CROWE

The Street Health Report

A study of the health status and barriers to health care of homeless women and men in the City of Toronto

May 1992

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Eileen Ambrosio is a Registered Nurse who came to Street Health with a background in palliative care. She has a special interest in seniors' health and ethics. Eileen is presently completing her doctoral degree in Bioethics at the Ontario Institute for Studies in Education in Toronto.

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Dilin Baker is a Registered Nurse who, along with members of the community who used the drop-in centres and shelters at All Saints' Church in Toronto, founded Street Health in 1986. She is the Executive Director and guiding light of Street Health. It was Dilin who first conceived of doing this health survey.

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Cathy Crowe is a Registered Nurse who has worked in community health since 1980. Cathy has an interest in the role of the nurse in the health care system, which was the subject of her recently-completed Masters of Education (Sociology) thesis at the Ontario Institute for Studies in Education in Toronto.

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Kathy Hardill is a Registered Nurse with a background in neurosurgical and trauma care nursing. She is a political activist and brings to Street Health an interest in the politics of health and health care.

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"We need to look more to the community instead of running expensive hospital programs. We need more preventive medicine."
– former domestic worker, interviewed in a women's shelter

"There should be universality of health care, regardless of who you are."
– young man interviewed in a soup kitchen

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416 Dundas Drop-In
Sistering
The Good Shepherd
The Scott Mission
St. Francis' Table
The 519 Sunday Drop-In
The Friendship Room
St. Bartholomew's Breakfast Program
The Christian Resource Centre
The Good Neighbours Club
Out of the Cold (Holy Rosary Parish)
Council Fire Native Cultural Centre
Single Women's Residence
Robertson House
Rendu House
Nellie's Hostel
Evangeline Residence
Street Haven At The Crossroads
Anduhyaun Residence
Salvation Army Men's Hostel (Sherbourne Street)
Salvation Army Men's Hostel (McCaul Street)
Seaton House Men's Hostel
Dixon Hall Men's Shelter
St. Simon's Overnight Shelter
Na-Me-Res (Native Men's Residence)

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Contents

Profile of the Sample: Who Are the Homeless?

We devised a sampling strategy which would generate a representative sample of homeless people in the City of Toronto. The methods used to construct the sample and the low refusal rate give us confidence that the 458 women and men we interviewed (106 women and 352 men) ranging in age from 16 to 83, comprise a fair representation.

Homeless people have largely been excluded from other census and health surveys which depend on people having an address or telephone number, neither of which this population have. We compare and contrast what was learned from homeless women and men in our survey with data from surveys of the general population.

Younger Compared to the General Adult Population

76.3% of our sample were between the ages of 25 and 49, compared with 50% of the adult population in the 1986 census for the City of Toronto; 12.3% of the sample were 50 years of age and over, compared with 30.9% of the adult population in Toronto in the 1986 census.

Ethnic and Geographical Backgrounds

One third of all respondents (32.4%) were Native, Black or Asian. Although everyone interviewed had enough facility in English to complete the interview, 41.7% of people speak a language other than English. Most commonly spoken were French or an aboriginal language.

One quarter of our sample (24.2%) was born outside of Canada. The most common countries of origin were the United Kingdom, Jamaica and the United States. Numerous other countries were also represented.

Of those born in Canada, 30% named Toronto as their birthplace. Of those born outside of Toronto, most respondents were born somewhere else in Ontario or in one of the Maritime provinces (New Brunswick, Prince Edward Island, Nova Scotia or Newfoundland).

Mobility

The sample appears to have a high mobility. 42.4% had lived outside Toronto at some point in the year prior to the survey. 13.9% had come to Toronto for the first time in the year prior to the survey. The most important reasons people in our sample gave for coming to Toronto were: to find work, to find housing, family reasons (to be near family, moved with one's family, to get away from family) or came to Toronto when immigrating to Canada.

Living Below the Poverty Line

While people reported having received income in the past year from sources including social assistance, wages, self-employment and unemployment insurance, 15% had no income in the past month and 30% had an income of less than $500 in the past month. Only 10% reported having received more than $1,000 in the month prior to the survey. Most of the sample reported income figures which are well below the poverty line.

Further compromising the low incomes reported is the fact that over one half of the sample reported using cheque-cashing services to cash cheques. Because banks frequently demand several pieces of identification or require a minimum balance to be kept in accounts, homeless people are often deterred from using banks because minimum balances are next to impossible to maintain, and keeping even one piece of identification is difficult given one's inability to store belongings safely. Cheque-cashing services apply substantial service charges, which further penalizes those with already insufficient incomes.

Loss of Housing

68% of those interviewed had paid rent on some form of housing in the year prior to the survey. The most common form of accomodation was rooms (57.1%), followed by apartments (31.0%). The most common reasons for leaving a last place of residence were living conditions (lack of safety, too much noise, too much alcohol or drug use there). The next most common reasons were economic (couldn't afford it, lost job or could no longer work because of illness). Clearly, the safety and quality of accomodation is at least as important as affordability.

Challenging Stereotypes

Contrary to stereotypes related to alcohol and drug use among homeless people, 16.8% of our sample reported daily drinking, as did 16% of the general Toronto population (as reported in the 1988 Toronto Community Health Survey). Less than 10% of our sample used licit or illicit drugs on a daily basis. Alcohol was used more than all other drugs combined.

Highlights of the Report

Chronic Health Conditions

"It is hard to control my diabetes by diet because if you're going to the drop-ins you just eat what they have."

– young man in his 20s with no fixed address

Homeless women and men do not have "different" illnesses than the general population. However, their living circumstances and poverty affect their ability to cope with health problems. The significantly higher prevalence of chronic conditions noted in our sample as compared to the general population, and the additional health risks faced by homeless people substantiate the argument that homeless women and men must be included in health data collection efforts.

Many of the conditions below are commonly higher among women and older people, both of which are underrepresented in our sample. This makes the differences between the two samples even more significant and strongly supports the argument that this group of people should be given priority in terms of health policy directives.

This table compares the prevalence of the following chronic conditions in our sample to those reported by the Toronto Community Health Survey (1988) where comparisons were available:

Condition	Sample	General Population
arthritis/rheumatism	29.8%	13.4%
allergies/hay fever	18.7%	24.7%
emphysema/chronic bronchitis	17.8%	3.6%
hypertension (high blood pressure)	13.2%	12.5%
asthma	12.2%	4.6%
myocardial infarction (heart attack)	7.4%	4.1%*
epilepsy	6.3%	1.0%**
head injury	4.5%	—
angina	2.9%	—
diabetes	3.1%	2.4%
stroke	2.0%	—

(*) this figure from the Toronto Community Health Survey combines heart attack and other "heart trouble"
(**) this figure is from Epilepsy Ontario statistics (1992)

Accidents and Injuries

"I got frostbite this year because I had no place to go and I was walking all night."

– young man in his 30s, interviewed in a hostel

11.4% of our sample reported traffic-related injuries (as pedestrians), which is significantly higher than the 2.0% reported by the general Toronto population (Toronto Community Health Survey, 1988). As well, 8.5% of our sample had experienced frostbite in the past year. Homeless people are more vulnerable to these types of injuries due to their greater exposure to the streets, to traffic, and to extremes of temperature.

Physical Assault

"I was assaulted twice in the last year by security guards in shopping centres."

– man in his 50s, interviewed in a shelter

"I was beaten by the cops with night sticks. I had welts all over my back. They always stop you for ID. I got fed up, started to walk away. They started beating me."

– man in his 20s, interviewed in a shelter

40% of our entire sample had been physically assaulted during the past year. Over one half of these people had been assaulted more than one time. One quarter of those assaulted (10.0% of the entire sample) had been assaulted by members of the police force.

Almost one half of all the women we interviewed (46%) had been assaulted in the past year.

Sexual Assault and Rape

On sexual harassment: "It happens almost every day."

– young woman, interviewed in a shelter

43.3% of the women reported having experienced sexual harassment or assault in the past year (defined as having received unwelcome sexual advances or of having been touched or grabbed without their consent). In total, one in five people we interviewed had been sexually harassed in the past year.

"I've had seven attempts of rape. One was like a professional. I was punched in the face and told to stay still or I would die. I don't know what I felt. I just walked up and down. I couldn't go anywhere."

– woman in her early 20s

More than one in five women we interviewed (21.2%) had been raped in the past year. In total, 5.8% of the entire sample admitted to having been raped in the same time period.

Clearly homelessness is a dangerous circumstance to be in. This danger is significantly magnified for women in terms of both physical and sexual violence.

General Wellbeing

"The right to healthy and secure rest should be guaranteed to every being on the planet— just like food and air. Street life is not conducive to rest. A couple of times it might be exciting or romantic to stay up all night, but when you live that life, the glamour wears off and the inhumanity affects your rationality."

– young man in his 30s, interviewed in a hostel

43% of our sample reported fatigue in the past 30 days as compared to 16% of the general Metro Toronto population surveyed in the Toronto Area Survey (TAS, 1992). One half of our sample (48%) reported having less than 6 hours of sleep on 4 or more nights of the past 7 nights, often related to their living circumstances.

As well, gastro-intestinal problems in the past 30 days had a much higher prevalence in our sample than in the general population (TAS, 1992): specifically vomiting (26% vs. 8%), diarrhea (30% vs. 15%) and stomach pain (25% vs. 15%). Coping with gastro-intestinal problems is aggravated by the lack of access to washroom facilities experienced by homeless people.

Many of these symptoms are stress-related. All of them are further complicated by the difficulties encountered when one has no place of one's own to safely sleep, rest and relax.

Psychological Effects of Homelessness

"The hardest part of being on the street is that it takes away your self respect and confidence. You're constantly lining up for a meal, sleeping with your clothes on, trying to look decent."

– man in his 30s, interviewed in a soup kitchen

Overwhelmingly, the picture of mental health portrayed by respondents was one of men and women experiencing the psychological effects, sometimes severe, of coping with extreme adversity on a daily basis. Almost one third of the sample reported that

lack of self respect, feelings of worthlessness and lack of control over one's life comprised "the hardest part of trying to stay healthy when you are homeless."

Greater than one in four people (26.8%) had considered suicide in the past year. 7.8% had actually attempted suicide in the same period. Only one half of our sample reported knowing anyone who could help them if they were to have an emotional crisis which they were unable to handle on their own.

Women's Health Issues

"When I was a child I was sexually abused by my father. I didn't tell my mother because I was afraid she would give me to the Children's Aid. The doctor let him get away with it by believing my father and not me. They did not protect the victim."

– young woman in her 30s, interviewed in a shelter

Although there were no questions about childhood abuse, 8.5% of the women we interviewed reported having been physically or sexually abused during childhood.

"In the past 12 months, I have been beaten up too many times to remember."

– teenage woman interviewed in a shelter

Almost one half of the women in the sample (46.2%) had experienced physical violence in the past year.

"I've been sexually harassed several times in the past year. It happens more times than you think, in passing on the sidewalk. Not to the point of trauma, but definitely to touch my chest."

– middle-aged woman, sleeping outside at the time of the survey

43.3% of women had been sexually harassed or assaulted. Of these women, almost one half had been sexually harassed or assaulted more than five times in the past year.

"Earlier this year I was staying at a friends'. Now he's no friend of mine. He insisted I have sex with him because I was staying at his place. He wasn't really violent, just forceful. I guess I was lucky because there's so much violence against women and he didn't really hurt me."

– woman in her 50s, interviewed in a soup kitchen

More than one in five of the women we interviewed admitted to having been raped in the past year.

Two thirds of all of the women in the sample (66.0%) had attempted suicide some time in their lives. 63.5% had contemplated suicide in the past year, and 30% had actually attempted suicide in the year prior to the survey.

Connection to the Health Care System

Most people in our sample reported having had some contact with the health care system in the past year. For example, two thirds had seen a physician in the year prior to the survey. Despite the fact that many reporting having used the health system, respondents reported a number of barriers which prevented them from receiving appropriate and/or compassionate care.

Structural Barriers to Health Care

> *"I was refused care in emergency because I didn't have a health card. It's getting to be like the States now."*
>
> – man in his 30s, sleeping at time of survey

Almost 40% of the sample did not have an Ontario Health Card at the time of the survey. 6.7% of people we interviewed had been refused health care because they lacked this card. Being refused health care for any reason is unacceptable, given the principle of universal access to health services upon which health care was founded in Canada.

> *"I sprained my ankle and they told me I need crutches but they were $20 and I didn't have any money."*
>
> – man in his 30s, interviewed in a hostel

> *"The doctor told me to avoid heavy lifting. Working temp work, you have no choice. Either you take a job or you go hungry."*
>
> – man in his 50s, interviewed in a hostel

25.3% of our sample reported that they had been unable to carry out treatments or follow health advice they had received because of their living circumstances. For example, 23% of the sample had been unable to afford required supplies, and 14.1% could not purchase or store the specific foods which they had been advised to eat.

Attitudinal Barriers to Health Care

> *"Living on the streets you learn there is lots of prejudice in the medical world against you. You don't have the same rights as everyone else. You see very bad attitudes from the people who should be most concerned."*
>
> – man in his 40s, interviewed at a meal place

40.5% of the women and men we interviewed reported having experienced an episode in the past year where they felt unhappy or frustrated with the kind of health care they had received.

20% of our sample felt that their health problem was not taken seriously or investigated adequately at some time in the past year. They related this to discrimination because of some aspect of their homelessess, such as having no address to give to reception staff, or looking disheveled because they lacked resources to maintain clean clothes.

Use of Physicians

"If there is anything that really ticks me off, it's this form filling out bullshit."

– man in his 40s, interviewed in a hostel

Two thirds of our sample had been in contact with a physician in the past year. Over one half reported having a family doctor whom they had seen in the same time period. An astounding 36.7% of all respondents had needed to visit a physician for the express purpose of having a form completed (such as forms for welfare or Family Benefits, authorization for transit tickets, special equipment authorization, etc.).

Physicians are the only point of access for people to obtain not only health but social service benefits which, for the most part, could be competently assessed by non-physicians. Public funds are used to reimburse physicians for the visits required for form completion. One has to question whether this is a sound use of health care dollars or physicians' services.

Use of Hospital Emergency Departments

"I went to St. Michael's emergency room to check a bump on my head after I fell off a bunk bed. Was treated fine until they discovered where I lived. I was looked at as if I were a bum. The doctor did not even do an x-ray. I had to go back a second time."

– man in his 20s, staying in a hostel "

I had an allergic reaction to a drug. I waited at the Wellesley emergency room for 3 hours. The staff were all walking around laughing with their coffees. They almost called me a liar. If I had pulled up in my Mercedes-Benz with a three piece suit they would have seen me right away."

– young man, sleeping outside at time of survey

Over one half of our sample (54.4%) had used a hospital emergency department at least once in the past year. Almost one in five use emergency rooms more than any other place for health care.

Almost one half of all of the reported episodes of being refused health care due to the lack of an Ontario Health Card occurred in emergency departments. This should never happen and is not acceptable.

Of those who had used an emergency department in the past year, 30.7% had felt treated rudely by staff because of their appearance. 24.5% had felt treated rudely because of where they said they lived (that is, a hostel, the street, or no fixed address). 42% of the people who left an emergency department prior to being seen by a doctor or nurse did so because of prejudice and discrimination on the part of staff.

The prevalence of prejudicial attitudes towards members of the homeless population, particularly in institutions created to provide "care," is unacceptable, especially given the prominence of low self esteem and lack of self respect identified by our sample.

Use of Hospital In-Patient Services

> *"While I was in the hospital for a broken leg, my doctor told someone to phone a rehabilitation hospital for me to be admitted there. They refused to take me because I had no address."*
>
> – man in his 40s, sleeping outside at time of survey

One quarter of our sample (25.3%) had been admitted to hospital in the past year. Almost one half of those had been admitted more than one time.

38.1% of those admitted to hospital in the past year were discharged to a hostel or to the street. Of the 43 people having no place to go upon discharge, the majority (79%) were not assisted by the hospital to find a place. This could be because these respondents intentionally concealed their homelessness from staff. However, it could also be because hospital staff did not inquire, based on the assumption that everyone has a place to go after discharge. In inner city hospitals, which are the institutions most frequently used by our sample, this assumption should never be made.

Preventive Health Care

Despite the amount of contact with the health care system reported by our sample in the past year, approximately two thirds (62.9%) had not been offered a vaccination against influenza. The Canadian Disease Weekly Report (June 1991) includes in its criteria for administering this vaccine 1) adults with chronic respiratory disorders and 2) those residing in facilities where the institutional environment may promote the spread of disease. Surely both shelters and the streets qualify under this last criterion. Homeless men and women must receive equitable access to this preventive health measure.

40% of our sample expressed interest in taking a smoking cessation program if it were held in a location familiar to them and at no cost. Since over twice as many people in our sample smoke daily as compared with the Toronto Community Health Survey sample, it is imperative that homeless people be given at least equal exposure to and benefit from anti-smoking education and smoking cessation programs as the general population.

Dental Care

Our sample was almost twice as likely not to have received dental care in the past year as the general population (Toronto Community Health Survey, 1988). Almost one quarter of our sample had not seen a dentist in more than five years. Only 8% of the general population had not seen a dentist for this long a period of time.

The most important reasons for not having seen a dentist in the past year were financial barriers such as not having dental coverage at all, or limitations on coverage by social assistance dental programs.

Not surprisingly, our sample reported a significant amount of dental pathology in the month prior to the survey, such as sore or bleeding gums, toothaches, cavities and loose teeth. These findings will not improve, given Metro Toronto Council's recent elimination of all but emergency dental care coverage for social assistance recipients. Eliminating preventive dental care coverage will certainly result in increased prevalence and severity of dental pathology in this population.

Recommendations

Homelessness is a stark reminder of the inadequacies of our health and social service systems. Given the current erosion of health and social programs, it is imperative that those most vulnerable be given priority. The recommendations are organized by areas of responsibility for change. The required changes are possible given the political will to accomplish them.

City of Toronto Department of Public Health

1. That the Department of Public Health designate homeless people as a priority and ensure that financial and health promotion resources reflect this.
2. That the Department of Public Health's community grants program recognize the high risk of this population and add homeless people as a category to their grant application procedures.
3. That the Department of Public Health reevaluate the existing role of the Public Health Nurse with homeless people and the potential role of the Public Health Nurse towards identifying and developing responses appropriate to the homeless community.
4. That the Department of Public Health make the homeless population a specific target for advocacy related to the basic prerequisites of health, more specifically support and work with community groups and advocates on issues such as safe housing, poverty and zero tolerance of violence.
5. That the Department of Public Health provide smoking cessation programs to people with low incomes in the places they spend time such as shelters and drop-in centres and develop these programs with the community.
6. That the Department of Public Health expand its influenza and other immunization programs by putting into place a systematic strategy for immunizing all homeless individuals against influenza by fall 1992.
7. That the Department of Public Health implement strategies to ensure the inclusion of homeless people in all health surveys and policy directives, and that they ensure that the content of these surveys be made relevant to this population.
8. That the Department of Public Health establish a dental clinic where homeless people and others with low incomes can receive free dental care including preventive and emergency care.
9. That the Department of Public Health recognize that the level of physical and sexual assault and harrassment of the homeless is unacceptably high and appalling and include this community in its efforts to address violence as a public health issue.

Metropolitan Toronto Council

1. That Metro Hostel Services Division provide education and training to shelter staff regarding incest, child sexual and physical abuse, adult sexual abuse and harassment that will improve their ability to support men and women who are staying in shelters.
2. That Metro ensure that training is provided for staff in drop-in centres that will help them provide support for the victims/survivors of incest, child sexual and physical abuse, and adult sexual abuse and harassment.
3. That Metro Social Services Division be proactive and advise social assistance recipients of their eligibility for medical benefits such as drug cards, dental care, etc.
4. That Metro Hostel Services Division explore ways that hostels can accommodate the needs for "recuperative" care for minor episodic illnesses among homeless people staying in hostels which close during the day.
5. That Metro address the barriers that General Welfare recipients face in utilizing banking establishments and work with community groups that are currently trying to address these problems.
6. That Metro explore and promote the development of a central registry for co-operative, non-profit and public housing.
7. That Metro adequately fund drop-in centres to provide adequate and safe surroundings while homelessness exists.

Metropolitan Toronto Police Services Board

1. That the Police Services Board direct the Chief of Police to 1) develop a standing order to address the problem of discriminatory treatment of and violence towards people who are homeless; and 2) through education, training and sanctions develop mechanisms for the effective implementation of the order.
2. That the Police Services Board communicate to the Solicitor General that the Police Services Act be amended to transfer current responsibilities of the Police Departments Internal Affairs Unit and the Provinces's Special Investigation Unit to the Office of the Police Complaints Commissioner and that civilian staff in that office carry out all investigations of public complaints against police from day one.
3. That the Police Services Board recommend to the Solicitor General that police training be removed from Police Colleges and incorporated into post-secondary social service programs in Community Colleges or Universities in order for trainees to benefit from established humanities programs which would provide for their sensitization to the social and human needs of communities.

City of Toronto Hospital Emergency Departments

1. That Emergency Room staff receive sensitivity training regarding the community they serve in order to improve their attitudes and care of the people they serve such as the homeless.
2. That Emergency Departments acknowledge the use of their departments for non-life threatening health problems and address ways in which they can be more responsive to and less judgemental of their clients' needs.
3. That the staff of Emergency Departments meet together to discuss their collective need to address the issue of non-emergency use of their departments.
4. That Emergency Room staff ensure that clients have access to the supplies necessary to do prescribed treatments and if necessary the institution should provide the supplies.

City of Toronto Hospitals

1. That hospitals utilize their computer systems to develop ways to identify clients who give an address such as "no fixed address", a hostel or known rooming house in the neighbourhood. These clients should receive an immediate referral to the Social Work Department to allow for discharge planning to start on admission.

Family Practice Units and Community Health Centres

1. That Family Practice Units and Community Health Centres make allowances in their daily scheduling for people who need same day appointments.
2. That Community Health Centres acknowledge the health needs of homeless people in their communities and develop strategies to respond to those needs.
3. That Community Health Centres approach the Community Health Branch of the Ontario Ministry of Health to explore the provision of funds for dental programs.

City of Toronto Mental Health Services

1. That local mental health agencies and institutions focus on the provision of accessible, appropriate, community-based mental health services for homeless individuals in their communities.

Ontario Ministry of Health

1. That the Ministry of Health prohibit all publicly funded health care institutions from refusing care to individuals who do not have their Ontario Health Card.
2. That the Ministry of Health mandate that family practice units, emergency departments and fee-for-service physicians assist clients in acquiring their Ontario Health Card.
3. That the Ministry of Health require Metro Toronto Home Care to provide services to homeless individuals despite their lack of a recognized residence.
4. That the Ministry of Health implement strategies to ensure the inclusion of the homeless population in all health surveys and policy directives and to ensure that the content of these surveys be made relevant to this population.
5. That the Ministry of Health recognize the high prevalence of physical and sexual assault experienced by this population and immediately direct targeted grant funds to community agencies for the purpose of employing counsellors to work with victims/survivors of sexual abuse and violence.
6. That the Ministry of Health examine physician gate-keeping with the goal of providing alternatives in order to ensure that homeless people are not dependent upon physicians for their access to housing, economic security, social services and community-based wellness care; and further, that the Ministry recognize the education, skills, knowledge and experience of other health care professionals in providing these alternatives.
7. That the Ministry of Health redirect a substantial portion of the funding currently channelled to trauma services to brain injury prevention education, rehabilitative care, family support care and supportive housing for brain-injured individuals.
8. That the Ministry of Health explore existing community institutions such as convalescent hospitals to provide recuperative care for homeless people recovering from minor episodic illnesses.

Ministry of Colleges and Universities

1. That the Ministry of Colleges and Universities ensure that the curriculum in Ontario Medical Schools addresses the social inequities of health, and recognizes that prejudicial attitudes towards the homeless come from a narrow medicalized interpretation of "illness". This education must be integrated throughout the entire medical education process.

2. That the Ministry of Colleges and Universities ensure that all health discipline programs address the social inequities of health, and recognize that prejudicial attitudes towards homeless people come from a narrow medicalized interpretation of "illness". This education must be integrated throughout the entire medical education process.

Ontario Ministry of Community and Social Services

1. That the Ministry of Community and Social Services date Family Benefits cheques with the date of issuance or no date at all.
2. That the Ministry of Community and Social Services address the barriers homeless and low income people face in utilizing banking establishments.
3. That the Ministry of Community and Social Services adequately fund drop-in centres to provide adequate and safe surroundings while homelessness exists.

Health Status

Chronic Health Conditions

This table compares the prevalence of the following chronic conditions to those reported by the Toronto Community Health Survey (1988) where comparisons were available:

Condition	Sample	General Population
arthritis/rheumatism	29.8%	13.4%
allergies/hay fever	18.7%	24.7%
emphysema/chronic bronchitis	17.8%	3.6%
hypertension (high blood pressure)	13.2%	12.5%
asthma	12.2%	4.6%
myocardial infarction (heart attack)	7.4%	4.1%*
epilepsy	6.3%	1.0%**
head injury	4.5%	n/a
angina	2.9%	n/a
diabetes	3.1%	2.4%
stroke	2.0%	n/a

(*) this figure from the Toronto Community Health Survey combines heart attack and other "heart trouble"
(**) this figure is from Epilepsy Ontario statistics (1992)

Homeless women and men do not have "different" health problems than the general population. What differs are the ways in which one's living and economic circumstances affect one's ability to cope with health problems. As well, one's living circumstances can increase the severity of conditions. Many of the above conditions are higher among women and older people, both of which are underrepresented in our sample. This makes the differences between the two samples even more significant.

Arthritis/rheumatism

Our sample reported a higher prevalence of arthritis or rheumatism than is reported in the general population. Reasons for this are not obvious; it is possible that greater and more prolonged exposure to cold or damp weather and the high prevalence of trauma experienced by our sample could potentiate these kinds of inflammatory conditions.

Respiratory Conditions

Allergies or hay fever have reported rates of prevalence in the sample group which are comparable to those of the general population. The prevalence of emphysema and chronic bronchitis in the sample group is over four times greater than it is in the general Toronto population. Asthma is more than twice as prevalent in the sample population than it is in the general Toronto population. These three conditions were among the five most prevalent chronic health conditions reported by the sample group.

Cardiovascular Conditions

Because we differentiated between conditions in this survey, we do not know the overall percentage of the sample with cardiovascular disease (one person may have reported more than one of hypertension, myocardial infarction, angina or stroke). Our sample had a higher prevalence of myocardial infarction (7.4%) than that reported in the Toronto Community Health Survey for all "heart trouble" combined (4.1%).

The Heart and Stroke Foundation of Ontario states that approximately 25% of the Canadian population has some form of heart disease, blood vessel disease or stroke (1992). The Foundation reports that communities with lower average incomes experience higher death rates from cardiovascular disease than those with higher levels of income, which suggests that even equivalent prevalence rates in the sample group will result in more harmful outcomes for the homeless population.

Epilepsy

6.3% of our sample reported having epilepsy. Epilepsy Ontario (1992) reports that the current prevalence rate for epilepsy is 1.0% of the Canadian population, which suggests that the condition is significantly more prevalent in the homeless population. Reasons for this are unclear. As only 5 people who had experienced a seizure reported having been born with epilepsy, this would suggest that the remaining 23 people developed epilepsy sometime later in their lives. However, the cause of epilepsy is unknown for almost two thirds of those with epilepsy in the general population, so it is difficult to hypothesize why the prevalence is so high among the survey sample.

Seizures

As well as those people reporting epilepsy, 20.0% of the sample had experienced at least one seizure sometime in their lives. A seizure is a symptom caused by something which irritates or harms the brain. A number of factors can be responsible for this. When we asked respondents what factors they believed to have been the cause of their seizures, various forms of injury to the brain (a blow to the head, an accident, a fall or a fight) formed the number one reported cause.

What is significant is that various forms of accidental and violent injury to the brain combine to form the leading cause of seizures among the people we sampled. A significant number of respondents had experienced a brain injury severe enough to produce a seizure at some time in their lives. Whether this is comparable to the general population is unknown. The Ontario Head Injury Association (1992) states that "every blow to the head that one sustains throughout (one's) lifetime is personality altering."

Brain injury

> *"I was in a coma for six weeks in 1987. I had a serious head injury. I had to re-learn everything."*
>
> – man in his 20s, interviewed in a hostel

Although we did not ask directly about brain injury in the survey, 20 individuals (4.5% of the sample) identified that they had suffered a brain injury in the past. Some reported having had lengthy periods of unconsciousness, which is indicative of severe injury usually resulting in permanent damage such as diminished memory span, reduced concentration, difficulty with abstract thinking ability, behavioural changes and physical deficits.

Had we specifically asked about past brain injury, it is likely that a greater incidence would have been discovered in our sample, as many people with a history of brain injury do not consider that it may be currently affecting their lives.

We cannot support a correlation between brain injury and homelessness. However, we do know that the health care system falls short in the lack of follow-up care for those surviving traumatic brain injuries. Hospital-based trauma services receive vast amounts of Ontario health care dollars to resuscitate accident victims. However, the Ontario Ministry of Health does not sufficiently fund prevention education, rehabilitation services, family support care or supportive housing for those suffering from head injuries.

HIV Infection

Although we did not ask respondents directly about HIV seropositivity, 5 individuals (1.1% of the sample) volunteered that they had HIV infection or AIDS. Three (3) were women; two (2) were men. It is certainly possible that more than 5 respondents were HIV-infected but either were not aware of their HIV-status or chose not to reveal this information to the interviewers.

Being homeless and HIV-positive is a potentially devastating combination given that HIV infection compromises one's immune system as does homelessness itself through poor nutrition, fatigue and exposure to a multiplicity of communicable respiratory infections in crowded spaces.

Physical Trauma

Accidents and Injuries

11.4% of our sample had been hit by a motor vehicle (such as a car, truck, TTC vehicle) in the past 12 months. The Toronto Community Health Survey found that 2.0% of the general Toronto population had experienced a traffic-related injury in the year prior to that survey.

8.5% of our sample had experienced frostbite in the past year. This is a good example of how homelessness itself is a risk factor for morbidity.

The prevalence of having been hit by a vehicle and of having had frostbite reflects the greater vulnerability of our sample population to these types of injuries because of their greater exposure to the streets, to traffic, and to extremes of temperature.

Physical Assault

An alarming 40.4% of all respondents had been assaulted in the past year. Over one half of the people assaulted in the past year were assaulted more than one time. An even higher proportion of women (46%) had been physically assaulted in the past year.

59 respondents identified assault-related injuries as a reason for having used a hospital emergency room in the same time period. When we asked respondents to state reasons for having been admitted to hospital in the past year, 33 respondents had been admitted to hospital due to physical injury or assault. That this number of assault-related injuries required emergency care or hospitalization reveals the severity of some of these injuries.

Physical Assault by the Police

Police-inflicted injuries have been seen in Street Health clinics for a number of years. Those respondents who reported having been assaulted in the past year were asked if any of those assaults had been committed by the police. 25% of those assaulted in the past year (45 women and men) stated that the police had physically assaulted them during this time period. This represents 10.0% of the entire sample. Of those admitting to having been assaulted by the police, 35.6% had been assaulted more than one time.

These figures do not include those who had experienced police violence prior to the one year time frame imposed by the questionnaire (of which there were a number). It also does not include those who refused to answer this question (5 people).

Sexual Harassment

We asked respondents if, during the past year, they had experienced unwelcome sexual advances or had been grabbed or touched by someone when they did not want to be. One in five people (20.9% of the sample) had experienced such harassment in the past year. The majority of these people (69.7%) had been sexually harassed more than one time. 13 individuals stated that this happened to them so frequently that they could not count the number of times.

43.3% of all of the women we interviewed had experienced sexual harassment or assault in the past year. Of these women, almost one half had experienced this five times or more.

Rape

5.8% of the sample admitted to having been raped in the year prior to the survey. More than one in five women (21.2%) were raped in the past year.

General Wellbeing

Respondents were asked whether they had experienced a number of common general symptoms in the past 30 days. These same questions were asked of 299 non-homeless people in Metropolitan Toronto in the Toronto Area Survey (1992), conducted by The Institute for Social Research. This table compares the percentages of each sample reporting these symptoms in the preceding 30 days:

Symptom	Sample	General Population
headaches	54%	42%
back/neck pain	50%	47%
joint pain	47%	46%
fatigue	43%	16%
diarrhea	30%	15%
vomiting	27%	8%
stomach pain	25%	15%

Compared with the general Metropolitan Toronto population, there was no significant difference between the two samples in reported frequency of headaches, neck and back pain, or joint pain.

Energy Levels and Lack of Sleep

"The hardest part is there's a lot of stress and worry. That's why I don't sleep. I sleep about two hours a night."

– woman in her 20s, interviewed in a shelter

Lack of energy is a common problem for the homeless population. Almost one half of the respondents (43%) indicated that they had lacked the energy required to do light physical work in the 30 days prior to the survey. This compares to only 16% of the general population.

"Lack of energy" is a subjective state that can be precipitated by a number of complex and interacting factors. One half of our sample (48%) reported having less than 6 hours of sleep on 4 or more nights in the week prior to the survey.

Several factors were identified as causing sleep disturbances. For those trying to sleep in hostels, "too much noise" was the most common reason, followed by other factors such as being awakened by others, fear of being hurt, noisy hostel staff, physical discomfort and unclean conditions of the sleeping area. Also reported were personal reasons for lack of sleep, such as the inability to relax, bad nerves, and nightmares, which also indicate the stress of homelessness and not having a safe place to sleep.

Gastrointestinal Problems

Notable differences were evident in the symptoms related to gastrointestinal problems, with our sample experiencing a greater frequency of diarrhea, vomiting and stomach pain than the general population.

The higher incidence of fatigue, lack of energy and gastrointestinal symptoms in the homeless population can be related to the difficulties encountered when one has no place of one's own as a refuge to rest and relax in safety. Having to be constantly vigilant for self-protection over long periods of time, coupled with the inability to rest, raises stress levels and could contribute to stress-related illness.

This may account in part for the higher number of reports of gastrointestinal problems among the homeless. Other living conditions such as the scarcity of public bathrooms and the lack of facilities for maintaining personal hygiene further complicate these problems.

Mental Health

Lack of Self Esteem

"The hardest part is maintaining emotional stability – because you're not getting anywhere. Your self esteem goes down the tubes."

– young man in his 30s, interviewed in a shelter

30% of all the women and men in the sample told us that the most difficult part of being homeless were the psychological effects of being on the street: the lack of self respect, feeling worthless, the lack of respect from other people, the lack of control over one's life, and the fact that being homeless is depressing.

The psychological effects of homelessness were considered to comprise one of the most difficult parts of staying healthy for the women and men we interviewed. These effects are best described in the words of the women and men we interviewed:

Suicide

> *"I promised my dad I'd make something of my life before he died. He's gone now, and I still haven't done anything with my life. I spend lots of time in bed at night thinking of the best way to hang myself. I even dream about it – looking at my own coffin – wake up covered in cold sweat."*
>
> – young man in his 30s, interviewed in a shelter

The table below refers to percentages of the entire sample population:

Considered suicide ever	49.2%
Considered suicide in past year	26.8%
Attempted suicide ever	25.5%
Attempted suicide in past year	7.8%

Large numbers of our sample had considered suicide or had actually attempted suicide at some point in their lives. In the year prior to the survey, 26.8% had considered suicide and 7.8% had actually made an attempt on their own lives. These questions were replicated from the Ontario Health Survey (data not available at time of printing). Once this data is available, it will provide a comparison sample of non-homeless people.

The picture of the mental health of homeless people may be different than the commonly expected stereotype of the "homeless mentally ill." What we found most prominently were women and men who were feeling the severe psychological effects of coping with extreme adversity on an ongoing basis.

History of Mental Illness

24.4% of the sample group had at some time been given one or more psychiatric diagnoses. Of these individuals, almost half of them had been diagnosed with either depression (33.6%) or a drug or alcohol dependency (14.0%).

Only about 13% of the entire sample had received a diagnosis such as schizophrenia, manic depressive disorder, panic disorder or cognitive impairment.

22.8% of the sample reported that they had been hospitalized for a mental health problem at some time. Of those individuals, 39.8% had been hospitalized one time and 19.4% had been hospitalized two times. Almost half (48.5%) had experienced this hospitalization prior to the age of 21 years.

Since less than 6% of the survey sample was under the age of 21 years old, this illustrates that most respondents' mental health admissions to hospital occurred in the past at a young age.

A number of individuals spoke of their negative experiences with the mental health system. 25 individuals (5.6% of the sample) had received electro-convulsive treatment (shock therapy) at some time in their lives.

> *"I was taken to a psych ward against my will. Somebody had to help me but they made me feel even worse. I think they could have just asked me how I was feeling. Instead, they terrified me. I didn't want to take the pills so I flushed them down the toilet and then they forced me to take injections."*
>
> – woman in her 40s, interviewed in a hostel

> *"I had 10 treatments of ECT from 1959 to 1962. It made me feel like a thing instead of a person. It's scary."*
>
> – man in his 50s, interviewed in a hostel

Smoking

This table shows the tobacco smoking habits of the sample population:

smoke daily	77.1%
smoke occasionally	10.3%
do not smoke at all	12.6%

Of those currently smoking, one half of the population reported smoking between 18 and 20 cigarettes daily. Of those currently not smoking at all, 24 used to smoke; 34 have never smoked.

The Toronto Community Health Survey (1988) found that 31% of its sample over the age of 15 years currently smoke tobacco. This number has declined from the 1983 survey which found smokers comprising 36% of people in the same age range.

Two and one half times as many individuals in our sample smoke daily as did the general Toronto population in 1988. Given the higher prevalence of respiratory diseases found in our sample, as well as what is known about lung cancer and other smoking-related conditions, it is clear that the sample population is extremely vulnerable to smoking-related illnesses.

The decreasing prevalence of smoking reported in the Toronto Community Health Survey from 1983 to 1988 may reflect current anti-smoking public health campaigns and the availability of quit smoking courses to the general population. The sample represents a group which must be given equitable exposure to and benefit from smoking cessation education and opportunities.

Alcohol Use

86.8% of our sample admitted to having consumed alcohol (defined as beer, wine or spirits) in the past year. The 1988 Toronto Community Health Survey (TCHS) found that 85% of the general Toronto population consumes alcohol, which is comparable to our findings.

The table below shows the frequency of alcohol consumption by our entire sample:

daily	16.8%
3-4 times/week	9.8%
1-2 times/week	14.8%
several times/month	8.5%
1-2 times/month	22.4%

The Toronto Community Health Survey found that 16% of its sample group reported consumption of alcohol daily, which is comparable to our finding of 16.8% of our sample.

Substance Use

We asked respondents if they used substances other than alcohol which they had consumed to "get high or make themselves feel better." We did not differentiate between licit and illicit substances; these figures refer to both the so-called "street" drugs such as cocaine or heroin as well as cannabis, inhalants and prescription medications used for non-medical reasons.

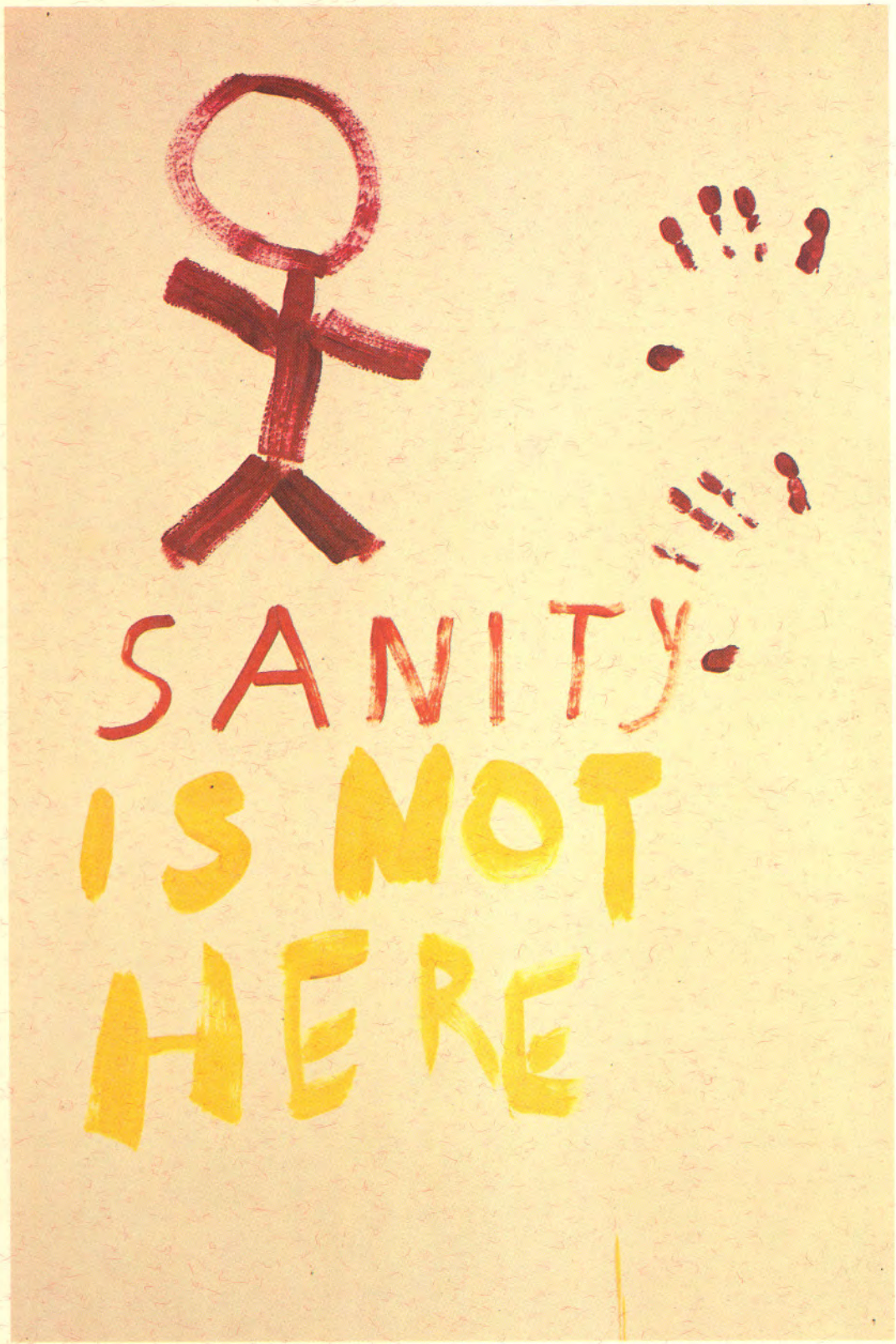
68.5% of the sample had used such substances at some point in their lives. In the month prior to the survey, 43.6% of our sample reported having used drugs.

The table below indicates the frequency of drug use in the month prior to the survey (percentages of the entire sample):

daily	9.8%
3-4 times/wk	6.3%
1-2 times/wk	8.1%
several times/month	6.5%
1-2 times/month	12.5%

We did not ask respondents to identify which drugs they had used, primarily because we were more interested in access to health care than in drug use. However, in the larger picture of substance use, a higher number of respondents reported alcohol use than all other drugs combined.

Access to Health Care



Where do homeless women and men go for health care?

The table below summarizes utilization of routine health services by the sample group:

saw a general practitioner in past year	66.2%
had complete physical in past year (women)	64.2%
saw a family doctor in past year	57.4%
had complete physical in past year (men)	50.4%
used a walk-in clinic in past year	34.0%
would turn to family doctor for health advice	25.1%
saw a specialist in past year	27.1%

Two thirds of our sample (66.2%) had seen a general practitioner (physician), and 27.1% had seen a specialist physician in the past year. Very few had seen health workers such as physiotherapists or chiropractors.

57.4% of the sample have a family doctor whom they had seen in the past year. Of those who had not seen a family doctor, the most common reasons given were that respondents had not felt it necessary or had not been sick. About one in five (22.6% of those who had not seen a family doctor) had not done so because they did not know a doctor they liked, they did not trust doctors, or they did not know where to find a doctor.

Almost two thirds of the women and one half of the men had had a complete physical examination within the year preceding the survey. 79.3% of women and 64.3% of men had had a complete physical within the last two years. Reasons given for not having a recent physical included fear of going, dislike of physicians and previous negative experiences in visiting a doctor. This may be comparable to the general population.

11.9% of our sample had not seen any health worker in the year prior to the survey. Again, it is not known if this figure is comparable to the general population.

In general, most respondents reported having had contact with the health care system in the past year. However, utilization of services does not reveal anything about the quality of care or the reasons for seeking care. The high percentages reporting having had a recent complete physical could reflect the number of examinations required for social service benefits. The following section identifies a number of barriers to receiving appropriate care which are faced by homeless women and men.

Structural Barriers

The Ontario Health Card and Being Refused Care

37.4% of the entire sample did not have an Ontario Health Card at the time of the survey. (This card demonstrates eligibility for provincial health insurance. All Ontario residents are entitled to it).

55 people had either lost their card or had it stolen, which is directly related to the disrupted nature of life when one is homeless. Another 14 people did not know how to obtain a health card, which suggests that information about how to apply is not readily available to the members of this group. Some people had not resided in Ontario long enough to qualify. Others said they did not need a health card.

We asked those without health cards if they had ever been refused health care for this reason. 6.7% of the entire sample had at some time been refused care because they had no health card. Most commonly this occurred in a hospital emergency room. It also occurred in walk-in clinics, physicians' offices and a community health centre. Recalling the Canada Health Act, which sets out universality of care as a basic tenet, this figure is unacceptable.

In the past year have you been unable to follow instructions given to you by a health worker because of your living circumstances?

> *"I can never do what is recommended. You don't have the stability of your environment. Anything you have to follow over a period of days is difficult."*
>
> – man in his 30s, interviewed in a hostel

24.4% of the sample had experienced the problem of receiving advice or instructions from a health professional which they could not carry out because of their living circumstances.

Most commonly cited was the example of being told to rest for a few days in bed, and being unable to do this because the respondent had no place to live or was staying in a hostel requiring that she or he be outside during the day.

In the past year have you been unable to follow instructions given to you by a health worker because this required purchasing something you could not afford?

> *"I fractured my heel and couldn't afford crutches so I walked around on the ball of my foot."*
>
> – man in his 60s, interviewed in a shelter

22.1% of our sample had experienced the problem of receiving advice from a health professional which they had been unable to carry out because they could not afford to buy something required for the treatment.

The most common example of this which was being told to buy supplies such as dressings, disinfectants or bandages, and not being able do so, resulting in the treatment not being done.

Also frequently mentioned was the example of being unable to afford medications which were either not covered by Ontario Drug Benefit cards (such as over-the-counter products) or which were covered but the respondent had no drug benefit card.

In the past year have you been prescribed a special diet for health problems and been unable to follow this diet?

> *"When I had diarrhea, I was told to eat soups and the like at first and then move up to something my stomach could handle but I did not have access to the foods I needed. Took 7 days to clear up my problem instead of the usual 3-4 days."*
>
> – man in his 40s, interviewed in a hostel

Respondents were asked if they were supposed to follow a special diet for health reasons (such as low salt diets, diabetic diets, calorie-reducing diets, a diet to avoid irritating a stomach ulcer, etc.). 21.3% of the entire sample stated "yes" to this question.

Of those requiring a special diet, two thirds (663%) were not able to follow this diet because they were not able to afford the foods required or had no place to store food.

Attitudinal Barriers

> *"I went to an emergency room after I was raped. The doctor was very rude. He said I deserved what I got. He asked me if I was still working the streets and I said no. He said 'why are you still getting raped then? It must have been one of your old customers you ripped off.'"*
>
> – woman in her 20s, interviewed in a meal place

> *"After the cops beat me up I was being sutured in emergency. They thought I was scum because I'm poor. They pulled the stitches too tight and when I reacted, the cops entered the room, hauled me down, and told them to give me a needle. I woke up and I was in the nut house for the next three days."*
>
> – man in his 20s, interviewed in a hostel

40.5% of all respondents reported at least one incident in the past year where they had felt unhappy or frustrated with the kind of health care they had received or had felt treated badly by a health care worker.

Significantly more women than men reported such episodes. One half (50.9%) of the women we interviewed and over one third of the men (36.7%) had experienced poor treatment in the past year.

Almost one quarter (23.2%) of these poor treatment episodes were experienced in a hospital emergency department.

Many respondents specifically related the problems of not being taken seriously, being inadequately investigated or not being listened to, to having been judged negatively by health care staff. That is, having no address to give to the receptionist, looking dirty or disheveled because of lacking the resources to regularly wash one's clothes, and receiving social assistance (that is, not being able to tell the receptionist where you work).

The table below shows the most frequently given examples of poor treatment. The numbers refer to the percentage of examples which incorporated these reasons:

Not being taken seriously by a health worker	22.1%
Inadequate investigation of their problem	22.1%
Not being listened to by health workers	19.3%
"Judged" because of homelessness/poverty	15.5%
Information not given to the respondent	14.4%
Physicians being rushed	8.3%

(totals are >100% because respondents could give more than one reason why their care was poor during any one incident).

Physician Services

Two thirds of respondents reported having had some contact with a general practitioner in the past year. Over one half reported having a family doctor whom they had seen in the past year.

Poor Treatment by Physicians

6.7% of the sample had been refused care because they did not have an Ontario Health Card. The Ontario Health Card is primarily a way for physicians to receive payment for their services; therefore what "being refused care" most often means is "being refused the care of a doctor." This is not acceptable practice for physicians.

Anecdotally, respondents also reported attitudinal discrimination by physicians.

"If you're a street person you don't get good treatment. I'd say 7 out of 10 doctors don't treat you well."

– man in his 50s, interviewed in a hostel

Two respondents volunteered that they had been sexually harassed or assaulted by a physician. Considering the recent Report of the Task Force on Sexual Abuse of Patients (1991), which has brought to light the prevalence of abuse by doctors, it is worth noting that two respondents reported this type of abuse despite the fact that we did not ask about it.

"I made an appointment with a psychiatrist and he said something sexual that disgusted me and I walked out and never went back."

– woman in her 30s, interviewed in a shelter

We asked respondents if, in the past year, any doctor had explained something to them about a health problem which they did not understand because he or she used medical terminology which they could not understand. 16.1% of the sample had had such an experience; half of these people had experienced this two times or more.

"I was asked: 'Do you ambulate?'"

– man in his 30s, interviewed in a hostel

Completion of Forms by Physicians

Respondents were asked if, in the past year, they had needed to visit a physician expressly to have a form completed and signed by a physician. An astounding 36.7% of our sample had been required to do this.

This table shows which forms respondents had needed to be completed by a physician and the number of people requiring each form:

welfare forms	86
Family Benefits forms	52
physical examination for housing or work	31
form to obtain public transit tickets	12
authorization for glasses	11
authorization for special devices	11
Worker's Compensation Board forms	5
pension forms	2

What is significant is that physicians are the only point of access for people to obtain both health and social services benefits which could be competently assessed by non-physicians, such as public transportation tickets for individuals who have a physical disability and are unable to travel to appointments without them.

Completing Family Benefits forms (which require determining disability) could also be accomplished by other health workers, such as physiotherapists, occupational therapists, nurses and psychologists. Depending on the cause of disability, any of these health workers may in fact be better able to accurately assess a given disabling factor than a physician.

As well, public funds (the Ontario Health Insurance Plan monies) are used to reimburse physicians for each of these visits to complete forms. One has to question if this is a sound use of health care dollars or physicians' time.

Hospital Emergency Services

Over one half (54.4%) of the entire sample had used a hospital emergency department in the past year. Of those, 42.4% had visited an emergency room one time. 19.2% of the entire sample stated that they used an emergency room more than any other place for health care.

Below is a table revealing the most common reasons for going to emergency and the number of people who gave this reason:

physical problem	137
injury	111
assault/beaten up	59
brought in by ambulance	52
dental problem	23

Despite frequent use of emergency departments, respondents reported a number of problems:

Being refused care

Of the 30 incidents of being refused care due to lack of an Ontario Health Card, almost one half (14) of these occurred in an emergency room.

Satisfaction with Care

> *"A couple of times, I've been looked at, like, what kind of a person are you because you are homeless. You have no place, no money, no place to clean up."*
>
> – young man in his 20s, interviewed in a shelter

It is worth noting here that 23.2% of all the episodes of poor treatment in the health care system reported by respondents in the past year occurred in emergency departments.

30.7% of those who had used an emergency room in the past year had felt treated rudely by staff because of their appearance; 24.5% had felt treated rudely because of where they said they lived (eg. a hostel, the street, no fixed address). 42% of those who left an emergency department before being seen by a doctor or nurse did so because of the attitude of reception staff.

44.6% of those using an emergency room had not had their problem taken seriously during at least one visit in the past year. This perception resulted in 23.2% of those using emergency departments leaving the emergency room feeling that their problem was not taken care of.

Besides "problem not taken seriously" (the most common reason given) people also gave the following reasons for leaving without their problem looked after: "staff referred me elsewhere"; "staff said they were too busy"; "told me to come back the next day"; and "told me to do a treatment I could not carry out."

Given that low self esteem and lack of self respect were reported so prominently by respondents, the incidence of prejudicial attitudes towards them, particularly in institutions established to provide "care," is significant and not acceptable.

Over one half of the people we interviewed had used an emergency room at least once in the past year. Almost one in five use emergency rooms more than any other place for health care. However, a certain degree of dissatisfaction with emergency care was reported by respondents. Being refused care because of not having a health insurance card is unacceptable. A high degree of prejudice and discrimination was also reported, in some cases severe enough to deter respondents from receiving care. This too is not acceptable and results in the erosion of universal access to health care.

Hospital In-Patient Services

30 respondents were told in an emergency room that they should be admitted to hospital but that there were no beds available. The problem of not admitting members of this population when they should be admitted is that they generally have very few resources to manage an acute illness independently. Housed people can at least recuperate at home; this group of people cannot do this. Homelessness should be considered a criterion for deciding on the need for admission to hospital.

25.3% of our sample had been admitted to a hospital in the past year. Almost one half of those (48.7%) had been admitted more than one time.

Most commonly people were admitted for a physical problem or illness, followed by injuries and/or assault.

Discharge from Hospital

We asked those admitted to hospital in the past year if they had a place to go after their discharge from hospital. The table below reveals the place they were discharged to and the number of people citing each location:

hostel	31
own place	25
nowhere/the street	12
friend's place	9
relative's place	9
hotel	2
rehabilitation hospital	1

38.1% of those admitted to hospital were discharged to a hostel or to the street. Those who stayed with a friend or relative (15.9%) may well have had no fixed address, and it is not known how long after discharge they were able to stay there. Of the 43 people having no place to go after discharge, 79% were not assisted by the hospital to find a place.

This could be because the respondent intentionally kept his or her homelessness concealed from hospital staff. However, it could also be that hospital staff were unaware of the respondent's homelessness (did not inquire) because of assumptions that all patients have a place to go to upon discharge. In inner city hospitals, which are the places most frequently named by our sample, this assumption should never be made.

Hospital After-care

We asked respondents if they had required some type of follow-up care after being discharged from the hospital (such as daily wound dressing changes). 27.8% of those discharged from hospital reported that they did.

This table reveals who actually performed this care for those requiring it among our sample. (Some respondents named more than one source of care):

did it myself	8
* hospital out-patient clinic	4
Street Health nurse	4
* visiting nurse	3
friend/relative	2
shelter staff	2
* family doctor	2
drop-in staff	1
walk-in clinic	1

A large number of people did the care themselves. This may or may not have been appropriate. The responses marked with an asterisk (*) refer to resources/ agencies whose mandate it is to provide this type of care. Of those requiring hospital aftercare, only 9 individuals (36.0%) received it from one or more of these services. That is, almost two thirds did not receive this care from a service whose responsibility it is to provide it.

Preventive Health Care

Influenza Vaccinations

We asked all respondents if they had been offered an influenza vaccine in the past year. 62.9% (or almost two out of every three people) had not been offered this preventive health measure.

The criteria for administering this vaccination include:

1) adults with chronic cardiac or pulmonary disorders
2) those residing in facilities where the institutional environment may promote the spread of disease

(Canadian Disease Weekly Report, Vol 17-24, June 15, 1991)

Given the high prevalence of respiratory disorders (asthma, emphysema and chronic bronchitis) in our sample, and given that over 80% of our respondents were using hostels when we interviewed them, it is obvious that the homeless population should be given priority for vaccination against influenza.

Smoking Cessation Programs

Respondents who were current smokers (both daily and occasionally) were asked if they would consider taking a free quit smoking program held in a location familiar and comfortable to them. Of this group, 39.3% would consider taking such a program.

Access to Condoms

74.7% of the entire sample had had at least one sexual partner during the past year. 26.0% of the sexually active group say they use condoms "all of the time." 28.4% use condoms some of the time. 39.0% of the sexually active group said that they never used condoms. (The remaining 6.6% answered "not applicable" referring, for example, to those having lesbian partners).

We asked those who use condoms where they obtain condoms. Almost one half (47.8%) name drop-in centres as a source of condoms. 14.3% obtain condoms from street outreach workers, and 13.2% get their condoms from hostels.

Given that the people in our sample are among the poorest economic group in Toronto, and given that three in four are sexually active, it is imperative that ready access to free condoms in places where people spend time should be maintained and expanded.

Dental Care

When did you last see a dentist?

Only 37.1% of our sample had visited a dentist in the past year. The Toronto Community Health Survey (1988) reported that 68.0% of the general Toronto population had seen a dentist in the year preceding that survey; that is, our sample was almost twice as likely not to have received dental care in the past year than the general Toronto population.

These findings are comparable to research on homeless adults in Los Angeles in 1985 (Gelberg et al. 1988), which found that 26.7% had seen a dentist in the previous year, as compared with 55.0% of the general American population.

Almost one quarter of our sample (23.9%) had not seen a dentist in more than five years. This compares to a figure of about 8% of the general Toronto population who had not seen a dentist in the past five years (Toronto Community Health Survey, 1988).

Why have you not seen a dentist?

We asked respondents to indicate the most important reasons they had not seen a dentist in the past year. Financial barriers, namely the lack of dental benefits coverage, and limitations on coverage by social assistance dental programs prevented 34.2% of respondents from seeing a dentist in the preceding year.

Respondents reported a significant amount of dental pathology in the month preceding the survey. 24.2% of the sample reported sore or bleeding gums and 22.8% reported a toothache or a cavity during this time. 12.1% of the sample reported a loose tooth or teeth.

When asked to state the reasons for not seeing a dentist for one of these problems, cost factors combined to deter 32.0% of those with a dental problem in the past month.

23 respondents used a hospital emergency department in the past year for a dental problem.

It should be noted that since completion of the survey Metro Toronto Council has eliminated all dental services except emergency care, including preventive care, for General Welfare and Family Benefits recipients. This decision creates a further barrier to individuals in obtaining any dental care other than emergency work. It is

also illogical that coverage for prevention has been discontinued, as the lack of preventive care will surely result in greater dental pathology and greater future expenses.

Mental Health Services

> *"I was raped as a child and would like to talk to someone about it. I've got a lot I want to talk about but I'm scared. I want someone I can trust. I wouldn't even fight the thought of going into hospital for therapy. I'd welcome it."*
>
> – man in his 40s, interviewed in a hostel

46.3% of respondents had wanted to talk to someone about mental or emotional problems in the past year. Of these, more than one half (54.1%) did not find anyone to talk to.

As well, 47.2% of the entire sample did not know anyone who could help them if they were to have an emotional crisis which they were unable to handle on their own.

Considering that 26.8% of the entire sample had contemplated suicide in the past year, and that 7.8% of the sample had actually attempted suicide in the past year, it is worrisome that such a significant percentage of the sample do not know someone they could talk to in the event of an emotional crisis.

Women's Health Issues

Childhood Abuse

"I left the Maritimes because I was sexually and physically abused throughout my childhood. I have lots of anger which I turn inside."
– woman in her 20s, interviewed in a hostel

8.5% of all the women we surveyed reported having been physically or sexually abused (including incest) during childhood. This is remarkable, considering that we did not ask any questions about this subject. This figure is entirely based on the women who voluntarily mentioned this during the course of the interview. Themes relating to past abuse (as a child and as an adult) arose repeatedly in interviews with women.

Physical Violence

"I wouldn't call it assault. There were no broken bones, just bruises."
– woman in her 40s, interviewed in a hostel

Almost one half of all women interviewed (46.2%) had been assaulted in the past year, compared to 38.6% of men. Three (3) of these women were assaulted by the police.

Sexual Violence

"Sex has always hurt me and bothered me. I've always felt I've never had a choice. I consider that rape – psychological, emotional – everything. I've always lived behind the wall of having no choice."
– woman in her 30s, sleeping outside at the time of survey

43.3% of the women in our sample had received unwelcome sexual advances or been grabbed or touched when they did not want to be in the past year, as compared to 14.1% of men. Almost one half of these women had been sexually harassed or assaulted in this manner five times or more.

More than one in five women we interviewed (21.2%) reported being raped in the past year.

Homelessness is clearly a much more dangerous condition to be in for women. Violence against women is a common cause of homelessness. Violence in the past was also a common theme in the stories we were told. Here we find evidence that once homeless, that violence continues and possibly intensifies.

Mental Health Issues

> *"I was in the hospital for an overdose and I was being tied to the bed with restraints. There were trying to make me take all these drugs and sticking tubes down my throat and catheters. Because of the pain I was struggling and the orderly punched me in the face. I was crying and crying, they treated me so bad."*
>
> – young woman in her 20s, interviewed in a shelter

Two thirds of all the women in the sample (66.0%) had tried to commit suicide at some time in their lives.

An overwhelming 63.5% of all the women we interviewed had considered suicide in the past year as compared to 53.1% of the men. 29.4% had attempted suicide in the past year.

Access to menstrual supplies

> *"I just use kleenex or toilet paper."*
>
> – woman in her 40s, interviewed in a hostel

Menstruation is a basic part of the lives of all women during their child– bearing years. It is hard for most of the general population to imagine having difficulty obtaining and/or storing supplies which are such a necessity. However, these problems are part of the lives of many homeless women.

Many women had experienced the following problems:

1) pads or tampons are too expensive
2) shelter provides only 1-2 at a time
3) supplies not available at shelter/drop-in
4) no place to store supplies

Pregnancy Care

14 women (13.2% of women in the sample) were pregnant at the time of interview. All of these women were homeless.

Women who were currently pregnant or who had been pregnant in the last three years were asked about prenatal care. 21 of these 26 women (80.8%) reported going for prenatal check-ups, with the median number of check-ups being between 8 or 9 times. Those who received prenatal care seem to have received good care, reporting that they were offered prenatal vitamins, referrals to public health nurses, information on nutrition, smoking or consuming drugs or alcohol during pregnancy, etc.

However, when asked about nutrition, 5 of the 14 women pregnant at the time of the survey reported having missed four or more meals in the past 30 days because of lack of money. Three (3) missed meals on 20 days or more. This highlights the necessity of combining education (about prenatal nutrition, for example) with material resources when working with people having limited resources.

6 out of 20 women who delivered their last baby in a hospital had no place to go after discharge.

In Their Own Words

The women and men we spoke to described what it was like to be homeless.

The Psychological Effects of Homelessness

"The hardest part is being lonely, not having companionship or someone to talk to. In the shelter I don't talk to anyone because you don't know who to trust."

– man in his 40s, interviewed in a hostel

"The hardest part is psychological. Not having a place is the worst thing that can happen to you. It's very depressing."

– woman in her 40s, interviewed in a shelter

"The hardest part is that you can't do the things that are good for you psychologically because you have to follow someone else's agenda. You can't control your diet, you can't control the situation – you're not able to control your life at all. Every aspect is like a game of chance."

– woman in her 40s, interviewed in a shelter

"If you don't have your own place, there's a high measure of other people controlling your life – your social life, your diet. Freedom and choice, all those things count towards your health."

– man in his 20s, interviewed in a shelter

Poverty

"Money and shelter mean comfort and without comfort your health goes. Trying to stay healthy means trying to get enough money."

– young man in his 20s, interviewed in a shelter

"Money Mart takes $40 off my cheque. That's my food for a week. Someone stole all my ID so I can't use banks. It is much easier in Vancouver. There you get a letter describing your appearance. You can use it to cash cheques at a bank. We need that."

– man in his 30s, interviewed in a shelter

"I worked as a domestic worker for seven months and received $400 in total for housekeeping."

– recent immigrant woman, interviewed in a shelter

"The hardest part is lack of money, because with money you can do what you want and eat what you want and you have more choices. If I had the money, everything else would fall in place. That's just the way it is."

– man in his 60s, interviewed in a hostel

"The hardest part is not having the money to get the basic necessities – doing laundry, buying rolaids, for example – and not being able to afford a place."

– man in his 30s, interviewed in a hostel

Job Issues

"It is hard to find work at my age. I go to temp agencies but the work is now very slow. You can stay all day from 5 a.m. and never get a job. Today at Queen and Parliament, there were 80 of us. They only took 9 people."

– man in his 50s, interviewed in a hostel

"You go for this job and don't get it – you get discouraged. Especially when you know how to do a job and no one wants to hire you – or there's just no jobs."

– man in his 30s, interviewed in a hostel

"When you're staying at the hostel and working at these temp places, you miss breakfast and get back after supper. That's why some of these guys don't work temp. Besides, they fuck you in the end and all you get is enough money for a pack of smokes and a coffee. I work until 5:30 or 6:00 and miss the meal here at the shelter. I have to go buy food with the money I just made."

– man in his 20s, interviewed in a hostel

Lack of Privacy

"The lack of privacy encompasses alot. You don't go to bed alone, to the bathroom alone, you don't eat alone. You have to build up walls. The hostels are very gloomy."

– woman in her 40s, interviewed in a hostel

"The hardest part to deal with is the lack of privacy when you are feeling ill. I want my own place. It is terrible to have to share a toilet with others. It is humiliating and embarassing when you have bowel problems."

– woman in her 50s, sleeping outside

Housing

"When I lost my place, I got first and last months' rent (from welfare) and stayed in a place for two weeks. I was afraid for my life. It was a crack house, and violent, so I went back to the hostel. I reapplied for first and last months' rent and they told me I was not eligible to ask for a year."

– man in his 50s, interviewed in a hostel

"I left my last housing because the landlord was having trouble with fire regulations because he had too many people so he had to evict a few."

– man in his 30s, interviewed in a hostel

"The hardest part is not being able to find a room to rent. Some landlords look at me and will not rent because my shoes are dirty. Some places still don't even have hot water."

– man in his 20s, sleeping outside

Hostels

"Hostels are geared to day working. If someone works midnight shifts, there is no place to sleep during the day. There is no place to eat after 7 p.m. Hostels are not structured to help you get ahead."

– man in his 30s, interviewed in a hostel

"In hostels you share everything. You worry about dirt and disease. Colds pass around alot. You get better only to room with another sick person. There is no privacy."

– woman in her 20s, interviewed in a hostel

Getting Proper Sleep and Rest

"The hardest part is when they put you out on the street at 6:30 in the morning and you have no place to go until 7:00 at night. Walking the streets in the cold, tired, unable to lie down anywhere. Those 12 hours are the hardest. You have places to go and eat but you don't have the energy to walk there. At the hostels you don't sleep well because there is fighting and arguing. So you are tired when you come out in the morning."

– man in his 50s, interviewed in a hostel

"The hardest part is the lack of rest, having time to yourself to close the door and say 'ah'."

– man in his 50s, interviewed in a hostel

Safety and Fear

"If you don't have a foundation, you have a house that tumbles. You have homelessness and fear. You have fear that the law will pick you up as a vagrant."

– woman in her 40s, interviewed in a hostel

"Not feeling safe makes it hard for me to sleep."

– woman in her 20s, interviewed in a hostel

"You never know who might steal your stuff, so I sleep with my clothes on."

– man in his 30s, interviewed in a hostel

"I've lost three sets of clothing and ID in the past year."

– man in his 40s, interviewed in a hostel

Food

"I'm allergic to milk, eggs and orange juice. You have no choice when you're in a hostel. When you're hungry, you eat what you can. You eat to fill up. If I miss breakfast at the hostel, I feel 'blah' enough not to have the energy to walk to lunch across town."

– man in his 20s, interviewed in a meal place

"When the shelter makes pork, I can't eat it because I am Muslim. There is no choice of anything else so I can't eat that meal."

– refugee woman in her 20s, interviewed in a shelter

"The food is not up to par. You won't starve, but beans and weiners and macaroni and cheese couldn't support someone doing a hard day's work. It doesn't sustain you except for day to day."

– man in his 30s, interviewed at a meal place

Basic Hygiene

"It's not easy washing your feet in public washrooms."
– woman in her 50s, sleeping outside

"You let basic things slide, like washing and brushing your teeth, when your basic need is to find a place to stay."
– man in his 30s, interviewed in a shelter

"The main thing is trying to stay clean. It's hard to keep clean and well-groomed. The feeling that you don't belong. When you're let out of here in the morning people look at you funny. I'm looking for work but not being well-groomed, it's hard. I applied for a job at a place where they had a "help wanted" sign and they said they weren't hiring. I get really depressed."
– man in his 20s, interviewed in a hostel

Appendices

Glossary

drop-in centre – a community agency providing day time space for people. Drop-in centres sometimes provide food and activities for clientele.

drug card – card which ensures prescription drug coverage for social assistance recipients; officially known as the Ontario Drug Benefit Card.

Family Benefits – refers to long term social assistance that is operated by the provincial government which provides assistance to people who are disabled and single parent families.

General Welfare – refers to social assistance that is operated by the municipalities. Individuals may receive an emergency welfare cheque, medical welfare for a short period of time or general welfare.

hostel – a publicly or privately operated agency which provides temporary space for night time shelter (see shelter)

meal place – for the purposes of this report is synonymous with soup kitchen (see below)

Ontario Health Card – the Ontario provincial health insurance card that replaced the OHIP card in 1991 and which provides access to insured services as designated by the Canada Health Act

sample – refers to the total group of respondents completing the questionnaire

shelter – see hostel

soup kitchen – a facility providing free or very low cost meals to those with low incomes

temp work – refers to temporary short term work provided by privately-run employment agencies.

walk-in clinic – refers in this report to medical "for profit" health clinics, often set up in convenient public locations such as shopping malls.

Origins of the Street Health Survey

Since Street Health began operating in 1986 we have collected basic data on our clients: the number of client visits to the nursing stations, date of birth, sex, race, languages spoken, housing status (no fixed address, hostels, rooms or apartments) and the reasons why they see the nurses.

However cursory, these statistics comprise a large part of the health data collected on homeless individuals in Toronto. Mainstream public health agencies and the provincial Ministry of Health have generally failed to gather information on the health of this group of women and men.

Two recent community health surveys, the Toronto Community Health Survey (1988) and The Ontario Health Survey (1990), were administered by telephone and household to household, respectively. This means that people without an address (homeless people) and people unable to afford telephones (which applies to homeless people and others with low incomes) are excluded from such surveys, despite the fact that one would intuitively expect that it is these people who are most likely to have health problems or difficulties gaining access to health care.

We decided to complete a survey that would be written by us, useful to the homeless community and their advocates, and reflective of their experiences and problems with the health care system.

Over the years we have been advocating on behalf of our clients and for equal and fair access to the health and social service system with limited effect. We wanted to begin documenting the health problems and barriers to services (structural and attitudinal) frequently encountered by the people we work with.

As well, we believed that a comprehensive, rigorously executed research project could prevent the marginalization of our findings and add strength to our lobby efforts.

Survey Methodology

We were assisted immeasurably in designing the survey methodology by David Bates and David Northrup from the Institute For Social Research (ISR) at York University in North York, Ontario.

Questionnaire Design

We chose a questionnaire format using face-to-face interviews for a number of reasons. We wanted to use a strategy which would not assume or require literacy on the part of respondents. As well, a questionnaire allowed us to replicate some questions from the Ontario Health Survey (1990) in order to compare our sample to

the general population. We wanted to generate information on the prevalence of some conditions and also felt that anonymous one-to-one interviews would enhance disclosure of extremely personal information by respondents.

Although the questionnaire includes many quantitative questions, we also added a number of open-ended questions to be answered in respondents' own words. As well, we included a question designed to give respondents an opportunity to identify "the hardest part" of trying to stay healthy when homeless and to tell us anything else that they had not had the opportunity to disclose and which they believed was important for us to know.

Sampling Strategy
How many interviews?

Given the difficulty of determining with any confidence an accurate census of the homeless population, we decided to construct a sampling strategy which would not depend on enumerating the total size of this group. We decided to aim for a minimum of 400 completed interviews so as to be able to have confidence in the results to +/- 5%, 19 out of 20 times. We then decided to increase the targeted number of completed surveys to 450 to allow for the possibility of incomplete, unreliable or duplicate interviews, all of which would be excluded from the data set.

Definition of homeless

We developed a narrow definition of "homeless" to determine eligibility for participation in the survey. Although Street Health believes that those with marginal housing have many of the same health problems and barriers to access as the homeless population, including this group would have necessitated developing a sampling framework for rooming houses in the City of Toronto. We abandoned this idea because of the overwhelming logistical problems this would pose, and because of limitations on resources for the project.

For the purposes of the survey, we decided that an individual would be considered homeless if, in the thirty days prior to being approached, he or she had spent 10 or more nights sleeping:

1) in a shelter;
2) in an indoor or outdoor public place;
3) at a friend's place because they had no place of their own or no safe place of their own;
4) or any combination of nights spent in any of these circumstances totalling 10 or more.

Someone who has spent 5 nights of the past 30 sleeping in a shelter is probably no less homeless than someone spending 10 nights in a shelter. However, we wanted to exclude, for example, young people who had quarrelled with parents and left home for a week and who happened to find their way to a shelter. In arriving at a total of 10 nights or more, we felt we would be including people who were inarguably homeless. However, in doing so we recognize that we excluded many people who are also homeless.

Selection of Survey Sites

A detailed and time-consuming process was used to select the interview sites. An inventory was compiled of more than 100 locations frequented by homeless women and men throughout the City of Toronto.

We classified these locations into four categories:

1) places providing beds (shelters)
2) indoor gathering places (drop-in centres)
3) places providing meals (meal places)
4) outdoor gathering places (eg. parks, stairwells)

We carefully compiled information on each of these locations to determine the number of individuals using each place, the percentage of those who were homeless, the times of highest occupancy, etc..

We visited approximately 24 outdoor gathering places, generally at night, to find out if the people we found there ever use any services such as meals or beds. What we discovered was that all but a very few of the people we contacted had used meal services at least once every day or every second day. Although some homeless people completely shun services, we concluded that most people could theoretically be included in our survey if we sampled in meal places. We recognize that a small percentage of the homeless population (that is, those who use no services at all) were excluded from our sample.

A short survey of about 200 people was carried out in shelters, drop-in centres and meal places to determine to what extent they utilized more than one type of service. We discovered that an overwhelming 99% of the people who completed this small survey used either a shelter and/or a meal service.

This led us to decide to interview in shelters and meal places only, excluding drop-in centres. In meal places, individuals were not eligible if they had recently used a shelter. This was incorporated to prevent over-representation of shelter users in the sample; that is, we assumed that those using shelters would have a chance of being interviewed in shelters. We did this in order to increase the representativeness of the sample.

The actual interview sites were selected based on the site inventory we had developed. We estimated the number of homeless people at each site (based on the number of people using each site and the estimated percentage of those who were homeless).

A total of 26 sites were selected. Half of them were shelters and half were meal places. 10 sites were agencies which serve exclusively or almost exclusively women. Based on the percentage of homeless people using each site, we determined the number of completed interviews required at each location.

One of the initially-selected 26 sites had to be omitted from the site selection because it had been designated as a women's meal place, but once field work began, no eligible women were discovered there. The number of completed interviews required from this site were made up at another women's meal place.

Remuneration

We decided to pay respondents for their time and expertise. We debated whether or not to use non-monetary compensation such as cigarettes or chocolate bars. However, we believed that this would deny people the choice involved in deciding how to spend money. For a group of people whose choices are already severely limited, this was an important consideration.

We opted to offer financial compensation. Given that the average interview lasted about one hour, we decided to make the amount equal to that of the interviewers' hourly wage. Recognizing that this would increase the risk of duplicate interviews (that is, one person completing the survey twice), we built in a way to identify duplication and over-sampled to allow for repeat interviews.

Data Collection

We interviewed 458 women and men in 25 sites over a period of approximately six weeks beginning in December 1991 and finishing in January 1992. 76 people were interviewed in meal places; 382 in shelters. We interviewed 106 women and 352 men. Interviews lasted anywhere from 45 minutes to 2 hours, with most lasting a little over one hour.

Interviewing was carried out in two stages. The Street Health nurses screened randomly-selected individuals at each site in order to determine their eligibility for participation in the survey. This screening involved approaching every second person who entered an agency, or stood in a meal line, or was already in a room, and asking about where they had slept in the past 30 days. A one page screening tool was used to record this information.

Decisions were made from time to time to exclude from this screening process people who were obviously too mentally ill or who were intoxicated, recognizing that it would be difficult for them to complete the interview. Occasionally the nurses were approached by people who wanted to be interviewed or who asked what kinds of

questions they would have to answer to qualify. We emphasized the randomness of the process and kept the content of the screening questions concealed. In some cases, we altered the order of the screening questions in order to disguise eligibility requirements.

Once individuals were deemed eligible (that is, were homeless by our definition) and agreed to participate, the questionnaire was administered by the interviewers. The 15 interviewers we hired completed a 10 hour training period during which we discussed the systemic causes of homelessness, the importance of sensitivity to respondents and the purpose of the survey. Knowledge of some of these issues was facilitated by the fact that a number of interviewers had some previous experience working with homeless people.

We made every attempt to ensure that completing an interview would not interfere with respondents' immediate needs, such as obtaining a meal. For example, in sites where a meal was being provided, those agreeing to participate in the survey were asked to come back for the interview after they had eaten.

Very quickly into the data collection process, it became apparent that respondents were providing anecdotal information and insights which some interviewers had made note of somewhere on the questionnaire. Some of these comments were so insightful that we asked interviewers to record all such comments which were made during the course of an interview. This resulted in a wealth of anecdotal information, primarily in the words of the people we interviewed, some of which has been included throughout the body of this report.

We had a response rate of approximately 70% (that is, 70% of those who met the screening criteria completed an interview). This is an unexpectedly high rate given our knowledge that completing a survey is negatively correlated with low incomes, unemployment and other characterteristics common to the homeless.

Data Analysis

The City of Toronto Department of Public Health (DPH) generously offered to complete data processing, verification and analysis at no cost to Street Health. A written memorandum of understanding was signed by both DPH and Street Health explicitly stating that the survey data was the exclusive property of Street Health and could not be used by DPH without express written permission.

We completed a total of 458 interviews. Once unreliable or duplicate interviews were excluded, 447 questionnaires remained in the data set. Data entry and analysis was completed approximately three months following the completion of field work.

Note:

A more detailed description of survey methodology can be obtained from Street Health for those interested.

Street Health

All Saints' Church, located at the corner of Dundas and Sherbourne Streets in downtown Toronto, is situated in the midst of one of the largest concentrations of homeless and underhoused people in the city. In 1986, it was operating 2 drop-in centres and a low cost clothing store during the day, and 2 overnight shelters for men and women. The minister of the church along with the men and women who used the facilities started to work together to plan a rent-geared-to-income apartment building on church property. In the course of discussions about what type of housing people wanted to live in, the community's concern about the inadequate and discriminatory health care they received emerged as an unexpected but recurrent theme.

A group of people who were concerned with health care issues began meeting. This group consisted of 14 members of the "street" community who used the facilities at All Saints' Church and a community organizer. At that time, a nurse doing volunteer clerical work at the church was approached by the group to become a resource person in these discussions. They began meeting weekly to figure out what the problems were and what they as a community could do about them.

This led to the birth of Street Health: community-run nursing stations for the homeless and underhoused community, located where people congregate, to provide appropriate hands-on health care and assistance gaining access to the existing care health system. Street Health opened its first nursing station in September of 1986 at one of the drop-in centres at All Saints' Church. In January 1987 we opened a nursing station at Dixon Hall Men's shelter on Thursday evenings, commencing when the shelter opened for the night.

Because we have always believed that Street Health needs to be responsive to the community we serve, we have never had a fixed site and have been able to come and go as the homeless community moves around. In 1992 we have 4 nursing stations at different locations in drop-in centres and shelters. Over the years we have had other nursing stations in different locations.

Street Health's mandate is three-fold:

1) to provide "hands-on" nursing care to clients in an environment which is comfortable to them;
2) to assist clients to gain access to appropriate care in the mainstream health system; and
3) to lobby the existing health care system to become responsive to the needs of homeless people.

Because Street Health began as a community-initiated response to community-identified needs, it was fundamental that community control be built in from the start. The organization is managed by a board of directors, at least half of whom must have experienced homelessness. Open board meetings are held monthly at All Saints' Church at a time which does not conflict with shelter curfews. Dinner is served to accommodate those members who may be missing a meal by coming to the meeting.

Street Health began receiving funding from the Ontario Ministry of Health in 1989.

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