is not without its challenges and constraints.

WHAT CHALLENGES DO AGENCIES EXPERIENCE IN IMPLEMENTING INFECTION CONTROL MEASURES?

Implementing infection control measures in social service agencies raises a number of concerns and issues for consideration. First, the congregate nature of these settings means that airborne diseases are easily spread. One key stakeholder noted that most social service agencies are not purpose-built, but instead are created in repurposed spaces (such as warehouses). This means that the ways in which the physical spaces are designed may not be optimal for implementing infection control strategies. In relation to this issue, one stakeholder noted that "Anytime you have a congregate setting it's easier to spread anything. This is the case with drop-ins and shelters. Ideally you should have smaller groups, more rooms, more bathrooms – that would be better and reduce transmissions between groups."

Fortunately, as many social service providers noted, very few homeless individuals actually became infected with H1N1 during the outbreak. As a result, the majority of agencies did have enough physical space to enable them to isolate clients and keep them away from congregate areas. However, there was a common belief that if the pandemic had become considerably worse, most agencies would not have been able to quarantine large numbers of clients. Among the most commonly noted spatial challenges were small quarantine rooms and/or the need for more quarantine rooms, inconvenient room locations (such as on higher-level floors, which ill clients had to climb stairs to access), being in public buildings where entry / access is not controlled, shared ventilation throughout the building, shared sleeping accommodations (and the use of bunk beds), being at full shelter capacity, not having access to a negative pressure chamber, and not having rooms for screening potentially infected clients. Because very few social service agencies are purpose-built, they experience a range of infection control challenges related to the physical spaces they occupy.

In addition to an agency's physical design, its size is often an important factor in how well it can address infection control needs. One stakeholder noted that the size is a critical factor that plays a large role in determining what can be done. For instance, smaller agencies may have less resources to address an outbreak, but may only experience one rapid occurrence in which everyone becomes ill at the same time. Larger agencies, in contrast, may have more resources but often have to deal with prolonged cycles of infection. This larger agency issue was comparable to hospital settings, according to one key stakeholder, where even the best guidelines cannot necessarily stop the spread of a fast moving virus.

One effective way that shelters and drop-in centres can reduce disease transmission in congregate settings is through the use of air purification systems. Following a large outbreak of tuberculosis in Toronto's shelters, officials from Shelter, Support and Housing hired environmental consultants to examine each city-operated shelter against the infection control guidelines they had previously established (in collaboration with Toronto Public Health). Subsequently, each shelter was given a report detailing their agency's adherence to these guidelines, as well as a set of recommendations for improving public health conditions. At the time of this study, not every shelter had adopted the recommendations and one key stakeholder noted that officials from Shelter, Support and Housing were monitoring the requests for funding related to air purification. With enough resources, shelters and drop-in centres could install ultraviolet germicidal irradiation (UVGI) air purification technology. This approach, according to one stakeholder, is considered the "Cadillac response to air purification," and would greatly decrease the transmission of airborne diseases in service agencies.

During the outbreak, one of the largest challenges many agencies faced was trying to provide health care, without being health care mandated. According to one stakeholder, the most important issue was asking agencies whether they were able to care for someone who was ill. Reportedly, this question was important because there was an undue expectation that shelters and drop-in centres could provide health care, even though many did not have the training and resources needed to operate as health care providers. Further, while the staff were expected to perform personal health and public health duties, they had to uphold their regular responsibilities as well. To address the gap in expectations and abilities to care for the infected, a few agencies expressed the need for a centrally located homeless sector infirmary that could care for infected clients (thus removing the burden for on-site care at each individual agency).

This solution, however, poses many logistical barriers. For instance, it was not clear which agencies (if any) would want to house infected clients, how health care and cleaning staff would be assigned, and where the resources would be obtained in such a short period of time. The most commonly proposed idea was to nominate Sherbourne Health Centre as the designed H1N1 homeless centre. According to one key stakeholder, "Sherbourne Infirmary should be beefed up. They have to have the capacity to take on more, help congregate setting issues for people who are sick. They don't have isolation rooms, though they need that sort of capacity. It gets back to the issue of congregate settings. We need more infirmary type places, but we need more isolation. If someone gets chicken pox, there is nowhere to isolate them. That role could be beefed up in the sector. It would definitely get used."

The current sector response often struggles to incorporate sound public health measures, given the limitations of congregate settings, repurposed buildings, limited physical spaces, lack of funding for air purification, and expectations that are not in-line with staff training and/or organizational mandates. While there is no doubt that the homelessness sector needs to be built on a strong public health foundation, the best way to achieve this is not always clear. There is currently a disconnected relationship between the demands of public health and the demands of daily work in the homelessness sector. How can we reasonably expect social service workers to take on the additional responsibilities and demands of public health? The only way to achieve this is through the addition of resources, discretionary funding, and qualified health care workers. According to one stakeholder, "The whole issue regarding community infection control in the homelessness sector needs to be addressed, with explicit resources for that." Fortunately, this stakeholder continues, "We're getting there. We're trying for funding for a public health infection control position to work with community agencies – someone to draw on in an emergency, pre-existing infrastructure. We already do that with senior's homes, schools, etc. We need pre-existing infrastructure to carry this out, and the person responsible for infection control in the sector should have a direct line to high level people. That will happen."

Take-Away Messages

- During H1N1, homeless individuals continued to use shelters at a steady rate, but were less inclined to use drop-in centres than usual.
- Operational changes were observed within service agencies.
- As a whole, social service providers were well prepared to work through H1N1.
- Toronto Public Health communicated H1N1 information to agencies on an on-going basis.
- Homeless individuals did not rely on social service providers for H1N1 information.
- Social service agencies faced four main challenges in relation to H1N1 supplies (cost, demand / storage, consumption of hand sanitizer, and mask confusion).
- The strategy for vaccinating homeless persons was to hold outreach clinics in shelters and drop-in centres.
- Infection control was a priority for social service agencies.

LEARNING FROM H1N1

The experience of H1N1 provided many learning opportunities for the homelessness sector of Toronto. This section provides reflections on what was learned for future outbreaks, and particularly for pandemics that might be considerably more serious in nature.

WHAT DID THE HOMELESSNESS SECTOR LEARN ABOUT THEIR OWN PANDEMIC PREPAREDNESS FROM H1N1?

Overall the homelessness sector response to the H1N1 pandemic was well planned and prepared for. Yet, as with any emergency situation there is a considerable amount that can be learned. Within the context of H1N1 one of the biggest lessons was the value of pandemic planning itself. Thinking through some of the challenges that might arise, and identifying means of addressing them was seen as a beneficial exercise by social service providers and key stakeholders alike. Homeless persons were noticeably absent from the planning process, and although they had no comments on the subject in this study, their need to hold a place at the planning table is an important finding. There is considerable literature documenting the benefits of including marginalized individuals in pandemic planning (Appleyard, 2009; Blickstead & Shapcott, 2009; Blumenshine et al., 2008; Chen, Wilkinson, Richardson, & Waruszynski, 2009; Hutchins, Truman, Merlin, & Redd, 2009; John Hopkins Berman Institute of Bioethics, n.d.; Ng, 2009; Upshur et al., 2005; Uscher-Pines, Duggan, Garron, Karron, & Faden, 2007). The importance of including members of high-risk groups in the planning process is a valuable lesson for Toronto's homelessness sector.

In the aftermath of the H1N1 outbreak, social service providers and key stakeholders reflected on what was learned. According to many service providers, having flexible and accessible plans was the best way of managing the pandemic outbreak. They believed that every agency should have a plan for dealing with outbreaks, although it was recognized that limitations around funding, guidance / leadership, supplies, and expertise may arise (particularly for those in smaller agencies). The need for flexibility in planning was an important learning from H1N1 that stakeholders shared as well. In this regard, one stakeholder noted that agencies can make a plan, but that the plan

cannot possibly cover all instances and events that might emerge during an emergency. It is important that everyone involved in a pandemic response be prepared to adapt and respond in a way that is beyond what is written in the original planning document. As one stakeholder noted, "Until you're in an emergency, you really don't even know what information is going to be important."

There was some debate among key stakeholders on how early the homelessness sector should have been brought into the H1N1 pandemic planning. While one believed that the sector should have been engaged earlier than it was, another stated that earlier involvement would not have meant the response worked any better. In planning the response to H1N1, the City of Toronto closely followed the World Health Organization pandemic stages. One key stakeholder noted that as a key learning, in future pandemic outbreaks the city will aim to use an approach that is "more linked in to what is occurring locally." This local focus, the stakeholder noted, is particularly important for pandemics, which are determined geographically and not by severity. In preparing the homelessness sector for future pandemics, the stakeholders noted that they will continue to work closely with agencies and particularly to host role-playing meetings where service providers can engage in simulated pandemic scenarios and develop "muscle memory."

At the time this research was conducted, there had been no system-wide debriefing on H1N1 and the strengths and gaps in the homelessness sector response. However, many of the stakeholders noted that internal reviews had been conducted within city departments. Following H1N1, Shelter, Support and Housing conducted an internal meeting to discuss and evaluate their response. Accordingly, they talked about where the continuity plans failed, resourcing issues, and how to best adjust the plan moving forward. Prior to H1N1, planning within this department had been "mostly an academic exercise" that was completed once a year. As an outcome of H1N1, the department now has two internal pandemic planners who collaborate on a regular basis. Within Toronto Public Health, it was noted that following H1N1 responsibilities had been decentralized and that they did not have a co-ordinating position which could be enacted in an emergency situation (although two stakeholders believed a position of this nature

would be effective). It was suggested by a stakeholder that Toronto Public Health could greatly assist the homelessness sector if an official met with homeless agencies once a year to "check-in and refresh pandemic plans." In this regard, their guidance could be particularly beneficial for smaller agencies in advising how to best make use of limited financial and other resources.

Despite not having a sector-wide debriefing, many service agencies conducted their own internal reviews of their response. In relation to H1N1, nine of the fifteen agencies interviewed stated that they had reviewed their pandemic plan, and two of these had hired an external consultant to review their plan. Although some changes were made, no agency drastically overhauled their pandemic plan in the wake of H1N1. Primarily, agencies reviewed how well particular procedures worked during the outbreak and modified protocols as needed. The top priorities related to staffing issues, infection identification and control, quarantine, and closures if another outbreak were to happen. Many service providers also noted that trying to incorporate better overall health and safety procedures into their daily operations was an outcome of the pandemic reviews. Other outcomes that two service providers noted emerged out of their respective agency reviews included assigning one person to oversee all pandemic planning, and moving from a more general emergency plan to one that is pandemic-specific. Notably, upon reflection, one service provider stated that the role-playing which was a cornerstone of the Shelter, Support and Housing response was not thought to be as useful as having an organized and well thought out pandemic plan. According to this service provider, what each agency needed was the tools and the ability to understand how the agencies fit together within the sector, not scenario-based play.

HOW PREPARED IS THE HOMELESSNESS SECTOR FOR THE NEXT (POTENTIALLY MUCH WORSE) PANDEMIC?

H1N1 was commonly described as a "good practice run" by the key stakeholders. By this, they mean that it provided an opportunity to engage the homelessness sector in pandemic planning activities, without many negative consequences or harm. At the same time, one stakeholder noted that while the outbreak was an opportunity to engage the sector, it was also a challenge for stakeholders because it was not severe enough to require the enactment of emergency policies. If it had been far worse, the Medical Officer of Health could have evoked emergency procedures and taken over services. According to one stakeholder, "It would have been fairly horrific, but straightforward." As it was, H1N1 did not require these kinds of drastic measures challenging stakeholders to manage an 'in-between' situation, "where no doomsday hammer is needed."

The concern that emerged out of this relatively mild pandemic was that while agencies engaged in planning it may have lowered their level of alarm for future outbreaks. One stakeholder, in particular, worried that agencies and clients may see H1N1 as an example of 'crying wolf' because the infection rates were low, and that they may become blasé in the event of future outbreaks. How prepared is the homelessness sector to deal with future outbreaks? As a theoretical exercise, service providers, stakeholders, and homeless individuals were asked to think about how the pandemic response might have gone differently if H1N1 had been more severe. This question allowed participants to reflect on sector preparedness for future outbreaks, which may be considerably worse.

In interviews with stakeholders, service providers, and homeless individuals, five key issues were raised as potential challenges to future / much worse pandemic outbreaks. The first was the preparedness of the sector itself, and the ways organizations would work together if services had to be closed and/or amalgamated. Nearly every service provider stated that their own agency was prepared for a future outbreak, but they were

evenly divided on whether they thought the sector would be prepared. Co-ordination between agencies and leadership of the initiative were expressed as primary concerns. In one service provider's words, "In a crisis, someone has to drive the boat." Several providers were concerned that there would be no strong leader who would emerge to oversee the agencies' co-ordination and communication. This is slightly surprising, however, given that most felt Toronto Public Health did an excellent job of providing leadership during the H1N1 outbreak.

In the event of a future, more serious pandemic, the sense is that agencies would have to coordinate service provision to meet the needs of their clients. There was no consensus on how this would be organized, and at what point various services would be put on hold. Several service providers noted that they would contact Toronto Public Health for guidance on closures, with providers being divided on how severe the outbreak would have to be before they closed (a few stated they would not close under any circumstances). Faced with the possibility of agency closures, most providers stated that their clients would go to 'another agency' but provided no detail on which agencies these may be. Hospitals and clinics were the preferred referral places to send clients, but there was no solid plan of action (recall that many sector partnerships are informal in nature). This lack of formal partnerships is concerning in the event of an emergency situation, given that it may leave homeless individuals without consistent access to health care. When asked where they would get health care in the event of a serious pandemic outbreak, the most common response given by homeless participants was that they would go to their usual source (38.3%). Given that their usual source is to access the health services of shelters, drop-in centres, and community health centres, there needs to be a firm plan in place to address any service closures that may negatively impact the health of clients.

The second concern in the event of a future, more severe outbreak was the availability of staff. One third of the social service providers interviewed worried about what would happen if large numbers of their staff became infected and how it would impact service operation and delivery (particularly medical staff, residential staff, managers, food workers, and cleaning staff). These agencies did note that having these concerns meant they focused on putting plans in place to address the issue. For instance, many would call relief staff or shuffle positions within the agency. Some agencies reported that they would close non-essential services, to allow them to focus on health care and providing shelter. Yet other plans included turning food services into brown-bag lunches, borrowing staff

from another agency, phone triaging, and cancelling scheduled appointments to allow for emergency walk-ins. One service provider's agency had asked staff to fill out a form listing additional skills they possessed, so that they could call on people to take over positions in the event the regular staff member became ill.

The welfare of clients, particularly in the event of uncertain service provision, was the third concern raised in relation to future, more severe, pandemic preparedness. When homeless participants were asked about their plans in the event of a more severe outbreak, 45% stated they would still go to a drop-in centre or shelter. The reasons given were that they had no other options (38.3%), would not be concerned about becoming infected (12.1%), and need the services (8.7%). Of those who stated they would definitely not go to a shelter or drop-in centre during a severe outbreak, the reasons included a fear of getting sick (14.8%), not trusting the organization or their staff (8.7%), and wanting to avoid being around other homeless persons (1.3%). Instead, these individuals would spend time at a family member or friend's house (10.7%), outside in a public place, such as a park or street corner (9.4%), and inside a public place like a mall or library (6.7%). To meet their nutritional needs during a more severe outbreak, homeless individuals report that they would rely on a shelter or drop-in centre (15.4%), purchase it themselves (15.4%), or get it from friends / family (8.7%), a food bank (4.0%), outreach vans (2.7%), or by stealing it (1.3%). Because many homeless persons rely on social services to meet their daily needs in non-pandemic times, these services need to be available to them in emergency times. Arguably, they may be even more important in a crisis.

Providing services requires that agencies have the resources to maintain a high quality of standards. The fourth concern, in the event of a future / more serious outbreak, was the strain that would be put on already limited financial and spatial resources. All but four service providers had concerns about the physical design of their agencies, and how that would impact infection control measures (like isolation) in the event many clients became ill. The most commonly expressed concerns pertained to having small rooms, congregate settings, and a lack of control over how individuals moved through the buildings. Resources would be needed to reduce the spread of illness among the clients in these spaces. Given that acquiring and stockpiling supplies was a challenge for many agencies during H1N1, due to limited budgets and space, there was considerable concern raised among the service providers that this issue would continue – or be exponentially worse – in the event of a severe outbreak.

The final concern raised in relation to future pandemics was how effectively members of the homelessness sector would be able to coordinate with other institutions and bodies outside it. For instance, some service providers expressed concern that hospitals and EMS workers would be overloaded and that their clients would not be a top priority. According to one service provider, large institutions, like police services and hospitals, "don't do a great job at reaching out to smaller communities." As with relations within the sector, the networks and relationships that are built during non-emergency times would be those most likely to be sustained during a pandemic. Developing these relationships is a key way to support clients, within and beyond the homelessness sector.

Take-Away Messages

- Advanced, flexible, planning is key to being prepared for a pandemic.
- In the event of a future / more serious outbreak, five key challenges would need to be addressed (sector preparedness and co-ordination, availability of staff, welfare of the clients, further strains on already limited financial and spatial resources, and co-ordination with external bodies like hospitals and emergency services).

CONCLUSION AND RECOMMENDATIONS

The Toronto homelessness sector responded to the H1N1 pandemic with many identifiable strengths. The social service workers, policy-makers, and health care providers undertook the difficult task of managing a public health crisis, while recognizing the unique needs of their clients. Overall, very few individuals within the homelessness sector were infected with H1N1. However, despite the efforts of many who went above and beyond their regular duties, the experience of H1N1 also highlighted some flaws in the sector. Emergency preparedness depends on a solid base. The best way to ensure the homelessness sector will be ready to response to a future health crisis is to ensure its smooth operation in non-crisis times.

This study identified many key findings through interviews with stakeholders, social service provides, and homeless individuals. These findings point to two larger systemic issues. First, the homelessness sector in its current state is fragmented, due to under-funding and a lack of resources. Tangible supports are needed in order to build capacity and formalize networks and partnerships within the sector. The second issue that frames the key findings is the discrepancy between the homelessness sector and the health sector. While social service providers are expected to take on health care duties (often in addition to their existing roles), they are not necessarily given the training, resources, and supports needed to do so.

Reflecting on the H1N1 pandemic provides an opportunity to rethink and reframe the current approach to homelessness service provision in Toronto. What is needed is a more dynamic, inter-connected system that address public health concerns, and is supported through ample funding and resources. This is no simple task. In order to utilize the best facets of the existing system, combined with improved measures, a number of recommendations are put forth below.

THE HOMELESSNESS SECTOR NEEDS MORE RESOURCES AND DISCRETIONARY FUNDING

H1N1 highlighted many pre-existing gaps in the system. While there were many conversations between stakeholders and service providers during the outbreak, it was clear that H1N1 was not necessarily the most pressing concern. According to one stakeholder, "The people from the sector we did have contact with were concerned with many of the larger systemic issues. We had to tell them this is not about all those issues. [They would ask] 'When will it be about that?' [We would respond] 'It's not ours to fix.' And that's the dilemma." There are so many pressing concerns facing the homelessness sector and its clients that crisis becomes the normal state of operation. Funding and resources are needed to help members of the sector address the existing gaps, help meet the complex needs of their clients, and shore-up the sector so that it can function as an inter-connected and integrated system.

Study Findings:

- ***The homelessness sector in Toronto is under-funded and under-resourced.*** More than half the homeless respondents used shelters and nearly all of them used drop-in centres on a regular basis. Homeless individuals' reliance on these services – for food, shelter, and support – creates perpetually high capacity and a heavy demand for service.
- ***Homeless individuals in Toronto are nutritionally vulnerable.*** Despite primarily depending on drop-in centres and shelters for food, many participants also reported getting food from dangerous sources, like strangers and garbage bins. On average only one-quarter of the homeless participants were able to eat breakfast, lunch, and dinner on a daily basis. More than half did not have daily access to fresh drinking water.
- ***Homeless persons experience complex physical and mental health challenges.*** Homeless participants stated they were in good health overall, but also reported a range of health issues. Nearly half considered themselves to have a disability, which primarily involved mental health challenges, like depression and anxiety. Homelessness was an emotional experience, and many individuals reported low motivation and/or high rates of substance use.

Recommendations:

1. ***More funding is needed for shelters and drop-in centres to cover the costs associated with operations, supplies, and staff salaries.*** At least part of these funds should be made available for Executive Directors to use at their own discretion (as opposed to being earmarked for specific expenses or initiatives).

2. ***Funding and resources are needed to meet the nutritional needs of homeless individuals.*** Policy-makers should prioritize the nutrition of homeless persons, by providing and/or supporting the funding of meal programs and the installation of fresh water fountains throughout the city. Social service providers should advocate for flexible meal programs that include outreach services, take-away options (such as recyclable food containers), and extended hours.

3. ***Funding and resources are needed to meet the physical health, mental health, and disability related needs of homeless individuals.*** Addressing the complex physical and mental health needs of homeless individuals often requires sustained engagement by teams of social workers and health care professionals. Policy-makers need to prioritize funding and/or service initiatives that support long-term approaches. Keeping homeless individuals connected to health care professionals is essential, given these are the people they trust, and listen to, in a pandemic situation.

THE HOMELESSNESS SECTOR NEEDS TO SYSTEMICALLY INTEGRATE ITS HEALTH SERVICES

The health needs of homeless individuals are often quite complex, yet they often resist accessing mainstream health care. Instead, many homeless persons rely on the health services that are available within the homelessness sector. As this research clearly showed, there are large discrepancies between the homelessness and health sectors. At present, the capacity to meet the health needs of clients is often strained and reliant on outreach and informal networks. Ensuring that homeless individuals receive the best health care possible requires a more systemically-integrated approach to health service provision. The networks that are put in place during non-emergency times are the ones that are most likely to be sustained and enacted during a crisis.

Study Findings:

- ***Access to health care is a concerning issue for homeless persons.*** Only slightly more than half of the homeless participants had a regular health care practitioner, and many had concerns over how they were treated by mainstream health care facilities (like hospitals). Homeless persons largely relied on the homelessness sector for health care, including onsite care at shelters and drop-in centres.
- ***Homelessness sector health care operates through networks and partnerships.*** Many social service agencies offer onsite health care, but often it is through the outreach services of another agency (such as a community health centre). Although some of these arrangements are formal partnerships, the sector also runs on informal networks of service workers who know one another and share a sense of responsibility for client health care.

Recommendations:

4. ***The health care needs of homeless individuals should be included in the curriculum of all medical / nursing education programs.*** Many homeless individuals report not accessing mainstream health care services due to stigmatization and a belief they will receive poor medical care. Including educational components on homelessness and the complex health needs they often experience could help reduce stigma and improve health service delivery for this population.

5. ***The homelessness sector should coordinate with medical / nursing programs to increase opportunities for practicums and placements within shelters and drop-in centres.*** The Inner City Health Associates are a group of physicians and health care practitioners who operate within the homelessness sector. Their expertise may be valuable for facilitating this connection between the homelessness sector and medical training programs.

6. ***Health services within the homelessness sector should be organized as an interconnected network of formal partnerships and coordinated service delivery.*** At present, many agencies rely on other agencies to provide health outreach, but the relationships are informally organized. A coordinated effort needs to be made between agency workers to formalize partnerships and organize health care delivery (such as hours of operation and services available) in a way that provides homeless individuals with a comprehensive and clear framework of care. The networks and partnerships that are developed in non-pandemic times are those most likely to be called upon for support in an emergency situation.

7. ***A new sector-wide position should be created to organize health service co-ordination across agencies.*** This position, funded through the City of Toronto, would work with shelters, drop-in centres, and community health centres. The key responsibilities of this position would be to liaise between service agencies, help formalize networks and partnerships, ensure agencies have health care supplies, and engage in on-going health training of agency staff.

PUBLIC HEALTH MUST BE A DAILY PART OF HOMELESSNESS SECTOR OPERATIONS

Pandemic preparedness is particularly challenging in the homelessness sector because many agencies are not optimally designed for public health. As many are non-purpose-built spaces, shelters and drop-in centres tend to be congregate settings in which clients are often in close proximity. As Ali (2010) has noted, the fragmented nature of the homelessness sector means that individuals regularly move through crowded, high stress, poorly ventilated agencies, which increases the risk of communicable disease transmission. Further, as homeless agencies are not within the health sector, they may lack the funding, resources, and knowledge needed to enact public health measures. Again, the best way to prepare for a pandemic is to make the response part of daily operations. Public health must be part of the daily operations of homelessness agencies, but additional resources and supports are needed to make this a reality.

Study Findings:

- ***Social service agencies are often congregate settings.*** Many homeless persons share bedrooms, sleep in close proximity to one another, and are often in touching distance of at least five other people at any given time. The congregate nature of these settings (combined with high demand) creates challenges to undertaking personal hygiene practices, like accessing bathing and laundry facilities.
- ***As a whole, social service providers were well prepared to work through H1N1.*** Prior to the outbreak, many agencies hosted on-site training for their employees pertaining to infection control strategies, infection screening, use of protective measures, quarantine protocols, and vaccinations. Staff expressed some concerns, primarily related to client welfare and staffing issues. The little resistance from staff (primarily related to the vaccine and its potential side-effects) was addressed through open-door policies.

Recommendations:

8. ***Homeless individuals require increased access to hygiene facilities, like laundering and bathing spaces, both inside and outside social service agencies.*** Lacking the ability to bathe and clean one's clothing on a regular basis is a public health concern that must be addressed. Funding is needed to allow shelters and drop-in centres to purchase and operate more laundering machines. Additionally, government allowances could be increased to allow recipients to more easily afford and access public laundry facilities.

9. ***Hygiene practices that increased during H1N1, such as hand-washing and disinfecting shared agency spaces, should continue to be enacted in non-emergency times.*** Public health measures like these are an important method for decreasing the spread of infectious diseases. Agency staff are advised to continue to implement these strategies and encourage them among their clients.

10. ***New social service agencies should be purpose-built with public health considerations in mind.*** At present, many agencies face challenges because of the physical design of their buildings (such as congregate spaces used for eating, bathing, and sleeping). Newly constructed agencies should consider the health risks associated with congregate living and build solutions, such as independent quarters, into their building designs (see Davis, 2004; Graham, Walsh, & Sandalack, 2008).

11. ***To help decrease the spread of communicable diseases, ultraviolet germicidal irradiation (UVGI) air purification systems should be installed in all shelters, drop-in centres, and community health centres.*** Where possible, special funding for these units should be made available through the City of Toronto (such as for city-operated shelters under the Shelter, Support and Housing budget).

12. ***On-going public health training is needed for all staff working within the homelessness sector.*** Prior to the H1N1 outbreak, the majority of staff members in the sector received educational training, through onsite sessions and/or city run workshops. This training proved to be an essential and effective part of the pandemic response. Carrying it through on a regular basis may improve the public health of homelessness agencies overall, strengthening the foundation of future pandemic preparedness.

13. ***A new sector-wide position should be created to coordinate public health initiatives within and between agencies.*** This position, funded through the City of Toronto under Toronto Public Health, would work with shelters, drop-in centres, and community health centres to ensure they meet public health standards, their staff are adequately trained in general public health measures, and that they have up-to-date pandemic plans. This position would work closely with the health co-ordinator (as recommended previously), to build upon sector partnerships and networks, for the purpose of public health promotion.

PANDEMIC PLANNING MUST REGULARLY OCCUR WITHIN AND BETWEEN HOMELESSNESS SECTOR AGENCIES

Given the constant state of emergency within the homelessness sector, pandemic planning may not be given top priority. However, when an emergency situation occurs it is crucial that a plan already be in place – an emergency is not the time to plan. Within the homelessness sector, a number of individuals need to be involved in the pandemic planning process, including policy-makers, social service workers, health care providers, and those with lived experience of homelessness. However, as with any system-wide initiative, politics plays a role in who is involved, which issues get taken-up, and who has decision-making authority. Pandemic planning exists within the context of these pre-existing political processes. This research found that in order for pandemic planning to be effective, it must be collaborative and open to change. For the purpose of pandemic preparedness in the homelessness sector, politics must be put aside.

Study Findings:

- ***Toronto Public Health took the lead role in co-ordinating the homelessness sector response to H1N1.*** As an established health authority within the city, they relied on pre-existing relationships with hospitals, other city departments, and health agencies. Other key stakeholders that emerged as H1N1 leaders were Shelter, Support, and Housing, and the Inner City Health Associates.
- ***Pandemic planning for homeless persons primarily followed the mainstream planning approach.*** Despite some special consideration for youth, pregnant women, and Aboriginal persons, homelessness was not considered to be a direct cause of being 'at-risk' during the pandemic. As a population, they received the same public health messages as the general public (such as to cover their mouths when coughing, wash their hands, and get the vaccine). Homeless persons were not consulted in sector planning initiatives.

- ***Most social service agencies had pandemic plans, but were unfamiliar with the city's plan.*** Although some plans were more developed than others, the majority of agencies had emergency and/or pandemic plans stemming from the SARS outbreak. These plans were often created through consultation with officials from Toronto Public Health.

- ***Advanced, flexible, planning is key to being prepared for a pandemic.*** Within the homelessness sector, in particular, having flexible and accessible plans were considered to be the best for meeting the complex needs of the clients during the outbreak. It was also recognized that on-going planning was needed, and that Toronto Public Health could assist by having yearly meetings with agencies to review and refresh existing plans.

- ***Pre-existing partnerships within the sector were a key source of pandemic planning support.*** Most agencies turned to their formal and informal partner agencies for guidance and advice on planning. Unfortunately, a general lack of funding meant that no concrete inter-agency plans of action were developed.

- ***Three main challenges emerged for the homelessness sector in relation to preparing for H1N1.*** These challenges included a lack of funding (in general and for H1N1 related expenses), strained capacity as social service providers had to take on health care related duties that went beyond their regular work expectations, and system fragmentation within the sector.

- ***In the event of a future / more serious outbreak, five key challenges would need to be addressed.*** These challenges, as identified by key stakeholders include: sector preparedness and co-ordination, the availability of staff, welfare of the clients, further strains on already limited financial and spatial resources, and co-ordination with external bodies like hospitals and emergency services.

Recommendations:

14. ***In the event of a pandemic, Toronto Public Health should be the recognized authority at the local level.*** During H1N1, Toronto Public Health took the lead role in organizing and facilitating the homelessness sector pandemic response. In the future, they need to continue to be strong and visible leaders of pandemic preparedness and response.

15. ***Pandemic planning for homeless individuals must involve persons with lived experience of homelessness, and take into consideration the unique challenges posed by homelessness.*** Planning for H1N1 primarily involved taking the mainstream approach and stretching it to include marginalized individuals. This strategy fails to recognize many of the realities of

homelessness that challenge effective pandemic planning and response (for instance, not having access to hygiene facilities, not having private places to convalesce, etc.). Including homeless persons in the planning exercises and planning from the standpoint of homelessness provides a better chance of identifying challenges and preparing for them.

16. ***Internal-agency pandemic planning should be a collaborative effort, but led by a designated public health staff member.*** Similarly to how certain staff members are designated as 'health and safety' contacts, one person should be made the 'public health' contact within each shelter, drop-in centre, and community health centre. This person would be responsible for working closely with the sector-wide public health co-ordinator (as previously recommended), to remain up-to-date on public health issues within their agency. This person would help with public health training, pandemic planning, and network building within their agency. These duties would need to be written into the staff member's job description to allow adequate time to undertake them.

17. ***Sector-wide pandemic planning should be an on-going and collaborative effort, facilitated through yearly meetings.*** The networks that are developed in non-emergency times are those most likely to be sustained in times of crisis. During the H1N1 outbreak, Toronto Public Health and Shelter, Support and Housing jointly hosted meetings for service providers to facilitate sector-wide information sharing and discussion. Holding similar meetings on an annual basis – including during non-pandemic times – would help agencies to develop and strengthen their existing networks, form new partnerships, and keep public health considerations at the forefront. The sector-wide public health co-ordinator (as previously recommended) could assist in facilitating these meetings and helping agencies to follow-through on any identified plans.

18. ***Designated funding needs to be made available to allow homelessness sector agencies to enact public health initiatives.*** During H1N1, many social service workers consulted with partner agencies for support and advice, but were unable to enact any concrete plans due to a lack of funding. The City of Toronto, under Toronto Public Health, could offer a funding program in which partner agencies could apply for small grants to fund specific public health initiatives.

PANDEMIC OUTBREAK REQUIRES A SYSTEMIC, INTEGRATED RESPONSE FROM THE HOMELESSNESS SECTOR

Pandemic preparedness requires an integrated sector-wide response. Moving forward, what is needed is a pandemic preparedness strategy that integrates social service agencies into one network, relying upon one another through formal partnerships. This kind of solidified response would be particularly beneficial for future pandemic outbreaks in which infection rates are high. Social service providers in this study expressed concerns such as, "someone could die because this [agency] is not a hospital" and "We do our best…What do you do with someone who is sick and disappears?" Formalizing and integrating a system-wide approach that goes above and beyond individual agencies is a necessary step in strengthening the collective response and reducing existing gaps.

Study Findings:

- ***During H1N1, homeless individuals continued to use shelters at a steady rate, but were less inclined to use drop-in centres than usual.*** It should be noted that while there was a decline in drop-in centre usage, more individuals still reported going to drop-in centres than to shelters.
- ***Operational changes were observed within service agencies.*** Notably, there were some improvements, in relation to pandemic planning, higher levels of cleanliness, and enhanced communication between staff and clients. However, there were also some challenges. Staff members at many agencies had to undertake additional tasks without a reduction of existing duties, many services and programs were changed or adapted to accommodate H1N1, and some staff members were unable to undertake their regular duties due to illness.

- ***Social service agencies faced four main challenges in relation to H1N1 supplies.*** First, the cost of supplies was an issue as many agencies had to redistribute their existing budgets to pay for them. Second, the demand for supplies combined with the general lack of storage space meant that many agencies were perpetually running low – or completely out – of supplies. Third, some agencies had concerns that clients would drink the hand sanitizers, due to the alcohol, and had to supervise its use. Finally, in the initial stages there was confusion over the kinds of masks that were needed and the number that needed to be ordered to meet demand.

- ***The strategy for vaccinating homeless persons was to hold outreach clinics in shelters and drop-in centres.*** Toronto Public Health ran a number of vaccine clinics in partnership with social service agencies. The uptake by homeless clients, according to social service providers, was considered to be considerably high (with estimates ranging from 50-60%), but key stakeholders felt it was lower than desired due to agency relations, staff resistance, poor inter-governmental communication, distrust of health care providers, and the mobility of homeless persons. Nearly every homeless participant knew there was a vaccine, but a quarter did not know about the on-site clinics. Of the homeless individuals in this study, 36.9% were immunized.

- ***Infection control was a priority for social service agencies.*** Nearly every agency had a plan for infection control, although some were more detailed than others. The most common approaches included screening for signs of illness, attempting to isolate infected clients, using protective coverings, and providing onsite medical treatment where possible. Some challenges that emerged for agencies in implementing infection control strategies included that they are often congregate settings, they are generally not purpose-built as social service agencies (or with public health in mind), and many are impeded by small size and/or a lack of resources.

Recommendations:

19. ***In the event of a pandemic, declining drop-in centre usage rates would need to be offset by increased outreach initiatives.*** Many homeless individuals rely on social service agencies – and particularly drop-in centres – to meet their basic needs, yet during the H1N1 pandemic usage rates declined. This decline in service access would mean individuals were not receiving the same level of support, which is particularly concerning during a health crisis. Additional funding would need to be made available to allow for the purchase of resources that could be distributed outside individual agencies (such as food / food containers, warm clothing, sleeping bags, toiletries, and first aid supplies). A coordinated, sector-wide approach (facilitated by the recommended health co-ordinator position) could allow agencies to organize a collective response and decrease service duplication.

20. ***Flexible staffing plans may be needed in a pandemic situation, to facilitate the transfer of duties between staff members, and the reduction of regular work expectations.*** During a pandemic, it is a real possibility that staff members may become infected and be unable to undertake their regular work duties. Agencies would benefit from flexible staffing plans that permit individuals to work from home, transfer duties between staff members, transfer staff between agencies, and reduce existing duties to allow for more pressing ones related to pandemic outbreak. Recommendations for facilitating staffing flexibility include making a list of required positions (such as food service, cleaning, health care, management), and having staff members fill out a form identifying their skills (including those beyond their current role).

21. ***The homelessness sector should develop a communal stockpile of pandemic supplies, to be rationed between agencies, determined by factors such as agency size, client need, and type of facility.*** This communal stockpile would be funded through a number of sources, such as individual agency budgets (on a sliding scale), Toronto Public Health, and the Ministry of Health and Long-Term Care. Logistical issues would need to be addressed, such as finding a warehouse or space where supplies could be held, formalizing policies for supply distribution, and organizing delivery of supplies. It is suggested that this communal stockpile could be facilitated by the proposed sector-wide public health and health co-ordinators.

22. ***Alcohol-based hand wipes could be distributed to homeless individuals instead of liquid sanitizer, to reduce consumption.*** Hand-washing and sanitizing were encouraged during H1N1 to reduce the spread of disease. However, some agencies reported that difficulties arose as some clients tried to drink the alcohol-based hand sanitizing liquids. To address this, individual alcohol-based wipes could be distributed to clients instead.

23. ***Outreach vaccination clinics should be held in shelters and drop-in centres for seasonal influenza as well as for pandemic outbreaks.*** The immunization strategy enacted by Toronto Public Health was generally considered to be an effective method of reaching homeless individuals. Many of the difficulties that arose could be addressed by hosting yearly vaccine clinics in shelters and drop-in centres. While Toronto Public Health already does this, it needs to extend its reach to a broader range of agencies (including youth-focused ones) so that vaccine clinics become a regular part of homelessness sector health services. Operating a larger number of yearly clinics would make them more visible (i.e. known) to clients, and would help facilitate smoother operations during emergency, pandemic outbreaks.

24. ***A health-based agency should be designated as the homelessness sector infirmary in the event of a pandemic outbreak.*** Although H1N1 was relatively mild, one of the primary concerns expressed by social service providers was how individual agencies would have managed infection control, had multiple clients become infected. Housing ill clients in one, well-equipped agency, would reduce the burden on non-health based agencies to provide care. It is recommended that the designated infirmary be centrally located and have their own means of transporting infected clients (such as a vehicle) so that they are not exposed to the general public. Health care staff could be brought in from other agencies within the sector, with incentives such as additional vacation days for working in the infirmary.

PANDEMIC COMMUNICATION WITHIN THE HOMELESSNESS SECTOR MUST INVOLVE MULTIPLE APPROACHES AND THE USE OF CLEAR LANGUAGE

Clear and consistent communication is essential for implementing and managing an effective pandemic response. In a crisis situation, messages often need to be transmitted quickly, and to a broad audience. However, multiple sources and/or conflicting information may make it difficult to know whom to trust and which information to believe. Ensuring that the most current and reputable information gets across is a challenging issue, and this research showed that during H1N1, pandemic information travelled through many channels. Learning from the experience of H1N1, future pandemic outbreaks require a strategy that uses multiple mediums but comes from one clear authority, like Toronto Public Health.

Study Findings:

- ***Toronto Public Health communicated H1N1 information to agencies on an on-going basis.*** The communication strategy included posting information on their website, hosting sector-wide meetings, making a health professional available for questions, and holding a weekly open phone call for updates). This response had several strengths – it reached a broad audience of social service providers, established Toronto Public Health as the H1N1 authority, and allowed them to work closely with stakeholders. However, it also had several challenges – there was not enough time or resources to do one-on-one visits, the phone calls were underutilized, and they were unable to use social media.
- ***Homeless individuals did not rely on social service providers for H1N1 information.*** Within social service agencies, information was distributed to clients through a variety of methods, such as posters, verbal communication, and information sessions. However, homeless individuals reported that health care professionals and the media were their best source of information (with social service providers being considerably lower on the list).

Recommendations:

25. ***Toronto Public Health should communicate pandemic related information to the homelessness sector using clear-language and a variety of mediums.*** The communication strategy utilized during H1N1 involved a number of methods (like meetings, phone calls, and the internet), and was generally believed to be successful. However, one criticism that arose was the under-utilization of the weekly phone call sessions. Toronto Public Health could help broaden the reach by recording these weekly calls and making them freely available through their website as podcasts.

26. ***To reach a broad audience and facilitate the rapid transmission of information, Toronto Public Health officials should utilize social media tools like Twitter and Facebook.*** Additionally, social service agencies should remove restrictions on the use of social media during pandemics, to allow staff to receive timely public health updates.

27. ***Toronto Public Health should meet with homeless individuals directly, to discuss pandemic related issues.*** This research found that homeless individuals do not turn to social service providers as a primary source of information, which was problematic given that part of Toronto Public Health's strategy was to have information filter from social service workers to their clients. In future pandemics, homeless persons may be better served by having a direct link to public health officials, such as through a general meeting or rotating presentations.

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