1 THE WORST OF TIMES: THE CHALLENGES OF PANDEMIC PLANNING IN THE CONTEXT OF HOMELESSNESS

Stephen Gaetz & Kristy Buccieri

In the context of growing concerns about the seeming inevitability of an influenza pandemic, all levels of government in Canada, as well as a broad range of institutions, have been working to develop disaster management plans. The H1N1 pandemic of 2009–2010 put such plans to the test in many ways, as governments, institutions and community agencies had to respond, either through rolling out existing plans, or by developing ad hoc strategies. Homelessness presents a key challenge to effective pandemic preparedness because of homeless people's vulnerability to disease and their socially marginal status and, most significantly, because of the inherent weaknesses in a response to homelessness that relies mostly on the provision of emergency services and supports.

We know that at the best of times, the health of homeless people is compromised by situational factors (such as nutritional vulnerability and compromised immunity), structural factors (such as lack of income and inadequate housing), and pre-existing health conditions. Yet ultimately what underlies their vulnerability is not simply the characteristics and behaviours of the population. We need to consider the ways in which the infrastructure we have built to respond to homelessness — in particular, our reliance on emergency services that are often characterized by overcrowding, congregate living and resources inadequate to maintaining hygiene — organize the lives of people who are homeless to exacerbate this vulnerability and create the possibility of potential disaster in the event of a serious infectious disease outbreak. A key question to ask is whether we are prepared — or more to the point, is it possible to prepare — to adequately respond to the risks faced by the homeless population in the event of a serious pandemic?

This chapter engages with these questions by exploring how the homelessness service infrastructure creates vulnerabilities that may jeopardize the health and well-being of homeless people and their communities in the event of a serious deadly pandemic. Subsequent chapters in this book detail the findings of a multi-city research study, funded by the Canadian Institutes of Health Research, and conducted in Victoria, Calgary, Regina and Toronto. This chapter lays the theoretical framework for thinking about the research findings that follow, by drawing the reader's attention to the key issues that all cities in Canada must consider when constructing their plans and responses to a pandemic within the context of homelessness. Although each city will have developed its own infrastructure, the underlying issues of poor physical and/or mental health, population mobility, inadequate service design and social isolation remain the same in all cities.

Using the analytic framework of social exclusion, we argue that the vulnerability of homeless people to the spread of infectious disease must be understood in terms of that population's profoundly restricted access to a range of social and economic goods, institutions and practices. In addition, homeless people's social exclusion is manifest through spatial marginalization, with segregation into separate sleeping, eating and service provision ghettos. They have restricted mobility and limited access to a range of spaces and places that many citizens take for granted, due to the increased policing and surveillance of homeless people (O'Grady, Gaetz, & Buccieri, 2013). The result is that they have much more restricted choice regarding their mobility, where and with whom they sleep and eat, how they organize their time and where they spend their days, all of which produces a higher risk of homeless people contracting infectious diseases. "The homeless have limited control over whom they are in contact with, while at the same time, the transient nature of homelessness often results in the number of potential contacts changing dramatically on a daily basis" (Ali, 2010, p. 85). Efforts to contain the spread of virulent infectious diseases within the homeless population must therefore address not only public health strategies, but also the need to radically reform our response to homelessness, so that individuals and families have access to safe, secure housing, income and necessary support services.

Background

Previous experiences with pandemics (in 1918–19, 1957, 1967, 2003 and 2009), have offered many lessons about how such disasters evolve and what should be done to prepare for them. However, despite these insights, there remains great uncertainty about when such events might occur or how severe they might be. In Toronto, two relatively recent occurrences have highlighted some of the challenges of preparing for a pandemic, as well as the risks faced by homeless people. The first was the outbreak of tuberculosis in homeless shelters in Toronto in 2001, with 15 people advancing to an active and highly infectious state. Three of these people died during treatment, with one man's death confirmed as being directly attributable to tuberculosis infection (Basrur, 2004; Tuberculosis Action Group, 2003). A Coroner's Inquest was called into this man's death and, in response, the Ontario Ministry of Health and Long Term Care provided Toronto Public Health with funding to develop infection control guidelines for shelters and drop-in centres in Toronto (Basrur, 2004).

The second event was the SARS outbreak of 2003. This event, in particular, enhanced our understanding of pandemics (Ali & Keil, 2008; Ali, Keil, Major, & Van Wagner, 2006; Keil & Ali, 2006; Leung, Ho, Kiss, Gundlapalli, & Hwang, 2008), and drew many Canadians' attention to the need for pre-existing effective disaster management plans. While no homeless people became infected, those working in the homelessness sector became acutely aware of the risks posed by a potential pandemic, and at the time people voiced concerns about what might have happened had SARS hit a major downtown hospital frequented by homeless people, rather than a suburban hospital. A study of providers of services to homeless populations by Leung et al. (2008) revealed important unique concerns, including aspects of communication, infection control, isolation and quarantine.

Since that time, and in response to heightened institutional and public awareness, preparing for an influenza pandemic has become a focus of disaster management for all levels of government in Canada, as well as for a range of institutions and service providers. A review of current federal, provincial and municipal pandemic plans reveals a lack of knowledge and

preparation in certain areas, specifically for vulnerable populations such as the homeless. In some cities, including Toronto, the municipal government did undertake consultations with the homelessness sector to advise and support pandemic planning, and identified resources for that sector.

The H1N1 pandemic highlighted the degree to which certain underlying assumptions frame our public health response to the spread of infectious diseases, and the ways that response is managed. The first of these assumptions is that self-care is not only necessary, but is possible for individuals to undertake. It is believed that individuals can and should take steps to reduce risks to themselves and others. The second assumption is that a person's home can and should serve as a natural site for effective prevention and recovery from illness. A poster commonly used by the Public Health Agency of Canada during H1N1, and widely reproduced across the country (PHAC, 2009b), highlights some of these assumptions. This poster suggests the most important ways to protect yourself and others are to: wash your hands often and thoroughly in warm soapy water or use hand sanitizer; keep common surfaces and items clean and disinfected; cough and sneeze into your arm, not your hand; stay home if you are sick; and contact a health care provider if your symptoms worsen. Another poster advises people to plan ahead, with advice to stock up on essentials such as pain and fever medications and easy meals; and to have important telephone numbers on hand, such as those for your doctor, local public health clinic and information lines (PHAC, 2009a).

These are well-thought-out, practical suggestions that are likely meaningful to most Canadians. Unfortunately, very little of this advice is helpful if you are homeless. Homelessness literally means being 'without a home' within which to recover and convalesce, and the poverty associated with homelessness usually means lacking the necessary resources to engage in the kind of self-care that is promoted in such public health campaigns. Planning ahead and stockpiling are not realistic for people who must, because of their poverty, focus on the immediate. The range of charitable services such as emergency shelters and day programs designed to support homeless individuals does not make up for these material deficits.

In thinking about pandemic preparedness and disaster management, it is increasingly understood that effective responses pertain not only to disease transmission, but also to broader social and structural factors. These include who has access to resources, and the degree of trust citizens have in the capacity of the state to respond adequately to protect them (and their subsequent willingness to cooperate and comply with requests). Consideration of vulnerability during an influenza pandemic must go beyond a concern about disease transmission to incorporate a social determinants of health perspective that explores how social and structural factors such as poverty, inadequate housing and income inequality contribute to the vulnerability of sub-populations (Commission on the Social Determinants of Health, 2008; Mikkonen & Raphael, 2010). The experiences of SARS and H1N1, as well as the ongoing battle against tuberculosis, have shone a light on the need to assess not only our emergency plans and responses, but also to consider the vulnerability of certain sub-populations, such as homeless populations (Hwang, Kiss, Gundlapalli, Ho, & Leung, 2008; Leung et al., 2008).

The Experience of Homelessness and Vulnerability

In Canada, it is estimated there are between 150,000 and 250,000 homeless people at any given time (Laird, 2007; Yalnizyan, 2005). Although the faces of homelessness vary from city to city, it is a challenging issue throughout the country, particularly in major urban centres. We argue in this chapter that homelessness presents a key challenge to effective pandemic preparedness because of homeless people's vulnerability to disease and their socially marginal status and, most significantly, because of the inherent weaknesses in the current national response to homelessness.

There is considerable evidence that homelessness is associated with poor health, a compromised immune system and barriers to accessing health services (Boivin, Roy, Haley, & Galbaud du Fort, 2005; Frankish, Hwang, & Quantz, 2005, 2009; Hwang et al., 2001; Khandor & Mason, 2007; Kulik, Gaetz, Levy, Crowe, & Ford-Jones, 2011). Negative outcomes include, but are not limited to, greater incidences of illness and injury, chronic

medical conditions, including heart disease, diabetes, seizures, arthritis and musculoskeletal disorders (Harris, Mowbray, & Solarz, 1994; Frankish et al., 2009), dental and periodontal disease (Gaetz & Lee, 1995; Lee, Gaetz, & Goettler, 1994), nutritional vulnerability (Gaetz, Tarasuk, Dachner, & Kirkpatrick, 2006; Tarasuk, Dachner, Poland, & Gaetz, 2009, 2010) and higher mortality rates (Baggett, et al., 2013; Cheung & Hwang, 2004; Hwang, 2000, 2001; Hwang, Wilkins, Tjepkema, O'Campo, & Dunn, 2009).

In addition, there is a body of literature on homelessness and health that highlights the increased prevalence of communicable diseases such as Hepatitis A, B and C (Roy et al., 2001, 2002), sexually transmitted diseases, including HIV infection (DeMatteo et al., 1999; Spittal et al., 2003) and, not insignificantly, communicable airborne diseases such as tuberculosis (Ali, 2010; Khan et al., 2011; Yuan et al., 1997). In a recent document, the World Health Organization explicitly named homeless people as among the most vulnerable populations when it comes to the spread of infectious disease (Biopole & WHO, 2008). Finally, approximately 30% of people who are homeless suffer from mental illness, which may undermine their ability to obtain and/or maintain housing, income and other necessary supports (CPHI, 2010; Nelson, Aubry, & Lafrance, 2007). Poor physical and/or mental health is a clear challenge in the event of a pandemic.

Further complicating these risks is the fact that homeless populations are often quite diverse. Several sub-populations, including Aboriginal peoples, youth and women, face special challenges because of their unique status, and may experience additional barriers to accessing health services and social supports. In addition, the characteristics of a particular pathogen must be considered. For instance, during H1N1, young people (and young pregnant women in particular) were considered highly vulnerable, which is generally not the situation in the case of seasonal influenza.

The experience of being homeless contributes to negative health outcomes (Story, 2013). Social and economic marginalization structures lifestyle choices and opportunities in ways that have a direct impact on health and access to health care. For people who are homeless, the clearest manifestation of their social exclusion is their limited access to safe, healthy, private

and affordable places to stay. Some people who are homeless may live temporarily with friends, partners and family members (a practice known as couch-surfing), while others will take their chances sleeping outside in parks, doorways, alleyways or rooftops. Most, however, wind up staying in emergency shelters.

The poverty that characterizes the lives of people who are homeless also shapes their income-generation strategies. Because obtaining and maintaining regular employment is difficult when you are homeless (Gaetz & O'Grady, 2002; Hagan & McCarthy, 1997; Hagedorn, 1998), many meet their needs by engaging in illegal or quasi-legal money-making strategies, including the sex trade, panhandling, squeegeeing, 'binning' and minor criminal acts, many of which involve direct contact with a large number of potentially dangerous or infected strangers.

Maintaining personal hygiene is also problematic when you are homeless. This includes not only washing clothes and showering on a regular basis, but also everyday hygiene practices such as brushing one's teeth or being able to regularly wash one's hands. Another manifestation of the degree of social exclusion experienced by homeless people is that they are often discouraged from using washrooms in stores, restaurants and public buildings — a right most people take for granted.

Finally, the biggest impact on health is caused by the barriers many experience in accessing health care (Frankish et al., 2005; Hwang & Bugeja, 2000; Hwang & Gottlieb, 1999). Access to coordinated primary care and specialists becomes problematic when you lack a health card, an address or a place where you can be contacted. In addition, because of real or perceived discrimination, many homeless people are often unable to see health care providers in traditional health care settings. The cost of medication and the inherent instability of life on the streets may make treatment plans designed for domiciled persons with a daily routine and incomes and/or benefits impossible for persons who are homeless. As a result, many homeless people are frequently unable to access health services until their often complex health problems become acute, resulting in their hospitalization.

The Response to Homelessness and the Production of Vulnerability

The day-to-day experience of homelessness is, in many ways, shaped by how we as a society structure and organize social services. Unlike other countries that have developed more aggressive strategies to prevent homelessness and rapidly rehouse individuals, the Canadian response to homelessness continues to emphasize an emergency response that 'manages' people while they are homeless (Gaetz, 2010). This management, organized at the local level through charitable organizations, the non-profit sector and local government, includes the provision of a range of emergency services such as temporary places to stay at night (for example, emergency shelters) and a range of programs or 'drop-ins' that operate during the day.

While these services have been designed to meet the immediate needs for shelter, warmth, food and companionship, these same services are constituted in ways that undermine individual autonomy, privacy, safety and freedom of movement. The design of these services often places people in vulnerable circumstances that may exacerbate the spread of infectious disease. One such example of the social exclusion of people who are homeless is that many depend on services that are in some ways highly rule-bound (with curfews, rules about substance use, etc.), but at the same time are chaotic and contribute to a lack of control. In the City of Toronto, for instance, over 4,000 of the roughly 5,253 homeless people stay in any one of over 60 shelters and hostels, for an annual total of over 27,000 different individuals who use the shelter system (City of Toronto, 2013). Most of these emergency shelters are in the downtown core of the city and vary in size (from 20 to 600 beds), capacity, programming and target population. Many, if not most, homeless shelters are characterized by congregate living and dangerously overcrowded situations (with sleeping quarters ranging in capacity from 3 to 50 persons per room), inadequate access to hygiene maintenance, and poor air quality (Cheung & Hwang, 2004; Dachner & Tarasuk, 2002; Hwang, 2000).

During certain times of the year, many shelters become overcrowded and residents are often required to sleep side by side on cots or on mats on the floor. In addition to official shelters, many cities, including Toronto, provide 'out

of the cold' programs that operate through the winter months and are run by church groups and local charities. It is not unusual to find 100 people sleeping in a church basement side by side. It is not clear whether such volunteer-based services would continue to operate in the event of a pandemic, which would put further pressure on the publicly-funded shelter system.

Most shelters are mandated and funded to provide a place for people to stay only at night. They typically have restricted hours of operation, meaning that residents must leave the premises by a set time in the morning and cannot re-enter until the evening, even if they are ill, disabled or otherwise incapacitated. The resulting enforced movement means that people who are homeless spend much of their time in public spaces such as the streets, city parks, and shopping centres, and at least part of their time in drop-ins, soup kitchens and other places where people who are homeless receive services.

Day programs, such as drop-ins, provide a low-threshold environment where people can rest, get food, socialize with friends and potentially access counselling and support. These programs also play an important role in providing a sheltered environment for people wishing to escape the cold or the heat. Drop-ins can become a place where relationships are nurtured, not only between people experiencing homelessness, but also with staff. While largely designed to meet the needs of people who are homeless, drop-ins also attract a large number of domiciled people who are living in poverty and may be socially isolated. This is important, because it is in these settings (which, like shelters, are also often overcrowded, chaotic, poorly ventilated and without adequate hygiene facilities) that there is a high degree of interaction and contact between the homeless population and the under-housed poor.

When not actually at the agencies set aside to serve them, people who are homeless must also navigate public spaces that are highly policed. They are often discouraged from accessing restaurants and shopping areas, and police and private security guards play a role in limiting the spaces and places that homeless people can inhabit, even to rest for a moment. Legal restrictions that target homeless individuals, such as the Ontario Safe Streets Act, add to the difficulties (Gaetz, 2004; O'Grady et al., 2013). The enactment and enforcement of these laws are exacerbated by the increasing gentrification

of the downtown cores of many Canadian cities. These laws also further restrict the available spaces for people who are homeless, increasing the likelihood of encounters with police, and resulting in pressure to live in the most marginalized and often most dangerous places in the downtown core. The containment and criminalization of homelessness is as much a part of the response to homelessness as the provision of shelters and day programs.

The lives of homeless people can be characterized by generalized instability and chaotic day-to-day experiences. This means that when one is homeless, long-range planning becomes extremely difficult, and much time is spent tending to immediate needs, such as identifying where one can eat, drink, sleep and rest in safety. The spaces and contexts within which homeless persons are expected to operate inevitably produce a greater risk of illness, injury and assault and, not incidentally, rarely provide the opportunity for uninterrupted sleep or a hygienic lifestyle. The fact that most homeless people circulate through many of these shelter situations contributes to the inherent instability of their lives. For example, people who are homeless often do not know where they are going to sleep on a given night, who will be there, and whether they will be safe. One of the cumulative results of how the homelessness sector is organized is that people who are homeless are forced to spend much of their time, both day and night, in the company of other homeless people who, like them, are more likely to be sick and have communicable diseases. In the context of a pandemic, one has to question whether it is even possible to make many — if not most — of these environments safe.

Helping Homelessness Sectors Prepare

While pandemic planning is mandated by governments, a network of non-profit and charitable services is at the front lines of the work with homeless people in most municipalities. Until there is a dramatic shift in the Canadian response to homelessness, this will be the system we have in place, and it will need to be well prepared. The organizations of services and the sector as a whole, as well as the highly structured yet chaotic nature of the world that homeless people inhabit, raises important questions about what might happen in the event of a pandemic.

There are some positive attributes to the existing system that can be built upon. As front-line service providers for people who are homeless, support agencies have pre-existing expertise in working with marginalized populations. They have generally also established strong relationships with client groups, including potentially 'hard to reach' groups, if their work contains an outreach component. At the same time, agencies serving homeless people tend to be poorly funded, operate with minimal staff and suffer from inadequate supports for workforce development. In the event of a serious deadly pandemic, there are a number of factors to be considered to help service providers and their clients be well prepared. Six factors that are particularly important are: support for planning; infection control; system capacity; inter-sectoral collaboration; communications and training; and the heightened challenges of unpredictability faced by the homeless population.

Support for planning

Many organizations in the homelessness sector do not have a strong culture of planning or much planning capacity due to limited and/or contract budgets. Because of the nature of their day-to-day work dealing with emergencies in a chaotic environment, long-range planning is often not a priority. The organizational structure of many of these service providers is often flat, meaning there may be only a manager and front-line staff, which can hinder effective planning. To develop appropriate pandemic plans, agencies may need to reach out to external supports, such as their city's public health unit. Establishing connections when there is no current pandemic is one way to build relationships that will serve as an important resource in the event of a pandemic.

Infection control

In overcrowded shelters and drop-ins, infection control becomes an obvious challenge (Duchene, 2010), as does the issue of quarantine and isolation, since most shelters have not been designed with infection control in mind. Increased attention to supporting hygienic practices and better ventilation will be necessary, along with plans to ensure that agencies have quick access to medical and hygiene supplies and food, and space to store them. All these needs have resource implications for a sector with inadequate funding.

The coordination of supports for infected individuals must also be considered. Agencies should know their proposed role in identifying and/or diagnosing infected clients, providing quarantine and respite care, and offering general access to services for the broader population in a way that does not increase clients' vulnerability. One example of a collaborative strategy, where the homelessness sector worked collaboratively in Ottawa during H1N1, designated one shelter to have responsibility for infected clients. The effectiveness of this plan was not put to the test because the outbreak was not severe.

System capacity

Pandemic preparedness includes a need to consider the robustness and resilience of systems, critical factors that determine vulnerability. During a pandemic, homelessness sector agencies — like all institutions — will be severely stressed and challenged, and will be potentially vulnerable to staff shortages and breaks in the chain of supplies. Many front-line agencies have policies regarding minimum staffing requirements to operate services, so an inability to maintain adequate staffing may present an added challenge during an outbreak. This poses a question for serious consideration: where will people who are homeless go to get their needs met if services are insufficiently staffed to operate?

Inter-sectoral collaboration

Agencies serving homeless people will not only have to work collaboratively among themselves, as in the Ottawa case previously cited, but will also have to engage other sectors, such as public health units, regional health authorities (to ensure access to immunization and other medical needs), local hospitals (to ensure that infected clients are not discharged into homelessness), social services and the police, all at a time when those systems will also be under stress. There has been almost no detailed mapping of critical dependencies within and between these sectors, though it is well known they are highly dependent upon each other. An effective response to a pandemic requires coordination of effort, and this will always be a challenge. Again, developing these relationships before a pandemic is essential for more cohesive operations in an emergency.

Communications and training

During SARS, one of the key complaints of agencies in Toronto was their difficulty receiving timely communications from public health (Leung et al., 2008). During H1Nl, Toronto Public Health actively engaged the sector with updates, Q&As and other communications supports. This was a very positive development, but it is not known whether this active effort in Toronto was replicated in other communities across Canada. In preparing for future pandemics, a solid plan will require that attention be focused on ongoing staff training, preparation and communication that is both timely and accurate. Agency staff will also need training and support for dealing with respite care, acute illness and death.

Having a well-thought-out plan for communications, training, and support for people who are homeless will be important as well, and will be a key challenge when dealing with a mobile and dispersed population that may experience language, cultural or mental health barriers. Traditional methods of communication and public health messaging through mass media may be of little use in communicating with the homeless population. We also learned from H1N1 that people in general, not just this population, have access to many sources of information that can confuse the issue in a context where 'what we know' can change rapidly and continuously. This would be exacerbated in a serious pandemic if people who are homeless began avoiding services, which would possibly create the need for a stronger outreach effort, putting further strain on agencies' staff.

Unpredictability

One lesson emergency planners have learned is that complex disasters have a way of evolving along unanticipated lines — and a pandemic is certainly a complex disaster. Compromised health and overcrowded living conditions may make people who are homeless particularly vulnerable in the event of a pandemic, forcing them to make different decisions because of their circumstances. Factors that impact on decision-making include having fewer options (for example, regarding shelter and transportation), limited access to resources or the ability to prepare in advance (by stockpiling food and other necessities), and being unable to adhere to forced or voluntary quarantine without a home of their own. Because of overcrowded conditions and safety

concerns, many people who are homeless will limit their use of such services or avoid them altogether. This presents additional challenges for infection control, tracking and follow-up.

One final area of unpredictability has to do with stigma and discrimination. During a serious deadly pandemic, if the public began to identify homeless people as a potential source of contagion, it is not clear if and how their rights would be protected or, conversely, violated. As Mosher (2014) has pointed out, both substantive and procedural rights of marginalized populations are often set aside for public safety claims. In a post-911 world, people have been shown to support a trade-off that restricts rights in the name of safety when the rights at issue are those of others. There is a need to consider how this perceived balance would be approached in relation to marginalized groups, such as these who are homeless.

Conclusion

The Canadian response to homelessness continues to emphasize providing community-based emergency services characterized by congregate living, overcrowded conditions, inadequate access to hygiene maintenance and poor air quality. The lives of people who are homeless are regulated and controlled through the institutional organization of emergency services in a way that exacerbates their social exclusion. This ordered world also creates chaos in their lives. For example, homeless people have little choice about when to access services, with whom they room or eat, what they eat, when they go to bed or when they must wake. Compromised health and well-being are a consequence of overcrowded living conditions, lack of access to safe and private spaces, reliance on shelters and drop-ins to meet daily needs, and barriers to accessing services.

There are important issues to be raised about how we plan for future pandemics to ensure the health and well-being of homeless populations. This chapter identifies a number of points that governments and service providers will need to consider as part of their future planning efforts. At the same time, this may simply be a case of 'rearranging the chairs on the

Titanic.' If we really want to protect the health and well-being of people who are homeless, we need to move away from a heavy reliance on emergency services and toward a response that focuses on prevention, to stop people from becoming homeless in the first place, and to help people move quickly and with necessary supports into housing when they do become homeless. Planned approaches to ending homelessness are emerging elsewhere in the world (for example, in the United States, Australia, and the United Kingdom), supported by investments in affordable housing. Housing First (Gaetz et al., 2013a), both as a philosophy and an intervention, should be fundamental to how we respond to the situation of people who fall into homelessness, so their time on the street is as short as possible. If people have homes and supports, it reduces the need to force large numbers of Canadians (over 30,000 people experience homelessness on a given night (Gaetz, et al., 2013b)) into emergency shelters or other inhospitable situations. The best solution to concerns regarding homelessness and pandemics is to ensure that people are not homeless.

References

Ali, S. H. (2010). Tuberculosis, homelessness and the politics of mobility. *Canadian Journal of Urban Research*, 19(2), 80-107.

Ali, S. H. & Keil, R. (Eds.). (2008). *Networked disease: Emerging infections in global cities*. Oxford: Wiley-Blackwell.

Ali, S. H., Keil, R., Major, R., & Van Wagner, E. (2006). Pandemics, place, and planning: Learning from SARS. *Plan Canada*, 46(3), 34-36.

Baggett, T. P., Hwang, S. W., O'Connell, J. J., Porneala, B. C., Stringfellow, E. J., Orav, E. J., … Rigotti, N. A. (2013). Mortality among homeless adults in Boston: Shifts in causes of death over a 15-year period. *JAMA*, 173(3), 189-195.

Basrur, S. (2004). *Tuberculosis prevention and control services for homeless/ underhoused persons and inmates of correctional facilities*. Toronto: City of Toronto, Medical Officer of Health.

Biopole, L. & WHO. (2008). Concept note: International technical conference: Cities and public health crises. Lyon, France: WHO Office.

Boivin, J. F., Roy, E., Haley, N., & Galbaud du Fort, G. (2005). The health of street youth: A Canadian perspective. *Canadian Journal of Public Health*, 96(6), 432-437.

Cheung, A., & Hwang, S. (2004). Risk of death among homeless women: A cohort study and review of the literature. *Canadian Medical Association Journal*, 170(8), 1243-1247.

City of Toronto. (2013). *Street needs assessment 2013*. Toronto: City of Toronto, Shelter, Support and Housing Administration.

Commission on the Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health. Final report to the Commission on Social Determinants of Health*. Geneva: World Health Organization.

CPHI (Canadian Population Health Initiative of the Canadian Institute for Health Information). (2009). Mental health, mental illness and homelessness in Canada. In J. D. Hulchanski, P. Campsie, S. Chau, S. Hwang, & E. Paradis (Eds), *Finding home: Policy options for addressing homelessness in Canada* - revised edition. Toronto: Cities Centre Press, University of Toronto.

Dachner, N., & Tarasuk, V. (2002). Homeless "squeegee kids": Food insecurity and daily survival. *Social Science & Medicine*, 54(7), 1039-1049.

DeMatteo, D., Major, C., Block, B., Coates, R., Fearon, M., Goldberg, E., … Read, S. E. (1999). Toronto street youth and HIV/AIDS: Prevalence, demographics, and risks. *Journal of Adolescent Health*, 25(5), 358-366.

Duchene, M. (2010). Infection control in soup kitchens and shelters. *Home Healthcare Nurse*, 28(8), 471-478.

Frankish, C. J., Hwang, S. W., & Quantz, D. (2005). Homelessness and health in Canada. *Canadian Journal of Public Health*, 96, S23-S29.

Frankish, C. J., Hwang, S. W., & Quantz, D. (2009). The relationship between homelessness & health: An overview of research in Canada. In J. D. Hulchanski, P. Campsie, S. Chau, S. Hwang, & E. Paradis (Eds), *Finding home: Policy options for addressing homelessness in Canada* - revised edition. Toronto: Cities Centre Press, University of Toronto.

Gaetz, S. (2004). Safe streets for whom? Street youth, social exclusion and criminal victimization. *Canadian Journal of Criminology and Criminal Justice*, 46(4), 423-455.

Gaetz, S. (2010). The struggle to end homelessness in Canada: How we created the crisis, and how we can end it. *The Open Health Services and Policy Journal*, 3, 21-26.

Gaetz, S. & Lee, J. (1995). Developing dental services for street youth. *Ontario Dentist*, 72(9), 34-37.

Gaetz, S. & O'Grady, B. (2002). Making money: Exploring the economy of homeless workers. *Work, Employment and Society*, 16(3), 433-456.

Gaetz, S., Tarasuk, V., Dachner, N., & Kirkpatrick, S. (2006). "Managing" homeless youth in Toronto: Mismanaging food access and nutritional well-being. *Canadian Revue of Social Policy*, 58, 43-61.

Gaetz, S., Scott, F., & Gulliver, T. (Eds.) (2013a). Housing First in Canada–Supporting Communities to End Homelessness. Toronto: Canadian Observatory on Homelessness Press.

Gaetz, S., Donaldson, J., Richter, T., & Gulliver, T. (2013b). The State of Homelessness in Canada–2013. Canadian Observatory on Homeless / Canadian Alliance to End Homelessness.

Hagan, J., & McCarthy, B. (1997). *Mean streets: Youth crime and homelessness*. Cambridge: Cambridge University Press.

Hagedorn, J. M. (1998). The business of drug dealing in Milwaukee. *Wisconsin Policy Research Institute Report*, 11(5), 1-30.

Harris, S. N., Mowbray, C. T, & Solarz, A. (1994). Physical, health, mental health, and substance abuse problems of shelter users. *Health & Social Work*, 19(1), 37-46.

Hwang, S. W. (2000). Mortality among men using homeless shelters in Toronto, Ontario. *Journal of the American Medical Association*, 283, 2152-2157.

Hwang, S. W. (2001). Mental illness and mortality among homeless people. *Acta Psychiatrica Scandinavica*, 103, 81.

Hwang, S. W., & Bugeja, A. L. (2000). Barriers to appropriate diabetes management among homeless people in Toronto. *CMAJ*, 163(2), 161-165.

Hwang, S. W., & Gottlieb, J. L. (1999). Drug access among homeless men in Toronto. *CMAJ*, 160(7), 1021.

Hwang, S. W., Kiss, A., Gundlapalli, A. V., Ho, M. M., & Leung, C. S. (2008). Infectious disease exposures and contact tracing in homeless shelters. *Journal of Health Care for the Poor and Underserved*, 19, 1163-1167.

Hwang, S. W., O'Connell, J. J., Lebow, J. M., Bierer, M. F., Orav, E. J., & Brennan, T. A. (2001). Health care utilization among homeless adults prior to death. *Journal of Health Care for the Poor and Underserved*, 12(1), 50-58.

Hwang, S. W., Wilkins, R., Tjepkema, M., O'Campo, P. J., & Dunn, J. R. (2009). Mortality among residents of shelters, rooming houses, and hotels in Canada: 11 year follow-up study. *BMJ*, 339, n.p.

Keil, R., & Ali, S. H. (2006). The avian flu: The lessons learned from the 2003 SARS outbreak in Toronto. *Area*, 38(1), 107-109.

Khan, K., Rea, E., McDermaid, C., Stuart, R., Chambers, C., Wang, J., … Hwang, S. W. (2011). Active tuberculosis among homeless persons, Toronto, Ontario, Canada, 1998-2007. *Emerging Infectious Diseases*, 17(3), 357-365.

Khandor, E., & Mason, K. (2007). *The street health report 2007*. Toronto: Street Health and the Wellesley Institute.

Kulik, D., Gaetz, S., Levy, A. S., Crowe, C., & Ford-Jones, L. (2011). Homeless youth's overwhelming health burden–a review of the literature. *Pediatrics and Child Health*, 16, 43-47.

Laird, G. (2007). *Shelter–homelessness in a growth economy: Canada's 21st century paradox*. Calgary: Sheldon Chumir Foundation for Ethics in Leadership.

Lee, J., Gaetz, S., & Goettler, F. (1994). The oral health of Toronto's street youth. *Canadian Dental Association Journal*, 60(6), 545-548.

Leung, C. S., Ho, M. M., Kiss, A., Gundlapalli, A. V., & Hwang, S. W. (2008). Homelessness and the response to emerging infectious disease outbreaks: Lessons from SARS. *Journal of Urban Health*, 85(3), 402-410.

Mikkonen, J., & Raphael, D. (2010). *Social determinants of health: The Canadian facts*. Toronto: York University School of Health Policy and Management.

Mosher, J. (2014). Accessing justice amid threats of contagion. *Osgoode Hall Law Journal*, 51(3), 919-956.

Nelson, G., Aubry, T., & Lafrance, A. (2007). A review of the literature on the effectiveness of housing and support, assertive community treatment, and intensive case management interventions for persons with mental illness who have been homeless. *American Journal of Orthopsychiatry*, 77, 350-361.

O'Grady, B., Gaetz, S., & Buccieri, K. (2013). *Tickets…and more tickets: A case study of the enforcement of the Ontario Safe Streets Act. Canadian Public Policy*, 39(4), 541-558.

Public Health Agency of Canada. (2009a). *Poster: Know how to prepare for the H1N1 flu virus*. Canada: Public Health Agency of Canada.

Public Health Agency of Canada. (2009b). *Poster: Know what to do to fight the H1N1 flu virus*. Canada: Public Health Agency of Canada.

Roy, E., Haley, N., Leclerc, P., Boivin, J., Cedras, L., & Vincelette, J. (2001). Risk factors for hepatitis C virus infection among street youths. *Canadian Medical Association Journal*, 165(5), 557-560.

Roy, E., Haley, N., Leclerc, P., Cedras, L., Bedard, L., & Allard, R., (2002). Seroprevalence and risk factors for hepatitis A among Montreal street youth. *Canadian Journal of Public Health*, 93(1), 52-53.

Spittal, P. M., Bruneau, J., Craib, K. J., Miller, C., Lamothe, F., Weber, A. E., … Schechter, M. T. (2003). Surviving the sex trade: a comparison of HIV risk behaviours among street-involved women in two Canadian cities who inject drugs. *AIDS* Care, 15(2), 187-195.

Story, A. (2013). Slopes and cliffs in health inequities: Comparative morbidity of housed and homeless people. *The Lancet*, 382(S3), S93-S93.

Tarasuk, V., Dachner, N., Poland, B., & Gaetz, S. (2009). Food deprivation is integral to the 'hand to mouth' existence of homeless youths in Toronto. *Public Health Nutrition*, 12(9), 1437-1442.

Tarasuk, V., Dachner, N., Poland, B., & Gaetz, S. (2010). The "hand-to-mouth" existence of homeless youths in Toronto. In J. D. Hulchanski, P. Campsie, S. Chau, S. Hwang, & E. Paradis (Eds), *Finding home: Policy options for addressing homelessness in Canada* - revised edition. Toronto: Cities Centre Press, University of Toronto.

Tuberculosis Action Group. (2003). *TB or not TB? There is no question. Report of a public inquiry into the state of tuberculosis within Toronto's homeless population*. Toronto: Tuberculosis Action Group.

Yalnizyan, A. (2005). *Divided and distracted: Regionalism as an obstacle to reducing poverty and inequality*. Canada: Canadian Centre for Policy Alternatives, Social Watch.

Yuan, L., Simor, A. E., Louie, L., Pollock, S., Gould, R., & Jamieson, F. (1997). Tuberculosis clusters among the homeless in Toronto, Canada. *37th Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC)*. Toronto, Canada.