Homelessness and Health:
Social Determinants of Health in York Region

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The York Region Alliance to End Homelessness extends special gratitude to survey participants. This report and resulting improvements to health and access would not be possible without your participation and insight.

About the York Region Alliance to End Homelessness
The Alliance is a coalition of social service agencies and other stakeholders that work collaboratively to understand, plan and implement a strategic response to issues of homelessness in York Region. Our vision is "Connected and Engaged Communities: Homes for All" and our mission is to facilitate collaborative solutions to homelessness and poverty in York Region.

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Executive Summary

Background

Health outcomes are not only determined by access to medical resources or individual decisions, but also a variety of other situational circumstances and living conditions referred to as the social determinants of health[iv]. The ability of homeless and at-risk people to maintain good health is a recognized challenge in York Region. However, there are a very limited number of studies that document the specific health-related challenges of homeless and at-risk individuals in York Region. The findings documented in this report parallel a health needs assessment sister report and are based on a survey conducted to gain a broader understanding of the specific health needs and behaviours of homeless and at-risk members of the York Region community[vii]. These findings, along with the health needs assessment findings, are intended to increase understanding of the relationship between conditions of homelessness and health, as well as guide and inform the development of specific health initiatives that will help to improve the health of homeless and at-risk people in York Region and increase their ability to access appropriate care.

Methodology

A paper survey questionnaire was used to collect data from frontline staff of local agencies based on their understanding of their client populations' main needs. A total of 85 surveys were mailed out with individual return envelopes to 28 organizations and 40 surveys from 15 organizations were returned, although 3 surveys had to be excluded because they were not accompanied by a signed consent form. Analyses in this report are according to broad demographic groups based on descriptions provided by participants. Some demographic categories may overlap as many organizations serve more than one client group. The methodology and survey questionnaire were approved by the York University Ethics Sub-Committee and simple statistical analyses were conducted by the York Institute for Health Research.

Results

Demographics

For the purposes of these analyses, the following demographic categories were created: serving adult females (65%); serving adult males (57%); serving male or female youth (51%); serving newcomers including immigrants, refugees, or non-status (51%). These are overlapping categories, with many organizations serving more than one client group.

Basic Essentials

Just under half (43%) said that most of their clients had stayed in an emergency or transitional shelter in the last two months. Almost 1 in 5 participants (19%) said their male clients had stayed somewhere outside in the last two months. The inability to afford rent (66%) followed by relationship break-up (34%) and evictions (26%) were the most commonly given reasons for why participants' current clients may have become homeless. Half of all participants (50%) said that they had supported clients that had a problem with mould at a place where they were staying in York Region. Fifty-eight percent (58%) of participants said that at least half of their clients were on a waiting list for subsidized housing.

Access to identification is a significant concern. About a third of participants (35%) said that their clients had been refused healthcare because they did not have a health card. Participants said that clients were most often refused healthcare at a walk-in clinic (31%), an emergency department or hospital (19%), or at a family doctor's office (15%). The most common reasons why clients did not have a health card were that they had lost it (30%) or that they were not eligible for a health card (24%). Several participants also said that many of their clients had been refused banking services (37%) and Ontario Works (26%) because they did not have identification.

Participants reported that the majority of their clients relied most heavily on Ontario Works, followed by the Ontario Disability Support Program (ODSP) and employment wages. About a third of participants said that their clients usually cash cheques at a bank or trust company (36%) or a cheque cashing service like MoneyMart (31%). About a quarter of participants (26%) said that some of their clients did not have a bank account because they did not have identification and were refused services.

Only 3% of participants said that their clients had never been hungry because of a lack of food. Participants reported that clients most often went to food banks (73%), grocery stores (57%), or a meal program or soup kitchen (51%) for food. Half of participants identified food as a major challenge in an open-ended question about the hardest part for clients to stay healthy without a permanent place of their own to live. Under two thirds of participants (64%) were supporting clients that needed to follow a special diet for health or cultural reasons.

Several participants reported that their clients had told them about difficulty sleeping due to bad nerves and inability to relax (70%), feelings of pain or discomfort (49%), and/or nightmares (41%).

Healthcare Access

Less than a quarter of participants (23%) said that most of their clients did not have a particular medical professional or place that they usually go to when sick or in need of health advice. Of those who supported clients that did have a usual source of healthcare, 61% said that it was usually a particular medical professional (74% of these said a doctor), and 39% said it was usually a particular place (67% of these said a walk-in clinic and 52% said a family doctor's office). The most common reasons participants gave for why clients might not have a usual source of healthcare was a lack of transportation (36%), followed by clients having recently moved (21%), clients moved around a lot (21%), or clients were too busy finding food, shelter, or other necessities (21%).

In the past year, participants said they had most often referred or sent clients to a family doctor's office (62%), hospital emergency room (57%), or walk-in clinic (57%). The two most common reasons for sending a client to the emergency room were a mental health problem (23%) or a physical problem other than an injury (20%), followed by an injury (19%) or a prescription refill (17%). Almost all participants who said their clients had left the emergency department early (89%) said that their clients had left early because the wait was too long. Over a third of participants (35%) said their clients had nowhere to go or that they stayed on the streets after being discharged from hospital.

Less than half of participants (44%) said that their clients had a drug benefit card and almost two thirds of participants (64%) said that their clients needed prescription medication but were unable to obtain it in the past year. The two main reasons for why people were unable to get their prescription medications were that they could not afford it (73%) and that they did not have a drug benefit card (31%). Less than a third of participants (31%) said that their clients had told them about a need for medical supplies or equipment that they were unable to obtain in the past year. The primary reason given for not being able to get necessary medical supplies or equipment was that clients could not afford it (76%).

Social Interaction

More than half of participants (58%) also said that they had clients who had told them about being physically assaulted or beat up in the past year. More than a third of participants (39%) said that their clients had told them about being sexually harassed in the past year. A quarter of participants said that they had clients who had been sexually assaulted or raped in the past year.

In an open-ended response about the hardest part of their clients trying to stay healthy, 21% of participants mentioned stress and isolation. Just over 1 in 5 participants (22%) said that none of their clients participates in any recreational or social programs. Participants reported that the most common reasons for clients not to participate in recreational or social programs were that they did not want to (37%), they lacked transportation to access programs (34%), it was too expensive (31%), or that they did not know where to find programs (29%).

Discussion

Due to various restrictions, the findings presented in this report reflect generalized patterns regarding the impact of social determinants of health on homeless and at-risk people in York Region and more specific details could not be captured through this study. Overall, the findings of this report illustrate how social determinants of health have a significant impact on the health outcomes of homeless and at-risk people in York Region. In particular, participants' clients' low level of income and struggle to find or maintain housing due to cost and availability.

Proper identification also determined whether or not participants' clients could access essential healthcare, banks, and financial assistance. Food insecurity is a major challenge in York Region as almost all participants said that their clients had gone hungry due to a lack of food.

Only 74% of participants estimated that most of their clients had a doctor that they usually turned to, compared to 93% of Central LHIN residents 18 years or older that have a family physician[ix]. Newcomers, a major demographic in York Region, seem to turn to a broader diversity of supports like nurses, nurse practitioners, and alternative healthcare. Findings in this report support increasing the availability a broader range of healthcare resources. Transportation continues to be a barrier to accessing adequate healthcare support[v].

More than half of participants referred clients to a hospital emergency room for mental health problems, physical problems other than injury, injury, and prescription refill. Participants said clients that left the emergency department did so because the wait was too long.

Injury, physical violence, sexual harassment, and sexual assault were fairly prevalent among homeless and at-risk clients. Stress and isolation among clients were a major concern. The ability to access social networks and feel connected and included is an important social determinant of health. The enhancement of social networks may help to directly improve physical and mental health as well as provide a point of access to medical professionals, alternative healthcare, and other resources like healthy food or local information.

There is an opportunity for the Central LHIN to work with the community to enhance alternative healthcare resources for homeless and at-risk people in York Region. Health Providers Against Poverty[xii] and Inner City Health Associates[xiii] are example networks who work together to provide affordable, untraditional healthcare solutions in Toronto. York Region may benefit from a similar local network.

Background

Recent reports clearly document that people who are homeless or at-risk of becoming homeless have significantly poorer health and higher rates of chronic disease compared to the general population[i, ii, iii]. *The Street Health Report 2007*, a comprehensive health survey among homeless individuals in Toronto, provided an update to the 1992 *Street Health Report*. Both reports outlined a number of significant health challenges faced by homeless individuals in Toronto, directly related to their living conditions and a general lack of resources, support, and access to adequate healthcare [ii, iii].

Sick and Tired: The Compromised Health of Social Assistance Recipients and the Working Poor in Ontario (2009) presents that it is not only street homeless people who suffer poor health. Social assistance recipients also have "higher rates of diabetes, heart disease, chronic bronchitis, arthritis and rheumatism, mood disorders, anxiety disorders and many other conditions" than those in the general Ontario population[i]. *Social Determinants of Health: The Canadian Facts* (2010) also illustrates that health outcomes are not only determined by medical resources or individual decisions, but also a variety of other situational circumstances and living conditions, like low income, referred to as the social determinants of health[iv] (Appendix A).

Despite the growing number of reports illustrating the significant health impact of homelessness and poverty nationally, provincially, and in urban centres like Toronto, much less data exists regarding the health of homeless people in suburban and rural areas, such as York Region. The ability to maintain good health is a recognized challenge in York Region, especially relating to social determinants of health and individuals' physical ability to access healthcare resources[v]. However, there are a very limited number of studies that document the specific health-related challenges of homeless and at-risk individuals in York Region.

In 2009, the York Region Alliance to End Homelessness conducted a pilot study[vi], based on Toronto's Street Health Survey, which included a basic health assessment of homeless and at-risk individuals in York Region. This pilot study demonstrated that homeless and at-risk people in York Region tended to have poorer physical and mental health. Several participants also identified health barriers relating to broader determinants of health, such as income, physical environment like shelter, proximity to services, or accessibility of healthy food, social environments, personal health practice or coping skills, as well as health service access.

Although the pilot study conducted in 2009 has provided some direct insight to some major concerns about health and access to healthcare among homeless and at-risk people in York Region, the scale of this study limited the amount of information that could be collected and analyzed. The findings documented in this report parallel a health needs assessment sister report and are based on a survey conducted to gain a broader understanding of the specific health needs and behaviours of homeless and at-risk members of the York Region community[vii]. These findings, along with the health needs assessment findings, are intended to increase the knowledge base of the relationship between conditions of homelessness and health, as well as guide and inform the development of specific health initiatives that will help to improve health and access to care among homeless and at-risk people in York Region.

Methodology

A paper survey questionnaire was used to collect data from frontline staff of local agencies based on their understanding of their client populations' main needs. The survey questionnaire was based on Toronto's Street Health Survey because of its recognition as a reliable tool that has been tested in other similar communities.

Modifications were made to the original questionnaire to account for participants being service providers rather than service users, and the revised survey was tested with a small subgroup of frontline workers similar to the intended survey participants.

A total of 85 surveys were mailed out with individual return envelopes to 28 organizations with an invitation letter explaining the purpose of the survey and instructions for participation. Instructions asked participants to complete an entire survey based on a particular client population group, as could be defined through selecting demographic descriptions listed in the first question. Analyses in this report are based on broad demographic groupings from these descriptions. Since participants were asked to check off all characteristics that applied, some categories may overlap as many organizations serve more than one client group. All participants were required to sign a consent form included in the mail package.

A total of 40 surveys from 15 organizations (Appendix B) were returned within the 5 weeks allowed. Three surveys were not accompanied by a signed consent form and, unfortunately, had to be excluded from the analysis. The methodology and survey questionnaire were approved by the York University Ethics Sub-Committee and simple statistical analyses were conducted by the York Institute for Health Research.

Results

Demographics

Participants were asked to indicate the main demographic characteristics of client groups served. Since participants were asked to check off all characteristics that applied, some demographic categories may overlap as many organizations serve more than one client group. Frontline workers that participated in this needs assessment reported that 70% of them supported clients who were at-risk of homelessness and 54% said they supported homeless clients. Up to half of participants indicated that they served recent immigrants (51%), refugees (27%) or non-status clients (22%).

When broken down by gender and age, just over half of participants served women (59%), men (54%), youth (51%), and younger children (51%) (Table 1).

Table 1: Gender/Age Characteristics of Clients Served

Characteristics	***Frequency***	***Percentage***
Women (age 27+)	22	59
Men (age 27+)	20	54
Younger children (age 0 to 6)	19	51
Youth (age 16 to 26)	19	51
Families	17	46
Older children (age 7 to 15)	14	38
Transgender	11	30

Almost two thirds of participants also said that they provided support to clients with mental health concerns (62%) and/or addictions (59%). About half said their clients were struggling with HIV/AIDS (49%) or being a victim of domestic violence (49%). Several participants also said that client groups were challenged by developmental (32%) or physical disabilities (22%) (Table 2).

Table 2: Health-Specific Characteristics of Clients Served

Characteristics	***Frequency***	***Percentage***
Mental health	23	62
Addictions	22	59
HIV/AIDS	18	49
Victims of domestic violence	18	49
Developmental disability	12	32
Physical disability	8	22

The cultural distribution of clients served is highly diverse. The majority of clients served were White, Caucasian (86%) and Black (65%), South Asian (65%), and West Asian (65%) (Table 3).

Table 3: Cultural Demographic Breakdown

Cultural Group	***Frequency***	***Percentage***
White, Caucasian	32	86
Black	24	65
South Asian	24	65
West Asian	24	65
East Asian	21	57
First Nations	19	51
Southeast Asian	19	51
Hispanic, Latin American	18	49
Other	6	16
Don't know	3	8

For the purposes of the subsequent analyses, the following demographic categories were created: serving men; serving women; serving youth (male or female); serving newcomers (immigrants, refugees, or non-status). These are overlapping categories, with many organizations serving more than one client group. The breakdown by these four categories is represented below in Table 4.

Table 4: Demographic Categories for Analyses

Characteristics	***Frequency***	***Percentage***
Women (age 27+)	24	65
Men (age (27+)	21	57
Youth (age 16 to 26)	19	51
Newcomers (immigrants, refugees and non-status)	19	51

Basic Essentials

Homelessness and Housing

Just over half (54%) of participants said that most of their clients had stayed in a rented room, house, or apartment, while just under half (43%) said that most of their clients had stayed in an emergency or transitional shelter in the last two months. About a third (35%) of participants said that their clients had stayed with a friend. Although participants reported this trend consistently for all demographic groups, 19% of participants also said their male clients had stayed somewhere outside in the last two months. Slightly more than a quarter

of participants said newcomers (26%) and men (29%) had stayed in an emergency or transitional shelter, compared to more than a third who said the same for youth (42%) and women (37.5%). Of the main demographic groups, women (29%) were most likely to have their own place, compared to men (19%) who were least likely to have their own place.

The inability to afford rent (66%) followed by relationship break-up (34%) and evictions (26%) were the most commonly given reasons for why participants' current clients may have become homeless. Youth (74%) were most likely to become homeless because of the inability to afford rent, and women (37.5%) were most likely to become homeless due to a relationship break-up. Adult men and women (each 33%) were most likely to become homeless after being evicted. More than a third of participants (36%) said something about shelter or housing when asked in an open-ended question to describe the hardest part for their clients to try staying healthy without a permanent place of their own to live.

> *"Some of my clients have been couch surfing, staying in motels or shelters prior to finding housing. The stress of 'the unknown' is what prevents them from maintaining either good mental health or physical health."*

Half of all participants (50%) said that they had supported clients that had a problem with mould at a place where they were staying in York Region (Figure 1). This was particularly common among participants who supported youth (67%).

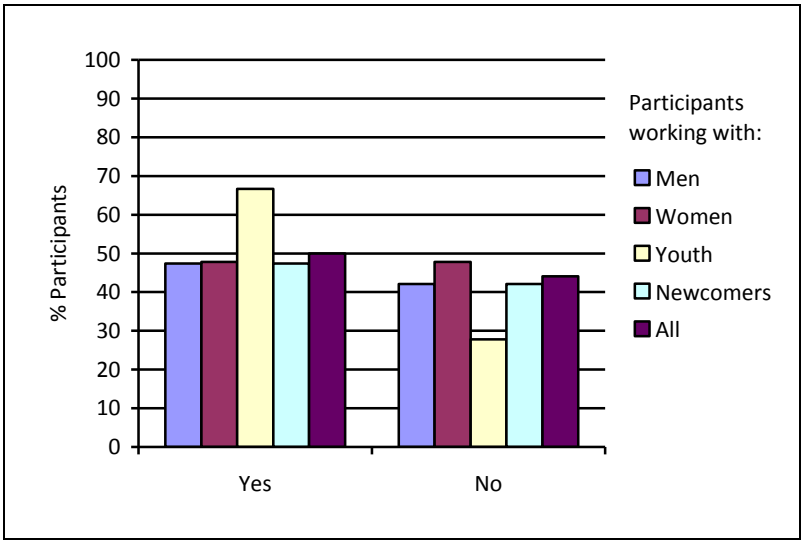

Figure 1: Percentage of participants supporting clients that had mould in housing

Fifty-eight percent (58%) of participants said that at least half of their clients were on a waiting list for subsidized housing. Thirty-six percent (36%) of these participants said that more than half of clients on a waiting list had difficulty staying on the list. The estimated length of time on the waiting list ranged from 3 weeks to 10 years, although most participants (46%) said that 3 years was the estimated average time that their clients were on the waiting list.

About three quarters of participants said that their clients were receiving help with finding housing through their agency (56%) or through other means (21%). The most common forms of housing help were a housing list (30%), a short-term agency staff worker (30%), and a long-term agency staff worker (22%). Participants said that men (33%) and newcomers (32%) were more likely to find assistance through a short-term agency staff worker, compared to women and youth (each 31%) who seemed to turn more to a housing list. Participants also said that of their clients who were not receiving housing help, the most common reasons for not receiving help were that clients did not know how to ask for help (47%) or that they did not want assistance (33%). The most common barriers that participants identified as keeping their clients from finding and maintaining their housing were that the cost of rent was too high (68%) and that there is a lack of suitable housing (27%).

"A lack of safe and affordable housing has affected their emotional and mental health also. This makes them somehow more susceptible to actual physical illnesses or at least depression. The other physical symptoms are varied but more constant than persons with homes: coughs, sore throats, aches, insomnia, headaches, cuts, bruising, low immune resiliency overall, and depression due to situational concerns."

Identification

About a third of participants (35%) said that their clients had been refused healthcare because they did not have a health card. This was particularly common among participants that served newcomers (41%) and youth (39%). Participants said that clients were most often refused healthcare at a walk-in clinic (31%), an emergency department or hospital (19%), or at a family doctor's office (15%). About a third of participants supported women (39%) and youth (31%) that had been refused healthcare at a walk-in clinic because they did not have a health card (Figure 2).

Figure 2: Places where participants' clients have been refused healthcare because they did not have a health card

Half of participants (50%) said that their clients had either a health card (40%) or a temporary health card (10%), while a third of participants (35%) said that their clients did not have a health card. The most common reasons why clients did not have a health card were that they had lost it (30%) or that they were not eligible for a health card (24%).

Several participants also said that many of their clients had been refused banking services (37%) and Ontario Works (26%) because they did not have identification.

Income and Employment

Participants reported that the majority of their clients relied most heavily on Ontario Works, followed by the Ontario Disability Support Program (ODSP) and employment wages. Almost two thirds of participants (64%) said that at least 60% of their clients rely on Ontario Works, a third of participants said that at least 60% of their clients rely on ODSP, and less than a fifth of participants (17%) said that at least 60% of their clients relied on employment wages as a major source of income. Other commonly identified sources of income included family or friends (37%), Child Tax Benefit (34%), and alimony/child support (31%).

About a third of participants said that their clients usually cash cheques at a bank or trust company (36%) or a cheque cashing service like MoneyMart (31%) (Figure 3). Just under two thirds of participants (64%) said that most of their clients had a bank account. About a quarter of participants (26%) said that some of their clients did not have a bank account because they did not have identification and were refused services.

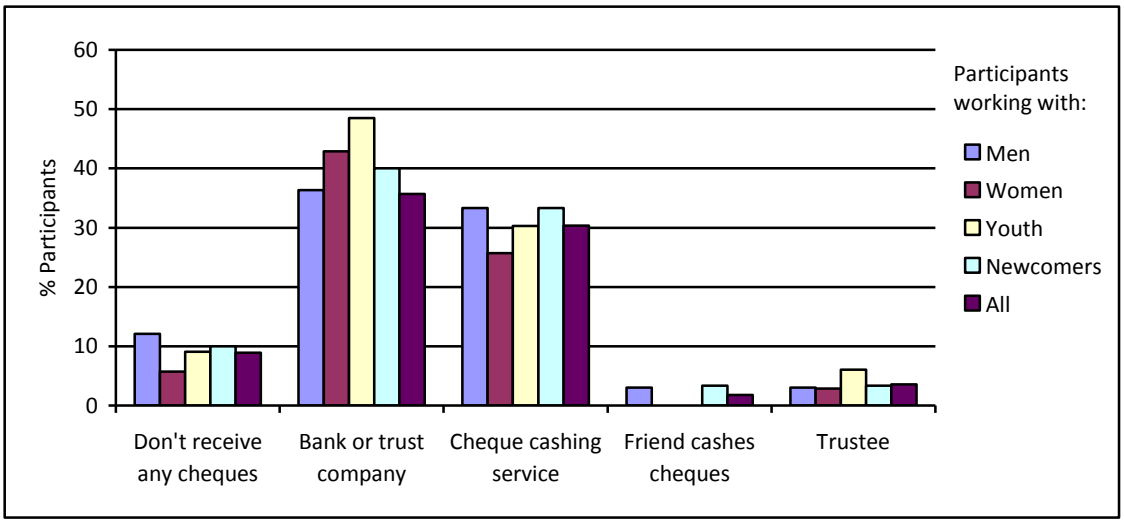

Figure 3: Methods that most of participants' clients use to cash cheques

Nutrition, Food Security, and Sleep

During the 3 months prior to completion of the survey, only 3% of participants said that their clients had never been hungry because they could not get enough food. In contrast, many more participants said that their clients had been hungry at least a couple of days a week (31%), at least one day a week (14%), or at least one day a month (11%). Participants reported that clients most often went to food banks (73%), grocery stores (57%), or a meal program or soup kitchen (51%) for food. Half of participants identified food as a major challenge in an open-ended question about the hardest part for clients to stay healthy without a permanent place of their own to live.

"Food access/security is a very big issue. Not only not enough money to buy food but to buy healthy food and the ability to get to a grocery store and carry groceries home or on YRT. Food banks are so limiting in terms of access as well and can be a challenge."

Under two thirds of participants (64%) were supporting clients that needed to follow a special diet for health or cultural reasons. This was particularly common among participants that support newcomers (79%). The most common types of diets were diabetic (87%) and cultural or religious (48%). Half of participants said that they were supporting clients receiving a special diet supplement. Participants said that clients not receiving the special diet supplement had either not applied (34%) or they had applied but had been denied (31%) (Figure 4).

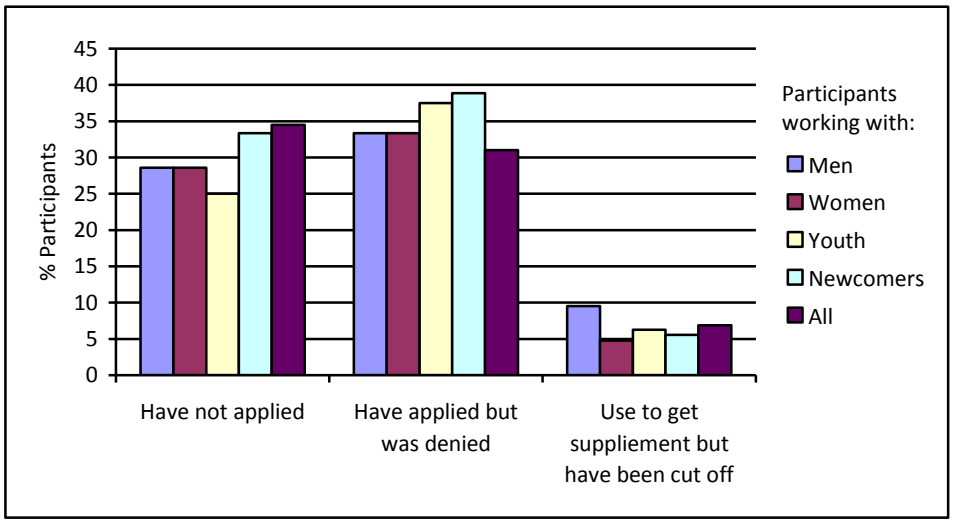

Figure 4: Participants' reasons why clients are not receiving the special diet supplement

Several participants reported that their clients had told them about difficulty sleeping due to bad nerves and inability to relax (70%), feelings of pain or discomfort (49%), and nightmares (41%).

"It is hard for them to stay healthy by maintaining a suitable diet. Foods that are healthy are expensive and it is hard to juggle finding affordable housing and eating appropriately. This affects their stress levels and being stressed 24/7 drains and wears down the body."

Healthcare Access

Access and Source of Care

Slightly less than a quarter of participants (23%) said that most of their clients did not have a particular medical professional or place that they usually go to when sick or in need of health advice. This was particularly common among newcomers, where almost a third of newcomers (32%) did not have a usual medical professional or place to go to when sick or in need of health advice.

Of those who supported clients that did have a usual source of healthcare, 61% said that it was usually a particular medical professional (74% of these said a doctor), and 39% said it was usually a particular place (67% of these said a walk-in clinic and 52% said a family doctor's office). Participants who worked with newcomers said that their clients tended to turn to a broader diversity of supports. Newcomer clients were reported to rely less often than all clients on a doctor (58%) compared to a nurse (16%), nurse practitioner (11%) or alternative healthcare professional (11%). The most common reasons that participants gave for why clients might not have a usual source of healthcare was a lack of transportation (36%), followed by clients having recently moved

(21%), clients moved around a lot (21%), or clients were too busy finding food, shelter, or other necessities (21%).

In the past year, participants said they had most often referred or sent clients to receive healthcare from a family doctor's office (62%), a hospital emergency room (57%), or a walk-in clinic (57%). The two most common reasons for sending a client to the emergency room were a mental health problem (23%) or a physical problem other than an injury (20%), followed by an injury (19%) or a prescription refill (17%) (Figure 5).

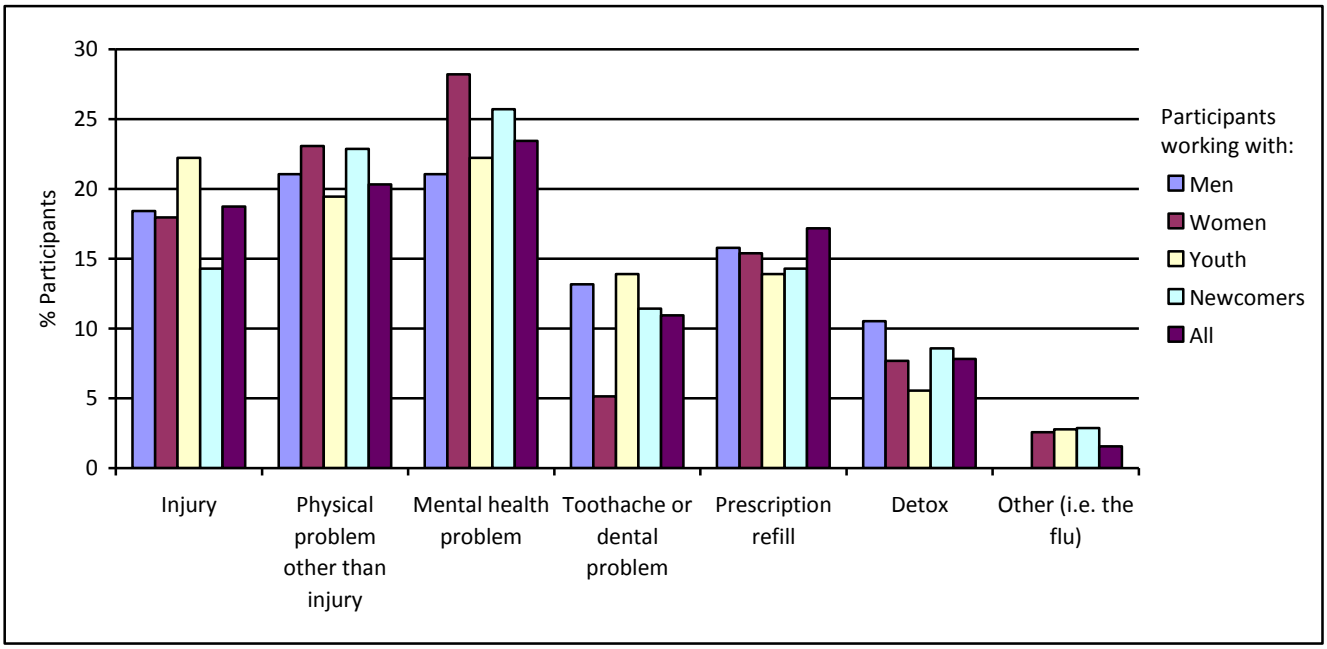

Figure 5: Reasons for why participants sent clients to the emergency room in the past year

Participants were asked to provide the top reasons their clients gave them for leaving the emergency room before being seen. Almost all participants who responded (89%) said that their clients had left early because the wait was too long. The second most common reason was that the clients had been brought to the emergency room by police but they did not want to stay (42%).

When discharged from an overnight hospital stay, most clients of participants went to a shelter or hostel (58%), a friend's place (46%), a relative's place (42%), or their own place (42%). Over a third of participants (35%) said their clients had nowhere to go or that they stayed on the streets after being discharged from hospital.

More than a tenth of participants (14%) said that their clients had told them about some kind of negative experiences with hospital security, such as being physically removed (8%). Men and newcomers in particular told participants that they had been physically removed (13% and 14%, respectively), or threatened or verbally assaulted (each 9%).

Medication and Medical Supplies

Less than half of participants (44%) said that their clients had a drug benefit card and almost two thirds of participants (64%) said that their clients needed prescription medication but were unable to obtain it in the past year. The two main reasons for why people were unable to get their prescription medications were that they

could not afford it (73%) and that they did not have a drug benefit card (31%). Just under two thirds of participants (66%) were aware of prescription medication that clients were supposed to be taking currently, most commonly anti-depressants (79%) and pain killers (54%). Of the participants who reported knowledge of clients' prescribed medications, 46% said clients sometimes ran out and did not refill prescriptions when they should, and 42% said clients sometimes could not afford to take medication.

Less than a third of participants (31%) said that their clients had told them about a need for medical supplies or equipment that they were unable to obtain in the past year. The primary reason given for not being able to get necessary medical supplies or equipment was that clients could not afford it (76%).

Social Interaction

Injury and Violence

More than a tenth of participants (17%) said that they had clients who had been hit by a car, bicycle, truck or bus in the past year. Participants said that youth (21%) were particularly vulnerable to these types of injuries. More than half of participants (58%) also said that they had clients who had told them about being physically assaulted or beat up in the past year. Participants reported that this occurred more commonly among youth (68%) and newcomers (63%) (Figure 6).

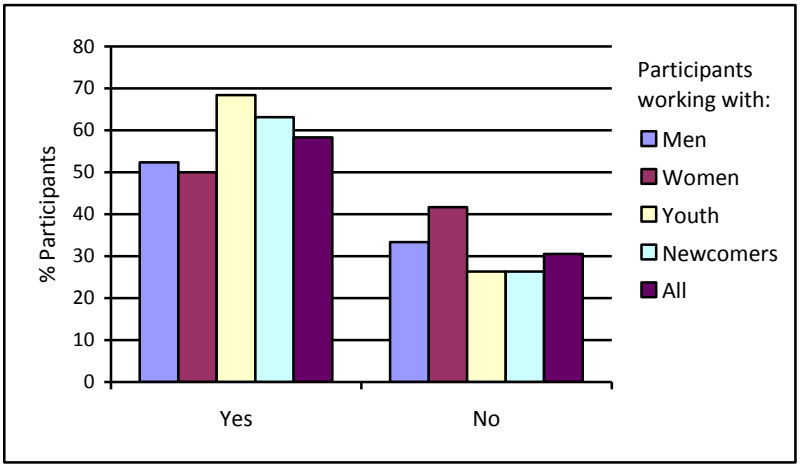

Figure 6: Percentage of participants whose clients had been physically assaulted or beat up in the past year

About three quarters of participants (76%) said that these assaults were by a boyfriend, girlfriend, partner, spouse, or significant other. Assaults were also often by acquaintances and friends (48%) and strangers (38%).

> *"Many of our [clients] are dealing with issues of abuse leading to homelessness. Abuse issues as a determinant of health are a challenge. Homelessness for prenatal women and the issues impacting them increase their risk of low birth weight babies and later complications."*

More than a third of participants (39%) said that their clients had told them about being sexually harassed in the past year. Sexual harassment appeared to happen more commonly among youth (47%) and newcomer (42%) clients of participants. A quarter of participants said that they had clients who had been sexually assaulted or raped in the past year. This occurrence was highest among youth (37%) and female (29%) clients of participants (Figure 7).

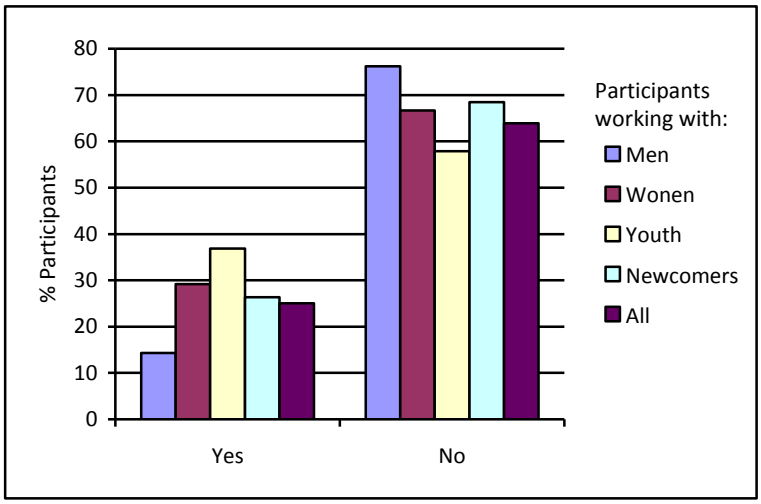

Figure 7: Percentage of participants with clients that had been sexually assaulted or raped in the past year

Social Services

When asked in an open-ended question about the hardest part of their clients trying to stay healthy, 21% of participants mentioned stress and isolation.

> *"Lack of hope for the future. Loneliness and sense of isolation. Stress of caring for their children's needs. Overall feeling of being unable to 'get ahead'."*

Recreational and social programs may provide opportunity to form and strengthen social networks. However, just over 1 in 5 participants (22%) said that none of their clients participates in any recreational or social programs, especially adult women (21%) and men (19%). Although just over half of participants (53%) said that up to 20% of their clients participates in a recreational or social program, especially newcomers (58%). Participants reported that the most common reasons for clients not to participate in recreational or social programs were that clients did not want to (37%), clients lacked transportation to access programs (34%), it was too expensive (31%), or that clients did not know where to find programs (29%).

Discussion

Due to resource restrictions, this study was conducted through survey questionnaires with frontline agency staff rather than directly with homeless and at-risk members of the community. This methodology was chosen because YRAEH did not have sufficient resources to compensate people for their participation, nor the staff time to conduct personal interviews with people or train peer researchers. These restrictions unfortunately did not allow for YRAEH to collect more detailed information or perform more detailed analysis regarding specific health concerns or behaviours of individuals. Instead, data needed to be based on more general observations of frontline staff that interact regularly with clients. As a result, the findings presented in this report reflect generalized patterns regarding the impact of social determinants of health on homeless and at-risk people in York Region and more specific details could not be captured through this study.

Overall, the findings of this report illustrate how social determinants of health are having a significant impact on the health outcomes of homeless and at-risk people in York Region. In particular, a consistent theme throughout the report is that participants' clients struggle to find or maintain housing due to cost and availability. Clients also may not have access to other essential resources like food, healthcare, medication, medical supplies, and social inclusion due to a lack of affordability, transportation, and availability of resources.

Only about half of participants said that most of their clients were housed in their own place, although the quality of housing is not always adequate. Mould is also a major problem for clients of participant organizations as half of participants identified this as a commonly reported issue, especially among youth. Participant responses reflected that the main reasons why people did not have their own place to live was because of cost, relationship break-ups and/or evictions. Affordable housing is also difficult to access. Clients may have difficulty staying on the waiting list for subsidized housing and almost half of participants said 3 years is a typical waitlist time, although estimates ranged up to 10 years. Housing support is a valuable resource that exists in the community as several agencies are involved in providing direct assistance to people in need of housing. However, the most pertinent barriers that prevent people from finding and maintaining housing are cost and an inadequate supply of suitable housing.

Proper identification was another determinant of whether or not participants' clients were able to access essential services and supports like healthcare, banking opportunities, and financial assistance. Participants noticed particular challenges among those that relied on Ontario Works, which is a main source of income for most clients.

Food insecurity is a major challenge in York Region as a strong majority of participants said that their clients had at some point gone hungry due to a lack of food. In many cases, this was as often as a couple days a week. Participants' clients relied heavily on food banks and meal programs in addition to buying their own groceries, which suggests that emergency food supplies are inadequate and do not meet the needs of homeless and at-risk people. For example, individuals are only able to access food banks once per month and receive enough food for 2 to 4 days[viii]. York Region residents may not be able to afford to buy food while also maintaining their housing, as supported by a York Region Food Network report that illustrates how low-income households in York Region cannot afford both the cost of rent and a nutritious diet[viii].

Only 74% of participants estimated that most of their clients had a doctor that they usually turned to for healthcare support, compared to a reported 93% of Central LHIN residents 18 years or older who have a family physician[ix]. As discussed in the Street Health Pilot Study, individuals with access to a primary care physician tend

to have greater access to primary and preventative healthcare like medical referrals, access to prescription medication, and preventive care, such as TB tests, flu shots, and complete physical examinations[vi]. According to the Regional Municipality of York, almost half of York Region residents (43%) are immigrants[x]. Since newcomers seem to turn to a broader diversity of supports like nurses, nurse practitioners, and alternative healthcare, the findings in this report support increasing the availability of a broader range of healthcare resources. As demonstrated in a previous transportation needs assessment, transportation continues to be a barrier that prevents individuals' ability to access adequate healthcare support[v].

More than half of participants said they referred clients to a hospital emergency room to receive healthcare. Reasons for referral included mental health problems, physical problems other than injury, injury, and prescription refill. Participants also said that they had clients that left the emergency department before being seen because the wait was too long. These findings are in support of the goals of all four planning priorities in the new Integrated Health Service Plan (IHSP) 2010-2013 released by the Central Local Health Integration Network (Central LHIN). As stated in the IHSP, "reducing wait times is an issue that can't be solved by focusing on the emergency department alone" and "there is a high rate of emergency department use due, in part, to limited access to alternative resources" [xi]. As several referrals to an emergency department may not be urgent or in need of emergency care, the Central LHIN should work with the community to enhance the development and use of alternative resources to meet the healthcare needs of homeless and at-risk people in York Region. It is important to note that many of the organizations providing support to homeless and at-risk individuals are not funded through the Central LHIN.

In other jurisdictions, such as the City of Toronto, there are growing networks of healthcare professionals sympathetic to the unique challenges faced by people in poverty. Health Providers Against Poverty[xii] and Inner City Health Associates[xiii] are examples of these networks who work together to provide affordable, sometimes untraditional healthcare solutions for homeless and at-risk people in Toronto, while also raising awareness among peers and advocating for improved service access for marginalized groups at the government level. York Region may benefit from a similar network to provide alternative healthcare for homeless and at-risk people.

Another action identified under the Central LHIN IHSP 2010-2013 is to improve discharge planning. Over a third of participants in this study said that their clients had nowhere to go or their clients stayed on the streets after being discharged from hospital. The Central LHIN and the community should work together to develop a strategy so that all homeless and at-risk individuals should be discharged safely to a shelter or alternative place of care.

Access to medication and medical supplies was also a challenge identified by participants. The most common barriers to medication access were cost and not having a drug benefit card. Access to a drug benefit card should be increased as it may help increase affordability and access to medication. A strategy should also be developed to help increase access to medical supplies so that individuals may be able to better maintain their health and quality of life and prevent further complication that may result in hospitalization.

Injury, physical violence, sexual harassment, and sexual assault were fairly prevalent among homeless and at-risk clients. Participants said consistently that youth were particularly vulnerable to each of these occurrences, although newcomers and women were also susceptible to some forms of physical and sexual violence. There is insufficient evidence in this study to indicate whether violence may be a contributing factor to homelessness or if being homeless may increase the risk of violence. However, the findings in this report support the need for increased violence prevention and response activities in York Region, particularly among youth, newcomers and women.

Stress and isolation among clients were a major concern to participants and several said that many clients, especially adult women and men, do not participate in any recreational or social programs. Although some clients may not be interested in recreational or social programs, the lack of participation was also often because of a lack of transportation, cost, or not knowing where to find programs. *Social Determinants of Health: The Canadian Facts* (2010) states that "the lack of supportive relationships, social isolation, and mistrust of others further increases stress," which over a prolonged time is associated with severe negative impact on physical and mental health outcomes[xiv]. Since the ability to access social networks and feel connected and included is an important social determinant of health, this presents an opportunity for health promotion by the reduction of social isolation. The enhancement of social networks may help to directly improve physical and mental health as well as provide a point of access to medical professionals, alternative healthcare, and other resources like healthy food or local information.

Recommendations

The following recommendations for next steps can be drawn from the findings of this report:

1. Improve quality and increase availability of affordable housing stock.
    a. Create a healthy quality standard for rental accommodation.
    b. Increase the number of affordable housing units in York Region.
2. Develop a collaborative Food Security Strategy for York Region that would address food access and affordability issues for low income residents.
3. Enhance partnerships and explore funding opportunities through the Central LHIN to work together to achieve goals under the four priorities: Emergency Department and Alternate Level of Care Strategy, Chronic Disease Management and Prevention Strategy, Mental Health and Addictions Strategy, and Health Equity Strategy.
4. Reduce hospital emergency wait times by exploring potential partnerships with local healthcare providers such as doctors, dentists, psychiatrists, optometrists, nurse practitioners, and alternative healthcare practitioners to increase access to non-emergency health-related care among homeless and at-risk people in York Region.
    a. Explore the potential to develop a York Region chapter of existing networks like Health Providers Against Poverty or Inner City Health Associates, or establish a similar York Region network.
5. Build partnerships between hospitals and local community agencies to improve discharge planning.
6. Increase access to drug benefit plans and develop a strategy to increase access to medical supplies to agencies providing supports to homeless and at-risk individuals.
7. Further develop collaborative violence prevention and response activities in York Region, especially those focused on youth, newcomers, and women.
8. Develop safe spaces (e.g. drop-ins) to improve quality of social determinants of health like social inclusion, where homeless and at-risk people can feel free and comfortable to build social networks and gain exposure and access to key healthcare resources and information.
    a. Facilitate access to additional recommended resources, such as alternative treatment options and healthy meals.
9. Conduct further research directly with homeless and at-risk individuals in York Region to better understand more detailed specifics from their perspective of their own health needs, challenges, and recommendations for improvement.

Appendix A – Social Determinants of Health[xv]

There are several models of social determinants of health. The following list was developed at a York University Conference in 2002. These social determinants of health have been shown to have greater influence on health outcomes than behavioural factors like diet, physical activity, tobacco, and excessive alcohol use.

1. Aboriginal status
2. Disability
3. Early life
4. Education
5. Employment and working conditions
6. Food insecurity
7. Health services
8. Gender
9. Housing
10. Income and income distribution
11. Race
12. Social exclusion
13. Social safety net
14. Unemployment and job security

Appendix B – Participant Organizations

1. Blue Door Shelters
2. Canadian Mental Health Association
3. Citizens for Affordable Housing
4. COMPASS
5. Inn from the Cold
6. John Howard Society of York Region
7. Krasman Centre
8. LOFT/Crosslinks Street Outreach and Services Network
9. Mosaic Interfaith Out of the Cold
10. Salvation Army
11. Sandgate Women's Shelter of York Region
12. Vaughan Community Health Centre
13. Yellow Brick House
14. York Region Rose of Sharon Services for Young Mothers
15. York Support Services Network

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