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DOWNTOWN EASTSIDE COMMUNITY HEALTH PLAN

COMMUNITY UPDATE

February 1995

DOWNTOWN EASTSIDE COMMUNITY HEALTH PLAN
COMMUNITY UPDATE
TABLE OF CONTENTS

ACKNOWLEDGEMENTS

This Community Update is a result of work done by the local planning group of the Downtown Eastside Community Health Plan.

The Listening Surveys were undertaken by planning group volunteers:

Kathleen Boyes, Joan Morelli, Don Baker, Verna Beaudin, Melissa Eror, Ken Klyne, Lore Krill, Karen Wolfchild, Leith Harris, Brenda Kwan, Rickey Monkman, Phillip Mo, Alison Cameron, Domi Palomino, George Bahry, Gary Thompson, Ilain Pupo.

The Community Health Plan planning group would like to thank the following community service agencies who participated in the Service Provider Listening Survey and Community Outreach:

Alcohol and Drug Services
Ambulance Service
Dr. Batt.
Central City Lodge
Chinese Community Library Services Association
Chinese Cultural Centre
Chinese Freemason Housing Society
Chiu Lin Tower
Cooper Place
Cordova House
DEYAS
Downtown Community Health Clinic
Downtown Eastside Strathcona Coalition.
Downtown Eastside Women's Centre
Fire Hall #2
First United Church
Harbour Light
Dr. Howard
Jenny Pentland Place
The Living Room
Lookout
Lord Strathcona Elementary School
McLean Housing
Mental Patients Assoc.
North Health Unit
Pender Detox
Portland Hotel
Sheway
St. James Social Service
St. Paul's Hospital
Strathcona Adult Day Centre,
Strathcona Community Care Team
Strathcona Community Centre
SUCCESS
Triage
Native Health Clinic
Victory House
Watari

The following individuals also provided assistance, information, and advice: Thank You. . .

Bob Taylor—Vancouver Police Dept.
Marg Green—Neighbourhood Helpers,
Don Raines, Steve Williams—Vancouver Health Region,
Dr. Gary McDonagh—Downtown Community Health Clinic
Stella Tsang, Dr. Barry Reeve, and Dr. Jim Thorsteinson, and
Ken Mattinson—St. Paul's Hospital.

Special thanks to Brian Johnston of the Vancouver Health Department who conducted noise readings and Joe Anderson who assisted him.

DOWNTOWN EASTSIDE COMMUNITY HEALTH PLAN
COMMUNITY UPDATE

SECTION I

Introduction

The purpose of this **Community Update** is to provide information on the development a Community Health Plan and Community Health Council for the Downtown Eastside. The **Community Update** is also designed to gather feedback on the work done so far, and to let you know what will happen next.

LOCAL PLANNING GROUP

Since May of 1994 community residents have met regularly to discuss the formation of a Community Health Council and Community Health Plan in the Downtown Eastside. Twenty four meetings have been held, with an average attendance of about 25 people. The local planning group in the Downtown Eastside is one of thirteen citizen groups in Vancouver local communities, involved in health care reform.

The local planning groups are not formally constituted bodies; they have acted as a vehicle for citizen input into regionalization of health care in Vancouver. The local planning group in the Downtown Eastside has provided community direction to help guide the development of the Community Health Plan and Community Health Council.

A NEW REGIONAL HEALTH BOARD

Representatives from planning groups across the city helped put together the governance structure and mandate of the new **Vancouver Regional Health Board** which came into being in December 1994. One of its 14 members is **Ms. Lorelei Hawkins**, an active Downtown Eastside community member. Lorelei keeps in close contact with the local planning group and makes sure people know what is happening at the Vancouver Regional Health Board. Lorelei also seek people's opinions and views on issues that are coming before the Regional Board to make sure the Downtown Eastside is heard.

COMMUNITY HEALTH COUNCILS

Now that the Regional Health Board is set up, the next big step will be to establish Community Health Councils in Vancouver. There will be six Community Health Councils in Vancouver. The Downtown Eastside will be part of Community Health Council area #2 that includes Strathcona and Grandview Woodlands. (The CHC area boundaries are listed in Appendix I.)

There have already been a number of planning meetings between local residents in our Community Health Council area, to discuss the best way to set up the Community Health Council. In the next three months there will be more discussion and community debate about forming the Community Health Council, including nomination procedures and representation. The local planning groups in the Downtown Eastside and Grandview Woodlands want to involve as many people as possible in this important discussion. It is hoped that the Community Health Council for this area will be in place in April 1995. Local neighbourhood committees will also be formed to ensure there is ongoing local input and action. If you are interested in plans to form the new Community Health Council, please let

the Community Health Plan office know. You can also register your interest and comments in the feedback section (see page 72).

MANDATE AND ROLE OF COMMUNITY HEALTH COUNCILS

When it is formed the new Community Health Council will likely have 12-15 community members. Membership will come from Neighbourhood Health Committees which will act as the primary vehicle for citizen input into local health planning and issues.

In general the Community Health Council will:

- **identify community health needs;**
- **set community goals and priorities, and develop a community health plan;**
- **ensure that co-ordinated and integrated planning and evaluation of health care delivery occurs;**
- **provide community input into regional decision making; and promote and support citizen involvement and advocacy in health.**

SECTION II

DEVELOPING A COMMUNITY HEALTH PLAN

While the local planning group in the Downtown Eastside has participated in the work to help figure out the structure and mandate of the new Community Health Councils, much of its attention and energy has been directed to the development of a Community Health Plan for the Downtown Eastside.

In general a Community Health Plan is:

1) **a statement of the beliefs and values regarding health that are held by the community;**
2) **list of health issues, goals and priorities identified by the community;**
3) **an identified strategy for addressing the community priorities.**

The Downtown Eastside is the first neighbourhood in Vancouver to start a community health plan. **The plan has not been developed yet.**

When it began in May 1994, the local planning group agreed that the first major step in developing a Community Health Plan was to find out what the community felt and believed about its own health. As a result the planning group set about gathering information from various sources to begin to get a picture of the community's health.

Information has been gathered from:

- community residents
- service providers
- community data and reports
- Ministry of Health
- Statistics Canada

The planning group also identified **key health data** they wanted to gather concerning the overall health of the community. Some of this information (it is still in progress of being collected) is contained in Appendix II. Other key data will be available in the near future and can be obtained by contacting the Community Health Plan office. Key health data will become part of the Community Health Plan document. If you have ideas or suggestions about health information that would be useful for the Community Health Plan you can add your comments in the feedback section and return it to the Community Health Plan office.

SERVICE AGENCY ANALYSIS

As part of the information gathering process the Vancouver Health Region has been developing a service analysis. Local agencies and services funded by the Ministry of Health have been contacted by the regional office in connection with the analysis. The first phase of the service analysis is now available. It lists all the agencies that provide services in and to the Community Health Council area, that the Downtown Eastside is part of. (See Appendix I for boundaries).

The analysis will identify the agency, where it is providing the service, a brief description of the service and statistical information about the service.

A later phase of the service analysis project will provide health statistics and health status data customized to the Community Health Council area.

SECTION III

WHAT THE COMMUNITY HAS SAID

This Section of the Community Update provides a summary of information that has been gathered by the Community Health Plan Planning Group about health concerns in the Downtown Eastside. **IT IS INFORMATION THAT HAS COME FROM THE COMMUNITY**. There are no conclusions formed about the information; it is presented for your information and feedback.

More detailed information is contained in Appendix III, page 17, (**Listening Survey Summary**), Appendix IV, page 26 (**Service Provider Listening Survey**), and Appendix V, page 35 (**Chinese Community Outreach**).

With the assistance of Marg Green at Neighbourhood Helpers, volunteers from the local planning group conducted a **Listening Survey** to hear and record the concerns and issues of people who live in the community. Approximately 500 community residents were listened to over a five week period during the summer. The process was very helpful in understanding the feelings of community residents about the overall health of the community and its people.

The process was repeated in the fall with volunteers visiting 28 community agencies to conduct a **Service Provider Listening Survey.**

Outreach work in the Chinese community involving close to 400 people has also provided detailed information about health issues and concerns in this community.

In addition, a pre-existing Alcohol and Drug Advisory Committee of Alcohol and Drug Services forwarded information to the Community Health Plan planning group, gathered from eight focus groups conducted during 1993. A summary of the recommendations from the Focus groups is

contained in Appendix VI, page 40. The recommendations from the Committee will become part of the information used to develop the Community Health Plan. This committee is continuing to meet and will liaise with the Community Health Plan planning group. To follow up the work done by the Committee in 1993, it was agreed to do two more focus groups involving I.V. drug users. The results of this work can be found in Appendix VII, page 42.

Overall, the information gathered from the community showed there are very serious concerns about safety, housing, mental health and the impact of alcohol and drugs. Service providers and residents identified the provision of better integrated, comprehensive services, focusing on the overall needs of a person as important. The need for stable, affordable housing, came out as a major issue.

Listening Survey with local residents

In the Listening Survey with community residents, strong feelings about fear and neglect in the neighbourhood were expressed. People feel de-humanized by a system of poverty and services that removes individual choice and control. There are strong feelings about lack of dignity and respect that comes from a system where others are in control and passing judgement. Residents said the physical and social environment needs to be changed and improved, including things like, less noise and dirt, better and more stable housing and decent jobs. Lack of safety in the community was voiced very often by both alcohol/drug users and non-users alike. Many positive suggestions were made to help improve the sensitivity of services and their delivery, and make services more accessible to people.

Listening Survey with Service Providers

After the completion of the first Listening Survey it was decided that a similar process with Service Providers would be helpful in understanding other perspectives about health in the community. Twenty eight community agencies and services participated in the process. Many comments were recorded about the need for services that help the whole person. Major issues that emerged included increasing concern about mental health, HIV drug users and better housing choices for people. The need to develop harm reduction strategies particularly for dual diagnosis and drug users, was also identified as a key issue. Concern was expressed about health care reform and how the new Community Health Councils will manage changes.

Community Outreach

Since it began the Community Health Plan planning group, has met with Downtown Eastside Community Organizations to let them know about the Community Health Plan process and to request involvement. Contact has been made with the DERA board, Carnegie Centre Community Relations Committee, Strathcona Residents Assoc., Raycam Community Centre Assoc. board, Strathcona Community Centre Assoc. board, the Gastown Residents Assoc., and Strathcona School Consultative Committee. There have been many questions about the health care reform process in Vancouver and where the community fits in. Some things have become clearer over the months, and there are questions that still need to be talked about. This Community Update is to provide an opportunity to comment on where things are at now and what's going to happen next.

SECTION IV

WHAT'S NEXT?

As a result of this Community Update and feedback gathered, the Community Health Plan local planning group will review the information and begin a process of developing draft goals and priorities for the Community Health Plan. Appendix VIII, page 53, provides a summary document that outlines the major steps in the development of a Community Health Plan. The local planning group hopes that by the time the Community Health Council is set up (April 1995), goals and priorities for the Community Health Plan will have been developed as a result of broad agreement in the local community.

The local planning group will also participate in a joint committee with the Grandview Woodlands planning group to discuss the formation of the Community Health Council in our area.

Work on the Community Health Plan and the service analysis will continue with the Community Health Council, and Neighbourhood committee once it is established.

SECTION V

We want to hear from you

Are you interested in learning more about the proposed Community Health Council and Community Health Plan?

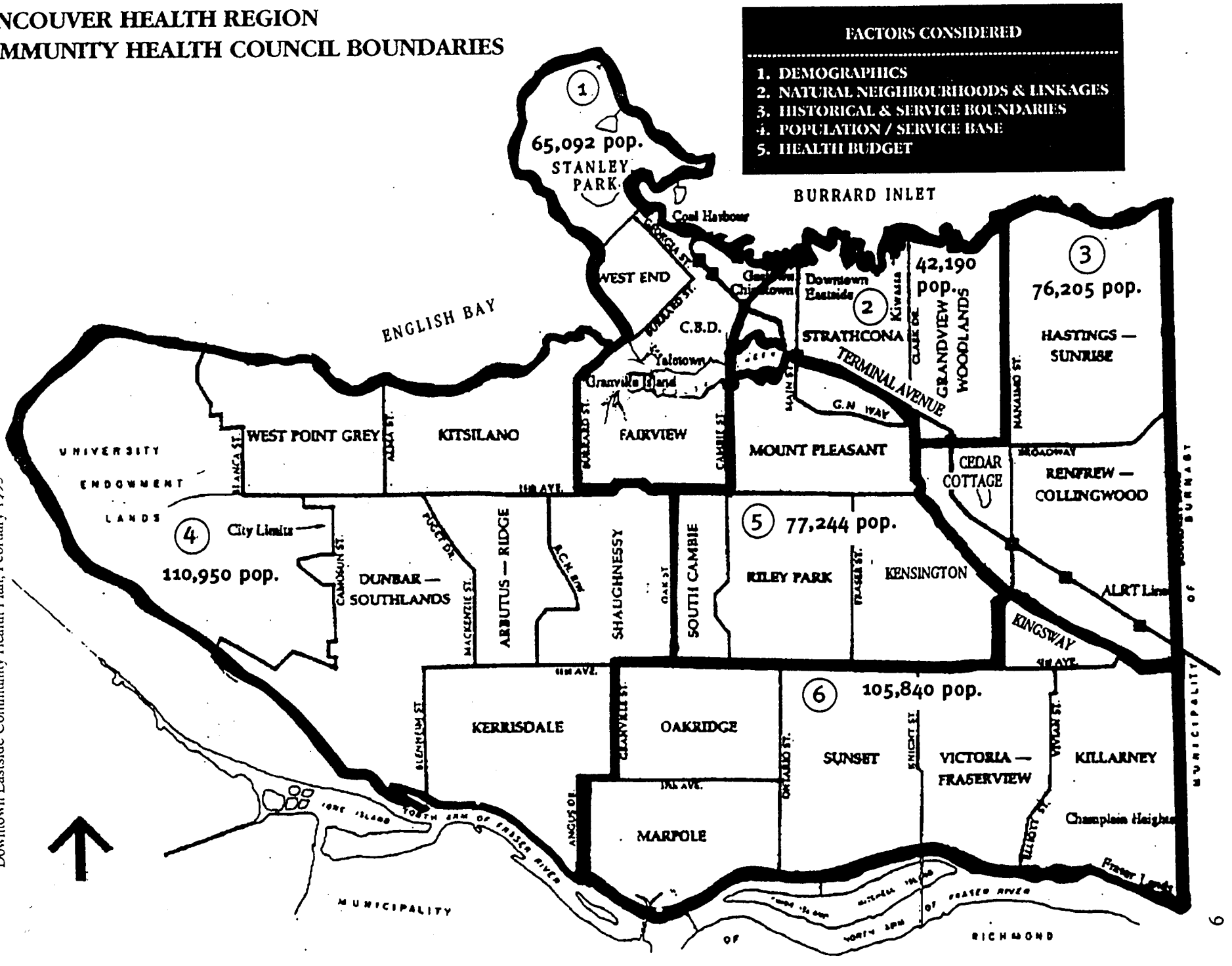
As a community resident you may want to get involved in the health planning process and discussions about the Community Health Council. As a service provider and/or resident you may want to get involved in helping to develop draft goals and priorities for the Community Health Plan. We want to hear your ideas and suggestions!

Your feedback and opinions are important to the process.

There are several ways for your voice to be heard:

- complete the feedback section, (page 72)
- attend Community Health Plan meetings
- drop-by with your comments
- if you belong to a Community Organization invite representatives from the Community Health Plan to your group's meeting for discussion and comment.

VANCOUVER HEALTH REGION
COMMUNITY HEALTH COUNCIL BOUNDARIES



APPENDIX I: Community Health Council Boundaries
Downtown Eastside Community Health Plan, February 1995

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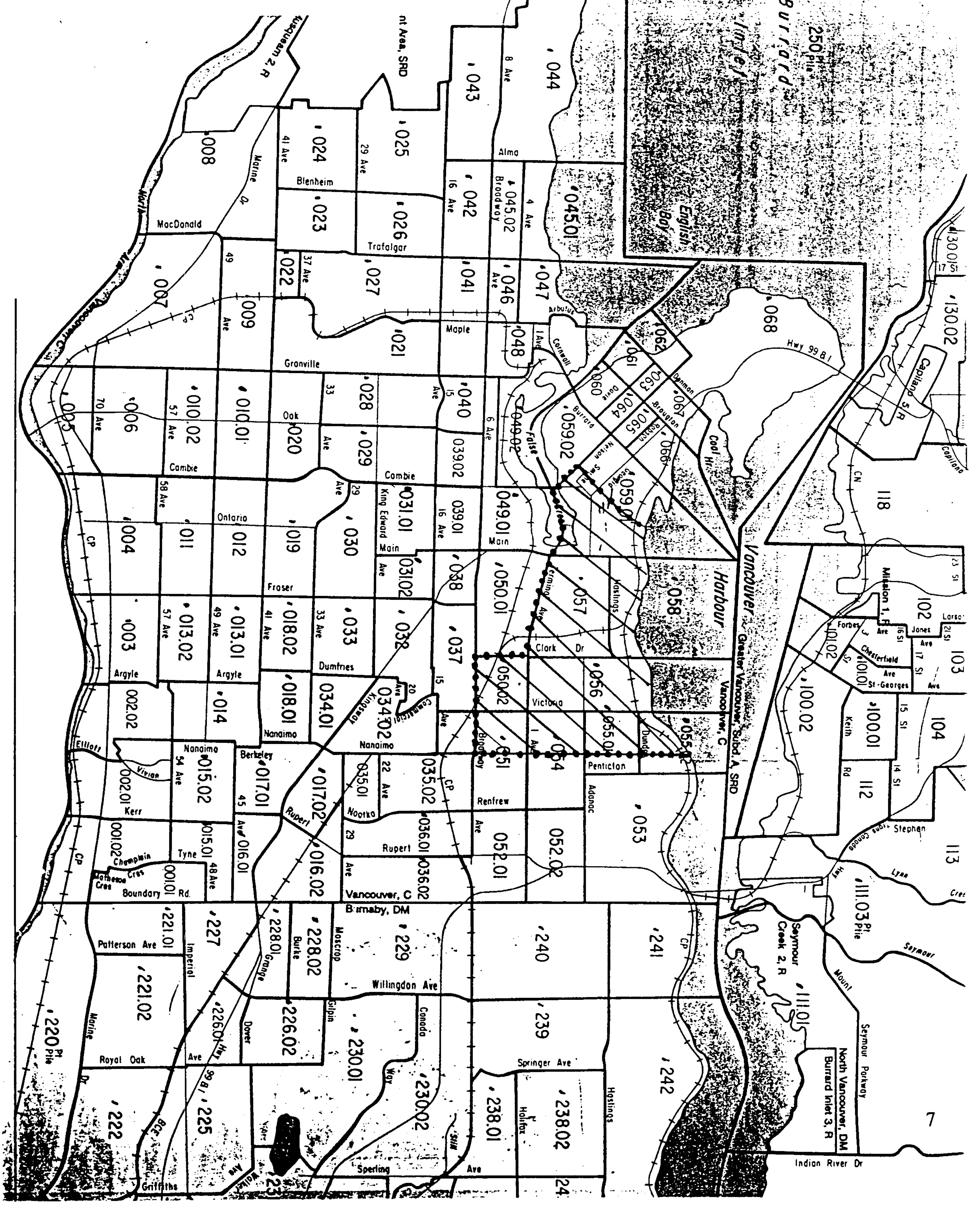
Downtown Eastside Community Health Plan, February 1995



APPENDIX II

DOWNTOWN EASTSIDE COMMUNITY HEALTH PLAN

KEY DATA

By Ken Bayfield

At the August 11, 1994 CHP meeting, The Downtown Eastside Community Health Plan Planning Group identified several categories of key data that they felt would assist in the creation of the Community Health Plan, these are noted on page 9.

One of the challenges in gathering data is that the physical boundaries used in data collection vary. The boundaries used to define the Downtown Eastside neighbourhood itself vary from study to study as well. The planning group selected census tracts 57, 58 and 59.01 as the boundary definition that most closely approximates the Downtown Eastside. Data by selected postal codes can also be used to approximate the boundaries of the Downtown Eastside.

Some of the data requested is not available. Although a great deal of data is available by census tract, most reports are not based on census tracts. Trying to make useful comparisons between the Downtown Eastside, and other areas of Vancouver, is hindered by the inconstancy in boundaries used in data collection.

The Vancouver Health Region is in the process of completing a service agency analysis which will consist of a listing of all the agencies in the proposed geographical boundaries of our Community Health Council: Community Health Council #2. This will be a valuable resource for service providers and the Community Health Council. Work has also been started on collecting health statistics and health status data specific to the Health Council boundaries. The service agency analysis and the health statistics/status data will be added to this update when available.

With the above in mind, the information in this report will still be useful for the development of the Community Health Plan and as a resource to the Community Health Council. It will be best used to paint a picture of health issues that are obviously problematic, even if data is not available specifically for the Downtown Eastside.

The following two excerpts, taken from Health Region Statistical Profiles for British Columbia, New Directions in Health, BC Ministry of Health and Ministry responsible for Seniors, 1993, give us a very quick and general overview of the status of health in Vancouver:

Health Status Highlights

In Vancouver, the Mortality rates for both females and males were generally higher than provincial norms. The ASMR *(Age Standardized Mortality Rate, a method of directly comparing different regions removing the variations in age structure)* for males was significantly higher for alcohol related-deaths (4.8) when compared to the BC rate (2.9). Residents of this health region experienced fewer hospitalizations for listed causes than the BC averages. Vancouver Health region had the lowest fertility rate (1,398.5) in BC.

Utilization Highlights

The rates per 1,000 population for acute care cases have been declining in the Vancouver Health region and were below the provincial average. The rate for ambulatory care visits was three times higher than the rate for BC. Rates for medical services per 1,000 population were the highest in the province for both general practitioners and specialists. The rates per 1,000 senior population for both males and females in continuing care facilities were higher than the provincial norms.

Notes on Population

Population of Vancouver,	1991:	477,745
Estimated population,	1996:	516,812
Population of BC	1991:	3,284,538
Combined population of census tracts 57, 58, 59.01	1991:	16,605

The Downtown Eastside has approximately 3.5% of the population of Vancouver.

Categories of Key Data Requested by Planning group

1) Level of smoking
2) Deaths from ginseng, heroin , and addictions
3) Percentage of people with chronic illness
4) Percentage of people with their own teeth
5) Number of sex trade workers
6) Percentage or number of teenage runaways
7) Number of emergency calls to the area and by specific location
8) Percentage of income spent on rent
9) Percentage of income spent on medications, prescription drugs, vitamins, etc.
10) Percentage of income spent on food
11) Cost of food compared to rest of city.
12) GAIN rates
13) Number and percentage of local residents who use services/agencies as opposed to the number of "visits"
14) Number of liquor licensed premises seats, and as percentage of city capacity
15) Volume of traffic at key locations
16) Measure of transportation access for people.
17) What is the stress level?
    a) How many people get holidays
    b) How long does it take to get to community recreation facilities, especially for families, for activities like swimming, and how much does it cost.
18) Noise levels at key locations

KEY DATA

1) LEVEL OF SMOKING

We do not have data on smoking levels and smoking attributable mortality specifically for the DES, however it may be available by postal code area in the near future through the Ministry of Health. Here is what is available at present:

Smoking Attributable Deaths for BC, ages 35+, 1992: 14,011[†] The total number of observed deaths in BC for 1992 was 24,411[†]. Approximately 57.4% of the deaths in BC for 1992 were either directly or indirectly related to smoking. Statistically, smoking is the largest, single health hazard in BC.

[†] Selected Vital Statistics and Health Status Indicators, Annual Report, 1992, Division of Vital Statistics, BC

2) DEATHS FROM GINSENG, HEROIN, AND ADDICTIONS

It is not possible to separate ginseng brandy from other alcoholic beverages as a cause of death. The terms used in the cause of death column are the terms particular to the source of the information used.

Cause of death	Area	Year	Number of deaths	Notes	Source
alcohol related	Vancouver LHA (#39)	1991	189	80 Local Health Areas in BC, LHA 39 = City of Vancouver	1
alcohol related	Vancouver LHA	1992	182		2
alcohol related	BC	1991	780		1
alcohol related	BC	1992	799		2
drug induced	BC	1992	245		2
drug induced	Vancouver LHA	1992	96		2
deaths from opiates	census tracts 57, 58, 59 (59.01 +.02)	1991	13	includes heroin, but no non opiate based drugs	3
deaths from opiates	census tracts 57, 58, 59 (59.01 +.02)	1992	15	48.4% of Vancouver's deaths by opiates	3
deaths from opiates	Vancouver LHA	1992	31		3
deaths from illicit narcotics	City of Vancouver	1993	200	equals 60% of OD's for BC, 45.5% increase over 1992	4
deaths from illicit narcotics	BC	1993	331	104% increase over 1992	4

"In the last year, the number of deaths of BC residents from accidental poisonings (ICD-9 E850-E869) increased dramatically, from 170 deaths in 1992 to 393 deaths in 1993. . . .Opiates . . . which includes heroin, accounted for more than half of the increase in accidental poisoning deaths between 1992 and 1993."[3]

"Deaths due to the use of illicit drugs have become epidemic in British Columbia in recent years, increasing from 39 deaths in 1988 to 331 in 1993. . . .the number of deaths increasing by over 800 percent over the last six years."[4] In 1993 the leading cause of death in BC for females and males in the age range of 30 to 44 years is illicit drugs.

Source[1] Health Region Statistical Profiles for British Columbia, New Directions in Health, BC Ministry of Health and Ministry responsible for Seniors, 1993

Source[2] Selected Vital Statistics and Health Status Indicators, Annual Report, 1992, Division of Vital Statistics, BC

Source[3] 1993 Annual Report, Vital Statistics Division

Source[4] Report of the Task Force Into Illicit Narcotic Overdose Deaths in British Columbia, Office of the Chief Coroner, Ministry of Attorney General, 1995 (Cain report)

3) PERCENTAGE OF PEOPLE WITH CHRONIC ILLNESS

A general look at "how we're doin'" health-wise might be best answered by a health status indicator called PYLL-Potential Years of Life Lost Index. This index will be included when it becomes available for the DES area. A comparison between the DES and Vancouver Health Region should be very useful to the CHC.

4) PERCENTAGE OF PEOPLE WITH THEIR OWN TEETH

It is difficult to obtain data on the number of people with their own teeth, however, I contacted Dr. Gary McDonagh, dentist at the Downtown Community Health Clinic (Vancouver City Health Dept.), who provided the following information:

- The clinic does complete denture work; 91 patients received dentures in the last year. At times full-mouth extraction is required.
- Intake is generally from the Downtown Eastside. Patients from outside the area are seen as well.
- It is not a free dental clinic, although fees are approximately half of those at private practice. An examination costs $15.00.
- Six to ten emergency patients are seen per day.
- Non emergency appointments are booked three months in advance due to volume.
- Most common reasons for dental attention: pain; infection; trauma.
- Dental health of the patients seen is below average. This may be attributed to life style, economics, and inadequate education about dental care.
- The Ministry of Social Services provides funding for emergency visits only for clients that have Medical Services Plan V2 designation. If a dental emergency arises, the client must obtain an emergency dental form from the MSS. It is good for one emergency visit. Dealing with the Ministry of Social Services can be a trying experience. Ministry clients cannot book appointments in person, but must use a phone. Many of the clients do not have phones because phone service is too expensive. Those that have an H2 designation can have up to $500 worth of dental care per year. H2 designation is limited to those who are have handicapped or unemployable status through the Ministry, or are single parents.
- Education on preventative dental care is needed.

5) NUMBER OF SEX TRADE WORKERS

The Vancouver City Police did a census in 1992 of the number of sex trade workers at a location on Hastings St. There were 488 sex trade workers, 44 of them were children. If the population of the DES is approximately 16,605 (census tracts 57, 58, 59.01, 1991), the number of sex trade workers is equal to approximately 2.9% of the population.

6) PERCENTAGE OR NUMBER OF TEENAGE RUNAWAYS

No exact information could be found, but two separate sources estimate that there are between 300 and 500 street youth in Vancouver.

7) NUMBER OF EMERGENCY CALLS TO THE AREA, AND BY SPECIFIC LOCATION

Here are some statistics from British Columbia Ambulance Service for station 248, located at 726 Powell St. in Vancouver. Note that the number of calls has increased by only a quarter of a percent in the two periods shown, however there is a marked increase in DOA's and Drug and Alcohol OD's.

April 1992 - March 1993

Selected Categories	Number of calls
DOA	60
Drug and Alcohol OD	979
Infectious Disease	11
Interpersonal Violence	189
Chronic Disorder	328
Total calls, all categories	15,133

April 1993 - March 1994

Selected Categories	Number of calls	% difference from previous year	
DOA	87	Up 45.0%	
Drug and Alcohol OD	1,258	Up 28.5%	
Infectious Disease	14	Up 27.3%	actual increase is only 3 people
Interpersonal Violence	120	Down 36.5%	
Chronic Disorder	252	Down 23.2%	
Total calls, all categories	15,170	Up 0.25%	actual increase is 37 calls

8) PERCENTAGE OF INCOME SPENT ON RENT

In 1994, BC had the highest rental rates in Canada. Thirty-five percent of renters in Canada paid more than 30% of their income on rent (Statistics Canada, Housing costs 1993). In Vancouver, it is estimated that close to one in four tenant households spent more than 50% of their income on rent (City of Vancouver, CityPlan and Housing 4, Part 5:2). In the Downtown Eastside, a single "employable" person receiving income assistance usually pays the maximum allowable shelter portion ($325), or more for rent. This works out to be 59.5%, or more of their income. A family of two adults and two children receiving income assistance will pay 52.5%, or more, of their income on rent. According to the Ministry of Social Services, approximately 10% of British Columbians receive some form of income assistance. Affordable housing is in short supply.

9) PERCENTAGE OF INCOME SPENT ON MEDICATIONS/PRESCRIPTIONS/VITAMINS ETC. (no information at this time)

10) PERCENTAGE OF INCOME SPENT ON FOOD (no information at this time)

11) COST OF FOOD COMPARED TO REST OF CITY (info. on display at 390 Main St.)

12) GAIN RATES

Employable singles, couples, and 2-parent families
(who are employable and where no family member is aged 60—64)

Family Size	Support	Shelter Maximum	Total Maximum
1 person	$221	$325	$546
2 (couple)	383	520	903
3 (couple, one child)	486	610	1,096
4 (couple, two children)	589	650	1,239
5 (couple, three children)	692	700	1,392

Unemployable people or people between 60 and 64
(singles, couples, and 2-parent families)

Family Size	Support	Shelter Maximum	Total Maximum
1 person	$271	$325	$596
2 (couple)	433	520	953
3 (couple, one child)	536	610	1,146
4 (couple, two children)	639	650	1,289
5 (couple, three children)	742	700	1,442

One-Parent families

Family Size	Support	Shelter Maximum	Total Maximum
2 (parent with 1 child)	$462	$520	$982
3 (parent with 2 children)	565	610	1,175
4 (parent with 3 children)	668	650	1,318
5 (parent with 4 children)	771	700	1,471
5 (couple, three children)	692	700	1,392

13) NUMBER AND PERCENTAGE OF LOCAL RESIDENTS WHO USE SERVICES/AGENCIES AS OPPOSED TO THE NUMBER OF "VISITS"
(no information at this time)

14) NUMBER OF LIQUOR LICENSED PREMISES SEATS, AND AS PERCENTAGE OF CITY CAPACITY

In 1993 there were approximately 92 liquor licensed premises in census tracts 57, 58, and 59.01 and approximately 250 in the City of Vancouver. These figures do not include restaurants permitted to serve alcohol (Central Area Planning, City of Vancouver). This means that the Downtown Eastside has approximately 36.5% of the liquor licensed premises, but only 3.5% of the population of the City of Vancouver (1991 figures).

15) VOLUME OF TRAFFIC AT KEY LOCATIONS (no information at this time)

16) MEASURE OF TRANSPORTATION ACCESS FOR PEOPLE
(no information at this time)

17) WHAT IS THE STRESS LEVEL? (no information at this time)

a) How many people get holidays
b) How long does it take to get to community recreation facilities, especially for families, for activities like swimming, and how much does it cost.

18) NOISE LEVELS AT KEY LOCATIONS

On September 07, 1994 Libby and Ken met with Brian Johnston of City Health Dept., Environmental Health Dept. regarding noise levels in the DES and it's effects on stress/health. Brian assisted us with recording noise levels at five locations as seen in the charts below.

Background:

The City has three categories for noise zones: 1) Activity; 2) Mixed Use; 3) Quiet.

Much of the DES falls into the Activity noise zoning which is designated Commercial as far as property use zoning. Housing that resides within Activity zones is zoned CD1, this zoning is

specific to the particular site. What this means is that much of the DES residents are going to have all the noise that goes with Commercial zoning. The chart below shows the maximum allowable, continuous sound levels for designated zones. The City noise by-law describes continuous sound as sound occurring for a duration of more than three minutes, or totaling three minutes in a period of fifteen minutes. The sound levels are maximum values, residents should not be expected to endure the maximum sound levels continuously.

City of Vancouver max. allowable sound levels from point of reception			
Zones	Quiet	Mixed Use	Activity
Day	55	70	70
Night	45	65	65

Note that in the five location charts below. The average sound level (Leg) for the duration of the sound level recording is either above, or at 70 dB in four of the five cases and only significantly below the maximum in one case: 61.9 dB at the Ford building on the eighth floor. What does this mean? It's really noisy where we live. Sound levels are continuous at, or above, the maximum allowable level. This has got to affect the incidence of stress.

Notes:

- All noise levels were recorded on November 11, 1994, times are as noted.
- All levels are dBA slow (decibels measured using the "A" weighting network setting of a sound meter with a slow response, the standard used by the City of Vancouver).
- Leg = average noise level for period of sample
- L20 = average noise level for 20% of sample; continuous noise
- L90 = average noise level for 90% of sample; background level
- All locations contain high density dwellings.

Location # 1: NW corner of Main and E. Hastings Streets			
	Reading # 1	Reading #2	Reading #3
time of day	7:43 am	3:10 pm	
duration	10 minutes	10 minutes	
notes	street level	street level	
Leg	73.5	73.8	
Lmin	62.0	63.0	
Lmax	85.5	82.0	
L20	74.0	75.0	
L90		69.0	

Location # 2: Ford Building, eight floor, NW corner of Main and Hastings Streets			
	Reading # 1	continued	Reading #2
time of day	8:00 am	8:00 am	
duration	5 minutes	2 minutes	
notes	window open	window closed	
Leg	61.9	50.9	
Lmin	57	44.0	
Lmax	71	58.0	
L20	63	51.5	

Location # 3: Four Sisters Housing Co-op, fifth floor, 153 Powell St., facing Powell St.			
	Reading # 1	continued	Reading #2
time of day	8:30 am	8:30 am	3:25 pm
duration	10 minutes	10 minutes	10 minutes
notes	on balcony	window closed	ground level
Leg	71.7	37.7	67.8
Lmin	54.5	35.0	57.5
Lmax	90.0	45.5	77.0
L20	60.0	41.5	69.5
L90	61.0	36.5	61.5

Location # 4: SW corner of Powell and Carrall Streets (Maple Tree Square in Gastown)			
	Reading # 1	Reading #2	Reading #3
time of day	9:05 am	3:45 pm	
duration	10 minutes	10 minutes	
notes	street level	street level	
Leg	69.9	70.4	
Lmin	59.0	60.5	
Lmax	82.0	78.5	
L20	71.0	71.5	
L90	63.5	64.0	

Location # 5: SE corner of Campbell Ave. and E. Hastings St. (Stamps Landing)			
	Reading # 1	Reading #2	Reading #3
time of day	9:30 am		
duration	10 minutes		
notes	street level		
Leg	74.2		
Lmin	58		
Lmax	91.5		
L20	74		
L90	64.5		

The noise level readings are incomplete at this time. Ideally we will obtain sound level readings on three different days, four periods per day: early morning rush hour; noon; evening rush hour; and after 10:00 p.m.. Levels cannot be taken when it is raining.

Brian provided us with a copy of the new noise bylaw and articles on how noise levels affect health through increased stress.

Notes and General Information

At the meeting with Brian Johnston we also discussed the garbage problem in our neighbourhood alleys. This does not fit into any of the categories of key data requested by the planning group, however, it is a health issue. There are three basic problems:

1) businesses and property owners contract for garbage bins that are too small for the amount of garbage that they generate

2) individuals dump their garbage in the alleys as a quick way to dispose of waste

3) There is a suspicion that the commercial "waste management" companies may not contract to pick up containers in areas that they feel are difficult to access. This leaves the "unfavorable pick up areas" to be serviced by the City. This would not be a problem except that the amount of clean up required is enormous.

There is no effective way to enforce business and property owners to contract for large enough bins, or to prevent individuals from leaving garbage in the alleys. This subject will have to be addressed by the Community Health Council.

APPENDIX III

DOWNTOWN EASTSIDE COMMUNITY HEALTH PLAN

LISTENING SURVEY SUMMARY (Residents), AUGUST 31ST, 1994

Summary Report by Alison Cameron

The people working on the Community Health Plan in the Downtown Eastside sent 10 volunteers into the area to conduct a Listening Survey. It took five weeks and was completed on August 24th.

A Listening Survey has one basic question "What do you like, or dislike, or want to see changed in your health care?" Any physical and environmental thing is considered a health issue.

Approximately 500 people were asked from the following list of cultural definitions:

Addicts-drug/alcohol
Black
Chinese
Disabled
Employees/workers
European
Families
First Nations
Francophone
Gays
Homeless
Indo-Canadian
Japanese
Mental Health consumers
New Immigrants
People With Aids
People with criminal records
Seniors
Sex Trade workers
Single men
Single mothers
Single women
Spanish
Street kids
Transients
Transvestites
Vietnamese

Locations where the 10 surveyors found the participants:

Abbott Rooms
Bicycle Shop
Carnegie Centre - 2nd floor
Columbia Hotel
Columbia House
Crabtree
Crosswalk
DES Senior's Centre
Downtown Handicapped Program
Dugout
Ford Building
Four Sisters Co-op
High Risk
La Boussole
Native Health Clinic
New Zealand Rooms
Oppenheimer Park
Ray Cam - mother's group
SOS
St. Elmo Hotel
Strathcona Community Centre
Sheway
Stores
Streets
Tomari Gumi
Vancouver Community College
Women's Centre
Women's Centre - Crab Park picnic
Youth Detox

FEELINGS

- There is an overall feeling of despair in the Downtown Eastside, with a high level of grief. People are afraid of each other because knives are available and child molesters are on the streets.
- Residents are classified or labelled by subjective interpretation with little or no concern for the potential for being wrong. It gives a feeling of institutionalization.
- Too many disadvantaged are dumped into the area. The transients take advantage of services and the long term residents feel they have to fight harder to receive programs. Residents feel too many professionals have a financial agenda that overrides the needs of the clients.
- The fear is BC will adopt the social policy of Alberta and service providers are apathetic.
- There is a lack of spirituality.

(Feelings continued)

- The youth feel there is no role or recognition for them in the community and they are discriminated against.

YOUTH

- The youth claim they will continue to do drugs into their twenties and then become "decent" citizens. They are disenfranchised, have a phobia about the government and the ones living on the streets they can't get ID to access jobs and housing.
- The youth priority is employment and training. They know the exposure to the events on the streets is harmful to them.
- They want safe houses from sexual and physical abuse, but when a crisis arises there is no one or place they can approach, especially late at night.

PARENTS AND CHILDREN

- Parents feel there is a value judgement based on their poverty and not being able to afford new clothes.
- Single mothers are apprehensive and believe authorities are stealing their children. They want more child-care facilities.

HOUSING

- The availability is dependant on discrimination and places are filthy, mice and cockroach invested, which cause illness and are not good for families. People living in condemned buildings with vermin and rats, which bite.
- Hotels need mandatory wheelchair access and kitchen facilities, owners take advantage of residents (eviction without notice, rent to underage or very ill, short change and over-charge). The people in Co-op housing worry about those living in the hotels.
- Need more housing for youth and seniors.

  Market housing needs rent subsidies and the people with mental health or special needs want to be independent with support housing. The service providers are taking housing stock.
- Parents worry the gates in some complexes are not high enough.

EMPLOYMENT

- The available non-skilled jobs are too low paying to raise a family. Long term residents feel limited in getting training opportunities.
- Too many non-profit organizations produce little or no jobs for people using the services.
- Language barriers prevent people from getting work.

SEX TRADE WORKERS

- Some Sex trade workers feel they have been forced into the trade. They all want safe, permanent and legal places to work without harassment, particularity from pimps. They think there are too many prostitutes and want better programs to prevent the young girls entering the trade. They have a need for better medical services to help them with health and addiction problems.
- Some people think the "Shame the Johns" campaign is only creating more hostility, divisiveness and suspicion in the neighbourhoods. Some residents think more and harsher prosecution for the pimps and johns, especially when underage people are involved.

WELFARE DEPENDENCY

- Social assistance needs to be increased by a minimum of $70.00 and policies are not consistent (different results for same requests). Long time residents have to fight with the Financial Aid workers for most requests.
- The system is set for the convenience of the workers not the clients. Services are denied because of holidays.
- Too many food banks, welfare and other like services.

CLINICS

- Can only see nurses who can't diagnose. Not enough doctors in the clinics and no specialists and they are not open 24 hours.
- People want more respect from the health givers and an avenue for accountability of their attitudes or opinions and be able to use the clinics with their BCMSP card.
- There are no prenatal and postnatal or translation services available.
- Clinics have burned out staff because of under staffing. People don't like it when a problem has to reach a crisis point before action is taken.

OTHER AGENCIES

- Residents feel the people working in agencies don't respect them and are prejudiced. They want new people with new ideas.
- The systems are too bureaucratic, inundated with paper work, controlling, impersonal, clinical, apathetic and gives poor treatment. There is little or no accountability for the staff and policies. Equipment and staff training are poor.
- Some people see there are two sets of rules: none for the clients and one for the providers.
- If personal issue is too complex or might need confrontation between agencies there is a reluctance to find a solution. There is not any recourse for individuals to obtain accountability.
- The food given out by some agencies has caused food poisoning. People don't like having to sit through sermons to get a meal.

(Other Agencies continued)

- Homemakers need to be caring, clean, strong and industrious people. Homemakers are seen to be lazy and stupid, won't do heavy cleaning and clients feel they are looked upon as sub-human.
- The elderly are taken advantage of by staff, not given baths regularly and their dignity isn't respected. Those confined to home need more help and respite workers.

DETOX CENTRES

- An attitude of apathy; administration is put before the client. Clients are put into forced programs. It is a "factory" mentality and all drugs and users are thought of as the same.
- Addiction is not considered a disease.
- Providers threaten or accuse clients of lying and manipulating the facts. Providers are given full benefit of the doubt. Clients have no say on treatment they receive.

DOCTORS

- Patients are misdiagnosed often and doctors are not interested in what medical knowledge the patient has. Doctors won't allow the patient to make decisions, or won't give options on medical treatment. Children are getting sick from double immunization shots. Doctors prescribe pills as the only treatment and people are just numbers.
- The doctors are judgmental (impose their morals, values and beliefs) and think everyone in the Downtown Eastside are addicted to drugs or alcohol. People are made to feel uncomfortable.
- The patients aren't willing to pay extra billing and think doctors are only interested in making money. They want to know exactly how much they are to pay Chinese doctors and some White people think the Chinese medical personnel are over charging them.
- It is believed the doctors make people sick or crazy—some people avoid seeing them.

HOSPITALS

- Are too far away and considered horror house where people are treated like machines. People go to the hospital when they think it is a crisis and are issued pills and told to make an appointment.
- Emergency services need more availability of blood and oxygen.

TB & OTHER COMMUNICABLE DISEASES

- People are undiagnosed for TB and there are some collecting cigarette butts which could have the disease (and others) on them. A strong fear of contacting AIDS because the needles are lying in the open and some people work in the sex trade.
- HIV carriers—There aren't any places for AIDS patients to hang out in. Doctors refuse to treat them and there are only two dental clinics (UBC and in Surrey) willing to serve patients.

HIV trans-gender people want to be segregated to the sex they wish.

DRUG USE

- There are too many drug users and they leave their needles everywhere. The streets are stressful and dangerous with users' violence and behaviour.
- Too many users are using muddy water to mix with. There are too many bars and serving the underage too often. People are under pressure to use drugs and alcohol and its hard to avoid because its everywhere.
- The drug users have labels on them and can't get services if they have track marks. Methadone patients feel they are treated as sub-human because the program is so strict that they would be better off on parole. Their feelings are of being treated as a commodity by the agencies and keep getting shuffled from one to another.
- Users have no place to go to feel completely safe from bureaucracy or government intervention and the street scene.

DENTAL CARE

- The available dental services are poor and too expensive. There is a need for more dentists.

PREVENTATIVE AND ALTERNATIVE HEALTH CARE

- Lots of people want massage or reflexology therapy on the BCMSP. They want psychiatrists off the plan and psychologists or other therapists on the plan. Incest survivors want treatment centres.
- People want nutritionists, better food and cleaner water. They also want the choice of herbal remedies on the BCMSP

TRANS-GENDER

- There are not enough places for them to go to and Crabtree has a problem with them using the facility.

LANGUAGE BARRIERS

- Easier and more access to information about language education and translation services.

CONFIDENTIALITY

- More people don't like Pharmanet than do. Information sharing among agencies happens too often and unqualified people have access to the individual's files and data.

POLLUTION

- Noise pollution, dirty streets, alleys and parks are greater concerns than the black dust in the air.

POLICE

- People aren't treated with respect by the police. Other neighbourhoods are given preferential treatment and police have given up on the Downtown Eastside.
- There aren't enough foot patrols. The Jay-walking laws aren't enforced in Chinatown and the 100 block of East Hastings. The timing of the traffic lights is too fast, for elderly and disabled people to cross intersections.

OTHER

- No casino.
- More recreation facilities.
- More money available for employment training.
- More facilities and wider training for nurses.
- Lower cost for vitamins C and complex B and ENSURE (food supplement).
- Not enough support groups for allergies and information.
- Cigarettes aren't sold as singles.

SUGGESTED SOLUTIONS

YOUTH

- More recreation facilities
- More work training

HOUSING

- Rent subsidies for market residences
- Low cost housing in other neighbourhoods, so that people have an alternative

EMPLOYMENT

- More training and job creation, including services performed at home
- More community or volunteer work as training
- More user-friendly social services
- More translation or ESL services
- More child care facilities
- Compulsory retirement—older people do the volunteer work and younger get the jobs
- Teens paid to work with their peers

SEX TRADE

- Better programs to prevent girls entering and assist those to get out of the business
- Programs designed to deal with self-esteem, addiction, housing, training, life skills and how to change lifestyles
- More severe consequences for johns and pimps, especially when the under aged are involved
- More emphasis on stopping sexual abuse to prevent girls entering the trade
- Area restriction for the business
- Decriminalize the business

CLINICS

- Government registry to give out illicit drugs
- Needle Exchange gives out bleach
- Patrolling medics
- One 24 hour clinic with all services
- Complete education of disease symptoms and high risk situations (i.e. unsanitary tattoo parlours)
- Give out vitamins C and B complex
- More support groups to stress allergies

AGENCIES

- Employ users at minimum wage
- Cut present wages
- Have worker work along with community
- More detoxes or home detox programs
- Less controlling staff and policies
- Safe drop-in centre for users

DOCTORS

- Community sensitive training
- Stop making synthetic drugs
- Teams to go out on the street with a one to one approach
- Herbal medicines on the health plan
- Up to 54 massage and chiropractic visits on the health plan
- Nutritionists on health plan
- Include different types of massage therapies
- Take psychiatrists off the plan and put other therapists on
- Incest survivor's treatment centres

HOSPITALS

- Like Children's Hospital have colourful walls, peaceful music and fresh food
- train families and friends how to give nurturing and emotional support

DRUG USE

- Ban the sale of Ginseng brandy
- Legalize heroin, cocaine and marijuana
- Legalize heroin, but not cocaine
- If we're giving out needles put something in them
- Sell cigarettes as singles

DENTISTS

- More dentists in clinics

CONFIDENTIALITY

- Public inquiry as to how information gets shared
- Watchdog committee to prevent malfunction

POLLUTION

- am maximum hour for noise
- Flatten Main and Hastings intersection
- No cars at Main and Hastings
- More trees and parks
- Community body to clean alleys and streets and look after security

POLICE

- More foot patrols

OTHER

- ENSURE (food supplement) needs to be more available, too expensive
- More recreation facilities for all

APPENDIX IV

DOWNTOWN EASTSIDE COMMUNITY HEALTH PLAN

SERVICE PROVIDER LISTENING SURVEY: SUMMARY, JANUARY 1995

Summary by Libby Davies

INTRODUCTION:

As a follow up to the Listening Survey done with community residents in August 1994, and as a result of discussions with service providers in the community, the Community Health Plan planning group conducted a Listening Survey with Service Providers, during the months of November and December. The Listening Survey is part of a community process to ensure that the Community Health Plan responds to the identified needs of the community.

Fourteen volunteers visited 28 agencies and services in the community (most were providing some level of health service), to hear and record the views and perspectives of service providers concerning health in the Downtown Eastside. Two basic questions were asked: "How does your agency/service meet the health needs of the Downtown Eastside", and "Is there a need for any change?"

Volunteers recorded information in notebooks, and also gave feedback at report in meetings. In keeping with the first Listening Survey, the summary of comments, concerns, issues and suggestions, is NOT identified by source. **There is no objective to evaluate or judge various services in the community, only to record the views and concerns of service providers as heard by community volunteers.** Obviously not all services were visited, due to time and resource constraints, but the Community Health Plan planning group believes the Listening Survey with Service Providers will provide valuable information to assist with on going discussion and development of a Community Health Plan.

The results from this Listening Survey, like the one done in August, will become part of a **Community Update** for further comment and follow up. It is anticipated that following the Community Update, joint workshops between community residents and service providers will be held to consider the information gathered so far, for the development of draft goals and priorities for the **Community Health Plan.**

NOTE: The following summary does not describe services provided by agencies that participated in the Listening Survey; the summary highlights the observations, views and comments of service providers pertaining to general health and services in the community.

SUMMARY:

ISSUES * OBSERVATIONS * CONCERNS

Mental Health

Dual Diagnosis becoming more common

- HIV amongst mentally ill a growing concern, especially in past 10 years

not enough mental health beds

- Core related magnet theory a concern

(mental health continued)

- biggest problem is finding a place for people with dual diagnosis to live
- temporary episodes of violence are high
- number of mental health cases are increasing
- biggest problem for mental health is lack of proper housing
- big problem is getting patients to take their medication; sometimes admittance to hospital is answer
- clients don't get comprehensive treatment; no family DR.
- not enough time to do home visits as needed
- how to fit into whole community ? mentally ill have no voice
- more mentally ill here than anywhere else; tolerance, services, cheap rooms are a draw
- to 15% of residents have a serious mental illness
- people in this area get faster better psychiatric treatment than elsewhere
- why are GVMH and Provincial Mental Health separate—would be better co-ordinated
- worse in winter than summer
- feels like we got everything into place for mental health clients then drugs took over the neighbourhood
- because of drugs, seeing more HIV clients
- mentally ill are not violent—biggest safety problem is drugs and outside "yahoos" coming here to "party hearty"
- Mental Health Act has swung too far; too liberal, have to wait too long to treat people
- small changes can have a big impact; i.e. when cigarette price goes up, clients spend less on food
- not much support for parents, children in the area
- need to support the family more; need to do more community outreach
- disturbed by number of seriously mentally ill children in area and the degree of disturbance (i.e. suicide attempts by young children)
- most people don't have family Dr's; most referrals can come from building mangers/staff

<u>Housing</u>

- many clients in emergency housing have been barred from BC Housing
- many housing places have policies that are too restrictive for dual diagnosis and behavioural problems
- estimated 200–600 chronically homeless people in the Downtown Eastside
- inadequate living accommodation, not even enough hot plates in many places (people have to go on a waiting list)
- inadequate wiring
- many students live in poor housing and come to school with colds and flu

(housing continued)

- inspectors don't return to see if ordered work was completed
- no standards to prevent overcrowding; four families living in one house, sharing bathroom and kitchen
- kids in hotels and rooming houses don't have sufficient cleanliness and cooking facilities
- battered women after transition house can't get proper housing; they end up in hotels and rooming houses
- desperate need for housing
- biggest problem is getting stable housing
- if you give people a place that feels like home and doesn't reject them; it seems trite but its basic
- why are we putting dollars into health services and not housing?
- housing gentrification; and lack of decent affordable housing

Alcohol and Drug

- Ginseng Brandy a big health problem
- Alcohol and Drug OD's big problem
- people who switch to cocaine and heroin become more violent
- people leaving detox can still have serious illness
- increase in HIV drug use
- Detox (first come, first served) means many get turned away
- Detox based on rehab. model; no other choices
- ambulance calls most frequent cases A&D OD and terminal violence
- influx of hard drugs into the area
- drug scene is much bigger than it used to be; especially coke and heroin; makes things more unpredictable
- Needle Ex was started to deal with HIV; now big issues are Hepatitis and Endocarditis; causes 1–2 deaths/month
- traditional A&D service providers lack knowledge of HIV— disagree with harm reduction method
- addicts face discrimination because of race, gender, being IV drug users and being HIV
- IV drug users don't get same treatment as "traditional" HIV patients
- fear of influx of addicts from back east because of higher conversion rate
- not enough treatment facilities; especially for women and natives, can fill maybe 1 in 10 requests for treatment
- methadone should dispensed here with close supervisi

(alcohol and drug continued)

- price of heroin has gone up; there are more people desperate for drugs that come in for help

Service Delivery

- language barriers present a major problem (i.e. ambulance)
- specialists sometimes don't want to see DES patients because—they don't keep appointments
- if hospital patient has a Dr. with no admitting privileges (or no Dr. at all), then the system breaks down and patients don't get the advocacy and follow up in the system
- Dr.'s too isolated in this area
- BCMA has a lot of clout and like the status quo; they don't want to look at alternate funding mechanisms
- parents think the needle exchange promotes drug use and want to get rid of it; they need education
- no medical monitoring of virus' (i.e. hepatitis B) for recent arrivals
- months for wheelchairs to be delivered is too long for patients
- hospitals release people mainly on Friday afternoon (no back up)
- nurses do a lot of trouble shooting between clients/ Dr's and FAW's
- duplication of emergency response (ambulance/police/fire)
- hard to get minor equipment (canes, crutches, walkers etc.) MSS requires too much paper work; it's a struggle to get a signature
- too much duplication (patients double doctoring)
- rules often exclude people (i.e. mental health can't deal with alcohol abuse)
- Strathcona Outreach is not big enough for the DES
- bureaucracy in Victoria have no idea what's going on
- services are available but its a tangled process; most people have had a negative experience
- there's a vast delivery system but based on a very narrow pathology
- we give medical solution (Prozac) to social problems; they're given pills because it's the easiest solution
- revolving door is a problem; but at least its harm reduction
- it's hard to get people to take medications especially for diabetes and epilepsy
- emergency vehicles get called out when not actually needed
- emergency service delivery is subject to calls in other areas, leaving the DES incomplete
- communication between different parts of a service can deteriorate, particularly if other languages are involved
- nobody goes into hotel rooms; if more care givers did there would be less crime
- lots of different standards for care; need more uniformity in standards of care
- native health funding is stretched to limit

(service delivery continued)

- nearest Dr. after hours is St. Paul's
- DES is very "institutionalized"
- Saturday is usually busy at Native Health Clinic
- private labs cannot do a lot of the fancy blood work that needs to be done
- not enough sessional payments to cover Doctors' time
- patients need to be more stable if they are referred to other specialities; can't live up to middle class expectations
- government shouldn't run direct services
- hard to deal with transients who don't have adequate medical coverage
- Doctors feel isolated and alone; there's so many sick people

Community profile

- seeing more young women with mental ailments who are lost and lonely
- loneliness; lack of meaningful purpose/work for residents
- nutrition and lack of food are a big problem
- residents don't have any say about their lives; don't have an identity
- seeing less hunger in schools since the breakfast/lunch program was introduced
- this area is more tolerant
- single moms work long hours in Chinatown for minimum wage; many work 7 day weeks and don't have holidays
- lack of knowledge of laws causes fear and distrust of professional (i.e. a home maker can remove you from your home)
- major health issue in DES for women is unhealthy and abusive relationships, but the "here and now" puts everything else on the back burner
- attitude of "you're going to die anyway"
- social and physical environment is very poor
- people are very honest down here; people are very grateful for the little things you do
- people are sleeping outside without proper clothing
- sometimes it's very hard for a client to get through to FAW or SW, advocates make a big difference
- increasing number of street kids, homeless, drug dealers, mentally ill are swamping the DES; easy access of D&A, services, & low income housing
- most frequent weapon; knives
- sex trade workers are being abused and tortured
- people have no family; loneliness a big problem
- volunteers aren't respected; too much is expected of them

Staff/Safety and Security

- emergency/front-line work is very stressful
- lack of security for staff
- staff get burned out and can have tunnel vision
- staff isolation
- staff can feel intimidated by people and problems
- some home visits are listed as two person visits because the place is dangerous (not client but atmosphere)
- nurses have stopped visiting Balmoral due to danger element (they don't fear losing their jobs), but home care workers still go
- police assistance isn't always available for other emergency staff
- social problems in the area make emergency work very stressful

Community Health Plan/Council

- CHP will be worse for students because dollars for needed programs won't be available
- CHP is a good idea but it won't make a difference and could be damaging
- concern that the CHP will have a medical emphasis, when what we really need is more housing
- mentally ill will be pushed out of area because CHP will want to clean up neighbourhood
- seriously mentally ill won't be represented on CHC
- pressure will be on providing services to "healthier" clientele
- CHC is "scary"; perhaps people will not make good decisions
- how will services servicing a larger community fit into CHP/CHC
- they shouldn't be controlled by CHC
- don't understand why agencies are shut out of health council
- services that are close to CHC boundary; confused and concerned about which CHC they will relate to
- big fear of drastic change in health field
- so called health experts in Victoria don't understand
- under regionalization, fear that bureaucrats will make major decisions; community groups only figure heads and then Liberals get in. What happens?
- what will Regionalization mean for little agencies who plug gaps?

SUGGESTIONS * IMPROVEMENTS

Mental Health

- need an asylum (it used to be a good word) or sanctuary
- need more education around mental illness

(mental health continued)

- the answer is not hospitalization for mentally ill, but more resources in the community
- if had "power" would have more Portland style places (but better quality building)
- would like more sheltered workshops; the prestige of doing work, making extra money means a lot to people
- key tool in treating mental illness is medication

Housing *

- need more permanent housing; including support function
- need housing AND care giving
- affordable housing
- other communities should have their own emergency shelters
- special needs housing
- more supported housing (i.e. cooked meals)
- * similar comments were repeated often by service providers

Service Delivery

- need more places where people are accepted not rejected
- need better liaison
- it would be nice to have one place with everything, as long as it isn't institutional
- computerization to better assess clients' needs
- billing procedures need to be more flexible
- guidelines for assessing length of care to avoid service dependency
- single phone # for easier access
- ensure privacy for clients with minimum information sharing
- need nurse decision making
- need to look at whole person and their issues and problems
- multiple diagnosis needs to be treated and not separated out
- wellness includes nutrition and housing
- need better networking/integration for home care; daily nursing
- REACH clinic is a good model of local comprehensive health care
- mobile nursing teams
- need seminars/classes about how to cope in an emergency situation, before the arrival of emergency services
- need more unique care for acute chronic alcoholics
- need variance in licensing for extended care beds to allow palliative care
- need to build trust

(Service Delivery continued)

- needs small facilities that are co-operative not adversarial

Services

- needle exchange needs to be expanded
- need funding for licensed half way houses
- community health nurses are needed
- need more nurses in clinics to help relieve load of Doctors
- need female Doctors
- need more visits from community nurses to existing services
- cell phones for community nurses
- need longer clinic hours
- need convalescence centre (somewhere between hospital and home)
- community health centre; open extended hours, well located, user friendly, less bureaucracy, allow alternate medicine, convalescence
- provide portable alternatives to emergency services that are more locally focused
- counselling; one stop shop
- need emergency beds in the community (attached to a clinic?)
- would like to see another clinic in addition to DHC
- need space for respite and convalescent care
- general need for outreach workers, particularly for women and people with mental health problems
- better dental care needed
- everyone needs one good nutritious hot meal a day—would like to see it provided free
- provincial health initiatives should be community based
- need options for detox services that are client driven
- have teams of people that pick up people from streets instead of using emergency services
- need First Nations style treatment (like sweat lodges) and counselling services
- more day-care with emphasis on play and music therapies bright walls and more home like
- need more adult day care programs
- people need to be able to get blood tests without cards

continued

Education

- doctors need better education on addictions; people are discharged (detox) and then Dr. prescribes valium
- need to improve education/training of key people in the community (i.e. building managers), to enable them to be aware of service options
- require mediator/advocate to act as conduit of info. between professional and client (professionals need to rid themselves of jargon)

Community Health Plan

- need active advisory group to gather feedback from the community
- what we need is a holistic approach to the CHP; where individual is looked at as an individual; needs and priorities are worked on with as much participation as possible

Community

- need to change hotel bars to better uses like cafes
- need social as well as medical attention
- change welfare Wednesday /staggered cheque issue
- ban Ginseng brandy
- people need to feel more connected; need more services and support
- leave decisions about changes to people who live in the community; they know what they want
- better policing needed
- maybe "legal" houses would help prostitution
- politicians should be more active
- public fountains
- community kitchens to teach skills and nutrition to people
- need street "mom or dad" to connect to street kids

APPENDIX V

DOWNTOWN EASTSIDE COMMUNITY HEALTH PLAN

OUTREACH TO THE CHINESE COMMUNITY: SUMMARY

By Yuet-lan Lee

INTRODUCTION

Since August, 1994, a series of outreach activities has been conducted in the Chinese community in Downtown Eastside, China Town, Strathcona and City Gate. It is part of a community process to ensure that the Community Health Plan responds to the identified needs of these neighbourhoods in the community.

METHODOLOGY

1. Target

- Groups of the local organizations
- Drop-in groups of the local organizations
- Individuals living in this community
- Family members of the groups

2. Approach

- Talk, questionnaire and discussion
- Questionnaire and discussion
- Questionnaire
- Talk and discussion
- Kitchen table discussion
- Discussion

PLACES VISITED

Chinese Community Library Services Association (2 meetings)
Chinese Cultural Centre
Chinese Freemasons Housing Society (2 meetings)
Chiu Lun Tower
Columbia Housing Advisory Society
Jennie Pentland Place (2 meetings)
Lord Strathcona Elementary School (3 meetings)
McLean Housing (2 meetings)
S.U.C.C.E.S.S.
Strathcona Adult Day Centre
Strathcona Community Centre
    Seniors' Group
    Women's Group
    Stroke Club
    Nobody's Perfect
Individuals

Apart from working with the groups listed above, contacts were made with following organizations to ensure better local participation:

Britannia Community Centre
Canadian Chinese Radio
Community Cable 4, Roger Cable
Crosby Property Management Ltd.
Downtown Eastside/Strathcona Coalition
Fairchild T.V.
First United Church
Ming Pao
Morning Voice
Mosaic
Overseas Chinese Voice Radio
Sing Tao Yat Po
Strathcona Mental Health Care Team
Strathcona Residents Association
Talent Vision
Vancouver Chinatown Housing Society
Villa Cathay
Watari

PARTICIPATION

No. of discussion meetings:	10
No. of kitchen table discussions:	4
No. of drop-in meetings:	4
No. of groups we mail out questionnaire:	4
No. of visits to individual:	7
No. of discussion meetings with service providers:	31
No. of residents participated:	246
No. of non-residents participated:	75
No. of service providers/staff/volunteers/users met:	68
Total no. of persons participated and met:	389

PROMOTION

Interview with the Community Information of the Canadian Chinese Radio on September 15, 1994

Interview with the "Chinatown Today", Community Channel 4, the Roger Cable on October 23, 1994

Interview with the News Report of the Overseas Chinese Voice on January 3, 1995

Interview with the Mandarin Community Information of the Canadian Chinese Radio on January 11, 1995

SUMMARY OF THE QUESTIONNAIRE RESULTS

Note: Only the issues or concerns that were strongly expressed are summarized below:

1. Positive issues

- good place for grocery shopping
- convenient because it is the centre of the public transportation
- no communication barrier as most people speak Chinese
- a place with Chinese characteristic
- acceptable cost of living

2. Issues, respondents are concerned about:

- Safety and Security. Respondents really upset with the following issues:
  - alcohol and drug
  - prostitution
  - break and enters
  - robbery
  - car stolen
  - needles and condoms
  - panhandling
  - the homeless
- hygiene and cleanliness
- language barrier
- housing
- employment opportunity
- service delivery
  - poor assessment of home support service which as a result, needy cases do not get the service while cases not in need get it;
  - lack of nursing support in the community;
  - lack of mobile nursing team

3. Feelings about the community

Most respondents felt very positive about their community.

4. What makes people and our community healthy?

- a safe and secured community, i.e. no drug or alcohol, no prostitute or homeless, no theft or break in, no needle or condom
- clean and quiet environment
- good daily activities
- good social interaction and supports
- balanced diet
- secured housing

5. Our neighbourhood would be a healthier place to live if...

- it is a safe and secured community, i.e. low crime rate, no drug, no alcohol and no prostitute, no theft and no break in
- it is clean and quiet
- there is no language barrier
- there is a gym with swimming pool and ice rink
- where social support is available

6. If our neighbourhood was given $1 million budget to address our health needs, how might we spend it?

- to address to the needs of being safe and secured
- to ensure it is clean and quiet
- to solve the language barrier by having more Chinese speaking staff, ESL course, translation/interpretation and etc.
- provision of gym including swimming pool and ice rink
- shelter for the homeless
- public health education and mobile nursing team
- to take actions on the illegal usage of side walks in Chinatown
- accessible to medical services
- decentralize the social services

7. How can we help you to participate in working out a good community health plan?

- to have Chinese fact sheet
- to have promotion in the Chinese newspapers, radio and T.V.
- Chinese to be one of the languages in the community meetings
- to have forum for the Chinese speaking residents
- to have door to door delivery of the fact sheet and meeting schedule

SPECIAL REQUESTS FROM INDIVIDUALS/GROUPS/ORGANIZATIONS

1. Drinking driving is an offence. Why drinking walking is not charged?

2. To set up a better system to maintain the existing welfare and to make sure the new system is not being abused.

3. A few people goes to see their doctors without medical needs. It is necessary to draw a line for medical consultations and hospital admissions as well as seniors getting unnecessary medication. To ensure the medical service plan is not being abused, people should pay the extra bills from their own money and to have open clinic for those people who cannot afford.

4. Those Chinese who are not speaking English should have a say through their children who are not living in this neighbourhood. Their next of kin should get involved in the Community Health Council and should have the chances to become a council member.

5. The drug and alcohol cases should be treated by drug and alcohol program. Half-way centre is suggested for these cases instead of direct services from the mental health program.

6. Accessible to specialists.

7. We respect human rights. But we must take action when human rights is at our expense.

8. Chinese Freemasons Housing Society

   Seniors living in this housing project express their concerns about emergency rescue and immediate medical attention when they may have a problem. They would like to see an affordable medic-alert system for seniors living alone.

9. McLean Housing

   Garbage disposal is a problem in this housing project. Safe garbage disposal is strongly suggested by the residents here.

10. Stroke Club/Strathcona Community Centre

    This is a group of people with past history of stroke. They meet once every week for socialization and rehabilitation with funding from City of Vancouver. But, the grant was cut back in 1995. Members view the club as a preventive measure for them. They are upset with the cut back and appeal for ongoing funding and support from the government.

11. Jennie Pentland Place

    There have been break and enters in this housing project. Residents are extremely upset especially when one of the break and enters was in the unit of a 101 year old female resident. A request for night duty security guard in their building has been made.

12. City Gate neighbourhood

    Residents here feel Lord Strathcona Elementary School and playground is too far away. The Community Health Plan Office is providing liaison to develop more outreach activities.

WHAT YOU CAN DO:

- **Educate yourself** – Read the full report, *Community Voices: Results of Seven Focus Group Discussions Concerning Alcohol and Drug Services in the Downtown Eastside and Strathcona.* It contains a summary of the focus group discussions and more details about these recommendations. The report is available from the address given below.
- **Talk to your friends** – Discuss the report with your friends and neighbours. If you think something is missing let the committee know.
- **Organize or join a discussion group** – If your concerns are not addressed in these recommendations you can work to improve them. Contact the committee to learn how to organize or join a discussion group which will address your concerns.
- **Get involved in creating solutions** – The committee meets on a regular basis at First United Church. Contact the committee to find out when the next meeting is. Community residents take part in all discussions and have been active in the establishing the focus groups which this report is based on.

FOR MORE INFORMATION:

If you have questions or want to get involved in creating solutions to alcohol and drug problems in your community please contact:

Downtown Eastside Community Health Plan
390 Main St.
Vancouver, BC
V6A 2T1

Phone: 682-3088 Fax: 775-2582

Community Voices

ALCOHOL AND OTHER DRUGS
IN THE
DOWNTOWN EASTSIDE AND STRATHCONA

People who live in the Downtown Eastside and Strathcona are affected by many problems associated with abuse of alcohol and other drugs. Heroin overdoses, the distribution of ginseng brandy, and access to effective services are among the challenges facing community residents.

The Downtown Eastside / Strathcona Alcohol and Drug Advisory Committee has been meeting for over a year to improve alcohol and other drug services available to the community. Residents, representatives of government and service agencies and other interested people are included on the committee.

Last year seven focus groups were formed to discuss existing alcohol and drug services and how they could be made to be more effective. The following groups were represented in the focus group process: First Nations residents, French speaking residents, Latin American men, men, people with a dual diagnosis, seniors, and single parents.

This pamphlet summarizes the main recommendations contained in a report on those discussions. Please read it carefully and contact the committee if you have any comments or suggestions.

c/o Downtown Eastside Community Health Plan
390 Main St.
Vancouver, BC
V6A 2T1

Phone: 682-3088 Fax: 775-2582

RECOMMENDATIONS

Recommendations are based on discussions held by participants in seven focus groups. Groups consulted were: First Nations residents, French speaking residents, Latin American men, men, people with a dual diagnosis, seniors, and single parents. Recommendations are not listed in order of priority.

ACCESS:

Services which support all community residents in their recovery from problems associated with alcohol and other drugs

1) *Improve access by all residents to detox and other alcohol and drug services.*
2) *Establish a community based clinic which offers 'round the clock street level alcohol and drug services.*
3) *The needs of women and single parents be taken into account in the design and delivery of alcohol and drug services.*
4) *The needs of seniors be taken into account in the design and delivery of alcohol and drug services.*
5) *The needs of people with a dual diagnosis be taken into account in the design and delivery of alcohol and drug services.*
6) *The needs of First Nations residents be taken into account in the design and delivery of alcohol and drug services.*
7) *The needs of people who do not have English as a first language be taken into account in the design and delivery of services.*

PREVENTION:

Programs which help residents understand the consequences of using alcohol and other drugs

8) *Improve prevention and information programs about alcohol and drug issues, programs and services.*
9) *Improve targeted programs for specific groups about alcohol and drug issues, programs and services.*
10) *Improve referral and follow-up information available to consumers of detox and other services about alcohol and drug issues, programs and services.*

COORDINATION:

Services which are coordinated with other support systems

11) *There be better coordination and communication between services which deal with alcohol and drug issues.*
12) *ADP work closely with the Ministry of Social Services to ensure that people who want access to alcohol and drug treatment are not prevented from doing so by financial barriers or ministry regulations.*
13) *Alcohol and drug information and support be coordinated with other services including housing and employment counselling.*

PARTICIPATION:

Consumers are able to participate in decision making about alcohol and drug services

14) *Ensure participation by all members of the community in all aspects of policy development and decision making.*
15) *Client feedback be included in agency evaluation methods.*
16) *Support be provided for community circles in order to discuss alcohol and drug issues, barriers and solutions.*

Full details of the focus group discussions and recommendations are available in a report entitled *Community Voices: Results of Seven Focus Group Discussions Concerning Alcohol and Drug Services in the Downtown Eastside and Strathcona.* See the back page of this pamphlet to learn where you can get more information about this report and how you can get involved in creating meaningful solutions.

APPENDIX VII

DOWNTOWN EASTSIDE COMMUNITY HEALTH PLAN

INTRAVENOUS DRUG USERS: FOCUS GROUP #8, NOVEMBER 02, 1994

Report by Melissa Eror

Agenda

To make sure everyone gets a chance to talk, it is normal for Focus Groups to use a "round robin" system. One person begins talking and at the end of what they have to say turns the conversation over to the next person, or if there are questions, this is when to ask them. So, keep notes.

Its important to ask questions as this is the only way to clarify ideas and compare them. Every opinion is valid and to be respected.

The four key issues the Strathcona Alcohol and Drug Advisory Committee used as a basis for the seven original focus groups were; access, prevention, co-ordination and participation.

1. Introductions between focus group members
   - Why we are here and what we hope to accomplish by adding to the original seven focus groups.

2. General Health Care
   - What is known about how health care works in BC and the changes taking place in health care reform?
   - How has the overall health care system worked for you, your friends and family? Health care in the sense of overall care, including housing & nutrition is meant here.
   - What service are used by you in the Downtown Eastside? Are they good on the whole? Changes?

3. I.V. Health Care
   - What services are used in the Downtown Eastside by I.V. users, because of their use only?
   - Is it easy to get the services you are looking for?
   - Are you happy with these services?
   - How have you been treated by health care givers when they know about your drug use?

4. Services Available
   - Do you know what services are available?
   - Vein and syringe maintenance is taught along with safe sex?

5. Some Users Fix in the Alleys, Yet. . .
   - is it unhealthy?
   - does it cause friction with other people in the area?
   - Why do people use the alleys and other unsafe places?
   - Can this be changed? Should it be changed?

6. What should be done to change things if anything and everything could be changed?
   - How can we start to make changes?
   - especially on how changes can be made?
   - Can anything be done?
   - is it too late?

7. what kind of support is needed?
   - How can we help users that don't want to quit, as well as those that do?

8. Can we trust the system
   - Do we want to trust the "system"?
   - Do we want to trust each other and are we able to?
   - Why do people overdose? What can be done?

9. What problems have you experienced being a user?
   - Is there anyway to help stop the discrimination and myths about users?

KEY QUESTIONS ARISING FROM AGENDA:

- What are our most basic, immediate needs?
- How can they be met and what can we do?
- What are some viable solutions?
- How can we make them come about?
- What should be recommended to the Ministry of Health?
- What are the most important point and solutions they should take a serious look at?

INTRODUCTION

In total, seven people took part in the I.V. focus groups. There were two separate I.V. focus groups, as it was not possible to get all participants together at one time.

The first group was made up of four men and one woman. The second group consisted of two men.

Besides the predominance of men in both focus groups there were other similarities. All were Caucasian, heterosexual and in the largest age group for I.V. users, 30-45. None were labeled dual or multi-diagnosis patients. Everyone used the Needle Exchange, clinics and other health services in the Downtown Eastside/Strathcona areas to a great extent.

Out of the second I.V. group, one man lived in the Downtown Eastside/Strathcona area and the other lived out of the area, but spent the majority of his time in the area. The first I.V. group was similar, three people lived in the Downtown Eastside, while 2 lived outside the boundary, but visited the area quite frequently.

Both groups were split down the middle, as far as their drug of choice went, as well. In the first group, three preferred heroin or similar drugs, while two preferred cocaine or similar stimulants. In the second group, one preferred heroin and the other cocaine. The second group, however, was much more inclined to interchange drugs, depending on the quality and quantity of what could be obtained at the time.

Both I.V. focus groups also believed that drugs should be decriminalized or legalized.

THE FIRST I.V. GROUP *

In general, the health of the group was good. Everybody was covered by basic medical insurance.

They felt that the medical and dental clinics were adequate in the Downtown Eastside/Strathcona area and that the staff usually did the best they could with what they had. Three people found little or no problem with St. Paul's Hospital Emergency and thought it was okay. The other two had experienced cruel and overt discrimination at St. Paul's.

The one woman related a story about an extremely painful P.I.D. (Pelvic Inflammatory Disease) infection (caused by a previous surgery)while living near St. Paul's. The doctor was on holiday and even though the person was too sick to work at all because of protracted, intermittent pain, the emergency ward refused to treat her, despite a pharmacist sending her there in an ambulance.

The person also had a great deal of trouble in St. Paul's Maternity, despite taking only drugs a physician prescribed after finding out about a pregnancy. The baby was ill because of the P.I.D. infection that had never really disappeared. Yet, St. Paul's decided the baby was drug addicted. The only evidence was an enlarged liver. The fact the baby was compromised by the infection while still in the womb was not considered.

The other person who had experienced problems in the emergency with severe stomach pains. Not only did they leave him abandoned in a hallway for hours, no tests or medications were administered to him at all. The person ended up leaving the hospital in order to stop the pain.

Everyone had heard stories about I.V. users and incidence of discrimination. Most preferred certain clinics over others because of the attitudes of the staff. Main Street and Native Health on Hastings Street were two of the clinics mentioned frequently.

* One of the participants came late and made up the missing time at a later date.

When asked why they thought that discrimination occurred, there were several answers;

a) some health care workers don't know much about or understand I.V. users and their specific problems

b) some discrimination happens because of how the user looks and acts in the health care facilities

c) the type of medication needed could be a factor, some doctors don't like to prescribe narcotics at all because of the system of triplicates

d) some doctors believe they are being conned all the time and even when pain killers are obviously needed, and they are still afraid to prescribe to "at risk patients".

Everyone agreed discrimination happened in all levels of society and that health care workers were not immune to seeing users as a problem to be solved, not individuals deserving of the same respect as any other person.

The least liked of all the services were the detoxes. Most had been through detox at least once. No one thought the present system worked well. Cold turkey was thought to be cruel and inhumane; an actual deterrent from going into detox.

There were complaints of overly restrictive rules and staff that liked to "play head games". Individuality was suppressed as the philosophy and inviolate routine of detox turned people into commodities to be processed.

Despite these problems people also complained that when they wanted to go to detox they were always full. It was admitted that the busiest time for detoxes was between cheques as most people were on welfare. When asked why they couldn't wait, the general consensus was that when a detox was needed, it was needed then, not later. Most people felt the need for harm reduction was more important then the rules set up for how many times a person can enter a detox per year, not the lack of bed space when detoxes are full during certain times of the month.

No one really knew about the changes going on in BC's Health Care system and didn't seem much interested in what changes occurred as they felt that there was nothing they could do about them anyway. The feeling was that no one was going to listen to a "junkie" on any subject.

They did know about the major health series, especially the user specific services, although some of the smaller and less advertised services, i.e. vein maintenance, were not known about by the group.

There was little concern about overall nutrition, except by two users, one of whom had children. The person with the children was understandably the most concerned, but this was a distant third compared to housing and jobs.

Perhaps because this group was in the prime of life, as far as age and health went, they were all focused on jobs and homes.

Most felt sure if they just had a bit of a hand up in life (everyone's hand up was slightly different), they too, would be holding down jobs and living in decent housing.

Some talked about training or work, others talked more about a home base as being more important. No one held out a lot of hope as discrimination and the ability to fit in were added to the problem of getting a job or subsidized housing in a market where both jobs and homes are at a premium. But hope they did. The question on everyone's mind was why drug use should automatically make a person less eligible for a decent life, if they are found out, even people on the legal methadone program.

One "hand up" several people were curious about was methadone, as this is the only program that was not drug free. It was pointed out that the restrictions of the methadone program were severe: supervised urinalysis, a maximum of four days only can be picked up at one time (even holiday trips have to be restricted to weekends) and the first day's dosage is to be drunk at the pharmacy. 80 mg. is the maximum daily recommended dosage. If, for some reason. the patient is on more than 80 mg. they have to pick up the prescription more often. Usually any other psycho-active substance detected in the urine can be grounds to cut the person off the program. No matter the problem, it is very difficult to get any type of pain or anxiety medication from doctors. Approximately 70% of methadone patients are forced to go daily.

It was pointed out these rules were not law, but guidelines and that every doctor interpreted them slightly differently. But the backlash of contravening the guidelines could cost a doctor his license, as it already had for some. Few doctors dare to dispense as they see fit, if they do not agree with the guidelines. It was also pointed out that the majority of new patients end up at one of the two clinics in the Lower Mainland. These require an initial fee and a monthly bill of $60. - 65. It was also pointed out that with the restrictions it is nearly impossible to train for job and hardly less difficult getting and keeping one as the doctor and pharmacy visits can take up a lot of time, plus, there is till discrimination because other treatment program uses a drug.

At this point, the facilitator asked why fixing in the alleys was so common. Two claimed they did not fix in the alley. The other three did, but all gave reasons as to why this was done. The main reason was that there was little choice. There simply weren't many places to fix. Compared to the alternatives, it was also a safer place to fix, as it was almost impossible to have a "narc" jump you.

The question of hygiene was raised. How could anyone fix in such a bacteria and germ laden area. The answer came back that it was not as unhygienic as it seemed, as new rigs and fresh water from the Needle Exchange were readily available. There was some disagreement since the drugs were poured right into the works without the benefit of filtering through cotton, even when the filter was chalk or an equally unhealthy cut. Some believed filtering was even more unhealthy, as the cotton was not sterile and could produces "cotton chills" an unpleasant side effect that occurs when a strand of the filter or dirt is injected along with the drug. This can produce intense cold and pain for hours. Some felt that the chills happened as much or more without a filter and people were much more susceptible to infections without filtering. Here the group basically agreed to disagree, although it was admitted that neither system was perfect.

It was also point out, with bitterness, that some of the people were fixing in their homes, as many users had trouble finding a place to live in, except for the alleys and streets, thus making hygiene a real problem since washing oneself and ones' clothes was a real difficulty. No one had much sympathy for those that were offended by the practice of fixing outside. Complaints were perceived to come from people that had a better life situation, than they did and were not interested in the real problems. Only

the "unsightly look" of people fixing in the alleys. The first focus group felt that if other people didn't like it, they didn't have to look. However people that fixed near family housing were thought to be part of the problem as they were thought to be irresponsible fixing around children. There are many other alleys to use where run-ins with families would not happen.

Overdosing was the last topic of discussion with this group. The loss of community and the loss of knowledge that was once part of the I.V. community about how to threat overdoses were blamed as much for the rise in overdoses as the rise in quality and potency of the drugs. Users no longer looked out for each other as they once did. Everyone in the group felt they had a few friends they could depend on, but no longer was there a code of ethics for the I.V. community. Much of the blame was placed on the police and government polices for the fractures in a once solid community. Users no longer trusted other users to the same degree and most of the users did not know what to do in case of an overdose since there were few people left to teach them what to do in case of emergency.

Since there were few ways, especially for men to make money, the incidence of being ripped off has risen sharply, making users even less trustful of each other. As well, the user population has risen and where users once know almost all the other users, now there are too many to remember or even meet, making rip-offs even more tempting for some.

So mistrust of mainstream society is coupled with mistrust between I.V. users. This causes a great deal of stress on the street making abandonment of overdose victims and violence much more common than a few decades ago and the situation continues to worsen.

Having said this though, the first focus group would like to be able to revive the I.V. community and have it return to the more cohesive, helpful group it once was. It was thought that this however was not possible given the present situation and that new ideas were needed to help I.V. users.

When asked what could be done to improve the situation, there wasn't much hope that improvements could be made, as the situation stands right now.

The focus group talked about what other countries had done (even ones that had also signed the international UN Papers on Drug Use (the same international Agreements Canada hides behind to some extent) but it was realized that in more liberal countries the government itself supported reduction/cost-reduction measures. Liberalized drug laws were not the only thing the other countries have done for their addict population. Social housing, job clubs and training are also supported through self-help clinics and user groups, that are funded by the government. Newsletters like Amsterdam's Mainline are used as organs of communication with and among users. The addict populations perhaps more importantly are consulted as experts on the subject of drug use and users. They actually have a say in social policy and the running of their own lives.

This way of thinking seemed a long way off in Canada and the suggestion of a Red Light District by one of the group was quickly dismissed as an idea whose time had not yet come.

A Drop-in for users was then proposed where and I.V. user could come in, sleep, have a shower, access help from advocates and nurses, talk to friends over coffee and access a sterile place to fix and even get help and impromptu training on how to inject properly and as safely as possible. This idea was thought to be unworkable by the majority after quite a long debate. Most felt that it was a situations that could get out of control.

The next idea looked at was a variation on detoxes, where one side would be a place to wash, sleep and get information on drug related subjects. This would be one of the few places someone "high" would be able to rest and get a place to sleep. The second part of the suggestion was to have a detox on the other side for people who wanted to access the service.

The second part of the suggestion met with some resistance. It was felt that this connection might scare "hard core" users away; the very people this place would be aimed at helping.

It was agreed, in general, that at least a place for users to sleep, shower and obtain information was needed as the homeless grow daily in number and for users there is little or no refuge off the street. This was felt to be the minimal harm reduction strategy needed right now.

More would like to have been suggested but until more liberal laws are a reality in Canada, it was felt there wasn't much else that could be done. Perhaps stable users could be trained as lay counsellors, but that was as far as anyone was willing to go.

THE FIRST I.V. GROUP-CONCLUSION

It was agreed that drugs should be legalized with little or no strings attached, but there was disagreement on how this should be done. Some want "hard" drugs restricted by doctors and cocaine was a questionable drug to some. Others in the group were willing to have drugs sold like either alcohol or even tobacco.

It was also agreed that housing and jobs were needed, not unlike other low income groups in the area. However, the focus group also realized that lifestyle skills and a general boost in self-esteem needed to be addressed first. Even a small thing like being taught a bit of CPR in impromptu sessions might be a start.

Motivation in such a hostile environment as drug users find themselves in, can also be a problem. "Why try when you won't get anywhere anyway?" Support is needed no matter whether a person is using, not using or trying to quit. There should be equal opportunity for all but that is not possible with the current situation.

Users may need help and a temporary place to rest and get cleaned up but it is also up to the users to show as much responsibility and independence as possible. The Needle Exchange tries to get users to be responsible for returning their syringes and it has worked to a large extent, as they get back more syringes than they give.

It should be just as important to listen to drug users as anyone else, if not more, when deciding on laws that affect drug users.

THE SECOND I.V. GROUP

The second focus group was made up of two men, both in their mid to late 30's. One preferred cocaine, the other heroin.

The person who preferred cocaine was a "binger" and so didn't use everyday, but used and parties until the drugs and money ran out. This could last for days or weeks. Even though he lived well out of the downtown core, the majority of his drug use was in the Downtown Eastside.

The second person preferred heroin overall and used daily. This person was always on the hustle to make money. He lived in the various hotels dotting the Downtown Eastside with their presence.

Both men know each other quite well and I know both of them. Originally they considered it quite the joke and tried to give the most outrageous answers possible. If we had not talked about out mutual mistrust of society in general, this focus group might have been dissolved early on. Fortunately this did not happen and interesting contrasts and similarities between the two focus groups surfaced.

Neither person had much of an idea on how the Health Care system worked and seemed to be even less interested in the changes taking place there. They did not feel these changes would do anything for them and that no matter what system was in place, they refused to believe that drug users, like themselves, would ever have any kind of a voice, even about their own needs.

Having said this though, they were both glad for the basic medical and dental care provided by the province and actually seemed grateful these services existed for everyone in need. However, on asking more specific questions, the two claimed to use the Needle Exchange and the Main Street Clinic (upstairs from the Needle Exchange) almost exclusively as they felt to be the least discriminatory and most understanding of all health services in the area. Both felt St. Paul's Emergency was "okay", although only minor injuries had ever needed attention by either party. Detoxes, on the other hand, were even less liked by this focus group then the first focus group.

Both individuals refused to go to detox, looking at it almost like a jail. Neither person could understand the need for anyone to kick their habit at a detox, when people are still free to do so at home. The only reason to go to detox was when a person had no where else to go and no means to support themselves. In this way they saw detox almost like a hostel of last resort with detoxification as payment for a place to stay. Little wonder they didn't like the detox system and avoided it at almost all coats. It should be added here that at no time have I ever heard either person voice a desire to quit drugs. A large part of their frustration and anger seemed to stem from the idea that everything was geared towards getting people off drugs when they didn't want to quit at all. In fact they both have claimed at various times that if this type of pressure and expectation wasn't there they very likely would not use as much.

They also know about what could be termed preventive services, like food banks and the various Drop-ins, but wanted little to do with what they perceived to be government institutions. Most of the services do not accept known users anyway, certainly if anyone is perceived to be "high", even if they are not, they are refused entry almost everywhere except for a few clinics and of course the detoxes.

Even though their knowledge of the various places and services was quite broad, they did not know about the less well known services, such as vein maintenance, taught by some clinics. On hearing about this particular service, both people exclaimed that they wished the service had been around when they started using.

They did not like being on welfare but again the illegality of drugs and all the problems associated with that were blamed for the situation. The argument was challenged at this point; that they weren't looking realistically at the picture and perhaps training even might be lacking.

One person admitted that they were not trained for anything specific, but the other person was not only mechanic, but had his welding ticket as well. Why didn't he try to work them was the query? He laughed and explained that besides having a difficult time because of his use, he also had a criminal record and that jobs in both fields were hard to come by. Having gotten out of jail only a few months

back, he explained, neither was he yet ready to re-enter the work force and pay taxes that help put him and other users behind bars.

At this point both went so far as to argue against legalizing drugs when asked what they thought about the drug laws. They meant to keep them illegal so the government wouldn't even be able to collect taxes on them let alone regulate them in any way. When it was pointed out that keeping drugs illegal only helped the government to hire more police, build more jails and keep us trapped as a client base for the judicial and medical systems, they both laughed at these rather obvious observations and explained that they had been only semi-serious when going on about keeping drugs illegal. They were more in favour of decriminalization. To them this was the least of all evils. Decriminalization, they felt, would take all the drug laws out of the books and the government would only collect taxes as legal free enterprise would import and distribute drugs, much like tobacco is imported and sold now.

Legalization, on the other hand, kept drugs regulated by the government as laws would not disappear from the books but only be amended. They both felt that any regulation was too much regulations.

When asked why the person who liked heroin had never gone on the methadone program, as it was at least legal and quality control ensured, the same answer about legalized drugs was echoed. The government had too much control and the patient had none. The fact that the program had become even more restrictive over the last few years had not escaped his notice either.

They realized that there were many diseases and infections that users are prone to even deadly one, like AIDS, but even that did not seem to matter to them as much as they way they were treated by the rest of society. Both were old enough to remember the "community of addicts" that helped each other out and its slow demise at the hands of the "establishment" over the years. Obviously these two were not willing to go too far in trusting a world they felt had gone far to destroy them and others in the same situation they certainly didn't care that "straights" were upset about users fixing in alleys. For them it was quick and convenient and being able to obtain clean water and syringes was the only positive thing done for them, in their eyes. Both claimed to pick up their syringes and paraphernalia and not leave a mess. They also claimed not to use around family housing. This is probably true. Most people who fix in alleys don't want trouble and so are smart enough to stay away form these areas, but as they themselves pointed out, "there's always jerks who toss their works or fix in stupid places".

Did they trust society? Laughter from both exploded. "Wasn't the answer obvious after all that was said?" Yes, it was, I had to admit but was there not even a glimmer of trust? "NO, there wasn't." What about other users then? Could the "community" ever be reformed? They felt things had gone too far. Not only were communication lines cut and the population much larger, but users did not even trust each other any more. The situation on the street was described as being so bad now that users were ripping each other off just to survive on the street. There are friendships, but only limited ones, as well as relationships but because of the economics of the street nothing is permanent.

Was there no hope for the future then? They didn't think there was and in fact had even less hope that the first focus group. Overdoses were seen by the second focus group as a good example of the hopelessness felt on the street especially by the older users.

SECOND I.V. GROUP-CONCLUSION

Both felt the most immediate needs were housing, jobs and an atmosphere of tolerance where users were afforded the same benefits as users who try to quit. Drug use itself should not lead to discrimination.

How could this come about? Drugs had to be decriminalized to lay the ground work for acceptance, but this was not likely to happen soon. They also mentioned a red light/free zone district like some countries in Europe had. They realized that this would also take time and they also proposed some type of drop-in where they could fix and stay around without worrying about being tossed out. Parks where even suggested as possible "free zones". However for the second group, even this type of set up was looked on with a jaundiced eye as the government would still be in control.

In the end only three recommendations were proposed

a) legalize drugs without strings attached

b) to help people without a home to stabilize their lives a bit with a place or drop-in they can go to where they can stay in between places and feel safe and accepted. Drug use tolerated - some type of free zone

c) give addicts a feeling of self worth, they were unclear on how this should be done but felt that addicts should be free to make their own decisions. Some only need a job, others may need other types of help to boost morale. Some want to be left alone - everyone is different and requires different types of help or support, as the laws now stand.

CONCLUSION

There is little doubt that the first I.V. focus group was less radical in it's outlook than the second I.V. focus group.

While the second group harboured a certain bitterness and anger against the rest of society for its drug laws, the first focus group looked for ways to compromise and communicate with the rest of society. Both groups wanted acceptance though. The major difference seemed to rest on hope. The first focus group still believed it was possible to "get through" to society and change the situation. The second focus group seemed to have lost its hope and didn't feel they would ever see positive changes or acceptance in their lifetime. Part, or perhaps, most of the division between the two focus groups on this subject may have come from the fact that although there were only two people in the second focus group, the added jail time far outweighed the added jail time in the first focus group, that had five people in it.

Despite the sharp differences in the two groups, there were significant similarities.

1) Both groups believed in the need for radical changes in the drug laws.

2) Even drug users are individuals and should be treated as such.

3) As individuals many types of programs should be available to suit the needs of different people.

4) Everyone in both focus groups chose clinics and other health facilities on how they were treated and to some extent on how other users had been treated there, not on how close the facility was to them.

5) There were self-esteem and morale problems in both groups. Both groups recognized the problem in the I.V. population generally.

6) There is a great deal of stress in the I.V. population which actually leads, in the end, to more drug use. "If only they would leave me alone I probably wouldn't use nearly so much," was a comment made by people in both focus groups.

7) Cocaine users were more inclined to talk about quitting than the people who preferred heroin.

8) Everyone in both groups wanted to take control of their own lives without uninvited intervention.

9) Both groups want addict representation, at the very least, on medical or judicial boards dealing with drugs use.

Appendix VIII
Summary for Community Health Planning Steps
from Proposed Framework for CHCPG's and CHC's in the Vancouver Region. January 1995

New Directions Principals	Community Planning (Process)	Health Plan 'Table of Contents'(Product)
• CHCPG's/CHC's Act as a Vehicle for the Development of the Health Plan in Addition to Health Services • Commitment to Identifying Capacities and Assets of the Community • Ensure Planning Process and Health Plan to be Developed Through Consensus • Health Plan Must Be Validated • Planning Process and Health Plan Document Must be Evaluated Within Vancouver Health Region • The Planning Process Is Done in Association with the Vancouver Region as well as Neighbourhood Groups	**Phase I** • Form a Planning Group • Evaluation **Phase II** • A Community Development Process -Identify the Community -Gather Information -Contact the Community -Identify Capacities and assets • Evaluation **Phase III** • Assessment • Evaluation **Phase IV** • Draft Vision, Goals, and Priorities (Linked with Regional Health Plan) • Ensure Community Supports Vision, Goals, Priorities • Document Community Health Plan Through "Table of Contents" • Set Plan into Action - Transition to CHC • Evaluation	• Background of Community • Community Profile • Define What the Community Health Plan Should Include • Beliefs About Health • Health Goals • Health Priorities • Action Plans for each Priority • Links with Regional Health Board

APPENDIX IX

DOWNTOWN EASTSIDE COMMUNITY HEALTH PLAN

SERVICE PROVIDER LISTENING SURVEY: ST. PAUL'S HOSPITAL

By Brenda Kwan

Notes:

- Words that may need defining are highlighted, with the definition provided at the end of each subheading.
- The appendices, for both report and addendum to report, have not been included. They are available through the Downtown Eastside Community Health Plan Office for those interested.
- The report was completed Nov. 23, 1994, the addendum was completed Jan. 18, 1995.

INTRODUCTION

This report is based on information gathered from 2 meetings (November 9 and 18, 1994) with Stella Tsang, Director of Community and Outpatient Services at St. Paul's Hospital (SPH, as abbreviated from here on). The meetings were part of the Community Health Plan listening survey of service providers of the Downtown Eastside (DES).

GENERAL OVERVIEW

SPH offers a variety of programs with **inpatient** and **outpatient** services (for a complete list of SPH programs draft list, see Appendix A); however, there are 6 key areas of medical specialization: heart, lungs, and critical care; digestive and nutritional disorders, kidney care; HIV/AIDS care; care for the elderly; and community health care (Keeping the Promise: St. Paul's Hospital 1884-1994).

inpatients: people with serious illnesses who require medical attention either on a continuous basis or with complex equipment or procedures, in hospitals (Sarafino, 1990). At SPH, this does not include emergency or outpatients.

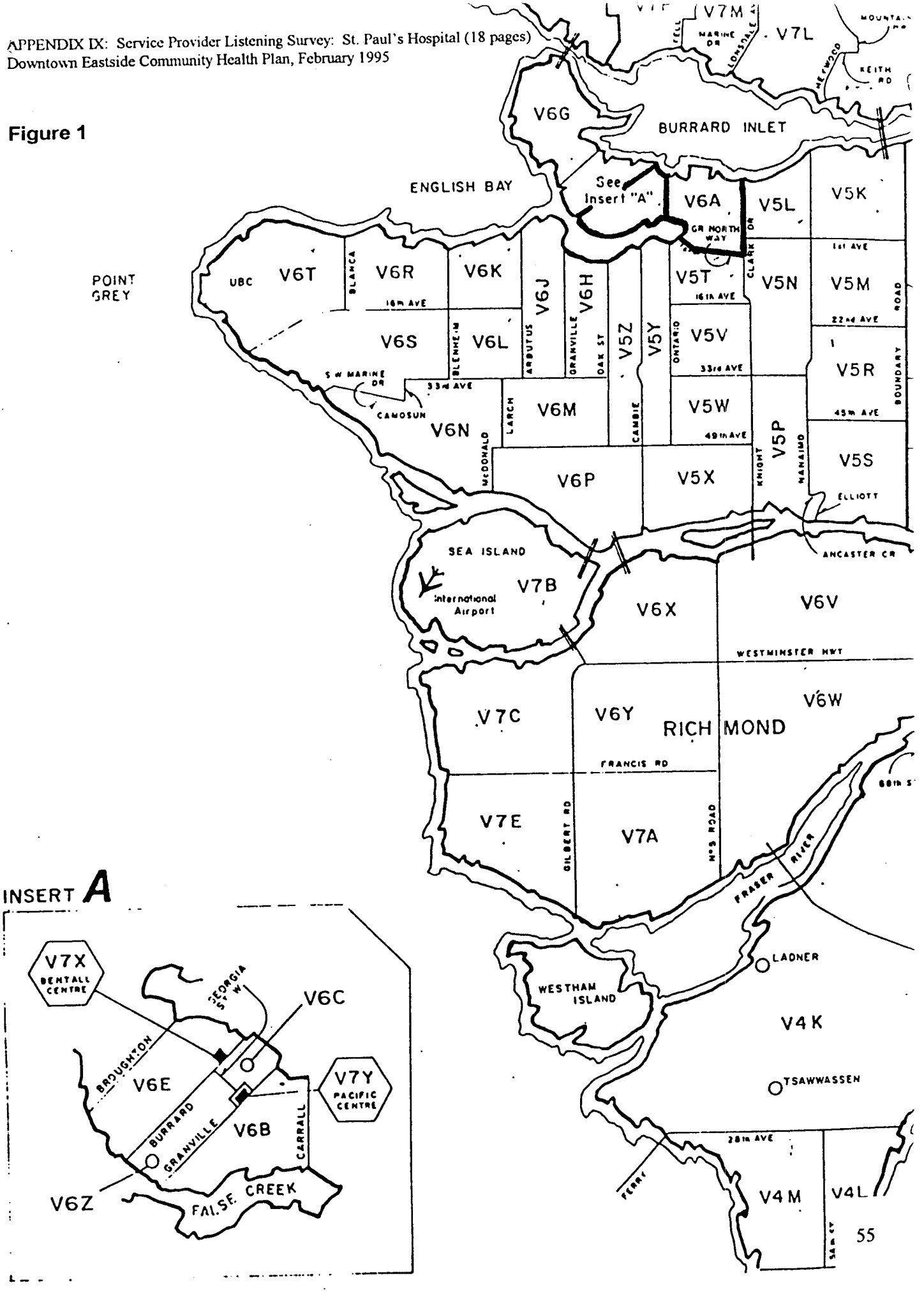
outpatients: people usually receiving clinical procedures and discharged within 24 hours.

STATISTICAL INFORMATION

Although SPH is located within downtown, it serves people outside the downtown area as well. To determine where patients come from, data are grouped by postal code; therefore the DES will not have its own distinct area among SPH data. Instead, the DES falls into 2 postal code areas, V6A and V6B (Figure 1). The boundaries for V6A are from Burrard Inlet along Clark Drive to Gr. North Way, along Gr. North Way to False Creek, and from False Creek along Carrall Street back to Burrard Inlet. The boundaries for V6B are from Burrard Inlet along Carrall Street to False Creek, and from False Creek along Granville Street back up to Burrard Inlet.

The data provided pertain mostly to SPH only; caution must be exercised when making conclusions. For example, if a high percentage or number is seen in the SPH data, this does not indicate that data from other hospitals would be lower in comparison. Unless we have data from other hospitals, we can not make such conclusions. As well, data pertain to particular years only; thus, trends can not be observed.

Figure 1



INSERT **A**

Where do SPH inpatients come from?

Data base

The data are based on 1992/93 (April 1, 1992 to March 31, 1993) SPH **Acute** Inpatient data.

acute: not long term care

Results

Table 1 and Figure 2 provide a breakdown of where SPH inpatients come from, including Vancouver, Greater Vancouver Regional District (GVRD) excluding Vancouver, BC excluding GVRD, and other (BC unspecified and non-residents). For each area, the number and percentage of **cases** and days are provided.

Of the 19,887 cases, a large proportion were from the Vancouver and GVRD areas as expected, with the largest proportion (5321 cases; 26.8%) from the West End, Central Business District, Strathcona, and Grandview-Woodlands combined.

We can also calculate the average length of stay by the equation: (# days)/(# cases)=(length of stay); this can be done for each area as well as for the total. It seems that the area of Vancouver with the largest proportion of cases (West End, ...) is also associated with a longer average length of stay of 9.2 days as compared to the total overall average of 7.9 days.

cases: number of hospitalizations counted as discharges, not number of patients (people can be hospitalized more than once in a year).

Table 1

St. Paul's Hospital
COMMUNITY AND OUTPATIENT SERVICES

Where do St. Paul's inpatients come from?

Area	Cases		Days		Averagg Length Of Stay
Vancouver					
• West End, Central Business District, Strathcona, Grandview-Woodlands	5,321	(26.8%)	49,054	(31.2%)	9.2
• Other Vancouver	5,289	(26.6%)	38,196	(24.3%)	7.2
GVRD excluding Vancouver	4,989	(25.1%)	33,568	(21.4%)	6.7
B.C. excluding GVRD	3,420	(17.2%)	30,697	(19.5%)	9.0
Other — B.C. unspecified & non-residents	868	(4.4%)	5,633	(3.6%)	6.5
Total	**19,887**	**(100.0%)**	**157,148**	**(100.0%)**	7.9

Source: 1992/93 St. Paul's Hospital Acute Inpatient Data

St. Paul's Hospital

COMMUNITY AND OUTPATIENT SERVICES

Where do St. Paul's inpatients come from?

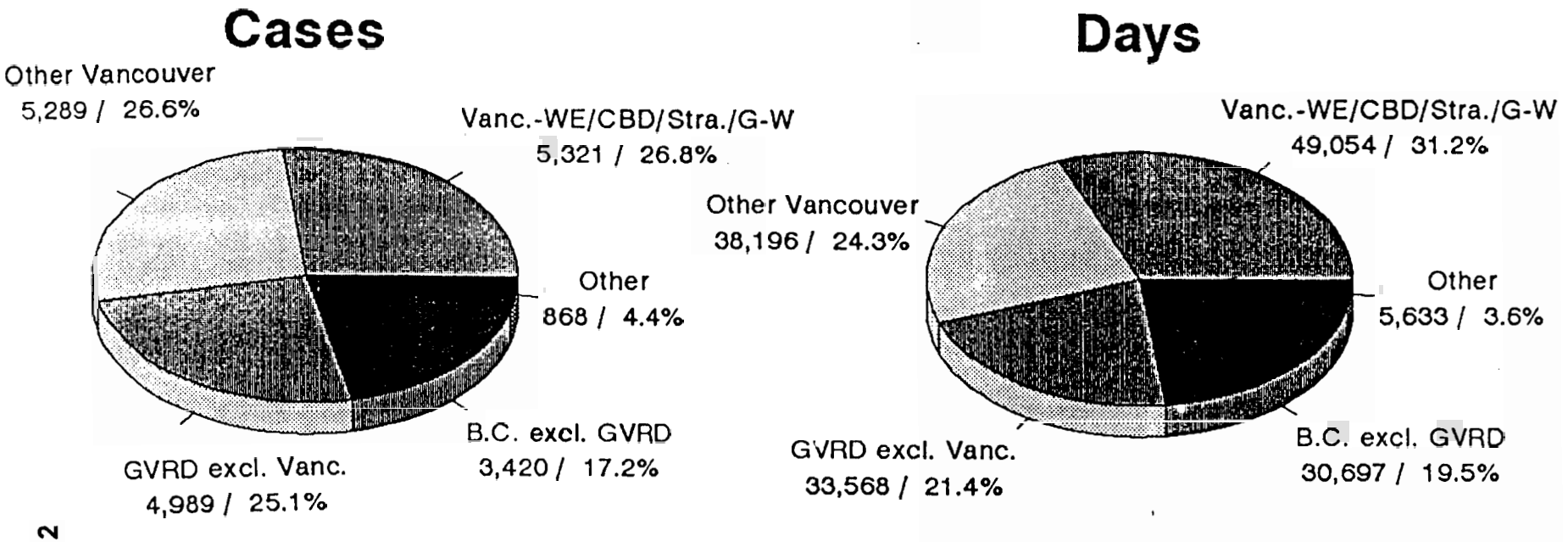


Figure 2

Source: 1992/93 St. Paul's Hospital Acute Inpatient Data

What hospitals do residents from V6A and V6B go to?

Data base

The source of information is 1992/93 Acute Inpatient Data (excluding newborns) for residents of V6A and V6B. The cases are for acute hospitalization, which includes hospitalization for **primary, secondary, tertiary,** and **quaternary care**. As well, data are from before the closing of University Hospital-Shaughnessy Site; thus, these cases have been separated out of the Vancouver Hospital & Health Sciences Centre (VHHSC), which includes Vancouver General Hospital (VGH) and University Hospital-UBC Site.

primary, secondary, tertiary, and **quaternary care**:

these refer to the different levels of care available; in the order shown, care becomes more specialized, i.e. quaternary care is the most specialized. As an example, primary care would be a general practitioner (GP). The GP may make a referral to a specialist for secondary care. This specialist could make a further referral, for example open heart surgery (tertiary care. If a further referral occurs, this would be quaternary care, for example a heart transplant.

Results

Table 2 and Figure 3 show the breakdown of the various hospitals that residents from V6A and V6B go to for acute hospitalization. As expected, since SPH is the closest hospital to the V6A and V6B regions, the largest proportion of cases (1,337 out of a total of 3,256; 41.1%) went to SPH. The second largest proportion went to VGH (931 cases; 28.6%).

Table 2

St. Paul's Hospital
COMMUNITY AND OUTPATIENT SERVICES

Acute hospitalization* of residents from V6A & V6B. What hospitals do they go to?

Hospital	Cases	
St. Paul's Hospital	1,337	(41.1%)
Vancouver Hospital & Health Sciences Centre		
• Vancouver General Hospital	931	(28.6%)
• University Hospital-UBC Site	115	(3.5%)
University Hospital-Shaughnessy Site	139	(4.3%)
St. Vincent's Health Care Society	55	(1.7%)
Mount St. Joseph Hospital	267	(8.2%)
B.C. Women's Hospital (Grace)	107	(3.3%)
B.C. Children's Hospital	36	(1.1%)
B.C. Cancer Agency	9	(0.3%)
Others (primarily outside of Vancouver)**	260	(8.0%)
Total	**3,256**	**(100.0%)**

* Includes hospitalization for primary, secondary, tertiary and quaternary care.
** Most frequent admissions among this group include Royal Columbia, Burnaby General, Richmond General and Lion's Gate Hospitals.

Source: 1992/93 Acute Inpatient Data (Excludes Newborn)

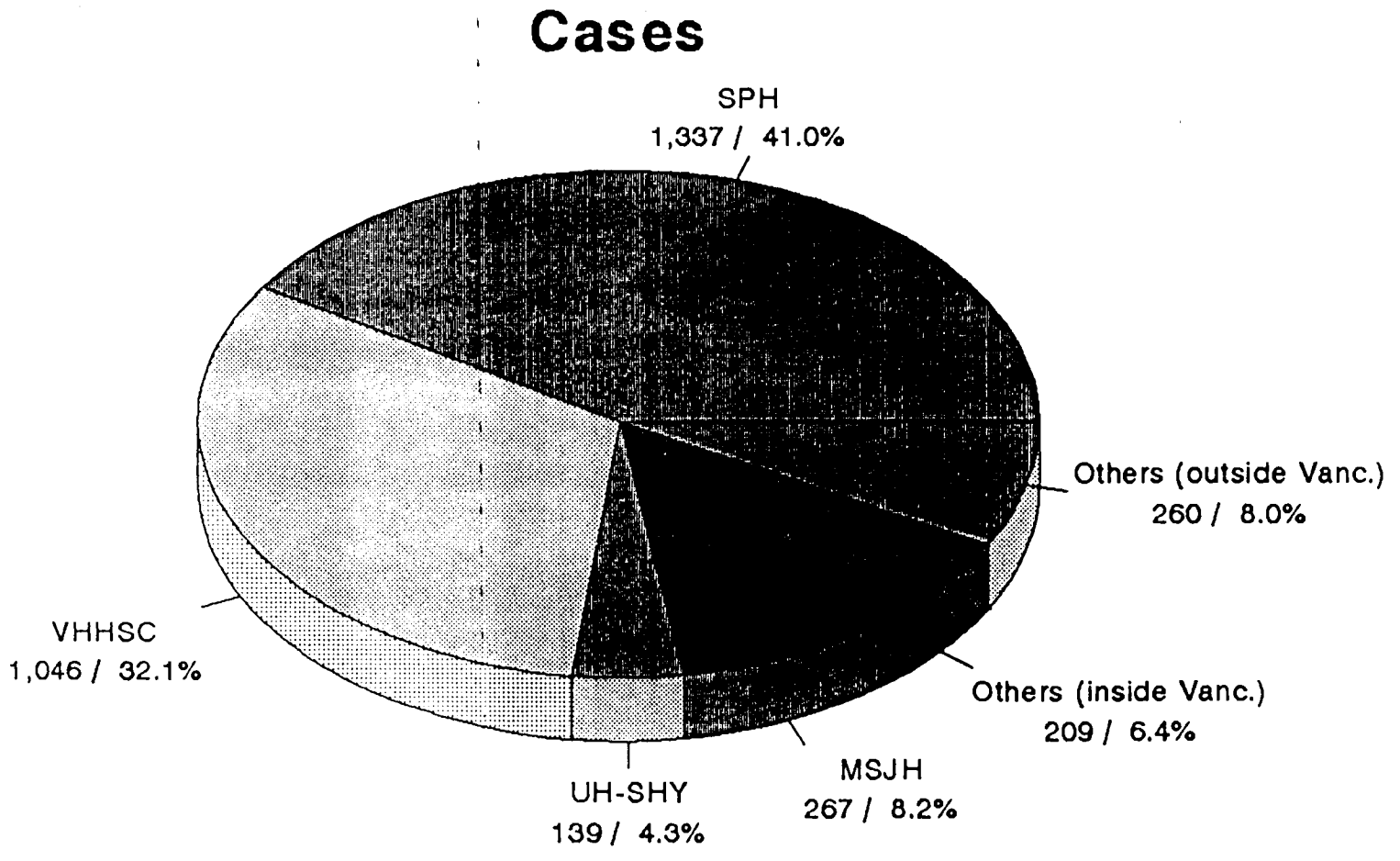
St. Paul's Hospital

COMMUNITY AND OUTPATIENT SERVICES

Acute hospitalization of residents from V6A & V6B. What hospitals do they go?*

APPENDIX IX: Service Provider Listening Survey: St. Paul's Hospital (18 pages)
Downtown Eastside Community Health Plan, February 1995

Figure 3



Includes hospitalization for primary, secondary, tertiary & quaternary care.

Source: 1992/93 Acute Inpatient Data (Excludes Newborn)

What are the estimates of V6A and V6B residents' hospitalization by selected doctor service as percentage of admissions to SPH and VHHSC? (selected doctor service is reflective of the most common primary and secondary services)

Data base

The source is 1992/93 Acute Inpatient Data. Data are for residents of V6A and V6B.

Results

Doctor service (Table 3 and Figure 4) is divided into 6 components: family practice; **internal medicine**; general surgery; **orthopedic** surgery; obstetric and gynecology; and psychiatry. Hospitalization is categorized into SPH, VHHSC, and other.

A large proportion of V6A and V6B residents go to SPH, instead of other hospitals, for the following doctor services: orthopedic surgery (69% of V6A and V6B residents); internal medicine (64%); and general surgery (47%). For psychiatry service, 56% (majority) of the residents went to VHHSC, while 34% went to SPH. Also, for obstetric and gynecology service, 57% (majority) went to other hospitals and 34% went to SPH.

Overall, 41% of all admissions were to SPH, 32% to VHHSC, and 27% to other hospitals. It seems logical that overall, a larger proportion of the V6A and V6B residents went to SPH, the closest hospital. However, by breakdown of doctor services, we see that SPH does not always take the largest proportion of admissions. This is probably due to the fact that different hospitals offer facilities that are different (size, etc.).

internal medicine:

> the branch of medicine that deals with the diagnosis and treatment of diseases of adults, except for those conditions that require management by a surgeon or an obstetrician; an internist is specially trained to deal with chronic illnesses (for example, diabetes and high blood pressure) and acute illnesses (for example, infections). (The New Illustrated Family Medical & Health Guide, 1990)

orthopedics:

> the branch of surgery concerned with the diagnosis and treatment of disorders of the bones and joints; for example, broken bones, bone tumours, etc. (The New Illustrated Family Medical & Health Guide, 1990)

Table 3

St. Paul's Hospital
COMMUNITY AND OUTPATIENT SERVICES

Estimates of V6A & V6B residents' hospitalization by selected doctor service* as percentage of admissions to St. Paul's Hospital and Vancouver Hospital & Health Sciences Centre

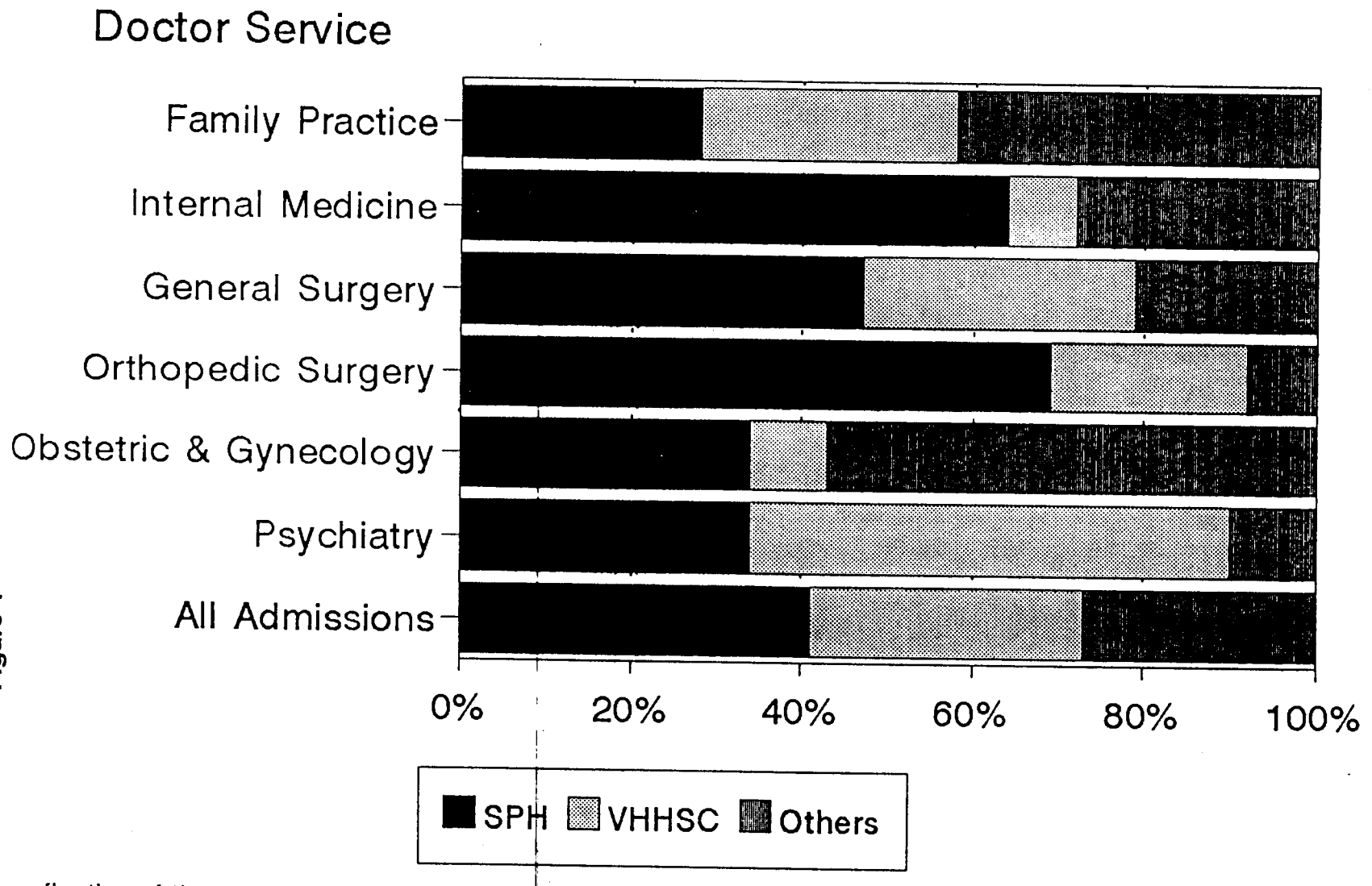
Doctor Service	SPH	VHHSC (VGH+UH-UBC)	OTHER
Family Practice	28%	30%	42%
Internal Medicine	64%	8%	28%
General Surgery	47%	32%	21%
Orthopedic Surgery	69%	23%	8%
Obstetric & Gynecology	34%	9%	57%
Psychiatry	34%	56%	10%
All Admissions	41%	32%	27%

* These are reflective of the most common primary and secondary services.

Source: **1992/93 Acute Inpatient Data**

Estimates of V6A & V6B residents' hospitalization by selected doctor service* as percentage of admissions to SPH & VHHSC

Figure 4



*. These are reflective of the most common primary & secondary services.

Source: 1992/93 Acute Inpatient Data

How many emergency visits to SPH are there from residents from V6A and V6B? What other information is gathered on these emergency visits?

Data base

The source is SPH Emergency Data October 1, 1990 to September 30, 1991. Data are for residents of V6A and V6B.

Results

Table 4 shows a breakdown of the emergency visits data.

The total number of visits, including re-visits, was 7,755. (Remember visits are not the same as patients. Not all visits result in inpatient admissions.)

28% of the visits were reported not to have insurance.

Re-visits can also be termed visit recidivism. With the 7,755 visits, there were only a total of 3,866 patients seen; thus some patients visited the hospital more than once. 443 patients (11%) had more than 3 emergency visits during the year. The range of the number of visits were from once to 35 times.

Of the 7,755 visits, there was a total of 972 admissions through Emergency. However, only 793 patients were admitted through Emergency; thus, there was admissions recidivism as well. 31 patients (4%) were admitted through Emergency more than twice. The range of admissions was once to 6 times.

What are the ages of the V6A and V6B residents who visit SPH?

Data base

The Source is SPH Community & Outpatient Services, Acute Inpatient Information for the calendar year, 1993. The Data are for residents of V6A and V6B.

Results

Table 5 shows the breakdown of admission for acute inpatients according to age categories.

Table 4

St. Paul's Hospital
COMMUNITY AND OUTPATIENT SERVICES

St. Paul's Hospital Emergency visits by residents from V6A & V6B

Activities:	
• # of visits	7,755
• % visits reported not to have insurance	28%
• % male	77%
• % over age 55	18%
• total admissions through Emergency	972
Emergency Visit Recidivism:	
• # of patients seen	3,866
• range of visits over 12 months	1—35
• # of patients who had more than 3 emergency visits during the 12 months	443
• % of patients who had more than 3 emergency visits during the 12 months	11%
Admissions Through Emergency Recidivism:	
• # of patients admitted through Emergency	793
• range of admissions over 12 months	1—6
• # of patients who had more than 2 emergency admissions during the 12 months	31
• % of patients who had more than 2 emergency admissions during the 12 months	4%

Source: St. Paul's Hospital Emergency Data Oct 1, 1990 - Sept 30, 1991

St. Paul's Hospital

COMMUNITY & OUTPATIENT SERVICES

Acute Inpatient Information for Residents of V6A & V6B

(Calendar Year 1993 Discharges)

Patient age	# of patients	# of discharges	# of patient days	Discharges without medical plan coverage		Readmissions with same or related diagnosis within 1 week		Readmissions with same or related diagnosis within 1 month	
				#	%	#	% of discharge	#	% of discharge
0 - 14	49	49	243	10	20.41	—	—	—	—
15 - 44	547	662	4,476	135	20.39	29	4.38	31	4.68
45 - 54	172	207	1,740	17	8.21	1	0.48	7	3.38
55 - 64	184	242	2,503	14	5.79	10	4.13	10	4.13
> 65	326	436	6,100	22	5.05	10	2.29	24	5.50
Total	**1,278**	**1,596**	**15,062**	**198**	**12.41**	**50**	**3.13**	**72**	**4.51**

Table 5

Other statistical information that has not been answered at this point in time, but that might be answered

SPH has a large database, but computer programs have to be developed to pull the necessary information. This can be labour intensive. However, Stella will do what she can to answer the following unanswered questions:

How many V6A and V6B residents are dead-on-arrival (DOA) at SPH?

How many emergency visits are substance abuse issues?

How many use Emergency instead of clinics or family doctors?

How many substance abuse issues get referred to Detox?

What is SPH's philosophy on care for alcohol and drug issues? (will contact Ken Mattinson)

Other statistical information that can not be answered with the SPH database

There are some questions that just can not be answered with the kind of information that is gathered, simply because some data are not or can not be collected. Stella will provide a copy of the paperwork involved when someone visits the hospital. With the paperwork, we can get a better idea of the type of data that is collected. Some of the questions that can not be answered include:

How many are homeless/transient? This would be a difficult question to answer. Part of the paperwork requires an address. Some people live in hotels, while some may be transient or homeless, but may provide a previous address.

How many are English-speaking? How many are not? SPH does not collect information on what language is spoken.

What statistics does SPH look at to measure the health of a community? In general, SPH looks at the mortality rates of BC and Canada and health care professionals' perceived needs for program and service planning. Health status information by small community units have not been available. The role of a hospital is to help a community achieve its goals as opposed to stating the goals for a community. SPH is becoming more involved at looking at the health of communities. SPH has a Neighborhood Advisory Committee (NAC), whose purpose is to "provide a forum for hospital/community dialogue and collaboration in an effort to better understand and respond to the needs of the local community served by St. Paul's Hospital" (see Appendix B).

How many psychiatric visits to SPH Emergency are there? This is difficult to answer, because it is very hard to diagnose someone with psychiatric needs based on one visit to the hospital, especially if the reason for the visit is not psychiatric. However, if someone is diagnosed, he/she is assessed by the psychiatric nurse in the department.

What are the most common prescriptions? SPH is not a community pharmacy. However, the pharmacy at SPH provides special medication for the following outpatient groups: AIDS, cancer, and renal transplant patients. There is also pre-packaged medication from Emergency, such as painkillers and antibiotics.

OTHER INFORMATION OF INTEREST (NON-STATISTICAL)

Medical Coverage

As of July 1993, medical coverage is automatically granted to a patient who has lived here for more than 3 months (fulfilled the residency requirement) and who is on welfare. As well, people are still accepted as inpatients even if they have no coverage.

Doctors

A GP can participate in the care of his/her patients if he/she has admitting privileges at SPH. If a GP does not have admitting privileges, he/she can refer the patient to a specialist, who can then admit the patient to the hospital, if he/she has admitting privileges; however, the GP does not participate in the care of the patient. Usually, physicians have admitting privileges at only one hospital. An exception are specialists who are in low supply.

Criteria for admission

Because there are a limited number of beds, admission is prioritized based on clinical urgency that is life-threatening or a health hazard. The decision is made by the attending physician.

Detox

When a person is brought in for substance abuse intoxication, they are first assessed by a nurse. The patient can then be referred to Detox, if the patient is willing. There are 2 agencies that SPH has a good rapport with; they are Harbour Light and Pender Street Detox.

CONCLUSION

The Community Health Plan came up with a list of many questions, and an attempt was made to answer as many of them as possible. Although some of them can not be answered and some of them have yet to be answered, the ones that were answered have provided useful information concerning the residents of the postal codes V6A and V6B, as well as general information about SPH and some of the hospital's procedures. It is hoped that the Community Health Plan group and St. Paul's Hospital will continue to work together to respond to the health needs of the community.

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ADDENDUM TO
SERVICE PROVIDER LISTENING SURVEY: ST. PAUL'S HOSPITAL

INTRODUCTION

This addendum report is based on information gathered from a meeting (December 20, 1994) with Ken Mattinson, Clinical Nurse Specialist, Chemical Dependency, at St. Paul's Hospital (SPH, as abbreviated from here on). The meeting, a follow-up to the meetings with Stella Tsang, was part of the Community Health Plan listening survey of service providers of the Downtown Eastside (DES).

QUESTIONS AND ANSWERS

What does SPH classify as an substance abuse issue?

Substance abuse issues include the use of cocaine, heroin, prescription drugs, valium, morphine, marijuana, etc. Most of the people who are seen by Ken Mattinson are multiple-users (abuse more than one substance).

How many substance abuse cases does SPH deal with?
Approximately 180-200 patients are seen by Ken Mattinson per year. Annually, there are about 600-700 visits, or on average each patient is seen about 3.5 times in a year by Ken.

However, SPH deals with about 20,000 admissions per year, of which Ken estimates 30-40% (6000-8000 cases) have addiction problems (this estimate includes re-admissions). Thus, Ken does not see all patients who have addiction problems.

What are the standard procedures in dealing with a case of substance abuse?

First, a patient is identified as a substance abuse case, either by himself/herself or by SPH staff. After identification, the patient is assessed by Ken, using the Chemical Dependency Assessment Tool (see Appendix A). Some of the information sought during the assessment include: alcohol and drug history, family background of addiction, use of prescription and over-the-counter medication, and treatment history.

After assessment and if the patient is willing, Ken makes a referral to one of the following: detoxification, outpatient counselling, residential treatment, self-help, or other. These various discharge plans are described in the SPH pamphlet "Help for Alcohol and Drug Problems, Information for Patients and Family Members" (see Appendix B). Basically, detox provides an environment for withdrawal from the intoxicating effects of alcohol or other drugs, outpatient counselling provides counselling with support and therapy groups, residential treatment provides counselling and group therapy at a more intensive level, and self-help provides an environment where emphasis is placed on the influence of others in the group as part of the recovery process.

How is the decision made on where to refer a patient?

Referrals are done with consultation with the patient. First, the patient must be willing to be referred. Sometimes, patients may request a referral in a certain location, like Vancouver.

What happens if the place of referral is full?

If the place of referral is full, the patient can choose whether he/she wants to be on the waiting list (which can be several months long), request referral to another place, or turn down further referrals (tired of waiting for a place with immediate room).

Does SPH follow-up on its substance abuse patients?

Yes, SPH tries to follow-up patients who have been referred upon discharge from SPH. Follow-up is difficult; however, with treatment centre referrals, SPH tries to check patients after 6 weeks or 2 months. Upon leaving treatment centres, most patients go back to the community, but some do go to recovery homes. However, admittance to recovery homes requires a minimum of 3 months stay, which means the patient must give up his/her usual place of residence (room, apartment, etc.) for the time being; welfare sometimes pays to keep the patient's usual residence until he/she finishes the program.

How do SPH staff in general feel about dealing with substance abuse?

There is a tendency to focus stereotypically on skid row residents; however, substance abuse cases are not limited to the residents of any area.

SPH does have a Nurses' Chemical Dependency Resource Group. Some of the concerns of the group members include: how to approach and work with patients, acquire a better understanding of addiction, be a resource to their own units in the hospital, and be sympathetic to patients. More education and training in the area of dealing with substance abuse issues and cases would be helpful to staff.

Another important issue nowadays is the recent increase in the number of intravenous drug users who have become HIV positive. SPH has committees set up to look at reducing the harm of drug use and at reducing the number of drug users who turn HIV positive.