

# Those who need the most often receive the least

A community needs assessment



Words from those most vulnerable and the service providers who work with them about accessing health services: *The case for outreach health in the Cape Breton Regional Municipality*

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“This is a disadvantaged population because of how they’re treated in the community, the fact is that they’re seen as undesirables in the community.”

(Service Provider)

## Acknowledgements & Project Leadership

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Local findings would not have been possible without the willingness of the 21 service providers and professionals who engaged in valuable conversations with us and the 52 individuals living in our communities who openly shared their experiences, challenges and ideas. We thank you for adding your voice to this work.

## Background

After over two decades of working closely with and alongside the vulnerable population in Cape Breton on numerous issues the Ally Centre took action and invited community partners around one table to explore opportunities for more effectively addressing the health needs of our most vulnerable populations in the Cape Breton Regional Municipality (CBRM). The CBRM Street Outreach Health Advisory Group was formed to explore equitable access to health services in response to growing community need.

The Ally Centre is well positioned to take a leadership role in overseeing the local needs assessment and subsequent service planning. The Ally Centre is a community organization with an active board and a 24-year history. It administers the Sharp Advice Needle Exchange that provides services Island wide using an outreach natural helper model. It serves as a drop in centre, offers peer support and has a food bank that is often used by street involved and at-risk individuals. Ally offers LGBTQ programs, an anonymous and confidential testing service for the detection of sexually transmitted blood borne pathogen infections (STBBI) and various prevention and education programs. The Centre also offers an overdose prevention program including take-home Naloxone. In September 2015, the ALLY Center partnered with a family physician to offer primary health care services one half-day per week and will soon add a second physician two Mondays a month.

*More information on the Ally Centre can be found at: <http://www.allycentreofcapebreton.com/>*

For those who work daily with the most vulnerable in the CBRM (those who are street involved, homeless, insecurely housed, and/or living with addiction or mental illness), it is clear that there are insufficient and inappropriate primary health services that reached out to this population. The Ally Centre on behalf of its service users recognized that it was critical that they take a lead in determining a model for service delivery for this population that is broad, holistic and that encompassed the many factors that underlie the health of these most at-risk individuals and populations.

Looking to other communities in our province, the Mobile Outreach Street Health (MOSH) service that was established and has been effective in Halifax Regional Municipality (HRM) since 2009, may have application to the situation in the CBRM. A key learning from MOSH is to ensure a creative and flexible service that is community owned and directed that also has a collaborative and supportive relationship with the formal health and social service systems. MOSH ensures first-voice representation and meets the needs of those most at risk. Many of the health issues encountered in their street service are related to homelessness, street involvement, poverty, addiction, and/or mental health with a smaller percentage involving physical health problems that require “medical” attention. The MOSH team has organized their service delivery mainly by reaching out to individuals through community agencies who are already serving vulnerable populations in the HRM. For example, a MOSH nurse accompanies services such as Mainline Needle Exchange as they provide harm reduction equipment to those who inject drugs plus they have regularly scheduled visits to food banks, shelters, outreach agencies, etc. Working this way in the community has resulted in a service that is accepted and utilized by those who are most at risk and least likely to access traditional health services.

Hearing anecdotally from those living and working in Cape Breton, along with learning more about what other communities have done in response to the needs of those most at risk, the Ally Centre initiated a working group to oversee a needs assessment aimed at collecting local information that would be used to design and propose an outreach street health model for the CBRM. CBRM’s geographic layout is unique with five distinct small towns – Sydney, North Sydney, Sydney Mines, Glace Bay, and New Waterford. Due to this geography there are special challenges in mobile outreach not present in the HRM MOSH model.

We turned to existing community statistics and research to inform what we asked in our needs assessment and to ground our results. The evidence to support the development of an outreach service to provide access to those living at risk in the CBRM is abundant. A more in-depth look at what we knew about the challenges and risks facing our communities prior to the needs assessment can be found in Appendix B beginning on page 35.

## Introduction

Primary health care is not only about the delivery of health care services, but also about creating the conditions that help people become and stay healthy. *Community participation* is a key guiding principle for primary health care that calls for involving all of the community's resources in promoting health and addressing health problems at the grass-roots level. The pre-requisites for health as defined in the seminal 1986 Ottawa Charter are peace, shelter, education, food, income, social justice and equity. These concepts are the basis of the determinants of health model that we have all come to understand, but yet have many challenges utilizing when promoting health and providing services. *Intersectoral collaboration* recognizes that any community's health and well-being does not depend solely on effective health care services. Governments, businesses and community organizations in other sectors are equally important in promoting the health and self-reliance of communities.

Within the CBRM, community-based organizations have been creative in providing a support network for those living in very challenging situations. Many would say they are caring for those who have been alienated from our formal systems. The capacity, however, in the CBRM to manage the severity and complexity of the problems is limited: financially, as most of the public resources are located within our formal health and social system budgets; geographically, as almost all services are isolated in the city of Sydney and not accessible to those living in neighboring communities; and by a lack of expertise to work with these growing street level issues that are often complicated by serious addiction and mental health problems.

As we embarked on the needs assessment we expected that in the CBRM, similar to findings elsewhere, many of the health issues identified would be related to homelessness, poverty, addiction, and mental illness. We also assumed that because of the multitude of barriers associated with accessing primary care for these populations, the development of a service that *reaches out* to the population most at risk would be the first step in bridging the divide between the street and formal health and social services.

## Needs assessment participants

Our needs assessment included 52 first-voice individuals who are service users in the CBRM. They were met where they frequently and comfortably access services such as at Food Banks, Loaves and Fishes "soup kitchen" and via the Needle Exchange Service. The feedback offered by these individuals is identified using 'FV' after applicable quotes to represent 'first voice.'

Additionally, we spoke to 21 service providers (identified as 'SP' after quotes). These providers work closely with vulnerable populations on a regular basis and include those working in justice, health, mental health and supportive community/not-for-profit sector services. The full list of those taking part can be found in Appendix B.

## Methodology

A research committee was developed with membership from Cape Breton University, the Ally Centre, and Public Health to oversee all research phases. An ethics application was submitted to and approved by Research Ethics at Cape Breton University.

Two interview guides were developed. The first for use with first voice individuals and the second for service providers. All interviews were conducted between January and April 2017. The full list of questions asked can be found in Appendix C and D.

Consent was obtained from participants and an audio recorder was used, with permission, to aid in accurate transcription. First-voice participants were provided with an honorarium valuing \$10.00 to thank them for their time. Data was themed and coded using the software *Atlas.ti*. This program supported the qualitative analysis and captured how often certain themes emerged along with key quotations for theme areas.

To help inform our needs assessment, a **literature review** was performed across a variety of scholarly databases (*EBSCO, ERIC, JSTOR, PsycINFO, PubMed, CINAHL, Wiley Online*). Google and Google Scholar were also used to locate and identify relevant governmental and NGO reports. The search was performed using terms such as vulnerable and underserved populations (e.g. street involved, homeless) and their needs, risks, and accessibility, outreach health, outreach street health, best/promising practices, harm reduction and street social work.

Predominantly, the literature in existence focuses more so on the barriers, obstacles and life situations of those in vulnerable populations rather than on services designed to best meet their needs. There is also more American than Canadian information. What we learned from other studies and reports will be tied in with our own findings throughout this report.

## What we heard

The data we collected tells a story that fits under three main areas:

- The challenges faced by first voice individuals living in our community throughout various aspects of their lives and especially when accessing health care. This includes the everyday, complex life situations of people we spoke with.
- What is working well in our community that we might build upon and learn from.
- The actions and changes that could enhance health care access from first-voice and service provider perspectives.

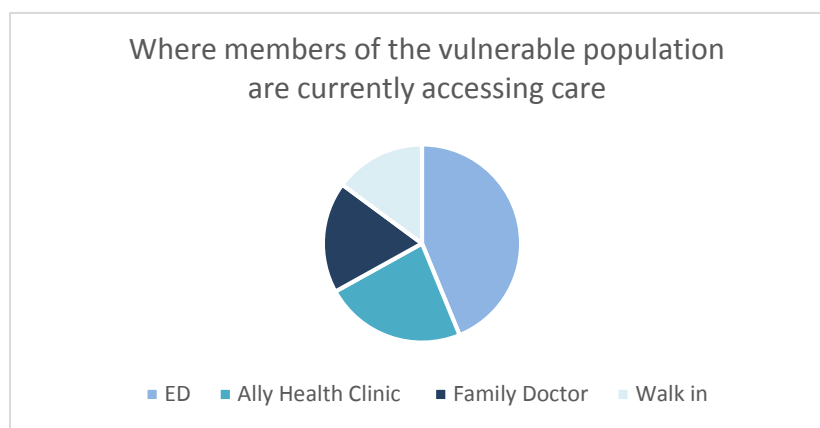
It is important to stress that overall, we found that the experiences shared by first voice individuals and the observations and feedback from local professionals were very similar.

## Where are first voice individuals accessing care now?

We wanted to understand where members of the vulnerable population were currently attempting to access the care they need.

Both service providers and first-voice individuals indicated the emergency department (ED) is the most common place accessed for care (mentioned 53 times). This is consistent with existing research noting that those who are homeless, which represents just one segment of the vulnerable population, are four times more likely to use the Emergency Department than other citizens (Tansley, 2008). Health Quality Ontario (2016) also reported high rates of ED visits among the homeless. Additionally, Schiefelbein et al. (2014) indicated high rates of ED use among vulnerable populations in general with homeless patients having the highest rate of ED utilization.

Other facets of care used were the Ally Centre Health Clinic (mentioned 28 times), family doctors (mentioned 22 times), and walk-in clinics (mentioned 18 times).



It must be noted that many individuals are estranged from the health care system and are not accessing anything for their care. They may go without health attention for prolonged periods of time and/or are seeking care from peer/informal helpers. The following quotes highlight that vulnerable individuals are often **not connected to any formal systems**:

*“A lot out there that we are still not seeing at all.” (SP17)*

*“I think people are in quiet desperation.” (SP5)*

*“So many times we had problems that we should’ve went to the doctors, but like I said you’re judged and I’d rather not go and we’d rather help each other out.” (FV40)*

*“The supports are very hidden, sometimes it’s in people’s basements or hanqina around a store.” (SP8)*

# What are the life situations of service users in need of primary health services?

## **POVERTY**

Poverty was a major term we heard in our data collection being mentioned directly in 47 quotes and indirectly throughout all interviews.

First-voice individuals simply do not have the resources needed to make ends meet. Words like 'tremendous' and 'multigenerational' were used by service providers to describe life situations of their clients.

Poverty prevents people from taking good care of themselves in the first place due to poor nutrition, lack of dental care, stress, exposure to the elements and unsafe living environments.

Struggles to find employment in our community were highlighted by both service providers and service users in 23 quotes.

*"It's pretty complex the background story of some of these folks that utilize our services." (SP18)*

*"It's ridiculous what they are expected to live on." (SP16)*

*"It's not poor (money) management --- there's just nothing." (SP20)*

In our needs assessment we mention poverty first because it tends to be 'at the root' of everything else we heard. Poverty must be closely examined because as Andermann (2016) noted people who are poor have more health problems and die earlier. Ruckett and Labonte (2016) reported a life expectancy of 7.1 years higher for men and 4.9 years higher for women in the highest income bracket than those in lowest income bracket. The health and social challenges of marginalized individuals can be complex and intertwined and health equity must become a priority in the health sector in order to improve population health.

A number of physicians across our country have recently been outspoken about social conditions like poverty. In a March 2017 piece, Dr. M. Cohen of Ontario voiced: “Ask any emergency physician how often during a shift they see a patient whose problem is primarily social rather than medical. When you have nowhere to go at least the emergency department won’t turn you away, even if your main problem is hunger or a lack of shelter beds.” Dr. Cohen added that “addiction, poverty, violence and homelessness won’t find long-term solutions at the hospital.” She feels that the current reactive response, a response she calls ‘duct-tape doctoring,’ is as costly as social problems are. Similarly, Dr. J. Ross of Dalhousie University in Nova Scotia stated in March 2017 that “Disease care can’t keep up having to manage and fix all the failures of economics, stress, poor education, etc. The number one determinant of poor health is poverty.”

## **MENTAL ILLNESS & THE MENTAL HEALTH SYSTEM**

Untreated mental illness was a key theme. Stress, trauma, depression, self-harm, anxiety, and co-occurring mental illness and addiction were commonly mentioned. Hopelessness was apparent as well.

Lengthy wait times for mental health care were frequently discussed in the interviews. Service providers and first voice individuals spoke of a system in need of changes to better serve clients. Some spoke of service users being fearful of being institutionalized or on the other hand not being taken seriously and released after being assessed by crisis workers or other medical professionals.

Statements related to mental health showed up 102 times in our local data. This is fitting with research completed in other areas that found mental health care to be a major need in the vulnerable population. For instance, Farrell et al. (2005) found that 30-35% of the homeless population had mental illness.

*“I can’t even tell you the people that come in and can’t get better in any way because their mental health is suffering so badly. We need access there.” (SP17)*

*“There’s times I was on 5 different medications that didn’t work.” (FV19)*

*“My body is exhausted but my mind is constantly awake and worrying and I can’t settle down.” (FV49)*

*“The holidays were a train wreck, every day... suicide threats.” (SP7)*

*“We’ll see the same patient 36 hours later and the only difference is they have a bottle of whatever sedative and it’s a revolving door.” (SP7)*

## **ADDICTION**

Along with poverty and mental health, addiction was mentioned as one of the top three issues and showed up 86 times throughout the transcripts. Opiates were the most common substances referred to by respondents. Having trouble caring for oneself due to feeding one's addiction was another theme area.

Issues associated with methadone treatment appeared a number of times in the interviews. In fact, this was mentioned in 29 quotes by the first-voice individuals interviewed.

Hepatitis C, abscesses and infections, cardiac issues and overdoses were also discussed in relation to the consequences of drug use.

*"I can't go to work because of the drug habit and I wake up sick as a dog every day."  
(FV9)*

*"Less than 36 hours ago there was a narcotic overdose" (SP7)*

*"I don't even have a drop of food in the house, if I get money it goes towards a pill I have to take." (FV44)*

## **HOUSING AND HOMELESSNESS**

Many of those interviewed discussed issues relating to homelessness, street involvement and housing insecurity. In the transcripts housing problems/homelessness appeared 67 times.

20 of the 52 individual interviewed (38%) stated they were homeless in the past year and still others mentioned they had been homeless in previous years.

We heard stories of numerous individuals having to share a very small space, apartments that are too costly, few options in our community for safe affordable housing, mold and other unsafe conditions not being addressed and community members living on the street. We also heard stories about difficult decisions and limited options such as those involving people having to take money intended for food to pay for rent.

Ruckert and Labonte (2016) acknowledged that finding affordable and healthy housing is one of the biggest challenges facing low income Canadians and that the cost of housing is rapidly rising. We heard about these challenges in our own conversations:

*“You know we have homes here considered third world.” (SP5)*

*“People are out on the streets in extreme conditions and weather and they’re getting themselves really sick and could use medical care.” (FV10)*

*“Being diabetic and a drug addict I only had one set of clothing...I’d meet up with a friend as I was lucky they’d let me shower.” (FV34).*

*“It’s hard to get a place when you don’t have a phone or a way to even meet a landlord.” (FV 11)*

*“I was at the homeless shelter and that was hard because you walk around 12 hours a day (waiting for it to open).” (FV 47)*

## **LACK OF SOCIAL SUPPORT & SOCIAL EXCLUSION**

This theme area surfaced in about 25 quotes plus an additional seven related specifically to family violence. There were another 11 quotes from service providers that focused specifically on the lack of spaces for people to go.

Individuals are lacking access to support people to help them when they are unwell – there is no one to drive them places or wait with them or assist them through various levels of follow-up care that might be necessary.

“Burned Bridges” were commonly referred to when referencing relationships with family and also with some service providers. Abusive relationships and family break-up were indicated. Many quotes described that there is a lack of spaces where people could go to stay warm, meet with others and talk to an outreach worker without time constraints. We heard stories of the local library being utilized as a safe haven because of the short hours of other services. For example, the local Men’s Homeless Shelter is only open certain hours (mostly for sleeping) while Loaves and Fishes is open for three to four hours during meal time.

*“I don’t have family around here, my friends are limited, it’s just hard for me sometimes.” (FV2)*

*“They have fragmented and strained relationships...A lot of closed doors you know” (SP9)*

*“The support network largely falls back to like-minded individuals who are in the same circumstances.” (SP7)*

*“More support...my mom’s addicted to drugs and my father’s addicted to alcohol so that’s why I’m out here trying to seek help.” (FV19).*

*“There are no drop-in centres for high-risk people.” (SP5)*

## **CRIMINAL HISTORY**

Comments related to having a criminal background and related difficulties appeared 27 times in the transcripts.

The “revolving door” of Corrections was discussed by respondents. Due to complex issues still existing upon release (e.g. mental illness) people tend to cycle back into the system. Often supports that clients had access to ‘inside’ (e.g. medications, doctors) are not accessible when released back into the community.

Lack of employment was a major theme and frustration for first-voice individuals with criminal records. Expenses related to paying off fines and getting a pardon are major stumbling blocks intensified by little local opportunity for employment.

Pyra (2007) found that for some having a criminal background further reduced the chances of accessing public services due to appearances being too risky such as in the case of someone with an existing warrant for their arrest.

*"I'm looking for a job but can't get one because I'm a criminal." (FV28)*

*"I'm an ex con...they got me in a stereotype. I'm in a box." (FV 33)*

*"They end up in the Correctional Facility and they finally get access to their medications on a regular basis and then they're released with no doctor."(SP15)*



## FOOD SECURITY

This challenging life area showed up 33 times in the transcripts. Service providers spoke of the role food insecurity plays in the development of illness. Some indicated their clients may not even have the resources (e.g. working stove, can openers) to cook the food properly that they obtain from food banks (meats, canned goods).

Loaves and Fishes in Sydney indicated they serve roughly 138 people a day and this number is climbing. They noted that the clients they serve increased significantly when free transit buses were running in the summer of 2016. This highlights the benefit that adding increased routes and affordable transportation can have on one's ability to access other important services.

Many individuals and families are relying on Food Banks to eat. We found out that the Northside Food Bank had 700 active files and this is just one town of five in the CBRM.

*"We might give someone a can of soup but they can't open it...then they have to use a rock." (SP15)*

*"I think it has so much to do with food, they're just not eating and they get sick." (SP5)*

*"If it wasn't for the Food Bank, there would be a lot of hungry people." (FV31)*

*"They prescribed me a drug that wasn't covered and I had to pay \$130 a month. I showed the doctor my ribs and said, 'Look Doctor I'm mentally well now, but I'm starving.'" (FV48)*

## SEX WORK

Sex work wasn't mentioned outwardly as often as the other themes we heard, but did show up as a life situation. It was presented as a way to survive. Sex work brings with it many challenges, dangers, exposure to communicable disease and great stigma. Due to these risks and barriers, supporting those who are involved with sex work will be important for any service directed toward these vulnerable populations.

*"They said there are about 25-30 (women) on the street" (SP5)*

*"I was prostituting, just getting by..." (FV 6)*

*"It's a sin seeing the young kids out there, young girls out there prostituting themselves. It's a god damn shame. That's no life." (FV5)*

## PHYSICAL HEALTH CONDITIONS

A host of chronic and other health conditions were mentioned throughout the transcripts as being common concerns among those in the vulnerable population. These health conditions exist in combination with the mental illness, social exclusion, housing challenges, etc. that we heard about previously. In no particular order, these conditions included:

<i>Diabetes</i>	<i>Kidney and/or liver disease (e.g. Hepatitis C)</i>
<i>Cancer</i>	<i>Chronic Pain – back, knee, arthritis</i>
<i>High blood pressure</i>	<i>Eye problems</i>
<i>Dental problems</i>	<i>Foot care issues</i>
<i>Respiratory – e.g. COPD</i>	<i>Sexually Transmitted Infections (STIs)</i>

The Institute of Medicine describes a complex relationship between health status and being a member of the vulnerable population that must be recognized. For instance, when homelessness is considered there are: 1. health problems caused by homelessness (e.g. foot issues), 2. health problems that cause homelessness (e.g. chronic disability or disease that leads to unemployment) and 3. health problems difficult to treat due to homelessness (e.g. respiratory illness). McGuire et al. (2009) noted that homeless individuals must be treated as “high priority consumers of primary care” due to the high rates of serious medical problems faced.

Tansley (2008) found that the difficulties faced when accessing health care can make a vulnerable individual’s situation even worse. We must do a better job of ensuring timely and relevant service to avoid exacerbating already complex life situations.



# What prevents people from accessing the health care they need?

## STIGMA

Many of those interviewed shared how past negative experiences have caused reluctance in seeking care. In fact, the themes of judgement and stigma appeared 104 times.

Service users feel judged and misunderstood and as one expressed can feel as though *“a dog would be treated better.”* Many shared stories of being perceived as *“pill seeking”* when they had legitimate health concerns. Being *“blacklisted”* or *“red flagged”* and *“all painted with the same brush”* was referred to often. Additionally, some respondents voiced that they do have a family doctor but do not go to them due to the fear of being ‘found out’ or having to admit to drug use.

The service providers we spoke with shared a number of stories where they too witnessed judgmental behavior from other professionals. One reported overhearing a group of nurses stating *“Oh he did it to himself”* and another shared a doctor clearly stated *“If you are so concerned (about him being released) why don’t you take him home with you?”*

A lack of compassionate care seemed to be tied directly to stigma:

- *“This lady, her family doctor wouldn’t go in the room and examine her. He’d stand in the doorway and talk to her because of who she was.” (SP9).*
- A respondent with an abscessed tooth shared that in response to their pain they were told *“Stop crying you baby!”*

A health care provider discussed the difficulty of getting people, especially those living with mental illness and addiction to agree to care due to past unpleasant experiences:

*“They’re paranoid about going, they’ve had situations that haven’t been positive when they go there...In fact we get more refusal to go to the ER in emergency situations than we do acceptance of that.” (SP18)*

Another aspect of stigma mentioned was the ‘not in my backyard’ attitude that can result in apprehension about services being housed in certain areas (e.g. sharps/needle kiosk). There can be misunderstanding regarding harm reduction and what such approaches and interventions can actually do for safety in an area.

Some highlighted a need to educate the community and providers to reduce stigma and increase understanding:

- *“Their lifestyle is horrendous to the point where you wonder how they even survived. Anyone else would be called a warrior but they are called everything but.”* (SP15)
- *“Stop judging us... I was a functional member of this community.”* (FV3)
- *“This is a disadvantaged population because of how they’re treated in the community, the fact is that they’re seen as undesirables in the community.”* (SP6)

Others felt some shifts were beginning to happen in some systems: *“You know, the old thinking was you make your bed now lie in it, but now we’re learning more that these are health issues (i.e. addiction).”* (SP19)

Many voiced that being viewed as an ‘addict’ got in the way of their proper care:

- *“I swear to God I must have waited 10 hours and I just went home at the end of it. I was watching kids coming in with a little cough and I had lesions and I could barely move my arms. Once they saw the lesions and found out I was an addict I was done.”* (SU50)
- *“As soon as he found out I had a drug problem, he started treating me differently.”* (SU37)

The emotional repercussions of stigma became clear:

- *“Just being accused of being an addict is the worst thing in the world for me because I’ve overcome that and it isn’t part of my life anymore. But the fact that you can’t move on is kind of traumatizing for me. Because when giving me my medication all he (walk-in doctor) goes on about is street value and if I’m taking them as prescribed.”* (FV48)
- *“If your social situation puts you in a place where you feel like you don’t have the right to speak up or if you’ve been cast aside before, you’re less likely to speak up again. I think those folks get into a place like the ER and they are like wallflowers they sink into the background and people don’t see them. I honestly don’t believe they can advocate for themselves, they don’t know how or who to speak to and then you’re pretty much lost.”* (SP12)



Numerous other studies found stigma to be a common reported experience of those who are homeless, street involved and/or living with addiction. Drury (2008) reported a cultural divide “produced by vast differences in lived experiences” between marginalized individuals and health care providers. In Stergiopoulos and Harris’s June 2016 report, participants in Toronto expressed that hospital workers often disagreed about the appropriateness of ED visits. Many felt stigmatized and treated poorly. They voiced they were met with impatient staff and providers who were tired of seeing them, with addiction related stigma being described most often. Gold (2009) reported that those who use drugs by injection say they often encounter discrimination in mainstream care settings. Due to this stigma, many delay seeking care until they are extremely ill – which then often becomes very dangerous to the individual and very costly to the system.

## **WAIT TIMES**

Mental health wait times and emergency department wait times were often referred to. In fact, respondents talked about wait times in 69 different quotes. It is true that everyone in our province can face wait times but for those experiencing homelessness, insecure housing, addiction and/or mental illness, lack of food, transportation barriers, stressful life situations and little social supports these wait times become an even greater detriment.

*“I’ve been waiting 2 years now to see a psychiatrist.” (FV28)*

*“It’s hard enough to pick up the phone for help and then you have to wait” (FV11)*

*“The thing is that our clients, when they go into a crisis situation, they really do need the services right now and with the wait then the damage is done.” (SP2)*

*“They’re going nowhere, there isn’t anywhere for them to go. They’ll come see me and I link them and tell them they are going to wait 6-7 months for a phone call. That is it, and if they’re in crisis they’ll go in to see the crisis workers and then get sent home.” (SP15)*

*“There’s a long list and they don’t or can’t wait because their life is spiraling.” (SP19)*

## THE REALITY AND COMPLEXITY OF LIVES

Those we interviewed were clear that when you have no phone and have to schedule your day around your next meal (i.e. limited hours at essential local services like a Food Bank or Loaves and Fishes) it makes it difficult to seek and follow through with health-related care. Other difficulties included trying to find and pay for child care while health services are accessed. Citizens who are part of the vulnerable population do not fit the various systems as they are currently designed because their lives are so complicated. Rigid scheduling, service rules and appointments are major obstacles. This theme area showed up in 16 statements such as the following:

*“Hard to get anything done when you don’t have a phone or you’re on disability...the whole thing is hard. People just give up.” (FV11)*

*“People have difficulty scheduling their lives and keeping appointments because their lives are chaotic, they’re homeless, they don’t have a base to start from...They don’t often have a telephone to get a call back...people are thinking about their next meal and other things so 12 hours in an emergency room is not realistic for them.” (SP18)*

Shortt et al. (2008) similarly noted that members of the vulnerable population may delay seeking care because other needs (e.g. securing food and shelter) are more crucial to their immediate survival. In addition, Khanassov et al. (2016) indicated that the complex realities of vulnerable people can impact their ability to ‘seek, reach and engage with care’ in a system that is struggling to provide equitable access.

## SPACE AND SET UP OF SERVICES

The physical space and set up of locations like emergency departments came up as a barrier in 68 quotes within our transcripts. The busyness and chaotic nature of these spaces, the fact that there are multiple staff addressing your needs, the large crowds, the close proximity to others in the waiting room, and an overly clinical setting can be anxiety provoking, especially for those living with mental illnesses and for those who perceive and feel judgment from others. These spaces are not conducive to addressing complex needs.

Some expressed feeling unheard, alienated and intimidated in medical settings like emergency departments. Phrases like *“they don’t even know who you are”* and *“you are pushed out the door”* indicated these emotions. Many felt that confidentiality was important and that these spaces left them feeling exposed and vulnerable.

*“It’s hard to get comfortable with a certain doctor because you’re not going to have them all the time right? For somebody that doesn’t want to explain their situation over and over and over again it just kind of sucks right?” (FV24)*

*“For me to get their attention I have to get a little mad. From getting mad I feel vulnerable and useless. So I want to leave and you know.” (FV19)*

## TRANSPORTATION BARRIERS

Service providers and service users highlighted transportation as a major barrier. These discussions showed up 53 times in the interviews.

**62% of first-voice respondents answered 'yes' transportation is a major issue.**

Having to make a choice between spending money on transportation to meet health care needs or addressing one's other necessities was voiced. As one person interviewed shared, you have to *"give up something else to get there."*

Comments included the expense of taxis and the inconvenient and misaligned transit bus schedule that does not get people where they need to be (e.g. there is no bus service on Sundays when there is a Sunday walk-in clinic open).

The sheer amount of time it takes to get places if walking or relying on public transportation was also mentioned.

*"Just to go to North Sydney you need to take a bus that goes over twice a day so you have a three - hour gap...it's an entire day's experience just to go to North Sydney. When I get there I'm tired and then you wait two or three hours just to see the doctor." (FV3)*

*"When you are really sick you don't feel like walking all the way to the hospital to sit there for 13 hours." (FV2)*



## TREATMENT PLANS AND FOLLOW UP

Seventy-seven quotes made note of the difficulty experienced in following through with treatments and referrals, with 52 of these quotes pertaining specifically to prescription related barriers. Some expressed that getting to specialists, referrals and other follow-up care could be challenging due to lack of support in their lives, transportation and surviving day-to-day (finding one's next meal).

The cost of prescriptions and co-pays was commonly mentioned: *"You have a choice. You either pay for your prescription or go out and get a box of Kraft Diner or something to eat."* (FV33).

Sometimes people have to be 'creative' to ensure their prescriptions get covered under program regulations: *"Under social assistance, their medical, you have to have 4 prescriptions a month...I've seen people go to the doctor just to get a random prescription, like eye-drops or something, so the co-pays will get paid."* (FV30)

For some, even picking up prescriptions added another transportation burden as can tests ordered by a doctor: *"They don't have the transportation to get to the hospital so they take it (the blood work slip) and throw it away."* (FV6)

A number of those interviewed discussed barriers when attempting to get prescriptions at walk-in clinics: *"Especially with mental health or anxiety or anything like that they don't want to fill your medication. They want you to have a family doctor – but if you don't have one what are you supposed to do?"* (SU2). Being perceived as 'pill seeking' was mentioned in this theme area as a huge challenge to work through.

A lack of available care can prove to be dangerous when people do not have needed treatments: *"I ran out of pills one day because I don't have a doctor and I took an extra shot of my insulin and someone saw me on the road and helped me."* (FV39)

For many, after spending time in a facility, follow up appointments can be either non-existent or not soon enough and with no social support or family this can create an even less likelihood of remaining well: *"When they released him they just put him out on the street, there was no safety net, no medication. He had nothing."* (SP13)

Jahn (Halifax, 2012) found similar reasons for marginalized individuals not being able to follow treatment plans. These included: one's living situation wouldn't allow it, cost, could not incorporate the recommended plan into daily activities, and did not understand instructions. In fact, 27% of those they spoke with were unable to obtain needed medications. Williamson et al. (2006) collected data from low income individuals in Edmonton and Toronto. They reported that low income Canadians are 10 times more likely than higher income Canadians to report unmet health needs due to costs involved and/or transportation barriers. Dental care, prescriptions and over-the-counter medications posed great challenges for the individuals in their study.

## What can we learn from the good experiences we heard about?

Those interviewed did highlight some good experiences and mentioned collaborative relationships that are working well. There were 46 statements made referring to what is positive in our communities.

When a good experience was shared it tended to encompass aspects such as trust, acceptance, taking the time to build relationships, feeling genuinely cared for and being able to be open about your lifestyle and be your ‘true self’ with a provider.

The Ally Centre was mentioned often when positive examples were given by respondents. In fact, even the service providers that we interviewed mentioned the Ally Centre 17 times. First-voice individuals highlighted examples of the Ally Centre helping to find them apartments and “*get on the methadone program.*” Members of the vulnerable populations interviewed indicated that the doctor at the Ally Centre Health Clinic is “*awesome,*” “*fair,*” and “*really good to me and nice to me.*”

### Services going above and beyond

We heard numerous stories about community non-profits (organizations that are outside the formal system) often working well in excess of their mandates and often while struggling themselves due to being under-resourced, understaffed and lacking core funding.

We discovered that there are numerous, amazing local services to partner with and learn from.

We heard stories of non-profit service providers dressing wounds, transporting people in their own vehicles, waiting in the ED with clients for long periods, visiting clients in the hospital who had no family, putting home phone numbers on business cards, helping arrange funerals, and purchasing needed items (e.g. furniture, clothes).

Community non-profits often step in when others end care and treatment: “*The paramedics arrived on the scene and refused to take him so I had to put him in my car and take him.*” (SP15)

### Some examples of what is working well for individuals and services:

Dr. Keating at Ally Health Clinic, Ally Centre services in general, Food Banks, YMCA, VON, Elizabeth Fry, Transition House, Every Woman’s Centre, Opioid Recovery Program (e.g. “helps with transportation”, “saved my life”), Ann Terry, Housing First, local pharmacies (e.g. Black Diamond), plus stories about some psychiatrists and doctors providing great care and follow up, the Cape Breton Correctional Facility being open to what clients need, and police and EHS receiving more training on mental health.

# What could help improve access to primary health services?

## OUTREACH

- 94% of first voice respondents (49 out of 52) felt a mobile outreach service would be useful in the CBRM.
- The 21 service providers also spoke favorably about the need for an outreach component to health services. In fact, 39 quotes by providers mentioned outreach components.

Many agreed that it simply makes sense to go to where the people are in order to reduce many of the barriers and challenges we heard about previously. Working in an outreach capacity with the vulnerable population could also help staff and partners gain knowledge and shed light on the challenging life situations facing community members.

- *“You have to go to them. That’s the only way. You can’t expect someone in a life crisis to even think about getting help or going somewhere or having the means to.” (SP7)*
- *“It’s about getting out to see what’s going on – we’re so far removed we don’t know what’s going on.” (SP5)*

A number of statements made by service providers (12 quotes) demonstrated that a nonprofit organization should lead any model implementation due to having more flexibility and a close connection to the target population.

Those we spoke with felt that members of the vulnerable population would likely feel more comfortable and be more open about their needs when accessing care within an outreach model, rather than at an Emergency Department or other currently available health services.

Interviewees believed that an outreach model could work well given CBRM’s physical layout: *“We’re spread out geographically and there aren’t places for people in Glace Bay, North Side, New Waterford to access services.” (SP16)*

Numerous possibilities of modes of outreach were voiced. Vans and buses, similar to those in Halifax or other Canadian communities, were discussed while others mentioned street teams and street social workers.

Having an established schedule that people could come to count on, without having an appointment, was key. *“We’re really lacking based on this appointment system and there’s no one looking out for them if they don’t show up.” (SP10)*

Street outreach has brought favorable results in other areas. Greenberg et al. (1998) reported that injection drug users with four or more contacts with a street outreach program in a six-month period were more likely to report acting on referrals. In Deering et al. (2011), a peer-led mobile outreach program was found to play a role in women accessing detox and residential treatment. Rudolph et al. (2010) found that targeted street outreach got access to those who inject drugs and can help link to needle exchanges.

Allan, Ball and Alston (2008) found that social workers saw limited options for successfully intervening with vulnerable individuals within the health care system due to the bulk of issues being related to poverty and rural decline. They recommended an investment in outreach. Lamb et al. (1995) featured an outreach team involving psychiatric nurses, social workers and police that reduced criminalization of individuals by referring clients to the mental health system rather than inappropriately diverting them to the justice system. A report featuring street nursing in rural/interior British Columbia indicated that staff must spend time in areas where clients are located and engage in small talk, providing a sense of nonjudgmental acceptance (Self & Peters, 2005). They noted that outreach workers should ‘aggressively’ seek clients rather than waiting for clients to come to them. The dominant issues in the BC program were homelessness, addictions, mental health problems, involvement in criminal activities, lack of transportation and lack of ability to pay for prescriptions – very similar to the challenges reported by those we spoke with here in the CBRM. Llewellyn et al. (2004) fully support initiatives that are comprehensive, dynamic and able to meet multiple needs from shelter and food to mental health. Traditional services face difficulties to respond in a timely manner and are often not equipped for ‘multilayered problems.’ Lam and Rosenheck (1999) found that street outreach was useful to reach those who were more severely impaired, had more basic needs, were less motivated to seek treatment and who took longer to engage. As Cardarelli et al. (2008) state: *“Outreach is necessary to provide care to those who need it but are not receiving it.”*



## PLACING HEALTH SERVICES AT EXISTING COMMUNITY SITES

- 50 of 52 (96%) of first-voice respondents felt that placing a service within existing sites (Food Banks, Community Non-Profits) was a good idea.
- 33 quotes by service providers indicated a willingness to be involved in some manner with promoting/implementing outreach services within existing organizations/sites.

Those interviewed overwhelmingly supported a design that would see health care services placed in existing spaces well used and trusted by vulnerable populations.

They felt this would not only serve a need but also be achievable and cost effective: *“I think something like that would be more feasible than trying to set up a new location...set up with the nonprofits.”* (SP 12).

As another respondent stated, the importance of allowing clients to get multiple needs met at one time, in one place, in which they are comfortable is essential: *“If it’s one day that I know I’m getting 25 things taken care of, I’m going to be there.”* (SP3 – reflecting back on a community event for the vulnerable population known as *Under One Umbrella* which provides access to multiple service providers from various sectors).

A large number of the service providers we spoke with said they would be willing to provide space (e.g. a boardroom) for the provision of health services. They even indicated particular days/times at their service that would best reach clients: *“Love to have it here. We’d house the thing! We have a room you could use. During meals a nurse could come in”* (SP12). When space couldn’t be offered, service providers indicated numerous other ways they could help. This ranged from providing staff time, assisting with proposal writing, facility safety planning, promoting the service, making referrals, engaging in advocacy, and offering education sessions.

We were pleased to learn that partnership opportunities were abundant. Those we spoke with were enthusiastic when discussing their possible role: *“We would do whatever we could”* (SP3); *“It’d be a nice natural fit with what we do.”* (SP7)

Whether it was a mobile street outreach for our area or related supportive services placed within known community locations, first-voice respondents felt these community-based services would be extremely important in supporting change and for many could be the missing link in their recovery: *“Oh yeah. It’d be helpful to get back on your feet if you’re vulnerable and depressed. It’s a little bit harder for you to look for a place because you’re always thinking. I could deal with other things such as looking for a place.” (FV19)*

Those we spoke with also saw clear cost-related benefits of community-designed services:

- *“Yeah it would save time at emergency and would ease up on the doctors and save money.” (FV33)*
- *“It’s not a stretch to imagine that dollars into a program like this result in big savings on the other end.” (SP18)*
- *“It makes more sense to be proactive and catch things early with vulnerable people.” (SP18)*

O’Toole et al. (2016) reported a reduced use of acute care among vulnerable populations when outreach was provided to and with existing community agencies. They advocate for a whole-person approach where sustenance needs (food, bus vouchers, and hygiene kits) can be met in the same location as social and mental wellness needs. Outreach to people in shelters and at community locations like soup kitchens and resource centers was also suggested.

Farrell et al. (2005) describe the Psychiatric Outreach Team of the Royal Ottawa Hospital. The team serves over 50 community-based partner agencies (shelters, community health centres, drop-in centres, low income housing and supportive living environments). They initiate mental health care, promote linkages to appropriate community resources, provide education, and help to navigate systems. They spend most of their time on mental health assessment and treatment (62%), followed by addictions (24%), and medical treatment (14%). These numbers are quite similar to where Halifax’s MOSH team spend their efforts. Williamson et al. (2006) advocate for access for vulnerable populations to be improved via a broad range of services provided ‘under one roof’ in community centers in low income residential areas. Similarly, Khanassov et al. (2016) suggested a need for system change and policy to ensure that vulnerable populations ‘get the right service at the right place at the right time.’

## **SUITABLE STAFF**

We heard a great deal from those we interviewed about the characteristics that are best suited for staff working with members of the vulnerable population. Forty-two quotes voiced opinions about staffing.

Those interviewed indicated that staff need to be in this type of work for *“more than just a pay cheque.”* They must fully understand the population -- the barriers they live with and their various related needs.

Some first-voice respondents admitted they are not the easiest type of person to deal with and as a result, service providers should be both skilled and understanding.

Those we spoke with believed that staff should spend time building relationships, be flexible, genuine and not overly clinical in their approach. Words like *open, friendly, nonjudgmental* and *good bedside manner* were common.

The service would require staff with various backgrounds to address complex needs and as one respondent echoed *“in the design of a program (like this) there’s a social component, and the mental and health components.”* (SP6).

Many mentioned a nurse has a broad skill set and would be an essential member of any outreach service delivery: *“Nursing part is huge. So much that nurses can do – wound care, drawing samples, coming in to talk, the educational pieces.”* (SP17)

A number of respondents discussed the importance of having pharmacists on board, as well as rapport with the emergency department to support any outreach service delivery. Some of those interviewed felt that people with lived experience would make valuable team members. Having someone with a background in mental health and service navigation was another common staffing component indicated.

Collaboration was a key theme when discussing who would deliver the service:

- *“I don’t think there is any one expert here...I think it needs to be a combination of people.”* (SP1)
- *“I think there’s a whole cast of people.”* (SP4)
- *“It really doesn’t rest on any one shoulder.”* (SP10)

Time spent gaining trust and rapport with members of the vulnerable population was another evident theme and 26 quotes referred specifically to a need to build trust:

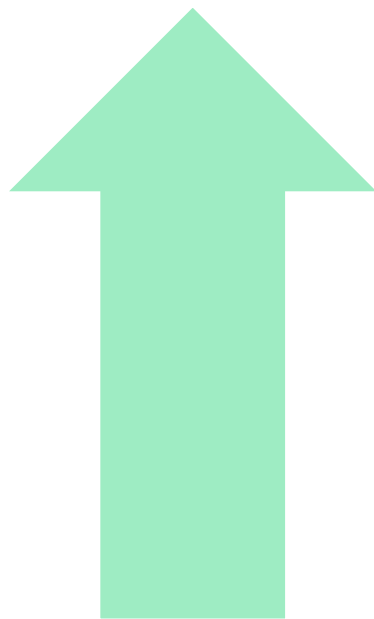
- *“Get those relationships going and then it all comes from there.”* (SP21)
- *“Make people feel that “this is for me” and that they belong.”* (SP3)
- *“They need someone who is going to advocate for them and provide that sense of warmth.”* (SP13)

The consistency of staff team members was also seen as crucial to enhance access. Respondents would like to see familiar faces knowledgeable about their life experiences: *“Say if something happened to you sexually, or something and you’re at a shelter, you don’t want to have to go to the hospital and explain it over and over again. If they had the same workers there you’d feel comfortable instead of different people.”* (FV2)

Kryda and Compton (2009) reported that individualized attention, empathetic listening, working to minimize stereotypes, providing choices, and employing formerly homeless people would build confidence in services for the chronically street involved. Michelen et al. (2006) highlight staff receptivity as essential for low income and socially marginalized groups, while Farrell et al. (2005) discuss that staff must offer flexibility in services, possess an ability to work with clients at various stages of readiness, network closely with agencies and be able to work as part of a multidisciplinary team.

Drs. Stergiopoulos and Harris (2016) call for staff that are trauma informed, non-stigmatizing, recovery oriented, and who can pay greater attention to the social determinants of health such as adequate housing, income and employment. Specifically, they point out multidisciplinary community response teams as a promising intervention. In a study in Toronto and Edmonton, Williamson et al. (2006) learned that low income Canadians avoid services where staff had been abrupt, rude, or judgmental or where they felt they were not listened to. Respondents desired staff “who are real,” kind, friendly and spend time asking about your day. In other studies, what was found to be important was that practical assistance was given and harm reduction measures were made available by staff who were consistent and familiar (Sun, 2012).

To summarize the barriers and needs we heard in our conversations with service providers and first-voice individuals, in conjunction with the challenges facing vulnerable populations as presented in existing research and literature, please see the following graph:



**VULNERABLE POPULATIONS SUFFER DISPROPORTIONATELY FROM:**

- stigma
- alienation, social exclusion
- shorter life expectancy
- substance use/addiction(s)
- chronic health conditions
- mental illness
- housing barriers
- dental problems
- nutritional deficits
- inability to pay for prescriptions
- transportation barriers
- threats to safety/higher rates of violence experienced
- trauma



**VULNERABLE POPULATIONS ARE UNLIKELY TO HAVE ACCESS TO CARE THAT IS:**

- holistic
- timely
- coordinated and socially supportive (e.g. links to housing and other required supports)
- continuous (continuity of services at discharge, follow up, etc.)
- flexible
- focused on prevention and harm reduction

These risks and gaps are highlighted well in the literature particularly in: Cardarelli et al., 2008; Burt, 2015; Hagedon, 2002; Hilton et al., 2001; Law & John, 2012; Khandor et al. 2011; Michelen et al., 2006; Pennington, 2010; Shortt et al. 2008.

## A summary of potential actions arising from what we heard:

- Bring services to clients *where they are* and *where they feel comfortable*.
- Carefully consider the location of where a service will be offered - some communities do have an existing safe and trusted space (e.g. a food bank) while other areas may not.
- Clients must be able to trust and rely on the schedule of the service developed – those we spoke with indicated it is important for staff to be there when they say they will be so a routine and sense of trust is established.
- Service must be flexible (e.g. beyond typical '9-5' service) and not focused on appointment-based methods. Many clients may not have phones or the ability to keep track of appointments.
- To ensure flexibility, most agreed a non-profit, with experience working with the vulnerable population, needs to take the lead on service design and delivery with government funding and support. Most mentioned the work and focus of the Ally Centre in our interviews.
- Many reflected the need to get as many issues addressed in one space and at one time as being valuable for vulnerable individuals. Peoples' lives are difficult and complex so if they can work toward addressing housing, medical needs, mental health, harm reduction (e.g. needle exchange) all at one time, that would be ideal.
- With the development of any service, especially those that are stationary, consider the provision of transportation supports. Transportation was mentioned as a major gap causing difficulty meeting daily needs, getting prescriptions, getting to follow-up referrals, and getting one's methadone etc.
- Safe spaces where individuals can go when shelters are closed for the day and/or when meals at Loaves and Fishes are finished need to be developed. There is a lack of supportive, drop-in style services that are flexible and without rigid rules and timespans. We need to continue to address social isolation and exclusion. Spaces could be designed to offer a range of resources including snacks and refreshments, computer, phone and fax access, educational and self-help groups, assistance with completing forms and follow up (i.e. occupancy forms, Legal Aid) and could serve as a hub for existing services like opioid recovery, Housing First, and immunization programs to reach a client base.
- Work closely with community partners in outlying areas to build a base and to strengthen the community's capacity to open their doors to those most isolated and vulnerable.
- There is an opportunity to learn from and build upon what we heard is already being well received among vulnerable populations. For example, any new outreach components might work alongside the existing needle exchange service.
- The outreach staffing component was described as functioning best if multidisciplinary and using a team-based approach to deal best with complex life situations.
- Most of those we spoke with discussed the importance of having the 'right staff' involved. This means hiring those suited for working in this field -- genuine, nonjudgmental, 'easy going', not overly clinical, skilled in dealing with crisis, and well-versed in community resources, etc.
- Involve first voice individuals whenever possible in helping to design and evaluate services that enhance access. Consider involving those with lived experience to act in a peer support capacity.

- Gaining community buy-in and support was mentioned frequently in our interviews. This is a crucial step to reduce the ‘not in my backyard’ type of attitudes that can exist as well as judgment, social exclusion and isolation. Community development and engagement approaches should be part of action planning. Appealing to values like safety and helping others may be promising.
- Connect with those service providers who were interviewed and expressed an ability to help in some way (this ranged from helping to ‘spread the word’ to actually designating space or staff time). Communicate regularly and reach out to partners so that ownership is enhanced.

## Other considerations moving forward:

- Connect with those service providers who were interviewed and expressed an ability to help in some way (this ranged from helping to ‘spread the word’ to actually designating space or staff time). Communicate regularly and reach out to partners so that ownership is enhanced.
- Continue to scan for funding opportunities at all levels of government as most of those we spoke with felt that the financial aspect/funding would be the most challenging aspect to secure.
- Design any actions/services so that evaluation components are built in from the beginning in order to effectively measure processes and outcomes. This will help determine any successes and strides made from the program activities and can be important in obtaining funding.
- There is a related opportunity to advocate for and promote trauma-informed, recovery-oriented, non-stigmatizing care through professional development, conferences, workshops, and within university programs (for physicians, social workers, nurses, police, etc.) so that people regardless of income and life situations have an increased chance of receiving sensitive and respectful care.
- Advocate where possible for upstream thinking, policy changes (e.g. stigma-free living incomes, housing access) and for inclusion of the many wellness aspects not currently covered for those without insurance – i.e. dental care, eye care, counselling and chiropractic care.
- Know upfront that it can take a while to build awareness and usage of any new approach or service. Gaining clients and their trust might be slow at the start.

## Conclusion

In Canada, we pride ourselves on universal health care. Unfortunately, increasingly numbers of people are becoming disenfranchised from their fundamental right to such care. As our research repeatedly indicated, these members of our communities have come to feel that *no one cares about people 'like us'; they don't understand what it is like for me; essentially, we do not matter*. Such experiences can cumulate into profound forms of hopelessness as one increasingly becomes 'given up on' or considered beyond help.

The data clearly highlights the numerous challenges faced by those who are most vulnerable population when attempting to access health services. It became clear that problems like poverty, inadequate housing, food insecurity, chronic disease, mental illness, addiction, criminality and social exclusion cannot be looked at in isolation as they are closely intertwined and symptoms of larger societal issues and complex life courses.

Developing a comprehensive, holistic service that reaches out to those most in need can help to address the current inequities that exist when it comes to health care access. The need to *engage* and *reach out* to the vulnerable population is clear, however, how we approach the situation is critical and requires both "street-wise" expertise and the involvement of compassionate health and social service providers.

There exists a real need to *create supportive environments* and begin foundational work in communities by working in partnership with local community organizations, particularly communities outside Sydney, where fewer supports exist. Friendship or Ally *services* could build capacity at the street level in our smaller communities. Such spaces would act as the foundation for outreach health and promote wellness, harm reduction, support, and advocacy. By fostering a non-judgmental acceptance of those most at-risk in our communities we can begin to build trusting relationships, breaking the isolation of vulnerable populations and facilitating access to health and community services.

Any service design must bend, weave, and flex with the different cultures and ways of being and not impose unrealistic standards or expectations. Our actions can be further guided by the key principles of Primary Health Care as outlined by the Canadian Nurses Association (2005):

- *Accessibility*: health services are available to all people with no unreasonable geographic or financial barriers.
- *Public participation*: individuals and communities are active partners in making decisions about their health.
- *Health promotion*: enabling people to increase control over, and to improve, their health.
- *Appropriateness* of technology, care, service delivery, procedures, and equipment. These should be socially and culturally acceptable and affordable.
- *Intersectoral cooperation*: commitment from all sectors is essential for meaningful action on the health determinants.

A close examination of these five principles ties in with what we heard in our local needs assessment. We know what is lacking and we know what could and should be done. As noted by The BC Centre of Excellence for Women's Health (2015), system change requires breaking the many 'vicious cycles' involving unresolved trauma, poverty, social exclusion, inability to find and/or maintain housing and ineffective services. Our action phase will be directed by the voices of those who openly shared their experiences and 'vicious cycles' with us and will be grounded in the principles above.

It was clear from the numerous community organizations we spoke with that there is a real and genuine desire to be involved in working together to increase access to health and other social services through flexible outreach and related approaches.

As insightfully put forth by Brownell at al. (2001), "A measure of any health system's merit is the way in which it treats its most vulnerable citizens." To remain silent on what was heard would be a disservice to *those who need care the most and often receive the least*.



# Appendix A

## Advisory Group:

- Christine Porter, Director ALLY Center Cape Breton
- Janet Bickerton, Board Chair ALLY Center Cape Breton
- Fred Deveaux, Cape Breton Community Housing Association
- Helen Morrison, Transition House
- Louise Smith Macdonald, Every Woman's Center
- Gena MacDermid-Gosse – Correctional Facility
- Patricia Bates-MacDonald – Correctional Facility
- Paul Muise – Cape Breton Regional Police
- Judy Kelley – Public Health/Cape Breton Community Housing Association
- Billy Hill – Community Action Board on Homelessness
- Jeannine McNeil, Public Health Agency of Canada (by phone)
- Sharon MacKenzie, NSHA Opioid Recovery Program
- Judi Rutherford, Eskasoni Health Center
- Sharon Rudderham, Eskasoni Health Center
- Lindsay Sylvester, Jane Paul Women's Resource Centre, Sydney
- Laurie Clark, CB Metro VON
- Erin Neville, Public Health, NSHA Eastern Zone
- Kathy Bell, Primary Health, NSHA Eastern Zone
- Kim Bartholomew-Pushie, Primary Health Care NSHA Eastern Zone
- Dr. Margaret Dechman, Cape Breton University
- Darlene MacEachern, Director, Elizabeth Fry Society

## The research team included representation from numerous organizations:

- Janet Bickerton, RN, BN, MEd, Ally Centre Board Chair & Community Studies, Cape Breton University
- Margaret Dechman, PhD (Sociology), Communities & Connections, Cape Breton University
- Sam Libbus, BSc. (Psychology), Project Research Assistant
- Marcie McKay, MA (Community Psych), Health Promoter, Healthy Communities, Public Health Eastern Zone, NSHA
- Christine Porter, Executive Director, Ally Centre of Cape Breton

## Appendix B: Our local context

### What we knew prior to the needs assessment

#### Homelessness and poverty:

- Recent research, completed in Spring 2016, asked relevant CBRM service providers to assess the number of their clients who were homeless over a one-month period. Two hundred and seventy-nine adults plus 25 child dependents (304 people in total) were identified as being homeless or provisionally housed in the CBRM.
- During the same month, 137 people were identified as homeless on a one-day 'point in time' count.
- Poor income, addiction and mental health problems as well as family breakdown and criminal history were identified as the most significant barriers to finding housing.
- 29% of those identified as homeless were from corrections, police, or halfway houses.
- Food Bank usage in CBRM was up 11.5% in 2012 from 2008.
- 485 people at risk of homelessness attended *Under One Umbrella* in 2016. This event provides basic services such as access to a physician, hearing and vision checks, immunizations, hair-cuts, and information related to basic social support services.
- The rate of poverty stands at a staggering 1 in 3 children in the CBRM.
- The rate of those under the age of 6 living in poverty in CBRM is more than twice the national rate.
- The unemployment rate is also double the national average at 14%.
- In 2011, there were more families led by single parents than both the provincial and national average.

#### Substance abuse and barriers to health services:

- As reported in the Community Foundation of Nova Scotia Vital Signs report, in 2012 there were 187 drug violations. This rate was more than twice the rate of 89 in 2003.
- From April 1<sup>st</sup> 2016 to March 31<sup>st</sup> 2017, the Ally Center distributed 608,630 needles which equates to 4.6 needles per person living in Cape Breton, whereas Mainline distributed approximately 1.3 needles per person living on the Mainland (i.e. 1,025,642 needles).
- 74% of syringes were distributed throughout the island using an outreach approach through their Natural Helper Network.
- Recent research with the injection drug using population has indicated that approximately two out of three people who are injecting drugs in the CBRM do not have a regular physician who knows about their drug use.

- 82% of this same population have experienced abscesses, cellulitis, overdosing, and/or some other serious condition (mostly commonly Hepatitis C). For two-thirds of those with such illnesses, the condition has become severe enough to require hospitalization at some point.
- Concerns about being “found out” and/or the shame of being identified as an “injection drug user” are leading some people to delay or avoid treatment. As one respondent stated, “I don’t go until I am so sick I am dying.”
- In past research, local individuals voiced they often care for themselves or seek assistance from peers (natural helpers) when they are ill. While the natural helpers provide information and supplies to facilitate safe injection, they do not have medical training.

#### **Overdose:**

- Cape Breton had the highest incidence of overdose per capita in Nova Scotia according to the Medical Examiner’s Report 2011 to 2014.
- According to the Medical Examiner, overdose is the third leading cause of accidental death in Nova Scotia.
- EMS in Cape Breton responded to 330 drug poisonings between August 2011 and September 2012; a number that increased during the period of 2014 to 2015.
- Recent research conducted in partnership with the local needle exchange, Cape Breton University and Mental Health & Addictions, identified overdose as a main area of concern among all opioid using participants. The majority of participants had overdosed themselves or were present during an overdose.
- The rising concerns nationally around Fentanyl overdose suggests that we will see more of this tragedy, reinforcing the need for street based education and access to knowledge and equipment to prevent death by overdose.

#### **Mental health and health wait times:**

- The current wait for a mental health appointment under Adult Community-based Services is 383 days at the Cape Breton Regional Hospital. This wait time has faced criticism as help is not available when people seek it (accessed via <https://waittimes.novascotia.ca/> and reflects data available as of Aug.22, 2017).
- The Cape Breton area’s rate of Emergency Department closures was the highest of all areas in the province increasing by 18.1% from 2010.
- Mood disorder rates were 45.3% higher than the Canadian average in the Vital Signs report for the CBRM.

**Communicable disease and chronic disease:**

- In 2014, the Hepatitis C incidence rate in the former CBDHA was 3 times higher than the Nova Scotia provincial incidence rate.
- Of the 179 (71.6%) cases of hepatitis C reported in 2012, injection drug use (IDU) was the most commonly reported risk factor at 70.9%. For cases that reported IDU, 69.3% indicated sharing injection equipment.
- Rates for diabetes, high blood pressure, and COPD in Cape Breton are all higher than the Canadian average.

**Accessibility:**

- Most in the vulnerable population have no access to transportation and CBRM has a public transit system that does not allow for affordable ease of movement.
- The bulk of services that are most needed by this population are located in Sydney.
- Other than Food Banks in outlying communities and a smattering of other community help services, such as Townhouse in Glace Bay or Salvation Army thrift stores, there are basically no services at a street level that welcome or have the capacity to serve the population we are most concerned about.
- The Ally Health Clinic, from its first offering, has been at full capacity but because it is a stationary service housed only in Sydney it cannot provide for populations living in other CBRM communities.
- Outreach is lacking and we are aware that those most vulnerable and at risk often do not come forward on their own for any formal health or social services. There exists a lack of supportive environments to engage, offer services and improve the health of this hard-to-reach population.

The previous points found on pages 34-36 were drawn from sources such as: Dechman (2015); Drug Fatality Analysis 2007-2014; Community Foundation of Nova Scotia (2013); Nova Scotia Department of Health and Wellness (2012); Nova Scotia Government (2017); The 2016 Homeless Count Committee (Fall 2016).

## Appendix C: Services taking part in interviews

- Town House Glace Bay
- Glace Bay Food Bank
- Harvest House
- Carmel Centre
- Northside Food Bank
- Community CARES (Sydney Mines)
- Elizabeth Fry
- Ally Centre
- Ally Centre Health Clinic
- VON
- Ann Terry Employment
- Salvation Army
- Loaves and Fishes
- Cape Breton Community Housing Association
- Cape Breton Transition House Association
- Cairdeil Place
- Cape Breton Regional Hospital Emergency Department
- Cape Breton Regional Police
- Opioid Recovery Program, Mental Health and Addiction Services, NSHA
- Public Health – Eastern Zone, NSHA
- EHS Services/New Waterford Mobile Care Team
- Jane Paul Centre

**We thank all service providers who took part in our interview process for their time, concerns, ideas and interest in our next steps.**

# Appendix D: Interview guide for first voice individuals

## Client Interview

Contacted through Organization # \_\_\_\_\_

### Interview Questions:

1. Where do you usually go to get medical attention if you are sick or concerned about your health?
2. If you think there might be something wrong with you, do you go to a doctor right away or do you tend to put it off? If you put it off, why?
3. Do you find it difficult to get transportation when you need to see a doctor or nurse, or get your blood taken, or other tests done?
4. Have you had any bad experiences when trying to get medical attention?
5. What about good experiences, have you had any good experiences when trying to get medical attention?
6. Have you experienced any difficulties getting the prescriptions you need?
7. Do you have any suggestions about how our medical or health services could be improved?
8. Is there anything in particular that would make it easier for you to get the medical or health attention you need?
9. In some places, nurses travel around in a van to meet with people who are finding it hard to get the medical attention they need. Do you think that might be a good idea for here?
10. If we were to have such a van here, where do you think would be a good place for it to stop so that people in your area could get to it?
11. Do you think that having health professionals give regular clinics at shelters or other locations would be helpful to people? Why or why not?
12. Within the last year, was there any time when you didn't have a place to live? (If yes, can you tell me a little about that?)

13. Thinking about your life in general, is there anything you can think of that could help you have a healthier life? (if they do not seem to understand the question, you could say, “like having a secure place to live”)
14. Do you have any other advice for people who are trying to organize better health services for people in the CBRM?

Thanks for your time, we appreciate your input.

## Appendix E:

### ***Outreach Health Organization Interview Background and Questions***

The purpose of the interview we have asked you to participate in is to learn about what services are currently available to meet the primary health care needs of your most vulnerable clients, and your ideas for a workable outreach health care service delivery model. We also want to explore ways in which your organization might support a new model for health care service delivery for street involved and vulnerable people.

Background:

*The Working Group for street outreach health has identified that there are gaps in primary health care services for hidden and vulnerable people in the CBRM. These are people who often live with addiction and/or mental health problems, who are street involved, or who are homeless or insecurely housed.*

*The Working Group's goal is to understand more about the situations and health needs of this population and to present options to improve or enhance access to outreach primary health care services. The information gathered will also serve to inform a proposal to implement a mobile outreach street health demonstration project in the CBRM aimed at providing services for hidden and vulnerable populations.*

**Primary health care** *refers to an approach to health care services that goes beyond the traditional health care system. It includes services that play a part in health, such as income, housing, education and the environment. Within primary health care there is an element that focuses on direct health services like diagnosis and treatment of illness and injury and illness prevention. It is about easy access to health care that is suited to the population in need and it involves using a range of health care providers to deliver the service.*

*We are interested in hearing about your knowledge and understanding of the primary health care needs of the street involved and vulnerable people with whom you work. Specifically, we want to learn about what services are out there now that is meeting the primary health care needs of this population and your ideas for a workable outreach health care service delivery model. We also want to explore ways in which your organization might support a new model for health care service delivery for street involved and vulnerable people.*

*The responses from all of the interviews will be combined in a document for the Working Group. Any comments that you make during the interview will not be attributed specifically to you. We expect that the interview will take approximately 30 to 45 minutes.*

Questions for service providers:

1. What are the types of life situations that bring people to use your services?  
Who uses your services?
2. What do you consider to be the most difficult problems your clients face, whether health related or not?
3. What types of health problems do your clients most often experience?
4. What do you consider to be the three most serious health problems faced by your clients?
5. When your clients have health problems, do they receive medical attention as quickly as they should?  
  
**If no**, Why do they not receive medical attention as quickly as they should?
6. Are there things that make your clients reluctant to seek health care?
7. Where or to whom do your clients typically go for health care?  
Ex: services offered on site, specific community organizations, hospital, nurse, doctor.
8. Do you know of any particular difficulties your clients have experienced when they have sought health care?
9. Can you think of any good experiences your clients have had with particular health-care providers?
10. Do you have any experience working with or are you aware of any outreach health services models for street involved or stigmatized populations?  
  
**If yes**, What worked well or not so well with these models?
11. From your perspective, what would be the ideal way for your clients to access the health services they need?  
Ex: Would offering clients transportation to health services help? Should services be brought closer to clients?
12. How would you see such a model working?
13. Who would need to be involved in organizing and delivering the services?
14. In some communities, health services are delivered to street involved people by a mobile outreach van. Do you think that would work in the CBRM?  
Why or why not?  
What do you think would be the main challenges to implementing such a service?

15. In some communities, health services are offered to street-involved people by a team of nurse nurses and physicians who hold regular clinics at shelters or other locations where street involved or vulnerable people are likely to gather. Do you think that would work in the CBRM? Why or why not?  
What do you think would be the main challenges to implementing such a service?
16. In order to offer an outreach health service, we need to have a good understanding of where in the community such a service could most effectively be offered. When you think about your clients, are there any particular places within the CBRM that they tend to visit often? Where do you think they might be most likely to take advantage of a mobile outreach health service?
17. Do you have any other thoughts about potential outreach models that might work for your clients that we have not already covered?
18. Would your organization be willing to participate in a collaborative model to deliver health services to street-involved people? If so, in what ways do you think your organization could support the development and implementation of such a program?  
PROBE: support in principle, support to advocate for funding, space, promote service to clients, allocate staff time, other in-kind contributions.
19. We may have additional questions as a model begins to emerge from our discussions with other people. May we call you again as we develop a proposal for this potential service?

Thanks for your time, we appreciate your input.

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