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August 25, 2003

To: Board of Health

From: Jane Pitfield
Co-Chair, Advisory Committee on Homeless & Socially Isolated Persons

Subject: TB or not TB? Report of a Public Inquiry into the State of Tuberculosis within Toronto's Homeless Population

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At its July 11th, 2003 meeting, the Advisory Committee on Homeless & Socially Isolated Persons heard a presentation from the TB Action Group on its June 2003 report entitled "TB or not TB? Report of a Public Inquiry into the State of Tuberculosis within Toronto's Homeless Population" (as attached).

The Advisory Committee endorsed the recommendations of the TB Action Group report and asks the Board of Health to adopt the health-related recommendations of the report as listed below. The recommendations related to Community & Neighbourhood Services have been referred to the September meeting of Community Services Committee for consideration.

It is recommended that:

1) the Board of Health adopt recommendations 8, 16, 17, 18, 19 and 20 of the TB Action Group report to the Board of Health, specifically that:

    a) Toronto Public Health must immediately inspect shelters and drop in centers (day shelters) to identify and correct deficiencies that have negative implications for public health safety;
    b) Toronto Public Health must develop and implement protocols for the prevention and management of infectious and airborne diseases in homeless service systems. Such protocols are critical and are urgently needed;
    c) Toronto Public Health must develop and implement comprehensive TB screening programs in shelters, drop-in centres (day shelters) and other homeless service centres that includes TB skin testing. It is not sufficient to rely on contact tracing among homeless populations;
    d) Toronto Public Health must develop and implement a standard of care for contact tracing among homeless people that tests individuals based on *locations* they have frequented, rather than on traditional tracing methods which depend on accurate recall of people with whom an infected person has had contact;

e) Toronto Public Health must expand its D.O.T. (Directly Observed Therapy) program to include D.O.P.T. (Directly Observed Prophylactic Therapy) among homeless populations; and
f) Toronto Public Health staff must liaise closely with health providers in jails to reduce the likelihood of losing individuals with LTBI or active TB to follow-up after release;

2) the Board of Health adopt recommendations 7, 14, 15, 21, 22, 23, 24, 25, 26, and 27 of the TB Action Group report related to the federal or provincial governments with a request that Toronto Council forward these recommendations to the appropriate ministry, specifically that:

a) the Ministry of Health and Long Term Care must expand the Mandatory Core Program and Service Guidelines for infection control to include a requirement that Boards of Health must inspect shelters, drop in centers (day shelters) and other programs that provide temporary shelter for those who are homeless;
b) the Province of Ontario must provide adequate funding to Toronto Public Health so that it can ensure sufficient TB prevention, detection and treatment programs are in place to safeguard the public's health;
c) the Ministry of Health and Long-Term Care must create a network of comprehensive TB clinics across Toronto for the purpose of diagnosing and treating latent or active TB. To reduce barriers to obtaining care, such as lack of health insurance, lack of identification and lack of transportation resources among homeless people, such clinics must provide convenient hours of operation, geographic access, and access to individuals regardless of health insurance status;
d) the Ministry of Public Safety & Security must recognize the public health risks associated with dangerous overcrowding in correctional facilities and immediately move to reduce such overcrowding;
e) the Ministry of Public Safety & Security must develop a protocol for ensuring that inmates who are being treated for active TB and are released into the community be provided with comprehensive discharge planning including referral to local public health authorities prior to release, to ensure appropriate follow-up is arranged;
f) the Ministry of Public Safety and Security must test all inmates for TB within 24 hours of confinement, and must develop a mechanism for maintaining and transferring records of inmates' TB status when inmates are transferred to other facilities;
g) the Ontario Ministry of Public Safety & Security must develop and administer guidelines for treating latent TB infection in jails which call for prophylaxis only in cases in which a full course of treatment can be guaranteed, or in those cases in which comprehensive discharge planning can be done;
h) the federal government must provide Federal Interim Health Benefits to refugee claimants immediately upon entry to Canada;
i) the federal government must provide all newcomers with comprehensive TB screening, and ensure timely follow up of any abnormal findings; and

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j) the Ministry of Health and Long Term Care must provide Ontario Health Insurance cards to landed immigrants immediately (without the current three-month waiting period) upon entry to Ontario.

Background:

The report "TB or not TB? Report of a Public Inquiry into the State of Tuberculosis within Toronto's Homeless Population" documents the results of a day-long session of testimony before a panel of experts. People testifying at the session included people with expertise in homelessness, emergency shelter, health and mental health care, immigration and refugee issues, harm reduction, HIV/AIDS, Hepatitis C, and the jail system. An inquiry panel of five people heard the testimony. The panel was comprised of a mental health outreach worker, a formerly homeless person, a family physician, an academic, and a former Toronto City Councillor.

The need for an inquiry arose from the concerns of front-line health workers about the rate of TB infection among people who are homeless. This includes people staying in shelters as noted in the June 2001 micro epidemic of TB in two shelters (Seaton House and Maxwell Meighan) in which 15 men developed active TB. Three of these men eventually died. The provincial Office of the Coroner has promised to conduct an inquiry into one of these three deaths although a date has yet to be scheduled.

Toronto Public Health did work with shelter staff to contain the shelter micro epidemic. However, homeless health workers remain concerned about conditions, such as poor nutrition, lack of housing and adequate incomes, lack of access to health care services and overcrowded shelters, which continue to place homeless people at increased risk of developing TB.

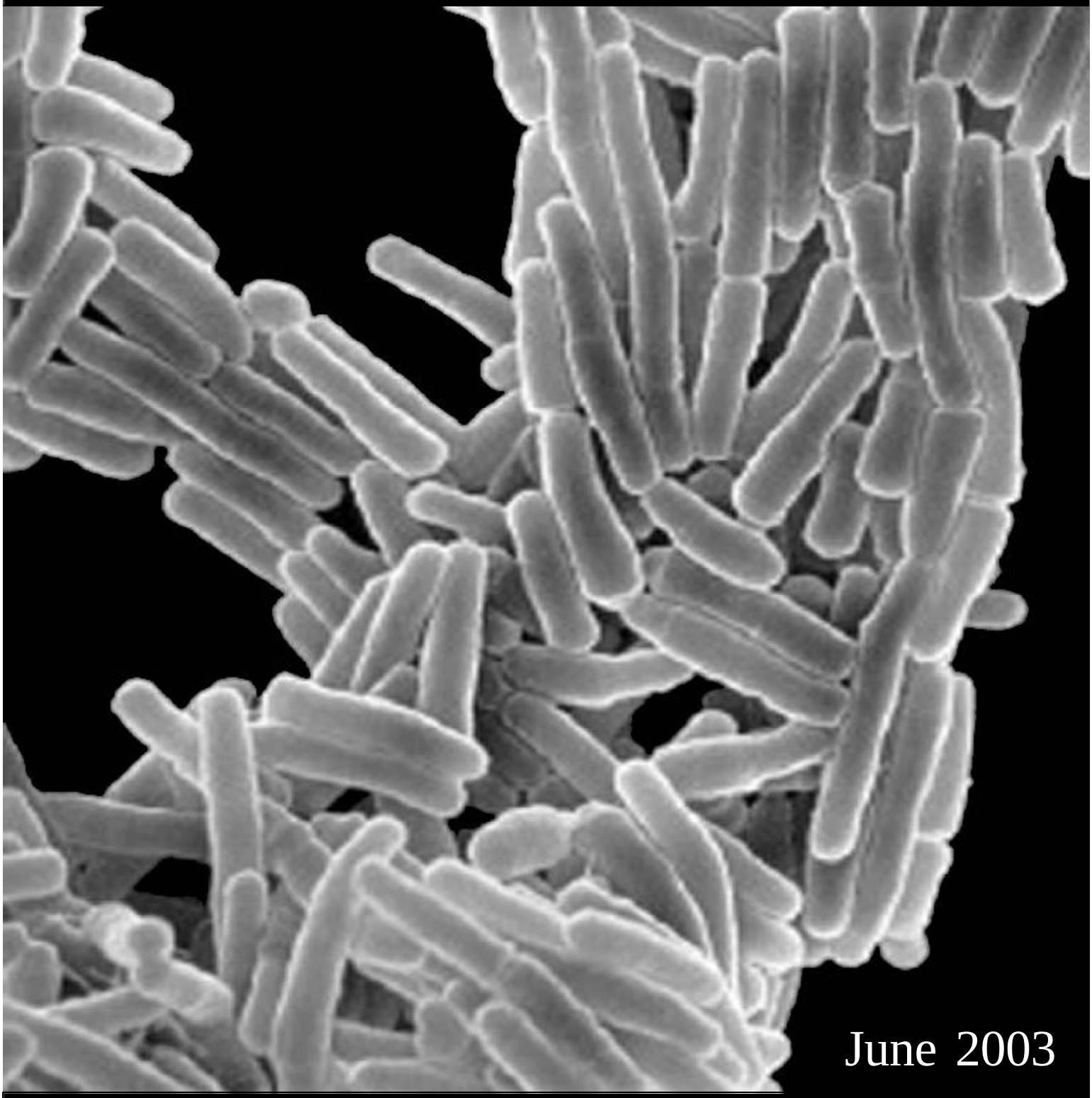
In response to issues identified at the inquiry, the Inquiry Panel made 28 recommendations related to housing, income, shelter conditions, health, jail conditions and immigrants and refugees.

Sincerely,

Councillor Jane Pitfield

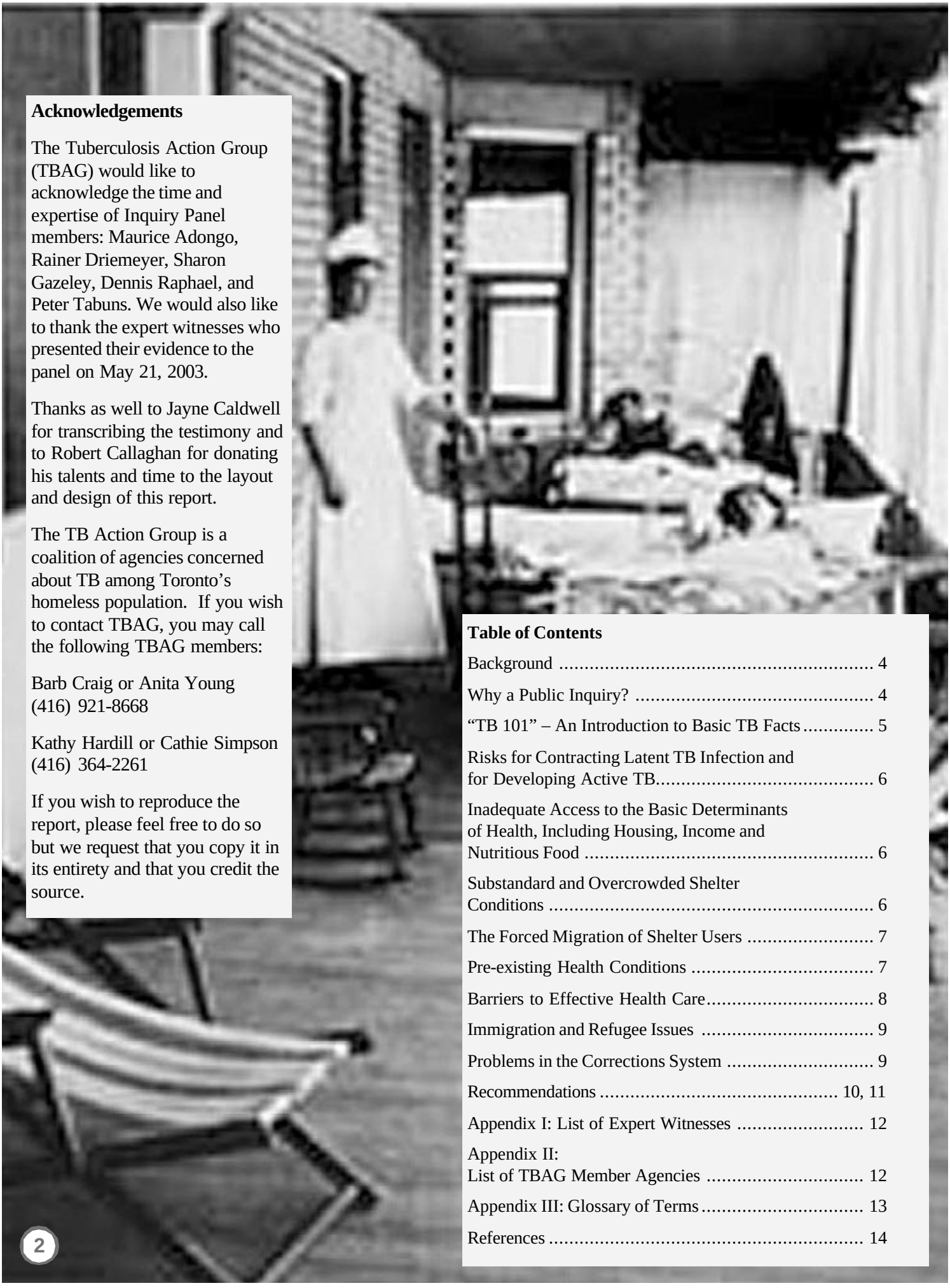
TB or not TB?

There is no question



June 2003

Report of A Public Inquiry into the State of Tuberculosis Within Toronto's Homeless Population



Acknowledgements

The Tuberculosis Action Group (TBAG) would like to acknowledge the time and expertise of Inquiry Panel members: Maurice Adongo, Rainer Driemeyer, Sharon Gazeley, Dennis Raphael, and Peter Tabuns. We would also like to thank the expert witnesses who presented their evidence to the panel on May 21, 2003.

Thanks as well to Jayne Caldwell for transcribing the testimony and to Robert Callaghan for donating his talents and time to the layout and design of this report.

The TB Action Group is a coalition of agencies concerned about TB among Toronto's homeless population. If you wish to contact TBAG, you may call the following TBAG members:

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(416) 921-8668

Kathy Hardill or Cathie Simpson
(416) 364-2261

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Public Inquiry Panel Members

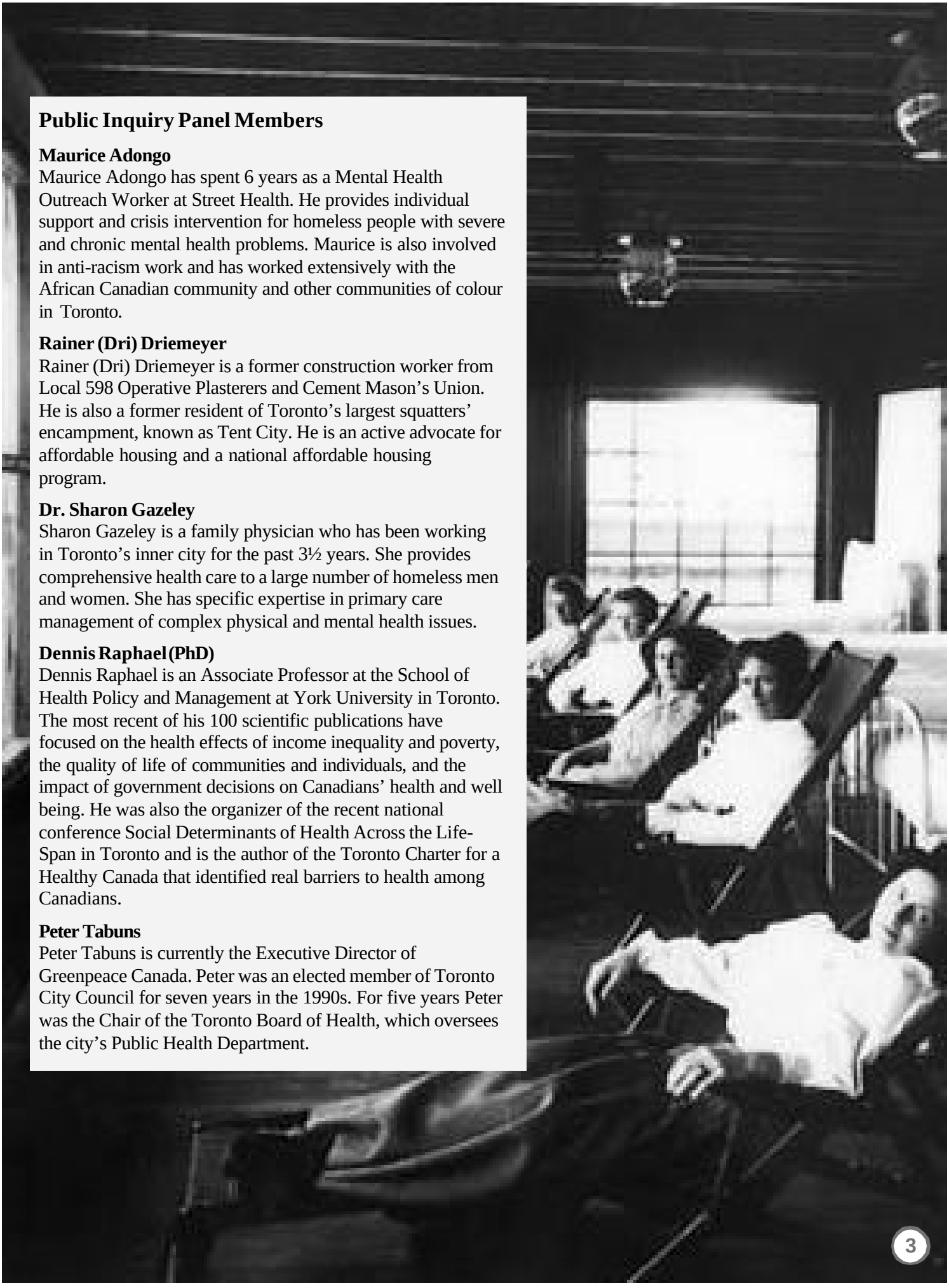
Maurice Adongo
Maurice Adongo has spent 6 years as a Mental Health Outreach Worker at Street Health. He provides individual support and crisis intervention for homeless people with severe and chronic mental health problems. Maurice is also involved in anti-racism work and has worked extensively with the African Canadian community and other communities of colour in Toronto.

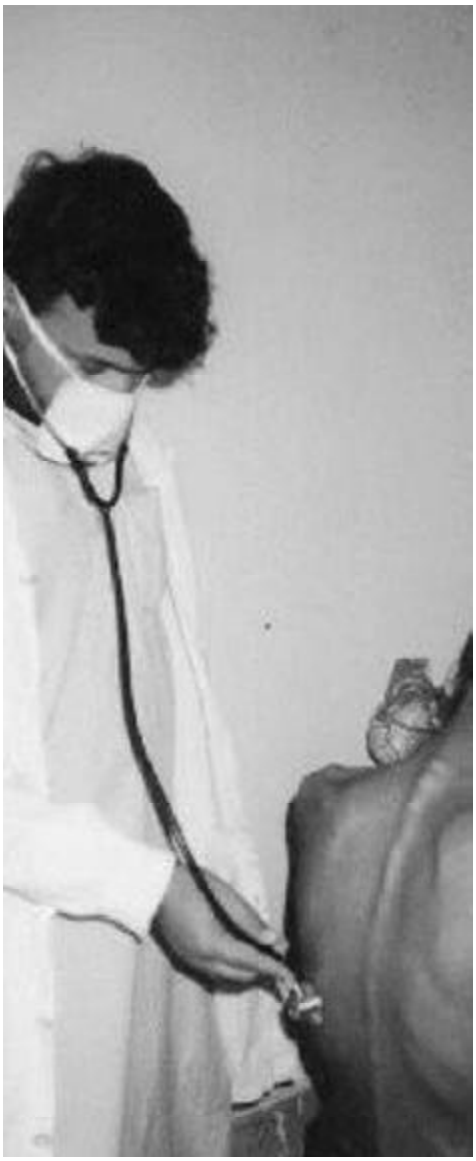
Rainer (Dri) Driemeyer
Rainer (Dri) Driemeyer is a former construction worker from Local 598 Operative Plasterers and Cement Mason's Union. He is also a former resident of Toronto's largest squatters' encampment, known as Tent City. He is an active advocate for affordable housing and a national affordable housing program.

Dr. Sharon Gazeley
Sharon Gazeley is a family physician who has been working in Toronto's inner city for the past 3½ years. She provides comprehensive health care to a large number of homeless men and women. She has specific expertise in primary care management of complex physical and mental health issues.

Dennis Raphael (PhD)
Dennis Raphael is an Associate Professor at the School of Health Policy and Management at York University in Toronto. The most recent of his 100 scientific publications have focused on the health effects of income inequality and poverty, the quality of life of communities and individuals, and the impact of government decisions on Canadians' health and well being. He was also the organizer of the recent national conference Social Determinants of Health Across the Life-Span in Toronto and is the author of the Toronto Charter for a Healthy Canada that identified real barriers to health among Canadians.

Peter Tabuns
Peter Tabuns is currently the Executive Director of Greenpeace Canada. Peter was an elected member of Toronto City Council for seven years in the 1990s. For five years Peter was the Chair of the Toronto Board of Health, which oversees the city's Public Health Department.





"Homeless people with hepatitis C cannot afford the risk of contracting TB because their impaired liver function may mean they cannot tolerate the anti-TB drugs. Homeless people with Hepatitis C must be taken out of shelters immediately and put into housing to reduce their TB risk and allow them to get Hep C treatment."

– Deb Phelps,
Inquiry Witness,
Hepatitis C Outreach Worker

Background

Concerns about the risk of tuberculosis (TB) within Toronto's homeless population first arose among front-line community health providers in 1993. From this concern the Tuberculosis Action Group (TBAG) was formed, a coalition that included front line workers, drop in centre staff, street nurses and shelter staff. Through its efforts, TBAG began a dialogue with the former City of Toronto Department of Public Health. In 1996 the Tuberculosis Pilot Project was initiated and resulted in the creation of a report entitled "Report on the Tuberculosis Pilot Project in the Homeless/Underhoused." It detailed the development of strategies for TB prevention, identification and treatment in the homeless population. This project warned of a future tuberculosis outbreak within this high-risk population and recommended various strategies to circumvent such an occurrence. Some of the recommendations were heeded, however, not all were implemented. Since the 1996 initiative, numerous documents and predictors have surfaced urging for a systematic and coordinated approach from various levels of government to prevent a TB epidemic in the homeless sector.

In February 2001, a resident of Seaton House, Canada's largest men's hostel, was diagnosed with active tuberculosis. He was living in the Annex Program, which is a harm reduction program assisting men with chronic alcoholism. In June 2001, Toronto Public Health identified the situation as a micro epidemic but did not make this public until November 2001 when it held a press conference to announce the outbreak. Two shelters, Seaton House and Maxwell Meighan Centre, were implicated in the micro epidemic in which 15 men developed active TB. All of the infections were DNA-linked, indicating a common source of infection. Three men died either directly or indirectly of tuberculosis. Shortly after learning of the outbreak, the TB Action Group (TBAG) re-formed itself. In March 2002, the Toronto Disaster Relief Committee, including a TBAG representative, met with representatives from the Coroner's Office and called for an inquest to be conducted. The Coroner responded with the promise of an inquest into *one* of the deaths. However, as of this writing, we are still waiting for the inquest date to be scheduled.

Why A Public Inquiry?

After waiting for more than one year for the TB inquest to be scheduled, TBAG decided that the issue of TB in the homeless population was too urgent for ongoing delays. A decision was made to conduct a Public Inquiry. A panel of experts was called together to hear a day of testimony from homelessness experts on the issue of TB among the homeless population and the factors likely to have contributed to the shelter outbreak. The Inquiry took place in Toronto's downtown Church of the Holy Trinity in May 2003. Witnesses included people with expertise in homelessness, shelters, homeless health care, mental health workers, immigration and refugee issues, harm reduction, HIV/AIDS, Hepatitis C and the jail system (see Appendix I). Panel members heard testimony, similar to the way an inquest jury would hear evidence, asked questions, took notes and retired at the end of the day to develop recommendations based on the evidence they heard.

The following is a synopsis of the evidence heard by the Inquiry Panel from expert witnesses:

"TB 101" – An Introduction To Basic TB Facts

TB is the most common infectious disease in the world. One third of the world's population is infected**.** Two million people die annually worldwide of the disease. In Toronto there are approximately 400 new diagnoses of active disease per year, accounting for 25% of all the TB in Canada. This is three times higher than the overall rate for Canada. Twenty percent of cases in Toronto are resistant to at least one drug used to treat TB; three percent of TB cases in Toronto are multi-drug resistant (TB Subcommittee of the Board of Health, 2002)**.**

In the above-mentioned TB Pilot Project conducted in 1996, 38% of shelter users tested for TB were found to have a positive TB skin test**,** indicating that they were infected with TB, and therefore at risk of developing active TB. In the TB skin testing carried out in the wake of the outbreak at Seaton House's Annex Program, more than 60%, of those who had contact with those having active TB developed positive TB skin tests, indicating the presence of latent TB infection (LTBI). Compared to the housed Toronto population of 15-20% with LTBI (Sharon Stone, Toronto Public Health, personal communication, June 10, 2003), these rates are very alarming.

Latent TB Infection (LTBI)

It is important to differentiate active TB disease from latent TB infection (LTBI). Not everyone with a positive TB skin test will be infectious. Sometimes, people are exposed to TB germs but their bodies contain the germs safely in a capsule. In this situation, the TB germs do not cause any symptoms of TB nor can they be passed on to other people. These people are said to have LTBI, meaning that they have the potential to develop the disease and to be infectious at a later time. A person with latent TB infection has a 10-15% chance of developing active TB within the first year. In fact, the greatest risk of developing active TB occurs within the first two years after becoming infected (Dye et al, 1999). After that, the risk of becoming infectious decreases, assuming that the person is in good health. Being in poor health, including having poor nutrition and an impaired immune system, increases one's chances of developing active TB disease after being infected with the TB germ. There are no statistics indicating the rates of infectivity in people who are in poor health but it is safe to assume that the rates would be increased. It is possible to treat a person with latent TB infection prophylactically with usually six to nine months of antibiotic medication.

Active TB (TB Disease)

If someone has active TB, she or he can infect other people with whom she or he comes in contact. When a person has *active TB*, she or he will infect 10-15 other people on average before detection and treatment occurs. In conditions where there is crowding of people in poor health, these numbers are obviously higher. Treatment for active TB consists of the administration of multiple antibiotics (a minimum of three different antibiotics) over a period of 6-18 months. Hospitalization may sometimes be required until a person is no longer infectious.

Traditionally, public health approaches to containing TB rely on a strategy known as contact tracing, which involves identifying everyone who had close contact with an infected person and testing each of them. This works fairly well with those who have stable housing and can readily identify those they are in close contact with. Obviously, identifying homeless people who may have had contact with another homeless person infected with TB is much more difficult. In fact, research indicates that this traditional contact tracing strategy does not reliably identify homeless people infected in an outbreak (Barnes et al., 1997).

Multi-drug resistant TB is an increasing problem in Toronto. Fortunately, the men who contracted TB in this micro epidemic did not have a drug-resistant strain of the bacteria. The mortality rate and the costs involved in multi-drug resistant cases are much higher. For example, in New York City, an outbreak of multi-drug resistant TB in the jail system cost $1billion USD to contain (John Howard Society, August 2002).

"TB should be eradicated. There is a cure. But as we know, TB is a disease of poverty. We have an obligation to home and world communities to improve living conditions for our poorest people…TB can be eradicated."

— Wangari Muriuki,
Inquiry Witness,
Mental Health Outreach Worker

"…Affordable housing and adequate social assistance could whittle away the very existence of homelessness...the tragedy I see every day…is preventable, but better conditions in homeless systems could keep people healthier in the meantime."

— Dr. Melissa Melnitzer, MD,
Inquiry Witness,
Parkdale Community
Health Centre

Risks for Contracting Latent TB Infection and for Developing Active TB Disease

TB is most commonly a respiratory disease primarily spread by coughing. In places where people are together in close proximity for a length of time with poor ventilation, the chances of contracting this infection are greatly increased. This is especially true for homeless people living in often overcrowded shelters (Canadian Lung Association, 2000). In the homeless population, the rate for developing TB is 20-300 times greater than in the general public (Yuan, 2002).

This increased risk of contracting latent TB infection and of developing active TB in the homeless sector may be explained by various factors:

1. Inadequate access to the basic determinants of health, including housing, income and nutritious food.
2. Substandard and overcrowded shelter conditions**.**
3. The forced migration of shelter users.
4. Pre-existing health conditions.
5. Barriers to effective health care.
6. Problems in the corrections system.
7. Immigration and refugee issues.

Inadequate Access to the Basic Determinants of Health Including Housing, Income and Nutritious Food

In 1995 the Ontario government cut social assistance rates by 21.6%. A few years later they enacted the Tenant Protection Act that effectively abolished rent control, sending previously affordable rental units to rates unattainable by many. This legislation also made it much easier to evict tenants. In addition, both federal and provincial governments have drastically reduced the amount of affordable housing being built. Because of these policies, homelessness has burgeoned. Indeed recent statistics put out by the Government of Canada reveal the ongoing trend of the increasing disparity between the wealthy and the poor. As income and social position increase, health status improves (Health Canada, 2001).

People who receive social assistance such as Ontario Works benefits do not have enough funds to pay for public transit, proper meals, or basic supplies such as soap, let alone housing. People are forced to walk long distances, often in inclement weather, to get to their various destinations. This overall lack of access to the basic determinants of health, including safe shelter, housing, livable and secure incomes, good nutrition, sleep, and hygiene facilities, greatly increases a person's stress load and diminishes the immune system, putting the individual at risk of many diseases and infections**.** *It is difficult to believe that the 15 men who contracted TB in the shelter outbreak would have done so had they been living in their own apartments.*

Substandard And Overcrowded Shelter Conditions

While there are some well-run shelters that provide relatively nutritious meals, supportive staff and acceptable living conditions, there are many that fall far below the City of Toronto Hostel Services Division's own revised Hostel Standards (TDRC, 2003). In fact, there are many shelters that do not meet UN standards for refugee camps in terms of public health measures (TDRC, 2000). In some hostels and shelters as many as 60 people could be sharing the same washroom, sleeping a mere 14 inches or less apart from their neighbour on a thin mat, in a space that is dangerously overcrowded.

Toronto City Council passed a motion in 1999 that the shelter occupancy rate should not exceed 90%, and that if it did, then the city must immediately open additional shelter beds to bring occupancy down below 90%. However, since that time the shelter system has consistently been operating at greater than 90% occupancy rates but additional beds have not been forthcoming. Even city shelter staff admit that at 90% occupancy, a shelter should be considered "full." The system is clearly overcrowded, enhancing the likelihood of infestations and infectious disease transmission like tuberculosis and Severe Acute Respiratory Syndrome (SARS).

Moreover, as a result of the overcrowding, increased violence among the shelter users occurs, theft is rampant

and quality of sleep is greatly diminished or non-existent. Stress levels among staff and shelter users run chronically high and the mental and physical health of all suffer (TDRC 2000, 2003). One formerly homeless witness told of a shelter where people were subjected to bugs in the food, unwashed bedding between clients, and lack of soap for personal hygiene. Other witnesses echoed this statement saying that people using the shelter system and soup kitchens are often fed poor quality meals and must eat whatever is being served regardless of their medical conditions such as diabetes, or dietary restrictions.

The Out of the Cold Program is a volunteer-run, faith-based seasonal shelter program. Many homeless people prefer the program because volunteers are kind, the food served is often very good, and there is less bureaucracy for shelter users. The difficulty is that, although it includes these sleeping spaces in its nightly occupancy statistics, the city claims not to have jurisdiction to enforce standards in this program. This results in some Out of the Cold sites being very crowded. Very few provide actual beds, opting for more portable mats which can be moved during the day. Many programs are held in church basements or halls never meant for use as shelters, so toilet facilities are limited and air ventilation may be poor.

The Forced Migration of Shelter Users

Some shelters have maximum lengths of stay, such as two weeks. After that time people are required to leave that particular location. In the Out of the Cold Program, because each site generally operates for one night only per week, a very high transience is built in because people using the program must travel to a different location nightly. In this program, which operates only in the cold months, people are forced to move virtually every day. Numerous witnesses gave expert opinions that the Out of the Cold system is simply untenable now. It has grown too big, it is too geographically disparate, it has no consistent standards and it builds too much transience into the system. One Out of the Cold volunteer remarked upon the pervasive "readiness to move" of homeless "guests," where people sleep in their clothes with their belongings guarded at their sides because theft is all too common, where they are regularly unable to wash themselves due to the overcrowded bathroom conditions, where they are expected to be fully awake and up by seven in the morning after having a fitful night's sleep. During the day, homeless people seek out meals at various drop in centres (sometimes called day shelters) and soup kitchens, where overcrowding also exists.

This forced migration from shelters to drop in centres to shelters results in exposure to many different people, greatly increasing the chances of coming into contact with an infectious individual. As well, it creates a logistical impossibility of performing contact tracing for Toronto Public Health staff in the case of a TB outbreak**.** Even the most competent, well-funded public health department in the world cannot trace individuals who change location every single day.

Pre-existing Health Conditions

People who have other serious health problems such as HIV/AIDS and hepatitis C are at a much greater risk of developing active TB if they are exposed to the bacteria because their immune systems are already greatly compromised. Though there are no studies to pinpoint the prevalence of HIV and hepatitis C in the homeless population, we do know that rates are high in sub-populations of homeless people such as those who use substances and those who have been incarcerated. Homeless people are more at risk of developing active TB disease because they are more likely to have underlying medical conditions and poor nutritional access which impairs their immune function as well (Canadian Lung Association, 2000).

For example, people with latent TB infection and HIV have *10 times the risk* of developing active TB than those who do not have HIV infection. Compared to people who have not been exposed to TB, these dually infected individuals have a *68 fold higher risk* of developing active TB. In fact, having HIV is one of the greatest risk factors for acquiring active TB infection (TB Subcommittee of the Board of Health, 2002). According to researchers from University of California in Los

"What if the first person with SARS had walked into (a downtown hospital used by many homeless people)? Had SARS entered the shelters, it would have been impossible to contain. The consequences are unthinkable. If the city can inspect restaurants, surely it can also inspect shelters."

– Barb Craig, RN,
Inquiry Witness,
Shelter Inspection Team Member

"It is the most disturbing phenomenon: our homeless guests have developed the ability to be awake, fully clothed, with bags in hand within five minutes. The sense of moving on is constant. We don't know where they come from or where they go to"

– Margaret Sumadh,
Inquiry Witness,
Homelessness Action Group and
Out of the Cold volunteer

Angeles (UCLA), when HIV prevalence in a population is 9% or greater, the average size of TB outbreaks can almost double if there are low to moderate TB treatment levels (Blower, et al., 2001).

Furthermore, those whose livers are damaged or compromised (as in hepatitis C or cirrhosis) may not be able to use the medications used to fight TB, as these medications are frequently toxic to the liver.

Testimony was heard from several witnesses urging the need for shelters to adopt harm reduction models in order to curb the spread of HIV and hepatitis C. Often people are barred from staying at a shelter if they are using substances. Frequently, if shelter staff discover drug use equipment, it is confiscated. This exacerbates the public health risks associated with sharing drug use equipment thereby increasing the risk of disease transmission. Homeless people who use substances are at high risk for TB because they are more likely to have underlying medical problems and their use of health services may be episodic at best. The Mayor's Homelessness Action Task Force Report (1999) estimated that 20% of shelter users have both addictions and mental health problems. However, the current shelter system does not come close to providing harm reduction services that reflect even this conservative estimate.

Barriers to effective health care

Several witnesses, including a family physician, acknowledged the structural and attitudinal barriers to good health care for homeless individuals. Because of the chaos and theft that invade people's daily existence, it is very difficult to maintain ID and health insurance cards, of course making it nearly impossible to access a physician. If people are fortunate enough to have a health insurance card, they are often unable to attend appointments due to various obstacles such as lack of transportation, difficulty with memory, or fear of the medical system. If they are fortunate enough to attend an appointment, homeless people are often treated with disdain and disrespect by health care providers because of the stigma that homelessness, mental illness, and substance use carries.

As well they may be met with respect but be given instructions that cannot be followed because of lack of income, or lack of facilities to engage in the prescribed treatment, or because of language/cultural barriers. While damaging experiences with health care providers is not everyone's experience, it is unfortunately all too common among homeless people and serves as a deterrent to future use of the health care system. Because of people's previous negative experiences with the health system, they often will disregard their illnesses until they reach a crisis in their health. If a homeless person with active TB is reluctant to seek care, many people could possibly become infected because of delays in seeking medical care. Some witnesses suggested that establishing "one stop shopping" TB clinics would expedite homeless people's access to prompt and effective TB care. Others identified the need for infirmary type care for homeless people with all manner of serious illnesses.

One witness worked in a shelter that had a case of active TB. This shelter was located in an area previously described by Toronto Public Health as a "hot zone," meaning it had increased TB activity and clusters of cases. It is the area with the highest concentration of homeless people in Toronto. It is also located next door to the shelter where the outbreak later occurred. Despite repeated requests, Toronto Public Health initially refused to do contact tracing because they felt residents should be "responsible to see their own doctors" and also that it would be a "waste of time" to come in since there was no guarantee that residents would attend testings. It was only after consistent advocacy from community agencies that Toronto Public Health finally consented to do contact tracing at the shelter.

It must also be emphasized that Toronto Public Health has been requesting increased funding from the province of Ontario to enhance TB control programs and has not received sufficient dollars. One witness pointed out that, because Toronto Public Health TB staff were seconded for months to work on the SARS crisis, TB programs in Toronto may well be in worse shape as of this writing than they were when the shelter TB outbreak began in 2001.

Immigration and Refugee Issues

Tuberculosis is pervasive in the developing world. This is of increased concern when people migrate to Canada from countries where TB is endemic. Although all newcomers are supposed to be screened for TB prior to entering Canada, in reality this often does not happen in a comprehensive manner. For example, newcomers are often highly mobile when they first arrive, making it difficult to connect to health services. Those with LTBI may not link with public health authorities because it is almost impossible to do so without being connected to primary health care. Newcomers may not know where to go or how to seek out follow-up care.

It can be very difficult for refugees who are lacking identification to access health care in the first months after their arrival. Theoretically, refugees immediately receive Interim Health Benefits from the federal government, but there are often delays in receiving documentation. Landed immigrants are granted Ontario Health Cards after a three-month waiting period. Sometimes this creates delays in obtaining health care, including TB screening and follow-up. As well, primary care providers may not routinely screen for tuberculosis. Although some physicians will provide an immigration physical, they may not follow up with the client in the event of a problem.

Fifteen to twenty years ago, "Welcome Homes" existed to help refugees and immigrants make the transition to their new life in Canada. These days, refugees are inappropriately shuttled to shelters. Often these refugees have endured traumatic events and suffer from post traumatic stress. These issues as well as the culture shock they experience in coming to Canada are not addressed by the mainstream shelter/hostel systems. Because of the overwhelming stress that new Canadians experience, those who have latent TB infection are at high risk of developing the active disease. The crowded, confined spaces of shelters provide opportune conditions for spreading tuberculosis.

Problems in the Corrections System

Prison conditions are deplorable: they are overcrowded and poorly ventilated; the inmates are malnourished and lack adequate health care (Chest, March 2001). Between April 2001 and March 2002, Ontario's Ombudsman received 567complaints from inmates regarding the paucity of health care. 141 of these complaints were related to the administration of incorrect medications (Ombudsman Ontario Report 2001-2002).

TB screening is not carried out in a timely or routine manner. Inmates who are given prophylactic TB treatment are not followed once they have been discharged even if their treatment has not been completed. This is a serious problem since it may foster the development of drug-resistant tuberculosis. Full adherence to the tuberculosis treatment program is essential once the treatment has started. Often clients begin treatment within or outside of the prison system, but continuation of treatment is missed once inside the correctional system or once the client has been released into the community without adequate supports to survive, much less treat the disease.

The physical conditions of the jails combined with the emotional impact of incarceration provide ideal opportunity for tuberculosis to manifest itself. Additionally, many inmates would be exceptionally vulnerable since HIV and hepatitis C rates are higher than in the general population (Correctional Service of Canada Report, 2003).

It is important to consider that half of all people in provincial correctional facilities are on remand. They have not been convicted of any crime but are being held in custody simply because they are poor, and cannot afford bail or are denied bail because they have no fixed address (John Howard Society of Ontario, January 2002). Additionally, many of the crimes that homeless people are convicted of are crimes associated with their poverty and relate to their forced use of public spaces and lack of access to privacy. Every month 250 inmates are released from the Toronto Jail with no fixed address; hence they often find themselves in the shelter system.

"The highly transient nature of incarcerated and homeless populations, when…combined with the toxicity of an increasingly overcrowded correctional environment, poses serious and harmful health risks"

– Amber Kellen,
Inquiry Witness,
John Howard Society

Recommendations

Improve Access to Basic Health Determinants – Housing and Income

1. All levels of government should immediately implement the One Percent Solution, a social housing strategy that calls on all levels of government to double their spending on a comprehensive new social housing strategy. This would provide decent affordable housing with a range of options and supports including supportive and flexible housing for people with a range of health issues.

2. The Ontario Ministry of Housing must immediately increase the allocation of Rent Supplement units to the City of Toronto for both private and not-for-profit housing providers so that an emergency re-housing program can begin to reduce overcrowding in shelters.

3. The Ontario Ministry of Community and Social Services must ensure that the process by which individuals with active TB are fast tracked to the Ontario Disability Support Program (ODSP) continues to be made available.

4. The Ontario Ministry of Community and Social Services must increase social assistance rates (Ontario Works and ODSP) to livable levels. Social assistance rates must be indexed to the cost of living. The housing portion of funds needs to be enough so that people can live in healthy circumstances.

5. The Ontario provincial government must increase the minimum wage to $10 per hour. On a lesser wage people cannot afford to live in safe housing nor eat healthy foods.

6. The City of Toronto must create a fast track process to the Rent Supplement Program to rapidly house homeless people with active TB, and also those homeless people with any serious health issue that increases their risk from TB infection including Hepatitis C, HIV/AIDS, and cancer.

Improve Shelter Conditions

7. The Ontario Ministry of Health and Long Term Care must expand the Mandatory Core Program and Service Guidelines for infection control to include a requirement that Boards of Health must inspect shelters, drop in centers (day shelters) and other programs that provide temporary shelter for those who are homeless.

8. Toronto Public Health must immediately inspect shelters and drop in centers (day shelters) to identify and correct deficiencies that have negative implications for public health safety.

9. The City of Toronto Shelter, Housing and Support Division must develop a fast-track process to implement its revised Shelter Standards in all Toronto shelters. In particular, those standards that ensure adequate space, nutritious food, proper air ventilation and fair barring practices must be addressed.

10. The City of Toronto Shelter, Housing and Support Division must open more shelter facilities to reduce dangerous overcrowding. Shelter occupancy rates in each shelter must not exceed the city's own recommendation of 90% occupancy.

11. The City of Toronto Shelter, Housing and Support Division must eliminate all forced movement of homeless people between shelters, and to this end must develop a comprehensive shelter strategy to eliminate reliance on volunteer-based seasonal shelter programs (The Out of the Cold Program).

12. The City of Toronto Shelter, Housing and Support Division must recognize the risks associated with overcrowded drop in centers (day shelters) and immediately develop a plan to adequately and stably fund such programs with core funding.

13. The City of Toronto Shelter, Housing and Support Division must create shelters with policies and structures in place to accommodate people with serious addiction issues. At least 20% of shelter beds need to be dedicated to harm reduction to begin to meet the needs of the conservatively estimated number of shelter users with addictions and mental health issues.

Recommendations

Improve TB and Infectious Disease Detection, Control and Treatment

14. The Province of Ontario must provide adequate funding to Toronto Public Health so that it can ensure sufficient TB prevention, detection and treatment programs are in place to safeguard the public's health.

15. The Ontario Ministry of Health and Long-Term Care must create a network of comprehensive TB clinics across Toronto for the purpose of diagnosing and treating latent or active TB. To reduce barriers to obtaining care, such as lack of health insurance, lack of identification and lack of transportation resources among homeless people, such clinics must provide convenient hours of operation, geographic access, and access to individuals regardless of health insurance status.

16. Toronto Public Health must develop and implement protocols for the prevention and management of infectious and airborne diseases in homeless service systems. Such protocols are critical and are urgently needed.

17. Toronto Public Health must develop and implement comprehensive TB screening programs in shelters, drop-in centres (day shelters) and other homeless service centres that includes TB skin testing. It is not sufficient to rely on contact tracing among homeless populations.

18. Toronto Public Health must develop and implement a standard of care for contact tracing among homeless people that tests individuals based on *locations* they have frequented, rather than on traditional tracing methods which depend on accurate recall of people with whom an infected person has had contact.

19. Toronto Public Health must expand its D.O.T. (Directly Observed Therapy) program to include D.O.P.T. (Directly Observed Prophylactic Therapy) among homeless populations.

20. Toronto Public Health staff must liaise closely with health providers in jails to reduce the likelihood of losing individuals with LTBI or active TB to follow-up after release.

Improve TB Care Within the Corrections System

21. The Ontario Ministry of Public Safety & Security (Corrections) must recognize the public health risks associated with dangerous overcrowding in correctional facilities and immediately move to reduce such overcrowding.

22. The Ontario Ministry of Public Safety & Security (Corrections) must develop a protocol for ensuring that inmates who are being treated for active TB and are released into the community be provided with comprehensive discharge planning including referral to local public health authorities prior to release, to ensure appropriate follow-up is arranged.

23. The Ontario Ministry of Public Safety and Security (Corrections) must test all inmates for TB within 24 hours of confinement, and must develop a mechanism for maintaining and transferring records of inmates' TB status when inmates are transferred to other facilities.

24. The Ontario Ministry of Public Safety & Security (Corrections) must develop and administer guidelines for treating latent TB infection in jails which call for prophylaxis only in cases in which a *full* course of treatment can be guaranteed, or in those cases in which comprehensive discharge planning can be done.

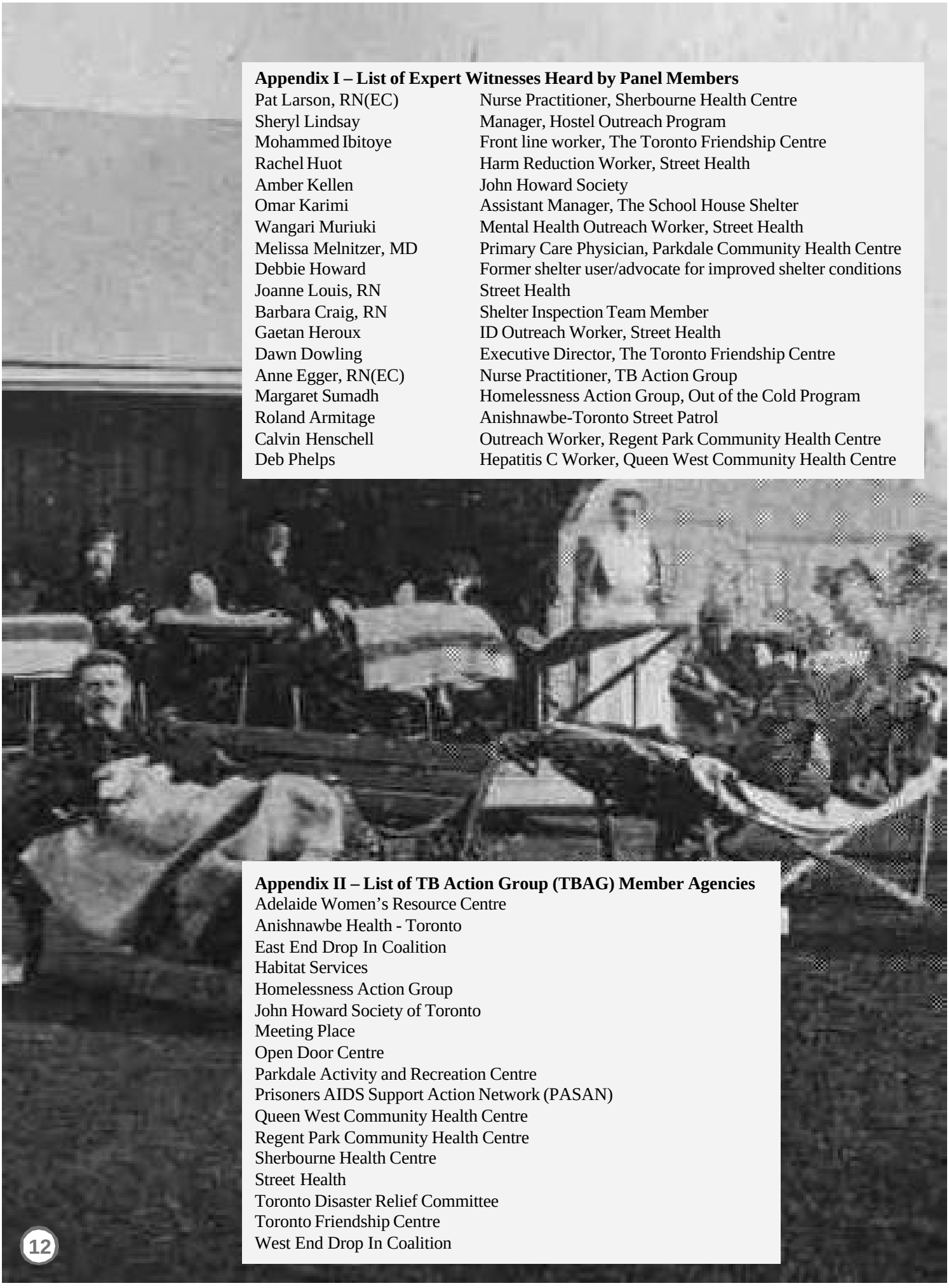
Improve TB Care of Newcomers to Canada

25. The federal government must provide Federal Interim Health Benefits to refugee claimants immediately upon entry to Canada.

26. The federal government must provide all newcomers with comprehensive TB screening, and ensure timely follow up of any abnormal findings.

27. The Ontario Ministry of Health and Long Term Care must provide Ontario Health Insurance cards to landed immigrants immediately (without the current three month waiting period) upon entry to Ontario.

28. The provincial and federal governments must reinstate funding to Welcome Homes to help new refugees and immigrants settle into Canada in order to minimize their settlement trauma.



Appendix I – List of Expert Witnesses Heard by Panel Members

Pat Larson, RN(EC)	Nurse Practitioner, Sherbourne Health Centre
Sheryl Lindsay	Manager, Hostel Outreach Program
Mohammed Ibitoye	Front line worker, The Toronto Friendship Centre
Rachel Huot	Harm Reduction Worker, Street Health
Amber Kellen	John Howard Society
Omar Karimi	Assistant Manager, The School House Shelter
Wangari Muriuki	Mental Health Outreach Worker, Street Health
Melissa Melnitzer, MD	Primary Care Physician, Parkdale Community Health Centre
Debbie Howard	Former shelter user/advocate for improved shelter conditions
Joanne Louis, RN	Street Health
Barbara Craig, RN	Shelter Inspection Team Member
Gaetan Heroux	ID Outreach Worker, Street Health
Dawn Dowling	Executive Director, The Toronto Friendship Centre
Anne Egger, RN(EC)	Nurse Practitioner, TB Action Group
Margaret Sumadh	Homelessness Action Group, Out of the Cold Program
Roland Armitage	Anishnawbe-Toronto Street Patrol
Calvin Henschell	Outreach Worker, Regent Park Community Health Centre
Deb Phelps	Hepatitis C Worker, Queen West Community Health Centre

Appendix II – List of TB Action Group (TBAG) Member Agencies

Adelaide Women's Resource Centre
Anishnawbe Health - Toronto
East End Drop In Coalition
Habitat Services
Homelessness Action Group
John Howard Society of Toronto
Meeting Place
Open Door Centre
Parkdale Activity and Recreation Centre
Prisoners AIDS Support Action Network (PASAN)
Queen West Community Health Centre
Regent Park Community Health Centre
Sherbourne Health Centre
Street Health
Toronto Disaster Relief Committee
Toronto Friendship Centre
West End Drop In Coalition

Glossary of Terms

Active TB (TB disease)
The state of having acute, infectious TB disease which is causing symptoms such as cough, shortness of breath, fevers, night sweats, weight loss, loss of appetite. It is treated with a minimum of three different antibiotics for many months. Until antibiotic treatment has begun, people with active TB are capable of infecting others.

Barring
A practice used in shelters to prohibit individuals from using a specific shelter if they contravene shelter rules. Although the City of Toronto's Shelter Standards requires barring to be governed by guidelines and used sparingly, in reality barrings are handed out frequently, often at the arbitrary discretion of staff and for trivial infractions. Although it is rarely supposed to occur, many homeless people are "barred indefinitely" or "barred for life" from certain shelters. The frequency of barring reflects inadequate staff:client ratios, insufficient staff training and the lack of harm reduction services in the shelter system.

Contact tracing
The public health practice of determining who has had contact with someone having active TB (TB disease) and then locating those people in order to determine if they have been infected, such as through skin testing or collection of sputum samples.

Directly Observed Therapy (D.O.T)
A practice of treating active TB in which public health workers meet TB clients daily or several times weekly to observe them taking their TB medications. It is associated with an increased rate of completion of treatment.

Directly Observed Prophylactic Therapy (D.O.P.T)
A practice of treating latent TB infection with preventive antibiotics in which public health workers meet clients daily or several times weekly to observe them taking their TB prophylactic medications.

DNA-linked
A process of identifying the DNA of a TB strain to determine if several individuals with TB have been infected with the identical strain. This confirms that the cases are connected to one another.

Drop In Centre
Commonly known as day shelters. These are services usually open during the day which provide homeless and other low income people with a place to rest, sleep, eat, use a telephone and meet others. Some offer health services, harm reduction services, assistance with housing searches, showers, laundry and counselling.

Drug Resistant TB
Strains of TB resistant to one anti-TB drug. The other TB drugs are able to eradicate the infection.

Latent TB infection (LTBI)
The state of having been exposed to TB bacteria, which are contained in the body and not causing symptoms nor capable of infecting anyone else.

Multi-drug Resistant TB
Strains of TB resistant to more than one anti-TB drug. This is more challenging to treat, as the usual array of anti-TB drugs is ineffective.

Out of the Cold Program
A volunteer run faith based program offering temporary emergency shelter and food. They are often located in unused or basement rooms located in churches, temples or synagogues. They generally operate one evening per week from November to April. They are located all over the City of Toronto, including the Greater Toronto Area. There are currently more than 50 such programs. They account for on average 200 to 300 sleeping spaces per night during the winter months.

Screening
The public health practice of offering TB testing to groups or populations, even if they have no known contact with someone with active TB (TB disease).

TB Skin Test
Sometimes called a Mantoux test or a PPD (purified protein derivative) test. It involves the administration of a very small amount of inactivated tuberculin protein under the skin of the forearm. If the person has been infected with TB, it "recognizes" the tuberculin protein and causes an immune system response, which causes a swelling of the skin at the test site. If the swelling is greater than a certain diameter, the test is considered positive. Further tests must then be carried out to differentiate latent TB infection from active TB (TB disease).

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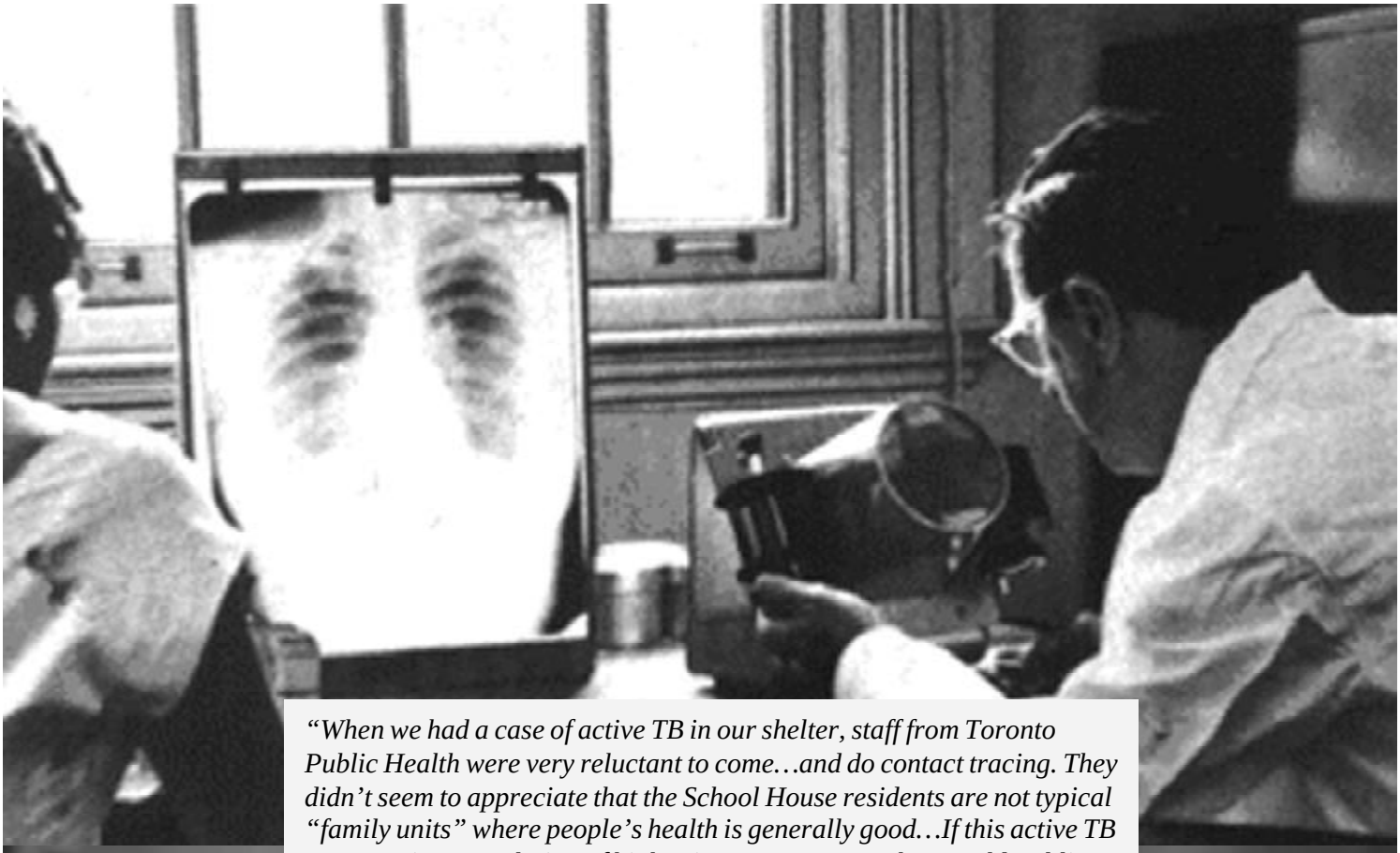

"When we had a case of active TB in our shelter, staff from Toronto Public Health were very reluctant to come…and do contact tracing. They didn't seem to appreciate that the School House residents are not typical "family units" where people's health is generally good…If this active TB case was in a population of higher income earners, what would Public Health's reaction have been? What was alarming beyond their initial refusal to test people was the lack of understanding…that the public health worker demonstrated by saying that people who live in shelters are not homeless since they have a roof over their heads. This is certainly something that makes us wonder. It makes us think about the relationship (between) politics and health."

– Omar Karimi,
Inquiry Witness,
Assistant Shelter Manager

"All the kindling is there for a conflagration. All it needs is a spark."

— Peter Tabuns,
Inquiry Panelist, former chair of Toronto Board of Health, current Executive Director of Greenpeace Canada