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AN EVALUATION OF THE LONDON COMMUNITY ADDICTION RESPONSE STRATEGY (LONDON CARES): FACILITATING SERVICE INTEGRATION THROUGH COLLABORATIVE BEST PRACTICES

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INTRODUCTION

Homelessness in Canada has been on the rise since the 1980s. In 2006, the United Nations Committee on Economic, Social and Cultural Rights made a number of recommendations for the federal, provincial and territorial governments of Canada to address homelessness and inadequate housing as a “national emergency” (United Nations, 2006). Research has repeatedly found that individuals with addictions and mental illnesses are overrepresented among those experiencing homelessness (Argintaru et al., 2013; Bharel et al., 2012; Draine, Salzer, Culhane & Hadley, 2002; Drake & Wallach, 1999; Forchuk, Csiernik & Jensen, 2011; Goering, Tolomiczenko, Sheldon, Boydell & Wasylenki, 2002; Hwang et al., 2013; Khandor et al., 2011), with approximately two-thirds to three-quarters of the homeless population experiencing mental health challenges. This chapter describes the evaluation of a municipal strategy which focused on the housing needs and health outcomes of individuals experiencing addiction, poor mental health and poverty.

Priority populations identified in London's Community Plan on Homelessness (City of London, 2010) and Homeless Prevention System (City of London, 2013) include those who are experiencing persistent or chronic homelessness or at immediate risk of becoming homeless as a result of having to live on the street for the first time as well as youth, street-involved sex workers and Aboriginal populations. An objective of London CARES is increasing community integration while decreasing the costs to and demands on emergency, health, social and justice systems.

London CARES is a highly flexible service collaboration established to address the needs of particular priority populations experiencing persistent and chronic homelessness. The efforts to assist individuals served through London CARES exist within a context of considerable systemic barriers to long-term housing stability. London CARES participants are offered access to private market and subsidized scattered-site independent housing, along with intensive in-home and

community-based supports necessary to achieve housing stability. Their choice of neighbourhood and community is a primary determinant when selecting their housing.

Similar to other Housing First initiatives, London CARES is a recovery-oriented model driven by participant choice and strengths. Specifically, London CARES participants are supported with interventions and other support including health, community services and justice remedies along with social, recreational, educational, occupational and vocational activities. Interventions and supports are voluntary, culturally appropriate, individualized and, most importantly, participant driven. The program is based on respect and inclusion and encourages social and community integration through employment, vocational and recreational activities (Gaetz et al., 2013; Tsemberis et al., 2003).

London CARES applies a Housing First approach which was developed through Pathways to Housing in New York in the early 1990s. This approach considers housing as a basic human right and the model offers access to permanent immediate housing of varying types to individuals experiencing homelessness, based on their unique circumstances and with appropriate and dedicated in-home support. Gaetz, Scott and Gulliver (2013) reviewed Housing First approaches and outlined common core principles in order to clearly articulate this approach. These principles include:

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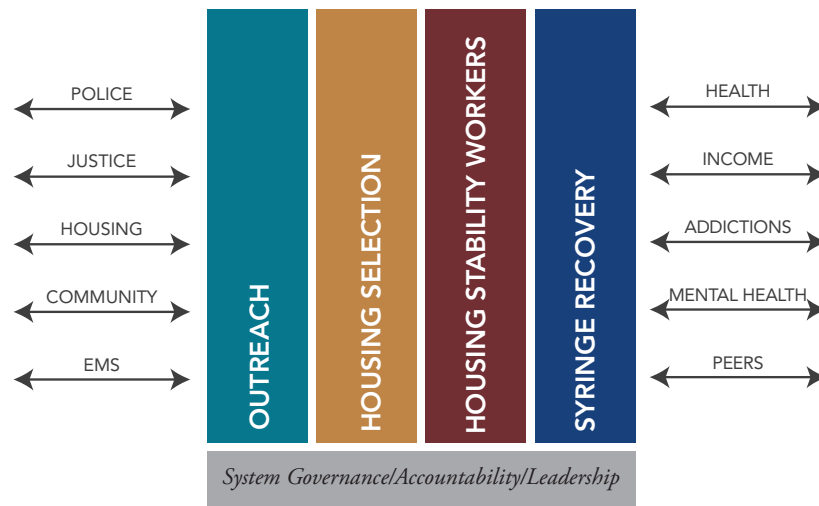
1. Immediate access to permanent housing with no housing readiness requirement;
2. Consumer choice and self-determination;
3. Recovery orientation;
4. Individualized and client-driven supports; and
5. Social and community integration.

The Housing First approach is considered a best practice to ending homelessness and has been proven to address homelessness by supporting individuals in obtaining and maintaining homes without increasing poor mental health symptoms or substance use (City of Toronto, 2007; Collins et al., 2012; Goering et al., 2014; Kirst, Zerger, Misir, Hwang & Stergiopoulos, 2015; Metraux, Marcus & Culhane, 2003; Padgett, Gulcur & Tsemberis, 2006; Palepu, Patterson, Moniruzzamen, Frankish & Somers, 2013; Toronto Shelter, Support & Housing Administration, 2009; Tsemberis, 1999; Tsemberis & Eisenberg, 2000; Tsemberis, Moran, Shinn, Asmussen & Shern, 2003; Tsemberis, Gulcur & Nakae, 2004; Tsemberis, Kent & Respress, 2012). In contrast to the traditional ‘treatment first’ approach that believes individuals experiencing homelessness must address their addictions and mental health issues prior to being deemed suitable candidates for housing (Padgett, Gulcur & Tsemberis, 2006), Housing First does not believe independent housing should be based on sobriety or acceptance of treatment. Housing First programs promote harm reduction strategies and support respectful environments and interventions that meet individuals ‘where they are at’ with their current substance use and treatment goals (Tsemberis & Eisenberg, 2000).

LONDON CAReS BACKGROUND

London CAReS began as an innovative City of London council-approved strategy focused on a community-based systems approach to improving the health and housing outcomes of individuals experiencing homelessness and who live with the complex and co-occurring challenges associated with addictions, poor mental health and poverty. The first five years of the integrated strategy commenced in 2008 and focused on individuals with these complex and often co-occurring challenges residing in or relying on the downtown and core neighbourhoods. This first stage of London CAReS was designed and delivered through a range of street-level services aimed at engaging individuals and families experiencing homelessness while

FIGURE 1 *London CAReS Model of Collaboration*



liaising with neighbourhood residents, businesses and other community organizations. In 2011, based on experiences and the results of an evaluation which took place between 2008–2010, along with the approval of the London Community Plan on Homelessness, London CAReS re-focused its objectives to build on community integration and housing outcomes for the targeted populations. These recommendations were further supported through the development of London’s Homeless Prevention System, which focused attention on prioritized action plans associated with homelessness services, including London CAReS. London CAReS shifted its focus to align with Housing First principles and strengthen service collaboration. The restructured London CAReS model of service

was based on the cooperation of community services, business and neighbourhood associations, the London Police Service, individuals and all orders of government with specific leadership by the City of London.

The following components form the comprehensive service collaboration:

1. System governance, accountability and managing director;
2. Street outreach;
3. Housing selection;
4. Housing stability;
5. Syringe recovery; and
6. Administrative space.

Component 1: London CARES Coordinator, System Governance, Accountability and Leadership

London CARES is a voluntary service collaboration. It is comprised of three funded organizations: Addiction Services of Thames Valley, Regional HIV/AIDS Connection and Unity Project for Relief of Homelessness. The three funded agencies, through the participation of their executive directors, along with the London CARES managing director and the City of London designate, act as the administration committee for the London CARES strategy.

The administration committee oversees the conduct, outcome, objectives and evaluation of the London CARES strategy. These community leaders and their organizations possess a strong commitment to the collaboration, unique expertise, knowledge and resources that contribute to the overall guidance and success of London CARES. The London CARES managing director administers and oversees all of the program components, including street outreach, housing stability, housing selection and syringe recovery, to ensure a focused, integrated and collaborative response to priority groups. The London CARES managing director is employed by one of the funded agencies and is accountable to the London CARES administration committee. On a quarterly basis, the London CARES managing director and administration committee report on the program activities and outcomes to representatives of management from key community stakeholder groups and organizations directly or indirectly serving individuals experiencing homelessness.

Component 2: London CARES Street Outreach

The London CARES Street Outreach Team establish and maintain relationships with individuals at risk of persistent homelessness and individuals at imminent risk of homelessness as a result of their 'first time' street presence. Provision of services on a 24 hour a day, seven day a week basis supports active contact with street-involved individuals. This allows street outreach staff to monitor circumstances and emerging concerns. These issues could include individuals and families who might be new to living on the street residing outdoors unsheltered, situations requiring crisis response and diversion, assistance with warm transfers or creating community linkages with other services or at-risk situations due to use of contaminated street drugs. The team supports individuals 'in the moment' in an effort to initiate a rapid exit from the street and into a sustainable housing plan. All Street Outreach Team services are focused on creating opportunities for the individuals or families to transition off the streets or out of emergency shelters and into a home and neighbourhood of their choice. The Street Outreach Team assists individuals and families to connect with services and resources through warm transfers. Depending on participant needs, services can include more immediate basic needs such as a meal, survival gear, harm reduction supplies or an emergency shelter bed. However, when individuals indicate readiness to move to housing, immediate opportunities will be offered such as quickly available housing. The team also provides crisis response, meeting participants where they are in an effort to support diversion from emergency services when these services are not necessary. Housing options can be offered rapidly or at times immediately to a participant due to available housing stock secured through London CARES housing selection services.

Component 3: Housing Selection

The housing selection component assists London CARES to provide housing stability by finding private sector and subsidized housing units scattered throughout the city, recruiting landlords and developing relationships and effective working partnerships with landlords, property owners and/or property management, and the City of London's Housing Division. Housing Selection staff have a unique skill set that requires them to have an understanding of the needs of housing providers as well as provide analysis of housing market trends to assist with housing stock search and acquisition. The primary role of housing selection services is to support the landlord. A 24-hour crisis response is available to landlords and tenants to prevent eviction and build positive tenancy.

Component 4: Housing Stability Team

The Housing Stability Team provides a participant-driven approach aimed at supporting participants as they transition to housing stability. Housing Stability Workers establish and maintain a relationship with individuals and families who have experienced persistent and chronic homelessness and focus their efforts on supporting housing stability and prevention of homelessness. Housing Stability Workers offer intensive in-home and community-based ongoing support, as directed by the needs and interests of the participant, connecting the participant to other services and assisting participants to transition into their housing and communities. London CARES participants that are housed and supported by a Housing Stability Worker have access to a 24-hour crisis support service. The crisis and after-hours support is provided by Street Outreach and Housing Stability Workers on a scheduled on-call basis.

Component 5: Syringe Recovery

The London CARES Street Outreach Team provides syringe and drug paraphernalia recovery within the geographical boundaries of London CARES. They assist with responding to calls received by the London CARES telephone service, record messages from this service and assist with all relevant data collection. Data collected assists with identifying and mapping 'hot spots.' Identifying hot spots creates more efficient responses to recovery allowing for safer public space and reduces the risk of biohazardous material being found in public spaces. Stationary needle collection bins, located in strategic locations, are maintained by the Street Outreach Team as part of a community service to reduce the amount of discarded drug-using equipment on the streets and assist in overall community safety.

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Component 6: London CARES Administrative Space

London CARES maintains its own secure space used solely for administrative purposes by London CARES Staff and the administration committee. The London CARES managing director works on-site and manages the office space in cooperation with the funded agency. The office space is not meant for face-to-face meetings with participants. Participants are supported in the community (i.e. on the street, in coffee shops, libraries, drop-in centres, their homes, hospitals, community agencies, the police station, etc.).

In 2013, London CARES moved from a strategy to an annualized funded service under the London Homeless Prevention System. The London CARES continuum of

care is aimed at improving housing and health outcomes for those living with addiction and mental illness and experiencing homelessness, reducing the incidence of homelessness in London and enhancing the quality of life in the downtown core areas.

This unique approach applies the highly successful Four Pillar Approach (City of Vancouver, 2015), which incorporates treatment, prevention, justice response and harm reduction, to respond to addictions. London CARES has created a fifth pillar of ‘collaboration and integration.’ This unifying pillar engages individuals with lived experience, businesses and residents in the design and delivery of London CARES.

STUDY OBJECTIVES

The main objective of this study was to evaluate a unique Five Pillar Community Addiction Response Strategy that uses a Housing First approach to improve the housing and health outcomes of individuals experiencing homelessness and the challenges associated with addictions, poor mental health and poverty. This evaluation addressed two levels of enquiry: individual (i.e. impact of the service on consumers) and community (i.e. an exploration of London CARES implementation and service/agency collaboration). This paper focuses primarily on the individual level outcomes across time to compare the year prior to entering the program to the year after. The study explored health and housing outcomes as well as health care utilization and emergency shelter use by London CARES participants before and after enrollment in London CARES.

RESEARCH QUESTIONS

The central research questions were:

Question 1: What changes in health, including housing stability, are reported by individuals accessing London CARES?

Question 2: What is the difference in the use of emergency health services, emergency response and emergency community services when comparing the year after enrollment in the London CARES program to the year prior?

Question 3: Is there an increase in the use of addiction and poor mental health prevention and treatment services in comparing the year after London CARES enrollment to the year prior?

METHODOLOGY

The research team received ethics approval from Western University in March 2013.

The study utilized a mixed method (i.e. qualitative and quantitative measures) using interviews, focus groups and service databases. Qualitative data was obtained by incorporating open-ended questions into the interviews and by conducting focus groups. Open ended interview questions focused on the specific housing, health and health care needs of the individual clients and how these changed before and after enrollment in London CARES. Focus group questions sought to explore common experiences of clients during their involvement with London CARES and challenges faced in terms of maintaining their housing on a broader policy level (e.g. discussing rules that helped or hindered). CARES service provider and other stakeholder focus groups examined the positive aspects and challenges of implementing the London CARES model and experiences of collaboration between London CARES and other involved agencies. Opportunities for improving the London CARES service were also discussed.

Qualitative data were obtained from focus groups with 18 London CARES staff and 28 other key community stakeholders at baseline and 10 months. In order to

incorporate as many key stakeholders' views as possible, arrangements were made to meet separately with those key stakeholders unable to make the set focus group times. Key community stakeholders included individuals from a wide range of programs and agencies who interact with London CARES or London CARES participants. As such, these key stakeholders provide direct or indirect services to individuals experiencing homelessness. Information elicited through the focus groups included: benefits and breakthroughs of implementing London CARES; collaboration of London CARES with other community services; changes in health and housing of individuals accessing services through London CARES; and challenges and areas of improvement for the London CARES initiative.

Enrollment of client participants focused on those individuals receiving intensive housing stability support from a housing stability worker, along with some individuals identified through street outreach. The London CARES participant sample was obtained by London CARES staff mentioning the study to individuals accessing London CARES services through the housing stability and street outreach programs. If individuals expressed interest a member of the research team met with them to explain the study and

obtain their informed consent to participate. The sample consisted of 65 London CARES participants; 40 (61.5%) of whom enrolled from the housing stability program and 25 (38.5%) from the street outreach program.

London CARES staff also aided in the retention of participants for follow-up; their consistent contact with many of the participants allowed researchers to connect with individuals at baseline and at two follow-up time points, five and 10 months post-baseline for interviews and focus groups. Numerous alternative contacts were obtained, such as family, friends and service providers at other agencies who also assisted with finding study participants for follow-up. As compensation for their time, all participants were given \$20 in cash at the end of interviews and focus groups. All three interviews were completed with 56 (86.2%) of the 65 participants enrolled. Of the nine individuals who did not complete all interviews, four were lost to follow-up, one withdrew from the study, one no longer met inclusion criteria and three passed away. There were 33 participants in the focus groups, 20 of these also participated in individual interviews.

Leveraging the experience of and resources from leading community organizations, London CARES is able to provide a seamless continuum of supports to participants from 24-hour street outreach and crisis support, intensive in-home case management from Housing Stability and actionable housing options from Housing Selection. This streamlined process allows for individuals to rapidly exit from the street into housing with identified supports oftentimes in under 30 days.

For qualitative analysis of both the interview open-ended question responses and focus group data, the research team used a matrix method (Leininger, 2002; Miles & Huberman, 1994). Focus group discussions were audio-taped and later transcribed and validated.

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For the focus groups, the matrix consisted of three columns for participant groups (i.e. London CARES participants, frontline London CARES staff and other key stakeholders) and rows across for emergent themes. Groups were first analyzed separately using the phases of qualitative data analysis described by Leininger (2002). Research team members developed and validated a coding structure for emerging data to reveal patterns across and between groups and determine any similarities or differences in meanings. The matrix design allowed this direct comparison. Recurrent findings were then synthesized into unique concepts/themes. The data were analyzed until saturation occurred, meaning that no further unique themes arose (Leininger, 2002). The advantage of the matrix approach was that it provided a visual overview which captured all the major issues and allowed for connections to be made across data sets (Miles & Huberman, 1994).

Quantitative data used in this study came from several sources: records from four emergency shelters within the City of London; provincial records of participants' health service utilization prior to and after involvement with London CARES (obtained through an analysis at the Institute for Clinical Evaluative Sciences (ICES) where provincial health data is held); and a final set of quantitative data were obtained during the research interviews conducted with London CARES participants.

During the individual interviews a selection of previously used and/or validated quantitative research instruments were used to gather data of relevance to the demographic, health, housing and social integration characteristics of participants (see Table 1). To address the research questions explored in this chapter, the analyses focused on three of the tested instruments described in Table 1: the Demographics Form; the Health, Social, Justice Service Utilization Questionnaire; and the Housing History Form.

TABLE 1 *Research Instruments and Resources*

Research Instrument	Purpose	Source
ACCESS	Questionnaire assesses whether participant has a regular doctor, a regular place they go when they're sick (e.g. walk-in clinic, community health centre) and whether there has ever been a time they needed health care recently but could not access it.	MHCC
COMMUNITY INTEGRATION QUESTIONNAIRE (CIQ)	Uses 13 questions (summing to two scores) to assess the level of physical integration (community presence/participation) and psychological integration (sense of belonging).	Dijkers, 2000
CONSUMER HOUSING PREFERENCE SURVEY (MODIFIED SHORT VERSION)	Identifies current housing, preferred housing, preferred living companions and the supports needed.	Tanzman, 1990
DEMOGRAPHICS FORM	Collects basic demographic information including age, sex, marital status, education, current employment and presence of any psychiatric diagnoses.	Forchuk et al., 2011
GLOBAL ASSESSMENT OF INDIVIDUAL NEEDS SUBSTANCE PROBLEMS SCALE (GAIN-SPS)	Modified from the GAIN Short Screener (GAIN-SS); evaluates the probability an individual is currently experiencing or has previously experienced a substance issue.	Conrad et al., 2008
HEALTH, SOCIAL JUSTICE, SERVICE USE	Information collected includes the types and frequency of healthcare and social service utilization in the recent six months. Includes visits to service providers, visits to the ER and contact with community authorities (e.g. security, arrests and detentions by police).	Goering et al., 2011
HOUSING HISTORY SURVEY	Identifies types of residences lived in over the previous two years, length occupied, reasons for moving and housing satisfaction.	Forchuk et al., 2011
LEHMAN QUALITY OF LIFE: BRIEF VERSION	Used to evaluate clients in a number of areas including life in general, health, social relationships, family relationships, safety, finances and employment. Measurements include both the subjective (client's perceptions) and the objective (number of activities).	Lehman et al., 1994
MIGRATION FORM	Assesses the migration of individuals (recentness) and the reasons for it. Also includes an assessment of the situation under which the individual became homeless.	Kauppi et al., 2009
PERCEIVED HOUSING QUALITY	Examines the quality of current housing (e.g. safety, privacy, friendliness) as well as affordability and length of time in the current housing.	Tsemberis et al., 2003
SF-36 HEALTH SURVEY	This is a 36-item self-report checklist of the general physical and emotional health of the participant.	Ware & Sherbourne, 1992
WORKING ALLIANCE PARTICIPANT VERSION	Identifies the strength of relationship between the participant and main health care provider (e.g. London CARES worker).	Horvath et al., 1989

Individual outcomes were evaluated across time as appropriate for the individual data sources utilized (i.e. interview data versus provincial health data). For individual interviews, data collected at the start of the evaluation (baseline) was compared to that collected at five and 10 months into the evaluation using a repeated measures ANOVA analysis. For provincial health care utilization data, data from six months pre-enrollment was compared to that of six months post-enrollment using paired t-tests for normally distributed data and Wilcoxon Signed Rank test for non-normally distributed data. Following this, data from 12 months pre-enrollment was compared to that of 12 months post-enrollment where data was available and using the paired t-tests and Wilcoxon Signed Rank test as described above.

FINDINGS

Sample Characteristics

Table 2 displays the demographic characteristics of the sample as reported via the demographic questionnaires. The average age of participants was 41.3 years and almost two-thirds were male (66.2%) and had never been married (64.6%). Most individuals self-identified as being Caucasian (75.4%). Just over a quarter of the sample (27.7%) stated having at least one child under 18 years of age.

With respect to mental health indicators, the most prevalent self-reported mental health diagnosis in the sample was a substance/addiction issue (55.4%), followed by mood disorders (47.7%) and anxiety disorders (33.8%). Furthermore, over half the sample had previously had a psychiatric admission (58.1%). Although 55.4% identified having a diagnosed substance-related disorder, 79.7% reported having a current substance/addiction issue. The most prevalent self-reported substance/addiction issues within the sample included tobacco (56.9%), alcohol (27.7%) and marijuana (24.6%). Almost the entire sample identified with having been homeless sometime in their lifetime (96.9%). On average, homelessness had occurred approximately 4.5 times during their lifetime, with the average age for first-time homelessness being 27.7 years.

TABLE 2 *Characteristics of the Sample (n=65)*

Characteristic	n (%)
AGE (YEARS) [MEAN (SD)]	41.3 (14.40)
GENDER	
Male	43 (66.2%)
Female	22 (33.8%)
ETHNIC GROUP	
European origins (i.e. Caucasian)	49 (75.4%)
Aboriginal	11 (16.9%)
Visible minority/mixed ethnicity	5 (7.7%)
LEVEL OF EDUCATION	
Grade school	26 (40.0%)
High school	27 (41.5%)
Community college/university	12 (18.5%)
MARITAL STATUS	
Single, never married	42 (64.6%)
Separated/divorced	17 (26.2%)
Married/common law	3 (4.6%)
Widowed	3 (4.6%)
Has children	38 (58.5%)
NUMBER OF CHILDREN UNDER 18 YEARS OF AGE (N=38)	
0 children	20 (52.6%)
1 child	10 (26.3%)
2 or more children	8 (21.0%)
Has custody of children (n=18)	1 (5.6%)
CURRENTLY EMPLOYED	
	5 (7.7%)
MENTAL HEALTH DIAGNOSES	
SUBSTANCE/ADDICTION ISSUES	
	36 (55.4%)
Mood disorder	31 (47.7%)
Anxiety disorder	22 (33.8%)
Disorder of childhood/adolescence	16 (24.6%)
Schizophrenia	11 (16.9%)
Post-traumatic stress disorder	9 (13.8%)
Personality disorder	6 (9.2%)
Other	1 (1.5%)
Mental health diagnosis present but type unknown	1 (1.5%)
Developmental handicap	0 (0%)
Organic disorder	0 (0%)
Has had a psychiatric admission (n=62)	36 (58.1%)
NUMBER OF PSYCHIATRIC ADMISSIONS IN PREVIOUS YEAR (N=35) [MEAN (SD)]	
	0.7 (1.37)
TOTAL NUMBER OF PSYCHIATRIC ADMISSIONS IN LIFETIME (N=30) [MEAN (SD)]	
	5.5 (7.62)
CURRENTLY HAS A SUBSTANCE/ADDICTION ISSUE (N=64)	
	51 (79.7%)
CURRENT SUBSTANCE/ADDICTION ISSUES	
Tobacco	37 (56.9%)
Alcohol	18 (27.7%)
Marijuana	16 (24.6%)
Prescription drugs	13 (20.0%)
Caffeine	12 (18.5%)
Other	11 (16.9%)
Cocaine/Crack	5 (7.7%)
Heroin	3 (4.6%)
Hallucinogens	2 (3.1%)
Has been homeless in lifetime	63 (96.9%)
AGE WHEN FIRST HOMELESS (YEARS) (N=61) [MEAN (SD)]	
	27.7 (13.43)
NUMBER OF TIMES HOMELESS (N=49) [MEAN (SD)]	
	4.5 (5.72)

QUESTION 1

The first question examined changes in health including housing stability as reported by individuals accessing London CARES. Question 1 was explored through interview and focus group data. The findings from these are discussed separately.

London CARES Participant Perceptions of Changes in Health and Housing Stability – Interview Findings Related to Question 1

While many (n=29, 50.8%) participants stated their needs were being met prior to engagement with London CARES (e.g. “perfect”; “not bad” and “pretty good”), just as many (n=28, 49.1%) participants indicated their health care needs were not being met prior to engagement with London CARES. Some attributed this to not having a family doctor (n=2), with being homeless (n=4) or with substance use (n=2), not being on medication (n=2) and not eating nutritious food or having access to enough food (n=2). Barriers to accessing health care included lack of transportation, difficulty getting a family doctor and “struggling with being able to get a health card.”

Poor health was often associated with being homeless, “struggling” to live on the streets or “going from shelter to shelter” and difficulty finding “somewhere to rest.” One individual stated “I have high blood pressure because of the lifestyle... [and I] don’t sleep good.” Others (n=2) associated poor health with their addiction/substance use. One participant reported “not using clean needles” and another was skipping scheduled appointments due to “use.” Not visiting health care professionals was a common theme in the open-ended questions and often related to the effect of addictions on mental health: “I was a drug addict, I wasn’t seeking help at all”; “I rarely went to the doctor”; “I was addicted to drugs a lot, I didn’t care about myself.” The stigma associated with addiction was also mentioned; one person found it “embarrassing” going to the hospital because they were labeled an “addict.”

Some participants (n=3) indicated their health had not changed since being involved with London CARES and a few mentioned that their health has generally gotten worse (n=7). Those who elaborated further stated this was due to substance use or mental health issues: “... some family things went down and I started using again... right now I’m just trying to get my stability back”; “my health has gotten worse. Not because of London CARES though.”

Overall, after involvement with London CARES participants indicated their health had improved for a variety of reasons (n=48). For some (n=8), this was associated with obtaining housing; “after I met them, it improved. They got me a place. I slept on the streets for 10 years.” For others better health was associated with reduced substance use, being “clean” or “no longer suffering from major addictions.” Participants also spoke about eating better and having access to food. Responses also indicated London CARES was aiding individuals in accessing health care (n=17) by connecting them to health care, providing transportation to appointments and advocating when working with health care professionals. For example, “London CARES has advocated for me in situations... I’ve been in because of my addiction and people in health care actually listen now.” Participants viewed London CARES staff as a support system, offering encouragement for them to see a health care professional and being seen as approachable and always being “there” to talk to, specifically in relation

to having an “urge” to use substances. One participant mentioned their mental health has been “stabilized” and another noted “...I have a place. The depression is less now. My lifestyle is better.”

The majority (n=51, 78.5%) of interview responses indicated housing needs were not being met before involvement with London CAREs; participants described themselves as: being “homeless”; “living off shelters”; “on the streets”; or “couch surfing.” Some (n=5) participants described themselves as being in and out of homelessness or being homeless for long periods of time, as one participant noted “I was homeless for a decade.” Participants described their housing needs as being met “poorly,” “bad,” or “barely at all.” A few participants expanded upon their difficulties in finding and/or maintaining housing. Only a small number of participants (n=2) indicated their housing needs were being met before involvement with London CAREs. Participants explained that London CAREs helped them to find or access housing and, in some cases, homes they would not have been able to obtain on their own. Specifically, London CAREs’ role in providing assistance with rent and advocating with landlords was discussed. For those who elaborated, this included rent subsidy, paying first and last month’s rent and setting them up with direct payment methods to help secure and maintain homes as well as making the housing affordable.

Practical assistance, such as arrangements with moving, was also mentioned, including renting a moving truck and physically helping the participant move their belongings. Participant responses indicated housing was good quality, of their choice and met the needs/wants of individuals, such as “they worked with me to find a place based on what I needed”; “they really rally to find you appropriate housing, and not the bottom of the barrel. They’re nice apartments with good landlords.” A couple of participants described how London CAREs ensured they had housing set up before they were discharged/released from jail or the hospital, mitigating their risks of re-experiencing homelessness and ensuring there isn’t a return to the streets or emergency shelter during this transition.

Participants commented how once they were housed, London CAREs staff worked with them to support their ongoing stability. One individual stated “they keep in contact with you to keep you stable.” Responses indicated they assisted with basic needs, such as support accessing food banks or ensuring food was in the apartment, providing assistance applying for ODSP and assistance with furniture and homewares.

Most participants (n=51) indicated their housing needs are being met and supported by London CAREs. Some participants (n=4) indicated that after their involvement with London CAREs they had yet to receive support in finding housing. A couple of participants indicated that, although they had received housing support, their housing situation had not improved due to poor quality or conflicting views with their London CAREs staff.

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London CARES Participant Perceptions of Changes in Health and Housing Stability – Focus Group Findings Related to Question 1

During focus groups responses were not counted since they were part of a discussion with many group members nodding heads or otherwise indicating agreement with issues raised. Where there was a divergence of opinion this was explored by the group facilitator. The discussions around this research topic tended to focus on the concrete help that was offered through London CARES to address barriers and some of the ongoing challenges still faced.

Issues related to substance use and other mental health concerns were other major themes of discussion related to changes in health. Dependent on participant objective, London CARES was viewed as providing support for individuals to reduce or abstain from substance use or ensuring they were using substances safely through harm reduction. Many participants reported not using substances anymore: “I had a seven year addiction and because of London CARES I’ve made it a year straight.” Feeling comfortable with their assigned London CARES staff member and having a positive supportive relationship meant participants could work on their goals related to their substance use: “I’m also addict [sic] and alcoholic so they’re helping me stay clean and good. Helping me with triggers and that” and “they don’t put us down for our drug use, they bring us needles when we need them at bad times. We can’t see anybody else bringing us needles.”

Participants also described an improvement in their general health. In particular, indicators of improved health included discussions around better access to food. Focus group participants described how London CARES helped them get groceries by taking them to a store or food bank, or by bringing groceries if they were unable to get them themselves. If necessary, it was reported that Meals on Wheels would be arranged, so meals are delivered regularly. A participant mentioned regularly having food now at home and no longer needing to access church or organization meal programs. One participant

commented on having gained weight as “before I was so thin.” This was mentioned in the context of a supportive relationship with London CARES and a decrease in substance use. Lastly, participants in the focus groups also described how London CARES assisted them to access health care, especially by providing transportation to appointments and picking up prescription medication.

In discussing changes related to housing stability, generally focus group participants reported London CARES helped them in accessing housing and “getting off the streets.” Assistance with maintaining housing was viewed as highly important in remaining stable: “I would have slipped, I would have gone right back to the streets... but she (London CARES staff member) was there for me” and “bounced around place to place, foster homes, group homes, whatever. This is the longest time in my entire life I have ever stayed in one place.” The barriers encountered related to housing support related to those with special needs and waiting lists. Gaining housing was commented upon as “slow,” particularly for “wheelchair access” or “if you have a criminal record”. Location of housing was an issue with “the only places they’ve shown me were remote.” This was a concern due to the lack of transportation and bus passes. Challenges experienced after being housed by London CARES included lack of furniture and being overcharged by a landlord who “said I damaged the place.”

Participants described how addressing housing and substance use then helped improve quality of life more generally. Participants described how London CARES has helped them or others gain control of their lives and increase their quality of life; “you get that little push, they can get you to where you couldn’t get yourself” and now they [participants] “take care” of themselves. As one participant described, he “wouldn’t be alive right now if it wasn’t for London CARES.” Another said, “it’s been about 15 months now I think with London CARES. Before that I was a hopeless junkie on the streets and they saved my life.”

QUESTION 2

The second question examined the difference in the use of emergency health services, emergency response and emergency community services before and after enrollment in the London CAREs program. The sources to address this question included the ICES provincial data, focus group data and the city's emergency shelter data.

Provincial-level Data

Provincial-level data showed no difference in the number of psychiatric-related ER visits for the sample group at six months post London CAREs involvement (1.8 vs. 2.5, $p=0.889$), but did show a reduction in psychiatric-related ER visits at 12 months post London CAREs involvement (6.4 vs. 4.9 visits, $p=0.038$), suggesting a longer-term positive impact. There were no significant changes in the number of all cause ER visits in the six month comparison (3.9 vs. 5.1, $p=0.783$) or the 12 month comparison (12.4 vs. 10.2, $p=0.171$).

Focus Group Data

Focus group data was more optimistic about reduction in emergency services than what was reflected in the provincial dataset. Comments from London CAREs staff focus groups reflected that emergency room (ER) visits would have been far greater if London CAREs did not do crisis response, that both the police and ER services were appreciative of the diversion and that some London CAREs participants known to be ER frequent users were now housed. Some of the highest users were unfortunately not in the sample group. Refusal to participate in the evaluation process can be a limitation to reflecting results as accurately as possible. The difference between the qualitative and quantitative data on ER use may reflect that changes may have occurred with a few key individuals who were high users of ER services. London CAREs key stakeholder participants commented that reduced ER visits were noticed from those stably housed. The highest frequent visitor to the ER was reported as having had 276 ER visits

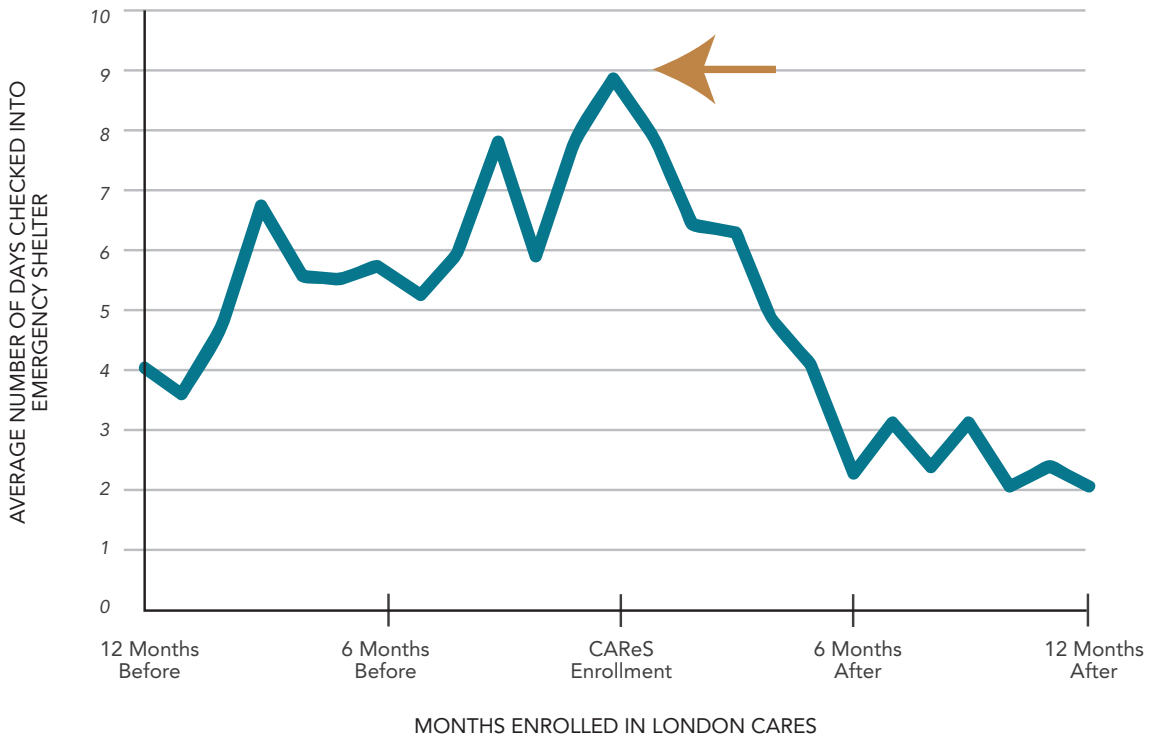
during the previous fiscal year and the next highest had 260 ER visits; that particular individual had not visited the ER since being housed. There was a drastic reduction in emergency department visits with eight of 10 particular service users tracked and it was commented that considerable savings could be had by reduced ER visits. For example it costs \$840 “just to register” and another \$250 “if coming by ambulance” and “something like 74% of frequent flyers come to the hospital using ambulance services.” Participants equated fewer ambulance responses with less police involvement. London CAREs staff facilitating home visits with primary care physicians also avoided ER visits. Key stakeholders observed London CAREs participants now attend the ER for more “medically appropriate reasons.” The reduction in a few key individuals’ use of the ER would create a reduction in health care costs, even if this small group was not statistically significant when added to the whole cohort.

The highest frequent visitor to the ER was reported as having had 276 ER visits during the previous fiscal year and the next highest had 260 ER visits; that particular individual had not visited the ER since being housed.

Monthly Emergency Shelter Bed Data

Monthly emergency shelter bed data revealed a decrease in the average number of days spent in an emergency shelter after first contact with London CARES (see Figure 2).

FIGURE 2 *Average Number of Days Spent in Emergency Shelter Before and After Enrollment in London CARES*



A noticeable drop in shelter night use by London CARES participants was also observed by the key stakeholder focus group participants, though they were not sure how much this might actually be due to being housed, as even when housed some individuals access crash beds because of issues such as loneliness or abuse.

QUESTION 3

The third question examined if there was an increase in the use of addiction and poor mental health prevention and treatment services after London CAREs enrollment compared to pre-intervention. Interviewed London CAREs participants indicated that prior to involvement with London CAREs they accessed a variety of services to meet their health needs, including visiting a physician (n=6), going to a drop-in centre or health care centre (n=8) or going to the hospital (n=5). Provincial agencies, such as Ontario Disability Support Program (ODSP) and Ontario Works were mentioned as services helping individuals meet their needs.

Initially, data from ICES was to be used to examine prevention and treatment services for addiction and mental illness. However, as treatment services for addiction are often community based and thus not attached to a person's OHIP (Ontario Health Insurance Plan) card, data on this aspect was not available through ICES. Consequently, the analysis focused on prevention and treatment for mental illness as defined by physician visits for psychiatric or any other reason.

There were no significant changes in physician visits between the six months before and after enrollment with London CAREs for either the average number of psychiatric-related visits (8.0 vs. 8.4, $p=0.889$) or visits for all causes (9.8 vs. 10.6, $p=0.476$). This observation remained true when comparing the numbers of physician visits both 12 months before and 12 months after enrollment with London CAREs for both the number of psychiatric-related visits (17.5 vs. 16.4, $p=0.560$) and visits for all causes (22.3 vs. 19.7, $p=0.325$). However, since the data that could be used for analysis through ICES was limited to physician visits this question could not be sufficiently answered.

The highest frequent visitor to the ER was reported as having had 276 ER visits during the previous fiscal year and the next highest had 260 ER visits; that particular individual had not visited the ER since being housed.

Discussion

London CAREs is reducing homelessness in London, Ontario by offering a collaborative community-based Housing First strategy. Through the support of London CAREs, participants who once experienced chronic and persistent homelessness are now obtaining and maintaining quality homes. Consistent with Canadian homelessness literature, London CAREs participants experience high rates of health challenges including physical, mental and addiction issues (Bharel et al. 2012; Forchuk et al., 2011; Goering et al., 2002; Hwang et al., 2013; Khandor & Mason, 2007). Self reports of improved health, better access to food, use of harm reduction strategies and, in some cases, reduced

substance use clearly outline the difference London CAREs has made in addressing health care challenges.

The decrease in psychiatric-related ER visits at 12 months after London CAREs involvement, but not at six months, suggests London CAREs' facilitation of service integration and community collaboration is effective at diverting individuals from psychiatric ER visits when introduced as a longer-term strategy. This diversion also suggests participants are having their mental health concerns addressed in the community and are avoiding unnecessary ER visits. The trend of increased physician visits at six months and decrease at 12

months post London CARES involvement may suggest participants' health care needs are being addressed early on. It can be suggested that stabilization of health care needs is occurring 12 months after first receiving support from London CARES, resulting in a trend of less physician visits.

Findings from emergency shelter data outline that with the focus on housing stability, London CARES is supporting participants in obtaining and maintaining quality homes and decreasing time spent in emergency shelters. For example, one key stakeholder observed a direct link "between housing stability and London CARES."

Diversion from the London Police Service was mentioned as London CARES often responds to participants in crisis. This is beneficial to the London Police Service as their resources are freed up to focus on other matters. The prevention of an unnecessary police contact benefits the participant by allowing for higher number of supportive responses from London CARES when considered more appropriate than enforcement.

A key component of the Housing First success is community integration (Gaetz et al., 2013). While participants did report increased stabilization and community involvement once housed, stigma was experienced by some and some reported experiencing difficulty "fitting in." This continued to act as a barrier to greater community integration and sense of neighbourhood belonging. Confronting stigma related to poverty, mental illness, addiction and homelessness continues to be an item to address. Increased community awareness and collaboration with agencies, neighbourhood associations and local businesses is helping to alleviate this. An additional effort taken by London CARES was the inclusion of a full-time recreation and leisure support worker to work with participants in engaging in meaningful neighbourhood-based activities and ultimately promote greater connection to their new surroundings. As well, London CARES has employed a recreational therapist to work with participants in engaging in meaningful activities to promote community integration. Another challenge has been the need to address a broad range of mental health issues in addition to substance-related concerns. This generally requires access to specialized services, which continues to be an issue for a number of participants and staff to navigate and gain access.

Limitations

Analyses conducted for this report were subject to several limitations. Firstly, the sample size meant that several of the quantitative analyses were underpowered (not sufficient information to be conclusive or to demonstrate significance). Only large effect sizes (i.e. drastic changes or differences) would have been able to achieve statistical significance (i.e. not just related to chance). Secondly, the information on emergency shelter bed usage was collected from a manual search through invoices received by the City of London. Thus, results are based only on individuals whose stay was paid for by the City and not those who were paying some room/board or staying at no charge such as crash beds and the Withdrawal Management Centre. Additionally, this analysis was based on the names and dates of birth of study participants, which may not be completely accurate due to individuals sometimes checking into emergency shelters with different names or dates of birth. Therefore, it is possible the number of days spent in emergency shelter is a conservative estimate for some individuals who may have checked in under a different name.

With respect to interview data, information collected was based on self-reporting, which may have led to underestimation of certain characteristics. For example, participants may not have accurately reported information pertaining to sensitive topics such as substance use, mental and physical diagnoses, and contacts with the justice system. This underestimation may also have occurred as a result of an inability to recall specific events as some questions asked the participant to think back in time. The open ended items on interviews were transcribed by the interview in situ and tended to be short answers.

Finally, as data at ICES often runs a year behind (i.e. October 2013 data became available for analysis in October 2014), only a six month comparison of data could be completed on all participants. Thus, the six months following enrollment in London CARES was compared to the same period of time prior to enrollment. Although a 12-month window was completed where available, the sample size for this sub-analysis was severely reduced and subsequently the analyses were underpowered.

CONCLUSION

The results from this evaluation further support the growing literature that Housing First approaches reduce community homelessness and support individuals in maintaining their homes. Improved housing and self-reported improved health outcomes were achieved through the support of London CARES. Diversion from psychiatric-related ER visits suggests participants are experiencing less mental health crises leading them to emergency services and greater contact with community-based supports. This decreases the strain on the health care system while supporting individuals in the community by preventing hospital visits. The decrease in visits 12 months after receiving support from London CARES but not at six months suggests Housing First approaches are successful when implemented as a long-term strategy. It should be recognized that implementation of Housing First strategies require a long timeframe and intensive supports before changes in health and housing outcomes are seen. Future research should take this into account and set up longitudinal evaluations in order to capture these changes. This is consistent with other Housing First research demonstrating that when working with individuals identified as persistently homeless with complex and co-occurring challenges results require long-term supports to be in place in order to see indicators of stabilization and decreased experiences of crisis.

Results of this evaluation prove Housing First strategies can be implemented and be successful in mid-size Canadian cities. To the knowledge of the authors, there is no other Housing First four-pillar approach that has incorporated the additional fifth pillar of community collaboration.

Addressing homelessness requires a community collaborative response due to the complex challenges facing individuals and families experiencing chronic and/or persistent homelessness. The London CARES approach outlines the need and success of facilitating a coordinated, unified strategy engaging various service providers, businesses, residents and individuals with lived experience in delivering the strategy. London CARES is an example of successful implementation of a five-pillar Housing First approach, and can be a leader for other mid-size Canadian cities looking to develop and introduce a community response to homelessness.

Practitioners, such as London CARES staff, often carry caseloads with individuals and families with quite

complex and co-occurring issues which necessitate prioritizing needs. In some agencies a small number of individuals require a disproportionate amount of contact time with support staff. Interventions within a homeless prevention system can be based on assessing risk and prioritizing responses. Individuals and families with low risk of homelessness may receive less intensive interventions while those at higher risk may receive higher focus (Homeless Prevention System, City of London, 2013). This is particularly so in the area of addiction and poor mental health which affects many homeless individuals and where relapse is often an ongoing concern. The results of this study highlight the lack of stable housing as a major risk indicator for both relapse and the extensive use of limited social service and health resources. However, when individuals have a safe place to live and feel connected to their community, the ability for them to readily engage in a broader change process is more likely to occur than while in a state of homelessness.

In the evaluation of London CARES, housing stability was a determinant which improved health issues,

including a reduction in substance use and helping participants to access health care professionals by providing information and resources. The reduction of costly ER visits impacts the cost effectiveness of the program. Furthermore, homelessness is associated with stigma and oppression. Having a fixed address is a substantive step toward re-establishing the dignity and self-worth that form the foundation of an individual's identity. Thus, individuals who have stable housing are more likely to be successful in achieving goals to address other life issues whereas those who remain homeless are more likely to require extensive services that produce little progress, impacting the ability to deliver service

throughout the entire system. This then also necessitates the need for practitioners to advocate for programs like London CARES in order to be able to better meet individuals' needs.

The contribution of this evaluation to the literature on homelessness, poor mental health and addictions in Canada and, more particularly, to individuals, practitioners, health and social care agencies and society in general, is that as Housing First is proven to address and reduce homelessness, it would be prudent for all levels of government and municipalities to adopt this approach to ending homelessness in Canada.

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