Toronto and Ottawa would benefit from supervised drug injection facilities

A harm reduction approach could break down barriers to “end-of-life” care

Toronto and Ottawa would benefit from supervised drug injection facilities


Background:
Supervised injection facilities (SIFs) are places where people can inject drugs under supervision. Two SIFs exist in Canada, both in Vancouver. Other cities are considering SIFs.

Study focus:
Do Toronto and Ottawa need SIFs? Is implementing SIFs in these cities feasible? We analyzed evidence from a variety of sources, and developed a mathematical model to predict whether the health benefits of SIFs would balance the financial costs.

Findings:
Toronto and Ottawa would benefit from multiple SIFs. We projected that introducing 3 SIFs in Toronto and 2 in Ottawa would:
- Reduce new hepatitis C and HIV infections.
- Reduce public drug use, since users who inject drugs outside were particularly interested in SIFs.
- Represent good investments of health care dollars.

Public opinion about SIFs has changed in recent years; many more residents now support SIFs.
- About half of residents felt strongly that SIFs should be implemented, if they work well to prevent infectious disease and reduce neighbourhood problems.
- An additional third had mixed opinions, but said they would feel better about SIFs if they had more information about them.
- Few residents are completely against SIFs.

Although many people who inject drugs also smoke drugs, there is not enough evidence to recommend a supervised smoking facility.

Implications for health policy and practice:
Our report provides an evidence base for discussions about introducing SIFs to Toronto and Ottawa.

Contact: Ahmed Bayoumi (BayoumiA@smh.ca)

A harm reduction approach could break down barriers to “end-of-life” care


Background:
Homeless and marginally housed people - especially those who use alcohol and illicit drugs - are often excluded from traditional (i.e. hospital or hospice-based) “end-of-life” care. Barriers include discrimination among providers, institutional anti-drug policies and fees for home care.

Study focus:
What services do substance-using homeless and marginally housed people turn to for help when they are dying? We interviewed health/social service staff in 6 cities across Canada.

Findings:
Harm reduction programs (e.g. needle exchange programs, shelters that tolerate alcohol use) are delivering end-of-life care to homeless and marginally housed clients who may otherwise fall through the cracks. Program staff:
- Do outreach, to find and build relationships with clients who have little access to health care.
- Facilitate referrals, for clients to wish to access traditional end-of-life care.
- Provide some support services (e.g. changing bandages) for clients who wish to die in a familiar place (e.g. shelter).

Providing end-of-life care and support is above and beyond the everyday responsibilities of harm reduction staff. Staff chose to help out because they wanted their clients to have the choice to die “at home.” Staff also felt that, although they had fewer resources than hospital-based services, their non-judgmental approach better responded to clients’ needs.

Implications for health policy and practice:
To further improve access to end-of-life care, we recommend stronger partnerships between traditional end-of-life care providers and harm reduction services, and the integration of harm reduction policies into hospital and hospice care.

Contact: Stephen Hwang (HwangS@smh.ca)
RICHEST AND POOREST IN TORONTO ARE HOSPITALIZED FOR DIFFERENT REASONS

Hospital care for all: An equity report on differences in household income among patients at Toronto Central Local Health Integration Network (TC LHIN) hospitals. Available at www.crich.ca.

Study focus:
We produced this report to show Toronto hospitals the socioeconomic status of their patients, to help inform their initiatives to advance health equity. We used census and administrative data to calculate the income profiles of all patients admitted to Toronto Central Local Health Integration Network (TC LHIN) hospitals. Patient income and place of residence results for each TC LHIN hospital are provided in the report, which can be downloaded in PDF and Powerpoint format.

Findings:
High and low income patients were hospitalized for different reasons. Most hospitals admitted:
- More high income than low income patients for day surgery.
- More low income than high income patients for mental health problems, emergency (non-urgent conditions), complex continuing care, rehabilitation and “alternate level of care” (i.e. patients occupy an acute hospital bed but don’t require acute services).

Implications for health policy and practice:
Hospitals can use this information to:
- Find out whether patient outcomes are linked to incomes.
- Tailor care to the needs of their current patient population.
- Work with others in the community to plan appropriate health services.

Our findings raised several questions, including:
- Did low income patients have unmet needs for hospital care? What barriers did they face?
- If high income patients had better access to hospital care, what were the reasons for better access?
- How if at all did the course or quality of treatment differ for patients at different income levels?

Contact: Kelly Murphy (MurphyKe@smh.ca)

BEYOND AWARENESS: HOW CAN PROVIDERS TAKE AN “ANTI-RACIST” APPROACH?


Background:
A growing number of service providers are integrating anti-racism and anti-oppression principles into their practices. The goals are to address the racism and oppression that are embedded in health care, and help improve health outcomes for ethnocultural and racialized groups.

Study focus:
What does it mean to “be” anti-racist or “do” anti-oppression? To find out, we reviewed the social sciences and medical literature.

Findings:
Mental health and social service providers who are anti-racist/anti-oppression:
- Help clients define for themselves the services they need, including alternative healing strategies (e.g. Indian Ayurveda, traditional Chinese medicine).
- Constantly monitor their own feelings and inner thoughts about people from other cultures, to watch for racist biases. Pursue ongoing training on how to challenge individual and institutional racism.
- Recruit, hire and train people of colour, to provide clients with staff at all levels with whom they can identify.
- Build alliances with other anti-racist service providers, to provide more comprehensive services and advocate for their client populations (e.g. protesting Canada’s proposed refugee health care cuts).
- Use language that doesn’t stigmatize clients. Use interpreters if the client prefers.

Implications for health policy and practice:
Mental health and social service providers can use the above anti-racist/anti-oppression practices to better respond to ethnocultural and racialized clients’ needs.

Contact: Vicky Stergiopoulos (StergiopoulosV@smh.ca)