Community Assessment and Diagnosis

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In this community assessment study, the aggregate population includes all visible and non-visible, and male and female homeless youth of the downtown Edmonton. According to Wright & Tompkins (2006), homelessness is difficult to define because homeless people are difficult to identify, and they are often mobile. The authors state that the problems in identifying homeless people are due to the following two main reasons, such as (a) homeless people are often moving around, and (b) identification of the homeless population is very complex in nature. Instead of providing a strict definition, authors Wright & Tompkins suggest viewing homelessness as a continuum.

Similarly, this assessment includes both absolute homeless and relative homeless population residing inside the downtown area of Edmonton. According to the United Nations (2010), "absolute homelessness" describes the condition of people without physical shelter who sleep outdoors, in vehicles, abandoned buildings or other places not suitable for human habitation. Similarly, "Relative homelessness" describes the condition of those who have a physical shelter, but one that does not meet basic standards of health and safety such as access to safe water and sanitation, and personal safety and affordability. According to Frankish, Huang & Quanz (2005) and Human Resources and Skills Development Canada (HRSDC, 2011), homeless people are generally categorized into (a) Absolute homeless: homeless people living outdoors under unsuitable environment (b) Transient homeless: people living under temporary basis and (c) At risk homeless: potential homeless people who are spending a big portion of their income in housing and other basic needs such as foods and clothing.

In this study, the geographical boundary is taken from Edmonton City

Police downtown boundary. The area boundary of this aggregate are approximately east of 111 street, west of 97 street, north of 89 avenue, and south of 106 avenue. A detailed map is presented in Appendix A and B.

Community Assessment and Method

In this study, assessment data were collected primarily from windshield survey and government and non government agencies such as City of Edmonton, Edmonton Police Department, Statistics of Canada and Government of Alberta. To maintain the reliability of the data, all of these electronic data were collected from such agency's official websites.

Demographic Characteristics and Epidemiologic Data:

In 2010, the statistics from Edmonton Committee to End Homelessness [ECEH] (2010) shows that there are a total of about twenty-two hundred homeless people in the Edmonton. Among them, about seventeen-hundred or 75% were males and about six-hundred or 25% were females. Though the number of males and females declined at roughly the same rate between 2008 and 2010 (by about 20%), the male gender counts in 2010 are still higher than female homeless gender counts. Since the number of males increased more dramatically than the number of females, the current number of males is 3.4 times higher than the 1999 figure and the number of females just 2.9 times higher. Males, therefore, accounted for 77% of the total 1999 to 2010 increase in adults, and the gap between the number of males and females has widened over the decade (ECEH, 2010).

Author Frankish, Hwang, & Quantz (2005) stated that homelessness is directly associated with poverty, unemployment and poor health. According to HRSDC (2011), even though Canada is regarded as one of the richest countries in the world, homelessness has always become an issue within the country. In Edmonton, in one side, due to the oil industry, the economy has been

flourishing, and on the other side, the widened gap put the marginalized population at the risk of being homeless. For example, between the years of 2006 to 2008, homeless people increased by 18% (ECEH, 2010 & Anielski & Johannessen, 2008). It is very important to note that a strong escalating trend in homelessness occurred between 1999 and 2008. Thus, while the 2008 homeless count is nearly triple the size of the 1999 count, the 2010 number of homeless is just double that of 1999 (Sorensen, 2010).

In comparison with the homeless population in the neighboring city of Calgary, the rate in Edmonton is still lower than the count increases found in Calgary's homeless population (Stroick & Hubac, 2007). During the year of 2006 to 2008, these rates are also similar in other Canadian cities; for example, Metro Vancouver has the rate of 22% and Calgary has a rate of 18.2% (Stroick & Hubac). The population of the homeless people in1999 was 836.Whereas in 2006, there were 2,200 homeless people in Edmonton (Patterson, 2007). The study of Edmonton homeless revealed that almost 20% had migrated in Edmonton from other provinces of Canada, mainly from Saskatchewan and Manitoba due to severe conditions on reserves including violence and alcohol abuse (Harding & Walton, 2009).

Geographic Characteristics:

During the windshield survey, the downtown community has been observed to be environmentally challenging. Noise pollution from various roads and LRT construction was visible. Most of the sidewalks indicate the sign of public smoking. This community includes a beautiful City Hall Park. Stanley A Milner Library at the Churchill Square shows the pride of the area which organizes numerous educational programs for the kids and adults. During the windshield survey, numerous public and Catholic Schools were also visible. The City is served by numerous public buses, trains, taxis and private cars, making the public transportation easy and accessible to

everyone, but it seems to be quite expensive to some people who cannot afford the fare. Due to the long lasting construction work on Jasper road, the sources of dust pollution are visible.

Socioeconomic Characteristics:

According to the Edmonton Police Services, Neighborhood Crime Map (2011), the crime rate in this downtown community has slightly dropped since 2012. For example, the number of major crimes such as homicide, sexual assault and other physical assault was about 360 in 2010, whereas, the number of the same crimes in this area was about 350 in 2011. According to the City of Edmonton website, this downtown location does not include any manufactured home, mobile home, truck station and other environmentally challenging industries. No industrial pollution is reported. Due to the heavy traffic, pollution from the vehicle exhaust is noticeable. During the windshield survey a number of homeless people were noticed around the Greyhound bus station and around the downtown library area, asking for money for number of reasons, some convincing some were not. These visible homeless people had very poor personal hygiene, long messy and dirty hair, and dirty, long nails. They were inappropriately dressed, and one of them had a shopping cart full of his personal items. They looked mentally unstable which could be due to alcohol consumption or substance abuse or mental disorder. The overall health status of the visible homeless people seemed remarkably poor.

Community Resources and Strength:

According to the Edmonton Public Library (EPL) (2012), Edmonton downtown has a largest public library with thousands of educational and entertainment material to serve the downtown population (Edmonton Public Library, 2012). The EPS is also providing services to coordinating various inner city events and festivals. Beside a huge library facility, the downtown Edmonton has various health care facilities, such as Royal Alex hospital, Capital Health,

Glenrose Rehabilitation Hospital, Norwood Senior Care, CHOICE, Alberta Health Community Care at 124 street, and homeless shelter at core downtown are just a few examples. In academic area, MacEwen University, NorQuest College and Athabasca University are easily accessible to the downtown population.

According to the Alberta Health Services (AHS) (2012), the downtown area also consists of a high school for marginalized teenage pregnant and new moms where immunization and all other healthy beginning programs are provided by the Bonnie Doon Public Health Care (PHC) center. Bonnie Doon PHC and Downtown PHC provide various kinds of public health services in this downtown areas. For example, according to AHS (2012), these services include Healthy Beginning, Health and Wellness, Health for Two and School Immunization.

Synthesis and Analysis of Data and Data Gaps

Many studies have shown that low socioeconomic status, as measured by income, education, or occupation, is strongly associated with higher mortality (Nancy & Newman, 2012). These differences are believed to exist because income, education, and occupation are markers for the various socioeconomic and health conditions of the community. Another such marker might be the type of housing in which a person lives. People who live on the street have been also linked to the increased mortality and homelessness (Nancy & Newman, 2012).

Aside from unaffordable housing, some of the factors that contribute to homelessness in Edmonton are: low income, unemployment, underemployment, drug/alcohol addiction, poor mental and physical health, disabilities, and physical and sexual abuse (AHS, 2008). Based on these factors, author O'Connell (2005) concludes that homeless people are three to four times more likely to die than the general population (O'Connell, 2005). This increased risk is especially significant in people between the ages of

18 and 54. Although women normally have higher life expectancies than men, even in impoverished areas, homeless men and women have similar risks of premature mortality. In fact, young homeless women are four to 31 times as likely to die early as housed young women (O'Connell, 2005 & O'Connell, Lozier, & Gingles (1997). According to O'Connell's conclusion, the average life expectancy in the homeless population is estimated between 42 and 52 years, as compared to 78 years in the non-homeless population.

Here, the major issues is that many homeless people don't know how to access health care services in their community or they are not aware of local community programs (Stroick & Hubac, 2007). Some of them are even reluctant to search for the community resources and help because they have had bad past experiences, such as mistreated by health care professionals (Whitbeck, 2009). Homeless people do not have access to family doctor or other community health recourses for routine medical needs such as routing check up, scheduled vaccination and disease screening (O'Connell, 2005 & O'Connell, Lozier, & Gingles (1997). Authors O'Connell & O'Connell, Lozier, & Gingles have indicated that these situations are mainly:

(a) due to the lack of fixed address, and

(b) inadequate knowledge about the diseases and it's prevention techniques. The study conducted by O'Connell (2005) shows that homeless people usually end up in the emergency room for any kind of illness more often than other general non-homeless people.

Community Diagnosis

Based on the assessment data, discussed in previous section, following community diagnosis has been concluded.

Lack of health care access and resources among homeless people related to psychological barrier and inadequate knowledge about the illness and available health care resources as evidenced by high mortality rate, low life expectancy

rate, high incidence of preventable disease such as HIV and AIDS.

Homeless people face a huge number of barriers to accessing quality health care. They likely have no regular health care provider. Without phone, email or physical address, it is very challenging for them to obtain and keep medical appointments, lab test results and referrals. Therefore, it is very challenging for them to follow-up the care they require. They often rely solely on emergency services to see a doctor, which means they don't have any continuity of care.

Health care is even more of a problem for people who are already homeless for a longer period of time. As we discussed earlier in the assessment section, homeless people are three to six times more likely to become ill than housed people (Stroick & Hubac, 2007). Homelessness hinders personal hygiene and nutritional needs. Homelessness also creates barriers for the basic first aid needs and further warrants the need of complex health care intervention. Additionally, conditions which require regular, uninterrupted treatment, such as tuberculosis and HIV/AIDS, are extremely difficult to treat or control among those without adequate housing. Diseases that are common among the homeless population include heart disease, cancer, liver disease, kidney disease, skin infections, HIV/AIDS, pneumonia, and tuberculosis (O'Connell, 2005). During the challenging weather season, people who live on the streets or spend most of their time outside are at high risk for frostbite, immersion foot, and hypothermia, especially during the winter or rainy periods.

However, not many homeless deaths are specifically attributed to these exposure-related causes such as frostbite, immersion foot, or hypothermia, the risk of death from other causes is increased eightfold in people who have experienced those conditions in the past (O'Connell, 2005).

During the assessment it is also found out that they do not seek or receive medical care or resources. Barriers to health care include lack of knowledge about where to get treated, lack of access to transportation, and lack of identification (Whitbeck, 2009). Although Canada has a universal health insurance system, many homeless people do not possess proof of coverage because their identification has been lost or stolen (Hwang, Windrim, Svoboda, & Sullivan, 2000).

Psychological barriers also exist, such as embarrassment, nervousness about filling out the forms and answering the questions properly, and self-consciousness about appearance and hygiene when living on the streets (Whitbeck, 2009). Mental health problems may also make it difficult for homeless people to access healthcare. Homeless people themselves have identified some factors that prevent them from accessing primary healthcare such as stigma (Whitbeck, 2009). Homeless people tend to encounter negative reactions when they try to access healthcare services. Trying to deal with administrative personnel can be particularly difficult. Homeless people also face discrimination while trying to access the health care. They find it harder to register with a General Practitioner than members of the general public. Requests for a permanent address and other details can lead to a real or a psychological barrier. Lack of continuation of the care is another barrier to the health care access. Many homeless people have lack of knowledge about the entitlements, for example, some homeless feel that they don't know what they are entitled to in the line of healthcare and services (Hwang, Windrim, Svoboda, & Sullivan). If they were better informed they would be more confident about trying to access them. The lifestyle of homeless people tends to add more problem to access the health care services because there is usually no flexibility in the healthcare system. A move from one

district to another may mean that a homeless person often finds himself or herself outside the health care system. As a result, many homeless people utilize hospital emergency rooms as their primary source of health care needs. Since this situation provides little or no continuity and follow ups, this is not only the least effective for them, it also increases the government's health care expenditure significantly.

Conclusion

Homelessness affects a significant number of Canadians of all ages and is associated with a huge burden of illness and increasing health care cost. More research is needed to identify better ways to deliver proactive care and services to this population. The search for long-term solutions to the problem of homelessness itself must remain a key priority for policy makers and all other public health care stakeholders. We need to keep these people as healthy as possible. Primary health care and proactive approach is essential to prevent illness and diseases that can be prevented by primary health care intervention. In one hand,

Edmonton's economy has been recognized to have the highest growth among all Canadian cities due to the rising energy price, on the other side, despite the economic prosperity of Edmonton, a significant number of Edmontonians are poor and homeless. To end homelessness, the province of Alberta and the City of Edmonton ventured in a partnership to solve homeless by 2019 by adopting a "housing first" approach. Under this approach, investments are focused on three areas: rapid re-housing; providing client-centered supports; and preventing homelessness.

Programs and policies are already in places; however, the main issues is that many of these homeless people are not aware of these community resources, programs and policies, offered by the government and non-government agencies. Research show that a huge number of homeless people are not even interested with public programs already

available in their local community. It is our responsibility to reach and motivate these marginalized homeless people for promoting their health and wellness.

References

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