



THE

STREET

HEALTH

REPORT

2007

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About Street Health

Street Health is an innovative, community-based health care organization providing services to address a wide range of physical, mental and emotional needs for those who are homeless, poor and socially marginalized in Toronto.

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“If people were housed, they could take care of their medical problems more easily... There’s all these condominiums going up all the time. Can they put up housing for the homeless, like just a couple, okay?
— Nancy, 45, 2.5 years homeless”



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THE STREET HEALTH REPORT 2007: HIGHLIGHTS

Homelessness is a devastating social problem that affects a large number of people in Toronto. While it is broadly recognized that homeless people have much poorer health than the general population, and often experience difficulties obtaining health care, there is a lack of comprehensive and current information on the health status and needs of homeless people in Toronto. *The Street Health Report 2007* presents the results of a survey on the health status of homeless adults in downtown Toronto conducted in the winter of 2006/2007. Our report reveals a picture of homelessness in Toronto that demands immediate action.

For many, homelessness is not a short-term crisis.

- One third of people in our survey had been homeless for 5 years or longer
- Only one in five had been homeless for less than a year

People become homeless and stay homeless largely because of poverty.

- Over one third of the people we interviewed had a monthly income of \$200 or less
- Over three quarters named their economic circumstances as one of the two most important reasons they were homeless

There are not enough affordable and supportive housing options.

- One third of the people we interviewed said they became homeless because they could not afford the rent
- One third said their physical or mental health conditions were preventing them from finding and keeping housing

The daily lives of homeless people are stressful and isolating.

Among homeless people in our survey:

- More than half experienced serious depression in the past year
- 1 in 10 attempted suicide in the past year
- 1 in 3 said they had no one to help them in an emotional crisis

Being homeless is extremely dangerous.

Among homeless people in our survey:

- 1 in 3 had been physically assaulted in the past year
- 1 in 8 had been physically assaulted by police in the past year
- 1 in 5 women had been raped or sexually assaulted in the past year

The health of homeless people is very poor.

Among homeless people in our survey:

- Three quarters have at least one chronic or ongoing physical health condition
- More than half live with extreme fatigue
- 1 in 7 are usually in severe pain

Homeless people have significantly worse health than the general population.

Homeless people in our survey are:

- 29 times as likely to have hepatitis C
- 20 times as likely to have epilepsy
- 5 times as likely to have heart disease
- 4 times as likely to have cancer
- 3 ½ times as likely to have asthma
- 3 times as likely to have arthritis or rheumatism
- Twice as likely to have diabetes

Despite their poor health status, homeless people cannot access the health care they urgently need.

Among homeless people in our survey:

- More than half do not have a family doctor
- More than a quarter were refused health care in the past year because they did not have a health card
- More than a third felt they had been judged unfairly or treated with disrespect by a health care provider in the past year
- 1 in 5 have had a negative experience with hospital security



“I will not live on a park bench anymore, or in a tent like I was doing. They should have a lot more housing for us. Because it’s terrible.”
 — Heather, 48, 9 years homeless

photo by Adrienne, courtesy of the National Film Board of Canada

The health of homeless people in Toronto has gotten worse in the past 15 years.

Many serious physical health conditions have become even more common among homeless people, and their access to health care has deteriorated. The worsening health of homeless people and the growth of homelessness itself are a reflection of social policy decisions that have been made over the past 15 years. These decisions have resulted in inadequate social assistance rates, a severe lack of affordable housing and the loss of hundreds of emergency shelter beds.

There are realistic and practical solutions.

The Street Health Report 2007 outlines an action plan consisting of targeted, feasible solutions to immediately improve the health of homeless people and to ultimately end homelessness. It sets out recommendations to:

- Address the poverty and inequality that underlies homelessness
- Improve access to affordable and appropriate housing
- Improve immediate living conditions for homeless people
- Improve access to health care and support for homeless people

We hope *The Street Health Report 2007* will be a call to action.

ABOUT THE STREET HEALTH REPORT

Homelessness is a devastating social problem that affects a large number of people in Toronto. Although the exact number of homeless people living in the city is unknown, approximately 32,000 different people slept in a Toronto homeless shelter in 2002¹. In 2006, about 6,500 individuals stayed in a shelter on any given night². In 1998, the City of Toronto endorsed a declaration acknowledging that homelessness is a national disaster.

Homeless people have much poorer health and higher mortality rates than the general population, and often experience difficulties obtaining the health care and social services they need. They are also largely excluded from broad-based government health and census surveys, which often depend on people having an address or telephone number. Even when these surveys reach homeless people, they do not address the unique circumstances and needs of this group. As a result, there is a serious lack of comprehensive information on the health status and needs of homeless people.

Fifteen years ago, Street Health, a community-based health agency serving homeless people, decided to conduct a study to explore the health status of homeless people and their ability to access the health care system. In 1992, we published *The Street Health Report*³, a resource on homeless people's health. It was the first of its kind in North America and continues to be used today.

In 1992, Toronto was emerging from an economic downturn. Political and business leaders promised that economic good times would bring rewards for everyone. Toronto has been on an economic high over the past 15 years. However, TD Economics, the research wing of one of Canada's largest banks, released a report in the summer of 2007 which noted that even in Toronto, Canada's "economic locomotive", social inequity and poverty are on the rise⁴. During the 1990s, the richest 10% of Torontonians saw their family income increase by about 8%, while the poorest 10% had a drop of almost the same amount⁵. Between 2001 and 2005, the bottom 20% of Canadian families saw an outright decline in their income⁵.

In the 15 years since the 1992 *Street Health Report* was published, homelessness and housing insecurity has increased in Toronto. The nightly count of people sleeping in homeless shelters has more than tripled, from about 1,900 in 1990⁶, to about 6,500 in 2006². This increase in homelessness is a reflection of a steady round of funding and program cuts at the federal and provincial levels, coupled with the downloading of responsibility for social programs to the provincial and city levels. These cuts and this downloading have had massive negative impacts on key social policies and programs. To name just a few changes since 1992: social assistance rates are much lower, rents are higher, and dramatically less social housing is being built. These social policy changes have had a disproportionate impact on low-income people, and have contributed to homelessness. In addition to the important social and political changes that have occurred since *The Street Health Report* was released in 1992, important new health issues have emerged in the homeless community.

The Street Health Report 2007 presents the results of a survey on the health status of homeless people in Toronto, conducted by Street Health in the winter of 2006/2007. This report discusses the nature of homelessness in Toronto and its root causes, followed by an exploration of the daily living conditions of homeless people. It then presents findings on the physical and mental health status of homeless people, how they use health care services, and the barriers homeless people face when using these services. Where possible, this report compares the health of homeless people in our sample with available information for the general population of the City of Toronto¹. It also explains how the health status of homeless people has changed in the 15 years since the 1992 *Street Health Report* was published. Based on these findings, we present an action plan consisting of realistic solutions to immediately improve the health of homeless people and to ultimately end homelessness.

¹ Where data for the general population of Toronto is not available, but information for Ontario or Canada was found, provincial or national data is used for comparison.

THE STREET HEALTH SURVEY

The Street Health survey was conducted over a three-month period between November 2006 and February 2007. We surveyed a representative sample of 368 homeless adults at meal programs and shelters in downtown Toronto about their health and access to health care.

For the purposes of this survey, homelessness was defined as: having stayed in a shelter; outdoors or in a public space; or with a friend or relative for 10 or more days in the 30 days prior to being surveyed.

78% of participants were recruited at shelters and 22% were recruited at meal programs. In order to capture a substantial portion of homeless people who are not regular shelter users (who instead stay in public spaces, outdoors, or with friends), those people interviewed at meal programs were only eligible for our survey if they had not stayed in a shelter in the last 10 days. Our study methods are outlined in more detail in **Appendix 1**.

While we are confident that our findings are representative of the experiences and health status of homeless adults in Toronto, this study does have some limitations. These limitations include: the definition of homelessness used in the study, our geographic boundaries, the gender breakdown of our sample, and the diversity of our sample. These limitations are discussed further in **Appendix 2**.

ABOUT SURVEY RESPONDENTS

In total, we interviewed 368 adults.

- 73% identified as male
- 26% identified as female
- 1% identified as transgender or transsexual

Age

The average age of the people we interviewed was 42 years.

Participants ranged in age from 19 to 66 years.

Age distribution

Homeless people in our survey compared with the general population

	Street Health Survey	General Population ⁷
18 to 24*	3%	12%
25 to 49*	77%	49%
50 or older*	20%	32%

ⁱⁱ *statistically significant difference

Compared with the general population of adults in Toronto, our sample was young. Although there were fewer people aged 18 to 24 in our sample compared to the general population, there was almost no one over age 65. There were only two people in our sample over age 65, while 15% of people in Toronto are older than 65⁷.

Racial or Cultural Background

Respondents were asked to identify which racial or cultural groups they belonged to, and could choose more than oneⁱⁱⁱ.

Racial or cultural groups identified by respondents	%
White or Caucasian	70%
Black or African-Canadian	15%
Aboriginal or First Nations	15%
Hispanic or Latin American	4%
East Asian	2%
South Asian	1%
South East Asian	1%
West Asian	1%

63% of the people we interviewed identified solely as Caucasian. 37% identified as non-Caucasian. There was a smaller proportion of visible minorities in our survey sample than in the general population of Toronto, where visible minorities make up 44%⁷.

ⁱⁱ Throughout this report, when comparing our survey results with other statistics, we note whether there is a statistically significant difference. Statistical significance means that the difference between two numbers is large enough to assume that the difference did not happen by chance.

ⁱⁱⁱ In cases like this where respondents were able to choose more than one answer, totals may add up to more than 100%.

Aboriginal people made up a much higher percentage of our sample (15%) when compared to the percentage they represent in the general population of Toronto (0.5%)⁸. This is consistent with findings from homeless counts across Canada which have also found that Aboriginal people are vastly overrepresented⁹.

First Language

81% of our sample said that English was one of their first languages. This refers to the first language learned at home in childhood and still understood, also known as mother tongue.

Of the 19% who did not report English as one of their first languages: 22% (15) reported French, 10% (7) reported an Aboriginal language, and 68% (47) identified other languages. This last group included a wide range of European, Asian and African languages. The other languages most predominantly cited were Spanish 14% (10), Italian 10% (7) and Portuguese 7% (5).

Place of Birth

32% of homeless people we interviewed were born in Toronto and an additional 45% were born in Canada outside of Toronto.

The 23% who were born outside of Canada were from a wide range of countries, the most common being Jamaica 11% (9), the United Kingdom 8% (7) and Portugal 7% (6). Immigrants were underrepresented in our sample compared to the general population of Toronto, where 49% were born outside the country⁷.

Of those who were not born in Canada, 53% (44) had Canadian citizenship, 36% (30) were landed immigrants and 5% (4) had refugee status. Five percent (5%) (4) of those not born in Canada had temporary or no status.

72% of our sample had lived in Toronto for 10 years or longer.

The people interviewed in our study had lived in Toronto for a long time. They were not newcomers to the city who had just arrived and were getting settled. Only 15% had lived in Toronto less than 5 years.

Education

The homeless people we interviewed had less education than the general population.

Level of education completed

Homeless people in our survey compared with the general population aged 25 to 54

	Street Health Survey	General Population
High school graduate*	53%	90% ¹⁰
College or university graduate or higher*	12%	61% ¹¹

**statistically significant difference*

Sexual Orientation

People who identify as lesbian, gay, bisexual, transgender or transsexual are at higher risk for some health issues, and often face specific barriers in accessing health care.

- 89% of our sample identified as heterosexual
- 8% identified as lesbian, gay, bisexual, transgender or transsexual (LGBTT)
- 3% refused to answer the question

It is possible that the number of people identifying as LGBTT might be under-reported in our survey due to the personal nature of sexual orientation and the stigma that surrounds it.

“I never used to have memory loss, where I would have three hours of not remembering what’s happened to me in a day, and it’s not drug induced. It’s not alcohol induced. Just exhaustion, because you don’t know ‘Where am I going to sleep tonight?’ Or I’m at some house and I can’t go to sleep because I don’t know what’s going to happen from minute to minute. You’re sleeping with one eye open. I had clumps of hair coming out.”

— **Ola, 39,
8 months
homeless**



photo by Keneisha, courtesy of the National Film Board of Canada

PATTERNS OF HOMELESSNESS

"You can't get out of poverty, no matter how you try. Nothing works together. They have systems but they don't work together. Believe me, I have tried every possible way but you can't. For three years I've been going around in a circle. And I can't get out of it. I'm very resourceful, I'm intelligent and I'm not lazy. I'm sure people give up but I keep going." - Survey Respondent

This section describes our findings on the nature of homelessness in Toronto and some of its root causes.

People in our survey had been homeless an average of 4.7 years.

The length of time that participants in our survey had been homeless throughout their lives ranged from 2 weeks to 50 years.

- 78% had been homeless for one year or longer
- 34% had been homeless for five years or longer

These findings show that homelessness is not, on average, a short-term crisis, pointing to the need for solutions that move beyond crisis-based services to address the root causes of homelessness.

WHY PEOPLE BECOME HOMELESS

Main reasons respondents gave for becoming homeless	%
Economic reasons (cost of rent, low income, unemployment)	52%
Unsafe or poor living conditions	31%
Eviction or conflict with landlord	25%
Respondent's own drug or alcohol use	23%
Relationship or family breakdown	20%
Institutionalization (went to hospital, substance treatment program, jail)	13%
Neighbourhood was inappropriate or too isolated	3%
Lack of support to keep housing	2%

WHY PEOPLE STAY HOMELESS

Main reasons preventing respondents from finding and maintaining housing	%
Economic reasons (cost of rent, low income, unemployment)	78%
Mental and physical health conditions	33%
Lack of suitable housing (unsafe or poor conditions, bad landlords)	24%
Housing waiting list too long	11%
Lack of adequate support to find and keep housing	10%
Discrimination (e.g. against welfare recipients, people with criminal records)	7%
Lack of personal identification	6%

Both the high cost of rent in Toronto and inadequate incomes were overwhelmingly cited as the main factors leading to homelessness and keeping people homeless. People become homeless, and stay homeless, largely because of poverty. Our findings are consistent with other studies, which have also found that poverty is the leading cause of homelessness in Canada. A 2005 survey of homeless people in Vancouver found that 66% cited lack of income or cost of housing as the main cause of their homelessness⁹. Poverty is a concern for many Canadians; 49% feel they are always just one or two paycheques away from being poor¹² and official estimates in 2001 stated that 1.7 million Canadian households were at risk of homelessness¹³.

Key changes to social policies in recent years have a direct connection to some of the most common reasons that people became homeless:

Not being able to afford the rent: A Shortage of Social Housing

From the early 1960s until 1993, roughly 20,000 units of social housing were built each year with the help of government funding, most of which came from the federal government. In 1993 the federal government withdrew its funding of social housing, and in 1995 the province of Ontario did the same. As a result, throughout most of the 1990s, very little affordable, supportive housing was built.

**Not being able to afford the rent:
Cuts to Social Assistance**

Throughout the 1990s, the federal government made major cuts in social program funding for the provinces. This resulted in less capacity for each province to provide social assistance payments to low-income Canadians. In real dollars, Ontario welfare benefits are now roughly half what they were in 1995 and disability benefits are about 22% less¹⁴. It has been estimated that the cuts to social welfare benefits in Ontario pushed 67,000 families out of their rental housing¹⁵.

**Not being able to afford the rent:
Easing of Rent Controls**

The easing of rent controls in Ontario since 1998 has led to unaffordable rents. Since 1998, the City of Toronto has lost 85% of its one-bedroom apartments renting at or below \$700 a month¹⁶. Rents have gone up at a faster rate than incomes. In the late 1990s to early 2000s, rent increases averaged 5% higher than wages¹. While average rents in Toronto grew by 30% between 1997 and 2002, from \$751 to \$976¹, real wages (adjusted for inflation) decreased for those earning minimum wage.

**Eviction or conflict with landlord:
Decreased Tenant Protections**

New laws were introduced in Ontario in the mid 1990s that decreased tenant protection and made eviction easier. The Ontario Rental Housing Tribunal received over 30,000 eviction applications by landlords to terminate tenancies in 2005; of these, 86% were because of rental arrears¹⁶. It is likely that many of the people in our survey were evicted because they couldn't afford the rent.

SOCIAL HOUSING & HOUSING SUPPORT

Many of the reasons homeless people in our survey gave for why they are unable to find or maintain housing point to the lack of adequate help to find

housing and the lack of subsidized and supportive housing options that are available.

- 47% said they were not currently getting help to find housing
- 44% were on the waiting list for social housing

The length of time on the social housing waiting list for survey respondents ranged from 1 day to 20 years. Fifty-two percent (52%) had been on the social housing wait list for 6 months or less. This large portion of people who had been on the wait list a very short time is probably a reflection of recently stepped up efforts by the City of Toronto's housing workers, as well as its new plan to address homelessness, which requires every homeless person they work with to apply for social housing. Among the 48% who had been on the wait list for longer than 6 months, the average wait time was 4.6 years.

Waiting ... and Waiting for Housing

According to the Toronto Community Housing Corporation (TCHC), which manages social housing in Toronto and maintains the wait list, people in Toronto can expect to be on the waiting list for approximately one to five years for a bachelor unit, and up to ten years for a one-to five-bedroom home¹⁷. Nineteen percent (19%) of the TCHC's applicants have been on the waiting list for 5 or more years¹. As of December 31, 2006, 67,083 households in Toronto were on the wait list for social housing¹⁸.

Homeless people have an immediate need for a place to live. Due to the general lack of subsidized housing, being put on the waiting list for housing does little to actually assist people to get housing in the near future. In the meantime, homeless people continue to live in shelters, with friends, outdoors or in sub-standard forms of housing. Beyond getting help with their rent, people with mental and physical health challenges, who lack the informal social support networks of friends and family, often require additional types of support to find and keep housing.

Helping People Get Housing: Models for Housing Support

An evaluation of the Emergency Homelessness Pilot Project, initiated in Toronto in 2002 to assist the group of people from the Tent City squatter settlement, reveals that homeless people can successfully move into housing and stay housed when adequate support is available.

In this project, individuals with long histories of homelessness were given immediate access to private rental housing using rent supplements and intensive personal support. Eighteen months after the launch of the program, most of the Tent City squatters (89%) were stably housed. It is important to note that the approach housing workers used was both intensive and holistic, and included: assistance in navigating housing and income support systems, mediating difficulties between tenants and landlords, helping tenants to get furniture, and helping with relocations. The evaluation found that 93% of people stressed the importance of the support provided by Housing Support Workers¹⁹.

INCOME

The homeless people we surveyed reported extremely low incomes.

36% of all homeless people in our survey live on \$200 a month or less.

Monthly income of respondents	%
No income	6%
\$1 to \$200	30%
\$201 to \$400	14%
\$401 to \$600	17%
\$601 to \$800	10%
\$801 to \$1000	9%
\$1001 or more	15%

Employment

Formal employment was a source of income for 20% of survey respondents:

- 11% did casual or piece work
- 5% did part-time work
- 4% did full-time work

In addition to formal paid work, the informal economy is an important source of income for many homeless people. Informal work includes panhandling, sex work, selling scrap metal or bottles and other street-involved work.

- 19% of respondents cited income from informal employment
- Panhandling was the most common type of informal work, cited as a source of income by 9% of all survey respondents

It is likely that informal work is a source of income for an even larger portion of our sample, but was under-reported because many types of informal work are illegal and /or stigmatized.

The High Cost of Living

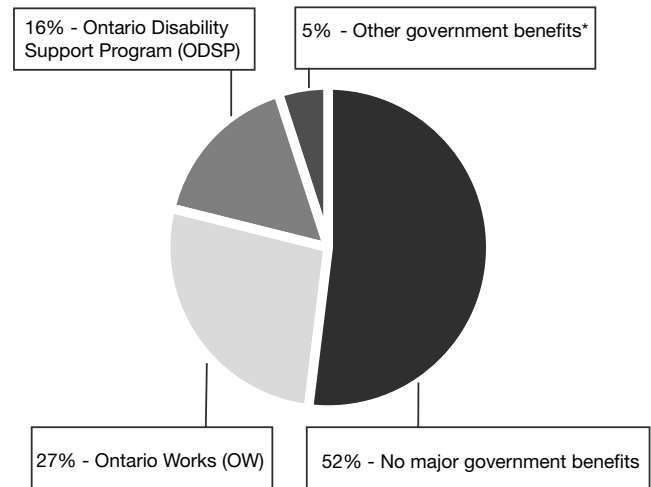
Even a monthly income of \$1,000 is not close to enough to live on in a city like Toronto. By Toronto Public Health's estimates, a month's worth of nutritious food costs \$188.92 for a single male aged 25 to 49, and an average bachelor apartment costs \$740. This adds up to monthly expense of \$928.92 before any spending on other necessities, including telephone, transportation, personal care items, clothing, etc²⁰.

85% of the homeless people we surveyed cannot afford even these very basic needs.

36% would have difficult purchasing adequate food, let alone paying for shelter.

Social Assistance

Respondents' access to government income supports



* This includes other government supports like government pensions, federal disability benefits, unemployment insurance, and workers' compensation benefits. It does not include small income supplements like the GST credit, Personal Needs Allowance (PNA), or Child Tax Benefit, which are not intended to be a substantial source of income.

As discussed in further detail in **The Health of Homeless People** section (on page 20), 74% of the people we surveyed have at least one serious physical health condition^{iv}. However, only 22% of those with serious illnesses are getting either ODSP or federal disability benefits.

38% of our entire sample felt that they were eligible for ODSP but were not receiving it. Of those who felt they should be receiving ODSP:

- 50% had not applied
- 19% had their application rejected
- 17% could not complete the application process
- 12% had applications still in process

^{iv} A "serious physical health condition" was defined as any of 22 serious conditions, including: cardiovascular and respiratory diseases, hepatitis and other liver diseases, gastrointestinal ulcers, diabetes, anemia, epilepsy, cancer and HIV/AIDS.

Other Government Benefits

A large number of survey respondents cited smaller streams of government benefits that provide important, but insubstantial, supplemental support.

Only 11% of respondents said they received the GST credit, despite the fact that the vast majority live on extremely low incomes and should therefore be eligible. This poor access to the GST credit is likely because of the barriers inherent in a tax return-based benefit, such as not having the resources to file your income tax. The amount of the GST credit is based on a number of factors including net income and number of children. A single adult earning \$400 per month could expect to receive approximately \$60, four times a year, in GST credits.

34% of respondents said they received Personal Needs Allowance (PNA) benefits. PNA is a stipend given to people staying in shelters to help meet incidental needs other than those provided for by shelters. PNA is currently \$3.90 per day. This works out to approximately

\$109 to \$120 per month. People cannot receive other social assistance benefits at the same time that they are receiving PNA.

Banking

60% of homeless people in our survey do not have a bank account. Of those who do not:

- 49% were refused bank services because of lack of personal identification
- 18% felt they did not have enough money to have a bank account
- 11% said they didn't trust banks
- 10% had been refused bank services for other reasons, such as bad credit or debt issues

Requiring multiple forms of personal identification to open a bank account is a significant barrier for people who are homeless. Identification issues are discussed in more detail in the **Barriers to Health Care and Social Services** section (on page 40).

Social Assistance?

In Ontario, government welfare benefits are obtained through the Ontario Works (OW) program. OW benefits are for people who need money because they are unable to find work or are temporarily unable to work. The Ontario Disability Support Program (ODSP) is the provincial government program that offers long-term disability benefits to people with serious disabilities who have little or no other way to support themselves.

The basic rate for a single person on OW is approximately \$548 per month. For ODSP, the rate is \$979.

Social assistance rates do not reflect the real cost of living, and are far from adequate. Social assistance benefits include two fixed portions, one for shelter and one for all other basic needs. According to the City of Toronto's estimates, in 2003, 70% of households receiving OW paid rent in excess of the maximum shelter component of their benefit²¹. Most homeless people only receive the basic needs portion of social assistance, and therefore receive substantially less than the basic social assistance rate.

Failing the Homeless: Barriers to ODSP for Homeless People with Disabilities

What we heard about the Ontario Disability Support Program (ODSP) in our survey is consistent with a separate study conducted by Street Health, which specifically examined the barriers homeless people face when attempting to access disability benefits²². The study found that homeless people with disabilities cannot navigate the overall ODSP application process without help, due to its complexity. Certain disabilities such as mental illness, developmental disabilities and learning disabilities make this system even more difficult to navigate.

With the right help homeless people with disabilities can get the ODSP benefits they need and are entitled to. Participants were provided with intensive, one-on-one support with all aspects of the ODSP application process and their related income, housing and legal needs. 93% of participants were able to secure ODSP benefits and 100% of those were then able to get housing.

60% of homeless people in our survey use cheque cashing services.

Even if you have personal identification, it can be difficult to find a bank in many low-income neighbourhoods. Between 2001 and 2003, 700 bank branches closed across Canada, generally in low-income neighbourhoods²³. This void has been filled by loosely regulated "financial services" companies that provide cash advances and cheque cashing services. Cheque cashing services typically charge fees of \$2.50 per cheque, plus an additional 3% of the total cheque amount. This means, on an average welfare cheque of \$548, these companies take about \$19. In addition, because these companies do not provide savings accounts, individuals have no choice but to receive the entire worth of their cheque in cash. This makes money management difficult and leaves people at risk of being robbed.

THE DAILY LIVES OF HOMELESS PEOPLE

"It's hard to want to stay healthy when you have to walk 'round the streets in the cold, rain, snow, broke. It's part of life. It's something I live with."
- Survey Respondent

This section outlines our findings on the daily reality and living conditions of homeless people in Toronto, detailing their experiences of obtaining shelter and food, as well as their experiences of social isolation and violence.

WHERE HOMELESS PEOPLE STAY

Homeless people have to think about where they can get shelter every day, and often stay in a variety of places within a short time period.

Places respondents stayed overnight in the past month	%
Shelter	88%
Outside (e.g. parks, streets, bus stops)	32%
Friend's or relative's place	26%
Hotel, motel, rooming or boarding house	10%
Hospital or treatment program	8%
Car or abandoned building	7%
Place of business (e.g. coffee shop, laundromat)	6%
Jail	4%

SHELTERS

39% of all homeless people in our survey were unable to get a shelter bed in the winter, at least once in the past year.

Access to Shelters

Almost all (96%) of the homeless people in our survey reported using shelters at least once in the past year. Of those who use shelters:

- 55% said that they had been unable to get a shelter bed at least once in the past year, on average 20 times
- Of those, 74% said that this had happened at least once in winter months

In Toronto, additional emergency shelter is made available in the winter months (mid November to mid April). Despite this, more than 1 in 3 homeless people in our survey could not get a bed at some point during the winter.

Shelter Conditions

"I'm a loner so I find it very difficult to share with 40 women - the washroom in the morning and you have to be in line for the shower or the toilet and sinks. And being told to be home by 11. You have no choice of when you eat, what to eat. I've been living on my own since I was 18 so I find it very difficult. But again, I'm not on the street. I have a place to stay."

- Survey Respondent

Shelter Closures: No Room at the Inn

Although shelters are not an adequate response to chronic poverty and a lack of affordable housing, they do provide a vital service for people who have nowhere else to go.

During the time that this study was conducted, 3 shelters in the downtown core closed.

Replacement beds are planned, but have not yet been built and will not cover the total number of emergency shelter beds lost. No one knows exactly how many shelter beds are needed in Toronto. If there was enough affordable housing, there would be far fewer people in the shelter system. Until then, shelter closures mean fewer people have a place to sleep at night. In addition to providing a place to sleep, shelters are also an important source of food. Fewer shelter beds also mean fewer meals for homeless people.

Some homeless people avoid the shelter system altogether. We asked people who had not stayed in a shelter in the last 10 days why they chose not to.

Common reasons respondents gave for avoiding shelters	%
Bed bugs	34%
Crowded conditions	31%
Fear of getting sick	23%
Fear of violence	20%
Fear of theft	15%

Bed Bugs

54% of all homeless people in our survey said they had stayed in a shelter with bed bugs in the past year. Thirty-six percent (36%) of all respondents reported that they had suffered bed bug bites in the past year and 20% said that bed bugs made it hard for them to sleep. Bed bugs have become a common problem for homeless people in Toronto. Bed bugs hide in cracks and crevices in beds, flooring and walls. Their bites can cause clusters of small but extremely itchy red bumps. Although bed bugs are not known to transmit infectious diseases, they can cause tremendous physical discomfort and a substantial degree of emotional distress²⁴.

SLEEP

"You can't go to sleep because you don't know what's going to happen from minute to minute. So you just keep staying up and staying up and staying up. And I noticed that physically - I had clumps of hair coming out ... and memory loss. I don't know if it's just exhaustion or nerves. But that's how it's affected me."
 - Survey Respondent

Survey respondents reported low levels of sleep. Forty-six percent (46%) of homeless people in our survey got an average of 6 or less hours of sleep per night. The most common reason that made it hard for respondents to sleep was too much noise or light. This reason, in addition to others that were prominent such as being woken up, overcrowding, cold, bed bugs and unclean conditions, highlights the poor conditions homeless people sleep in, both in the shelter system and when staying outside or in other public spaces. Some other common reasons, such as nightmares and bad nerves, suggest underlying psychological stress associated with homelessness. Pain and other physical health reasons were also cited by many respondents.

Sleep can serve as an indicator of health and quality of life. In Canada, people get an average of 8 hours of night-time sleep²⁵. Lack of sleep can have many important impacts on physical health, psychological well-being and energy level. When one considers how little sleep most homeless people get on a regular basis, it is not surprising that more than half of respondents said that in the past month, they had been so tired that they did not have the energy to walk one block or do light physical work. Research also indicates that sleep disturbances contribute to the development, or increase the severity, of various medical and psychiatric conditions, including heart attacks and depression²⁶.

More than half of the homeless people in our survey live with extreme fatigue. In the past month, 54% said they had been so tired that they did not have the energy to walk one block or to do light physical work.

Toronto's Shelter System

Approximately 32,000 different people used a shelter bed at least once in 2002¹. Shelters in Toronto range in size from about 25 to 750 beds.

While many shelters are doing their best with limited resources, a typical Toronto shelter is still a crowded place full of bunk beds, with a shared washroom for dozens of people, and few food choices regardless of dietary restrictions or medical conditions. Some shelters have maximum lengths of stay, forcing people to be constantly on the move. Some require people to leave early in the morning, leaving people with no place to rest during the day.

Out of the Cold programs are meal and shelter services run by faith-based groups and community centres across Toronto, primarily during the winter months (mid November to mid April). These programs are generally volunteer-run and often operate only one day a week. The shelter that these programs provide is sometimes just a mat and a blanket on the floor. Out of the Cold Programs provide accommodation for approximately 200 people per night.

HYGIENE

It can be difficult to take care of even basic health and hygiene routines when you don't have a permanent place of your own. When survey respondents were asked about some essential daily hygiene activities:

- 32% said they sometimes or usually had difficulty finding a place to use the washroom
- 25% said they sometimes or usually had difficulty finding a place to bathe
- 41% said they sometimes or usually had difficulty getting their clothes washed

Hygiene is an important part of overall health and is particularly important for some health issues. For example, getting rid of bed bugs requires exposing them to very high or very low temperatures. People are usually advised to put their clothes and bedding in the dryer at a high temperature if they have a bed bug problem. Almost half of the people we interviewed would have difficulty following this advice.

HUNGER & NUTRITION

"Sometimes I don't eat at all, some days. Sometimes the food is not available, you know, especially on the weekends - it's hard. A lot of places ain't open as frequently as they are through the week. So, I just do whatever I can. I see the health bus, I get vitamins."

- Survey Respondent

Issues of food and hunger came up frequently throughout the survey. In an open-ended question asking respondents about the hardest part of trying to stay healthy while homeless, nearly one third brought up issues of food. These included hunger, the inability to access healthy food, and the negative impacts of poor food on health.

69% of homeless people in our survey had experienced hunger at least one day per week in the past 3 months because they could not get enough food to eat.

Homeless people rely heavily on meal programs because they do not have places to store or cook food. 96% of respondents said that they regularly used meal programs at a shelter, drop-in or other organization. Despite relying heavily on meal programs for nourishment, homeless people are clearly not getting their food needs met by these programs: 58% reported that in the past 3 months they had still been hungry after going to a meal program.

Special Dietary Needs

33% of survey respondents said they are supposed to be following a special diet, mainly for health reasons. A special diet might be needed to control a medical condition such as diabetes, or because of a food allergy. Of those with special dietary needs, 53% said they were able to follow their special diet less than once a week.

Considering how essential it can be to follow a particular diet every day for health reasons, this is both an important health issue and a food security issue. The quality and variety of food available at meal programs, combined with not being able to afford to buy extra food and not having an adequate place to store or prepare food, explains why people are not able to eat the way they should to maintain their health.

Ontario Special Diet Supplement

Through the Ontario government's Special Diet Supplement, people receiving social assistance are eligible for additional income (up to a maximum of \$250) if they can provide evidence that they have a medical condition that requires a special diet. We asked those survey respondents who said they were supposed to be following a special diet whether they were getting this supplement. Seventy percent (70%) of those who were supposed to follow a special diet were not receiving the Special Diet Supplement.

Those not receiving the Special Diet Supplement gave the following reasons:

- 55% had not applied
- 14% were cut off from the supplement due to changing eligibility criteria

Where Are You Eating This Weekend?

A recent study identified 84 programs in Toronto that provide meals to homeless people outside of the shelter system. This does not include shelters or Out of the Cold Programs, which also provide meals in addition to overnight shelter.

Of these 84 programs, two thirds provide only a single meal per day. Most (63%) are open less than 5 days a week. It is very difficult to get food on weekends if you rely on meal programs. The study found that 79% provide no food on Saturdays and 82% provide no food on Sundays.

A detailed analysis of the meals served in a sub-sample of 18 programs found that the average energy content of meals served at meal programs was half of what a healthy adult would require for minimal physical activity during the day²⁷.

- 10% were not able to get the form filled out by a health care provider
- 9% had applied but were turned down
- 9% could not access the supplement because they were not receiving social assistance

Only three out of ten respondents with special dietary needs were able to access the Special Diet Supplement, despite a clear and important need. A large portion of those with special dietary needs had never applied for the supplement, likely because they did not know about it, did not know how to apply, or could not navigate the application. The rules and bureaucratic procedures associated with this benefit, including strict eligibility requirements and repeated visits to health care providers to fill out forms, have prevented many others from accessing this important health resource.

SOCIAL ISOLATION

Homeless people in our survey experience low levels of social support and high levels of social isolation.

37% said they had no one to help them in an emotional crisis.

- 34% said they never or rarely have someone they can count on to listen when they need to talk
- 38% said they often feel very lonely or remote from other people

Social support operates on an individual and societal level. It provides people with emotional and practical resources and has a protective effect on health. Conversely, social exclusion has a major negative impact on health, increasing one's risk for disability, illness, and addiction²⁸. Poverty creates social exclusion because it denies people access to decent housing, education and other factors that are important to full and equal participation in society. Discrimination, hostility, unemployment and stigmatization also contribute to social exclusion and are part of the daily reality of the homeless people we interviewed.

INJURY & VIOLENCE

Violence and lack of safety are part of the daily reality of homeless people's lives. Without their own private or safe spaces to go and stay, many homeless people are forced to live much of their lives in public, putting them at greater risk for injuries and accidents. Almost one in ten (9%) of survey respondents had been hit by a car, truck, public transit vehicle or bicycle in the past year.

Physical Assault

The lives of homeless people filled are with physical and sexual violence at rates much higher than in the general population.

35% of homeless people in our sample had been physically assaulted or beaten up in the past year.

Of the one in three people who were assaulted in the past year, 68% were assaulted more than once, on average 6 times. This is much higher than among the general population of Toronto, where less than 1% reported a physical assault to the police in 2005²⁹.

Who respondents reported being assaulted by the past year

Assault by:	%
Stranger	56%
Acquaintance	38%
Police	35%
Another shelter resident	27%
Partner or spouse	21%
Shelter staff	6%

Recent Changes to the Ontario Special Diet Supplement: How Much is AIDS Worth?

In 2006, new regulations by the provincial government made access to the Special Diet Supplement even more difficult, and reduced the amount that many people were already receiving. Everyone receiving the supplement was required to re-submit their applications on new, more restrictive eligibility forms. Additional diet income is now tied directly to specific medical conditions and, in some cases, to how sick you are as a result of the condition. For example, if you have diabetes, you are eligible to receive an additional \$42, while the amount someone receives if they have HIV/AIDS varies between \$75 and \$240, depending on how much weight they have lost.

Only 9% (34) of homeless people we spoke to were getting the Special Diet Supplement at the time of the interview. Of these, over half reported that the amount they received had been reduced in the 12 months prior to the survey, by an average amount of \$147.

Police Violence

12% of all survey respondents reported being physically assaulted by the police in the past year.

49% of those physically assaulted by police reported this happening more than once. In addition, three women told us they had been sexually assaulted or raped by the police in the past year.

Three quarters of respondents in our survey who had been assaulted by police said they did not lodge a formal complaint. The main reasons cited were related to fear of repercussions (46%), and feeling that it would not accomplish anything (46%).

"What for? To get beat again? I'm afraid of retaliation."

- Survey Respondent

"I tried to make a complaint before but the person I complained to came and beat me up too!"

- Survey Respondent

15 Years of Police Violence

The 1992 *Street Health Report* noted that police-inflicted injuries had been seen at Street Health nursing clinics for many years. The 1992 survey found that 10% of their sample had been assaulted by police in the past year³. A study conducted in 2001 found that 9% of homeless single adults and youths in Toronto reported an assault by a police officer in the past year³⁰.

Sexual Harassment & Assault

14% of the people we surveyed experienced sexual harassment in the past year. This was defined in our survey as being bothered by someone who is saying or doing unwanted or unwelcome things of a sexual nature. Of those, almost all (94%) had been sexually harassed more than one time. This experience was higher for women, 36% of whom had been sexually harassed in the past year. All of the transgender or transsexual people (3) we surveyed reported having experienced sexual harassment.

Respondents were also asked if they had been sexually assaulted or raped in the past year. This was defined in our survey as unwanted touching and/or sexual intercourse (vaginal or anal). Seven percent (7%) of our total sample said they had been sexually assaulted in the past year. Again, this statistic was higher for women, 21% of whom had been sexually assaulted in the past year.

1 in 5 women in our survey had been sexually assaulted or raped in the past year.

The extremely high rates of sexual assault among women are especially staggering when we consider that it is likely under-reported in our survey, due to the personal nature of the issue and the stigma that surrounds it.

“When people are homeless,
they’re already in a crisis. Why are they putting them
out to sleep on the street at night when it’s a lot more
dangerous? Almost always they come in and say
‘I’ve been raped.’ Stop it. Let them sleep indoors.”

— Susan, 45, 1 year homeless



photo by Keneisha, courtesy of the National Film Board of Canada

THE HEALTH OF HOMELESS PEOPLE

It is widely recognized that homeless people have much poorer health than the general population. Canadian research and literature reviews confirm that homeless people experience a disproportionate burden of chronic and multiple health issues^{31,32} and that mortality rates for homeless people are significantly higher than for the general population³³⁻³⁵. Other studies have found that people living in poverty are more likely to die from certain diseases, including cancer, diabetes and respiratory diseases, and particularly cardiovascular disease³⁶.

The section below presents our findings on the health status of homeless people in Toronto, documenting their general health and well-being, physical and mental health, and substance use.

GENERAL HEALTH & WELL BEING

We asked homeless people to rate their health and well-being in a variety of ways. Our findings speak overwhelmingly to the overall poor physical and mental health of homeless people, as well as the stress and isolation of being homeless.

For the table below, health was defined as not only the absence of disease or injury but also in terms of physical, mental and social well-being.

Self-rated health

Homeless people in our survey compared with the general population

	Street Health Survey	General population ⁷
Excellent or very good*	29%	61%
Good	29%	30%
Fair or poor*	40%	9%

**statistically significant difference*

We asked respondents to think specifically about their mental health.

Self-rated mental health

Homeless people in our survey compared with the general population

	Street Health Survey	General population ⁷
Excellent or very good*	33%	74%
Good*	27%	21%
Fair or poor*	38%	5%

**statistically significant difference*

Stress

When asked to think about the amount of stress in their lives, 44% of respondents said that most days were quite a bit or extremely stressful. In comparison, 24% of people in Toronto reported the same amount of life stress⁷. Stress has an important impact on health and well-being. High levels of stress can contribute to conditions such as high blood pressure, heart disease and stomach or intestinal ulcers. Chronic stress over long periods of time compromises the immune system, making people more susceptible to a range of other health conditions.

Pain

"I have a lot of pain throughout my body. I lived in the basement of an apartment which had a flood. I think that caused the dampness. It must have been that because that's when I got it - I had pain in my legs after that."

- Survey Respondent

14% of all homeless people in our sample are usually in severe pain.

Regular experiences of pain are common among homeless people. Homeless people in our sample suffer significantly more pain and discomfort, with greater intensity, than the general population.

Experiences of pain

Homeless people in our survey compared with the general population

	Street Health Survey	General population ³⁷
Usually in some pain or discomfort*	41%	15%
Intensity of pain (of those usually in pain)		
	Street Health Survey	General population ³⁷
Moderate*	46%	8%
Severe*	35%	2%

*statistically significant difference

These high levels of pain and discomfort among the homeless population suggest that many people may have disabilities and medical conditions that are not acknowledged, diagnosed or treated. Experiences of pain can also lead to low energy levels. Pain and low energy limit people’s ability to care for themselves and participate economically and socially in the community. Pain also has an important impact on other areas of health and well-being, including one’s ability to sleep. Almost one third (30%) of respondents said that they found it hard to sleep because of pain or discomfort.

PHYSICAL HEALTH CONDITIONS

74% of the homeless people we interviewed had at least one serious physical health condition^v. 52% of the total sample had two or more.

For people without any serious health conditions, the average time homeless was 3.7 years. The average length of time homeless for people with at least one serious health condition was 5.1 years. The significant difference between these two averages suggests that being homeless for a longer period increases one’s likelihood of serious illness. Other research has also demonstrated that the longer people live in disadvantaged circumstances, the more likely they are to suffer from various health problems, in particular cardiovascular disease²⁸.

Chronic or Ongoing Health Conditions

Chronic or ongoing physical health conditions

Homeless people in our survey compared with the general population^{vi}

	Street Health Survey	General population
Arthritis or Rheumatism*	43%	14% ⁷
Allergies other than food allergies*	33%	24% ⁷
Migraines*	30%	11% ⁷
Liver disease*	26%	10% ³⁸ in Canada
Hepatitis C*	23%	0.8% ³⁹ in Canada
Problem walking, lost limb, other physical handicap	23%	n/a
Asthma*	21%	6% ⁷
Heart disease*	20%	4% ⁷
High blood pressure*	17%	13% ⁷
Chronic Obstructive Pulmonary Disease (COPD)*	17%	1% ⁷
Stomach or Intestinal Ulcers*	15%	2% ⁷
Skin disease (e.g. eczema, psoriasis)	13%	n/a
Angina*	12%	2% ⁴⁰ in Ontario
Anemia	11%	n/a
Diabetes*	9%	4% ⁷
Heart attack in lifetime*	7%	2% ⁴⁰ in Ontario
Inactive or latent Tuberculosis	7%	n/a
Epilepsy*	6%	0.3% ⁴¹
Fetal Alcohol Spectrum Disorder (FASD)*	5%	1% ⁴² in Canada
Stroke in lifetime	4%	n/a
Hepatitis B*	4%	0.7-0.9% ⁴³ in Canada
Cancer*	4%	1% ⁷
Congestive Heart Failure*	3%	1% ⁴⁰ in Ontario
HIV positive*	2%	.006% ⁴⁴
AIDS	1.1%	n/a

n/a – data not available

*statistically significant difference

^v A “serious physical health condition” was defined as any of 22 serious conditions, including: cardiovascular and respiratory diseases, hepatitis and other liver diseases, gastrointestinal ulcers, diabetes, anemia, epilepsy, cancer and HIV/AIDS.

^{vi} Comparisons are with the general population of Toronto. For some conditions data was only available for the general population of Ontario or Canada, or was not available at all; this is noted in the table.

It is clear that the homeless population carries a disproportionate burden of many serious health conditions compared to the general population. The homeless people we interviewed had significantly higher rates for all conditions listed above for which we have comparable data. For example, our results show that homeless people are:

- **20 times as likely to have epilepsy**
- **5 times as likely to have heart disease**
- **4 times as likely to have cancer**
- **3 ½ times as likely to have asthma**
- **3 times as likely to have arthritis or rheumatism**
- **Twice as likely to have diabetes**

This comparison to the general population becomes even more striking when we consider the relatively young age of most of our respondents. We would expect many of the conditions discussed to be more common among older adults, yet the average age of survey respondents was 42, and the oldest person interviewed was 66.

Acute or Episodic Health Issues

There are some health conditions that are very common among homeless people, and that likely affect this population disproportionately.

Acute or episodic physical health issues reported by respondents in the past year	%
Problems with one's feet	37%
Bed bug bites	36%
Pneumonia	16%
Skin infection, skin sores or ulcers	14%
Seizure	11%
Head or body lice, scabies, or other similar condition	4%

Emergent Health Issues

There are several health conditions that have emerged as important health issues among the homeless population in recent years.

Tuberculosis (TB) is a contagious disease that had almost disappeared in Canada, but that has re-emerged in recent years. TB bacteria commonly

attack the lungs but can infect other parts of the body. People can have active or inactive TB. Inactive TB means that you have the TB bacteria in your body but it is not making you sick. Inactive TB can become active TB if the immune system is somehow damaged. TB is a major cause of death for people who also have HIV⁴⁵. Seven percent (7%) of the people we surveyed said they had inactive TB. It is likely that the reported rate of inactive TB among homeless people in our sample is an underestimation, as many may not know they have it.

TB has affected some populations disproportionately, including homeless people. While the majority of active TB cases in Toronto are among people who have travelled or lived in areas where TB is common, one third of cases affecting other populations were among homeless and underhoused people living in shelters or rooming houses⁴⁶. Crowded conditions in these living situations put this population at high risk for infection. Although TB is preventable and curable, and despite recent scaled up efforts by Toronto Public Health, it is still not easy for homeless people to get tested for TB or to access treatment.

Hepatitis C rates among survey respondents are close to 30 times higher than in the Canadian population.

Hepatitis C is a viral infection that attacks the liver and is transmitted through blood to blood contact. While 23% of our survey sample reported having Hepatitis C, it is likely that this number is even higher. Hepatitis C progresses slowly and most infected people do not experience symptoms for many years, so many do not even know they are infected. The Ontario Ministry of Health estimates that one third of people living with Hepatitis C do not realize they are infected. Despite a high need among this group, homeless people experience major barriers to accessing treatment or even acquiring basic information about the disease. Without education, many people are transmitting the disease unwittingly.

Hepatitis C can be effectively treated, but the treatment is difficult and it requires stability and support. Treatment requires following a strict schedule of medication and monitoring by a physician for at least six months. The side effects can be debilitating, and include severe depression, hair loss, flu-like symptoms and nausea. Many health care providers are unwilling or unable to provide

the extensive support homeless people need to successfully undergo treatment. Without treatment, Hepatitis C can cause liver disease, including cirrhosis and cancer. Without adequate shelter and nutritious food, homeless people are even more susceptible to some of these negative outcomes. Further, it is estimated that in Ontario, 25% of people with HIV also have Hepatitis C⁴⁷. HIV and Hepatitis C co-infection is problematic because each disease makes the other worse and it is hard to treat both simultaneously.

HIV/AIDS has been a growing health issue which has disproportionately affected homeless people relative to the general population. The prevalence of HIV is over 300 times higher among homeless people than in the general population in Toronto. It is quite possible that this condition was under-reported by survey respondents, due to the stigma attached to the disease and because some respondents may not know their HIV status. Homeless people with HIV are at extremely high risk for many medical conditions. In addition to having a compromised immune system due to HIV, homeless people tend to have their immune systems even further weakened by the harshness of their daily lives, which includes fatigue, poor nutrition and high levels of stress. Furthermore, homeless people are regularly exposed to countless communicable diseases and infections in crowded spaces such as shelters.

THE IMPACT OF LIVING CONDITIONS ON HOMELESS PEOPLE'S HEALTH

The particular living conditions of homeless people are a major contributing factor to their poor health status. In addition to poverty, stress and social isolation, key aspects of homeless people's unique living situation that affect their health are:

- **Food:** Homeless people lack control over the food they eat, and lack access to healthy food, which may contribute to, or make worse, conditions such as diabetes and stomach ulcers.

- **Violence and Injury:** Homeless people are more likely to be injured or assaulted, which often includes head injuries. Head injuries can lead to seizures. Violence also has a broad range of negative physical and psychological effects.
- **Density and Crowding:** Crowded conditions in shelters put homeless people at risk for infectious diseases like the flu and TB, as well as problems like lice, scabies and bed bugs.
- **Exposure to the Elements:** Homeless people are far more exposed to the urban environment and the elements than the average person. Many homeless people spend a major part of the day outside, exposing them to dampness, cold, extreme heat and pollution. This prolonged exposure may put homeless people at higher risk for arthritis, pneumonia, allergies and asthma. Foot problems among homeless people are common because many homeless people spend a large part of their day walking or standing, and because homeless people often have to spend the day with cold and wet feet.

Killer Heat

Climate change is having a dramatic impact on homeless and poorly housed people. In 2005, Toronto's Medical Officer of Health reported that more Torontonians are dying prematurely of heat-related causes in the summer than of cold-related causes in the winter⁴⁸. Homeless and poorly-housed people, who have very few options to escape the heat, are among those at greatest risk for heat-related illness⁴⁹. The number of smog and extreme heat days reached an all-time high in 2005. Rising temperatures due to climate change threaten to make this problem even worse.

MENTAL HEALTH

"You get a sense of despair; your self worth goes to hell."

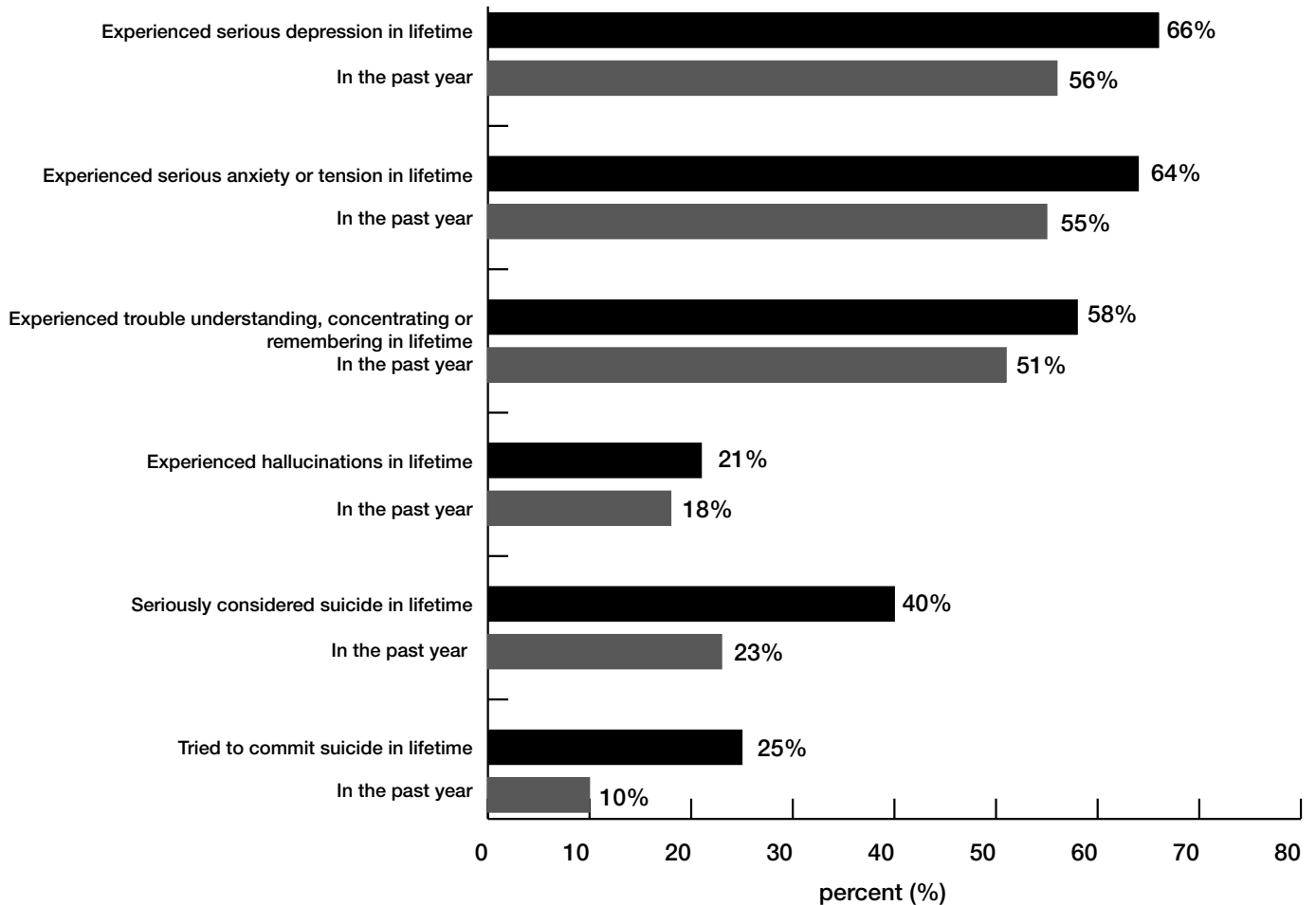
- Survey Respondent

"The physical part is one thing, but keeping your mental health is hard because you do not have a place to live - no job, no money - even for the telephone."

- Survey Respondent

Overall, the mental health status of the homeless people in our survey was severe and alarming. Homeless people we interviewed reported extremely high rates of mental health symptoms, suicidal ideation and attempted suicide. Contrary to the stereotype of the mentally ill homeless person who suffers from psychosis, the most common mental health issues among the people we spoke to were depression and anxiety.

Experiences of mental health symptoms, suicidal ideation and attempted suicide



Mental 'illness' does not cause homelessness, poverty does

A 1998 study by researchers in Toronto that examined the societal and personal factors that precipitate homelessness concluded that mental illness cannot be seen as a primary pathway to homelessness⁵³. The report argues that broader systemic factors need to be taken into account and uses an analogy of 'musical chairs'. As chairs (i.e. jobs and affordable housing) become scarce, it is not surprising to find people with mental and physical health problems among those without a chair.

Rates of suicidal ideation were significantly higher among homeless survey respondents than in the general population in Toronto, where 7% reported having suicidal thoughts in their lifetime⁵⁰. The high levels of depression, anxiety and suicidal ideation in our sample is a reflection of the extremely harsh reality of homeless people’s daily lives, and the lack of hope that many homeless people feel.

Diagnosis of Mental Health Problems

Respondents were asked if they had ever been given a diagnosis for a mental health problem by a doctor or psychiatrist. Thirty-five percent (35%) of our sample has received such a diagnosis in their lifetime.

The table below shows the prevalence of the most common mental health diagnoses in our sample, compared with that of the general population in Canada.

Mental health conditions

Homeless people in our survey compared with the general population of Canada

	Street Health Survey	General population ⁵¹
Depression*	17%	8%
Anxiety*	11%	1%
Bipolar*	8%	1%
Schizophrenia*	5%	1%
Post-traumatic stress disorder	5%	n/a

n/a – not available

**significant difference*

Not reflected in these numbers is the reality that many people with mental illness are initially misdiagnosed and that determining a diagnosis and a treatment plan is often an ongoing process, negotiated between specialists and clients. Many homeless people, because they do not have stable health care, are unable to go through this process and often live with misdiagnoses and ill-fitted treatments.

Mental health problems affect people of all income levels. It is estimated that “1 in 5 Canadians will personally experience a mental illness during their lifetime”⁵¹. Mental health problems do not directly cause homelessness. People with mental health issues become homeless when they lack income stability and appropriate supports. Many of the factors that compromise mental health, such as instability,

social isolation and violence, are also part of the daily reality of homelessness. Many people experience mental health problems, or have existing problems become worse, only after they become homeless.

While for some people, mental health issues may be one of the factors that contribute to becoming homeless, it is likely just one of many. Although many of our survey participants experience mental health issues, very few (5%) cited mental health issues as the reason they lost housing or the reason they were unable to find or maintain housing. Addiction issues came up as a more prominent reason for losing or not being able to get housing (cited by 23% for both questions). Although our study did not explore the prevalence of concurrent disorders, the term used when people have a combined mental health and substance use problem, other studies estimate that 30% of people diagnosed with a mental health disorder will also have a substance use disorder at some point in their lives⁵². Having a concurrent disorder can make it even more difficult to access treatment. Many mental health services will refuse treatment to a person with an active drug or alcohol addiction and some addictions services will not treat people for substance use problems until their mental health problem is treated.

Learning Disabilities

Homeless people report significantly higher rates of learning disability. Sixteen percent (16%) of our sample said they had been diagnosed with a learning disability, compared to only 2% of the general population in Toronto⁷. Of those in our sample who had received a diagnosis, the following specific learning disabilities were cited:

- 67% – Attention Deficit Disorder / Attention Deficit Hyperactivity Disorder
- 18% – Dyslexia
- 20% – Other learning disability

Learning Disabilities refer to a number of disorders that may affect the acquisition, organization, retention, understanding or use of verbal or nonverbal information⁵⁴. These are life-long disorders that can affect self-esteem, work, and relationships. Difficulties faced by adults with learning disabilities may include finding or keeping a job, time management, budgeting and managing money.

SUBSTANCE USE

Smoking

87% of the people we surveyed currently smoke cigarettes, compared to 18% of the general population of Toronto⁷.

Alcohol

77% of the people we interviewed reported having had a drink of beer, wine, alcohol or other spirits in the past year^{vii}.

Frequency of alcohol consumption in past 30 days	%
Daily or almost daily	13%
3 to 4 times/week	12%
1 or 2 times/week	16%
Several times this month	7%
1 to 2 times this month	17%
Never in the last month	35%

The proportion of homeless people who have had any alcohol in the last year is almost identical to that of the general population of Toronto, 70% of whom reported using alcohol at least once in the past year⁷. The percentage of people who abstained from alcohol in the past year is also similar in the homeless (23%) and general populations (30%)⁷.

Differences in patterns of alcohol use between homeless people in our sample and the general population occur mainly in the percentage of heavy drinkers. Seventy-two percent (72%) of people in our survey who reported drinking alcohol, reported heavy drinking (5 or more drinks on one occasion) at least once in the past year, compared to 44% of the general population⁷. Of those people in our survey who said they had consumed alcohol in the past year, 55% reported heavy drinking more than once a month in the past year. In the general population of Toronto, 22% reported the same⁷.

Non-beverage alcohol

7% (24) of homeless people we interviewed had consumed non-beverage alcohol in the past year. Four people said that they do this almost daily.

Non-beverage alcohol is alcohol in a form that is not meant to be consumed and includes things like mouthwash, hand sanitizer, cooking wine, and rubbing alcohol. Homeless people may drink non-beverage alcohol because it is less expensive and easily available. Some types of non-beverage alcohol (like methanol, found in anti-freeze) are extremely toxic and can cause blindness or death. Dangerous toxic health effects also result from the mix of other chemicals present in these products⁵⁵.

Drugs

"I've been looking for counselling and I haven't been able to find any. I lost my kid in the past year. My coping mechanism ... I'm embarrassed to say it ... but I've turned to street drugs. It's not good but I'd rather ... the medication you get for depression - most of them knock you around like a zombie. Marijuana is illegal but it seems to ease my depression, which makes me eat. If it helps, it helps."

- Survey Respondent

59% of the people we surveyed use at least one illicit drug regularly (3 or more times a week) other than marijuana. Twelve percent (12%) use marijuana only and 28% said they had not used any illicit drugs regularly in the past year.

Drugs used regularly by respondents in the past year	%
Crack	49%
Marijuana	48%
Cocaine	30%
Opiates/analgesics (other than Oxycontin)	16%
Sedatives, hypnotics or tranquilizers (other than downers)	16%
Oxycontin	15%
Morphine	10%
Heroin	7%
Hallucinogens	7%
Methamphetamines (crystal meth, uppers, speed)	4%
Downers	6%
Methadone	5%
Amphetamines (Benzedrine, Ritalin)	4%
Solvents and other inhalants	2%

^{vii} For our survey, we used a standard definition which defines 'a drink' as: one bottle or can of beer or a glass of draft; one glass of wine or a wine cooler; or one drink or cocktail with 1 ½ ounces of liquor.

Nearly half of our total sample reported regular crack use. This is very high compared to the crack use rate of 1% reported by the general Toronto population⁵⁶. Crack use presents many serious health risks, including Hepatitis, HIV and respiratory problems. There is also intense stigma surrounding crack use and few treatment or support options are available.

23% of those who had used any drugs regularly reported having injected drugs in the past year. This represents more than 1 in 10 of our total sample. Sharing contaminated needles makes injection drug use one of the leading causes of HIV, hepatitis and other blood borne infections⁵⁷.

People of all income levels use drugs for a variety of individual and systemic reasons. Drugs are often used to help people to cope with illness, trauma, stress or pain, and to relieve isolation and boredom. This is probably the case for many of the people we interviewed, 73% of whom said that they had used alcohol or drugs in the past year to relieve stress or pain or to feel better about their life. Since illegal drugs can be easier to obtain than prescription medications, it is likely that many people in our survey are “self-medicating” themselves to relieve symptoms that they cannot get medical treatment for.

ORAL HEALTH

Homeless people in our survey experience high morbidity in the area of oral pain and dental problems, and have poorer self-rated oral health compared to the general Canadian population.

40% of the homeless people we interviewed said that in the past month, they often or sometimes had pain or discomfort in their teeth or gums, or other dental problems.

Self-rated oral health

Homeless people in our survey compared with the general population of Canada

	Street Health Survey	General population ⁵⁸
Excellent or very good*	15%	55%
Good*	21%	31%
Fair or poor*	62%	14%

*statistically significant difference

Untreated oral diseases undermine quality of life through pain, difficulty eating and facial disfigurement. This can lead to loss of self-esteem, depression, social isolation, and adds another layer of social stigma to an already highly stigmatized group. This then limits educational and work opportunities.

Oral health also has an effect on overall physical health. Diseases of the mouth and teeth have been associated with a wide range of serious health conditions such as diabetes, heart disease, stroke, and chronic obstructive pulmonary disease⁵⁹. Poor oral health and the resulting loss of teeth can have a serious impact on nutrition. Research on oral health indicates that people with no natural teeth are twice as likely to experience significant weight loss⁵⁹. Although we did not specifically ask about tooth loss, 13 survey respondents volunteered that they had either lost all of their teeth or had them pulled out years ago. This is likely a reflection of the fact that tooth extraction is one of the few dental services that are covered for social assistance recipients in Ontario.

WOMEN’S HEALTH & ACCESS TO HEALTH CARE

There are many health issues that are specific to women; as well, women’s experiences of homelessness and health are different than men’s. This section presents our findings on women’s health and issues that affected women disproportionately among the homeless people we interviewed.

Length of Time Homeless

On average, women in our sample have been homeless for significantly less time than men: an average of 3 years, compared to an average of 5 years for men.

Violence

Homeless women experience high levels of violence. Thirty-seven percent (37%) of the women we surveyed had been physically assaulted in the past year. Of those women who were physically assaulted:

- 60% were physically assaulted by an acquaintance
- 54% were physically assaulted by a partner or spouse
- 48% were physically assaulted by a stranger

Homeless women in our survey experience higher levels of sexual violence than homeless men. 21% of homeless women we interviewed reported having been sexually assaulted or raped in the past year. Of those women who were sexually assaulted in the past year:

- 55% (11) had been sexually assaulted more than once
- 60% (12) were sexually assaulted by a stranger
- 45% (9) were sexually assaulted by an acquaintance
- 35% (7) were sexually assaulted by a spouse or partner

Although staggering, these numbers are likely an underestimate, because sexual assaults often go unreported. In addition, we did not survey at any of the shelters in Toronto known to be providing services for women who are victims of abuse. A 2001 review of records from a Toronto sexual assault care centre found that homeless women experienced more violent sexual assaults and were more likely to be sexually assaulted by strangers in public than women who were not homeless⁶⁰.

Mental Health

Having at least one mental health diagnosis was significantly more frequent among women in our sample than men. Despite reporting very similar experiences of mental health symptoms such as depression and anxiety, 55% of women reported mental health diagnoses compared to 28% of men.

Preventive Health Care

A Pap smear test is a basic preventative health care practice, performed to check for signs of cancer of the cervix. The government of Ontario recommends that women get a pelvic examination with a Pap test at least once a year as a preventative measure to lower the chances of developing cervical cancer⁶¹. Our data indicates that homeless women access Pap tests less frequently than women in the general population. Forty-one percent (41%) of the women we surveyed said they had had a Pap test in the past year. In the general population of Toronto, 62% of women reported having a Pap test in the last year⁷.

Breast cancer is one of the most common cancers among women⁶². The Ontario Breast Screening Program recommends that all women 50 and older have a mammogram screening every one to two years⁶³. Twenty-nine percent (29%) of women over age 40 in our sample reported having had a mammogram in the past year. This is much lower than for women aged 35 and over in the general population of Toronto, 65% of whom had a mammogram in the past year⁷.

Pregnancy

Three of the women we spoke to reported being pregnant at the time of the survey. More than 1 in 10 of the women we interviewed (13) said that they have had a baby while homeless or staying in a shelter at some point in their lives. We asked these women to think about the last time they had a baby and to tell us where they had gone after being discharged from the hospital. Four said they went to a shelter or hostel, three stayed with a friend, and three said they had no place to go or went back to the streets. Although respondents were not asked, we can assume that most, if not all, did not have custody of their children when they left the hospital.

In addition to experiencing high levels of violence, homeless women experience poorer access to preventive health care than women in the general population, and many do not have access to basic needs such as shelter, even when pregnant and after giving birth.

Women's Homelessness: A Common Occurrence

The impact of homelessness on women's health is addressed in detail in a 2002 report called *Common Occurrence*⁶⁴. The report summarizes the findings of a research study conducted by two community agencies, Sistering and the Toronto Community Care Access Centre, and explores the continuum of women's homelessness in ways that were not possible in this study. Their study documents the serious impact that visible and hidden homelessness has on women's emotional, mental, spiritual and physical health.

“I can’t do much, because I’m always short of breath, I have to sit down. I don’t sleep very often. And living in a shelter, to be honest with you, is not healthy at all. It’s not the best place to be...”
The place is infested with bugs. I got bitten three times.

— **Kathy, 37, 2 years homeless**



photo by Meghan, courtesy of the National Film Board of Canada

ACCESS TO HEALTH CARE

Homeless people often experience difficulties obtaining the health care and social services they need.

This section presents our findings on how homeless people in Toronto use health care services, and explores how various health services meet their needs.

WHERE DO HOMELESS PEOPLE GO FOR CARE?

Sources of health care used by respondents in the past year

	%	Average # of times
Emergency department	54%	5
Doctor's office	44%	12
Services at shelters, drop-ins, health bus	42%	15
Community health centre	31%	11
Walk-in clinic	29%	4
Hospitalization (at least one night)	24%	2
Hospital outpatient clinic	13%	9
Aboriginal health centre	6%	7
Alternative health centre	1%	10

High proportions of survey respondents used an emergency department and were hospitalized in the past year. Ten percent (10%) of homeless people in our survey reported not accessing any health care services in the year prior to the survey. The significant portion of people not accessing health care at all is particularly concerning when we consider how many people have serious health conditions.

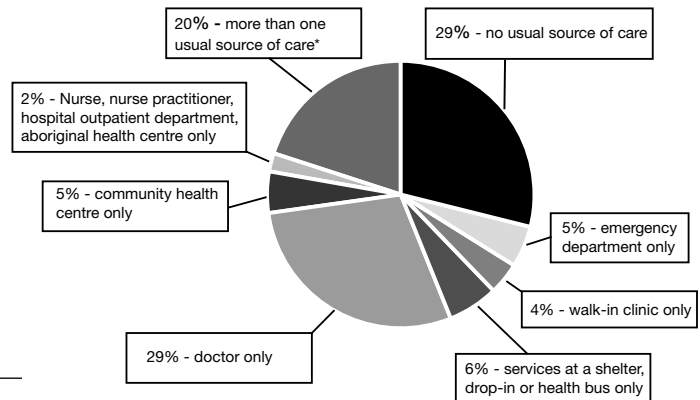
PRIMARY HEALTH CARE

"I went to the hospital but they couldn't help me because I didn't have a prescription, and I didn't have a prescription because I don't have a doctor. That's why it took so long for me to get my meds." – Survey Respondent

Many of the homeless people in our survey do not have a stable, comprehensive source of primary health care. Homeless people also have significantly worse access to family doctors than the general population.

59% of all the homeless people we interviewed do not have a family doctor, compared to only 9% of the Toronto population⁷.

Respondents' usual source of health care



*Respondents in this category cited two or more of the health care providers in this chart as their usual source of health care.

In addition to the substantial portion of survey respondents (29%) with no stable health care provider, 15% reported a usual source of health care that generally does not provide comprehensive and stable care^{viii}. Primary health care providers, like family doctors and nurse practitioners, provide both the first point of entry into the health care system and continuing care. It is important to have a stable

^{viii} This includes the proportion of respondents whose only usual source of care was: emergency departments (5%), walk-in clinics (4%) and services geared towards homeless people (6%).

primary health care provider who knows you and your medical history, and with whom you feel comfortable. Although emergency departments, walk-in clinics and services geared towards homeless people all provide essential health care services, they are generally not designed to provide continuity or to address all aspects of a patient's health care needs.

16% of the homeless people we interviewed cited community health centres as one of their usual sources of care. An important part of the community health centre model is to promote access to health for people facing barriers to care, and to provide comprehensive care that addresses a range of health-related needs. This makes them well suited to provide health services to homeless people but some barriers still exist, such as the lack of walk-in services and community health programs that do not focus on the specific needs of homeless people.

Almost one third (29%) of all the homeless people we interviewed said they did not have a usual source of health care.

Reasons given by those respondents with no usual source of health care	%
Seldom or never get sick	42%
Don't use doctors or treat self	24%
Don't have a health card	19%
Move around a lot within Toronto	15%
Negative past experience	12%
Recently moved to Toronto	11%
Don't know where to find care	10%

Many respondents cited not needing health care as a main reason for not having a stable health care provider. This is surprising and unlikely, considering that

three quarters of respondents have at least one serious physical health condition. This suggests that some homeless people have a lower sense of entitlement and lower expectations about their health and their right to access care. This is also related to homeless people's difficult living situations, where they often have to prioritize more immediate needs such as shelter, and do not have the luxury of addressing preventive health care.

PREVENTIVE HEALTH CARE

Physical Check-ups

35% of the homeless people we surveyed had not had a physical check-up in more than three years.

A wide range of reasons for not having had a check up in the past three years were cited, the most common being that 53% didn't think it was needed. The second most common reason cited by 40% was that they couldn't find a doctor taking new patients or didn't have a doctor to go to.

Immunization & Screening

Other specific preventative health measures appear to be more accessible to the homeless people we interviewed:

- 72% of respondents said they were offered a flu shot in the past year
- 60% of respondents reported that they had been tested for tuberculosis (TB) in the past year

While these findings are positive, we do not know how many homeless people actually received the flu shot, and we cannot presume that everyone who was tested for TB also received adequate and comprehensive follow-up.

"Street Health Services"

Street Health was started in Toronto 1986 when a group of homeless people got together to discuss their health care issues and the barriers they were facing in trying to navigate the mainstream health care system. In response, a group of volunteer nurses opened a nursing clinic at a drop-in for homeless people in the All Saints Church at Sherbourne and Dundas Streets.

There has been an increase in the number of health services geared towards homeless people since then. In 1989, there were perhaps 4 or 5 street nurses, but today there are more than a hundred street nurses working across Canada⁶⁵. These services are delivered outside of mainstream health care settings in places where homeless people spend time and where they feel comfortable. Some shelters and meal programs offer on-site nursing care during set times each week. Some health agencies operate mobile health vans or buses that drive around the city offering care at specific spots and along the way. Outreach workers and nurses take knapsacks and walk around parks, beneath bridges and in ravines, to reach people who might not otherwise be able to access health care on their own.

Health care services geared towards homeless people are a vital service because they provide homeless people with much-needed health care while also facilitating access to other mainstream health services. While many homeless people rely on these services for health care, they are not intended to provide comprehensive care or to replace the mainstream health care system. The increase of this type of health service is a reflection of increasing homelessness and homeless people's poor access to the mainstream health care system.

Sexual Health

63% of survey respondents reported being sexually active in the year prior to the survey. Of those who were sexually active:

- 51% said they always use a condom or dental dam for sex
- 27% said they often, sometimes or occasionally use a condom or dental dam for sex
- 22% said they never use a condom or dental dam for sex

Access is clearly an important issue that prevents condom use, as 14% of sexually active respondents said that they had needed condoms in the year prior to the survey but had not been able to get them.

80% of all respondents reported that they had been tested for HIV in their lifetime. This is a substantially higher rate than the general population, where it is estimated that just over a quarter (27%) of Canadians aged 15 and up have been tested⁶⁶. The higher rate of testing among homeless people is consistent with findings showing that people in high-risk populations are far more likely to have been tested for HIV in their lifetime⁶⁶.

EMERGENCY DEPARTMENTS

Hospital emergency departments were the most frequently used source of health care for homeless people in our survey, used by 54% of all respondents in the past year.

Reasons for emergency department use in the past year	%
Injury	46%
Physical health problem (other than injury)	42%
Detox or overdose	15%
To get a prescription	14%
Mental health issue	12%
Dental problem	12%
To get warm, food or rest	13%
Forced to go against will	6%

33% of respondents who had used an emergency department in the past year reported leaving at least once before being seen. The most common reasons for this include:

- 89% said the wait time was too long
- 33% left because of the negative attitude of reception staff
- 36% needed to get to a meal program before it closed, or to a shelter before curfew
- 21% were kicked out by hospital security

Inability to access care at emergency departments because of poor treatment is particularly disturbing when we consider that this is an important point of access to health care for the people we interviewed.

27% of the people we spoke to had used the emergency department for reasons that were likely a non-emergency: as a place to get rest or food, or to fill a prescription. As well, 5% of respondents named hospital emergency departments as their only usual source of health care. These findings speak to two important concerns:

- Homeless people are often faced with nowhere to go for very basic needs like food and warmth. This is particularly true at night and on the weekends
- Homeless people have few accessible primary health care options

As a result, homeless people are forced to use emergency departments for primary health care and basic survival needs. This use of emergency departments for non-emergency reasons is problematic for both individuals and for the health care system. Homeless people do not get adequate primary health care at emergency departments, and emergency departments are not designed to meet their needs for food and shelter. When homeless people use emergency departments for primary health care, there is more demand on the already over-burdened hospital system.

HOSPITALIZATION

Homeless people in our survey reported high rates of hospitalization. Twenty-four percent (24%) of respondents were hospitalized for at least one night in the past year, compared to just 5% of the general population of Toronto⁷.

For those who were hospitalized in the past year, follow-up care was poor:

- 47% did not get help filling prescriptions when they were discharged
- 55% had no arrangements made for them to ensure that they had a place to stay when they left

Follow-up care is especially important for homeless people, who do not have a place of their own in which to recuperate and who are less likely to have enough income or insurance coverage to get required medications. These issues point to the need for places like Toronto's Sherbourne Health Centre Infirmary. The infirmary opened in April 2007, and provides 20 beds staffed by health care professionals for homeless and with underhoused people who are recovering from a medical condition but do not require intensive hospital care. This facility provides homeless patients with a safe, caring environment where they can get the rest and nourishment needed to recover.

MEDICATION, MEDICAL SUPPLIES & ASSISTIVE DEVICES

"The hard part is when they prescribe over the counter stuff or tell you that you have to get more diabetic test strips. And no one will even give you two tickets to get to the doctor's. You spend all your money on diabetic supplies, the extra food, the over the counter stuff."

- Survey Respondent

Medication & Medical Supplies

In the past year, 32% of homeless people we surveyed were not able to obtain the prescription medication they needed, and 8% were not able to get medical supplies.

Reasons respondents could not obtain medication and medical supplies in the past year

	Medication	Medical Supplies
Can't afford them	62%	75%
Don't have drug benefit card	63%	39%
Drug benefits don't cover needed item	10%	7%
Don't know where to get them	(not cited)	21%

The high cost of medical supplies and supplementary health care necessities is something that many people who have private insurance coverage through their employers often take for granted.

Even when people can get the prescription medication they need, being able to take medication as prescribed is another set of hurdles for homeless people. Forty-eight percent (48%) of all respondents said they were supposed to be taking prescription medications at the time of the survey. Of these, 37% were not always able to take their medication as prescribed, mainly because they could not afford to buy it in the first place, or because of their difficult living conditions which led to medication being stolen or lost, having nowhere to store medication properly, or the timing of meals or shelter rules not allowing people to take medication as directed.

We asked people who were supposed to be taking prescription medications to name up to four of the medications that they should be taking. Frequently cited (50 times) were medications related to diabetes, blood pressure or heart conditions. The consequences of not taking these types of medications can be very serious and can lead to stroke, amputation and other complications requiring long-term care. Although antibiotics were named a smaller number (13) of times, the consequences of not accessing these drugs is also very serious. Many people who are unable to access antibiotics develop life-threatening infections that require hospitalization. Various anti-psychotics, mood stabilizers, and

46% of homeless people in our sample did not have an Ontario Drug Benefit Card.

Everyone receiving social assistance (Ontario Works, Ontario Disability Support Program or Personal Needs Allowance) is eligible for an Ontario Drug Benefit Card, which covers the cost of prescription drug products. However, many of the drugs that people need are not on the list of products covered by the program, and the program will often not replace medication that is lost or stolen. People with low incomes who are not on social assistance are not eligible for any prescription drug coverage.

sedatives were cited 65 times as medications that people were supposed to be taking. Mental health medications are only one aspect of treatment for a mental illness but are nonetheless important, and the effects of not getting medications of this type can be devastating.

Assistive Devices

13% of all respondents said they are in need of at least one assistive device, such as a wheelchair, artificial limb or brace, cane, crutches or walker; motorized scooter; or hearing aid, but are not currently using it. The major reason for not using the assistive device they needed was affordability, with 54% saying they could not afford it.

HEALTH ADVICE

"I'm on the street and they're telling me to rest, rest, rest ... well, it's pretty hard to rest when you're sleeping on concrete. The only way I fall asleep is to drink ... and then they tell me not to drink." - Survey Respondent

"The doctor said to stay off my feet because both my ankles were seriously bruised ... but I'm living on the streets. How am I going to stay off my feet?" - Survey Respondent

Beyond taking medications, health care providers give us advice and treatment plans that are essential for taking care of our health and recovering from illness.

33% of our sample said that in the past year there had been at least one time when they were not able to follow the advice or treatment plan of a doctor or nurse. Of those not able to follow the advice of their health care provider:

- 77% said that their living situation wouldn't allow it or that it was too difficult to do
- 24% said that the advice or treatment plan cost too much
- 20% said that there was no one to help them carry out the treatment

The main reason homeless people in our survey said they could not follow through on health advice was the difficulty of taking care of health needs while living in the shelter system or on the street. Getting enough rest, or staying warm or dry, can be impossible without a permanent place of your own. Many shelters do not allow residents to stay in bed during

the day, and have restricted periods when residents can access their medications. The lack of privacy in shelters can also make carrying out certain treatment plans difficult. Limited options at meal programs and shelters that homeless people rely on for food can also make following some health advice difficult.

Many people also said they didn't follow medical advice simply because it was too expensive. Most homeless people cannot afford the over-the-counter medication and vitamins that are often recommended. Many health care services and supplies, such as crutches or physiotherapy, are not covered by government health insurance.

In addition, some health advice is difficult to carry out on your own. For example, people often need help taking care of wounds or broken bones. Having no one to help with treatments was a common problem that many people cited. This highlights the social isolation of homeless people and the need for improved follow-up care from professional health providers.

MENTAL HEALTH CARE

Although 35% of respondents had been given one or more mental health diagnoses in their lifetime, many people in our sample reported unmet mental health care needs and difficulty getting adequate mental health care.

12% of the total sample said that they had needed mental health care in the past year but could not get help. Among those unable to obtain mental health care, the major reasons were:

- 38% (16) did not have a doctor to go to or didn't know where to get care
- 29% (12) saw a doctor but were not offered mental health care
- 24% (10) were not able to get a specialist referral
- 24% (10) did not have a health card

A stable health care provider who knows you and your medical history is especially important when trying to deal with a mental health condition. The process of diagnosing and treating a mental health problem is often long and complicated, and requires negotiation and trust. Even if you have a family doctor, mental health specialists are difficult to access. Homeless people face additional barriers to accessing specialists because of the inflexible nature of their service delivery, which demands a set appointment, a health card and communication by telephone.

58% of respondents with a mental health diagnosis had been prescribed medication for mental health reasons in the past year. Of those who had been prescribed medications:

- 28% said that the side effects were not explained to them
- 35% felt they did not have a choice or say in their treatment plan

When people do not feel well informed and are not given choice in their treatment plans, they often simply stop treatment. Medication is only one of the many things that people may need when dealing with a mental illness, but it can be an important part.

26% of the people we interviewed had been hospitalized for an emotional or mental health problem in their lifetime, an average of 5 times. Of those who had been hospitalized:

- 70% said their most recent hospitalization was voluntary
- 30% were forced to go against their will

When people voluntarily hospitalize themselves for a mental health problem, it is generally just for a short period of time. After a few days, they often return to a shelter or the street. Many do not receive the ongoing care they need after leaving the hospital. Our findings suggest that many homeless people with mental health conditions need and want help. Unfortunately, their needs are not likely met by short-term hospitalizations. Mental health care involves more than hospitalization and treatment from specialists, it requires having a safe place to live, enough money for basics like food, and other forms of support.

SUBSTANCE USE PROGRAMS

Access to treatment programs for addictions to smoking, alcohol and drugs is a significant problem for homeless people, despite an expressed need and desire for this type of health care.

Smoking Cessation

Although 87% of the people we interviewed said that they smoked, 46% of those who smoked said they would use programs to help them quit smoking if they were available, for free, in the places they spend time, such as shelters and meal programs.

Alcohol Programs

77% of homeless people surveyed said they had had at least one drink in the past year. Of those, 13% (35) had tried to get in to some type of alcohol treatment program in the past year, but were unable to.

Type of alcohol treatment programs respondents were unable to access in the past year

	% (#)
Detox	54% (19)
Long-term program (28 days or more)	51% (18)
Short-term program (less than 28 days)	37% (13)

Many people we interviewed expressed an interest in accessible alcohol treatment programs:

- 38% of respondents who had consumed alcohol in the past year said they would use programs to help them quit drinking if they were available for free, in places where they spend time, like shelters and meal programs
- 39% said they would attend a harm reduction program to help them reduce or control their alcohol consumption, if it was free and easily accessible

Detox

Detox services provide an immediate safe space, and access to additional services, for people who are trying to control or stop their use of alcohol. Many community health workers feel that there is a critical shortage of detox beds in Toronto. The City of Toronto has the lowest number of detox beds per person when compared with other cities in Canada⁶⁷. There are between 90 to 100 detox beds available for men, and between 30 and 35 beds for women⁶⁸. There has been a shift in recent years away from residential detox and treatment programs to programs where the individual may receive counselling or medical attention from a hospital while still residing at 'home'. This shift has been particularly hard for homeless people, who typically do not have a safe or comfortable place in which to go through the difficult process of substance withdrawal and addiction treatment. Without enough detox beds, homeless people who require this type of health care often end up in emergency rooms or police stations.

Drug Programs

71% of the people we interviewed reported using at least one illicit drug regularly in the past year. Of those, 21% (53) had tried to get into some kind of drug treatment program in the past year, but were unable to.

Type of drug treatment programs respondents were unable to access in the past year	
	% (#)
Detox	62% (33)
Short-term program (less than 28 days)	47% (25)
Long-term program (28 days or more)	42% (22)

Many drug users would be interested in accessible forms of drug treatment:

- 61% of regular drug users said they would use a program to quit drugs if it were available, for free, in places where they spend time, like shelters and meal programs

- 59% said they would use a free harm reduction program to help them reduce, control or make their drug use safer if it were free and easily accessible

Access to treatment for alcohol and drug use is very poor. Homeless people's difficulty accessing treatment is especially problematic given the high rates of substance use among the people we surveyed, and because addictions were cited by 23% of respondents as one of the two main reasons why they are not able to find and maintain housing. One direction that could address these gaps is supportive housing that operates within a harm reduction framework.

Models of Alcohol-Focused Harm Reduction

Harm reduction is a philosophy and model of service delivery. It is a non-judgmental approach to substance use, and includes any program or policy designed to reduce substance-related harm without requiring abstinence.

An example of such a program can be found at Seaton House, a large shelter in Toronto that runs a 124-bed harm reduction program for men with addictions. In addition to providing shelter and other supports like health care, nutrition and hygiene, men in this program receive controlled access to consumable alcohol. Evaluations of this program have shown that alcohol consumption decreases.

Harm Reduction & Drug Use

25% of regular drug users said they needed a clean needle or a safer crack use kit in the past year but had not been able to get one.

Needle distribution and **Safer Crack Use Kits** are available through several agencies in Toronto who provide drug users with access to sterile injection or smoking equipment (needles or pipes), health education, referrals and other services. These supplies reduce disease transmission and provide an important point of connection for community health workers to engage with drug users and to connect them with other health services. The City of Toronto began funding safer crack use kits in 2006. This funding should assist agencies to increase the reach of their kit distribution.

59% of regular drug users said they would use a safe consumption site if it were to open in their neighbourhood.

Supervised Consumption Sites are clean, safe environments where users can consume their own drugs under the supervision of clinical staff. Nurses and counsellors provide on-site access and referral to addiction treatment services, primary health care, and mental health providers, as well as first aid and wound care. Many cities in Europe have several supervised consumption sites. Canada's only supervised consumption site opened in late 2003 in Vancouver, and is for injection drug users only. Despite rigorous, independent third party evaluation which documents the positive health outcomes for users, as well as broader community benefits, this facility is currently under threat of being closed by the federal government.

DENTAL CARE

“One time I had a really bad toothache. I was in a lot of pain. And I couldn’t afford to go to the dentist. I went to the emergency. They didn’t do anything. Nothing. They told me I have to go see a dentist. I have no money, don’t you get it? They gave me two Tylenols and told me to go home. Eventually I tried to take it out myself but I broke it up so bad that I had to go back to the ER and then they took the rest of it out.”

– Survey Respondent

Homeless people have substantially less access to dental care than the general population. Forty-three percent (43%) of the people in our survey had not seen a dentist in the past three years, compared to only 14% in the general population of Toronto⁷.

Those who had not seen a dentist in three or more years were asked to give the two main reasons why they had not recently received dental care. Overwhelmingly, the most common reasons were economic:

- 50% said they could not afford dental care
- 44% did not have dental insurance

Despite its connection to physical health and general well-being, dental care is not part of Canada’s publicly financed health care system. Currently, the Ontario Ministry of Health only pays for some dental surgery, when it is done in hospital⁶⁹. Prior to 1992, adults on social assistance were entitled to basic preventive dental care; today they can only receive a restricted list of emergency services. This is likely why 7% of all survey participants reported going to the emergency department for a dental problem in the past year. While this may be an inefficient use of emergency services, it is one of the only places where the people we surveyed can afford to go for dental care. Much worse, dental treatment is often not available in emergency rooms, so treatment

usually involves pain killers, and does not definitively treat the source of the problem. Moreover, lack of access to preventive dental care means that homeless and low-income people are forced to wait until their dental problems become painful emergencies.

EYE CARE

Homeless people have poor access to eye doctors, and many are not able to get the prescription glasses they need.

55% of homeless people we surveyed had not had an eye exam in three years or more. This is substantially worse than in the general population in Toronto, 23% of whom had not had an eye exam in the same time period⁷. The reasons homeless people gave for not having had an eye exam in the past three years were primarily related to economic barriers:

- 32% said it was because they could not afford an eye exam
- 22% said it was because they did not have eye exam coverage

34% of all respondents in our survey said they had needed eye glasses in the past year, but had not been able to get them. Once again, the reasons for this were largely economic.

- 55% said it was because they could not afford to buy glasses
- 48% said it was because they did not have eye glasses coverage
- 25% said it was because they could not get an eye exam

It is likely that even more survey respondents would not have had the eye glasses they needed if not for the generic, non-prescription reading glasses that are now available in many pharmacies and discount stores. Many people in our survey revealed that this was where they had obtained the glasses they needed.

Eye Exams

It is generally recommended that people aged 20 to 64 have an eye exam every one to two years⁷⁰. Beginning in November 2004, the provincial government no longer covered eye exams for adults ages 20 to 64. An eye examination is covered for people under 20 and for those 65 and over, once a year. People on social assistance are covered for eye exams once every two years⁷¹. Major eye examinations are also covered every 12 months for everyone with medical conditions requiring regular eye examinations.

Eye exams are important, not only for people needing glasses but to diagnose and treat a range of eye diseases and conditions. Twenty-six percent (26%) of survey respondents reported having vision problems other than needing glasses.

“The longest I’ve gone without eyeglasses was probably two weeks. It’s not good for me because at night my vision is so bad that if someone was coming at me to hurt me, I wouldn’t know until it was too late. — **Anthony, 40, 20 years homeless**



photo by Keneisha, courtesy of the National Film Board of Canada

“I went to a hospital but they couldn’t help me because I didn’t have a prescription, and I didn’t have a prescription because I don’t have a doctor. So that was the problem, and that’s why **”** it was so long for me to get my meds. — **Markus, 48, 2 months homeless**

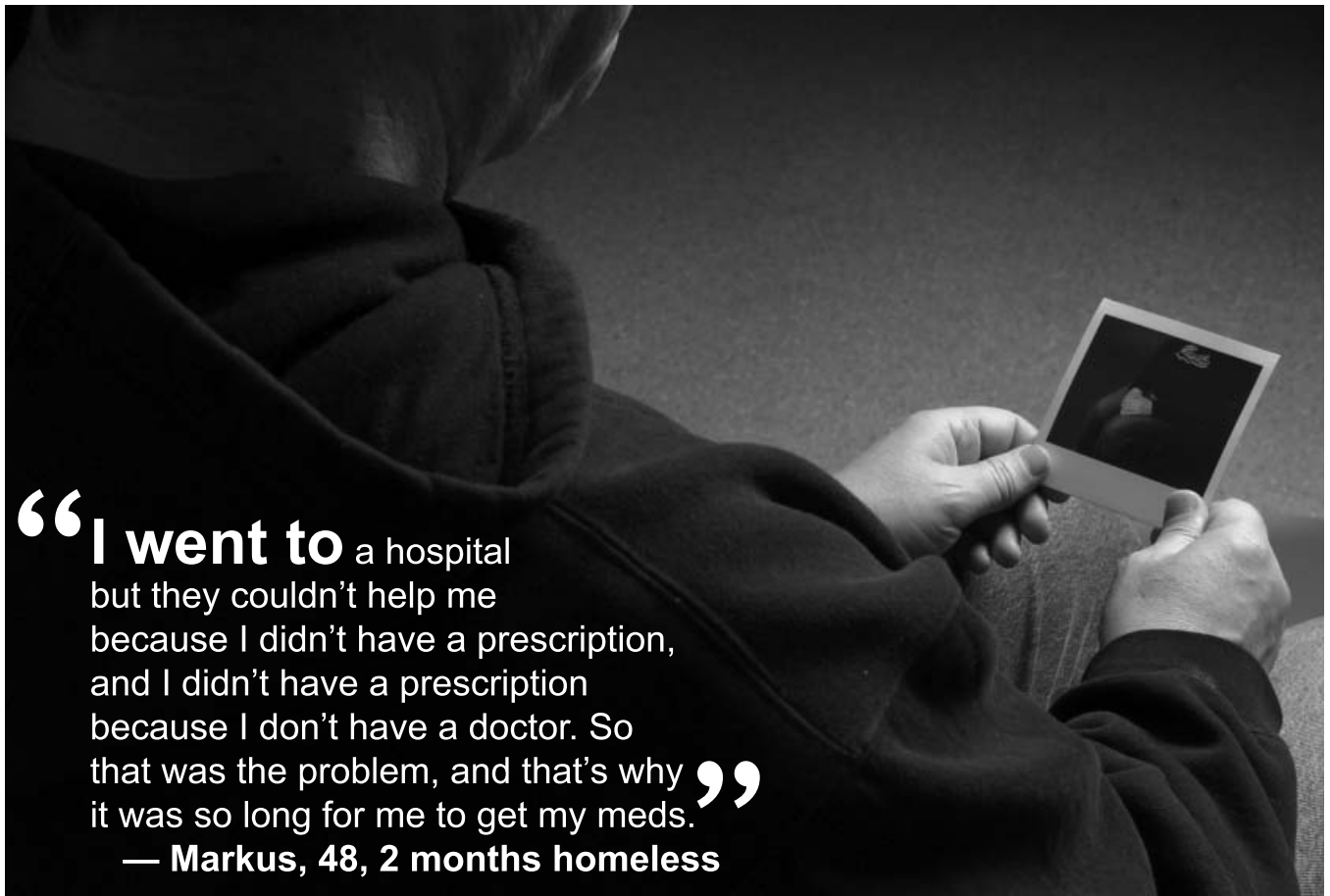
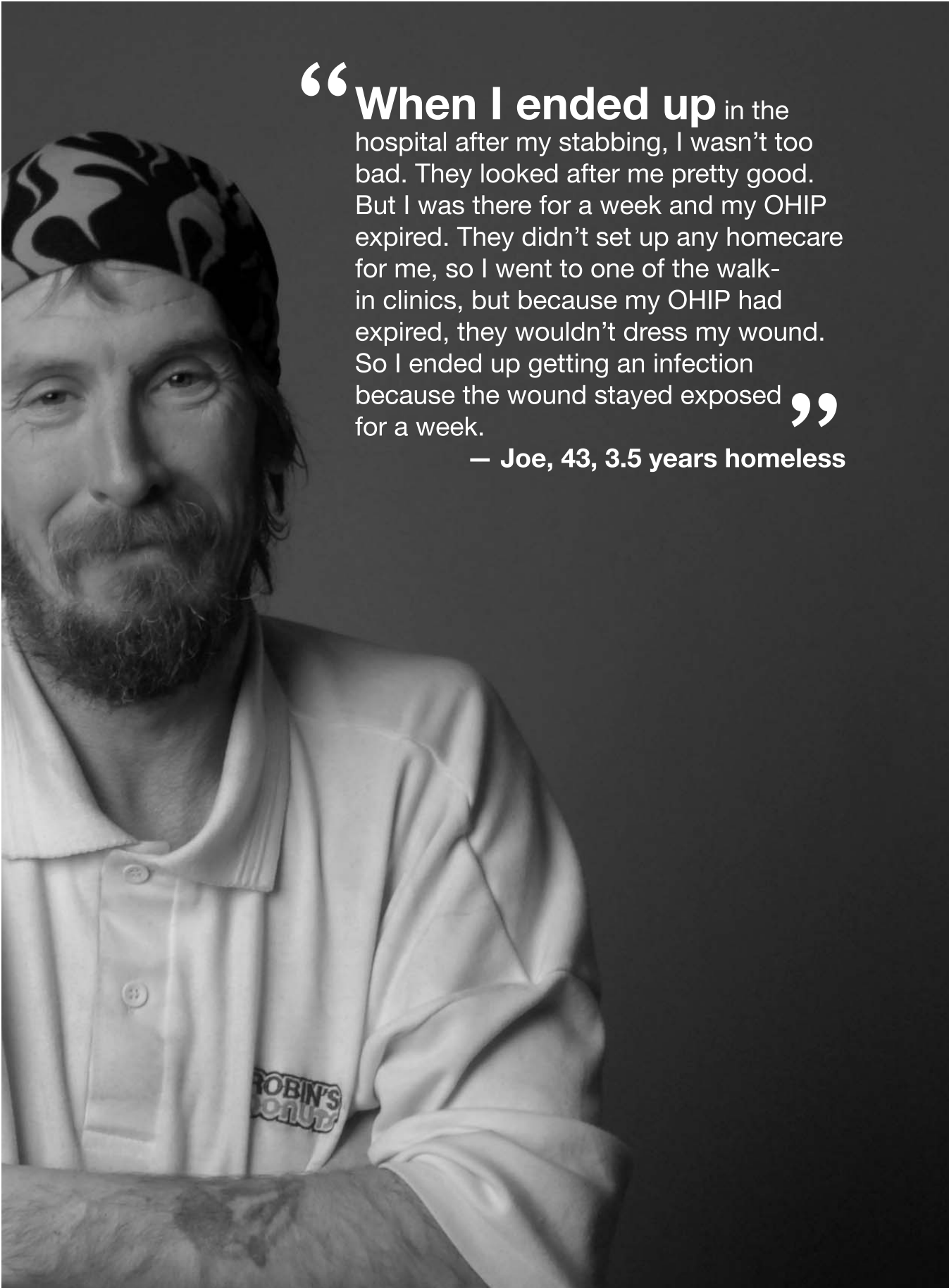


photo by Adrienne, courtesy of the National Film Board of Canada



“When I ended up in the hospital after my stabbing, I wasn’t too bad. They looked after me pretty good. But I was there for a week and my OHIP expired. They didn’t set up any homecare for me, so I went to one of the walk-in clinics, but because my OHIP had expired, they wouldn’t dress my wound. So I ended up getting an infection because the wound stayed exposed **”**

— Joe, 43, 3.5 years homeless

BARRIERS TO HEALTH CARE & SOCIAL SERVICES

The previous **Access to Health Care** section presents numerous barriers that homeless people in our survey identified as obstacles to obtaining health care. These barriers affect homeless people's access to various types of care, including hospitals, primary health care, eye doctors and dentists. Many of these barriers relate specifically to homeless people's poverty and the difficulty of life without a permanent home. Economic barriers include not having money to get to medical appointments or to pay for prescriptions. Barriers related to the instabilities of homelessness include not having a telephone or stable address and needing to prioritize survival needs such as food and shelter.

The section below identifies and discusses findings on other specific institutional and attitudinal barriers homeless people face when attempting to access health and social services.

HEALTH & SOCIAL BENEFITS FORMS

Participants were asked how many times, in the past year, they had needed to see a doctor or nurse practitioner just to get a form filled out in order to obtain health or social benefits, such as a special diet supplement. Forty-one percent (41%) of our sample said they had needed to do this, an average of two times, in the past year.

The burdensome and complicated process of having to get medical forms filled out in order to receive social assistance was cited as a major barrier that prevented homeless people from receiving Ontario Disability Support Program benefits, in a separate study conducted by Street Health in 2006²².

Health care providers remain a critical access point for a multitude of health and social benefits. This is especially problematic when 59% of our sample doesn't have a regular family doctor to sign their forms. Some doctors also charge a fee for getting forms signed, which presents an additional barrier.

IDENTIFICATION DOCUMENTS

Ontario Health Cards

"The doctor told me to go back to New Brunswick because I didn't have an Ontario Health Card."
- Survey Respondent

34% of homeless people in our survey did not have an Ontario Health Card^{ix}.

Not having a health card is a problem of access for homeless people, not a problem of eligibility. Of those without health cards, only 7% (9) said they were not eligible for one.

- 66% of those without a health card had either lost it or had it stolen
- 14% were waiting for a card they had applied for
- 4% said their health card had expired

The reasons given for not having a health card highlight how difficult it is for homeless people to replace and hold on to their identification documents.

28% of all respondents had been refused health care in the past year because they did not have a health card.

Places respondents were refused care in the past year due to lack of health card

	%
Walk-in clinic	46%
Emergency department	40%
Family doctor's office	23%

^{ix} Residents of Ontario must have an Ontario Health Card to receive health care services paid for by provincial health insurance.

Not having a health card is a key barrier to health care for homeless people and was mentioned frequently throughout our survey:

- Of those who do not have any usual source of health care, 19% (20) cited not having a health card as one of the two main reasons
- Of those who have not had a physical or check-up in 3 or more years, 6% (7) cited not having a health card as one of the two main reasons
- Of those who could not access the mental health care they needed in the past year, 24% (10) cited not having a health card as one of the two main reasons

Various forms of identification are essential for accessing a wide range of social services and resources. While not having a health card can prevent people from accessing health care, lack of a Social Insurance Number can stop people from accessing income support, training, housing and from getting a job. Citizenship documents are particularly important because they are the cornerstone documents that enable people to apply for and access all other pieces of identification.

Other Identification Documents

In addition to health cards, there are many other important identification documents.

- 50% of survey respondents did not have a Social Insurance Number card^x
- 29% did not have identification that provides proof of citizenship, such as a birth certificate, citizenship card, record of landing or passport

Homeless people in our sample cited many essential services that they were not able to access due to lack of identification documents.

Services and resources that respondents could not access due to lack of identification	%
Ontario Works (welfare) benefits	18%
Employment	14%
Food bank	12%
Housing	11%
Training/education	6%
Ontario Disability Support Program benefits	4%

Identification Theft

Although our study did not specifically ask respondents to identify who had stolen their identification documents, several volunteered that they had lost their identification as a result of being arrested, going to jail or because the police had taken it from them and had not returned it. Having identification taken by police or losing track of it while in the prison system was also noted in a 2006 Toronto-based study on homelessness and the criminal justice system⁷².

^x A Social Insurance Number is required to work in Canada and to receive government benefits.

DISCRIMINATION IN HEALTH CARE

Attitudinal Barriers

"Once they see that you're homeless, their attitude goes from caring to 'get out of here'."

- Survey Respondent

"Just the way they talk to you ... they look down on you and most of the time they are rude. I've stopped going to places because I know how they're gonna react."

- Survey Respondent

40% of homeless people we interviewed said that they had been judged unfairly or treated with disrespect by a doctor or medical staff at least once in the past year.

Reasons why respondents felt they were discriminated against by health care providers	%
Homelessness	66%
Respondent's use of alcohol or drugs	53%
Perception that respondent was drug-seeking	47%
Gender	14%
Race or ethnic background	13%
Ability to speak English	7%
Sexual orientation	5%

Discrimination and poor treatment indicates that, at best, many homeless people are still not having their health problems taken seriously or investigated adequately. At worst, it means that they may not be having their health problems treated at all. Other research has shown that a patient's trust in the medical profession has significant health implications – it is associated with greater adherence to treatment recommendations and is correlated with one's desire to seek care³⁰. Discrimination and negative experiences are real and serious barriers to health care, and prevent many homeless people from getting much-needed care.

Negative Experiences with Hospital Security

"After the doctor treated me, because it was Christmas and I had a bad foot, he said I could stay in the waiting room for a few hours to rest. The security guard said: 'Oh no, you're not' and tossed me out on the street."

- Survey Respondent

"I was helping my friend and he was dirty and did not look good, so security gave us a hard time and told us to go away."

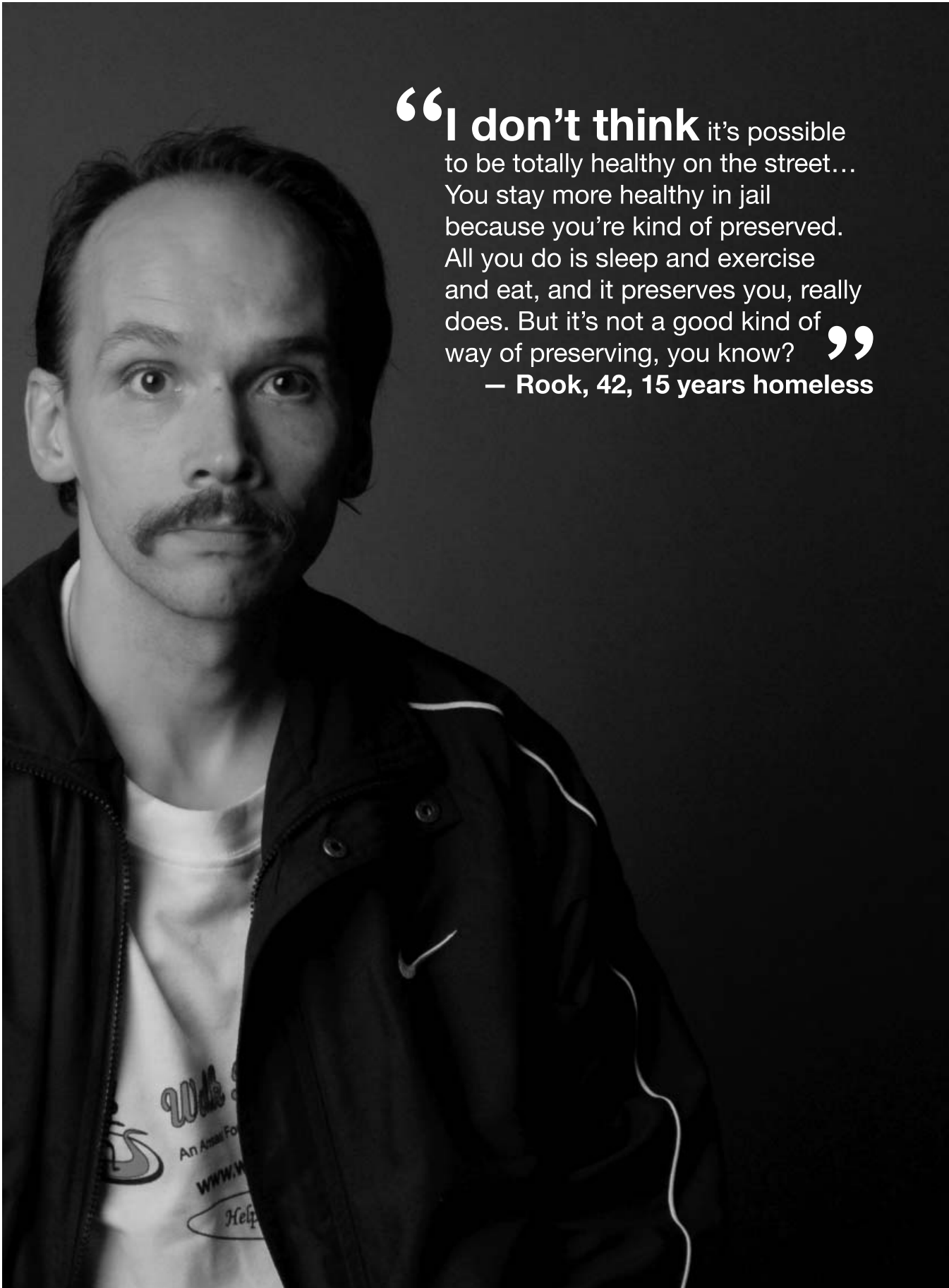
- Survey Respondent

21% of homeless people in our survey reported having had at least one negative experience with hospital security.

Survey participants reported the following negative experiences with hospital security:

- 12% had been denied access or told to go away
- 12% had been threatened or verbally assaulted
- 8% had been physically removed
- 5% had been beaten up or physically assaulted

These findings are even more startling and significant when we consider that homeless people use hospitals and hospital emergency departments at high rates. In addition to all of the other barriers that homeless people face when trying to take care of their health and access health care, literally not being able to get in the door or being physically assaulted is unacceptable.



“I don’t think it’s possible to be totally healthy on the street... You stay more healthy in jail because you’re kind of preserved. All you do is sleep and exercise and eat, and it preserves you, really does. But it’s not a good kind of way of preserving, you know? **”**
— Rook, 42, 15 years homeless

photo by Jess, courtesy of the National Film Board of Canada

HOMELESSNESS IN TORONTO: CHANGES SINCE THE 1992 STREET HEALTH REPORT

The last time a comprehensive, community-based survey of the health status of homeless people was undertaken in Toronto was in 1992. The 1992 *Street Health Report* was the first of its kind in North America and continues to be cited by academics and community groups because it provides unique information that cannot be found elsewhere. It found that a range of specific medical problems are particularly prevalent among the homeless population, including seizures, chronic obstructive pulmonary disease and arthritis; the report also identified many barriers to accessing health care. A series of policy recommendations based on the study findings were made to all levels of government and several were ultimately implemented.

Important societal changes have occurred in the 15 years since the 1992 *Street Health Report* was published. Government cutbacks to social programs, as well as new health issues and disease outbreaks, have had a dramatic and disproportionate impact on the health of homeless people. In this section we compare key findings from the 1992 and 2007 Street Health surveys which demonstrate what has changed about homeless people's health status and access to care, and what has stayed the same.

We deliberately replicated the overall methodology of the 1992 *Street Health Report* so that our findings would be comparable. Fifteen years later, the homeless people we interviewed share similar demographics. Both studies had a similar proportion

of visible minorities and similar proportions of people born in Toronto, the rest of Canada and outside Canada. One small difference is that the 2007 sample had fewer young people under age 25 and slightly more people aged 50 plus.

REASONS FOR HOMELESSNESS

In 1992 many of the same reasons were cited for loss of housing, with economic reasons and poor living conditions as the two main reasons cited in both 1992 and 2007.

INCOME

Homeless people are trying to survive on even lower incomes than they were in 1992. In the 1992 study, 44% of all respondents had a monthly income lower than \$500³. In our current study, a shocking 50% have an even lower monthly income of \$400 or less. When we take into account that the cost of living in Toronto has increased over the past 15 years, the \$400 that homeless people earn today is worth a lot less than \$500 was in 1992. Goods and services valued at \$500 in 1992 would cost \$667 today⁷⁴.

15 Years of Cuts to Housing

In the 15 years since the first *Street Health Report* was published, important social policies and programs that help create affordable housing have been cut and dismantled. Some of the key cuts over the years are outlined below:

- 1993: Federal government cancelled all funding for new affordable housing
- 1995: Ontario government cancelled its funding for new affordable housing, and 17,000 homes already approved for development
- 1996: Federal government downloaded responsibility for affordable housing to the provinces and territories, and began a steady decline in federal housing spending
- 1998: Ontario government downloaded responsibility for affordable housing to municipalities

Starved of funding and programs by the provincial and federal governments, and forced to take on the responsibility for affordable housing, the City of Toronto has a poor record of developing much-needed affordable housing. In the past decade, Toronto has completed only about 1,500 new affordable homes. In 23 of the city's 44 municipal wards, not a single new affordable home has been completed⁷³.

15 Years of Declining Incomes

In 1995 the Ontario government made massive cuts to social assistance rates. Welfare rates were cut by 22% and have not been restored. Despite marginal increases in recent years, a welfare recipient still receives about 46% less in real terms today than he or she did in 1992¹⁴.

The real value of the minimum wage decreased dramatically throughout the 1990s. After being frozen from 1995 to 2003, slight increases have recently brought the minimum wage up to \$8 per hour. However, a single full-time worker still needs to earn an additional \$2 an hour to meet what is considered to be a low-income threshold.

PHYSICAL HEALTH CONDITIONS

Overall, the health status of homeless people in Toronto has not improved since 1992. Many serious physical health conditions have become even more common.

Chronic or ongoing health conditions

Homeless people in our survey compared with the 1992 sample

	The Street Health Report 1992 ³	The Street Health Report 2007
Arthritis or rheumatism*	30%	43%
Allergies other than food allergies*	19%	33%
Chronic obstructive pulmonary disease (COPD)	18%	17%
High blood pressure or hypertension*	13%	17%
Asthma*	12%	21%
Heart attack in lifetime	7%	7%
Epilepsy	6%	6%
Diabetes*	3%	9%
Angina*	3%	12%
Stroke in lifetime	2%	4%

**statistically significant difference*

VIOLENCE

Experiences of physical assault, police violence and sexual assault have not changed significantly since 1992. Homeless people continue to experience assault at extremely high rates.

Experiences of assault in the past year

Homeless people in our survey compared with the 1992 sample

	The Street Health Report 1992 ³	The Street Health Report 2007
Physical assault	40%	35%
Physical assault by police	10%	12%
Sexual assault for all respondents	6%	7%
Sexual assault for women only	21%	21%

Homelessness is Not a Crime

"It's constant. If you're sleeping somewhere, you get charged with trespassing. You're just trying to get out of the rain or something to keep dry. You get charged all the time."

- Survey Respondent

Since the mid 1990s, new by-laws, as well as changes to policing practices around existing by-laws, have been introduced that criminalize the activities of people who are homeless. Prohibiting people from sleeping in public places like Nathan Phillips Square, and fining people for activities like panhandling, loitering, and public drinking, has turned homeless people into criminals and made their lives even more difficult. A recent Montreal study of this issue, found that 72% of homeless people who were given tickets for sleeping in parks went to jail because they couldn't pay the fine⁷⁵.

An extensive examination of the relationship between homelessness and the criminal justice system can be found in *Justice and Injustice: Homelessness, Crime, Victimization, and the Criminal Justice System*⁷², a 2006 research study conducted by The John Howard Society of Toronto and the Centre for Urban and Community Studies at the University of Toronto.

- The prevalence of allergies and asthma has increased significantly
- The rate of high blood pressure is substantially higher
- Diabetes is 3 times as prevalent among homeless people as it was in 1992
- Angina is 4 times as common now as it was in 1992

New conditions have emerged as health threats and concerns for homeless people since 1992. As noted in **The Health of Homeless People** section (on page 20), diseases like Hepatitis C, Tuberculosis, and HIV/AIDS disproportionately affect the homeless population. The 1992 study did not ask about these health issues because they were not known to be concerns particular to the homeless population at that time.

SUICIDE

Sadly, rates of suicidal ideation and attempted suicide have not changed significantly since 1992 and remain very high among homeless people.

Suicidal ideation and attempts

Homeless people in our survey compared with the 1992 sample

	The Street Health Report 1992 ³	The Street Health Report 2007
Seriously considered suicide in lifetime	49%	40%
Seriously considered suicide in past year	27%	23%
Attempted suicide in lifetime	26%	25%
Attempted suicide in past year	8%	10%

DRUG USE

The regular use of illicit drugs among homeless people seems to have increased dramatically since 1992. At that time, 16% of respondents said they used drugs other than alcohol regularly (3 or more times a week)³, compared to 71% of those surveyed in 2007. The emergence of new drugs since 1992 may be one explanation for why illicit drug use is higher. Crack cocaine and oxycontin are drugs that have emerged in the last 15 years and that have become popular among street-involved people. Crack began to gain popularity in Toronto in the early 1990s, around the time that the first Street Health survey was being conducted. Nearly half (49%) of the 2007 sample reported using crack regularly. In a recently published study by the Safer Crack Use Coalition of Toronto, people who used crack said they did so primarily as a coping mechanism to provide relief from physical and mental pain⁷⁶. It is not surprising then that, given the worsening life circumstances of homeless people, substance use is a commonly used coping mechanism.

The use of prescription opioids was almost unheard of 15 years ago. Today, 15% of our sample reported regular use of oxycontin, a popular prescription opioid. Opioids have a morphine-like action in the body and are mainly used for pain relief. More people reported use of prescription opioids than of heroin in our sample, which is consistent with other research documenting the increasing prevalence of prescription opioids use over heroin in Canadian cities⁷⁷. Prescription opioid users have told staff at Street Health that they prefer prescription opioid use over heroin because it is a cleaner, more predictable and in some ways safer, high.

HOMELESS PEOPLE'S ACCESS TO HEALTH CARE

Patterns of health care use have not changed since 1992. As shown in the table below, hospital emergency departments remain the most frequently used source of health care among homeless people, and about one in ten continue to have no access to any health care at all.

Sources of health care used in the past year

Homeless people in our survey compared with the 1992 sample

	The Street Health Report 1992 ³	The Street Health Report 2007
Emergency department	54%	54%
Hospitalized at least 1 night	25%	24%
Walk-in clinic	34%	29%
No health care in past year	12%	10%

Primary Health Care

Access to primary health care providers is significantly worse for homeless people in our sample than it was in 1992:

- In 1992, 57% of respondents had a regular family doctor³
- In 2007, 41% of respondents had a regular family doctor

Preventive Health Care

Decreased access to family doctors among homeless people has likely led to decreased access to physical check-ups. A significantly lower proportion of homeless people in our sample reported a recent check up than in 1992. In 1992, 54% of all respondents had had a check up in the past year³, compared to only 35% in the current sample.

Some preventative health measures have improved for homeless people. Access to flu shots has improved dramatically since 1992. Seventy-two percent (72%) of survey respondents said they were offered a flu shot in the past year. This is a major improvement from 1992, where only 37% were offered a flu shot³, and speaks to the success of Toronto Public Health's outreach and immunization campaign, as well as the Ministry of Health's broad commitment to provide flu shots to people in Ontario.

60% of homeless people in our sample said they had received a TB test in the past year. Comparable data is not available for 1992 because concerns about the risk of tuberculosis within Toronto's homeless population first began to arise among front-line community health providers in 1993. Advocacy efforts increased awareness about the issue and are likely the reason that there has been improvement by Toronto Public Health in the area of TB screening.

15 Years of De-Listing

"I got attacked by four guys with baseball bats - they broke my nose, my cheekbones and cracked the back of my head open. The police brought me to a hospital but they said it would be a 7 or 8 hour wait, so I left. And then they sent me a bill for the ambulance. I think it was \$50. How am I going to afford \$50?" - Survey Respondent

The past 15 years have been a period of increasing privatization of health care services in Ontario. People today are asked to pay privately for many health services and supplies that were once paid for by the provincial government. For example, user fees are now part of the Ontario Drug Benefit Plan. Fifteen years ago, homeless people did not have to pay for things like physiotherapy or getting a doctor to sign a form.

BARRIERS TO HEALTH CARE

Access to Ontario Health Cards

The proportion of homeless people without a valid health card has not changed from 1992, when 37% did not have a health card³. Today, 34% of homeless people we spoke to said they did not have an Ontario Health Card at the time of the interview. It is possible that this issue might be worse today if identification replacement and storage programs for homeless people had not been developed since 1992.

Being Refused Health Care

Being refused health care due to lack of a health card is a much bigger problem today than it was 15 years ago. Four times as many people (28%) were refused health care due to lack of a health card in the past year than in 1992, when only 7% had been refused care at some point *in their lifetime*³. This may speak to the Ministry of Health's efforts to prevent so-called "health care fraud", which have made it even more difficult to get or replace a health card and have encouraged health care providers to repeatedly require health cards for service. It seems that fraud prevention has disproportionately affected people with the highest burden of health problems.

Discrimination

Homeless people continue to experience similar rates of discrimination and poor quality of care when trying to access health care services. In the current study, 40% of people we interviewed said that a doctor or medical staff treated them unfairly or with disrespect at least once in the past year. This is similar to 1992, when 41% reported at least one incident in the past year where they felt unhappy, frustrated or had been treated badly³.

Can I See Some ID, Please?

Replacing personal identification is an onerous task even when you have a place to live. There are several agencies in Toronto, including Street Health, that now have programs to assist people who are homeless to obtain birth certificates, Social Insurance cards, Ontario Health Cards, landed immigration documents and other documents necessary in dealing with modern bureaucracies.

Replacing your identification when you don't have a permanent address can be very difficult, but so is holding on to your identification once you receive it. Street Health runs the city's only "ID Safe" program, which offers homeless people a safe and secure place to store their identification and related documents. In addition, protocols have been set up with service providers so that clients do not continually have to show original identification documents.

“We’ve both been

attacked, physically beaten. It’s constant. If you’re just sleeping somewhere, you get charged with trespassing. You’re just trying to get out of the rain or something, to keep dry. You get charged all the time.”

— Steven, 40, and Brenda, 31, several years homeless

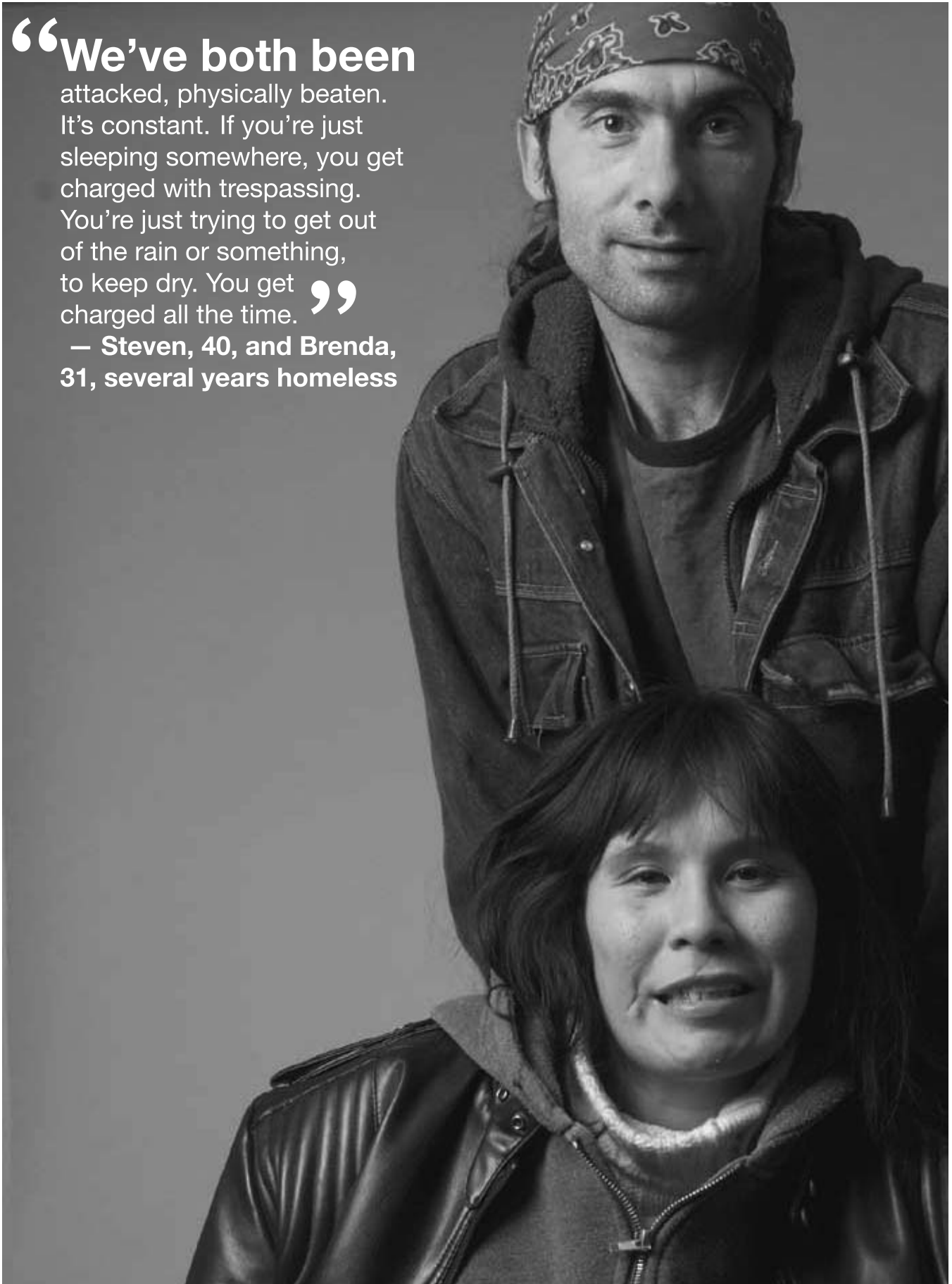


photo by Jess, courtesy of the National Film Board of Canada

STREET HEALTH ACTION PLAN

We hope that the findings of the *The Street Health Report 2007* will be a call to action to develop and implement a comprehensive strategy to address homelessness in Toronto.

Overall, homeless people in Toronto have much poorer health than the general population. Homeless people in our survey carry an alarmingly higher burden of many serious physical and mental health conditions. Three quarters suffer from at least one chronic or ongoing physical health condition. In the past year, more than half had experienced serious depression and one in ten had attempted suicide.

The health of homeless people in Toronto has deteriorated in the past 15 years. Many serious physical health problems have become more common, and new illnesses have emerged that disproportionately affect homeless people. The most important factors impacting the health of homeless people are the result of social policy decisions that have been made by our governments in the past 15 years, particularly the cuts to social assistance and the lack of investment in new affordable social housing.

Homelessness is a devastating and growing problem in Toronto. There is an urgent need to take action to:

- Address the poverty and inequality that underlies homelessness
- Improve access to affordable and appropriate housing
- Improve immediate living conditions for homeless people
- Improve access to health care and support for homeless people

Our action plan presents realistic solutions to immediately improve the health of homeless people and to ultimately end homelessness^{xi}.

ADDRESS THE POVERTY AND INEQUALITY THAT UNDERLIES HOMELESSNESS

People become homeless and stay homeless largely because of poverty. More than three quarters of the homeless people in our survey named their economic circumstances as one of the most important reasons they were homeless. More than a third of homeless people in our survey had monthly incomes of \$200 or less. Homeless people today live in even more extreme poverty than they did fifteen years ago.

Homelessness is an alarming symptom of an inequitable society. TD Economics, the research wing of one of Canada's largest banks, has confirmed that despite a strong and healthy economy, Toronto's poorest residents are getting poorer, and social inequity is on the rise⁴. It is estimated that 1.7 million Canadian households are at risk of homelessness¹³.

People need adequate incomes in order to be healthy. Currently, social assistance benefits and even full-time minimum wage work do not provide enough income for people to meet their basic needs. Welfare benefits in Ontario are worth about 46% less in real terms than they were fifteen years ago¹⁴. In addition, homeless people face many barriers to accessing social assistance, particularly Ontario disability benefits. Only one in five homeless people with serious illnesses in our survey were receiving disability benefits.

Many non-governmental organizations and initiatives such as the task force on Modernizing Income Security for Working-Age Adults (MISWAA), the Toronto City Summit Alliance and the Daily Bread Food Bank have pointed out the need to address the growing inequality gap in Toronto. Such groups have recommended improvements to the minimum wage and social assistance, and have called for increased accessibility to the Ontario Disability Support Program (ODSP). A study conducted by Street Health found that although many homeless people with disabilities cannot access ODSP, providing intensive, one-on-one support with all aspects of the ODSP application process enabled them to access the benefits they need and are entitled to.

Ensuring adequate incomes for everyone will reduce homelessness and improve the health of people who are currently homeless.

^{xi} Other organizations and coalitions such as the Income Security Advocacy Centre and Campaign 2000 have called for the Government of Ontario to implement a comprehensive poverty reduction strategy that, in addition to income security and affordable housing, includes strengthening public investment in areas such as child care, post-secondary education and training. These measures would likewise contribute to addressing homelessness but relate less directly to our study findings and, for this reason, are not included in our action plan.

Solutions	Specific Actions Needed	Responsibilities
1. Increase social assistance rates	<p>1.1 Raise benefit levels for Ontario Works (OW) and the Ontario Disability Support Program (ODSP) to reflect a minimum standard of living. Implement an increase of at least 40% for OW and ODSP over a 3-year period starting in the 2008/2009 fiscal year.</p> <p>1.2 Establish an independent committee (made up of labour, academic and community sectors) to determine the criteria by which rates are set, and to set rates and monitor their adequacy in meeting a minimum standard of living. Establish this committee by January 2008.</p> <p>1.3 Index and adjust rates annually to meet this minimum standard of living. Begin indexing immediately following the recommended increase to benefit levels.</p>	<p>Ontario Ministry of Community and Social Services (MCSS) to raise and index benefit levels, and to establish and support the independent committee (1.1–1.3).</p>
2. Improve access to Ontario Disability Support Program (ODSP) benefits	<p>2.1 Streamline the decision making process for ODSP eligibility to further reduce wait times and improve quality of service.</p> <p>2.2 Increase the availability of up-front supports to assist applicants in navigating the application process. To improve homeless people's access, immediately implement an Income Support Worker pilot project where community-based support workers outreach to and work one-on-one with disabled homeless people to help them access and maintain benefits.</p>	<p>Ontario MCSS to improve decision-making process and quality of service, and to design and fund up-front supports for applicants. Report on progress by March 2008 (2.1).</p> <p>Ontario MCSS and City of Toronto department of Shelter, Support and Housing Administration to fund pilot project to assist homeless people applying for ODSP (2.2).</p>
3. Increase the minimum wage	<p>3.1 Raise the minimum wage rate to \$10 an hour immediately.</p> <p>3.2 Establish an independent committee (made up of labour, business, academic and community sectors) to set rate and to monitor their adequacy in meeting a minimum standard of living, as well as their impact on employment and the economy by March 2008.</p> <p>3.3 Index and adjust the wage annually to meet this minimum standard of living. Begin indexing immediately following the recommended minimum wage increase.</p>	<p>Ontario Ministry of Labour to raise and index minimum wage rates, and to establish and support the independent committee (3.1-3.3).</p>

IMPROVE ACCESS TO AFFORDABLE AND APPROPRIATE HOUSING

In addition to poverty, people become homeless and stay homeless because there is a serious lack of affordable, adequate and supportive housing in Toronto. Homelessness was not a short-term crisis for most people in our survey, who had been homeless an average of 5 years. A quarter of homeless people in our survey have waited an average of 4.6 years on the social housing wait list. A third of homeless people in our survey said their physical or mental health conditions were preventing them from securing and maintaining housing, indicating a strong need for supportive housing to help address their specific needs.

The severe lack of social housing in Toronto is a reflection of social policy decisions taken throughout the 1990s that saw the federal and provincial governments cut funding for social housing and download responsibility to municipal governments. Instead of a coordinated strategy on housing we have a patchwork of poorly funded, short-term initiatives that do little to meet the real needs of Toronto's homeless population, let alone make them any less homeless.

People need adequate, affordable housing in order to stabilize their lives and be healthy. Several organizations and groups such as the Toronto Board of Trade, the Toronto City Summit Alliance, and the Wellesley Institute have called for comprehensive housing and homelessness strategies. The Wellesley Institute's *Blueprint to End Homelessness in Toronto* lays out a detailed plan for renewed funding and co-ordinated action to meet the real needs of Toronto's homeless population. Several innovative models of supportive housing have been highly effective in housing homeless people. The experience of the Tent City relocation project in Toronto demonstrated that providing intensive and holistic support, combined with rent supplements, can successfully enable homeless people to move into housing and stay housed.

Ensuring that Toronto has enough affordable, adequate and supportive housing will both move homeless people into housing and prevent people from becoming homeless.

Recommendation	Specific Actions Needed	Responsibilities
4. Increase the availability of affordable and adequate housing in Toronto	<p>4.1 Construct 4,500 new affordable homes annually, where rent is geared to income.</p> <p>4.2 Provide 11,600 rent supplements annually (at least 1,850 targeted to homeless people).</p> <p>4.3 Renovate 8,600 sub-standard existing homes annually, targeting social housing and low-income homes needing repairs.</p> <p>4.4 Implement inclusive planning and zoning tools that require at least 20% of all new housing developments to be designated as truly affordable housing for low-income people.</p>	<p>Government of Canada and Ontario government to provide adequate funding with sufficient flexibility for the City of Toronto to: administer funding for community-based, non-profit and co-op housing; share responsibility for administering rent supplements with social housing providers; and administer housing repair initiatives (4.1-4.3).</p> <p>City of Toronto to implement inclusive planning and zoning tools (4.4).</p>
5. Increase the availability of supportive housing in Toronto	<p>5.1 Construct 2,000 supportive homes annually. These supportive homes should be specialized, affordable models of housing designed to meet specific health and social needs and have support services in place to help people transition to and maintain housing. This includes housing designed to accommodate individuals with physical and mental health needs, as well as harm reduction housing which supports people with alcohol and other drug use issues.</p>	<p>Government of Canada and Ontario government to provide adequate funding with sufficient flexibility (5.1).</p> <p>The City of Toronto and Toronto Central Local Health Integration Network to jointly develop a comprehensive supportive housing strategy with community-based housing providers (5.1).</p>

IMPROVE IMMEDIATE LIVING CONDITIONS FOR HOMELESS PEOPLE

Access to adequate incomes and affordable housing is ultimately what is needed to end homelessness and improve the health of homeless people. In the meantime, there is an immediate need to improve the difficult daily living conditions of people who are homeless.

It can be hard for homeless people to access shelters. Over a third of all homeless people in our survey could not get a shelter bed in the winter, at least once in the past year. Not all shelters provide enough support for people with physical and mental health conditions or substance use issues. The conditions of some shelters increase homeless people's risk for acquiring certain illnesses and many homeless people cannot meet their nutritional needs through the shelter and meal program system. Two thirds of homeless people we interviewed were hungry at least one day a week. Due to gaps in the provision of meal programs and drop-in services, some homeless people need to resort to emergency departments, a costly alternative, to get food, to warm up or to rest.

Even as homelessness is growing, critical services for homeless people are not getting the funding they need to meet homeless people's basic needs. While many shelters, meal programs and drop-ins are doing their best with limited resources, more needs to be done to improve access and quality in these services.

Many organizations and coalitions in Toronto, such as the Toronto Disaster Relief Committee, have called for the maintenance and improvement of emergency services for homeless people. This includes more flexible and supportive shelter models such as the successful shelter-based, alcohol harm reduction program at Seaton House in Toronto.

Homeless people's daily lives are isolated and filled with violence. One in three homeless people in our survey said they have no one to help in an emotional crisis. One in three had been physically assaulted in the past year and one in ten had experienced violence at the hands of the police. These levels of violence, including police violence, have been part of homeless people's bleak reality since at least 1992.

Many organizations and coalitions in Toronto have pointed out the need to address police violence and harassment targeting homeless people and other vulnerable groups. As the Toronto Police Service rolls out its new third party complaints process, there is a need to ensure that it is accessible to homeless people.

Until income and housing security are adequately addressed, improvements to services for homeless people are needed immediately to improve their health and well-being.

Recommendation	Specific Actions Needed	Responsibilities
6. Improve access to and quality in emergency homeless services in Toronto	6.1 Improve and enforce shelter standards to address issues such as over-crowding, safety, and nutrition.	City of Toronto department of Shelter, Support and Housing Administration (SSHA) to improve and enforce shelter standards. Report to City Council on progress by March 2008 (6.1).
	6.2 Provide flexible, less institutional shelter alternatives designed to better accommodate homeless people's health needs, including an increase in the number of shelter beds that operate from a harm reduction philosophy.	
	6.3 Immediately increase the total number of beds in the shelter system to restore lost beds and create additional beds to meet current demand by November 15, 2007.	City of Toronto SSHA and the federal government's Homelessness Partnering Strategy to provide adequate funding to ensure that meal program and drop-in services offer expanded hours and enhanced services. City of Toronto SSHA to report to City Council on progress by March 2008 (6.4-6.5).
	6.4 Expand hours in existing meal programs, and increase the quantity and quality of food served so that homeless people have access to three nutritious meals a day, seven days a week.	
	6.5 Expand hours of existing drop-ins, so that homeless people always have a safe, indoor space to spend time and connect with other people.	

Recommendation	Specific Actions Needed	Responsibilities
7. Address police violence against homeless people in Toronto	<p>7.1 Ensure that the new third party police complaints system is accessible to homeless people, by providing community-based intake of complaints and support throughout the complaint process.</p> <p>7.2 Conduct mandatory education and training to increase awareness and understanding about homelessness and ensure that all police officers have strong skills in non-violent de-escalation.</p> <p>7.3 Set explicit directives to ensure that police violence and harassment against homeless people is eliminated.</p>	<p>Toronto Police Service to provide funding for the community-based intake process, and to conduct education and training of officers (7.1).</p> <p>Toronto Police Services Board to require Toronto Police Service to create an action plan with targets for addressing police violence against homeless people by January 2008, and to submit annual reports on progress in meeting targets (7.1-7.3).</p>

IMPROVE ACCESS TO HEALTH CARE AND SUPPORT FOR HOMELESS PEOPLE

Despite their poor health status, homeless people cannot access the health care they urgently need. They often receive inadequate care and frequently face discrimination from health care providers.

Homeless people's access to comprehensive primary health care is poor. More than half of the homeless people in our survey do not have a family doctor, and many have used hospital emergency departments instead, at far greater cost to the health care system. More than a quarter had been refused health care services in the past year because they did not have an Ontario Health Card. More than a third felt they had been judged unfairly or treated with disrespect by a health care provider in the past year.

Until access to primary health care improves, hospitals will continue to be a frequently used source of health care for homeless people. Many homeless people receive inadequate care and discrimination in hospitals, and their unique needs are often not addressed. Hospitals do not always ensure that homeless people will be able to get the prescriptions and follow-up care they need, the food they should eat, and an adequate place to rest when they leave the hospital.

Mental health and substance use services are in high demand and are difficult for homeless people to access. One in five drug users in our survey were unable to get needed treatment in the past year. Many substance treatment programs have moved towards home-based models, which require people undergoing treatment to have a safe, stable place to live and people to support them. These home-based models do not work for homeless people. In addition, few services focus on the substances most commonly used by homeless people in our survey, such as crack cocaine and prescription opioids.

Homeless people in our survey have very poor access to dental and vision care, as well as to prescription drugs. This not only affects their health, but also their ability to gain employment. Many groups, including MISWAA, have stressed the urgent need to extend dental, vision and prescription drug benefits to all low-income people.

Proper access to good primary and mental health care, dental and vision care, as well as prescription drugs, prevent illnesses from becoming more serious and costly to the health care system. Although adequate incomes and housing are the core solutions to improving homeless people's health and health care access, homeless people need good access to quality health care now. There is an immediate need to address barriers in the health care system for homeless people, and to assist homeless people in navigating the complex systems that deliver health and related services.

Most of the responsibility for the health care access solutions below currently falls under the Ministry of Health and Long-Term Care (MOHLTC). However, in the next few years this responsibility will be transferred to the province's new Local Health Integration Networks (LHIN), largely falling on the Toronto Central LHIN for the City of Toronto. It is the responsibility of the Ontario MOHLTC and the Toronto Central LHIN to ensure that in the transition, the unique needs of homeless and other disadvantaged populations are met.

Recommendation	Specific Actions	Responsibilities
8. Improve access to and quality in primary and preventive care	<p>8.1 Expand comprehensive, multidisciplinary, free-standing models of primary care such as community health centres and family health teams. These services should: provide easy access for homeless people through practices such as unscheduled walk-in hours and no health card requirements; include expanded community health work such as outreach, harm reduction, and case management; include dental and vision care; and offer services during evenings and on weekends.</p> <p>8.2 Increase awareness and capacity among family doctors about the unique needs of homeless people. Encourage them to provide quality services to this group.</p> <p>8.3 Build on existing community-based services that address homeless people's health related needs and extend them where necessary, until the need for these services decreases. This should include increasing the number of community-based case workers who assist homeless people in navigating various aspects of health and social service systems.</p> <p>8.4 Enhance public health and community-based efforts addressing Tuberculosis, Hepatitis C, and HIV for homeless people, to ensure an integrative, proactive approach to education, testing, follow-up and access to treatment.</p>	<p>The Ontario Ministry of Health and Long-term Care (MOHLTC) and the Toronto Central Local Health Integration Network (LHIN) to:</p> <ul style="list-style-type: none"> - Provide increased funding for comprehensive, multidisciplinary primary health care models and encourage them to meet the specific needs of homeless people in the 2008/2009 fiscal year (8.1). - Begin to work with health care providers immediately to deliver training, supports and incentives to family doctors (8.2). - Provide stable and increased funding for health related services and case management for homeless people in the 2008/2009 fiscal year (8.3). <p>Toronto Public Health to immediately enhance disease-specific public health efforts for homeless people (8.4).</p> <p>Public Health Agency of Canada (PHAC) and Ontario MOHLTC to increase funding to enable disease-specific programs focused on homeless people in the 2008/2009 fiscal year (8.4).</p>
9. Improve access to Ontario Health Cards and other identification documents	<p>9.1 Build on existing programs that help homeless people to replace health cards and other identification and establish additional programs across Toronto.</p> <p>9.2 Build on existing programs that help homeless people to store their identification safely and establish additional programs across Toronto.</p>	<p>Ontario MOHLTC to provide stable and increased funding for identification replacement programs (9.1).</p> <p>The federal government's Homelessness Partnering Strategy and Ontario MOHLTC to provide stable and increased funding for identification storage programs (9.2).</p>

Recommendation	Specific Actions	Responsibilities
<p>10. Improve access to and quality in hospital care</p>	<p>10.1 Conduct mandatory education and training for all hospital staff to increase awareness and understanding about homelessness. For medical staff and others who provide health services, provide additional training to ensure that the unique needs of homeless people are considered and addressed.</p> <p>10.2 Create a Community Support Worker position within emergency departments, 24 hours a day, and 7 days a week, who provides support to homeless people when they are accessing the emergency department.</p> <p>10.3 Ensure that all hospital security guards receive mandatory education and training to increase awareness and understanding about homelessness, and have strong skills in non-violent de-escalation.</p> <p>10.4 Establish and maintain an accessible third party complaints process through a patient relations or similar office. Ensure that the process for making a complaint is clearly posted in all hospital departments.</p>	<p>All downtown Toronto hospitals to conduct education and training for hospital staff, create a community support worker position in emergency departments, ensure that education and training is delivered to security staff and implement a third party complaints process (10.1-10.4).</p> <p>Toronto Central LHIN to adequately fund strategies to address homeless people's access to quality hospital care, and to require all hospitals to implement these strategies as part of 2008-2009 hospital service agreements (10.1-10.4).</p>
<p>11. Improve access to and quality in mental health and addictions supports</p>	<p>11.1 Create and expand comprehensive, alternative models of community-based mental health and addictions services, including outreach, peer support, survivor-run services, 24-hour non-medical crisis support, and case management that addresses the social determinants of mental health and addiction.</p> <p>11.2 Increase the number of drug and alcohol detox beds in Toronto, as well as residential treatment options for people with addictions. Make homeless people a higher priority for accessing residential detox and treatment programs.</p> <p>11.3 Build on and expand community-based harm reduction strategies, such as safer injection and crack use kits, outreach services and support programs for substance users, in particular for people who use crack cocaine and prescription opioids.</p>	<p>Ontario MOHLTC and Toronto Central LHIN to:</p> <ul style="list-style-type: none"> - Provide increased funding for comprehensive community-based mental health and addictions services to meet the specific needs of homeless people in the 2008/2009 fiscal year (11.1). - Provide funding for more detox beds and residential treatment programs in the 2008/2009 fiscal year (11.2). <p>Toronto Withdrawal Management System to modify its detox access policies and procedures (11.2).</p> <p>Health Canada, PHAC of Canada, Ontario MOHLTC and City of Toronto to provide stable and increased funding for harm reduction strategies in the 2008/2009 fiscal year (11.3).</p>

Recommendation	Specific Actions	Responsibilities
12. Ensure access to dental, vision and prescription coverage for all low-income people in Ontario	<p>12.1 Extend dental services for all Ontario Works recipients to cover all basic dental care, as well as emergency care, by March 2008.</p> <p>12.2 Provide dental, vision and prescription drug coverage to all low-income people beginning in the 2008 2009 fiscal year.</p>	<p>Ontario Ministry of Community and Social Services to extend dental coverage for OW recipients (12.1).</p> <p>Appropriate Ontario Government Ministries to collaborate to provide dental, vision and prescription drug coverage for all low-income people (12.2).</p>
13. Make homeless people a health priority	<p>13.1 Establish a Toronto Central LHIN task force to develop an action plan to address health equity for homeless people. Reporting to the Toronto Central LHIN Board, this task force should ensure the input and representation of homeless people, and identify and promote appropriate and innovative strategies for health care access and addressing health disparities for homeless people, including mental health and addictions services. The task force should establish targets to improve homeless people's health and monitor their implementation and progress.</p> <p>13.2 Build on and enhance the inclusion of homeless people's health needs within Toronto Public Health's planning and strategies.</p>	<p>Toronto Central LHIN to establish the task force by March 2008 and ensure that adequate resources within the Toronto Central LHIN are allocated to address homeless people's health in the 2008/2009 fiscal year (13.1).</p> <p>Toronto Public Health to ensure that adequate resources are allocated to address the public health needs of homeless people (13.2).</p>

BE PART OF THE SOLUTION

For ideas on how you can take action to help improve the health of homeless people and end homelessness in Toronto visit Street Health's website at www.streethealth.ca.

APPENDICES

APPENDIX 1: STUDY METHODS

Surveys on health status and access to services were completed, data-entered and analyzed for a representative sample of 368 homeless men and women in Toronto.

Sample Size

The exact number of homeless people living in Toronto is unknown. According to the City of Toronto's Street Needs Assessment, a minimum of 5,052 individuals were estimated to be absolutely homeless on April 19, 2006⁷⁸. The City of Toronto estimates that 31,985 homeless individuals stayed in a Toronto shelter at least once during 2002¹.

Based on an estimated homeless population of 32,000 (as per shelter use), we set our target sample size at 350 to ensure a representative sample size, with accuracy of results within plus or minus 5%, 95% of the time. In total, about 380 people were interviewed; only 368 surveys could be used after excluding duplicates, unreliable data and incomplete surveys.

Stratification by Gender

Fewer women use homeless services than men, and there are fewer services targeted towards homeless women. In order to ensure that a significant portion of women were interviewed, women were recruited to make up at least 25% of our sample.

Stratification by Shelter Use

Many homeless people do not regularly use shelters, but instead stay in public spaces, outdoors, or with friends. In order to capture a substantial portion of homeless people who are not regular shelter users, we stratified our sample by "shelter users" and "non-shelter users". A target ratio of 80% shelter users and 20% non-shelter users was based on the proportion of absolutely homeless people staying in shelters (82%) to those staying on the street (18%) found in the City of Toronto's April 2006 *Street Needs Assessment*^{78, xii}. This was similar to the ratio that was used in the 1992 *Street Health Report*. In our total sample, shelter users made up 78%, while non-shelter users accounted for 22%.

Interview Sites

Participants were recruited at a wide range of homeless shelters and free meal programs across downtown Toronto. Twenty-six different sites were used for recruitment altogether. We chose to recruit only at meal programs and shelters, and to exclude outdoor gathering places and drop-ins, based on the 1992 *Street Health Report* methodology which found that the vast majority of homeless people in Toronto use either meal programs or shelters regularly⁷⁹. Based on these findings we are confident that our sampling strategy captured a representative sample of homeless people in Toronto.

Our survey sites were located from Lawrence Avenue in the north to Lake Ontario in the south, and from Jane Street in the west to Broadview Avenue in the east. Although some services exist for homeless people outside these boundaries, we deliberately focused on downtown Toronto to ensure that our study was comparable to the 1992 *Street Health Report* methodology.

In order to select survey sites, we generated a list of all meal programs and shelters in downtown Toronto, then stratified them by type of service, gender served (where appropriate), size and geographic area. After stratification, sites were randomly selected to ensure that (where possible) small, medium and large shelters and meal programs serving men and women were represented in each geographic area of the city.

Eligibility

In order to be eligible for the study, participants had to be what is often referred to as "absolutely" homeless. This was defined as: having stayed in a shelter; public place or other site not intended for human habitation; or with a friend or relative for at least 10 of the last 30 nights. A screening tool was used to determine eligibility.

As discussed above, enrollment in the study was stratified by shelter use. "Shelter users" were defined as people who had stayed in a homeless shelter in the last 10 days, including the night before the interview. "Non-shelter users" were defined as people who had not stayed in a shelter in the last 10 days, but were still considered to be "absolutely" homeless – that is, they had stayed in a public place or at a friend or relative's place (and not in a shelter) in the last 10 days. Accordingly, two different screening tools (a shelter and meal program version) were used at the appropriate survey sites.

Recruitment

Street Health used our established connections with community-based organizations serving homeless people across the city to establish partnerships with interview sites where participants were recruited. Enrollment at each interview site was proportionate to the number of unique homeless individuals using the site each month (based on City of Toronto statistics). Enrollment was stratified by gender to allow over-sampling of women to ensure that a significant number of women were surveyed. This gender stratification was done between gender-specific services, and within sites serving both men and women.

Random Selection

Participants were recruited by random selection. Random selection of participants was accomplished differently at different types of sites. In shelters, we generally used a bed list of people signed in for that day, and then randomly selected names from that list using random numbers. With the help of shelter staff, we attempted to find those people who were selected, approached them and asked if they wanted to participate, and if interested, screened them to see if they were eligible. If we did not get enough participants from this process, we would randomly select

^{xii} Although the City's Street Needs Assessment provides an estimation of the number of homeless people in Toronto, the "point-in-time" methodology it employed provides only a snapshot of the breadth of homelessness, and has been criticized for undercounting the numbers of homeless people. It is important to note that the count ignored people who are "couch-surfing" or otherwise living in insecure and temporary situations. It is quite likely that the proportion of homeless people who do not stay in shelters is higher.

more names from the bed list and start the process again until our target number of participants was recruited. In meal programs (and sometimes in shelters), we generally handed out numbers to people at random (usually by counting and selecting randomly numbered people as they walked in the door, or by walking around the room and counting those sitting at tables). Those who were given numbers were asked if they wanted to participate, and screened for eligibility. Again, if we did not recruit enough participants on the first round, we began this process again until sufficient numbers were recruited.

The Survey Instrument

The survey was pilot tested with a small group (N=10) of homeless men and women, and was revised accordingly. The survey consisted primarily of closed-ended quantitative questions on demographic factors, participants' health and well being, health determinants, lifestyle factors and access to care and services. A small qualitative component was also included to explore homeless people's self-identified health issues and concerns. Survey questions included:

- Questions from the 1992 *Street Health Report* survey, to ensure comparable data to the 1992 *Street Health Report*;
- Canadian Community Health Survey (CCHS) questions, to ensure comparable data to the general population; and
- Questions that were created to explore new and emerging issues.

The study was approved by the Research Ethics Board at St. Michael's Hospital.

Data Collection

We conducted our interviews during the winter months (between November 2006 and February 2007), when more homeless people were likely to be accessing the services for homeless people where our recruitment took place. This time period was also when the 1992 *Street Health Report* was conducted. A group of fifteen people with lived experience of homelessness were hired and trained to conduct interviews. Interviews were conducted verbally and one-on-one, with interviewers reading the survey and recording respondents' answers. The survey took approximately 45 minutes to one hour to complete. Study participants were given a \$15 honorarium for their time.

Data Analysis

Data was entered manually, stored and analyzed using SPSS 15.0 software. A series of five variables collected through the survey (i.e. gender, ethno-racial background, height, weight and date of birth) were identified and correlated for the purpose of identifying duplicate interviews. Duplicate surveys were deleted from the dataset.

Quantitative analyses focused on descriptive statistics, cross-tabulations, and comparison with 1992 *Street Health*

Report and general population data. Participants' answers to open-ended questions were reviewed, and some quotes illustrating key ideas were selected. All data was analyzed to identify key study findings, issues, themes and policy implications.

Community Involvement

A range of community stakeholders were involved at each stage of the research process, through our Community Advisory Committee and by employing Peer Researchers.

Community Advisory Committee

The study had a Community Advisory Committee (CAC) consisting of: representatives from community organizations and groups working on issues of homelessness, poverty, and health (including front-line staff, managers and researchers); academic researchers with expertise in these areas; and people with lived experience of homelessness. The CAC provided direction for the study by: 1) prioritizing research focus areas; 2) providing input into the study design; 3) participating in data analysis; 4) developing recommendations for policy change; and 5) directing related dissemination and advocacy.

Peer Researchers

A group of fifteen people with lived experience of homelessness were hired and received extensive training on community-based research, survey research, and how to conduct interviews. These peer interviewers administered the survey, provided input into the study design, and assisted with data analysis and crafting key messages for this report. Peer researchers were paid an hourly wage of \$15 for their work, including training and interviewing, and were compensated for travel to and from interview sites.

Using a peer researcher model had many benefits for the project. Peer involvement added to the quality of our data, because often survey participants were more willing to open up to people who shared similar life experiences and who they felt comfortable with. Their involvement in data analysis also enhanced the study's relevance to the homeless community by grounding it in the perspectives and priorities of individuals who have experienced the issues first hand.



photo by Davida Nemeroff, courtesy of the National Film Board of Canada



photo by Davida Nemeroff, courtesy of the National Film Board of Canada

Peer Researchers also told us that being involved had a strong positive impact on them as individuals. Several said that the experience of interviewing provided them with new insight and awareness about the issue of homelessness and people's unique experiences of homelessness. Many peers involved in the project also gained valuable skills and experiences, including making a contribution to the community, participating in regular constructive activities, increasing their confidence, and getting valuable experience in the work force.

"I think for me what's important about it is that the people who are being interviewed recognize that the people who are interviewing them have come from the same place they have and therefore they're a little more open about their responses. And it's important to me that [Street Health] is doing what the community wants them to be doing. The feedback that I'm getting from the community is the feeling of hope that we can actually accomplish something by doing this." - Peer Researcher

APPENDIX 2: STUDY LIMITATIONS

While we are confident that our findings are representative of the experiences and health status of homeless adults in Toronto, this study has some limitations that should be acknowledged.

Our survey only captures the experiences of a segment of the homeless population, often referred to as "absolutely" homeless. In addition to people who have no place of their own to live, the term "homelessness" includes people living in poor housing or overcrowded conditions, people at risk of becoming absolutely homeless, and people living on low incomes who spend a large part of their income on rent. People in these circumstances face many of the same health issues and barriers to health care as absolutely homeless people. However, we chose to narrow our focus to "absolutely" homeless people to ensure that our study was comparable to the 1992 *Street Health Report* study (which had this same focus), and because of the logistical challenges to including a much

less visible group of people who could be broadly defined as homeless. In addition, it is important to acknowledge that the small percentage of absolutely homeless people who do not use any services for homeless people were excluded from the study because we only recruited survey participants at shelters and meal programs.

Women are often less visibly homeless than men, because they are more likely to double up with friends or relatives, and "couch surf", or move between temporary situations. Fewer women use homeless services than men, and there are fewer services targeted towards homeless women. We deliberately recruited so that at least a quarter of our sample was women. If we had randomly recruited survey participants without regard to gender, it is likely that even fewer women would have been interviewed. By intentionally recruiting women to make up 25% of our sample, we ensured that we interviewed enough women to make our findings meaningful. However, because we used this strategy, the gender breakdown of our sample may not be representative of the proportion of women who are homeless.

The homeless population in Toronto is very diverse. Unfortunately we were unable to conduct our survey in languages other than English. Due to this limitation, our study excluded people who were not comfortable being interviewed in English. As a result, our sample may not reflect the actual diversity of the homeless population in the areas of: racial, ethnic and cultural backgrounds; languages spoken; immigration status; and country of origin.

When selecting survey sites, we excluded shelters focusing their services on families, women escaping violence, and refugees. These shelters were excluded because their services are tailored to specific sub-groups of homeless people, who have unique circumstances and needs that may be different from the rest of the homeless population, and were beyond the scope of the study. As a result, the health issues and needs of these particular groups are less likely to be reflected in the study findings.

Our survey deliberately focused on downtown Toronto to ensure that our study was comparable to the 1992 *Street Health Report* methodology. As a result, homeless people outside of the downtown core were excluded from the study. It is important to acknowledge that homelessness exists in the inner suburbs of Toronto and the experience of homeless people in these parts of the city may not be reflected in our study.

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STREET HEALTH STORIES: a note about the photographs and quotes

The portraits in this report, and many of the quotes, are from a sub-sample of 28 survey participants who took part in a personal narrative component of the study.

This component was a collaboration between Street Health, the National Film Board (NFB) of Canada's Filmmaker-in-Residence program, and St. Michael's Hospital.

For this part of the study, four young women with experience of homelessness conducted short open-ended interviews with a group of survey participants about their health and homelessness and took portrait photos. The women are part of another Filmmaker-in-Residence program (I WAS HERE) through the Young Parents No Fixed Address Network.

The portraits and stories these women collected form part of STREET HEALTH STORIES, a photo installation and film by the NFB's Filmmaker-in-Residence program. STREET HEALTH STORIES presents the personal stories and individual perspectives behind the statistics of *The Street Health Report 2007*.

For more information about STREET HEALTH STORIES or Filmmaker-in-Residence, please visit www.nfb.ca/streethealthstories or www.nfb.ca/filmmakerinresidence.