FOOD AS HARM REDUCTION (FaHR)

Summary report examining the intersections of food security, food access and harm reduction services for PLWHA who use drugs in Vancouver, BC

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EXECUTIVE SUMMARY

The Food as Harm Reduction (FaHR) study explores the role food provision plays in reducing the harms associated with illicit drug use. Specific goals of the project are: to determine how and when access to food (or lack thereof) impacts the health and well-being of People Living with HIV/AIDS (PLWHA) who use drugs (PWUD); document how PLWHA who use drugs navigate their environment in order to access food and harm reduction resources; and highlight the importance of safe and supportive food sites as a means of reducing the nutritional harms of drug use.

Study methodology included a survey of 60 PLWHA who also use illicit drugs (30 Dr. Peter Center participants, 30 non-participants) and mapping combined with qualitative interviews. The survey found that 88% of respondents experienced some level of food insecurity. One contributing factor is drug use. 70% said that in the past 12 months, they did not eat enough because of drug use. Additionally, 77% of all respondents said drug use did affect their diet, including what they ate (64%), how well they ate (62%), when they ate (60%) and where they ate (40%). All respondents used some form of food assistance, either a food bank program (91%), and/or a free or low-cost meal program (81%) and/or a community kitchen program (30%). The most commonly used programs were the Dr. Peter Centre, the Positive Outlook Program and the AIDS Vancouver food bank.

Qualitative mapping interviews (10 Dr. Peter Centre participants and 10 non-Dr. Peter Centre participants) which included mapping participants’ most common daily routes through the city indicated that participants did feel that drug use affected their diet. However, food resources, such as the Dr. Peter Centre, the Positive Outlook Program (POP) at Native Health and the food bank at AIDS Vancouver were critical sites for accessing nutrition and other needed services. In particular, the Dr. Peter Centre and POP were anchors in participant’s daily routines, often being utilized for breakfast and lunch. Continued support for these and other programs serving PLWHA who use drugs are critical for maintaining their health and well-being (see Appendix A).
INTRODUCTION

The Food as Harm Reduction (FaHR) study explores the role food provision plays in reducing the harms associated with illicit drug use. Specific goals of the project are: to determine how and when access to food (or lack thereof) impacts the health and well-being of People Living with HIV/AIDS (PLWHA) who use drugs (PWUD); document how PLWH who use drugs navigate their environment in order to access food and harm reduction resources and highlight the importance of safe and supportive food sites as a means of reducing the nutritional harms of drug use. In order to investigate these issues, we used a survey as well as qualitative mapping interviews, both of which are described below.

SECTION 1: SURVEY OF FOOD SECURITY, QUALITY, ACCESS AND HEALTH (FSQAH) PRELIMINARY RESULTS

The Survey of Food Security, Quality, Access and Health comprised a number of modules designed to investigate the relationship between food access and security, drug use and various health outcomes. These modules included 1) self-reported health status, 2) health service utilization, 3) medical conditions (co-infections, co-morbidities) that may affect diet, 4) medications and diet, 5) food security status (measured using the Household Food Security Survey Module), 6) diet quality (measured using the RRFSS Vegetable and Fruit Food Frequency Questionnaire), 7) food access and procurement (essentially which food providers respondents utilized), 8) substance use (including frequency) and use of harm reduction programs and services, 9) the effect of drug use on diet (self-reported), 10) the use of socially unacceptable forms of food procurement and 10) degree of social support.

This survey was administered to 60 individuals who are living with HIV and self-reported that they had used illicit drugs within the past 30 days. Half of those who responded were members of the Dr. Peter Centre and the other half were not. The recruitment for survey participants was done through posters at the Dr. Peter Centre as well as several AIDS service organizations in Vancouver. Potential respondents were screened for eligibility and if they met the criteria for study inclusion, were administered the survey by one of two peer research associates.
The following findings were generated from the survey. These findings are for the entire cohort and although the selection of survey respondents was not random they do suggest that PLWHA who use drugs are at significant risk of food insecurity and therefore are possibly at higher risk for negative health consequences associated with poor nutrition.

**Study demographics**

The average age of study participants was 50 (range 31 to 62). The majority of respondents were male (88%). Half were Caucasian, 33% Aboriginal, 13% multiracial (primarily Aboriginal and Caucasian) and 3% were Other. The majority (95%) received social assistance in the form of disability benefits, averaging around $1150/month and were therefore considered to be low-income. The majority lived in either a single room occupancy (SRO) hotel or supportive housing. 82% reported that they had cooking facilities where they lived.

**Drug Use and Food Access**

In the following section we present data from the FSQAH survey that speaks to the intersection of drug use, food security and food access. In particular, we were interested in understanding participants’ own perceptions on the relationship between their drug use and their food consumption.

**Drug of Choice and Frequency of Drug Use**

In this group, methamphetamines (33%), followed by crack/cocaine (28%) were the drugs of choice, opioids (23%) and other drugs (15%) including benzodiazepines and marijuana were less commonly identified as the drug of choice. In terms of frequency of use, the majority could be described as using drugs fairly regularly, with 38% indicating that they used their drug of choice daily, and 25% 3 to 4 times a week. Less commonly, respondents used their drug of choice once or fewer times a week (13%) or monthly (17%).
Use of Harm Reduction Programs and Services

Harm reduction programs and services can include supervised injection sites, needle and pipe exchanges, and peer support programs. Among survey participants, 53% reported using some kind of harm reduction service or program including Insite, the Dr. Peter Centre’s Supervised Injection Room, needle exchanges and peer support programs. The most common reason given for not using a harm reduction service or program is that respondents did not want or need these services. There was the perception among some that harm reduction was only for those who used injection drugs. In other cases, respondents said they preferred to use friends or others to help them inject. As well, some individuals did not feel safe or comfortable in harm reduction sites and preferred to inject at home.

Diet and Drug Use

The relationship between diet and drug use was measured by asking survey participants if they felt that their use of drugs affected their diet. 70% said that in the past 12 months, they did not eat enough because of drug use. Additionally, 77% of all respondents said drug use did affect their diet, including: what they ate (65%), how well they ate (62%), when they ate (60%), and where they ate (40%). For example, one respondent said that when they used drugs, they were more likely to eat sugary snacks. Another said they ate more fast food. Others reported eating nothing or very little because of a lack of appetite. Respondents also indicated that when they were using drugs they avoided leaving their residence to access food due to stigma and paranoia. At the same time as drug use was reported to affect diet, only 22% said that they had trouble accessing food because of their drug use and 65% of respondents said that they used strategies to mitigate the effects of drug use. These strategies included drinking Gatorade or Ensure, increasing their fluid intake to avoid dehydration, taking vitamins and eating small meals or snacks.
Food Insecurity and Diet Quality

Diet quality was measured by assessing the number of servings of fruits and vegetable consumed by participants. We found that 73% did not eat 5 or more servings of fruit and vegetables a day and the average number of servings of fruits and vegetables was 4 (range, less than 1 serving a day to 11 servings).\(^1\)

Food insecurity, defined as "the inability to acquire or consume an adequate diet quality or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so"\(^2\), was measured using the *Household Food Security Survey Module*. Food insecurity among PLWHA has been associated with negative health outcomes. Overall, 88% of respondents were found to have some level of food insecurity. 42% were considered moderately food insecure, meaning that the quality or quantity of food they consumed as inadequate and 47% experienced severe food insecurity which indicates that they reduced their food intake and/or experienced disrupted eating patterns.\(^3\)

Food Access

All respondents indicated that they used some form of food assistance, either a food bank program (92%), and/or a free or low-cost meal program (82%) and/or a community kitchen program (50%). The most commonly used programs were the Dr. Peter Centre, the Positive Outlook Program and the AIDS Vancouver food bank.

Non-Traditional Means of Food Procurement

Food insecurity often results in individuals using non-traditional means of food procurement, such as binning, stealing food, trading drugs or sex and food, which in turn, can increase their

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1. The percentage of individuals in BC who do not consume 5 or more servings of fruit and vegetables a day is 60% (Statistics Canada, 2014)
risk of disease, violence and incarceration. Among study participants, 68% had engaged in one or more “non-traditional” means of acquiring food in the past year. The most common strategies were borrowing money from a friend or family member for food (45%) selling, trading or pawning personal or household items for food (33%), and stealing food from a store, restaurant, service organization or other establishment (27%).

SECTION 2: MAPPING DAILY ROUTINES AND FOOD ACCESS

In the second phase of the research, we asked 20 individuals who had completed the FSQAH survey to participate in mapping and a qualitative interview (10 Dr. Peter Centre participants and 10 non-participants). In the mapping exercise, we asked participants to indicate their daily routines including where they accessed food and harm reduction programs. We asked whether they felt safe in these spaces and whether they had to pass through any areas that they considered unsafe to access food, harm reduction or other resources. The results are maps of individual’s daily routines as well as analytic maps showing areas that are safe, unsafe, which food resources people use most heavily and the daily pathways they use to get there.

We have included 4 digitized and anonymized maps (see Appendix B). Map 1 “Frank” is typical of Dr. Peter Centre participants. Frank lives at McClaren Housing on Howe street and uses the Dr. Peter Centre for most of his breakfasts and lunches. His other main food resources are grocery stores. He is also red zoned from portions of the Downtown Eastside where he accesses harm reduction services. He also feels that this area is unsafe and he avoids traveling on Hastings street in particular although he does occasionally go into the area.

Map #2, “Winston”, is typical of non-Dr. Peter Centre participants, most of whom resided in the Downtown Eastside. Winston resides in Native housing and accesses the Positive Outlook Program at Native Health for most of his breakfasts and lunches. In addition, he uses low-cost grocery stores such as Quest Food Exchange and Sunrise Market as well as the AIDS Vancouver Food Bank. He also accesses several harm reduction sites, such as Insite, the Drug Users Resource Centre and First United Church. He did not feel that anywhere he traveled to access food was unsafe.
Map #3, Who Uses Which Food Resource? Is a composite map showing the number of participants that indicated using each resource and the proportion of Dr. Peter Center participants compared to those who do not use the centre. The main food resources were 1) the Dr. Peter Centre, 2) the Positive Outlook Program at Native Health, and 3) the AIDS Vancouver food bank. Other food resources included subsidized or charitable meal programs at Boys R Us, the Gathering Place and Evelyne Saller, and the Dugout. Respondents also made use of low-cost grocery stores such as Sunrise Market in the DTES and West Valley in the West End.

Several respondents noted the importance of low-cost food retailers. For example, a couple of respondents spoke about being able to access inexpensive produce at Sunrise Market. Paul commented, “You can get really good deals on fresh produce. I’m trying to eat a little healthier. I noticed that sugars affect me a lot more now with the liver issues and stuff.” Additionally, Carlton noted that, “I usually go [to West Valley] because they’re quite cheap and they have small portions.” Some respondents also said that they purchased food sold on Hastings Street by street vendors because it was inexpensive.

Map #4, Food Access and Unsafe Space, presents a heat map of the unsafe spaces that participants identified as well as the food sites they accessed. The most frequently mentioned “unsafe” area were East Hastings Street from Carrall to Hawks and surrounding blocks. Although there are a number of heavily used food resources in the Downtown Eastside, they were rarely used by Dr. Peter Centre participants, who tended to limit their interaction with the area. Additionally, some residents of the West End indicated that they no longer went to the AIDS Vancouver food bank because its location was too far away, especially for those without a bus pass. Carlton said, “I just don’t use that service [AIDS Vancouver Food Bank], I don’t avoid it, I just don’t use it. It’s too far down, it’s too far out. The reason that I don’t go is that I have to pay for it on the bus.”
SECTION 3: QUALITATIVE FINDINGS

In addition to mapping, interviews were also conducted during the process. These interviews were transcribed and organized into three themes 1) Diet and Drug Use, 2) Risk Environments, 3) Safe Spaces. These themes speak to issues of the relationship between diet and drug use, where respondents felt safe and unsafe as well as how they negotiated these spaces and finally where and how participants experienced care in the form of food provision and other services.

Theme 1: Diet and Drug Use

There was general consensus that drug use does affect diet, although it seemed more profound with people who use cocaine/crack and methamphetamines when compared to opioids. There were three ways in which drug use could affect diet. The first was drug-induced anorexia, simply put respondents said that they lacked appetite. For example, Paul noted “When you’re using a lot of drugs you just have your mind on one thing that’s using drugs. You don’t think about eating or taking care of yourself.” Additionally, others reported not wanting to leave their residence when using drugs and in some cases avoiding food providers. Carlton explained, “When I’m using I tend not to eat. You’re so high and you’re where you are, you don’t want to go out and get it [food]. You’re paranoid or whatnot so yeah if you’ve got nothing in your fridge I usually, myself would just take a sleeping pill and wait till the next day and then that way everything is back to normal.” Finally, some respondents said that they ate differently when they were using drugs. Victor said, “Oh yeah maybe some water, maybe chips, chocolate bar just basically to live, I’d eat a chocolate bar, a sandwich, whatever…eating wasn’t a priority on my list.”

However, not all respondents said that drug use affected their diet. For example, when we asked Paul whether drug use affected his diet, he responded, “No I don’t let it. Maybe when I

Now that I’m older I guess I’m more conscious of my health and how long I’m going to live so it’s it just sticks in my head about taking care of myself and eating and staying regular.  – Paul (Native Health Participant)

“When I'm using, I tend not to eat.  – Carlton (Dr. Peter Center Participant)
was younger it did but as I’ve grown older I’ve learned to adapt to using and eating. I have no problems with appetite or anything.” Although, not everyone was able to manage to eat regularly, Gary said “Yeah, I guarantee I eat. Don’t worry I eat,” but then admitted, “Sometimes I don’t.” Some participants noted that they did watch what they ate and were concerned about their diet for health reasons including diabetes, liver problems and HIV. For example, Frank noted “Having HIV I kind of learned to look into what I’m eating, if it’s going to affect cholesterol.”

**Theme 2: Risk Environments**

For this study, we wanted to understand when, how and why participants potentially put themselves at risk in order to access food and harm reduction services. In general, Dr. Peter Centre participants considered the Downtown Eastside to be unsafe and tended to avoid the area although they did occasionally venture there in order to access some services, including the AIDS Vancouver food bank. One of the primary reasons that the area was considered unsafe was the level of drug use and dealing, which could be triggering for some.

For example, during the mapping Ricky said, “I’m going to zone [Hastings Street] out, it’s an unsafe space I’m going to tell you why…drug addiction central.” Yet, as Carlton noted, it is also a space where needed resources, including drugs, could be accessed. “All along, more or less along those three blocks that’s where a lot of the dealings would be going on and that’s where you shouldn’t be hanging around but when you’re in a sort of state you just head down there.” At the same time, others felt that the area was safe as long as you knew how to act. According to Jimmy, [The Downtown Eastside] is [safe]! You keep your mouth shut and you don’t bug anybody when you’re going through, they don’t bother you….”

We also wanted to know if changes, including gentrification and displacement, had an effect on when, where and how people accessed food and other resources. While some said that they hadn’t noticed any changes to their neighborhood, others spoke of more drug use while others noted higher-end stores and restaurants coming into the neighborhood. For example, Paul said, “It’s weird because I find it’s more of a mix now even though I was complaining about how there more people using crystal meth in the neighborhood but at the same time I
see more young families in the neighborhood. It’s a weird remix than before. A lot of things are positive; a lot of things aren’t. I don’t know what to think about it.”

Theme 3: Spaces of Care

Finally, we wanted to know where respondents felt safe and supported and why. Among those spaces were the Dr. Peter Centre and the Positive Outlook Program at Native Health. Two quotes highlight these sentiments. When asked why he liked the Dr. Peter Centre, Maurice responded, “Just knowing that I have a place to come to where will be safe for me rather than just wandering the streets. At least I can come here and watch some TV; just get away from the outdoors. The people that work here I like, they’re very understanding.” Paul said of the Positive Outlook Program, “[It’s] just the people and the atmosphere in there, everybody knows me there. It’s kind like Cheers when Norm walks in, I walk in and everybody’s like, “Hey Paul”. It’s really welcoming there.”

One aspect of care is the provision of food. Respondents generally found the food they received at all of the providers to be very good, although some noted that meals were sometimes “too healthy” and that they would prefer more “meat and potatoes”. Home cooking was noted as particularly important, as was having a choice in terms of what they were served. Jeffery noted, [At the First Baptist Church] “you get a really good, substantial amount and it’s almost like comfort food. It’s almost homemade. It’s as close to homemade cooking is you’re going to get.” Aspects of food provision that respondents liked included high quality and being able to select the food they wanted. Jody described the food at the Gathering Place as “Gorgeous, it’s very good. It’s very cheap. Sometimes I volunteer at the gym so they pay you with meal tickets. So it’s very civilized to get food there.” Jerald said,
“the meals are big [at the Kettle]. They have roasted chicken, mashed potatoes, gravy, pizza it’s a different meal every day." Being able to access food whenever you needed it was also important, especially if it was needed in order to take medications. Paul said, “[At the Downtown Community Health Clinic] we have cereal for breakfast or even in the middle of the day, they won’t refuse you if it’s the first time you’ve eaten since you’ve taken you’re a ARV [anti-retro virals], or any medications.”

SUMMARY

1. In spite of numerous food resources in Vancouver, PLWHA who use drugs still experience very high rates of food insecurity. This may be partially due to drug use which can serve as a barrier to accessing food because of loss of appetite, stigma and lack of money to purchase food. The frequency of drug use affects the extent to which these issues result in negative health outcomes.

2. At the same time, many participants in our study were aware of the nutritional harms of drug use and took steps to mitigate these effects. Keeping to a schedule or routine in terms of food access was one way in which they did this. Others used nutritional supplements or ate small meals.

3. Services like the Dr. Peter Centre and Positive Outlook Program at Native Health serve as an important food resources and social anchors for PLWHA who use drugs, providing food, harm reduction and social support. They also served as safe spaces where people feel supported.

RECOMMENDATIONS

1. Support and enhance daily meal programs for PLWHA who use drugs in spaces where they feel safe and supported including meals on weekends and evenings.

2. Nutritional standards are critical for PLWHA who use drugs. Fruit and vegetables in forms that are nutritionally adequate and appropriate in texture for people with dental and other issues should be provided.

3. Respondents liked being able to choose what they ate and wanted to have their preferences taken into account. Home cooking, or meals served with care and attention were most appreciated.
4. Respondents liked spaces that are welcoming yet regulated with membership, rules and expectations about behavior, and/or social contract that sets ground rules.

5. Respondents noted that providing safe space for participants involves more than just food; it should involve providing food with dignity, support and caring.
APPENDIX A: SERVICE PROVIDER INFORMATION SHEET

Rationale

Low-income people who use drugs (PWUD) and people living with HIV/AIDS (PLWHA) face a wide range of health impacts stemming from inadequate nutrition.

In BC, 72% of PLWHA who access AIDS service organizations (ASOs) experience food insecurity (Food Security Study, n.d.). PLWHA who are unemployed, use drugs, have low incomes, are visible minorities, and are women are even more likely to experience food insecurity and its side effects (Anema et al., 2009, Food Security Study, n.d.).

<table>
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<td>Often underweight, skip meals</td>
<td>Decreased immune system functioning</td>
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<td>High rates of malnutrition</td>
<td>Increased behavioural risk of HIV transmission</td>
</tr>
<tr>
<td>Some drugs suppress appetite</td>
<td>Adverse reactions to HIV treatment</td>
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<tr>
<td>Decreased immune system functioning</td>
<td>Decreased treatment compliance, and ARV effectiveness</td>
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<td>often place other priorities for survival over food, resulting in reliance on free/low-cost food providers.</td>
<td>Higher viral loads</td>
</tr>
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<td></td>
<td>Poorer physical and mental health (especially depression)</td>
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<td></td>
<td>Increased mortality</td>
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Food can reduce drug-related harms by improving nutritional status and food security for low-income PWUD and PLWHA. However, the ways in which food is provided can also enhance or detract from other harm reduction goals.

Study design

I conducted 27 qualitative, semi-structured interviews with harm reduction service providers like low-barrier housing and shelters, drop-in centres, low-barrier clinics, a needle depot, a supervised injection site, and two grassroots advocacy groups for PWUD across Greater Vancouver.

Food in Greater Vancouver’s harm reduction service providers

Food is provided in a variety of formats in almost all organizations with harm reduction service providers in Greater Vancouver. Common formats of food provision include cafeteria-style dining, community kitchens, and snacks.

Organizations report that their biggest barrier to providing their ideal food programming (e.g. more food, more frequent meals, more community kitchen-style food) is financial constraints. However, lack of appropriate and adequate cooking and eating facilities, and zoning constraints also impact what foods can be served, and when.
How food fits into a harm reduction paradigm

Harm reduction services are intended to be low-barrier and individualized, but food programs can sometimes present barriers. For example, line-ups, limited choices, concealing ingredients, and strict food service times can undermine harm reduction objectives emphasizing low-barrier services, participant choice, and flexibility.

Recognizing that organizations with harm reduction orientations are often reliant on donations, and limited budgets, the following two sections outlines some ways in which service providers can advocate for, and provide food programming in harm reduction-oriented ways.

Recommendations for harm reduction-oriented food programs

Food is part of almost every harm reduction-oriented organization. Given food’s prevalence, it is important that food be provided in ways that are consistent with organizations’ goals.

- Food directly reduces the harms associated with drug use and HIV, and therefore should be included in funding proposals in order to increase resources allocated towards food.
- Organizations should ask their participants what foods they consider healthy and desirable because that may differ from service provider perspectives.
- Food should be provided in ways that maximize choice, and minimize barriers.
  - Open pantry models, where a variety of ingredients are available for participants to prepare is appropriate for people who have the skills and desire to cook.
  - Cafeteria-style models can serve large numbers of participants, including those who are unable or unwilling to cook. However, participants should be given a meaningful, informed choice in what they eat (e.g. through displaying a menu).
- Many organizations rely on donations, and food quality may suffer as a result. Service providers should make it clear to funders that their participants require high quality foods that accommodate participant choice.
- Service providers can increase the capacity, variety, and geographical reach of their food programming through strategic partnerships with organizations sharing similar goals.

Prepared by Alison McIntosh as part of the Food as Harm Reduction project with Simon Fraser University and the Dr. Peter Centre.

References:


APPENDIX B: MAPS

Map 1: Frank’s Food Routine
Map 2: Winston’s Food Routine
Map 3:  Food Locations by Relative Use
Map 4: Food Locations by Relative Use in Unsafe and Safe Areas
# APPENDIX C: MAPPING PARTICIPANT DEMOGRAPHICS

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