

5 PANDEMIC PREPAREDNESS IN THE CONTEXT OF HOMELESSNESS IN REGINA, SASKATCHEWAN: THE CASE OF SMALL, ISOLATED URBAN CENTRES

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Introduction

As homelessness in Canada worsens, it is essential to ask what kind of impact an influenza pandemic might have on the homeless population and urban communities across the country. Estimates suggest that at least 200,000 individuals use homeless shelters annually across Canada (Gaetz, Donaldson, Richter, & Gulliver, 2013; Gaetz, Gulliver, & Richter, 2014). Canada's homelessness response system has historically been focused on emergency response, much of which is characterized by dangerously overcrowded sleeping conditions, poor air quality and residents being forced onto the streets during daylight hours. Homeless people typically suffer from poor health, nutritional vulnerability, compromised immune systems and barriers to accessing health services (Frankish et al., 2005). In the event of a pandemic, it is not clear whether the infrastructures to address homelessness, Public Health departments, or the health care system in general, will be prepared to adequately respond to the risks faced by the homeless population.

The purpose of the research described in this chapter was to better understand the ways in which the current emergency response to homelessness in cities across Canada would affect the vulnerability of this population in the event of an influenza pandemic. A majority of research has focused on experiences in larger urban centres and communities in dense networks of urban centres (e.g., the dense network of urban regions in southern Ontario). The case study presented in this chapter focuses on homelessness and pandemic preparedness in a small and relatively isolated city, specifically, Regina, Saskatchewan. The goal of this research was to identify the experiences and challenges of pandemic planning in the context of homelessness in smaller and more isolated urban areas, as well as suggestions for improved responses in the case of future pandemics.

We used Grounded Theory techniques and methods for data analysis (Corbin & Strauss, 1998) to explore the experiences of Regina's homelessness service sector in addressing the unique needs of homeless people during the H1N1 outbreak and the challenges of planning for a future pandemic. Themes that emerged from the data analysis formed a framework for understanding the status of pandemic preparedness in the context of homelessness in the city of Regina. Findings provided a preliminary assessment of institutional vulnerabilities in the homelessness sector and suggestions for improved effectiveness of pandemic preparedness planning.

Community Context and the Homelessness Sector in Regina

Regina is the capital of Saskatchewan and the second largest city in the province. The closest urban centres are Saskatoon (259 km) and Winnipeg, Manitoba (828 km), making the city relatively isolated in comparison to the dense urban networks surrounding larger Canadian cities. Several other small Canadian cities (e.g., Thunder Bay, Ontario, Brandon, Manitoba, Sault Ste. Marie, Ontario and Saskatoon, Saskatchewan) share similar experiences in terms of isolation from urban networks and larger urban centres. According to the 2011 national census, 193,100 people resided in the Regina Census Metropolitan Area (Statistics Canada, 2012a). This represented an 8% increase in population from the 2006 census. Most residents (69.2%) fell within the age range of 15 to 64; 17.6% of residents were under 15 years of age and 13.1% were over the age of 64. The 2011 census indicated that 9.5% of Regina's population self-identified as Indigenous (Aboriginal), compared to a national rate of 4.3% (Statistics Canada, 2012b; 2012c). On the other hand, only 10.5% of Regina residents self-identified as immigrants, while the rate was 20.6% nationally (Statistics Canada, 2012b; 2012c).

In 2006, there were 79,615 private households in Regina (Statistics Canada, 2012a). The home ownership rate (71.2%) was higher than the national average of 69% (Statistics Canada, 2012c). While housing was ranked as more affordable than the national average, the city had the second-highest rate of housing in need of major repair.

There is little published peer-reviewed literature on homelessness in Regina, although a few reports and articles provide some preliminary information on the nature of homelessness and related service provision in the city (Schiff 2010; Goulden, 2009; Greenberg, Schiff, & Howett, 2010a; 2010b; Greenberg, Salm, Spooner, & Schiff, 2009). The central area of Regina — primarily the neighbourhoods referred to as ‘North Central,’ ‘Core’ (or ‘Heritage’) and ‘Transition’ — house the majority of non-profit- and government-delivered social and health services. Health services are delivered through the Regina Qu’Appelle Health Region (RQHR), which serves a total of approximately 260,000 residents of southern Saskatchewan. The City of Regina delivers police and fire services, while the province provides a variety of income, employment and housing assistance programs, primarily through the Ministry of Social Services.

In 2011, five organizations provided most of the social (rent supplemented) housing in the city. Seven organizations provide supportive housing units, including one organization that provides long-term supportive housing and psycho-social rehabilitation services for over 100 individuals with mental health and developmental disabilities. There were five general emergency shelters for adults and three emergency shelters specifically for women escaping violence (victims of domestic violence, or VDV). Five shelters provided longer-term transitional accommodation for adults and two provide transitional VDV housing. Three organizations provided the majority of emergency and transitional shelter for homeless people although numerous other smaller organizations also provide shelter and supports. Of the three larger organizations, one serves only men, one serves only women, and the other serves both men and women. These shelter-providers also provided other services such as soup kitchens and emergency goods and services. There were also five shelters for homeless youth (0-17 years of age).

In 2010, there were approximately 323 shelter beds in Regina, of which 169 were emergency and 112 were transitional beds for adults (Greenberg, Schiff, & Howett, 2010). A number of non-shelter service providers also provided goods and services assistance to homeless people. A few of these organizations also housed health and social services delivered by, or on behalf of, the province and RQHR.

Methods¹

Semi-structured interviews were conducted between January and July 2011 with four Executive Directors or Program Managers who worked for homelessness service providers in Regina, including two emergency shelters and two non-shelter emergency service providers. Organizations were selected to represent the diversity of shelter and service types and populations served. The agencies that participated in this research study varied in size, number of clients and services offered to the homeless population in Regina, thus providing a diverse sample of agencies to participate in this research. Table 1 summarizes key characteristics of participant agencies.

Category/ participant	Shelter 1	Non- Shelter 1	Shelter 2	Non-Shelter 2
Position	Executive Director	Executive Director	Executive Director	Executive Director
Time in organization	1.5 years	2 years	14 years	1.5 years
Services provided	Emergency and supportive residential living	Advocacy, basic help with poverty issues	Emergency housing, supportive living, social programs	Crisis intervention
Number of clients/day	130	200-300	700	50
Health services?	Yes	Yes	No	No
Partnership with other agencies	Yes	Yes	No	No
Target populations	Males over 16 with chronic housing problems (homeless) only	Males over 16 with chronic housing problems (homeless) only	Women, children youth, families (other issues, not just homelessness)	Regina and surrounding areas

Table 1: Characteristics of Participants

¹ An overview of the project methodology can be found in the introductory chapter of this book. Findings from other cities, and comparisons, can be found in other chapters within this book.

The profile of participating agencies included two with the mission of providing residential housing, one that advocated and helped with poverty issues, and one that focused on crisis intervention. Two of the agencies offered health services to clients. Only two had developed any type of formal partnership with other agencies. In terms of size, one agency provided services for more than 300 clients per day, two agencies served between 100 and 300 clients, and one served about 50 clients per day. This variety of participating agencies allowed for exploration of pandemic experiences from diverse planning perspectives.

Interviews were conducted in person using a semi-structured open-ended interview guide, and each interview lasted about an hour. Participants were asked about their organization's experiences with pandemic planning and preparedness, challenges faced during the H1N1 crisis, and lessons learned for future events. This study was approved by the University of Regina Research Ethics Board.

Findings: Identification of Common Themes

Analysis identified five themes in experiences with pandemic planning and preparedness: experiences with pandemic planning; implementation of planning during the H1N1 outbreak; vaccination planning; working with other agencies and service providers; and communication with clients and health authorities. Participants also discussed lessons learned that could be applied to future pandemic events.

Experiences with pandemic planning

Based on responses, pandemic planning by homelessness service providers in Regina depended on the size of the agency and the availability of resources to dedicate to planning for general emergency responses. After the SARS experience, some plans and/or internal controls were put into place at one of the agencies that participated in our interviews, and these were adapted to the H1N1 experience. However, only two of the agencies reported having a pandemic plan in place before H1N1, and described their agency's response as reactive. None of the participants made reference to

having pandemic plans that specifically fit the H1N1 crisis. Two of the larger agencies that offered housing services to the homeless population had a type of pandemic plan before the H1N1 crisis. One of these agencies reported having a communicable disease mitigation plan, and the other reported having emergency internal protocols and plans related to the SARS crisis.

Due to a lack of plans specific to pandemic events, agencies relied on internal protocols for maintaining critical operations as their immediate response to the H1N1 outbreak. According to study participants, responding to H1N1 was often reactive, as there were inadequate or no plans in place before the pandemic. In the case of bigger agencies, existing plans dealt with general emergency responses. Agencies with existing plans used them as a starting point to develop specific responses to H1N1. For instance, agencies referred to the existence of internal protocols, such as scaling back to critical services, calling in on-call staff, or moving non-critical staff into a main building to support residence operations when human resources were limited due to staff sickness. One participant mentioned the importance of ensuring that someone was available to answer the phone to assist with clients' concerns related to H1N1.

The H1N1 outbreak was also seen as an opportunity for agencies to review plans and internal protocols already in place, and complement or modify them based on the recent experience with H1N1. Although the H1N1 crisis was not considered a severe outbreak in Regina, it gave agencies an opportunity to revise emergency strategies and to determine their agency's capacity to respond to a pandemic. In some cases, new plans were created; in others, a continuity plan was added as part of an existing communicable disease or mitigation plan. One agency adapted its general influenza and communicable disease protocol for the H1N1 situation. Another of the larger agencies created a pandemic planning committee to develop new policies and procedures. They expanded their existing plan into the agency's business continuity plan, and it included not only an immediate response to a pandemic, but also strategies to respond to the crisis and deal with media. This agency updated its overall sanitation and universal precautions, targeting priority areas, such as daycare spaces that could be easily contaminated. Only one agency did not implement any changes after the H1N1 experience.

A final concern regarding preparedness involved participants' lack of knowledge of the City of Regina's pandemic plan: none of the participants had knowledge of that plan. This demonstrated a concerning disconnection between the homelessness sector and other agencies involved in emergency response in the city. There was little to no consultation with homelessness service providers in the development of the City of Regina's Pandemic Plan. This also leads to concerns regarding the city's lack of recognition of people experiencing homelessness as a vulnerable population.

Implementation of planning during the H1N1 outbreak

The H1N1 event was not seen to have affected normal operations. Although there were certain concerns among staff about normal operations during the influenza pandemic, none of the participants mentioned any direct impact of H1N1 on their organizations' functions. Despite this, there was concern regarding staff preparedness, availability and training in the event of a severe pandemic event. Participants also indicated concerns about procedures for working with clients during pandemic events.

Staff preparedness, availability and training

According to participants, special measures were not taken to train staff members during the H1N1 outbreak. Two agencies did not provide staff with any resources or information on H1N1. One agency provided staff with written materials on universal precautions and reminders. The other provided general reminders on influenza and communicable disease control protocols. Training specific to H1N1 was nonexistent.

During H1N1, participants were concerned about limitations on their capacity to provide adequate services during an outbreak. For instance, one of the participants mentioned their agency's main concern was the capacity to sustain critical operations, such as maintaining shelter operations. Other participants were concerned about the lack of support from health authorities around preventive measures and responses to the pandemic. An agency with an on-site vaccination clinic was provided with hand sanitizers from RQHR, but the other three agencies were not provided with supplies, and did not feel they would have had adequate resources if the severity of the pandemic had increased. Staff at an agency that provided housing had prevention and

sanitation concerns and worried about contamination of program areas used by children. There were also ongoing concerns about lack of support from RQHR. A final concern related to clients who did not heed the universal precautionary advice, and the potential for those clients to increase the risk to other clients of contracting H1N1.

Working with clients

Staff at agencies with residences encouraged clients to take universal precautions to try to inhibit the spread of the H1N1 virus. Clients were advised to avoid being around people with symptoms of H1N1, remain attentive to personal hygiene and cleanliness, and maintain good nutrition. Some clients were concerned about whether other clients were infected with H1N1. Vaccination for clients was not mandatory at any of the agencies. Only two of four agencies identified high-risk clients who were especially vulnerable during the H1N1 outbreak. These agencies offered more encouragement for vaccination to high-risk clients by telling these clients about the risks associated with their vulnerabilities and providing transportation to vaccine sites in the city or offering on-site vaccination.

One of the larger agencies with a residence communicated through word of mouth with clients. Another of the larger agencies with a residence displayed information posters on self-care during the H1N1 crisis. One of the smaller agencies used word of mouth to communicate with clients and advertised when they would be holding an on-site vaccination clinic. Agencies without residences were not as engaged with clients around H1N1 prevention, self-care and precautionary measures to avoid contracting H1N1. This may have been because they did not have residential programs. The only on-site vaccination clinic was held at one of the smaller centres.

The agencies did not have a protocol to identify clients who exhibited symptoms of H1N1. At two of the larger centres, clients proven to have H1N1 were asked to withdraw from the agency's services and seek medical help. If residents were diagnosed with H1N1, they were quarantined to inhibit spread of the virus. There was no specific plan that outlined a protocol to follow; instead, these agencies made reactive decisions. At one of the smaller agencies, it was reported that staff followed "normal procedures

of caring for ill clients.” The other small agency did not have any procedures for identifying infected clients; however, this was also the only agency to offer on-site vaccination.

Vaccination planning

Several strategies were introduced in centres across Regina to enable clients to be vaccinated. These included bringing the service to the clients by offering an H1N1 vaccination clinic on-site and providing transportation to a vaccination clinic.

On-site clinics were offered by RQHR. Transportation was offered by agency staff or by RQHR. Participants believed this process was effective in reaching high-risk clients, helped control the epidemic and was an effective way of communicating information about H1N1 to clients.

All agencies disseminated information on locations and duration of vaccination clinics. Only one agency reported having an on-site clinic for two half-day sessions. This agency was a drop-in centre that dealt with people affected by poverty, not specifically homeless people, although the majority of their clients experienced absolute or hidden homelessness. The agency reported that if another pandemic were to occur, they would offer the clinic for a longer time period, as they estimated that less than 10% of their clients were vaccinated.

Agencies did not keep track of clients who were vaccinated. Participants estimated that between 40% and 50% of their clients had been vaccinated. One of the larger centres, which had a residence, reported having a history of collaborating with RQHR to offer on-site influenza vaccination. However, during the year of the H1N1 outbreak, RQHR removed the on-site vaccination program from this agency. This agency reported the percentage of vaccinated clients would have been higher if the service had still been offered on-site.

Working with other agencies and service providers

Three of the four participants identified provincial government ministry support as integral to the development of pandemic planning for their

agencies. In most cases, agencies reported that provincial ministries had provided the tools necessary to design and develop effective pandemic plans. One participant said that the provincial government made guidelines available on site. Ministries provided templates to develop a continuity plan and were identified as a source of knowledge for agencies. One participant felt these guidelines allowed their agency to consider issues, not addressed prior to H1N1, that were useful in developing a pandemic plan.

Participants indicated that during the H1N1 outbreak, their agencies networked with other agencies and vaccination clinics in the city. Two agencies reported challenges in dealing with other agencies. One agency faced challenges with: 1) hospitals, which asked the agency not to send clients to the hospital if they had influenza, 2) walk-in clinics, which were reported to have specific antisocial and restrictive requirements for who was welcome, and 3) regional health authorities, which overreacted about the severity of the pandemic. The second agency that identified challenges with other agencies reported difficulty maintaining working relationships with the public health sector and the regional health authority.

Although participants did identify the existence of networks among agencies in the city, they also identified challenges in maintaining these networks and reported that there were no formal networks in place for addressing H1N1 cases. At the time of the H1N1 outbreak, participants were not aware of any city-wide pandemic planning committees. One of the agencies put an internal planning committee in place during H1N1, but because there were no other committees, they could not collaborate outside of their agency.

Communication with Clients and Health Authorities

Communication with provincial and health authorities

Participants said that their main sources of information and news came from RQHR, the internet and other media sources, and nursing staff if they were employed as regular staff or for vaccination clinics at the agencies. Most participants said that agencies rarely received H1N1 updates from local health authorities. One agency said they received updates monthly.

Agencies did hear about vaccination clinics from RQHR while they were being offered in the city. Participants said that agency staff were informed of updates when available through newsletters, word of mouth, or through RQHR's pandemic committee.

Participants felt they did not receive adequate information from provincial government ministries regarding H1N1, and therefore felt personally responsible for accessing information through clinics, general communication pathways with on-site nurses and community members, and media. Although most participants said they were able to access information through other sources related to H1N1, some participants thought this information was not sufficient to inform the design and development of a pandemic plan, indicating a need for more support from provincial government ministries' authorities and RQHR.

Protocol for communicating with clients

Participants said that agencies did not have a strict protocol about communicating with clients during H1N1, so information flowed through normal communication channels, such as word of mouth, over the telephone and in person. Program staff offered the most support to clients, as they had direct access to agency Executive Directors and Chairs. Agency staff offered advice on universal precautions associated with disease, such as staying away from infected individuals and maintaining hygiene. Staff also provided support and instruction on personal care, and made referrals to appropriate services.

Participants identified several communication challenges. In particular, they noted that some clients did not pay attention to universal precautions, while other clients felt 'paranoid' and lacked trust in health care professionals and agency staff. Participants indicated that this attitude was not out of the ordinary.

Lessons Learned

The data reveal important considerations for future pandemic planning to improve the capacity of Regina's homelessness service providers to respond to such events. Participants discussed a number of lessons learned during the H1N1 outbreak, as well as suggestions for future planning and pandemic preparedness. In particular, interviews revealed five thematic suggestions for improvement of pandemic planning in the city of Regina: improving the level of preparedness for a more serious pandemic; improving coordination in the homelessness sector; improving access to supplies; improving education and awareness; and addressing challenges in treatment and isolation of affected individuals.

Improving preparedness for a serious pandemic needs improvement

In general, participants felt insufficiently prepared for the H1N1 pandemic. In the event of a more severe pandemic, participants thought their agencies would be unable to predict the challenges they might face, which might cause them to resort to crisis-mode operations. Some of the larger centres felt they had enough resources to deal with a pandemic, but still had concerns about communications with the city and health authorities, and about their own inability to predict issues regarding health and the spread of disease among clients.

Improving coordination in the homelessness sector is necessary

Most participants felt there was a need for an improved pandemic-specific coordination and communication plan between the ministries and homelessness agencies and also among the city's homelessness agencies. It was suggested that larger homelessness agencies with more human resources could be the main coordinators for future pandemic planning. It was also suggested that the larger centers become quarantine and vaccination sites in the event of a future pandemic.

Agencies need better access to supplies

Participants felt that on-site vaccination clinics should have been offered for longer periods of time. They also suggested that on-site and off-site clinics could be made more accessible to clients. Participants identified a need for improved access to sanitation and other supplies from the health authority.

Improved education and awareness of pandemics

Participants raised the important point that clients at their agencies tended to interact frequently throughout the day, which could increase the spread of disease in the population. Participants thought clients were at especially high risk if they were using housing services with shared communal spaces, where cross-contamination was likely; this is an issue that has been noted in the literature regarding the dangers of congregate living in homeless shelters (Ali, 2010; Hwang, Kiss, Gundlapalli, Ho, & Leung, 2008; Sasaki, Kobayashi, & Agui, 2002). Participants suggested there should be improved communication and education for service providers, city staff and the provincial government ministries around the high risks of infection and cross-contamination among homeless individuals and at homelessness service provider locations. They also spoke about the need for improving client education and awareness initiatives around specific viruses and the spread of disease. It was suggested that education and awareness for clients should be incorporated into pandemic planning within the homelessness sector in Regina.

Challenges for treatment and isolation

A final concern focused on the challenges associated with the shelter model when dealing with pandemics. The nature of communal living areas and programs creates challenges in sanitation and increases the risk of disease transmission (Sasaki, Kobayashi, & Agui, 2002). Quarantine was another significant concern for shelter providers: participants indicated that there were inadequate facilities for quarantine of infected clients, creating a need to identify suitable options in the event of future pandemics. Previous research has also suggested that new shelter designs should take into account the challenges of communal living and the potential need for quarantine spaces (Davis, 2004; Graham, Walsh, & Sandalack, 2008).

Conclusion

Overall, our findings suggest that coordinated pandemic planning was limited to nonexistent in the homelessness sector in Regina at the time of this study. Interviews revealed a significant lack of communication between

RQHR and homelessness agencies. There was also a lack of communication about strategies to address pandemic crises among homelessness service providers in Regina.

The ability of agencies to respond to the H1N1 pandemic depended greatly on the size of the agency and the services it offered. Larger agencies had general protocols in place around communicable diseases. Smaller agencies did not have plans in place to deal with communicable diseases, and implemented their resources in the most effective manner possible as situations arose. All agencies felt their response to the H1N1 outbreak had been reactive, and there was a need for preventive measures for future outbreaks.

Homelessness agencies in Regina identified several major challenges in implementing consistent pandemic controls, including a lack of appropriate training for agency staff, limited human resources, a lack of communication and guidance from local health authorities, a lack of education and awareness of pandemic diseases in the homeless population, and uncoordinated and haphazard efforts between homelessness agencies. Participants expressed the concern that their agencies were unprepared for a more serious outbreak.

These findings suggest the need to develop a consistent planning strategy in the homelessness sector in Regina. In addition, the challenges participants identified speak to the need for greater coordination between health and social service authorities and service providers in developing a collaborative city plan. This plan must address the vulnerability of homeless people to communicable diseases, and should address high-risk groups, such as residents of children's, women's and drug-users' residences, as well as other shared living spaces.

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