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Nowhere to turn

SPECIAL REPORT: The city's homeless people have special health-care needs, needs that can't be met fully because London doesn't have a respite centre. A London doctor is out to change that.

By ALEX WEBER, THE LONDON FREE PRESS
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Davey, who is being treated for cancer at the John Gordon Home, credits the facility with keeping him alive. (MORRIS LAMONT, The London Free Press)

A man is dropped off at Dundas and Adelaide streets with a fresh cast on his broken arm.

He has nowhere to go. And it's pouring rain. His cast rots in the rain and a severe wound infection would spread through his arm.

Another man is hospitalized with septicemia, a blood infection, and is released before completing a standard six-week antibiotic treatment. A pick line is inserted in his arm so the antibiotics can be administered at home. But he has no home. Unsupervised, the pick line instead becomes a jackpot for the IV drug user.

Another man, John, is dying of lung cancer and living at the Salvation Army's Centre of Hope in London. He's given a chance to die in a nursing home, but too embarrassed about his appearance and lifestyle, he chooses to stay among the familiar faces at the shelter. When he becomes too sick to stay there, he's sent to hospital, where he dies alone.

The men have three things in common: They're patients of London Dr. Jamie Harris, they're homeless and their health-care has fallen through the cracks.

Harris, a doctor at the InterCommunity Health Centre, treats members of London's homeless community and is fed up with the disconnect in the health care they receive.

"These people fall into the abyss," he says. "John's death was the last straw as far as I'm concerned . . . He had a choice between minimal nursing in the shelter where he wanted to stay or inappropriate hospitalization in a sterile environment with nobody he knew. And he died there, alone, without his family. It's sad."

That's why Harris is pushing London to become one of only a few Canadian cities to open a respite centre for street people - a place they could go to rest, recuperate and receive the medical care shelters lack.

"If you've been sleeping in crash beds, you've been eating poorly, drinking and drugging and some guy just beats you up in the ally and then you get sick, your chances of rebounding quickly are a lot less, so you need a home-like environment where you can go and convalesce for awhile," Harris says.

And with hospitals discharging people as quickly as they can, many homeless people are released half-healed and with nowhere to go.

"Everybody in society complains about being kicked out of hospital too quickly these days," Harris says. "It's different if you've got a home to go to . . . as opposed to people who are literally dropped off on the street to fend for themselves."

Although hospitals often set patients up with a Community Care Access Centre (CCAC) worker to help them receive treatment outside hospital, Harris says that because street people are migratory with no real home, they can be hard to track down. And health care often takes a backseat to other priorities such as finding money, food and shelter, so appointments with CCAC workers are hard to keep.

But illness runs rampant among the hundreds who call London's streets home. Mental health plagues the minds of many. Then there's a slew of infections and diseases that go hand-in-hand with substance abuse. Add to that a number of illnesses that stem from malnutrition and sleep deprivation.

"A large number of the people that we work with here, they're dying, they're actively dying," says Henry Eastabrook, an outreach worker at the InterCommunity Health Centre.

Harris says that although there are many places in London homeless people get help with health concerns, they're nine-to- five operations that can do only so much.

"There are various people trying to help with the homeless population medically . . . but unfortunately most of them are daylight operations only. . . The shelters aren't really equipped to provide any kind of nursing," he says.

Canada has only three respite facilities for the homeless - two in Toronto and one in Ottawa - but they're common in big U.S. cities.

The closest facility London has to a respite centre is the John Gordon Home, which opened in 1992 to act as an end-of-life care facility for people dying from HIV/AIDS and hepatitis C (HCV). But as the disease shifted into a relatively manageable illness for those with access to health care, it has evolved into a palliative care facility for those with HIV/AIDS and HCV who have no home.

The home has eight apartments where residents receive treatment. The nursing staff is available 24 hours a day and patients get home-cooked meals, social support and help balancing their money and accessing stable and affordable housing. They can stay in the home for up to 12 months, so getting their illness and their lifestyle under control is the staff's goal.

Roger, 54, has been staying at the John Gordon Home since late April. His face and his body bare the scars of a life on the street, but the care he's received at the home has allowed him to clear his mind and think about what he wants for his future.

He's had HIV since 1990, but neglected his health and refused to get treatment for many of those years. He was sent to the hospital this spring with severe pneumonia after a nurse at the AIDS clinic called an ambulance without him knowing.

"I just thought it would go away on its own," Roger says. "I didn't think it was that bad."

Upon his arrival at the hospital doctors, discovered that in addition to his pneumonia Roger had detached the retina in his right eye. He was already blind in his left eye - it had rotted away slowly after years on the streets. Roger says he's still not sure what happened, but suspects it was from his drug use and malnutrition.

Doctors scheduled an emergency surgery and saved his right eye.

When he arrived at the John Gordon Home he was only 115 pounds, addicted to injecting Ritalin, and felt like he wasn't "living, just existing."

But the stability and medical treatment he's received at the home has allowed him to focus on getting his life in order. He now has a prescription to take Ritalin orally for attention-deficit hyperactivity disorder (ADHD), which went undiagnosed for years, and has put on 50 pounds over the last four months.

"I'm really grateful to be here," Roger says. "I certainly wouldn't be as healthy as I am and as positive in my thinking as I am if I wasn't here."

After he leaves John Gordon Home, Roger says, he wants to start a men's group for addicts like himself who suffered abuse in their childhoods. Roger says he was abused physically and sexually as a boy, both at home and in a rural Ontario reform school where he was sent in his early teens.

Davy, another resident at John Gordon Home, is undergoing treatment for lymphoma. He's been living on London's streets for the better part of his 57 years and says he used drugs and alcohol to escape from the abuse he endured as a child.

In addition to lymphoma, he contracted Hepatitis C 12 years ago after sharing needles with someone who was infected.

He neglected his health for many years, he says, because he felt disrespected and judged when he'd visit hospitals. But when he discovered a lump on his neck, he knew he had to get help.

He says his stay at the home has given him a reason to get clean and try and develop a relationship with his young grandchildren.

"I wouldn't be alive today if it wasn't for this place . . . when I'm out I want to go fly a kite with my grandson," Davy says. "There are fun things to do without having to be high. That's what I hope to do."

The John Gordon Home has offered hope to these two men, but Bruce Rankin, the home's director, says there just isn't enough room at the home for everyone who needs its services.

And for those homeless people who may not suffer from HIV/AIDS or Hepatitis C, there's nowhere for them to rest, recuperate and get the medical attention they need.

Harris says that aside from the fact that caring for the community's homeless population is the compassionate thing do, it also makes sense economically.

"The big selling point . . . is that ultimately it's going to be a hell of a lot cheaper to have respite centres than have people going from crisis to crisis, to ICU, to acute care beds, back to the street and two weeks later back in the hospital bed. That is extremely expensive," Harris says.

"This is so fundamentally simple and proven to be effective - both on the compassionate level and on the economic level - it sells itself, but the first thing we have to do is get some kind of cohesion between the various stakeholders in the community. . . We need to get everybody on the same page."

Harris says he plans to hold an information session soon for all the parties involved, including the city, local shelters and the hospitals, to get everyone on the same page before appealing to the South West Local Health Integration Network (LHIN) or the Health Ministry for money for a respite facility.

He says he's confident that if the stakeholders in the community can come to an agreement, the public would be on board.

"People care about people. All of these people are someone's father, mother, sister, brother, children. They didn't just pop up in the alleys downtown," he says.

"Most families somewhere in their distant reaches have some black sheep that has drifted onto the street. If you care about that person in your family. . . then you care for all these other people, because they're all the same person really. I don't think it's a hard sell, but it has to get organized."

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