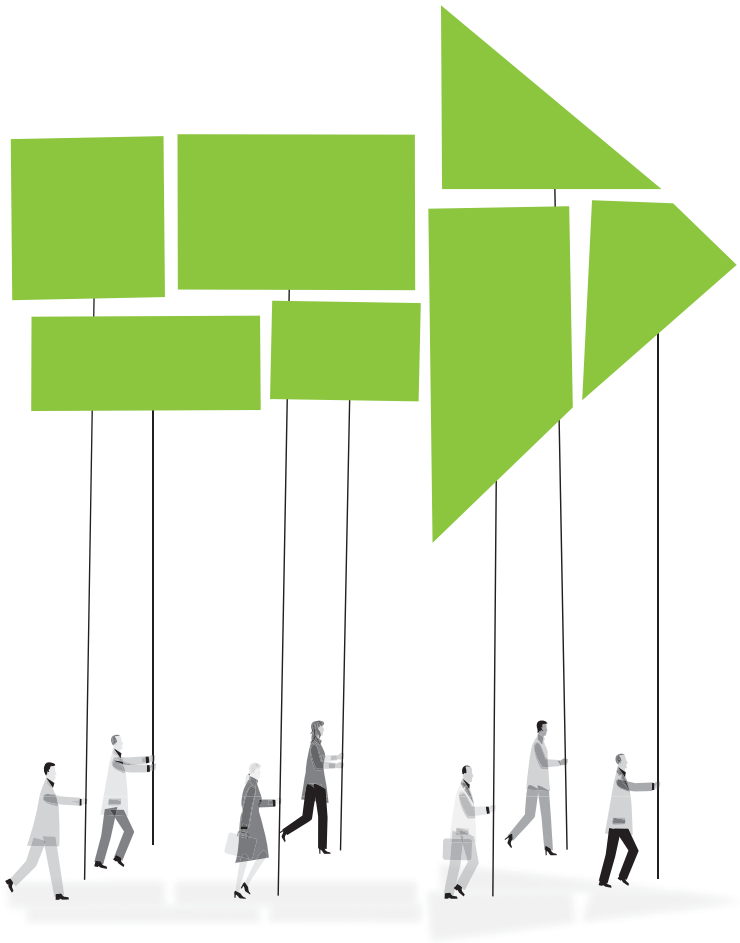
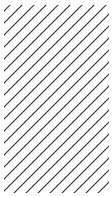
DISCUSSION PAPER #1

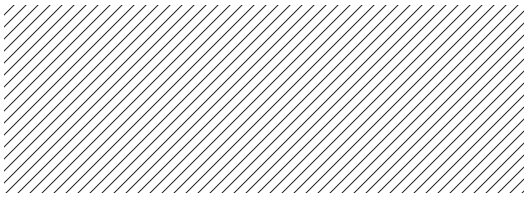


Working

with health agencies and partners in the Downtown Eastside



Vancouver
CoastalHealth



VCH introduction

THIS SUMMER WE COMMISSIONED THE RESPECTED VANCOUVER JOURNALIST CHARLES CAMPBELL TO MEET WITH MORE THAN FORTY REPRESENTATIVES OF OUR HEALTH SERVICE PARTNERS WORKING ON THE DOWNTOWN EASTSIDE, AS WELL AS SEVERAL OTHER COMMUNITY LEADERS AND REPRESENTATIVES.

This report is the first of several initiatives we will undertake as we mark fifteen years since the declaration of a public health emergency on Vancouver's Downtown Eastside (DTES). That declaration drew much-needed attention to a health crisis affecting many of this city's poorest and most vulnerable residents.

Fifteen years later the health gap between Vancouver residents and residents living in the DTES remains far too great, but remarkable changes have occurred. Two of the principal drivers of the crisis — HIV infection rates and heroin overdoses — have fallen dramatically. In their place, chronic conditions like chronic obstructive pulmonary disease (COPD) and hepatitis C have emerged that require different approaches to care. High rates of mental illness and addiction persist and are resistant to many forms of treatment — a problem exacerbated by the lack of adequate and secure housing.

As Charles Campbell explains, the strength and health of the relationship between Vancouver Coastal Health and its health service partners is a significant factor in our ability to meet the health needs of DTES residents.

Our ability to improve health outcomes relies not only on funding levels and clinical innovations, but also on the quality of communication, degree of accountability, and commitment to cooperation among each of the health service organizations active in the DTES.

We asked Charles Campbell to conduct confidential, long-form interviews on our behalf with the aim of better understanding and ultimately improving the relationship between VCH and its health service partners.

As you will read, Charles Campbell's findings contain tough words for VCH.

He faults Vancouver Coastal Health for often being too distant and bureaucratic, and for failing to adequately engage the community as equal and respected partners.

He suggests that as a service provider and as a funder, Vancouver Coastal Health's multiple roles sometimes appear contradictory and create suspicion and mistrust among other service partners.

VCH is also criticized for contributing to a precarious funding environment with consequences for staff and patients alike.

He also explains that many of our partners believe we need to do more to engage with patients and local residents in the design and governance of the services we provide and fund.

Many of our health service partners believe that we need to improve our reporting and evaluation tools, and focus, as one respondent says "on outcomes, rather than outputs."

We think that important progress has been made. From the first needle exchange programs to inSite, these victories have been hard fought and hard won. But we accept that VCH hasn't always been seen as ally in these achievements.

A second section of this document, prepared by Drs. Thomas Kerr and Rolando Barrios, offers a much-needed portrait of the key health trends that are shaping the demand for current services as well as new forms of care. The implications of their respective reports deserve to be read and discussed.

Going forward

Public organizations often play a defensive game, but we hope this exercise will be regarded as a sincere effort to open up a discussion, and begin to create the conditions for an improved relationship with our service providers.

With consideration to the reflections contained in this document, we think it's important that VCH staff continue to take pride in the work they do. VCH staff work hard, often in exceedingly difficult circumstances, as dedicated and professional public servants. As professionals, it is important to remember that our role isn't to shy away from criticism, but to engage with it as we work to improve our performance, and the leadership we provide.

This discussion and the words contained herein are important, but we know action is required. In response to his findings, Vancouver Coastal Health will work with its partners to immediately do four things within the next six months:

- Begin a discussion with our partners concerning a long-term health strategy for DTES to guide investment over the next fifteen years.

- Launch a series of workshops with our service partners to examine and improve how we provide services to DTES residents. We intend to start with the areas most identified in the report: Mental Health and Addiction Treatment.

- Work to improve the nature of our contracting arrangements with many of our health service contracts so that our service partners can invest in the services they provide, and create greater confidence among health service staff.

- Develop better reporting and program evaluation requirements so that we have a clearer sense of the value and outcomes of the health services we fund.

Warm regards,

Dr. David Ostrow
President and CEO
Vancouver Coastal Health

A note about this report

Charles Campbell

FIFTEEN YEARS AGO, VANCOUVER'S DOWNTOWN EASTSIDE WAS IN CRISIS. HIV INFECTION RATES AMONG INJECTION DRUG USERS WERE AMONG THE HIGHEST IN THE DEVELOPED WORLD, OVERDOSE DEATHS WERE RAMPANT AND HEPATITIS C WAS SPREADING.

To address the challenge, in 1997 the local health authority declared a public health emergency, and in 2000 the City of Vancouver introduced the Four Pillars strategy. Today, HIV infection rates are under control and area residents can, on average, expect to live much longer. However, the Downtown Eastside is far from well.

Vancouver Coastal Health wants to better understand the changes and the ongoing pressures that face this community's organizations and residents. Data alone can hardly convey what is working in the neighbourhood — and what isn't. As such, Vancouver Coastal Health invited me to interview local health service and community leaders to gather their candid views about:

- How they perceive Vancouver Coastal Health.
- Where it can improve.
- What an improved partnership with VCH would look like.
- What pressures will shape the next decade.
- How VCH could fund the innovation essential to improve health outcomes.
- What it could do as a funder, partner and service provider to work more effectively.

This report is a journalistic summary of those conversations, which took place in August and early September of 2012. The interviews were open-ended and unfettered, and this report is entirely my own. Most of the 40 people I spoke to head organizations that work with Vancouver Coastal Health, but I also spoke to a few clients, residents and frontline staff. By design, my picture of the DTES landscape from Vancouver Coastal Health's vantage point is limited by the small amount of time I spent talking with its managers and employees — the health authority wanted

How can Vancouver Coastal Health foster a renewed sense of partnership with agencies on Vancouver's Downtown Eastside?

the views of its partners. Each is different, often in significant ways. In many instances, I simply don't have the knowledge to tease apart contradictory views and complex issues in a helpful way. I have done my best to represent diverse opinions while focusing on what I see as the most consistent and productive views. If there are errors or omissions regarding good work done by either Vancouver Coastal Health or the many agencies on the Downtown Eastside, the fault is mine.

There are several recurring issues in this report. Addressing any one of them requires careful attention to the organizational dynamics of this neighbourhood and particularly the state of the relationships between Vancouver Coastal Health and the many groups and individuals in the Downtown Eastside. There is widespread agreement on a few key points:

- The health and related agencies need to create better partnerships marked by increased cooperation and clear common goals.
- Better communication can ease the distrust that exists between many agencies, Vancouver Coastal Health, and the community.
- VCH's strategic vision for the community needs to be coherent and clearly articulated, and respond to the needs of all facets of the community.
- Improved measurement of health outcomes will create greater accountability and help to develop services that work.

How can Vancouver Coastal Health foster a renewed sense of partnership with agencies on Vancouver's Downtown Eastside? That's the hard part, but several people argued persuasively that the health authority must carefully improve the structure of its relationships with the agencies and residents.

I have tried where possible to consider other important issues — housing for the mentally ill, addiction treatment, aging in place, women's and Aboriginal services, food, and social equity — in this context. By focusing on partnership, I have given short shrift to many conversations I've had about program needs in specific areas. In the end, though, I've decided that while I can't address individual issues, I can bring forward ideas from the community that will help those in the field work together more effectively to that end.

I have a few words about confidentiality. I've changed personal details to protect the identities of four residents and families of residents who discussed their private lives with me, although in only one instance did they ask me to do this. Regarding unattributed quotations, most people I spoke to were in some way sharply critical of Vancouver Coastal Health. I asked people to be frank and told them I would not put them in an awkward position by attributing their sharpest barbs. While I've used a few such quotations to convey the

depth of feeling around these issues, it's too easy for the broad discussion about improving Downtown Eastside healthcare to be sidetracked by individual areas of friction and disagreement. I have not presented recommendations here, just ideas that need to be discussed and developed. However, allow me to make just one: do not let bad history get in the way of a better future.

I told the people I spoke with that I would try to offer their sense of what a better arrangement might look like. *That* conversation is one Vancouver Coastal Health must continue to develop with partners, employees, experts and those who live with the consequences of its healthcare strategies in the Downtown Eastside.

Charles Campbell
Vancouver, October 2012

THE DOWNTOWN EASTSIDE IS A TROUBLING MEASURE OF OUR SOCIETY'S ACCOMPLISHMENTS. CAN PEOPLE OF VERY MODEST MEANS AFFORD TO LIVE IN VANCOUVER? WHEN THEY CAN'T, WHAT ARE THE CONSEQUENCES?

Partnership, communication, respect, and trust

The Downtown Eastside is a troubling measure of our society's accomplishments. Can people of very modest means afford to live in Vancouver? When they can't, what are the consequences? Do we properly care for people with mental illness? What happens when activities like drug use and prostitution are placed in semi-permanent legal limbo?

For Vancouver Coastal Health, there's another big question: What is health, and how can it best deliver health-related services to residents of Canada's poorest postal code? When, as one community activist put it, "75 per cent of what the provincial government does can be seen as a determinant of health," the answers are not easy. Nowhere is this challenge more evident than in the Downtown Eastside.

For Peter, a smart, capable, drug-free man in his late 20s living on $625 in income assistance in a private hotel at risk of gentrification, where he pays $410 a month in rent, the ability to cook his own food would be nice. Having enough money to *buy* his own food would be a plus. He wishes he could live more like his Aboriginal parents and grandparents did, where providing food was a communal activity that took time and connected people to each other and the environment. Instead, he waits for hours in food lines for what he describes as unappealing, unhealthy meals. To what extent are some basic tools for achieving wellness — food, and a place and the skills to cook it — the business of a health authority?

Other residents and past residents have more specifically clinical needs. Take Eric, 32, mentally ill and now happily residing at Colony Farm, a psychiatric forensic hospital, after injuring a DTES resident. Where will he go when he is released? Is there actually a facility where he might do well? Is the controlled environment he wants — civilized, supervised care that will keep him safe from himself, and others safe from him — readily available?

Then there's Rosetta, 53, once a Kerrisdale kid, now living in a quiet, private, clean single-room-occupancy hotel on Hastings Street. She's alcoholic like her mother but in good shape today thanks to family support, a new set of teeth from the Portland Hotel Society dental clinic, and esteem-building DTES volunteer work. If she loses track of herself and starts drinking heavily and smoking crack again, then decides she needs help, can she get world-class treatment in a timely manner?

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What about Alan? The former operator of a Vancouver small business had his work and family life submarined by drug addiction. He suffered from hepatitis C, and died last spring from chronic obstructive pulmonary disease. He once told me he wanted housing outside the Downtown Eastside because his caregiver was his enabler. Was that choice available to him?

The health of these individuals is the heart of Vancouver Coastal Health's enterprise. Yet in discussing such issues with those active in the Downtown Eastside, no individual policy area came up as often as one overarching subject: how Vancouver Coastal Health works with its partners and clients on the Downtown Eastside.

Most community groups, non-profits and others concerned about the health of the Downtown Eastside believe Vancouver Coastal Health can make the greatest immediate difference by being a better communicator and partner. All the groups I spoke to want to improve their working relationship with Vancouver Coastal Health. Yet many fear that it's about to get worse — that Vancouver Coastal Health wants to cut expenditures and more directly control service delivery.

Partnership is nowhere more critical to Vancouver Coastal Health's success than on the Downtown Eastside. Vancouver Coastal Health is a large, cumbersome organization with a huge range of responsibilities. Big organizations tend to be risk-averse. Government agencies such as Vancouver Coastal Health must be politically neutral. As such, it is often hard for them to innovate effectively in a politically charged community. So it's no surprise that non-profit societies and community agencies have led most initiatives to improve health on the Downtown Eastside, and that risk, improvisation, and shared effort on a shoestring budget have defined those efforts.

Vancouver Coastal Health deserves credit for funding many challenging initiatives. But the organizations that do this work feel they are closer to the problem, see it more clearly, and can spend money more efficiently. They are usually nimbler. And they are certainly in a better position to draw the broad community together in shared enterprise. One DTES executive director said there's a crisis in confidence that any government body can coordinate all the complex elements of providing health services in the Downtown Eastside.

Many of the positive developments on the DTES exemplify the view that effective solutions most often emerge from the community. There have been great successes where low-barrier employment and food are concerned. The United We Can bottle depot is one example. Its offshoot, the Potluck Café and Catering Society, which earns $1.5 million annually, mainly from corporate catering services, is another stellar model. It feeds Portland Hotel Society residents 30,000 meals a

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year. Its only government grant is $49,000 from provincial gambling revenue, which covers that program's food costs.

The examples of effective initiatives that originate in the community are legion. PHS Community Services Society, known as the Portland Hotel Society, remains widely respected for the leadership it has shown on a range of initiatives, and there are more in its plans. The Lookout Shelter has been providing low-barrier shelter since 1971. The Downtown Eastside Women's Centre, the Vancouver Native Health Society, the Vancouver Area Network of Drug Users (VANDU) — all these groups contribute to a rich organizational ecology.

Yet many leaders of the agencies on the Downtown Eastside feel that their work is not sufficiently valued, that Vancouver Coastal Health tries to impose its culture on their culture, or that VCH sees them as competitors whose purpose is to deliver the lowest bid without sufficient regard for health outcomes. "Partnership is really important," said one thoughtful, veteran administrator, who lamented that "Vancouver Coastal Health is trying to treat us as contractors that can be hired and fired."

Some wonder if Vancouver Coastal Health sees the main benefit of non-profits as providing political cover when the politics of DTES healthcare get particularly nasty.

Most agencies feel VCH's relationship with community groups is not well organized or managed. A few say its ambition is to squeeze the budgets of DTES agencies, eliminate organizational infrastructure and repatriate the delivery of clinical services. Critics of the agencies that work on the Downtown Eastside sometimes argue that consolidation and repatriation would be a good thing.

How, with so much disagreement and ill will, can Vancouver Coastal Health find its way? What are the alternatives to consolidation and control? Jonathan Oldman, Executive Director of the St. James Community Services Society, wants Vancouver Coastal Health to create forces and incentives that encourage more collaboration between services and groups. "Is VCH's central role as a provider or a commissioner of services and solutions?"

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As it stands, the structure of the health authority's relationship with community agencies often fosters insecurity. For instance, many Vancouver Coastal Health contract terms are for one year, which hardly creates confidence and stability. Arthur Paul of the Native Courtworker and Counselling Association says that not only limits their ability to plan, but also prevents their employees from even qualifying for a mortgage.

Some agencies lament that contracts are the only key point of contact with Vancouver Coastal Health. Others argue that Vancouver Coastal Health sees the Downtown Eastside mainly through its contracts at the expense of the broader community. "They think their stakeholders are the contracts that they hold," said one community leader, who feels the way housing and harm reduction strategies have been executed has harmed the community as a whole.

For many agencies, better partnership means establishing shared service objectives that focus more on outcomes than throughput. While it's harder to measure success with community care and preventive care, it's also true that, as one person put it, "You are what you measure." Says the Vancouver Area Network of Drug Users' Ann Livingston: "The criteria for providing a service are all about eligibility, not results. There isn't a sense that things are evaluated."

Communication, respect and trust are big problems, and that doesn't make for good partnerships.

Non-profits almost universally say they like and respect the middle managers they deal with, but they feel those managers have no decision-making power and that those who hold real power are too remote. Yet some of the harshest criticism of Vancouver Coastal Health regards its failure to communicate. Many acknowledge that Vancouver Coastal Health itself has recently gone through considerable change, exacerbating the challenge. Yet almost everyone interviewed for this report says the people who make decisions at Vancouver Coastal Health must quite simply become more connected and involved.

Most organizations professed that they have no idea what Vancouver Coastal Health's short- or long-term strategies are for the Downtown Eastside. Michelle Fortin, Executive Director of Watari, a DTES service that helps at-risk children, youth and their families, puts it this way: "If you don't reveal yourself, people have to invent you. That's Coastal Health."

St. James's Oldman is keenly interested in models that would result in better partnership between Vancouver Coastal Health and the DTES agencies it funds. As an example, he points to research on what's known as "collective impact," where agencies with a common cause get together to identify issues, indicators and routes for collective action, and believes

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such strategies could be applied on the Downtown Eastside. It's really just common sense with a method, but it is worth examining how such models have been successfully employed.

The article "Collective Impact," from the *Stanford Social Innovation Review,* explores the eponymous strategy's success in dealing with intractable problems in American education and other disparate fields, then outlines its recipe for success. The approach, of course, brings with it a familiar challenge, particularly in lean economic times. "Funding collective impact initiatives costs money, but it can be a highly leveraged investment," write John Kania, a former advisor with Mercer Management Consulting, and Mark Kramer, board chair of the Center for Effective Philanthropy and a senior fellow at Harvard University's John F. Kennedy School of Government. They argue that changing the way funders and philanthropists think about their roles has the potential to be hugely beneficial.

The St. James Community Services Society is exploring how a model such as collective impact could address the area's broad palliative care needs *(From "Isolated Impact" to "Collective Impact" in Vancouver's Downtown Eastside)*: "When we do research and development in the health sector, it's mostly about specific health interventions, not about systems and processes," Oldman says, arguing we need to explore different ways of working together in the neighbourhood that are more inclusive and collaborative, and target measurable outcomes. "Let's test them, and see what works."

Overall, Oldman believes Vancouver Coastal Health needs to clearly articulate its vision for its relationships with non-profits. "The health authority needs to define what it means by partnership in our sector."

How we structure and think about our working relationships is critical. Watari's Michelle Fortin says we must frame our roles and responsibilities clearly. She says she views her staff as her clients, and that her job is to ensure they are best able to serve *their* clients in the community. Yet she also believes good communications infrastructure is even more important than organizational structure.

Communication and cooperation aren't just Vancouver Coastal's problems. Many people talked about the tentative relationship among the DTES agencies themselves. The Portland Hotel Society, the largest agency in the Downtown Eastside, is widely regarded as an organization

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that has achieved great things but does not always play well with others. Some groups that work in the DTES do meet, but the networks are informal. It's hard to say the monthly get-togethers that draw substantially from the faith-based agencies represents a summit of power.

Some observers say the fight for scarce funding makes agencies disinclined to collaborate. Says one: "They're in fierce competition with each other."

Every organization's leadership is passionate about its particular mission, of course. And protecting that mission means getting the money to fund it. Oldman says there is growing pressure on midsized organizations such as St. James to deliver more complex services while organizational resources are being squeezed. How should the groups and VCH, as their key funder, respond? Will the midsized organizations consolidate or disappear, leaving real grassroots organizations on one hand and larger groups that are able to compete more effectively on cost on the other? Or are there other alternatives? Oldman thinks on-the-ground experience with the challenge is critical, and innovation arising from different philosophies can show us what works.

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The question is, what model will protect organizational diversity but result in DTES agencies taking a more collaborative approach? The first step, of course, would be for them to feel more secure. A clear message from Vancouver Coastal Health that it respects the unique skill sets of each organization — and wants to benefit from their experience — would certainly help. It must also create systems and incentives that foster collaboration and communication between agencies. That might begin with roundtables where groups with common policy interests — such as mental health supports, food policy, addiction treatment or patient rights — establish goals. But that in itself is just one step. "It's going to take something more structured and deliberate than working groups to change things," says Oldman.

Many people I spoke with criticized Vancouver Coastal Health for lacking strategic vision. But they don't mean that its senior managers should have a retreat and a "visioning" exercise. They want clear plans with jointly established goals, and then a sincere effort to work constructively with its partners to achieve them. Vancouver Coastal Health needs "to seriously reflect on the balance between tight control and collaborative gains," says one.

The Portland Hotel Society's Mark Townsend argues "there's been an overabundance of strategic vision and strategic plans." What's his advice for Vancouver Coastal Health? "Think carefully about what you want to do and then hire the best people to do it." Thinking carefully, of course, means you must speak clearly and listen well. Hiring the best people requires that you delegate your power.

Townsend also believes the health authority should work with what it's got, and notes that Portland's own strategic plan was drawn from the Community Directions planning exercise. "I always look at what's there and try and amplify and improve on it. I don't try and recreate it."

Partnership that involves clear goals, strong leadership and delegated responsibility can work. Vancouver Coastal Health and the loosely affiliated Providence Health Care, which runs St. Paul's Hospital, have proven this with harm-reduction strategies, which have employed a wide range of community partners. Along with AIDS treatment, efforts to reduce disease transmission and overdose deaths have contributed to substantial improvement in Downtown Eastside lifespans.

Another encouraging recent initiative is the Mental Health Commission of Canada's At Home/Chez Soi initiative, which explored and researched different support strategies for the hardest to house across the country. The Vancouver component is now coming to an end. The program's teams have drawn on successful models elsewhere in North America to deal with some of the Downtown Eastside's most challenging residents. Assertive Community Treatment (ACT) Teams and other elements of the At Home/Chez Soi initiative bring specialists in mental health, addiction, housing, employment and other fields together in a client-centred effort to stabilize the lives of the community's hard cases. Of course, it's not simple to achieve a multi-organizational client/staff ratio of roughly 10-to-1, nor is it always easy to get the police, Vancouver Coastal Health doctors and nurses, and staff from a variety of non-profits to work together. But that mix is a key factor driving the success of the project, according to Insp. Ralph Pauw, who supervises mental health initiatives with the Vancouver Police Department. "It's working," he adds, "because the decision-makers are at the table."

However, the ACT Teams also illustrate some of the shortcomings in Vancouver Coastal Health's working relationships. RainCity Housing and VCH were initially competitors for federal money. RainCity ran one ACT Team while Vancouver Coastal Health ran another. As Vancouver Coastal Health considers how to move forward, without the expected follow-through from the province to financially support the initiative, RainCity fears it may lose its team, despite its belief that it can do the job more cheaply than Vancouver Coastal Health, and that ACT Teams overall are a cheaper and more effective way to care for those most at risk.

A CLEAR MESSAGE FROM VANCOUVER COASTAL HEALTH THAT IT RESPECTS THE UNIQUE SKILL SETS OF EACH ORGANIZATION — AND WANTS TO BENEFIT FROM THEIR EXPERIENCE — WOULD CERTAINLY HELP.

IT'S ALSO TRUE THAT CLEAR ROLES AND CLEAR COMMUNICATION MAKE GREAT THINGS POSSIBLE. WITH THE STAKES AS HIGH AS THEY ARE ON THE DOWNTOWN EASTSIDE, CREATING A BETTER ARRANGEMENT IS ESSENTIAL TO EVERYONE'S SUCCESS.

The pending disappearance of funding to continue another project, the Rainier Hotel's residential addiction treatment program for women, initially funded by the federal government prior to the 2010 Olympics, has been a greater point of friction. As with the At Home/Chez Soi project, it shows the importance of effective planning and collaboration as pilot projects come to an end. It's easier to get governments to continue supporting the pilots that work if partners communicate and collaborate effectively.

Sometimes communication issues are the big, systemic ones. But it's critical to remember that the big issues all eventually boil down to small ones, like the fate of a patient who's just been discharged from hospital. When I spoke to the Carnegie Community Action Project's Jean Swanson, she told me that she had just met a man who had been released from hospital with an injured shoulder and leg. "He doesn't have a place to stay tonight." Over at First United Church, community services manager Lori Gabrielson cites the lack of discharge planning for acute-care psych patients. "People arrive with no notice," she says. Gabrielson wishes for social workers who might facilitate their transition to the community, and adds that while people with an address get 21 days of follow-up, those with no fixed address often get nothing.

Structural issues can also impair care for people at risk. Several people expressed concern that supports tied to housing don't move when people do, creating another big disruption in lives that need stability.

It's those lives that matter most, as Vancouver Coastal Health finds itself at a critical juncture. Too many of the Downtown Eastside agencies feel unappreciated and underutilized, and they expect that the situation is going to get worse, at the expense of all those people. It's also true that clear roles and clear communication make great things possible. With the stakes as high as they are on the Downtown Eastside, creating a better arrangement is essential to everyone's success.

Difficult mental-health policy transitions

Riverview Hospital closed its doors in 2012, just shy of its 100th anniversary. At its peak in 1950, it housed 4,630 people.

At times, Riverview sometimes exemplified our abuse of the mentally ill, and it became a symbol of that abuse — its wards seemed pulled straight from the 1975 film *One Flew Over the Cuckoo's Nest,* where Nurse Ratched would give medication by any means necessary.

The Fraser Health Authority will continue to operate some small programs on the site, as will the non-profit Coast Mental Health. But the idea of a provincial facility on the site for people who need closely supervised institutional care was not one the Provincial Health Services Authority could actively engage in.

Who wants Riverview back? Remarkably, just about everyone who works with the mentally ill on the Downtown Eastside. Not the old Riverview, of course. We gave *asylum* a bad name, and we need to give it a good name, says Coast Mental Health Executive Director Darrell Burnham.

What was good about Riverview? The grounds, if not the old wards, were always a therapeutic place. The community of Coquitlam accepted its role in providing the service to our communities. It had the potential to be a model for protecting the mentally ill from harming themselves and those around them. Perhaps it could perform that in the future. If not, more steps must be taken to create its equivalents.

Its absence from the scene certainly has people thinking about how we've managed our efforts to bring those with serious mental illness closer to home. For two years, on a contract with Vancouver Coastal Health, Coast Mental Health ran the transitional Brookside and Leeside programs on the Riverview site for "38 extremely vulnerable people," most of whom will need some form of ongoing institutional care. Burnham says 80 per cent wanted to stay where they were, and he believes the transition to other care has not gone well.

Riverview is not in Vancouver Coastal Health's geographic sphere, but it must deal with the consequences of its closure. The Provincial Health Services Authority still runs the adjoining Colony Farm for people with mental illness who have become criminally involved, and many people want to see the Riverview lands continue to play a role in providing a safe refuge for those struggling with mental illness. But that's not a challenge the provincial Ministry of Health is going to meet in a hurry. In the meantime, Vancouver Coastal Health must continue to develop its own alternatives. Reviews of the health authority's work in this area aren't all bad, but Burnham believes there are too many cracks in the system, and too many mentally ill people are defaulting to the Downtown Eastside.

In times of change, of course, communication and planning are critical. How do mental health organizations work together to achieve shared objectives? An inter-agency mental health committee used to meet monthly, Burnham says. "That meeting hasn't happened this year."

On the Downtown Eastside, the consequences are polarizing. "They didn't close Riverview, they moved it," a particularly frustrated business leader told me. Conversely, one service provider told me he believes hardly any patients from Riverview ended up in the neighbourhood. He allowed, however, that many people who would otherwise have been provided for in a facility like Riverview have ended up in a single-room occupancy hotel — generally not a place conducive to mental health. Let's take the story of one former Riverview

IN TIMES OF CHANGE, OF COURSE, COMMUNICATION AND PLANNING ARE CRITICAL. HOW DO MENTAL HEALTH ORGANIZATIONS WORK TOGETHER TO ACHIEVE SHARED OBJECTIVES? AN INTER-AGENCY MENTAL HEALTH COMMITTEE USED TO MEET MONTHLY, BURNHAM SAYS. "THAT MEETING HASN'T HAPPENED THIS YEAR."

Can Riverview eventually be revisited as a site to deal with those who want such care?

patient. Eric is paranoid schizophrenic and schizoaffective. After he attacked a fellow Downtown Eastside resident, he spent months in solitary confinement, without his medications, in the Surrey Pretrial Services Centre. That is the Fraser Health Authority's jurisdiction and not Vancouver Coastal's. But it was a medical choice — deinstitutionalization — that the provincial Ministry of Health made on his behalf. We need "to be more mindful of the healthcare provided in jails," says the Pivot Legal Society's Scott Bernstein, drawing attention to yet another area where one hand doesn't know what the other is doing.

Now that Eric is at Colony Farm, he is stable. However, when he is released, his family is fearful of where he may end up. Eric needs institutional care. He doesn't belong in the Vancouver General Hospital beds designated for the mentally ill. The Downtown Eastside could become his home again. And he may be provoked or even choose to do something just nasty enough to get him back to Colony Farm.

Can Riverview eventually be revisited as a site to deal with those who want such care? Could Colony Farm's mandate be expanded? Or, as some suggest, should the province build some clinical care "mini-institutions" that look like housing? The weight of opinion on the consequences of closing Riverview suggests that Vancouver Coastal Health needs to continue to raise the issue with the Provincial Health Services Authority and the provincial government itself.

There are good news stories, too. For Vancouver Coastal Health on the Downtown Eastside, the Strathcona Mental Health Team is held in very high regard, despite the pressures created by its caseload. There's also the acceptance of the new Dunbar Apartments after a flurry of fear mongering by area residents. It's part of a program involving 14 new housing sites being developed around Vancouver, and a good example of effective partnership — between the province, the City of Vancouver, the Vancouver Coastal Health Authority, the Streetohome Foundation, and non-profits such as Coast Mental Health.

The partnership to develop 14 sites in Vancouver also illuminates another contentious issue — the extent to which housing and services for the mentally ill should be provided on the Downtown Eastside. Some advocate a scattered-site model exemplified by the Dunbar Apartments and the ACT Teams' efforts to place clients in private accommodations throughout the city. Others say the nonjudgmental nature of the Downtown Eastside community is just the tonic for those with mental illness or some other social abnormality, and it's the quality of the housing and lack of money that make their environment problematic. A Carnegie Community Action Project survey of a cross-section of 655 residents indicated that 95 per cent would choose safe, secure housing in the Downtown Eastside.

Conversely, a survey conducted as part of the At Home/Chez Soi project suggested that well under 10 per cent of those served by the program wanted to be housed

on the Downtown Eastside. Housing is a polarizing, complicated question. But everyone agrees that people should have a choice, and that the challenge is clearly defining and delivering the better alternative.

One key concern of many in healthcare, housing, and the Downtown Eastside community at large, is that many housing projects are too large and bring too many at-risk people too close together. More clarity in the delineation of supportive housing and "tertiary licensed residential care" is another concern. A meaningful definition of supportive housing is yet another. Although housing is not VCH's core responsibility, given housing's critical role in fostering health, many feel the authority must help to shape effective housing policy.

For the agencies that work with the mentally ill, addressing these complicated, contentious issues requires leadership and partnership, especially in a period of transition. When they are lacking, people improvise. Right now, the Portland Hotel Society is building a new supportive housing facility at 111 Princess Avenue. One component has the potential to house people with acute mental illness — some of whom need to be, as the old parlance goes, "committed." The facility, with or without the mentally ill, is already a flashpoint for business groups in the Downtown Eastside. Yet if provincial health authorities leave a vacuum, someone is going to try to fill it.

The City of Vancouver decided to fill a vacuum with its homelessness strategy, just as health authorities and the city worked together to provide leadership a decade ago on harm reduction. The question now is whether we can do the same to ensure we've followed through on the promise of better care for the mentally ill.

Addiction treatment: practice-based evidence, or evidence-based practice?

Many concerns that arise regarding housing for the mentally ill are echoed with addiction treatment. Why are so many services located in the Downtown Eastside and so few elsewhere in the region? When is the availability of high-quality treatment going to improve? Who is orchestrating the substantial change that is required?

The City of Vancouver's Four Pillars Strategy — harm reduction, prevention, treatment and enforcement — used to inspire hope that we would tackle addiction on multiple fronts. Now, people shake their heads at the thought of it. "Harm reduction was never meant to be the only pillar standing there," said Susan Giles, a longtime Vancouver Coastal Health street nurse who, along with fellow Vancouver Coastal Health nurse Evanna Brennan, recently retired in frustration at Vancouver Coastal Health's management of its own staff on the Downtown Eastside.

Timely access to treatment can certainly be a problem. No one disputes the notion that addicts need it when they've bottomed out, when they've made their decision that they need help. Some programs can be quickly accessed, yet for others addicts often find they have to wait weeks.

Those most familiar with addiction treatment believe "rapid access is critically important" and early intervention strategies need to be improved. Another key issue is the lack of training and expertise in British Columbia. "We don't train doctors to take care of people with addictions in BC," says Dr. Evan Wood, a specialist in inner-city medicine. He believes that if we trained just five doctors a year over the next five years

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to improve the quality of our programs, the impact would be huge.

Some people feel we make assumptions about addiction that distract us from potential solutions. In focusing on addictions as a product of life circumstances, do we overlook the role of genetics? They believe treatment needs to be better grounded in science. "Sometimes we get practice-based evidence instead of evidence-based practice," says Watari's Michelle Fortin.

Fortin also thinks we need better day treatment more than we need additional treatment beds, and that we need to ensure we make referrals for the right reasons. She would also like to see Vancouver Coastal Health with a seat on the directorate of the Provincial Health Services Authority's *Ten-Year Plan to Address Mental Health and Substance Use in British Columbia.* Again, the issues of connectivity and communication arise.

Wood, who, with Dr. Thomas Kerr, his colleague at the BC Centre for Excellence in HIV/AIDS, has played a key role in both reducing HIV infection on the Downtown Eastside and documenting the results, also laments that drugs such as Vivitrol, which are used effectively elsewhere in addiction treatment, are not available here. He looks to Boston University's Clinical Addiction Research and Education as an example of effective addiction education and treatment. Wood wants Vancouver Coastal Health to ensure our universities play a more active role. He says Vancouver Coastal Health has addiction expertise at programs such as those offered at the Three Bridges Community Health Centre, and some of its leaders in the field understand the challenge. But he believes improved training and expertise are critical to the success of the health authority's efforts. If treatment programs are retooled right now, Wood wonders who will staff them. Building stronger relationships with universities and current research also creates the opportunity for increased funding, says Kerr, pointing to the funding from the National Institute on Drug Abuse that has funded the St. Paul's Urban Health Group's research on addiction and harm reduction. A donation of $3 million from Goldcorp was just secured through the St. Paul's Hospital Foundation to help train addiction specialists. (Another $2 million from Goldcorp, through the Vancouver Hospital Foundation, will fund a Vancouver Coastal Health ACT Team.) When there is leadership such as this, in areas of critical concern for Vancouver Coastal Health on the Downtown Eastside, how are Vancouver Coastal Health's key decision-makers connected to it? In what ways is Vancouver Coastal Health trying to amplify these efforts?

Addiction treatment will always be a frustrating enterprise. Recidivism is rife. Many people will fall in and out of drugs or alcohol use throughout their lives. As such, the Portland Hotel Society talks about providing respite, instead of treatment

with the objective of total abstinence. The people who can't quit for good, or at least control their use, *do* need to be cared for. Townsend urges realistic expectation: "What's the evidence on what you can really achieve?"

Yet there are still many people who wish to quit, who can quit, and who will quit. Almost everyone I spoke to believes we can do a much better job of assisting them. Kerr and Wood believe that just as we've succeeded and learned how to repeat that success on harm reduction, by combining science and innovative, focused service delivery, we can break new ground with addiction treatment.

Harm reduction: living in limbo

Periods of transition are always a challenge. The awkward, incomplete evolution of our social attitudes and government polices on recreational drugs is one of these challenges. The peculiar legal limbo in which prostitution and recreational drugs have been placed, where they are permitted under certain circumstances yet remain a lucrative criminal activity, is not going to change for an election or two. In the interim, we have medicalized the use of drugs, and our society remains confused and conflicted about what exactly our policies should be.

The use of methadone as a treatment for heroin addiction is certainly contentious. Some business and community groups are concerned that its prevalent use and availability harms businesses and families. Conversely, others are frustrated at the way in which people being treated with methadone are stigmatized. Unsurprisingly, pharmacies that focus on methadone and use cash incentives to draw clients are regularly derided.

Ann Livingston of VANDU expressed frustration at the cost of simply dispensing methadone on the Downtown Eastside, which she pegged at $12 million annually. With, according to Vancouver Coastal Health, 1,100 current or recent DTES residents taking methadone through a pharmacy or their doctor's office, Livingston's figure isn't out of line. Is there a cheaper, less disruptive, less stigmatizing way to provide this treatment? What's a realistic goal?

Several people interviewed are frustrated that access to methadone is too restrictive. One person said we wouldn't threaten to withhold a diabetic's insulin if they failed to take it, and complained that we do exactly that with methadone. Pivot Legal Society's Scott Bernstein, who represents a methadone users' group, asks: "Why is methadone treated so differently than any other medical therapy?" There's a lot of apprehension about abuse, about people reselling their methadone, but how serious is that problem?

Vancouver Coastal Health has an extensive 2010 report commissioned by the province, *British Columbia Methadone Maintenance Treatment Program: A Qualitative Systems Review.* Enormous effort went into producing it. Has as much energy been expended by Vancouver Coastal Health to develop widely supported strategies on the Downtown Eastside? Have all the people

ADDICTION TREATMENT WILL ALWAYS BE A FRUSTRATING ENTERPRISE. RECIDIVISM IS RIFE.

who have expertise in the area — including those who represent the users — been invited to sit at a table to discuss goals, strategies, impact and measurement?

Restrictions on medical access to drugs are punitive in a way that would be deemed absurd in the case of other prescription drugs. Critics say the lack of exit strategies for the completed NAOMI and ongoing SALOME clinical trials, which have used opioid medications as alternative treatments for heroin addiction, put the health of the subjects at risk. "Nowhere else in the world did a heroin trial end with no heroin," says one observer. Bernstein blames Vancouver Coastal Health for "dropping the ball" and not following through on the promise of the NAOMI trial, pointing to the success of such treatment regimes in several European countries. "There's no exit plan for the SALOME trial either," he says. Of course, there is a complicating layer of federal opposition here. But that makes it particularly important that decision makers have smart, open conversations about the implications.

Then there are the drugs where harm reduction policies have proved elusive. "Cocaine, they really don't know what to do," says Wood. Alcohol is confounding, particularly when it's consumed in its crudest forms, such as mouthwash. The Portland Hotel Society's Managed Alcohol Program, funded by Vancouver Coastal Health, holds some promise as a project based on partnership, science and innovation. But cocaine continues to be a problem. Again, open conversation and the organizational diversity that will contribute to innovation are a good place to start.

Sobering centres, detox programs and other tools for dealing with people in crisis are another area where different agencies could work together more effectively. There's been progress, but there is room for more. The costly issue of wait times — often hours long — for police when they take people in need of care to hospital emergency facilities is one key area of concern, as is the number of police and ambulance calls. Vancouver Coastal Health was praised by police for tackling the issue at Vancouver General Hospital; there is hope for more movement on this front from St. Paul's Hospital. Reducing the number of ambulance and police calls is a more complicated challenge. How can we best get those in need of immediate help to a service that works for them as quickly as possible?

Some people called for a careful review of how these services are delivered. One person said we don't always accord people in crisis their due respect. "The detox service is insane." Want to choose it for yourself? "You have to have a phone, you have to be able to make a call, you have to wait. Then you get shit because you want to have a cigarette." Of course doctors and nurses shouldn't encourage people to smoke, but in providing low-barrier detox services it seems reasonable to allow people to indulge their least problematic addiction.

Portland's Mark Townsend is more concerned with what happens when people exit these programs, although he wants to see detox and sobering facilities become less clinical and more hospitable, to encourage their use and to help people complete them. Detox is a service where those who need it benefit from multiple points of entry. The Insite supervised injection site is a key one. But Townsend said funding for the detox beds above Insite was hard to come by, and regrets that the facility doesn't serve the needs of people whose problem is alcohol.

WHAT IS VANCOUVER COASTAL HEALTH'S VISION FOR THESE SERVICES? HOW CAN VANCOUVER COASTAL HEALTH BETTER COORDINATE THEM AND ENSURE THAT ALL THOSE AFFECTED ARE INVOLVED IN REFINING THEIR DELIVERY?

There is, however, one major detox concern that Vancouver Coastal Health needs to address. "We want to get women into detox," says Alice Kendall, the Downtown Eastside Women's Centre's departing Executive Director. "We can't get them into detox." She says the few beds designated for women are often used for men. "Access to treatment is way more difficult for women," she adds, noting that they make up 40 per cent of the Downtown Eastside population.

"There aren't enough women-only options," adds Atira's Janice Abbott, adding that "women have nowhere to go when they get out of treatment."

What is Vancouver Coastal Health's vision for these services? How can Vancouver Coastal Health better coordinate them and ensure that all those affected are involved in refining their delivery? It can be a critical point of entry to treatment. Most importantly, what is the strategy for improving access for women?

Hastings Street's Insite doesn't get much criticism in and of itself — it's drawn a fair amount of injection off the street — but open drug dealing remains a huge sore point with area business-improvement associations. Of course, dealers are safer from the police and the business improvement associations when they're inside the Single Room Occupancy (SRO), some of which are run by the non-profits. But you can't really argue that it's good for the residents. Prostitution is also fraught.

Inside area residences, it's a problem — safer for the prostitutes but not for their neighbours. Push it outside and the dangers are different and, if history is any guide, demonstrably greater.

These are, in the absence of clear and cohesive political leadership from senior governments, intractable situations. Circumstances such as this require clear thinking and conviction on the part of Vancouver Coastal Health. If we don't train doctors in addiction medicine, don't boldly follow through on addiction-treatment trials we conduct, and don't manage methadone treatment in a manner that inspires confidence, one might wonder exactly what Vancouver Coastal Health is doing.

And again, if the people trying to address these problems on the Downtown Eastside aren't working together with mutual trust and openness, the success that is possible will be elusive.

Against a backdrop such as this, much smaller issues can become real sources of friction. The tension over medical records is one example. Shall we have triage or shall we have transparency? Do service providers' concerns about low-barrier access to service and patient confidentiality trump Vancouver Coastal Health's desire for records that might assist in appropriate treatment across a variety of agencies, or help root out patient abuse and duplication of service? Add the layer that everyone seems to want — where we measure outcomes, and bring science to bear — and

it gets messy. Yet it's the kind of problem that should be amicably resolved by agreeable people who communicate well.

The need for community-minded clinical care

Because drugs and drug-related illness have been so visible and problematic on the Downtown Eastside, other interests and concerns are often sidelined. Women obviously suffer a disproportionate degree of violence and degradation on the Downtown Eastside, and the provision of services to them in a manner that makes them feel safe is a subject of some contention. To what extent are women-only services required? In what situations do women feel unsafe, and how can that best be addressed? Service providers don't always agree.

The worst risks, of course, involve violence associated with prostitution and drugs.

However, the need for more women-only clinical services in the Downtown Eastside is hard to dispute. Sometimes it could simply be a matter of expanding the times and locations for services that do exist. The Downtown Eastside Women's Centre would certainly like to expand the range of services it offers (which include meals where all the food is purchased so they don't depend on donated food of dubious quality).

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Aboriginal health is another area that is overlooked. Vancouver Native Health Society executive director Lou Demarais often feels like he's in limbo. At times, he's suspected Vancouver Coastal Health has wanted to get rid of the organization. But not right now. Still, the place of Aboriginal health services on the Downtown Eastside does often seem to be an afterthought. "We were tucked away in addictions, or lumped in with the Downtown Eastside," he says. "Policy decisions are still being made on our behalf," he laments. Or, he says, sometimes the health authority declares: "'We're going to change this policy. Would you like to help us change this policy?'"

Now, of course, he's waiting hopefully on the creation in BC of a First Nations Health Authority, which is supposed to be completed by 2014. How will that affect what Vancouver Coastal Health does in the meantime? What exactly will happen with the society's Hastings Street clinic, where half the clients aren't Aboriginal? It's another challenge for Vancouver Coastal Health as it tries to get a grip on healthcare in the Downtown Eastside.

What about the Native Courtworker and Counselling Association's alcohol and detox programs? Will Arthur Paul make any progress getting longer-term contracts out of Vancouver Coastal Health when bigger changes are coming? What about Paul's dream of support programs for the children of incarcerated parents? "I can't get anybody to fund it." Uncertainty over the administration of a whole range of health and social programs for Aboriginal communities will hardly help him.

What are Vancouver Coastal Health's plans? "If there's an Aboriginal strategy," said Woodward's community outreach worker Am Johal, "I don't know what it is." Vancouver Coastal Health needs to bring

Conversations with Paul and Demarais do reveal one certain thing — that the issues that connect people are usually larger than the issues that divide them.

this underrepresented community to the planning table, to ensure the transition of some services to an Aboriginal health authority goes well.

Conversations with Paul and Demarais do reveal one certain thing — that the issues that connect people are usually larger than the issues that divide them. The quality of housing and addiction treatment, education on good nutrition, and care for the aging are high on their lists of priorities.

For Paul, aging in place is the number-one undiscussed issue on the Downtown Eastside. The Atira Women's Resource Society's Janice Abbott, Lookout's Karen O'Shannacery, St. James's Jonathan Oldman, and Watari's Michelle Fortin also place it near the top of their lists. Lifespans on the Downtown Eastside have increased; now VCH must deal with more chronic disease among the aging.

Some healthcare problems are the same wherever you go. Access to general practitioners is a problem. Clinics aren't taking new patients. But the focus on some acute and distinctive challenges on the Downtown Eastside has distracted attention from more prosaic needs. Carole Brown, coordinator of the Ray-Cam Co-operative Community Centre, thinks simple healthcare services to fill the gaps could be offered through her facility.

It's clear that as Vancouver Coastal Health tries to address these seemingly unmanageable, attention-getting problems that bedevil the Downtown Eastside, it must ensure that the primary healthcare services we all require receive their due.

Giving people the power to care for themselves

"The people that live here," says RainCity Housing associate director Greg Richmond, "they never get a voice in the strategies that are supposed to help this community."

One of the great successes in the Downtown Eastside is the Vancouver Area Network of Drug Users. It's run by the people it represents. It's a rarity. The same goes for United We Can, the internationally lauded binners' collective that has spawned some of the most encouraging low-barrier employment initiatives in Vancouver.

When Lou Demarais talks about the successes of the Vancouver Native Health Society, he points to the Dudes' Club, a men's health group that recently hired a virologist to speak about disease transmission. There was food and entertainment, and Demarais says about 200 people showed up. "It succeeded because the subscribers did all the work."

The Carnegie Community Action Project is dedicated to representing the views and interests of the people who call the Downtown Eastside home, and they know how hard it can be to ensure those voices are really heard. The project's Jean Swanson believes local agencies should

LIFESPANS ON THE DOWNTOWN EASTSIDE HAVE INCREASED; NOW VCH MUST DEAL WITH MORE CHRONIC DISEASE AMONG THE AGING.

have more local residents on their boards, and points to the REACH Community Health Centre as a model. How many non-profits have even one representative from among their clients?

Burnham says Coast Mental Health tries to ensure its board has a third of its members with lived experience with mental illness, either directly or through family. Coast is accredited by Accreditation Canada, which surveys non-profit healthcare organizations to help raise standards on governance, planning and patient care. He notes, however, that it's an expensive service that isn't always appropriate for smaller organizations.

Greater transparency regarding healthcare services is a key issue for some business and community groups on the Downtown Eastside. They want it from Vancouver Coastal Health, and they want it from the agencies it funds, such as the Portland Hotel Society. And again, little issues become big ones when people don't communicate. One critic wants to know why the Portland doesn't have a publicly accessible website. Because, says Townsend, the society hasn't spent the money to build one.

Vancouver Coastal Health must also ask itself how it can ensure that the people it serves on the Downtown Eastside have a voice in its process. One way it can do that, of course, is by building strong, respectful partnerships with the agencies that work in the DTES, and by listening closely to those most connected to the community. Another, and it was emphasized by Atira's Janice Abbott, is ensuring that patients always have a voice in decisions about their own healthcare.

Yet another is by connecting more directly with the range of people who live on the Downtown Eastside. Carole Brown, who has spent 25 years working at the Ray-Cam Community Centre, and Judy McGuire, coordinator with the Inner City Safety Society, feel harm reduction, narrowly defined, has distracted from healthcare for families and seniors. They believe addiction treatment and prevention require more attention, along with the needs of seniors and the immigrant families from the Raymur-Campbell Public Housing Project. McGuire, who was a key contributor to *The Downtown Eastside: A Community in Need of Balance,* places part of the blame on the governmental culture of contracting services, where the key relationship is between the agency and the funder. In this situation, she says, the people being served become "outputs."

We need to do more than just help people. We need to allow and encourage people to help themselves and those around them. VANDU's Ann Livingston says the most important unfunded thing in the Downtown Eastside is social networks of support: "You do harm by giving people clienthood when you should be giving them citizenship."

We need to do more than just help people. We need to allow and encourage people to help themselves and those around them.

Finding health and community through food

Some of the most promising health initiatives on the Downtown Eastside involve food. SOLEfood, for example, is building on the United We Can tradition as a social enterprise — creating low-barrier employment and skills development at urban farms in the heart of the Downtown Eastside. SOLEfood's fabulous produce is sold at Farmers markets, if you can't afford to eat it at Bishop's restaurant.

The example of innovation around food is a critical one for the Vancouver Coastal Health Authority. It shows the extent to which the incubation of small ideas that originate in the community can become important, relatively self-sustaining models for social progress. United We Can started with a $1,500 grant to an alcoholic binner with Crohn's Disease. Now it's at the forefront in the effort to give residents citizenship and control over their own lives.

The Portland Hotel Society has long had a partnership with the aforementioned and internationally lauded Potluck Café Society. The Carnegie Centre has a city-subsidized cafe that offers great lunches for about $2.50, and kitchen volunteers can earn their meals. Restaurant operators and housing agencies have partnered to experiment with how food services are delivered to their clients. Traditional soup kitchens still abound, but new models will overtake them.

People do insist on putting all sorts of unhealthy things in their mouths — from sugar and salt to cigarettes and crack pipes. But when good food and a sense of ownership in its creation are offered, it's a particularly beneficial alternative. Some addiction medicine is complicated, but as anyone who's tried to quit smoking knows, substitution is a critical strategy.

Nutrition was often mentioned as a critical tool to improve health. But effective food programs are about much more than good nutrition. They are about esteem and control. "People don't want to feel that it's charity," says Abbott. While some quite reasonably advocate for increased funding for residential food programs, Vancouver Coastal Health must also recognize and amplify the efforts of programs that give people a sense of ownership and control over their own diets.

It's another area where partnership is just as important as funding. Vancouver Coastal Health is understandably wrestling with its role in providing housing on the Downtown Eastside, as it tries to ensure it fulfills its core mandate of providing primary care. Food raises similar issues, and yet healthy food is the best medicine. "Women," says Abbott, "make better decisions when they're not hungry."

How can Vancouver Coastal Health leverage its role in providing food to those in supportive housing or licensed care to amplify and expand community-based food programs? How can it give those in need a sense of partnership in life's most important communal activity?

Poverty and gentrification, housing and homes

Vancouver Coastal Health's work on the Downtown Eastside plays out against a much bigger and highly charged political backdrop. Why have we housed so many marginalized people in such marginal circumstances? How did Vancouver become so balkanized? Where is the mixed-income neighbourhood in Vancouver that's not at risk of being overwhelmed by gentrification and redevelopment? What role has speculation

on real estate and the pace of change played in that?

Now, of course, redevelopment is washing over the Downtown Eastside, in a city where real-estate makeovers have quickly changed the character of many neighbourhoods. Many longtime residents are fearful. Rents in private buildings don't have to rise much to force people of modest means out of their homes. That sort of disruption can cost people their lives.

Conversely, many feel the solutions on offer — the current form of housing for the poorest among us and our inadequate response to addiction and mental illness — are not entirely helpful. "It's not social housing," says one critic. "It's housing with drug dealers and mental illness in tiny little rooms. What do you expect?"

The Strathcona and Gastown business improvement associations are angry about the failure to effectively manage street drug-dealing and consumption, street prostitution, and housing for people struggling with mental illness. While the police and the housing agencies get most of the flak for the impact on drug trafficking and use on the streets, they see Vancouver Coastal Health as complicit and agencies such as Portland as unaccountable to the community.

For housing facility managers trying to cope, sometimes there is no right answer. Should they push problem activity out of the housing and onto the street, or allow it inside? What rules should they impose upon their residents? Is it fair that residents don't have the same rights as tenants in private buildings? "If you are in Bridge Housing, you are not allowed to enter another Bridge Housing room," says VANDU's Livingston. It's rather hard to think of your shelter as a home if you aren't allowed to visit your neighbour.

For governments, it can also feel like a mug's game. Should they stagger the release of social assistance cheques to stem the Welfare Wednesday chaos, as the Strathcona Business Improvement director Joji Kumagai suggests, or would that result in more loansharking? A quarter century after the Expo 86 evictions began to galvanize our effort to do better on the Downtown Eastside, some things are worse. People need circumstances that "don't drive them to be loaded," says Watari's Fortin.

For the Carnegie Community Action Project's Jean Swanson, who has worked with and for the poor on the Downtown Eastside for 35 years, we need first to ask about social equity. "When there is greater social equity, we need fewer hospital beds," Swanson says. She wants people with influence to join the call for higher welfare rates.

How much of the cost that Vancouver Coastal Health faces on the Downtown Eastside is the result of inequality, in a city where real estate has become so expensive that even the middle class has trouble making its way? How much of the cost is the result of both national and local policies on recreational drugs?

As such, how should Vancouver Coastal Health measure the cost of the services it delivers to Downtown Eastside residents? It would be less if the neediest had better places to live on someone else's dime. It would be less if people could afford to buy their own food. At the other end of the ledger, it would be more if all those methadone users bought heroin on the black market. Or if more people slept on the street. Or if outreach care and needle exchanges and peer networks and food programs were undercut and more people ended up in hospital as a result.

Very few people believe the resources on the Downtown Eastside are sufficient. "Things are always better when there's more money," says Abbott. "It's really hard to leverage change in drug use when the social conditions are this abysmal," says RainCity's Greg Richmond.

Many argue that Vancouver Coastal Health should simply focus, as one service provider put it, on problems it can get its arms around. The representatives of most community agencies talk mainly about those smaller issues. The elephants in the room — drug policy, social equity — often go unaddressed. Some people don't speak to these issues because it seems futile, some because they're exhausted by our failure, some because they think they'll sound pedantic. Sometimes it's simply because the question is not raised.

Because homelessness is such a shocking, easily comprehensible issue, it has dominated the public and political conversation, and drawn additional public funding. "If the major provincial dollars are going into housing," notes Michelle Fortin, "then housing has the floor." Adds Evan Wood, "The major provincial dollars are going into housing without sufficient consideration for the kinds of services that should go into those buildings."

Housing will continue to dominate the agenda on the Downtown Eastside. As Vancouver Coastal considers whether to have BC Housing deliver the $12 million in housing services it currently provides annually in the neighbourhood, it must also help to shape solutions that work. Streetohome's Dick Vollet would like to see the health authorities push the issue at the Metro Vancouver mayor's table.

"The Vancouver Coastal and Fraser health authorities could come together and say to the mayors, 'We'll provide health, you provide housing.'"

The way in which housing has dominated the conversation raises another issue for Vancouver Coastal Health: how can it put health on the Downtown Eastside more effectively on the broad public agenda? Are there ways in which Vancouver Coastal Health can use its influence — its board, the fundraising infrastructure of the Vancouver Hospital Foundation — to foster health-related initiatives that can galvanize public support?

Primary care doesn't have much pull. It's always been hard to get money, from government or private sources, to care for the mentally ill. One executive director lamented that the United Way hasn't served Downtown Eastside groups well. Townsend says the Portland Hotel Society was able to raise half a million dollars from the Real Estate Foundation for one new building, but smaller non-profits simply don't have the organizational capacity to do that.

How can small non-profits raise money for their incubation projects? Are food initiatives a place where board and foundation resources could be beneficial? What could they do to assist in exploring new forms of partnership, such as the collective impact model? Is there a key piece of infrastructure that could be developed to change the dynamic on the Downtown Eastside?

There are blue sky dreams. First United's acting Executive Director Stephen Gray and community manager Lori Gabrielson would like to see some sort of infirmary on the Downtown Eastside. Facilities at the Pennsylvania Hotel already provide beds for those who would otherwise be an undue burden in a traditional hospital environment. What might a neighbourhood infirmary look like?

Would it be beneficial to the neighbourhood?

Swanson wants the Vancouver Coastal Health-owned Buddhist temple site, at Hastings and Gore, redeveloped with health services on the bottom and decent housing that people on welfare can afford on top. Several people expressed their frustration that Vancouver Coastal Health is sitting on this "eyesore." Could the redevelopment of that site become a catalyst for other changes? Would it be less costly to provide some health services in such a facility? What if many of the agencies that deliver services on the Downtown Eastside shared that space? Would it make them better collaborators? Could it become the place that fostered service providers' own social networks of support? Would such an initiative allow Vancouver Coastal Health itself to focus on ongoing programs?

Against an often discouraging backdrop of mistrust, failed communication and inadequate triage, people remain hopeful and imagine better things for the Downtown Eastside. There is enormous spirit in the community to be tapped. "We always have too many volunteers," says VANDU's Livingston. There is heart and intelligence among the people who deliver care on the Downtown Eastside, and the sense that many solutions are within this community itself.

The four themes mentioned at the start of this report — the need for improved partnerships, better communication, shared direction and vision, and better evaluation and accountability — must all be addressed by Vancouver Coastal Health in conjunction with that community. To do so, careful leadership is required. Despite the many political complexities, if people communicate better, work together, and imagine what's possible instead of focusing on the limitations, we can better meet the many needs that exist in Vancouver's most vulnerable neighbourhood.

This report is drawn from interviews with the following people:

Janice Abbott, executive director, Atira Women's Resource Society

Dr. Evan Wood, BC Centre for Excellence in HIV/AIDS

Dr. Thomas Kerr, BC Centre for Excellence in HIV/AIDS

Dominic Flanagan, executive director, supportive housing and programs, BC Housing

Craig Crawford, vice president, operations, BC Housing

Jean Swanson, veteran community activist, Carnegie Community Action Project

Darrell Burnham, executive director, Coast Mental Health

Herb Varley, co-president, Downtown Eastside Neighbourhood Council

Alice Kendall, departing coordinator, Downtown Eastside Women's Centre

Rain Daniels, incoming coordinator, Downtown Eastside Women's Centre

Stephen Gray, executive director, First United Church

Lori Gabrielson, community manager, First United Church

Leanore Sali, executive director, Gastown Business Improvement Society

Judy McGuire, coordinator, Inner City Safety Society

Karen O'Shannacery, executive director, Lookout Emergency Aid Society

Arthur Paul, regional manager, Native Courtworker and Counselling Association of BC

Scott Bernstein, drug and housing policy specialist, Pivot Legal Society

Mark Townsend, co-director, PHS Community Services Society

Greg Richmond, associate director, RainCity Housing

Carole Brown, coordinator, Ray-Cam Co-operative Community Centre

Major Richard Gilbert, director of rehabilitation programs and shelters, Salvation Army

Mark Brand, entrepreneur, Save-on-Meats

Jonathan Oldman, executive director, St. James Community Services Society

Joji Kumagai, executive director, Strathcona Business Improvement Association

Wayne Nelson, board member, Strathcona Business Improvement Association

Claude Lemay, past president, Strathcona Business Improvement Association

Dick Vollet, president and CEO, St. Paul's Hospital Foundation, former president, Streetohome Foundation

Ann Livingston, executive program director, Vancouver Area Network of Drug Users

Ayanas Ormond, community organizer, Vancouver Area Network of Drug Users

Lou Demarais, executive director, Vancouver Native Health Society

Susan Giles, former Vancouver Coastal Health registered nurse

Evanna Brennan, former Vancouver Coastal Health registered nurse

Insp. Ralph Pauw, youth services section and mental health policy, Vancouver Police Department

Sgt. Howard Tran, mental health initiative, Vancouver Police Department

Michelle Fortin, executive director, Watari Youth, Family and Community Services

Am Johal, community outreach worker, SFU Woodward's

I was unable to arrange interviews with the following people, because they declined or were not available in the window of opportunity: Bob Rennie of Rennie Marketing Systems, Lynda Gray of the Urban Native Youth Association, Diamond Liu of the Chinatown Business Improvement Association, Bob Lee of the Prospero Group, Ivan Drury of the Carnegie Community Action Project, and Karen Ward of Gallery Gachet.

Charles Campbell is a veteran Vancouver journalist who has edited the Georgia Straight, worked at the Vancouver Sun as a department head and editorial board member, is a contributing editor to The Tyee website, an instructor at Capilano College, and author of the 2006 David Suzuki Foundation report, Forever Farmland: Reshaping the Agricultural Land Reserve for the 21st Century.

Responding to a public health emergency in Vancouver's Downtown Eastside

PROGRESS, REMAINING CHALLENGES AND OPPORTUNITIES FOR ACTION

From time to time over the past many years, health researchers have provided important and sometimes challenging perspectives concerning the health status and health needs of Downtown Eastside residents. To encourage discussion, we invited Dr. Thomas Kerr, a well-known and respected health expert, to provide us with his assessment fifteen years since the declaration of the public health emergency. We consider this the first in a series and look forward to publishing and discussing the opinions of others. It is important to stress that this paper does not represent the views of Vancouver Coastal Health, nor should it be seen as a blueprint for action.

Report prepared for Vancouver Coastal Health by **Thomas Kerr, PhD**
Director, Urban Health Research Initiative, BC Centre for Excellence in HIV/AIDS
Associate Professor, Department of Medicine, University of British Columbia

Executive summary

Vancouver's Downtown Eastside (DTES) has experienced longstanding epidemics of infectious disease and fatal overdose, and is home to one of North America's largest open drug markets. In 1997, the Vancouver/Richmond Health Board declared a public health emergency for the DTES. In the wake of this declaration, various policy and programmatic initiatives have been launched, including initiatives at the municipal, regional, provincial and federal levels. As well, Vancouver Coastal Health initiated a number of innovative programs and redesigned several existing services.

The purpose of this document is to review the progress made in addressing the public health emergency in the DTES, to identify emerging and under-addressed health issues, and to highlight opportunities for action. The analyses contained herein are based on an assessment of data generated from various sources that address a range

THERE IS WIDESPREAD AGREEMENT AMONG VARIOUS EXPERTS THAT THE MAJORITY OF CONTINUING MORBIDITY AND MORTALITY WITHIN THE DTES IS BEING DRIVEN BY UNTREATED ADDICTION AND MENTAL HEALTH ISSUES.

of topics specific to the DTES, including health outcomes (e.g., HIV infection rates, mortality), health service utilization (e.g., emergency department utilization), housing and drug use patterns.

Although the DTES community continues to contend with an array of health challenges, significant progress has been made in addressing some of the most pressing health issues affecting the community, including those that prompted the declaration of the public health emergency. For example, large declines in HIV infection and overdose rates have been observed, and the life expectancy of DTES residents has increased. Further, increases in the use of addiction treatment and declines in the use of hospitals for treatment of infections have been observed. These improvements in health outcomes and service utilization are due in part to the programmatic efforts, including the establishment of novel programs and the redesigning of existing services.

Despite the noted successes, there are now a number of new and emerging health challenges in the DTES, as well as some problems that have persisted and have not been sufficiently addressed. There is widespread agreement among various experts that the majority of continuing morbidity and mortality within the DTES is being driven by untreated addiction and mental health issues. Large increases in crack cocaine smoking, diverted prescription opiate use, and non-beverage alcohol consumption are creating a new set of health challenges.

Problems with acute intoxication also account for a large proportion of hospital visits by DTES residents. While some programmatic efforts to address these problems are in place, much unaddressed morbidity and mortality persists. Currently, many harm reduction initiatives have not been brought up to an appropriate scale, and opportunities to extend and optimize programs have been missed. Likewise, while progress has been made in expanding addiction treatment, appropriate first- and second-line therapies (e.g., buprenorphine, heroin prescription), and newer treatments (e.g., naltrexone) are not available. As well, opportunities to test the effectiveness of novel approaches, such as novel treatments for cocaine dependence, have been missed. The ongoing challenges associated with untreated mental illness may also reflect, in part, the lack of a comprehensive mental health strategy designed specifically for the DTES community. Other major health challenges within the DTES include chronic obstructive pulmonary disease (COPD). Although hepatitis C incidence has declined recently, this is, in this instance, a reflection of epidemic saturation and suggests that advanced hepatic disease will become an important driver of morbidity and mortality in the years to come.

At a more structural level, challenges related to housing remain. Many residents of the DTES live in unstable housing and experience bouts of homelessness, and these exposures continue to drive much preventable morbidity and mortality in the neighbourhood. Challenges related to ensuring access to health services within

various housing environments and among the homeless remain, and the need for long-term housing for individuals with chronic and terminal illnesses will likely continue to grow in the coming years.

DTES residents account for a large proportion of visits to local hospitals for both emergency department visits and acute bed stays. Many of these residents delay seeking care until illnesses are in advanced stages and require extended treatment in hospital. Many residents also require short-term emergency care for intoxication (e.g., cocaine-induced psychosis, untreated mental illness) and trauma. Collectively, these findings point to a lack of optimal integration of existing VCH programs (e.g., Addictions and Mental Health) with primary and acute care programs, as well as a lack of appropriate integration between VCH- and non-VCH-run programs and services. The lack of short-term emergency and in-patient services within the DTES also likely serves to perpetuate the overreliance on hospital services by DTES residents.

It should also be noted that some subpopulations in the DTES — in particular, individuals of Aboriginal ancestry and women — continue to experience a disproportionate burden of morbidity and mortality, and also experience a range of barriers to prevention, care and treatment programs. This reflects, in part, the lack of a coordinated strategy to address these special populations.

Many persistent and emerging problems remain and now require concerted attention. Through the scale-up and optimization of existing programs, and the creation of new programs, further progress can be made toward improving the health of the DTES community.

In summary, much progress has been made in addressing the public health emergency in the DTES. However, many persistent and emerging problems remain and now require concerted attention. Through the scale-up and optimization of existing programs, and the creation of new programs, further progress can be made toward improving the health of the DTES community.

Background

Vancouver's Downtown Eastside (DTES) has, for decades, garnered significant public attention. Often described as Canada's poorest urban postal code, the neighbourhood has contended with epidemics of infectious disease and fatal overdose, and is home to one of North America's largest open drug markets.[1] Unique features of the DTES that contribute significantly to health of the residents include the widespread availability of various illicit drugs, including cocaine, heroin, methamphetamine and diverted prescription opiates, a network of single-room occupancy hotels, and large open drug and sex-work markets. The DTES is now also home to a remarkably high number of individuals contending with mental health challenges.

In 1997, the Vancouver/Richmond Health Board declared a public health emergency for the DTES.[1] This was done largely in response to the dual epidemics of HIV infection and overdose that were occurring at the time. In the wake of this declaration, various policy and programmatic initiatives have been launched, including initiatives at the municipal, regional, provincial and federal levels. As well, Vancouver Coastal Health initiated a number of innovative programs and redesigned several existing services.

In particular, remarkable gains have been made in addressing the HIV epidemic.

THIS CHANGE CAN BE ATTRIBUTED TO A NUMBER OF FACTORS, INCLUDING IMPROVEMENTS IN THE DELIVERY OF SYRINGE DISTRIBUTION EFFORTS, INCREASES IN SUPPORTIVE HOUSING, THE ESTABLISHMENT OF VANCOUVER'S SUPERVISED INJECTION SITE, AND THE DELIVERY OF HIGHLY ACTIVE ANTIRETROVIRAL THERAPY TO THOSE INFECTED WITH HIV.

The purpose of this document is to review progress made in addressing the public health emergency in the DTES, to identify emerging and under-addressed health issues, and to highlight opportunities for action.

Methods

The analyses in this document are based on an assessment of data generated from various sources. In particular, data from Vancouver Coastal Health (VCH) Public Health Surveillance Unit, the BC Centre for Disease Control (BC CDC), the BC Coroner's Service (BCCS), and the BC Centre for Excellence in HIV/AIDS (BC-CfE) were collected and reviewed. These data address a range of topics specific to the DTES, including health outcomes (e.g., HIV infection rates, mortality), health service utilization (e.g., emergency department utilization), housing and drug use patterns.

Progress to date

Although the DTES continues to contend with an array of health challenges, significant progress has been made in addressing some of the most pressing health issues affecting the community, including those which prompted the declaration of the public health emergency. In particular, remarkable gains have been made in addressing the HIV epidemic, as HIV infection rates dropped from a high of 8.1 per 100 person-years in 1997 to 0.37 cases per 100 person-years in 2011.[2]

This change can be attributed to a number of factors, including improvements in the delivery of syringe distribution efforts,[3] increases in supportive housing,[4] the establishment of Vancouver's supervised injection site,[5] and the delivery of highly active antiretroviral therapy to those infected with HIV.[6] There have also been substantial declines in fatal overdoses in the DTES.[7] This is due in part to a number of programmatic efforts, including the establishment of Vancouver's supervised injection site.[8] Similarly, the burden of mortality attributable to infectious diseases more broadly has also declined,[9] and the overall life expectancy of DTES residents has increased from 71.4 years during the period from 1997 to 2001 to 79.5 years from 2007 to 2011.[10] While some declines in mortality rates attributable to cancer and cardio/cerebrovascular disease have been observed, these declines are not as great as those seen for other causes (e.g., infectious diseases).[9,11]

In terms of health service utilization, substantial increases in uptake of addiction treatment have occurred, primarily as a result of increases in the availability and uptake of methadone maintenance treatment.[2] This has coincided with a decline in proportion of individuals reporting difficulty accessing addiction treatment.[2] DTES residents continue to account for a large volume of both emergency department visits and acute hospitalizations.[12,13] However, some positive trends have been observed. In particular, the proportion of visits and stays in hospital for infectious diseases and related complications (e.g., those related to HIV disease), including those requiring IV antibiotic therapy, has declined.[14,15] This may be due in part to recent programmatic efforts, the establishment of the supervised injection facility, which has been shown to expedite assessment of and referral for cutaneous injection-related infections,[16] and the establishment of an innovative IV therapy program (the Community Transition Care Team or "CTCT") established within the DTES.

All data considered, much has been achieved in the wake of the declaration of the public health emergency in the DTES. Importantly, the epidemics of HIV infection and overdose in the mid-1990s that prompted this declaration have been reversed.

Emerging and under-addressed challenges

There is widespread agreement among various experts that the unaddressed morbidity and mortality within the DTES is being driven primarily by untreated addiction and mental health issues. Accordingly, many of the challenges identified as falling within the categories below are effects of addiction or mental illness.

Drug and alcohol use

Over time, drug use patterns have evolved significantly in the DTES. With such changes come new challenges for those responding to the health issues among people who use drugs. Among the most pressing challenges in the DTES is the massive rise in crack cocaine smoking and the near total absence of programs to address this problem.[17] Recent analyses from the BC Centre for Excellence in HIV/AIDS (BC-CfE) have shown that heavy crack use is associated with HIV infection and other adverse health outcomes.[18] Crack use also contributes greatly to public disorder and engagement in the local drug and sex-work scenes, which has been shown to greatly exacerbate risk for violence and other adverse health outcomes.[19] The rise in crack cocaine use has coincided with a decline in the proportion of DTES drug users who are injecting illicit drugs. A further emerging problem is the increasing use (both injection and non-injection) of diverted prescription opiates, with recent data from the BC-CfE showing an alarming increase in the availability and use of these drugs.[20] The consumption of alcohol — in particular, non-beverage alcohol (e.g., Listerine) — remains a problem requiring further attention.

A review of the data on hospital utilization from VCH reveals that emergency department admissions for substance misuse and acute intoxication have increased steadily in recent years,[15] and large proportions of visits to emergency departments and hospital wards are for infections associated

There is widespread agreement among various experts that the unaddressed morbidity and mortality within the DTES is being driven primarily by untreated addiction and mental health issues.

with unsafe injecting.[15] Data from the BC-CfE also reveal that over a 10-year period, approximately 30 per cent of all admissions of local drug users to St. Paul's Hospital ended with the patient leaving against medical advice.[21] Given that many such individuals will leave before treatments are completed, there is much preventable suffering and cost associated with these Against Medical Advice (AMA) events.

Although considerable progress has been made in addressing drug use, and a managed alcohol program is now operational, problems with scope and scale remain. Further, while there is a misperception among some stakeholders that there has been significant investment in harm reduction programming and a lack of investment in addiction treatment, data on expenditures show clearly that this is not the case. For several years now, VCH has dedicated a far greater proportion of spending to addiction treatment in comparison to harm reduction programming. However, taken in sum, the current state of addiction treatment can only be described as patchy at best. This may be due to a lack of trained addiction specialist physicians who can lead the development of such programs. Further, some programs, such as the supervised injection site, remain restricted to small pilot projects. Data from the BC-CfE show that each day up to 50 individuals leave the supervised injection site before using the service because the wait time is too long. Despite positive findings from the NAOMI project,[37] heroin prescription programming remains under-supported. As well, although some crack use materials have been disseminated within the DTES, relatively little has been done to address crack cocaine use, and discussions regarding the establishment of supervised inhalation programs have stalled.[22] Although detoxification programming has been expanded, there remains a shortage of pre-tox and detox programs. Likewise, while progress has been made in scaling up methadone maintenance treatment (MMT), there is a lack of innovation in the delivery of MMT (e.g., no low-threshold methadone), and appropriate second-line opiate substitution therapies (e.g., buprenorphine) are not widely available. Further, new innovative approaches, such as naltrexone (an opiate antagonist, trade name Vivitrol),[23] are also unavailable. Although many other health issues are identified below, many of these problems are direct or indirect effects of untreated addiction, including problems related to mental illness, COPD, and hepatitis C. Lastly, problems related to a lack of integration between VCH programs (e.g., Mental Health and Addictions) and primary and acute programs remain, and there is also a lack of appropriate integration of some VCH-run and non-VCH-run programs and services. This results in missed opportunities to coordinate care and treatment efforts, and to prevent overuse of hospital services.

Mental illness

Untreated mental illness remains a major challenge within the DTES and in the healthcare settings that serve DTES residents. Although quality data on the population level prevalence of different

30 per cent of all admissions of local drug users to St. Paul's Hospital ended with the patient leaving against medical advice.

THE CURRENT PATCHWORK OF PROGRAMS TARGETING MENTAL ILLNESS IN THE DTES LIKELY REFLECTS, IN PART, THE LACK OF A COMPREHENSIVE MENTAL HEALTH STRATEGY FOR THE DTES AND THE LACK OF CLINICAL LEADERS EMPOWERED TO UNDERTAKE THE CAREFUL PLANNING, MONITORING AND EVALUATION OF SUCH A STRATEGY.

psychiatric disorders within the DTES are lacking, it is well known that people who use drugs in the DTES suffer from high rates of depression[24] and trauma,[25] and many attempt and commit suicide.[9] Further, health service utilization data provide some insights into the extent of these problems. For example, severe mental disorders (e.g., schizophrenia) are among the top reasons for acute hospital stays and emergency department admissions.[12,13] Overall, there have been increases in the use of hospitals for such disorders, and data from the BC-CfE show that suicide remains a major cause of mortality among people who use drugs in the DTES.[26] Currently, there are few psychiatrists and psychiatric nurses working in the DTES, and access to these professionals within the existing DTES clinics is limited. Despite significant gains made through the formation of the local ACT teams, these teams function under uncertain funding arrangements. Further, historically, many DTES residents were not well served by existing community mental health teams, who often view addiction as being outside of their mandate. However, there have been improvements in this area as well, with more and more DTES residents being served by these teams. While significant progress has been made in terms of improving service delivery through the creation of local ACT teams, and better coordination with the Strathcona Mental Health Team, there remains a lack of appropriate services for those DTES residents contending with mental illness, which in turn fuels the use of hospitals for these conditions. More could also be done to ensure that those who have been assessed and treated for mental illness are continuing their care and receiving appropriate clinical follow-up. The current patchwork of programs targeting mental illness in the DTES likely reflects, in part, the lack of a comprehensive mental health strategy for the DTES and the lack of clinical leaders empowered to undertake the careful planning, monitoring and evaluation of such a strategy.

Chronic Obstructive Pulmonary Disease (COPD)

Although no data specific to the incidence or prevalence of COPD among DTES residents exist, and COPD is not a major source of mortality among DTES residents at this time, the available hospital utilization data suggest that COPD remains a major problem within the community.[9,12] This is likely due to both tobacco and cannabis smoking within the neighbourhood, but also the inhalation of crack cocaine. Currently, programmatic efforts that target this problem within the DTES are lacking.

Hepatitis C and other infectious diseases

While data on hepatitis C suggest a pattern of declining incidence,[27] which may in part be due to programs that reduce the likelihood of hepatitis C acquisition, these data also reflect epidemic saturation. Data from the BC-CfE reveal that over 90 per cent of DTES injection drug users are

already infected with hepatitis C.[2] Although end-stage liver disease is not presently a major source of mortality among DTES residents, given the prevalence of hepatitis C, this is likely to change. While remarkable gains have been made in the treatment of hepatitis C, there is currently a lack of programs delivering treatment for hepatitis C for DTES residents. If this situation continues, hepatitis C will soon account for a greater burden of morbidity and mortality in the DTES, and if left untreated, DTES residents may become the "core transmitters" of hepatitis within the province.

As indicated above, infections associated with unsafe injecting constitute a significant source of morbidity among DTES residents and also account for a large proportion of visits to emergency departments and hospital wards for treatment.[15] However, many individuals being treated for injection-related infections leave hospital prematurely. Although progress has been made in addressing infectious diseases, particularly HIV disease, among DTES residents, there is a need for additional efforts to reduce the immediate and future burden of illness and healthcare use associated with injection-related infections. For example, although the IV therapy program (CTCT) has been a success, this program remains small, and opportunities to expand the program, including into existing VCH clinics, have been missed.

Short-term emergency and in-patient care

DTES residents account for a large proportion of visits to local hospitals for both emergency department visits and acute bed stays. Many of these residents delay seeking care until illnesses are in advanced stages and require extended stays in hospital, and others require short-term emergency care for intoxication (e.g., cocaine-induced psychosis), untreated mental illness and trauma.[12,13] Collectively, these findings point to the lack of short-term emergency and in-patient services within the DTES itself. Specifically, there is a lack of services of this kind that could help alleviate the burden on hospital emergency departments by serving individuals experiencing acute health challenges — in particular, those related to intoxication and mental illness — and those experiencing traumas (e.g., stab wounds). Programs and services that can promote early intervention and thereby avert longer hospital stays for untreated illnesses and infections are lacking. Also lacking are more services that can help direct individuals with more serious mental health problems into longer-term care, such as the Burnaby Centre for Mental Health and Addiction. Although the existing VCH clinics in the DTES could be modified to accommodate patients with a higher level of acuity, this is currently prevented by several factors, including the limited hours of operation and lack of appropriate physical space. As well, the clinics currently do not operate in the low-barrier or low-threshold manner needed for such programming.

Although end-stage liver disease is not presently a major source of mortality among DTES residents, given the prevalence of hepatitis C, this is likely to change.

Housing and long-term care

Data from the BC-CfE reveal that issues related to unstable housing and homelessness persist and are associated with significant health-related harm among DTES residents.[17,41,42] Many of the emerging and under-addressed health issues identified above are exacerbated by housing issues. Significant progress has been made in terms of scaling up supportive housing environments; however, more must be done to bring a range of prevention, care and treatment programs

Programs and services that can promote early intervention and thereby avert longer hospital stays for untreated illnesses and infections are lacking.

to these environments — especially since many residents in these environments may be disconnected from conventional health programs. Further, while many DTES residents may be able to reintegrate into mainstream society with appropriate addiction treatment and employment support, some contend with chronic refractory addiction, and others contend with disabilities that make returning to work, etc., highly unlikely. Accordingly, the need for long-term housing options for these residents, including more specialized housing services (e.g., palliative care) for those dealing with end-stage disease, is likely to increase in coming years.

Special populations: Aboriginal residents and women

A further unique feature of the DTES is its high proportion of residents of Aboriginal ancestry. Although provincial estimates suggest that 2–5 per cent of those living in the province are of Aboriginal ancestry, data from local cohort studies suggest that up to 30 per cent of DTES residents who use illicit drugs are of Aboriginal ancestry.[28] Data from the BC-CfE show that Aboriginal individuals are at heightened risk for various adverse health outcomes, including HIV infection and overdose.[28,29] As well, many of these health inequities are fuelled by barriers to healthcare experienced by Aboriginal people who use drugs, including barriers to HIV and addiction treatment.[30-32]

There is a considerable body of evidence indicating that women in the DTES also contend with unique health challenges, including those associated with gender dynamics within the drug market and sex-work scenes, and violence.[33-35] Further, women often experience unique barriers to prevention, care and treatment programs, in part due to threats posed by men within the DTES.[36] While some mobile services for women in the DTES exist, these are small in scale and none are funded by VCH.

The ongoing health inequities experienced by Aboriginal residents and women in the DTES may reflect in part a lack of coordinated programming for these populations, including a lack of optimal integration of VCH and non-VCH programs. Further, the lack of coordinated strategies to address the needs of these special populations remains a problem.

Some additional considerations

The DTES is home to various marginalized populations, including those who are disconnected from conventional public health programs (e.g., people who use drugs, sex workers). Research has shown that peer-led programs can help extend the reach and effectiveness of provider-led services,[44,45] and thereby connect with individuals who are disconnected from conventional programs and who are at heightened risk for health-related harms. However, opportunities to expand and improve upon existing peer-led/peer-involved programming have been missed.

THE ONGOING HEALTH INEQUITIES EXPERIENCED BY ABORIGINAL RESIDENTS AND WOMEN IN THE DTES MAY REFLECT IN PART A LACK OF COORDINATED PROGRAMMING FOR THESE POPULATIONS, INCLUDING A LACK OF OPTIMAL INTEGRATION OF VCH AND NON-VCH PROGRAMS.

There has been growing acknowledgement that health policies and programs should be based on the best available scientific evidence. While some VCH programs, such as the supervised injection site, have been subject to rigorous evaluation,[46] other programs have not. In some instances, programs are simply subjected to simple process evaluations. Although it may not be feasible to rigorously evaluate every program, novel and large-scale programs that are amenable to more rigorous investigation have not been well evaluated. Lastly, VCH has not recently conducted a comprehensive review of existing DTES programs and services. While many programs were designed to address the public health emergency in 1997 and were relevant at the time, some may no longer be needed or may be in need of significant modification in order to ensure ongoing relevancy to the current situation.

Limitations

There are limitations associated with the data and analyses contained herein. First, much of the data considered are limited in terms of period and scope, and thus provide only a limited view into the issues explored in this document. Second, the precise impact or lack thereof of individual programs and services cannot be captured in most instances (albeit with some exceptions). Third, this report focuses first and foremost on the public health emergency in the DTES, and accordingly much attention is given to problematic substance use and mental health. As a result, other subpopulations within the DTES, including children and the elderly, may not have been fully addressed.

Conclusion

The available evidence suggests that much progress has been made in addressing the pressing health issues that prompted the public health emergency in the DTES. This progress can be attributed, in part, to the implementation and redesigning of VCH and non-VCH programs and services. Despite this progress, some old problems remain and other new challenges have emerged. Addressing these issues will require new and concerted action that includes program development, review, evaluation, and improved coordination and integration of existing services.

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A few retrospective statistics about the Downtown Eastside

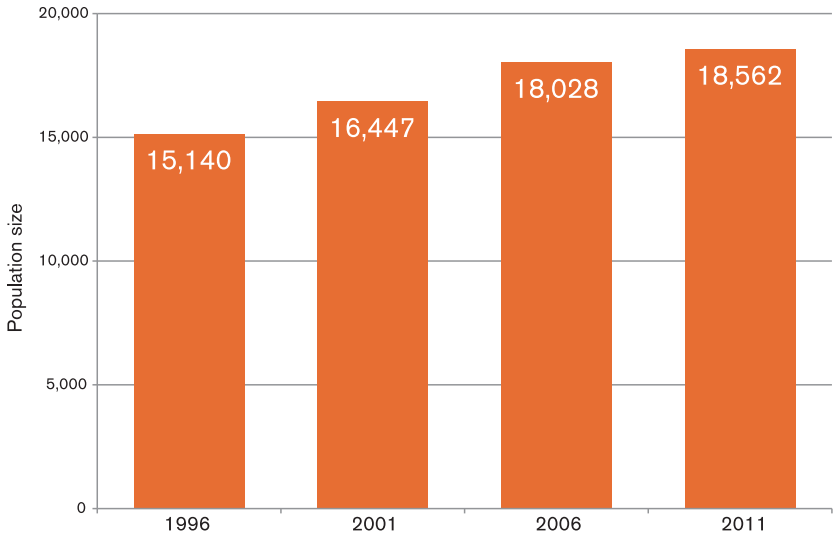
Dr. Rolando Barrios
Senior Medical Director – Vancouver Community Health Services

TO ILLUSTRATE SOME OF THE CHANGES IN HEALTH IN THE DTES SINCE THE DECLARATION OF THE PUBLIC HEALTH EMERGENCY 15 YEARS AGO, MY COLLEAGUES AND I HAVE COMPILED THE FOLLOWING STATISTICS.

We drew from research cohorts, the national census, public health records, provincial birth and death records, and health system databases. The topics reflect the health issues that prompted the declaration, namely epidemics of HIV and hepatitis C and a high rate of illicit drug overdose deaths.

The region in focus here is the DTES neighbourhood. The population currently numbers around 18,000 people, and has been growing, likely due to population migration.[1]

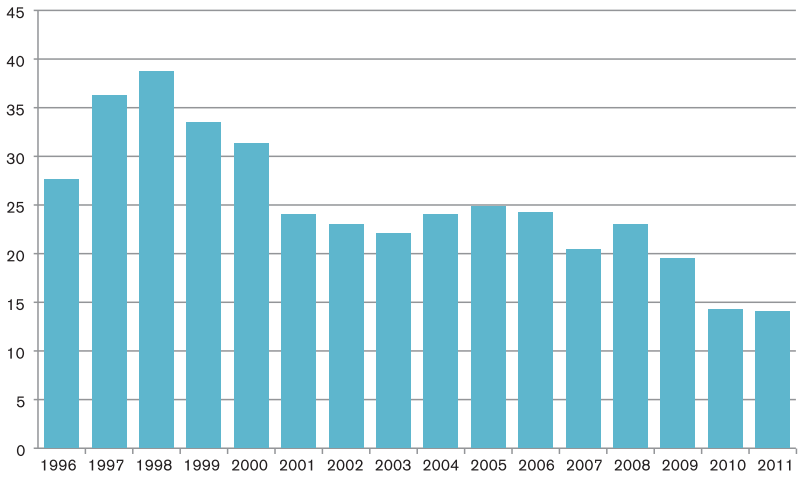
DTES population size



Data source: Census, Statistics Canada

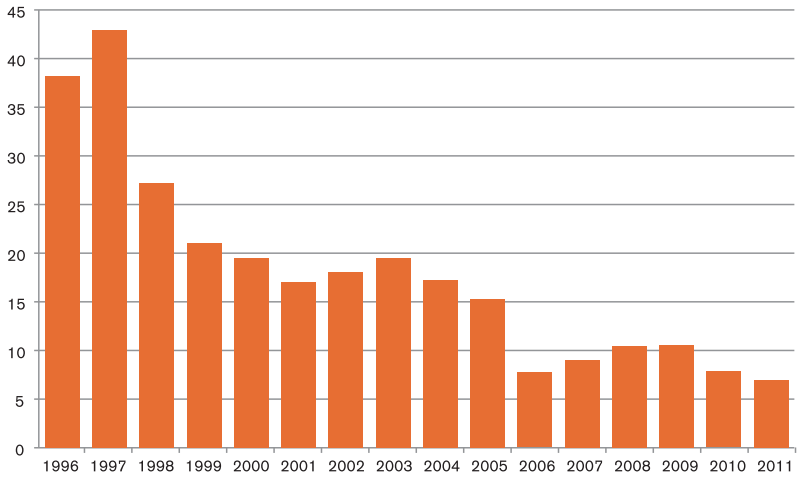
After 1998, patterns of intensive drug use shifted away from injecting cocaine and heroin toward smoking crack. While crack was rarely used by injection drug users in 1997, smoking crack daily has become more than twice as prevalent as injecting heroin or injecting cocaine with that frequency.

Per cent of people who inject drugs in Vancouver reporting daily heroin injection



Data source: BC Centre for Excellence in HIV/AIDS

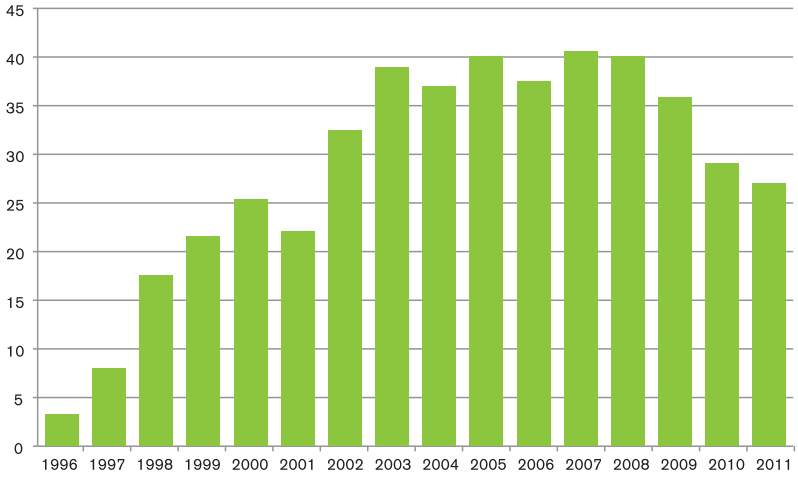
Per cent of people who inject drugs in Vancouver reporting daily cocaine injection



Data source: BC Centre for Excellence in HIV/AIDS

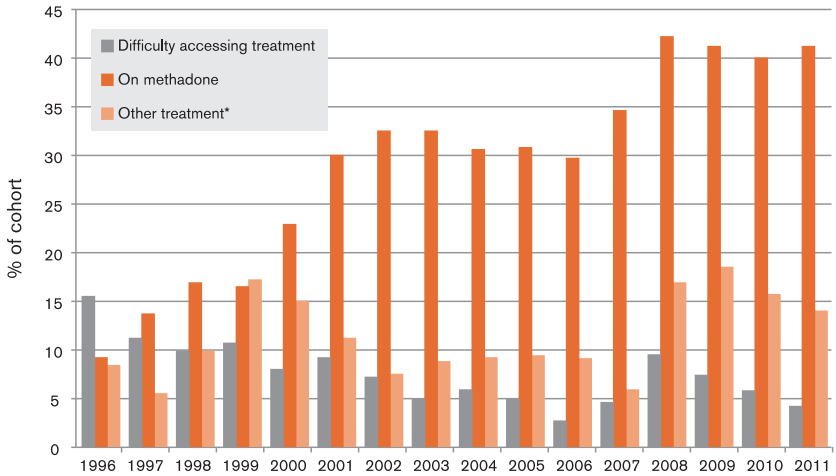
This pattern is not exclusive to injection drug users, but applies more widely to street-involved Vancouver residents. These changes may relate to increasing methadone treatment coverage, which rose from around 10 per cent of injection drug users in 1996 to more than 50 per cent in 2011.[2]

Per cent of people who inject drugs in Vancouver reporting daily crack smoking



Data source: BC Centre for Excellence in HIV/AIDS

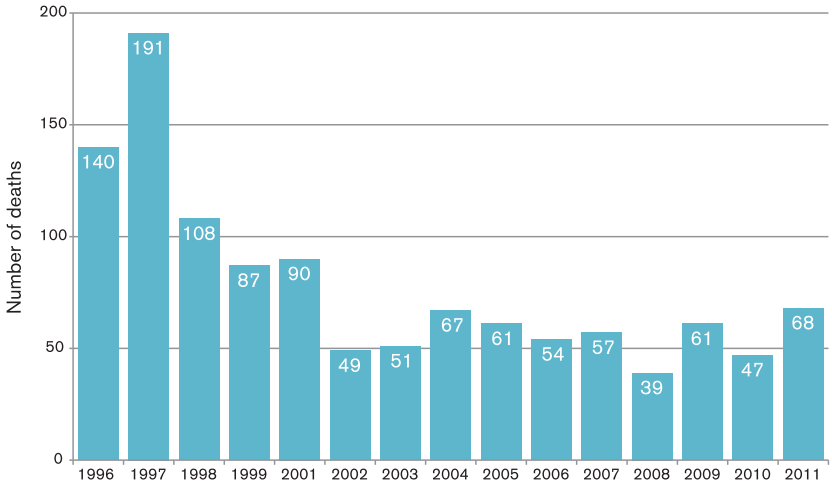
Patterns of access to addiction treatment among people who inject drugs in Vancouver



** Note: "Other treatment" includes detox, daytox, recovery house, treatment centre, NA/CA/AA and counselling.*
Data source: BC Centre for Excellence in HIV/AIDS

Overdose deaths in Vancouver have stabilized at about one-quarter the level reached in 1997.[3]

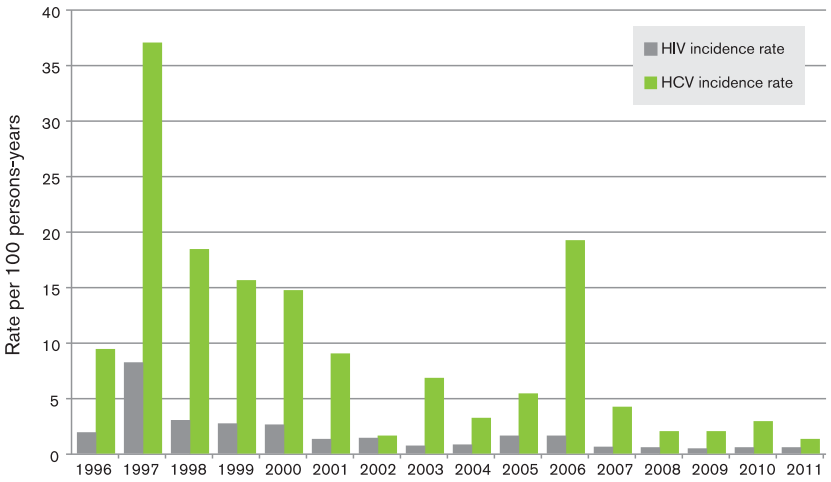
Illicit drug overdose deaths in the City of Vancouver



Data source: BC Coroners Office, September, 2012

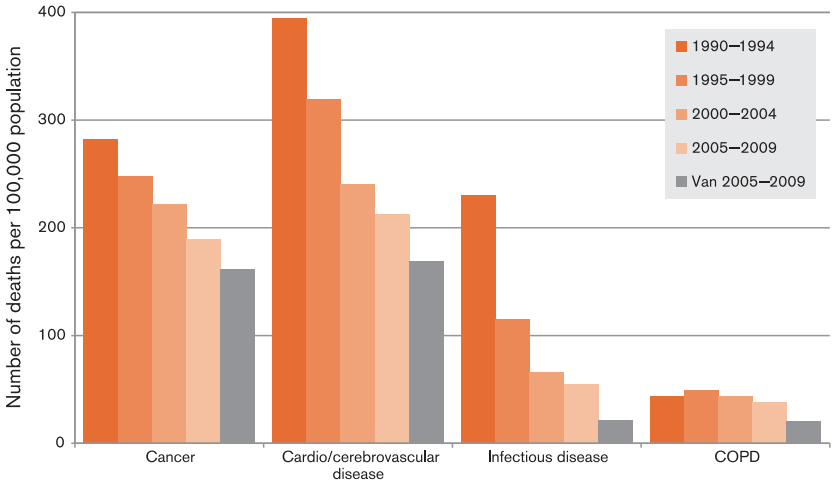
New HIV and hepatitis C infections among injection drug users have declined to a small fraction of 1997 levels. The rate declined significantly across the entire local health area since 2003. Note that this statistic is different from the number of people who have these infections.

Incidence of HIV and HCV infection among people who inject drugs in Vancouver, 1996–2011



Since 1994 the mortality rate has declined in the DTES health area for many major causes of death, typically by more than 50 per cent. These figures today are still much worse than those of Vancouver overall in every category.

Five-year mortality rate per 100,000 population by specific cause of death. Vancouver DTES and Vancouver HSDA, 1990–1994 to 2005–2009

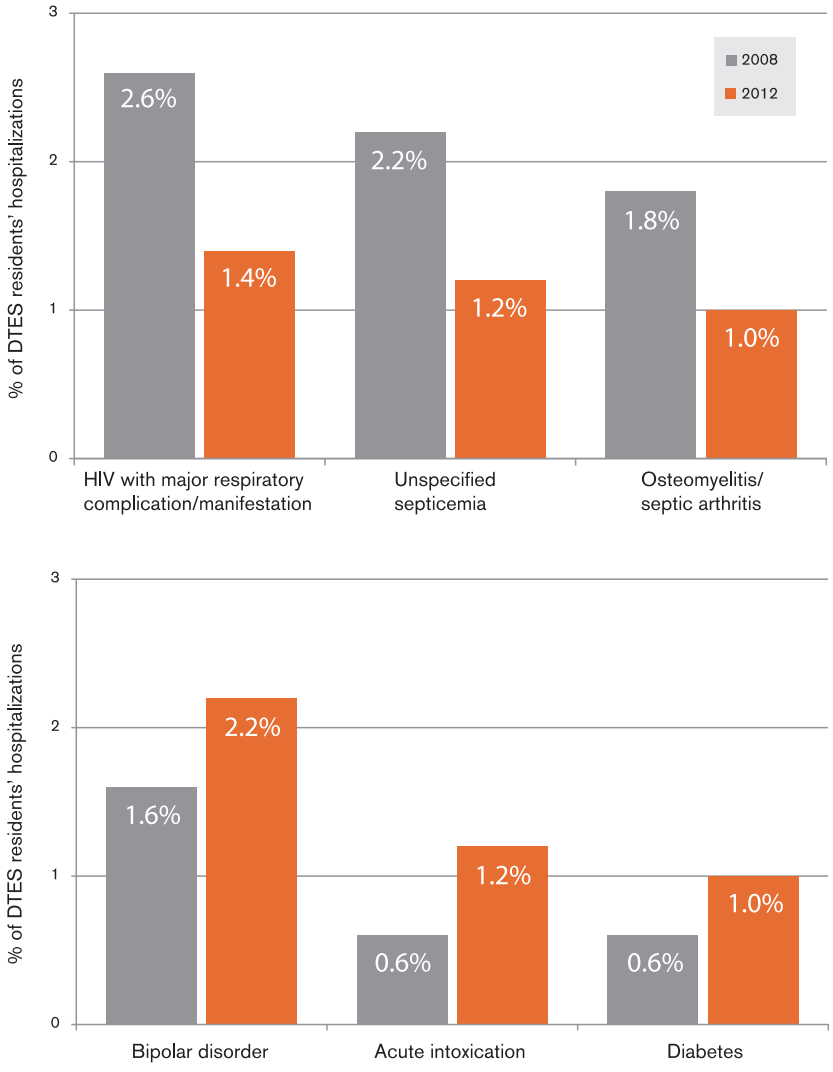


Prepared by: Vancouver Coastal Health, Public Health Surveillance Unit, September 2012
Data source: BC Vital Statistics Agency (VISTA), June 2012

Health in the DTES has improved in most aspects relating to the public health emergency of 15 years ago. While some conditions decline, others shift to the foreground. We find injection-related issues such as septicemia, osteomyelitis and HIV among the most declining reasons for hospitalization of DTES residents over the past five years.

Meanwhile, other substance use issues such as acute intoxication and withdrawal are among the most quickly escalating reasons. Diabetes hospitalizations are also on the rise. On the whole, the most prevalent reasons for hospitalization, such as schizophrenia and COPD, have generally maintained at a steady rate.[6]

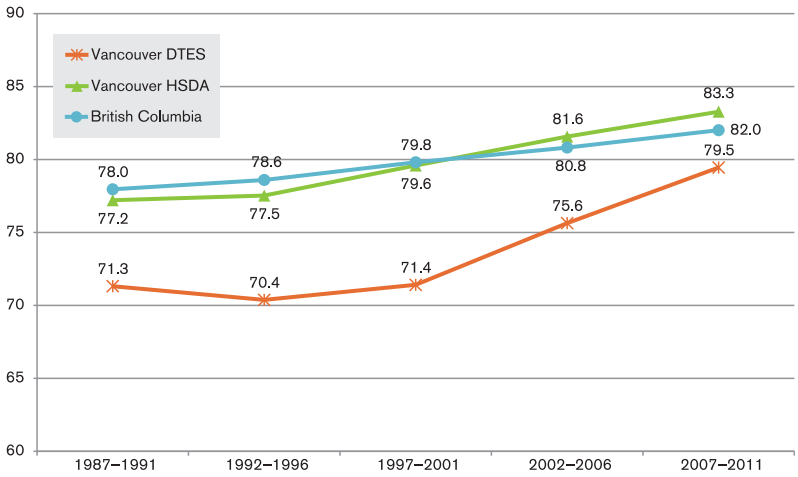
DTES residents' reasons for hospitalizations:
examples of largest proportional shifts 2008–2012



Prepared by: VCH Decision Support and Strategy Deployment Team, September 2012
Data source: Decision Support ADRmart, PARIS data extract

The big picture is that longevity, a central goal of healthcare, has increased in the DTES health area by about 10 years since 1996. In that time the gap in life expectancy between this area and BC overall has reduced by 65 per cent. We believe that health services have contributed to this change, but not more than the combination of other factors.[7]

Life expectancy (years) at birth. Vancouver DTES, Vancouver HSDA and British Columbia, 1987–1991 to 2007–2011



Prepared by: Vancouver Coastal Health, Public Health Surveillance Unit, September 2012
Data source: BC Stats, Ministry of Labour, Citizens' Services and Open Government, February 2012

The available evidence does not confirm the causes of the changes described above, but these data show that health conditions have shifted in the DTES. The epidemics of 15 years ago have not disappeared, but they have diminished. Different healthcare needs emerge with these changes, and we as healthcare providers should consider them as we strive to provide the best possible care.

It is important to note the limitations of these statistics. They sometimes reflect geographic areas that are larger than the Downtown Eastside core, for example the Downtown Eastside local health area, which includes Grandview Woodlands. Some statistics come from research cohorts that are not exclusively Downtown Eastside residents. The health system statistics are specific to the Downtown Eastside core area, but they show changes from only the past five years, and cannot shed light on the prior use of healthcare in the neighbourhood.

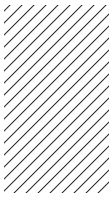
For helping to assemble this information, I would like to thank Jat Sandhu and VCH's Public Health Surveillance Unit, Chris Buchner and Dr. John Carsley from the office of the VCH Medical Health Officer, Michael Li and Aleem Teja from VCH Decision Support, and Ben Fair from Vancouver's planning team.

References

1. Data source: Statistics Canada census 1996, 2001, 2006, 2011. Geographic area: DTES core defined by four census tracts.
2. Data source: data on daily use and methadone from research cohorts in the Urban Health Research Initiative, BC Centre for Excellence in HIV/AIDS. Data on weekly use from adult street-involved drug user surveys in 2012 by the Centre for Addiction Research of BC. Geographic area: participant interviews conducted in Vancouver.
3. Data source: BC Coroners Service. Geographic area: City of Vancouver.
4. Data source: research cohorts in the Urban Health Research Initiative, BC Centre for Excellence in HIV/AIDS. Local health area vital statistics via VCH Public Health Surveillance Unit. Geographic area: participant interviews in Vancouver for cohorts, DTES local health area for vital stats.
5. Data source: BC Vital Statistics via VCH Public Health Surveillance Unit. Geographic area: Downtown Eastside local health area.
6. Data source: VCH health records databases. Geographic area: Downtown Eastside core as per City of Vancouver neighbourhood boundary.
7. See footnote 5.

Notes

Notes



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