

**Health Issues, Health Care
Service Needs, and Drug Use
of the Community Who
Use Fred Victor Centre**

Fred Victor Centre

Kirsten Schmidt-Chamberlain

August 2007

This report was completed as a group effort with the support of many Fred Victor Centre community members, volunteers, and staff.

A special thank you to:

All of the community members, tenants, and residents who participated in the interviews.

Michele Heath, Enza Trentadue, Carol Watson, Silke Haller, Holden Keys, Molly Bannerman, & Megan Vincett

Copyright:

Fred Victor Centre.

Written by Kirsten Schmidt-Chamberlain, August 2007.

Introduction

In July 2007, a team of interviewers from Fred Victor Centre undertook the task of conducting individual interviews with community members and tenants of Fred Victor Centre downtown services. This study was initiated to better understand the health service and information needs of the community with the specific intention of identifying how Fred Victor Centre could better meet these needs. We adopted the World Health Organization's definition of health – health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 2007). Further, we have considered the following social determinants of health (Public Health Agency of Canada, 2007):

- social inclusion and exclusion
- income inequality
- employment and job security
- working conditions
- contribution of the social economy
- education
- food security
- housing.

Existing Knowledge and Context for the Study

On any given night, it is estimated that 5,000 people are homeless in Toronto (Toronto Report Card on Homelessness, 2007; Street Needs Assessment, 2006). This number is no doubt much higher if we consider those who are inappropriately housed, couch-surfing, or at risk of being homeless. There has been extensive research documenting the severity and range of health issues faced by people who are homeless. Severe mental health issues, psychological issues, addictions, diabetes, acute infections, seizure disorders, chronic respiratory diseases, dental issues, musculoskeletal problems, hypertension,

dermatologic disease, HIV/AIDS, and STIs have been cited as common amongst homeless, low-income and marginalized adults (Bannerman, 2007; Cheung & Hwang, 2004; Daiski, 2007; Hwang & Bugeja, 2000; Tucker, Wenzel, Elliott, Marshall, & Williamson, 2004).

To be homeless, low-income, or marginalized means more than lacking secure housing. It indicates a disaffiliation with personal, familial, and societal connections (Nakonezny & Ojeda, 2005). Social inclusion – defined by Omidvar & Richmond as:

...making sure that all children and adults are able to participate as valued, respected and contributing members of society.... Social inclusion goes one step further: it calls for a validation and recognition of diversity as well as a recognition of the commonality of lived experiences and the shared aspirations among people (2003, viii).

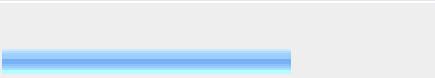
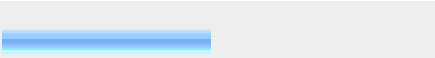
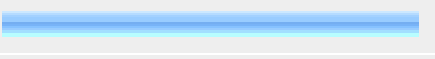
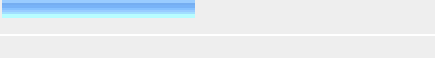
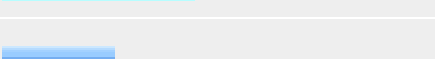
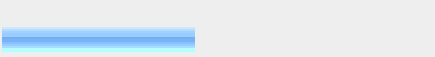
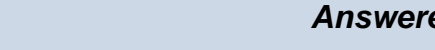
People who are not socially included, as is the case with homeless, low-income, and marginalized people do not experience their health in the same way that people who are more engaged with society. Further, people who are not socially included, experience health care services differently (Wen, Hudak, & Hwang, 2007). Given the profound physical, emotional, mental, social, and spiritual stress that living in poverty presents, it is not surprising that people face a number of health issues and barriers to accessing supports.



Methodological Process

A survey tool with 35 questions was developed in consultation with a staff team from Fred Victor Centre. The majority of the questions were quantitative in nature, lending to simple tabulation of results. Qualitative questions were analyzed thematically and presented in tables. Similar health survey tools from other community based health surveys were reviewed and relevant questions were used. The final draft of the survey was circulated for review to the Program Committee of the Board of Directors at Fred Victor Centre and key informants at St. Michael's Hospital.

Eighty-three 1-to-1 interviews were conducted across the downtown service sites in private areas. All of the interviews were conducted in English with trained interviewers.

Survey Site:			
		Response Percent	Response Count
Women's Day Program		16.9%	14
ERC		13.3%	11
Housing		26.5%	22
Restaurant		12.1%	10
Hostel		12.1%	10
Computer Club		7.2%	6
Open House Drop IN		12.1%	10
		Answered question	83

Random sampling was used in order to acquire the best information. At the Women's Day Program, Employment Resource Centre, Restaurant, Computer Club, and Open House Drop In, every fourth person to enter the room was asked if they would participate in the survey. Potential candidates were given an information sheet (see Appendix A) and told that they would be compensated \$10 for their time. At the Women's Hostel and in the Housing Units, the fourth resident on tenant/resident lists was invited to participate (see Appendix B). Target numbers for each site and the 25% ratio was determined in consultation with experts from St. Michael's Hospital.

Interviews took between 30 minutes to one hour.

Of the people interviewed, 54% were community members, 30% were tenants living in one of FVC's housing units, and 17% were individuals living in the Women's Hostel.

Referrals were provided to a number of participants throughout the interviews. The interviewers identified that it was frustrating for the interviewers and participants to have many health needs and few resources to help.

A simple literature review was conducted to strengthen our research. We conducted a search using relevant terms including "homeless", "health", "harm reduction", "health care", and "poverty".

Percentages used in this report have been rounded therefore totals may not equal 100%. All data were tabulated to identify themes using Survey Monkey.

To be homeless, low-income, and marginalized does not create a homogeneous population. Just like the general public, diversity in this population is extensive. Thus, using Survey Monkey, an anti-oppression lens was used to analyze the data from particular perspectives: How do the results look if we consider gender,

identity (disability, Native, newcomer), education level, drug use (crack users who smoke, crack users who inject), and specific health issues (people with mental health issues, people with psychological issues, people who identified HIV/AIDS as an issue, people who identified violence as an issue)? To understand health concerns and barriers to health care necessitates a solid understanding of the power dynamics that are at play for various populations and within the medical system in general.

Limitations & Learnings

In all areas, we were able to get the desired number of interviews except in housing – where we had hoped to get 40 and only achieved 22, meaning that housing tenants are under represented. In future, other methods for random sampling may have worked better in housing (e.g., 10 people from bingo night, 10 people from community meetings, 10 people randomly at the entrance, or 1 person per unit).



While using random selection was chosen to avoid bias, the voluntary nature of this survey meant that some people who were randomly selected chose not to participate. We did not keep track of how many people were asked versus how many said no and why they said no. Anecdotally, some people who were actively using alcohol/drugs or had active mental health issues chose not to participate. In future, this information should be collected.

Health is a very personal issue, particularly questions about drug use and where one acquires their drugs from. As a result, some participants were distrustful of the interviewers. It was noted that some participants lied given what the interviewers knew about the participants from day-to-day life (e.g., one active crack user denied using ever). Many referrals were made throughout the interviews – but no records were kept on where/how many. This would be

helpful to have collected. Additionally, a referral sheet should have been prepared ahead of time to give out as a resource for people.

Following the interviews, it was identified that there were some questions that were challenging for people to answer clearly. Conducting practice interviews ahead of time would have helped clarify these questions.



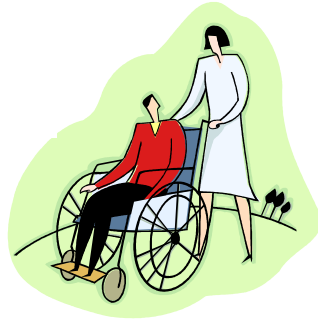
Participant Information

Of the 83 people who participated in the interviews, 40% identified as female, 8% identified as transgender/transsexual, and 53% identified as male. Participants were older – with 81% of participants being aged 30-59. The gender and age breakdown are reflective of the demographics of service users and tenants at Fred Victor Centre. One person did not give their age.



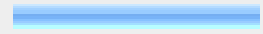
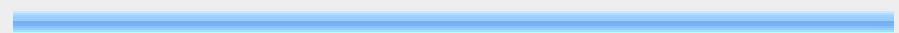

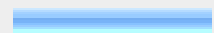
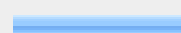

Age:		Response Percent	Res C
Under 16		0.0%	
16-18 years		0.0%	
19-24		3.7%	
25-29		7.3%	
30-44		36.6%	
45-59		43.9%	
60+		8.5%	
		<i>answered question</i>	

Participants were asked if they identified with one of the following 'targeted' populations: A person with a disability, First Nations, Francophone, or a Newcomer to Canada. Thirty-six people identified as being a person with a disability, eleven identified as First Nation, Metis, Inuit, Aboriginal, Status, or Non-Status, six as Francophone, and nine as Newcomers to Canada. The majority of the Newcomers to Canada had been in Canada over 10 years. Social exclusion is common amongst these target groups and well documented (Anderson, 2003; Government of Canada, 2005; Omidvar & Richmond, 2003) Newcomers were only interviewed at the Women's Day Program, Employment Resource Centre and Housing. It is unclear why this might be ~ although could reflect that there are a higher percentage of newcomers accessing these services than others at Fred Victor Centre. Further investigation would be needed to confirm this.



Regarding education, participants were asked what level of schooling they had completed. Participants often answered that they had not completed a given level fully, therefore the question needed to reflect a partial completion too (e.g., one participant stated that she had completed grade 11 but not all of high school).

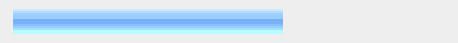
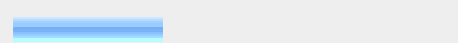
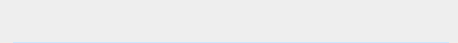
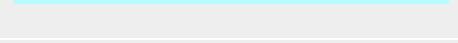
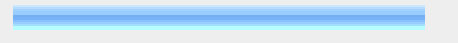
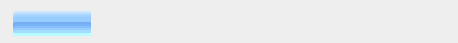
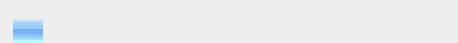


Education Fully/Partially Completed:		Response
Elementary		
High School		
Apprenticeship / Trade		
College		
University		
Other		
		<i>answered q</i>

The majority of participants identified as European/White ethno-racial background (62%), with African/Black and Caribbean participants being the next highest at 14.4%. Aboriginal (First Nation, Metis, Inuit, Aboriginal, Status, Non-Status) made up 13%. The remaining identified as East Asian (3.6%), Middle Eastern (3.6%), Mixed Origin (2.4%), Latin/Central/South American (1.2%) and South Asian (1.2%).

Regarding housing, participants were asked where they currently live. Fred Victor Centre housing was documented as “supportive housing” – however 26 people identified as living in supportive housing – meaning that four participants lived in a form of supportive housing other than Fred Victor Centre. Similarly, 14 residents of the Women’s Hostel were interviewed, but 25 people identified as currently staying at a shelter. Therefore, 11 people were staying at shelters other than Fred Victor Centre’s. One person did not answer.

Housing Status:		
	Response	Response

		Percent	Count
Housed Independently		17.1%	14
Social Housing		9.8%	8
Supportive Housing (FVC)		31.7%	26
Shelter		30.1%	25
Street		6.1%	5
At Friend/Family's place		2.4%	2
Transitional Housing		1.2%	1
Other	Hotel	1.2%	1
		<i>answered question</i>	82

Financially, the participants we interviewed received income from a variety of sources, with the majority receiving Ontario Works (welfare) (38%) and 30% receiving ODSP (disability support). Participants often had more than one source of income (e.g., PNA and sex work). One person did not answer.

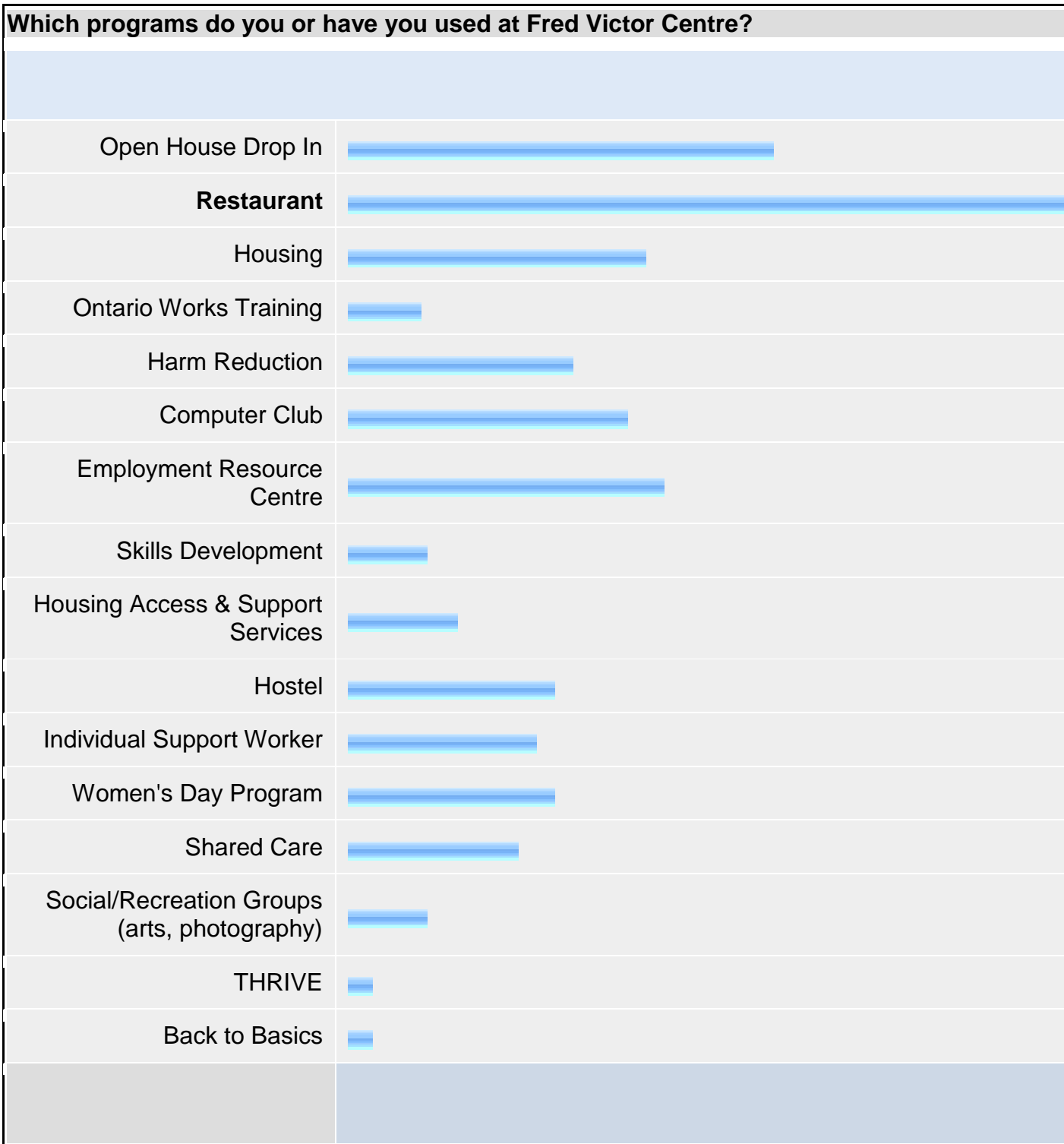


Where does your income come from?			
		Response Percent	Response Count
EI		0.0%	0

WSIB		0.0%	0
OW (Welfare)		37.5%	36
ODSP (Disability)		30.2%	29
Personal Needs Allowance		6.3%	6
CPP/Old Age Security		5.2%	5
Paid work (legal)		6.4%	5
No income		4.2%	4
Paid Work (under the table)		3.1%	3
Sex Trade work		3.1%	3
Panhandling		1.0%	1
Drug dealing		0.0%	0
Other illegal activities		1.0%	1
Other		18.3%	3
	<i>answered question</i>		82

Whether community members, tenants, or residents at the Women's Hostel, all participants utilized more than one service at Fred Victor Centre, with the restaurant being used by the most people ~ 66% of participants had been there.

Fifty-nine-percent of participants had gone to the Open House Drop in, and 29% had gone to the Employment Resource Centre and had lived in housing.



Newcomers used services at Fred Victor Centre differently than other populations. Newcomers used the Employment Resource Centre most. Fifty-six-percent of the newcomers had used the Employment Resource Centre ~ with 67% of them having used an Employment Resource Centre in the community.



Participants Health & Access to Health Care

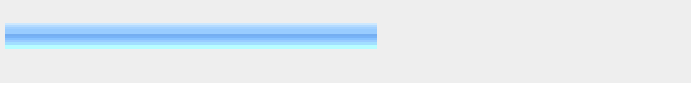
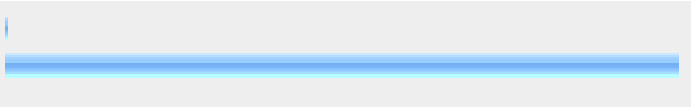
Participants were asked a range of questions during the interviews related to their health, access to health care, and drug use. The findings have been presented by question – rather than thematically. Recommendations follow.

Do you have a health card?			
		Response Percent	Response Count
Yes		84.3%	69
No		16.9%	14
	<i>answered question</i>		83

When asked why participants did not have a health card, all 14 had either lost the card or had it stolen.



Do you have a family doctor?		
	Response Percent	Response Count

No		36.1%	30
Yes		65.1%	53
answered question			83

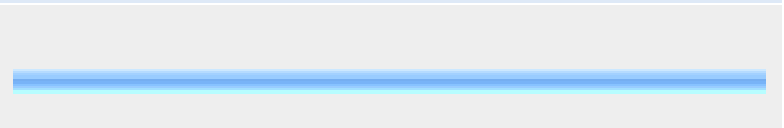
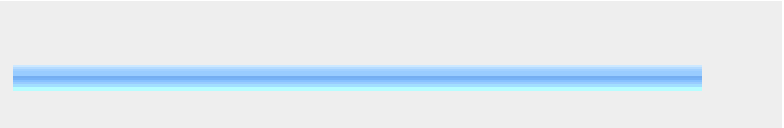
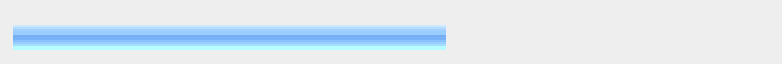
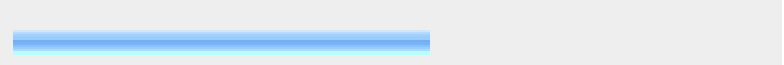
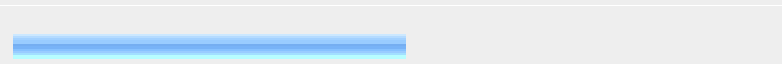
When asked to elaborate on why the participants did not have a family doctor, the following themes were identified: Can't find one (50%), don't trust doctors (17%), just moved to the area (10%), previous physician died/retired (10%), haven't looked for one (7%), and do not have a health card (3%).

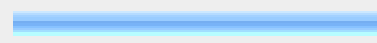
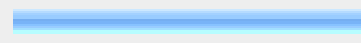
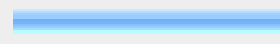
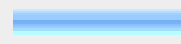
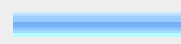
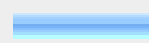
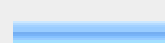
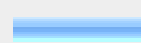
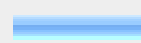
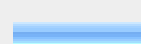

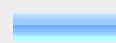
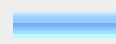





Participants who did have a family doctor visited their doctor an average of six times over the past year, with a range from zero to fifteen.

Each participant had been diagnosed with a health condition or was concerned about their health. When asked what issues they had been diagnosed with or were a concern, responses were:



What health issues have you been diagnosed with or are a concern for you?		Response Percent
Mental health problems (e.g. depression, anxiety, schizophrenia, etc.)		49.4%
Psychological issues (e.g. past abuse, grief, trauma, anger, guilt)		44.6%
Violence		34.9%
Lung Infection (e.g. Bronchitis, pneumonia, etc)		32.5%
Foot problems		28.9%

Poor diet / malnutrition		25.3%
Hepatitis C		20.5%
Cardiac (heart) problems		15.7%
Sexually transmitted infections (e.g. herpes, warts, syphilis)		10.8%
Pressure ulcers, skin sores, bed sores, bed bugs, flees		10.8%
HIV / AIDS		9.6%
Seizures		9.67%
Arthritis		7.2%
Hypertension/ cholesterol		7.2%
TB		7.2%
Diabetes		7.2%
Eye/ear problems		6.0%
Hepatitis B		4.8%
Digestive problems		3.6%
Spinal/back problems		3.6%
Hepatitis - type not known		2.4%
Other	Stress, Osteoporosis, Nerve Problems, Sciatica, Cancer, Smoking, Elbow Problems, Allergies, Bladder Problems, Sleep Apnia	14.5%
	answered question	

Mental health, psychological issues, and violence have all been found to be prevalent health problems for homeless, low-income, and marginalized people (Bannerman, 2007; Daiski, 2007; Dickey, 2000; Tucker et. al, 2004; Wong, 2002). Similarly, lung infections, poor nutrition, and foot problems have been associated as problems experienced by people in poverty (Daiski, 2007; Shapcott, 2005). The prevalence of these issues should strongly inform the services needed and delivered through Fred Victor Centre.

Analyzing this data by population provides interesting information (comments are only made when the results deviate from the general significantly):



Mental Health:

- Of the participants who identified that they had injected drugs, 30% of them had mental health problems.
- Of the participants who identified that they had smoked crack, 52% identified that they had mental health problems.
- Of the trans-identified participants, 60% of them identified that they had a mental health issue.
- Of the newcomers, 44% of them identified having a mental health problem.
- Of people with a disability, 74% of them identified having a mental health problem.
- Of the Native participants, 50% of them identified having a mental health problem.

Psychological Issues

- Of the participants who identified that they had injected drugs, 50% of them had psychological issues.
- Of the participants who identified that they smoke crack, 44% of them had psychological issues.
- Of the newcomers, 56% of them identified that they had psychological issues
- Of the people with disabilities, 63% identified that they had psychological issues.
- Of Native participants, 50% of them identified having psychological issues.

Violence

- Of the participants who identified that they injected crack, 50% of them felt violence was an issue for them.
- For newcomers, 44% felt that violence was an issue for them.
- For people with disabilities, 37% felt that violence was an issue for them.
- For trans-identified people, none of them felt that violence was an issue for them.

Lung Infections

- For people who injected crack, 60% of them felt lung infections were an issue for them.
- For people who smoked crack, 44% felt lung infections were an issue.

Poor Diet/Nutrition

- For people who smoked crack, 44% felt that poor diet was an issue for them.
- For people with disabilities, 34% felt that poor diet was an issue for them.

Hepatitis C

- For injection drug users, 44% of them reported that Hep C was an issue for them.

- For people who smoked crack, 44% reported that Hep C was an issue for them.
- Of the people who reported that Hep C was an issue, 35% were female.

Cardiac Problems

- For injection drug users, 30% reported that cardiac problems were an issue for them.

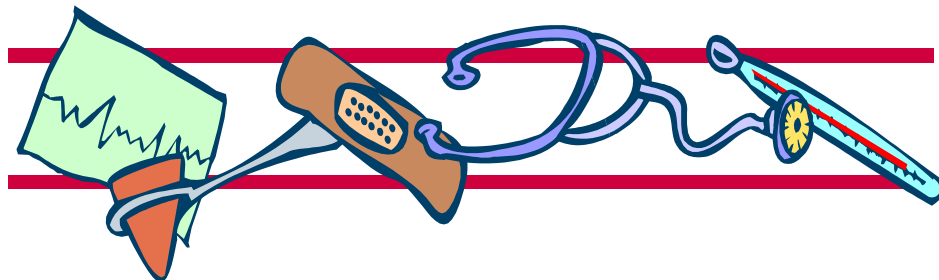
Sexually Transmitted Infections

- Of the Native participants, 38% of them identified that STIs were an issue for them.

HIV/AIDS

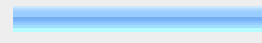
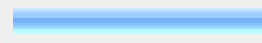
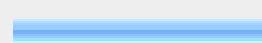
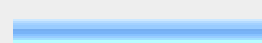
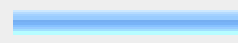
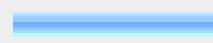
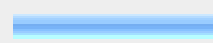
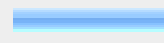
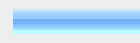
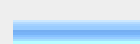

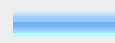
- For injection drug users, 40% of them identified that HIV/AIDS was an issue for them.
- Of those who identified that HIV/AIDS was a risk, 46% were female, 18% were trans, and 36% were male.

For people who had only fully/partially completed elementary school, 62% were male, 8% trans, and 31% female. Their health issues differed from the other populations: 46% had diabetes, 46% had foot problems, 46% had psychological issues, 46% had violence, 36% had cardiac problems, and 36% had lung problems. These differences may reflect a different nature of social exclusion ~ although drug use for this population was similar to the general.



Participants were asked about what health services they have used in the past year. Everyone had accessed some sort of service including:

What services have you used in the past year? (specify where / name and indicate frequency):			
		Response Percent	Response Count
Drop In Centres		75.9 %	63
Emergency Room		63.9 %	53
Family Doctor		60.2 %	50
Food Bank		51.8 %	43
Health Bus		50.6 %	42
Dental Services		42.2 %	35
Employment Centre		41.0 %	34
Community Organization		41.0 %	34
Walk-In Clinic		39.8 %	33
Community Health Centre		32.5 %	27
Counseling Services		30.1 %	25
Needle Exchange/Harm		26.5 %	22

Reduction Program			
Street Health Clinic		25.3 %	21
Hepatitis C Services		22.9 %	19
Health Education		22.9 %	19
Addictions Services		22.9 %	19
Eye Care/Glasses		21.7 %	18
In-patient Hospital Stay		20.5 %	17
Mental Health Services		20.5 %	17
Outreach Services		19.3	16
Alternative Medicine (naturopath, massage)		14.5 %	12
HIV/AIDS Services		12.1 %	10
Ethno-Cultural Centre		7.2 %	6
Other		8.4 %	7
<i>answered question</i>			83

Participants used a long list of services – many of whom Fred Victor Centre currently partners with and others that we can further develop. See Appendix B for the list.

Drop-In Centres were the most frequently used facility. Drop-In Centres are often the first point of contact for people who are homeless, low-income, or marginalized, making them ideal to co-locate with a health service. Similar to other research, the use of emergency rooms for basic health care was prevalent (64%) (Kushel, Perry, Bangsberg, Clark, & Moss, 2002).

When analyzed by population:

- 83% of trans-identified participants had used the health bus
- 82% of injection drug users had used emergency, 73% of them had used the health bus, Hep C services, and a needle exchange/harm reduction program.
- 80% of participants who smoked crack used the health bus, 60% of them had used a needle exchange/harm reduction program.
- 75% of Native participants had used a family doctor and 75% had used dental services.
- 75% of people with a disability had used emergency.

When asked about what the participant liked about the kinds of health care they currently receive, eighty participants responded, although 15 of them stated that they did not like anything. Twenty people described how important it was that the staff of the programs are compassionate and understanding.

What do you like about the kinds of health care you currently receive?			
		Response Percent	Response Count
The staff are compassionate & understanding		25%	20



I don't like anything, nothing		18.8%	15
They respond to the needs I have, I got help		11.3%	9
They give out free stuff: medication, hygiene products, socks, vitamins, basic needs stuff, coffee, blood tests on site, information, foot powder		8.8%	7
Accessibility – it's close by		8.8%	7
I don't have to wait, drop-in style		6.3%	5
Quality of care is good		6.3%	5
Happy to have a doctor		2.5%	2
Trans-friendly		1.3%	1
answered question			80

Conversely, in the following question about barriers to accessing health services, discrimination for a variety of reasons (e.g., poverty, drug use, racism, transphobia), bad experiences previously, lack of money, and lack of transportation were cited often. This is similar to other studies (Gillis & Singer, 1997; Sachs-Ericsson, Wise, Debrody, & Paniucki, 1999, Wen, Hudak, & Hwang, 2007).

When asked what barriers, if any, participants felt they experienced in accessing health care, 76 people responded:



What barriers, if any, do you have to get health care?			
		Response Percent	Response Count
Bad experiences in the past		44.7%	34
Can't afford it		38.2%	29
Don't trust medical people		36.8%	28
Discrimination due to poverty issues		30.3%	23
I don't have transportation to get there		26.3%	20
Discrimination due to drug use		21.1%	16
Discrimination due to disability		15.8%	12
I don't have a health card		15.8%	12
Racism		10.5%	8
Discrimination due to gender		10.5%	8
No time		10.5%	8
i don't know the nearest clinic		7.9%	6
Not able to access specialists (waiting times)		7.9%	6
Lack of doctors		5.3%	4
Transphobia		5.3%	4
Homophobia / Heterosexism		4.0%	3

Discrimination due to being involved in sex trade		4.0%	3
Can not read		4.0%	3
Other	Other people, family, roommates.	4.0%	3
answered question			76

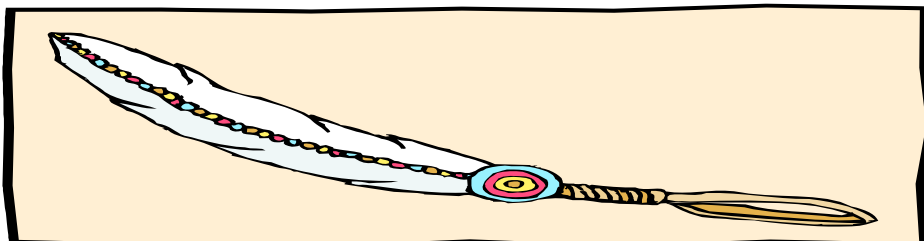
The nature of the barriers again is reflective of the social exclusion that homeless, low-income, and marginalized people face.

When analyzed by population:

- For newcomers, the number one barrier was “can’t afford it”
- For injection drug users, the number one barrier was “Discrimination due to drug use”
- For Native participants and participants who smoked crack, “Discrimination due to drug use” was number three
- For trans participants, their number one barriers were not having a health card and transphobia.

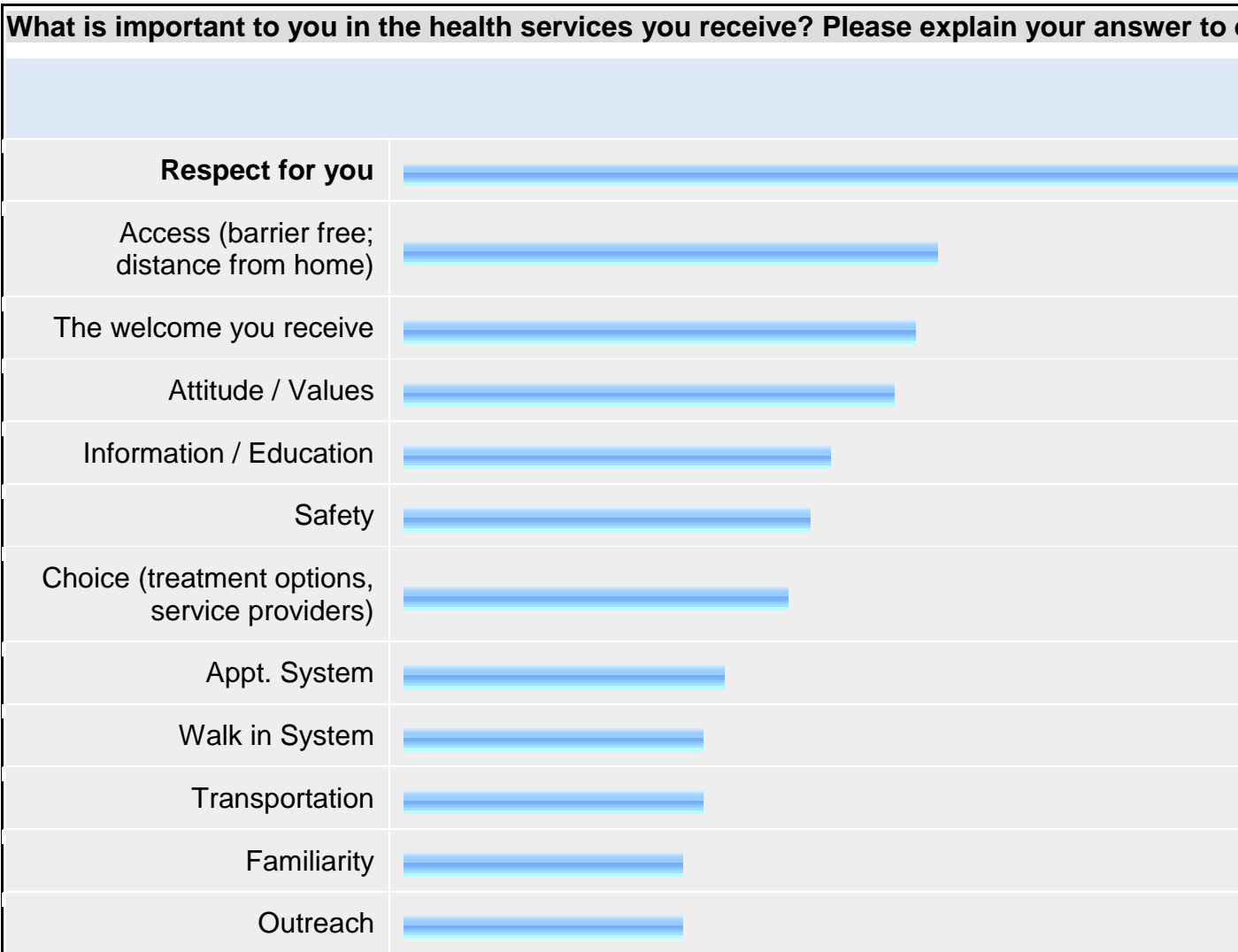
Not surprisingly, when asked if participants were receiving treatment for their conditions, 56% said no (43 people). When asked why not, they stated: lack of health care (22), fear/don’t trust doctors (3), don’t feel like going (3), can’t afford treatments (2), all health care experiences have been bad (1), side effects (1), no health card (1), can’t get treatment until clean for 3 months (1).

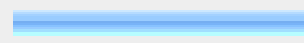
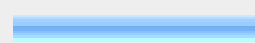
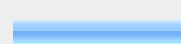
Those who were receiving treatment did so at: 410 Sherbourne, Maple Leaf Clinic, Family Doctor, Sherbourne Health Centre, PWA, St. Michael’s Hospital, CAMH, Shared Care, Women’s Res, and Mt. Sinai Hospital. Treatments ranged from daily to bi-annually.



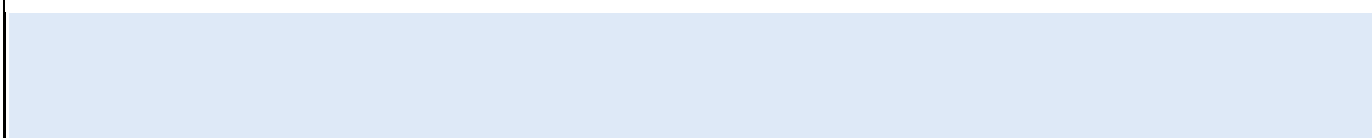
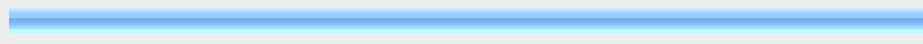
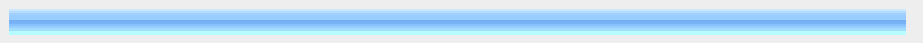
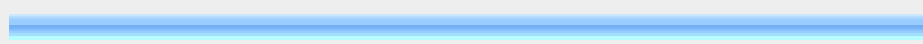
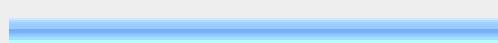
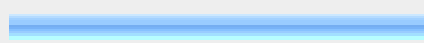
Creating Inclusive & Holistic Health Services

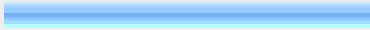
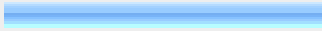


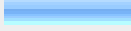



In order to better understand the nature of the health services that participants would like to access, they were asked to identify what was important to them. Seventy-eight participants answered. Again, of paramount importance to the majority of participants was “respect for you”.



Programs	
Services delivered at home / other locations	
Cultural sensitivity	

When asked how, where, by whom, and in what format the services would ideally be delivered, participants suggested that the services be open 24 hours per day or at least extended morning and night hours, the service should be downtown, co-located with a social service/one-stop-shopping model, and available by appointment or drop-in/walk-in. Regarding staff, participants suggested doctors, dentists, counselors, nurses, health outreach workers, and health educators. Further, when asked what kind of services would help maintain their health, 73 participants stated:

What kind of services would help you maintain your health?	
	
Family Doctor / Medical Care	
Health Education / Information Sessions	
Dental Care	
Individual Counselling (professional & peer)	
Addiction Services (including crack kits, counseling, safe injection site, AA/NA/CA)	

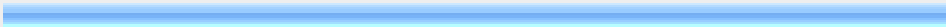
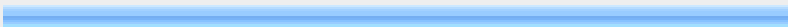

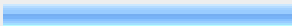
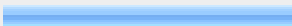

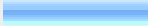
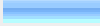




Alternative Medicine	
Group Counselling	
Homecare	
HIV / AIDS Care	
Healthy food, vitamins, and herbal remedies	
Eye/ear care	
Safe, clean, affordable housing	
Sports/fitness	



Drug Use

In preparing to conduct this health survey, it was noted that many of the community members, tenants, and residents at the hostel have addictions. In order to better understand what substances people are using, what harms they might be at risk of, and how people feel about their drug use, particular attention was observed to this issue. Sixty-one participants stated that they used one or more drugs.

In the last 30 days, which of these drugs did you use?

Alcohol	
Crack (Smoked)	
Marijuana (pot) and / or hash	
Crack (Injected)	
Powdered - cocaine	
Tranquillizers (i.e. Valium, Librium, Ativan, Halcion, etc.)	
Other Opiates (Dilaudid, Demerol, Talwin, T=3/4s, Morphine, Percadan, Oxycotan, Percacets, Codincontin, Kat, etc.)	
Ecstasy / MDMA, or Special K	
Amphetamines (i.e. Benzadrine, Dexedrine, Preludin, etc.)	
Ritaline	
Poppers	
Speed	
Other	Cigarettes

Similar to anecdotal experience at Fred Victor Centre, alcohol, crack (smoked), marijuana (pot) and / or hash were the drugs of choice. These results inform the

nature of addictions programming needed (e.g., AA, CA, harm reduction focused on smoking crack).

When analyzed by population:

- Newcomers identified using alcohol only – no injection use. Only half of them identified using alcohol.
- Of the participants who smoked crack, 65% identified violence as an issue.
- Of the participants with a disability, 80% identified using alcohol.
- Of the trans-participants, 80% of them identified smoking crack.
- 73% of the participants who identified HIV/AIDS as an issue, smoked crack.
- 83% of Native participants smoked crack.
- 17% of people with disabilities injected crack.
- Of the participants who identified HIV/AIDS as an issue, 46% of them injected crack.
- Of the participants who had only completed elementary school, 50% of them injected crack.

Regarding mental health and addictions (concurrent disorders), 74% of people for whom mental health was an issue drank alcohol, 52% of them smoked crack, 48% used marijuana (pot) and/or hash, 26% used powdered-cocaine, 18.5% used tranquilizers, 11% injected crack, and 15% used other opiates.

Of the 61 who stated they used during the previous 30 days, 58 responded about how often they used:

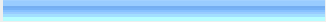

In the last 30 days, how often did you use?			
		Response Percent	Response Count
Twice or more every day		24.1%	14

Once every day		12%	7
Every other day		12%	7
Once or twice a week		33.0%	19
Once or twice a month		17.2%	10
Other	Less often	3.4%	2
answered question			58

Eleven participants stated that they had injected crack over the previous month. Other participants may have injected other substances, but method of using other drugs was not specifically asked. Of the participants who were injecting crack, two stated that they had used injection equipment that someone else had used in the previous 30 days and the same two stated that they had shared given, lent, rented or sold a needle that you had used, to someone else. One additional person stated that they had used and shared injection equipment.

When asked how people would rate their drug use, all of the people who were using responded:

How would you rate your drug use?			
		Response Percent	Response Count
I'm satisfied with usage and don't want any change.		38.9%	22
I'm satisfied but would		16.7%	9

like to reduce usage			
I'm satisfied but would like to reduce the "bad impact" it has on my life.		20.4%	12
I'm not satisfied and would like help to stop.		22.2%	16
I'm not satisfied and I don't expect any change		0.0%	0
Other	Need something new, using for pain relief	18.5%	2
	answered question		61

Recommendations

When “homeless adults receive care from an accessible homeless outreach program, which is designed to address their special needs, they will indeed utilize the health services and return for subsequent visits.” (Nakonezny, 2005, 5).

Based on the information that was gathered from the 83 interviews, there is a need for specific health services for the community who use Fred Victor Centre. Lack of health services, over-use of emergency rooms, and the number of people who are not accessing treatments indicates a strong need. The health services need to be holistic and respond to the broad definition of health ~ social, emotional, mental, physical, and spiritual ~ and the social determinants of health. Specific recommendations include:

1. Establish a health clinic that includes a variety of practitioners: 1 physician, 1 dentist, ½ psychiatrist, 4 counsellors (specialties in violence, concurrent disorders, addictions/harm reduction, and trauma), 1 naturopath, 1 nurse, ½ Native Elder, 1 health educator, and 1 outreach worker.
2. Ensure mental health, psychological issues, and violence are central to all work that happens at the health clinic.
3. Physical health issues that are common amongst homeless, low-income, and marginalized adults need to be addressed both in terms of care and weekly health education sessions.
4. The health clinic needs to be established within a social service setting, ideally that has a drop-in, to ensure an initial sense of safety and trust are established.
5. Specific counseling programs are needed – individual and groups – for: concurrent disorders, trauma, anti-violence, addictions/harm reduction, Hep C/HIV/AIDS.
6. Values/attitudes of all staff/volunteers and programs must include: compassionate, welcoming, respectful, understanding, culturally competent, trans-positive, harm reduction, anti-oppression, safety, and choice.
7. Staff/volunteers of the health services must be culturally diverse and include trans-people.

8. The health services should give out free items: vitamins, medication, condoms, needles etc., hygiene products, socks, and foot powder ~ and should provide coffee and nutritious snacks for patients.
9. Literacy levels and languages should be considered for all written materials. All materials should be multi-lingual and should clearly identify that services are free.
10. Pamphlets, posters, and other information should be easily available to patients.
11. Hours of the health services should be long – early morning to late evening and be available 7 days per week.
12. This level of programming and staffing will require a Manager of Health Services, a full-time receptionist, and a full-time administrator.

Further thought and investigation is needed to address:

1. An analysis of the partnerships that Fred Victor Centre has should be done to determine what level of partnerships we have with each of the services listed, given that we share clients.
2. Where are homeless, low-income, and marginalized people aged 19-29 and over 60 being served as numbers in this study are unusually low?
3. Does programming, outreach, marketing, and partnerships reflect the diversity of community members using our services? Given the number of people who identified as disabled, First Nations, and Newcomers (in some cases high and others low) does Fred Victor Centre look as welcoming and inclusive as it could to diverse populations?
4. Sixty-two-percent of participants identified as white, only 13% as Native and African/Caribbean at 14.4% and fewer still as East or South Asian – despite the population of Toronto being over 50% visible minorities, low-income people being disproportionately people of colour and Newcomers,

- and First Nations people being over represented amongst homeless folks.
Why is Fred Victor Centre's demographics predominantly white?
5. Forty-four-percent of people identified as having a disability, yet only 30% identified as being on ODSP as their source of income. Why? How should our services better respond to people with disabilities?
 6. Many people identified Ontario Works as their source of income. How could/should we enhance our relationship or advocacy work with Ontario Works?
 7. The health bus is well used – what should the relationship be to the health bus? How does our service enhance rather than duplicate this service?
 8. How can the restaurant better advertise that it provides healthy, nutritious meals that meet the Canada Food Guide, at low costs?

Appendix A

Community Health Needs Assessment Information Sheet

The following provides an overview of the Community Health Needs Assessment. After reviewing the information contained in this document you are asked to consider participating in a short interview. If you do go on to participate in an interview, this will serve as a proxy or function as implied consent.

Interviewers:

Holden Keys; Megan Vincett; Silke Haller Carol Watson; Kirsten Schmidt-Chamberlain

Purpose of the Needs Assessment:

The overall purpose this this needs assessment is to collect information from the community about your health needs and your experiences accessing health services.

Description of the Needs Assessment:

The interview includes 31 questions. The interview will take place between you and one of our interviewers and is estimated to take 30 minutes to conduct. All of the information you provide will be anonymous on the survey – meaning, no one will know it is you that provided specific information because your name will not be attached to the survey and all of the information you give us will be mixed in with the information from the other participants. The answers you give to the questions will be recorded on the interview form.

Confidentiality and Privacy:

Confidentiality will be respected and no information that discloses your identity will be released or published without consent unless required by law. All identifying information will be destroyed. This means that no information will be released or printed that would disclose personal identity. Demographic data will be collected and presented in aggregate only (meaning all of the data will be mixed together so no one person will be identified). The hard copies of interview and notes will be shredded upon completion of the report.

Potential Benefits:

You will not benefit directly from participating in this interview. Information collected from the interviews may be instrumental in informing Fred Victor Centre around the current health care needs of individuals that services are provide to.

Publication of results:

A comprehensive report will be written and used within Fred Victor Centre for planning purposes. The report and any presentations made from the report will be provided to other community partners, funders, and other stakeholders in our efforts to provide better services at FVC. Additionally, the report may be published in newsletters or journals.

Compensation:

Each person who participates in full or in part in the interview will be given \$10 in compensation for their time.

Participation and Withdrawal:

Participation in completing the interview is voluntary. If you choose not to participate or complete the interview, there will be no consequences and will not affect your access to services provided by Fred Victor Centre.

Appendix B

You are invited!

The Fred Victor Centre is doing a community health needs assessment. 25% of the community is being invited to participate – and you have been selected! After reading the information below, if you are interested in participating, please come down to the housing office on **Tuesday July 10th, between 4-8pm.** Bring this letter with you! You will be paid \$10 for your time.

Community Health Needs Assessment Information Sheet

The following provides an overview of the Community Health Needs Assessment. After reviewing the information contained in this document you are asked to consider participating in a short interview. If you do go on to participate in an interview, this will serve as a proxy or function as implied consent.

Interviewers:

Holden Keys; Megan Vincett; Silke Haller Carol Watson; Kirsten Schmidt-Chamberlain

Purpose of the Needs Assessment:

The overall purpose this this needs assessment is to collect information from the community about your health needs and your experiences accessing health services.

Description of the Needs Assessment:

The interview includes 31 questions. The interview will take place between you and one of our interviewers and is estimated to take 30 minutes to conduct. All of the information you provide will be anonymous on the survey – meaning, no one will know it is you that provided specific information because your name will not be attached to the survey and all of the information you give us will be mixed in with the information from the other participants. The answers you give to the questions will be recorded on the interview form.

Confidentiality and Privacy:

Confidentiality will be respected and no information that discloses your identity will be released or published without consent unless required by law. All identifying information will be destroyed. This means that no information will be released or printed that would disclose personal identity. Demographic data will be collected and presented in aggregate only (meaning all of the data will be mixed together so no one person will be identified). The hard copies of interview and notes will be shredded upon completion of the report.

Potential Benefits:

You will not benefit directly from participating in this interview. Information collected from the interviews may be instrumental in informing Fred Victor Centre around the current health care needs of individuals that services are provide to.

Publication of results:

A comprehensive report will be written and used within Fred Victor Centre for planning purposes. The report and any presentations made from the report will be provided to other community partners, funders, and other stakeholders in our efforts to provide better services at FVC. Additionally, the report may be published in newsletters or journals.

Compensation:

Each person who participates in full or in part in the interview will be given \$10 in compensation for their time.

Participation and Withdrawal:

Participation in completing the interview is voluntary. If you choose not to participate or complete the interview, there will be no consequences and will not affect your access to services provided by Fred Victor Centre.

Appendix C

Services Used by Participants: External to FVC

Mt Siani Hospital	St. Michael's Hosptial	Shout Clinic
Atrium on Bay Clinic	Queen West Clinic	U of T Health Services
Regent Park Community Health Centre	Lombard Dentist	St. Joseph's Hospital
Voices of Positive Women	The 519 – Trans Programs	Addiction Research Foundation
Diabetes Group at Mt Siani	Diabetes Group at Houselink	Ossington Detox
HIV Awareness at 2 Spirited People of the First Nation	Stop Smoking Group	Diet & Nutrition Group
Heart & Liver Health Group	John Innes	CEP
TEDNA	John Howard Society	Our Place
Good Neighbours	Gerstein Centre	Eritrean Community Ctr
Ralph Thornton Ctr	CODA	OCAP
The 519	Sistering	Street Haven
2 Spirited People of the First Nation	PARC	Evangilene Hall
ARC	Gateway	St Christophers
Metropolitan Church	Cornerstone	Good Sheppard
The 416	Meeting Place	Sketch
Friendship Room	AWRC	PWA
ACT	Public Health	The Works
Health Bus	Anishnabe Health	Council Fire
Sherbourne Health	CAMH	Women's Own Detox
St. Joeseph's Detox	AA	12 Step
Jean Tweed	2 nd Harvest	Daily Bread
Fort York	Salvation Army	Scott Mission
Our Lady of Mercy	77 River St.	Chesswood ERC
Parliament ERC	MiziweBiik ERC	Scarborough Town Centre ERC
River St ERC	Labour Link	Native Women's Resource Centre
Jamaican Canadian Black Action		

References

2006 Street Needs Assessment. City of Toronto.
<http://www.toronto.ca/housing/streetneeds.htm>

Anderson, J. (March 19, 2003). Aboriginal Children in Poverty in Urban Communities: Social exclusion and the growing racialization of poverty in Canada. Notes for Presentation to Subcommittee on Children and Youth at Risk of the Standing Committee on Human Resources Development and the Status of Persons with Disabilities, Canadian Council on Social Development.
<http://www.ccsd.ca/pr/2003/aboriginal.htm>

Bannerman, M. (2007). Women's Harm Reduction & Community Safety Project. South Riverdale Community Health Centre.

Cheung, A.M., & Hwang, S.W. (2004). The risk of death among homeless women: a cohort study and review of the literature. *CMAJ*, 170, 1243-1247.

Daiski, I. (2007). Perspectives of homeless people on their health and health needs priorities. *Journal of Advanced Nursing*, 58(3), 273-281.

Government of Canada. (2004). Advancing the Inclusion of Persons with Disabilities.
<http://www.hrsdc.gc.ca/en/hip/odi/documents/advancingInclusion04/index.shtml>

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

Nakonezny, P.A., & Ojeda, M. (2005). Health service utilization between older and younger homeless adults. *The Gerontologist*, 45(2), 246-255.

Omidvar, R., & Richmond, T. (2003). Immigrant settlement and social inclusion in Canada. Maytree Foundation.

Public Health Agency of Canada. (2007). The Social Determinants of Health: An Overview of the Implications for Policy and the Role of the Health Sector,
http://www.phac-aspc.gc.ca/ph-sp/phdd/overview_implications/01_overview.html

Toronto Report Card on Housing and Homelessness. (2003). City of Toronto.
<http://www.toronto.ca/homelessness>

Tucker, J.S., Wenzel, S.L., Elliott, M.N., Marshall, G.N. & Williamson, S. (2004). Interpersonal violence, substance use, and HIV-related behavior and cognitions: A prospective study of impoverished women in Los Angeles County. *AIDS and Behavior*, 8(4), 463-474.

Wen, C.K., Hudak, P.L., & Hwang, S.W. (2007). Homeless people's perceptions of welcomeness and unwelcomeness in healthcare encounters. *Journal of General Internal Medicine*, 10.

World Health Organization. (2007).
http://www.who.int/bulletin/bulletin_board/83/ustun11051/en/