ShelterCare: The Integration of Health and Housing Services as an Evidence-Based Shelter Model

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Introduction

Homelessness is a multifaceted issue which is incredibly prevalent across Canada. It was estimated in 2016 that at least 35 000 individuals experience homelessness on any given night, with more than 235 000 Canadians every year (Gaetz et al., 2016). This estimate does not include 'hidden homelessness' which is thought to be up to 50 000 people per night nationwide encompassing those who do not have permanent housing and temporarily stay with friends, relatives, in their vehicles, or other undocumented spaces, avoiding unsheltered homelessness (Gaetz et al., 2013). Due to the Covid-19 pandemic, routine homelessness enumerations have been delayed, although studies have projected a rising incidence in homelessness since the onset of the pandemic with estimated continued growth considering the impeding recession if no effective interventions are implemented (Falvo, 2020). This issue runs deeper than lack of stable housing as there are many social, economic, and systemic barriers faced by individuals who experience homelessness, making it a complex problem which requires comprehensive solutions. Of utmost concern, are the severe health impacts of poor housing and homelessness.

Individuals living in extreme poverty face greater chronic stress and have increased exposure to environments that threaten health. Canadians in the lowest income group are 3 to 4 times more likely to have poor to fair mental health (Mawani & Gilmour, 2010) and a 21-year reduction in life expectancy (DeLuca et al., 2012) than those in the highest income group. Those of low socioeconomic status are more often subjected to environments with greater uncertainty and conflict, traumatic events, and face more adversity which is detrimental to overall health (Kim & Cho, 2020). Being faced with excess adversity, but with access to less resources, puts significant strain on emotional wellbeing which manifests into higher prevalence of mood, anxiety, and substance use disorders as well as deteriorated physical health (Hao & Farah, 2020). Morbidity and mortality rates in homeless populations are significantly higher than housed Canadians, with higher prevalence of chronic health and mental health conditions (Ramsay et al., 2019). Homeless populations have been described in literature as being vulnerable to the 'tri-morbidity' of social marginalization being mental illness, addiction, and physical illness highlighting the main health risks associated with homelessness (Gicas et al., 2020).

These health disparities have negative impacts from an individual level, but also places disproportionate burden on our public healthcare systems. The higher prevalence of chronic health issues and medical complications amongst this population manifests into higher rates of emergency department visits placing a higher strain on emergency care services and hospitals. Higher rates of mental health disorders and substance use also contributes to greater need for emergency health services (Macnaughton et al., 2016). Studies have found people experiencing homelessness present to emergency departments over 8 times more often than matched control cohorts and have higher rates of readmission (Xie et al., 2022). Using emergency department visit data, Statistics Canada reviewed the demographics and geographic distribution of people experiencing homelessness across Ontario, concluding that homelessness is rising, especially in younger adults, and expanding outside of typical urban centres demonstrating the widespread implications of this issue and the increasing pressure on local community health services (Strobel et al., 2021). Homelessness poses complex healthcare needs and standard emergency departments may not sufficiently address the health issues present. There are many barriers to accessing adequate primary healthcare for the homeless population, including stigma and discrimination, insurance, lack of valid health identification requirements, lack of transportation, and navigating multiple healthcare service types when requiring multidimensional care (Ramsay et al., 2019). One study in Ontario found that only 28% of individuals experiencing homelessness in their sample group had a primary care provider in town and reviewed past literature which varied up to 56% of participants depending on the region (Gilmer & Buccieri, 2020). In Toronto, Ontario it was found that the chances of having a designated primary care provider decreases with each additional year spent homeless making it incredibly difficult to engage in health services (Khandor et al., 2011). These major obstacles to accessing primary care often leads to reliance on public emergency care and walk-in clinics which has been found to worsen health outcomes with higher rates of morbidity and premature mortality (Andermann et al., 2020). Lack of stable housing therefore decreases overall quality of life, exacerbates chronic health conditions and medical complications, and presents significant barriers to health access which negatively impacts individuals who experience homelessness and public healthcare systems.

Homelessness requires immediate interventions and should be a priority for all governing bodies in Canada but, as housing is a key social determinant of health, it should be a critical priority for health and healthcare decision makers. With the multitude of proposed models and pilot projects being conducted to address health inequities afflicting the homeless population, which solutions have promising measurable benefits and should be prioritized by health policymakers? Our current homelessness interventions focus on emergency and acute services to address a largely chronic problem. Emergency shelters are the most common and accessible shelter option across Canada which involves temporary, short-term accommodations. Emergency shelters sometimes offer other resources like food, clothing, or counselling, but many have reduced hours, only operating at night to provide a place to sleep (Employment and Social Development Canada, 2018). It has been suggested by health researchers that integration of healthcare services like mental health, substance use, primary care, and community health outreach could lead to better health outcomes and significant improvements to health access for homeless populations (Zhang et al., 2018). The onset of the COVID-19 pandemic necessitated the expansion of non-congregate shelters to accommodate social distancing and effectively control infection transmission. Low-barrier, non-congregate housing was an emergency response taken by multiple municipalities across Ontario and Canada to address these unprecedented public health concerns, and previously unavailable emergency funding allowed for development of these initiatives, providing promising results (Elliott et al., 2022). One model in particular, termed ShelterCare, took a coordinated community approach integrating intersectoral partnerships into a non-congregate, 24/7 shelter model allowing their clients access to counselling, medical experts, harm reduction and other public health resources, housing, and community social services all within the shelter walls.

This paper will review current housing and shelter interventions and evaluate the overall improvements to health and quality of life of the homeless population. Based on currently piloted housing initiatives and comparing to previously explored solutions, the ShelterCare model will be reviewed in-depth for its impact on health. The perspectives and impact of key stakeholders will be considered including municipal and provincial governing bodies, regional public health, hospital, and community health officials, related non-profit and

community advocacy leaders, social services sector, and clients themselves, as cross-sector collaboration is required to effectively implement this intervention. An approach to engaging with these stakeholders as well as a model for continuous evaluation of its impacts will be outlined, highlighting the gaps this service would fill and how it could be implemented effectively.

Evidence Analysis

To comprehensively support this model, an analysis of the available evidence considering the hierarchy of evidence is required. As noted in a systematic review from 2021, there is limited research evaluating the interrelationship between housing and health with a structured, high-quality methodology for systematic appraisal, even with the World Health Organization acknowledging housing as a determinant of health and declaring adequate housing as a basic human right (Alidoust & Huang, 2021). A similar systematic review from the Cochrane Database of Systematic Reviews assessed this relationship by evaluating health and social impacts on residents following improvements to the physical material of their housing, demonstrating that even enhancing thermal comfort can significantly improve overall health and wellbeing of residents (Thomson et al., 2013). The link between poor housing and poor health can be supported by reviewing access to adequate shelter in terms of infrastructure and health outcomes, but other research has evaluated how homelessness impacts access to various external health services. A study conducted in Niagara Falls, Ontario investigated key barriers and facilitators to accessing health care for those experiencing homelessness, attempting to gather evidence to support patient-centered policy reform and better health advocacy for marginalized populations (Ramsay et al., 2019). This report found multiple recurring barriers amongst participants, with the main themes being affordability, lack of available family physicians, incongruous psychiatric models of care, lack of trust with health care providers, transportation, and poor therapeutic relationships (Ramsay et al., 2019). Like many Canadians, those experiencing homelessness cannot obtain a family physician, making it incredibly difficult to receive primary care. Individuals experiencing homelessness are also more likely to have complex health needs that require multifaceted care that is difficult to navigate.

Other participants discussed experiences of stigma and discrimination, with health care professionals often acting dismissive of their health issues, ignoring requests, not providing information on other health supports, and lacking empathy leading individuals to completely avoid health care settings. Another systematic review investigating experiences of health- and social care amongst the homeless population found similar results, emphasizing the need for more information on the specific barriers and facilitators that affect access to care when it is widely reported that the homeless population has unmet healthcare needs. One of the key conclusions of this systematic integrative review was that current shelter systems still require individuals to prioritize acquiring basic human needs, which takes precedence over pursuing health- and social care, therefore forcing persons experiencing homelessness to neglect their health (Omerov et al., 2020). Omerov et al. further concluded that interaction with health- and social care providers was critical when experiencing houselessness, due to the higher need for support and likely lack of social network, recommending a team-base, multidisciplinary approach to provide collaborative and flexible healthcare options for those experiencing homelessness. Ramsey at al. identified corresponding facilitators of care-seeking including centralization of services, community healthcare outreach, and competent care providers for the population to reinforce positive relationships with health systems. Their final recommendation attempts to address all these facilitators to health care, suggesting implementation of shelters coordinating health care through greater collaboration between shelters and other community supports but also through integrating co-located, shelter-based clinics to address the barriers of trust with healthcare providers and systems, transportation, and continuity of care which allows providers to build rapport and foster positive relationships (Ramsay et al., 2019). The ShelterCare model strives to fill many of these gaps and lean on the facilitators identified in the literature, paralleling the guidance from Ramsey et al., better integrating health services into shelter models themselves.

Although similar models were envisioned for quite some time, the COVID-19 pandemic created the perfect storm for implementation and further development of the framework. COVID-19 disproportionately impacted persons experiencing homelessness necessitating additional funding to protect this high-risk population and provide suitable shelters with

reduced risk of transmission (Elliott et al., 2022). One of the interventions implemented offers low-barrier, non-congregate shelter with intersectoral partnerships integrated into on-site programs including housing support, medical services, addictions support, harm reduction services, and other social supports, termed ShelterCare, which has demonstrated incredible promise since the onset of the pandemic. Due to the novelty of this model, there is limited evidence specifically evaluating ShelterCare especially with high-quality, comprehensive methodology like systematic reviews. There is preliminary evidence and local results described in peer-reviewed journal articles or grey literature provided by community organizations, and the evidence synthesis of systematic reviews on topics relevant to this intervention can also be applied. Preliminary outcomes were described in a research study being conducted in two mid-sized cities in Southern Ontario, demonstrating that the initial intention of these community-based COVID-19 responses, to reduce spread of the virus, were successful, but of greater interest, this intervention has shown to have broader health and social benefits (Elliott et al., 2022). The rapidly evolving COVID-19 pandemic required community collaboration to establish shelters where physical distancing and isolation could be possible in an incredibly short timeframe, leading to many of these programs being run out of motels, hotels, and community spaces. An analysis report was released by the University of Washington reviewing hotels used as non-congregate emergency shelters, providing key insight into this model across North America. Their services needed to be expanded to be available 24/7 as well as either reducing capacity or moving to bigger spaces to 'de-intensify' the environment and create a safer environment amidst the pandemic. Non-congregate shelters found this model effectively reduced the spread of COVID-19, but also improved client stability, greater program engagement, noticeable improvements in health and wellbeing, and reduced interpersonal conflict (Colburn et al., 2020). Unlike typical emergency shelters where beds are crammed to maximize intakes and are only to operate as an overnight refuge, non-congregate models provide assigned rooms with one or two roommates as opposed to over six in traditional models, allowing residents a sense of privacy, dignity, and security. Interpersonal conflict and violence are common in shelter settings, leading to restriction of services and impact health due to injury, trauma, sleep disturbances, and more (Agrawal et al., 2019). Providing privacy as

well as personal space dramatically reduced violence and conflict, effectively lowering anxiety and tension amongst residents and improved community and trust (Colburn et al., 2020). This shelter structure also mitigates previous barriers to care, as a key deterrent is the focus on procurement of basic human needs, but the consistency, safety, and 24/7 service fosters stabilization and the ability to focus on the deep-rooted social and health needs being neglected. All of these improved outcomes empower individuals, with reports of greater focus on future goals and higher rates of exits from shelter to permanent housing (Colburn et al., 2020). Although some may argue that the average length of stay per client increases with ShelterCare, it is important to consider that a modest increase in shelter stay duration is preferred if it means more stable permanent housing outcomes are achieved, combating episodic homelessness and its associated health consequences.

Some of these improvements to wellbeing have been observed with other initiatives addressing houselessness as well. The Housing First model is often cited for its rapid reduction in houselessness and increased residential stability, especially due to its emphasis on autonomy and providing barrier-free housing without preconditions like abstaining from drugs or alcohol (Hwang et al., 2012; Parsell et al., 2020). Multiple systematic reviews have been conducted on the Housing First initiative, all deducing similar conclusions that this approach effectively improves housing stability and has moderate evidence of improving some aspects of health short-term (Baxter et al., 2019; Chambers et al., 2017). These reviews also emphasized the need for additional research and continuous evidence synthesis as current studies available have a high risk of bias with imprecise measurements of health and limited long-term health data (Baxter et al., 2019). Many studies were also found to have poor reporting, lack of blinding, or poor randomization of data collected (Menzies Munthe-Kaas et al., 2018). Another systematic review analysing the correlation between wellbeing and various housing interventions concluded similar benefits of Housing First, but also that there is only moderate evidence supporting improvements in personal wellbeing, mental health, and locality-related wellbeing as well as an absence of strong evidence supporting benefits to personal finance and community wellbeing (Chambers et al., 2017). There has been studies conducting comparisons of Housing First, assertive community treatment, intensive case management, and currently

implemented substance use treatment plans showing no significant differences in severity of mental health symptoms, self-rated mental health status, wellbeing, quality of life, or substance use (Onapa et al., 2022).

The current housing climate is also a significant barrier to the Housing First model as the rate of homelessness is exceeding the previously available housing options, and inflation, especially in the rent market, makes affordable housing unattainable especially when relying on social support and housing initiative funding (Doberstein & Smith, 2015). Other studies have also suggested that housing services may not be sufficient in reintegrating individuals who have experienced chronic homelessness, especially those with mental health issues, and are less likely to retain permanent housing leading to recurring episodic houselessness (Hyun et al., 2020). A systematic review article outlining the physical and mental health effects of housing on those experiencing homelessness and concurrent mental health issues found that direct placement into housing can improve quality of life, wellbeing, and general physical and mental health, but only with access to support services (Onapa et al., 2022). Multiple reports outlining limitations of Housing First principals state that many people in the program require ongoing support that exceeds the capacity of support workers and the programs themselves, putting an unrealistic timeline on when program participants should be ready to 'graduate' and live completely independently which can lead to housing loss following graduation (Noble, 2015). Although promising in theory, the Housing First model has many limitations especially in today's housing climate, and as discussed in a systematic review by Woodhall-Melnik and Dunn, the evidence base for this intervention is not sufficient for unilateral implementation in addressing chronic homelessness (2015).

Although also with limited evidence, the ShelterCare model may be an effective intervention to address these limitations. Based on the Waterloo Region's House of Friendship organization ShelterCare Evaluation Framework, the goals of the program can be considered in comparison to gaps within other housing interventions (2022). The main theory of change states the goals of the program are to:

- Support individuals in securing permanent housing, making their experience of homelessness as brief as possible;

- Support improvement of health, wellness, and life skills required to be successful in the program and remain housed; and
- Ensure that people have the skills, connections, and supports required to remain housed after leaving the program (Olusola Alabi et al., 2022).

Considering these goals, a key improvement in this model is the emphasis on skill development and addressing the many disadvantages chronically homeless clients must overcome. Housing First does attempt to target the highest acuity individuals, but a major drawback is the extensive support required to set participants up for success in non-supportive housing options and gain the tools to access supports on their own. It should be noted that the ShelterCare evaluation framework explicitly notes that this model does not intend to oppose Housing First principles, but instead recognizes the gaps in this model, and adapts the program to better meet everyone's needs. ShelterCare attempts to end episodic and chronic homelessness by addressing deep-rooted barriers to maintaining permanent housing, fostering growth and meeting individuals where they are at, so they acquire the skills required to maintain housing after being in survival mode for so long (Baxter et al., 2019). Unlike treatment first models, ShelterCare does not require adherence to treatment programs such as abstaining from substances to acquire housing services. The service philosophy of Housing First is foundational to the ShelterCare program being person-centred, strengths-based, recovery oriented, and applying harm reduction principles (Olusola Alabi et al., 2022). In this housing climate, the ShelterCare model would therefore provide a dignified, holistic housing option while improving wellbeing of clients to better prepare them for permanent housing when it becomes available. As reported by the Region of Waterloo, the wait time for community housing is currently between 3 to 8 years, as the demand is far exceeding affordable housing availability, and the ShelterCare model can fill this gap as more permanent housing options become available (Region of Waterloo Housing Services, 2023).

The deficit in community wellbeing and insufficient psychological support observed in Housing First interventions can also be addressed in the ShelterCare model. A systematic review and meta-analysis of randomized control trials evaluated the impact of psychosocial interventions in homeless populations, demonstrating the reduction in anxiety and

enhancement of mental health status that can support long-term permanent housing (Hyun et al., 2020). It is well-studied that social interaction plays a role in individual wellbeing, making the non-congregate yet communal setting of ShelterCare ideal for broadening social networks while engaging in different social supports available (Cummings et al., 2022). Higher intensity case management is also integrated within this model, which has been recommended as an initial step to reengagement with primary care to get thorough assessment and receive direct facilitation of engagement with appropriate health and social services (Menzies Munthe-Kaas et al., 2018). In the Waterloo Region ShelterCare pilot, the case management approach almost reflects assertive community treatment as it involves a multidisciplinary team of community-based services providing direct care on-site and allows for 24-hour service, which has been supported by meta-analyses to reduce homelessness and improve severe mental health conditions (Coldwell & Bender, 2007). A clinical guideline developed focusing on homeless and vulnerably housed populations recommend integrating intensive case management along with psychiatric support and harm reduction services like supervised consumption facilities, opioid agonist treatment, and needle exchange programs amongst other harm reduction measures (Pottie et al., 2020). Current shelters following the ShelterCare model have integrated consumption and treatment services directly on-site, with both the Waterloo and Ottawa integrated health shelters demonstrating significant benefits by including these services. In Ottawa, the implementation of a supervised consumption site with healthcare professionals has been estimated to have diverted 933 individuals to their shelter by emergency services instead of utilizing hospitals and jails during the 2020-2021 fiscal year, as well as have reversed an average of 1.2 overdoses per day (Shepherds of Good Hope, 2022).

Overall, preliminary reports of non-congregate hotel shelters and official ShelterCare pilot programs have demonstrated the potential for improving obtainment and maintenance of permanent housing, physical and mental health outcomes, and empowerment of marginalised individuals, addressing many limitations seen in other housing interventions and providing a safe, feasible interim solution to fit the current affordable housing crisis, inflation, and public health opioid crisis. The At Home/Chez Soi (AHCS) project was critical to development of these programs, but as stated in a review in the Canadian Journal of Psychiatry, these trials

demonstrated that integration of substance use and addictions support, vocational training, and social opportunities into Housing First programs would be necessary to improve non-housing outcomes, and there should be other interventions developed for individuals who are not successful in the current Housing First model (Aubry et al., 2015).

Change Management Approach

The implementation and diffusion of this model is critical to its success and wider long-term impacts on national homelessness intervention strategies. The initial 10 years of Housing First implementation was very successful, as they utilized intentional knowledge translation practices and its trajectory was carefully calculated to have bigger policy impacts. Although the pandemic and other current social, economic, and infrastructure-related setbacks have made Housing First infeasible for many communities, their knowledge translation strategy still provides appropriate guidance for implementation of ShelterCare and establishing the model as an evidence-based intervention.

Initially, I would suggest pilot models in various locations with varying environments, populations, and services available, similar to the At Home/Chez Soi (AHCS) project conducted to trial the Housing First model. Researchers conducted a randomized controlled trial applying Housing First as well as typical housing intervention treatment as a control with over 2000 participants experiencing chronic homelessness from Vancouver, Winnipeg, Toronto, Montreal, and Moncton over two years (Goering et al., 2011). These cities were chosen to evaluate specific sub-populations as Vancouver had higher levels of substance use than other cities, Winnipeg has a higher urban Indigenous population, Toronto includes a wide variety of cultures with a higher proportion of new immigrants, Montreal provides a dominant Francophone population, and Moncton is a smaller community that may better represent rural settings and settings outside of city centres. In a similar methodology, I would conduct a trial of the ShelterCare program but in a greater variety of settings, for four years, and would implement as many as the budget would allow. I would want to include more mid-sized cities, a greater variety of smaller towns, rural communities, and remote areas as these communities are all unique and differ quite significantly in need. A location in Northern Ontario, the territories,

more regions with high levels of substance use and addictions like Kingston, and some programs specializing in Indigenous populations would provide a better representation of how the program can benefit the diverse populations in Canada. Although I would prefer to implement these services across the entire country to help those in need as soon as possible, this is obviously not feasible or realistic in gaining stakeholder support. Implementing waves of the project would therefore be a more pragmatic approach, starting with as many projects as possible, but then as outcomes supporting its implementation arise within the first wave of pilot projects, further development and expansion of the program can be implemented across the country with increased social and political support. It is key in pilot projects to be cognizant of sustainability from the onset of the project, having thoughtful and intentional knowledge translation methods developed. The AHCS project utilized what they called integrative knowledge translation throughout their pilot project which relies upon the relationship between researchers and knowledge users and emphasizing an educational approach as opposed to an advocacy approach when working with policymakers. Involving researchers external from the project was important for the emphasis on education as decision-makers often hold evidence from trusted researchers at a greater value than from organizations themselves (Macnaughton et al., 2017).

The main goal of integrative knowledge translation is to sustain evidence-based programs following a research demonstration period for further scaling out or scaling up of the programs to other settings. The AHCS project enlisted the Mental Health Commission of Canada to act as a third part in gathering and synthesizing the data, which was beneficial as it is a non-profit created by the federal government so supports both federal, provincial, and territorial governments as well as community organizations in public policy implementation (Mental Health Commission of Canada, 2021). This provided an outside agency to disseminate the evidence in a way the government nor the Housing First leaders could not have accomplished on their own, connecting the two groups and framing results effectively in a government context (Macnaughton et al., 2017). Partnerships with the Canadian Alliance to End Homelessness and the Homeless Hub were also utilized to convey consistent and impactful messaging throughout the project. It should be recommended to integrate similar partners in

the initial research process of ShelterCare, including the Canadian Observatory of Homelessness, the Canadian Centre on Substance Use and Addiction, CAMH, and other local university and research institutes in the trial centers, ensuring the evidence gathered would be framed for greater policy applications and have more influence on housing intervention nationwide. This method will allow for smoother translation from research to policy, which will subsequently allow for growth past the pilot stage and greater change diffusion.

When initiating the research process, various working groups and advisory councils should be formed to get a variety of perspectives and engage key stakeholders from inception. In each community the pilot project is being conducted, there should be a working group and/or advisory board made up of community leaders, individuals with lived experience, frontline shelter workers, medical professionals, policymakers, other social service providers, and members of vulnerable populations like Indigenous and Francophone leaders to provide a variety of perspectives, develop the program to better support each individual context, and gain the support of key stakeholders. There should also be a national board including a representative from each involved community to create a sense of connection and share problems faced, solutions implemented, and interim updates that could benefit all programs. Key housing intervention leaders should be involved like Tim Aubry and Geoff Nelson from The Canadian Housing First Network Community of Interest, or executive directors from successful ShelterCare programs like John Neufeld from the Waterloo Region or Deirdre Freiheit from Ottawa. These working groups would aim to keep the research relevant to the interests and concerns of stakeholders, producing higher-quality evidence following the study that better addresses the target audience as well as gain support from critical stakeholders (Macnaughton et al., 2017). The advisory councils in conjunction with research institutes would allow for diverse engagement with the program and develop comprehensive evidence to support the ShelterCare program.

During this pilot project, continuous analysis and synthesis of the program's outcomes would need to be conducted to develop preliminary and interim reports providing updates throughout the research process. These interim reports will provide adequate updates to key stakeholders and provide a greater extent of evidence to later be synthesized into a systematic

review for evaluation with high-level research methodologies, further supporting the intervention as evidence based. Societal support would also strengthen the case for political and subsequent financial support, making it critical to involve the community in fundraising efforts, educational opportunities, tours of new spaces, and sharing the data and stories of clients to translate the impacts of this intervention in an emotionally driven manner. The House of Friendship attempted a similar approach by producing a ShelterCare specific website that includes the principal components of the ShelterCare program, easily digestible statistics on measurable outcomes of the program, and both video and written interviews of participant stories. I would recommend the implementation of a similar approach, but instead of creating a separate website for this information, I would include it as a page on the current local organization's website for easy access and include a variety of resources including yearly reports, summary reports, fact sheets, interactive maps of currently available programs layered on a heat map of homelessness density across Canada, and case studies tied to interviews or videos with program participants. Using multiple mediums, the knowledge being gathered can be accessible to researchers, policymakers, partner organizations, the general public, and those in need of services (Canadian Centre on Substance Use and Addiction, 2012). Public support influences political decision-making, and if the benefits of the program are understood and advocated for by the public, it will be of higher priority for key stakeholders. Social media should also be used as a tool to spread information to more populations and create partnerships with key community advocates like the On Canada Project to reach younger populations. Creating a podcast sharing the stories of individuals impacted by ShelterCare would also humanize the issue and produce a deeper social impact. It could be attempted to partner with popular podcasts to share stories of our program participants, emphasizing the positive outcomes the program can have firsthand, or an individual podcast channel could be developed to interview participants themselves as well as important community partners that can discuss their work within the project and how it has made a difference in their community. Public media in combination with ongoing data collection and evidence synthesis would therefore be imperative to ensuring sustainability of the program following pilot projects.

When reframing the Homelessness Partnering Strategy in 2017, Employment and Social Development Canada engaged with a wide breadth of stakeholders forming an Advisory Committee on Homelessness. During these consultations, a common issue raised was that success implementing the Housing First model heavily relied upon on housing being available, and that clients often have complex mental health and substance use issues that require high levels of clinical supports not accessible with Housing First methods (ESDC, 2018). These concerns led to the removal of Housing First investment targets to allow for adaptations to the model and use funds dependent on local community needs. The ShelterCare model would allow for greater adaptability, due to its dependence on community collaboration and intersectoral partnerships (Elliott et al., 2022). For implementation of the pilot project, a ShelterCare model framework package should be distributed that includes staff training resources, exemplar model frameworks, and data collection, evaluation, and auditing guidelines. As a first step, integrating pilot models in hotels, motels, or other community spaces like college/university dormitories available in these communities for a one-year trial period, similar to what occurred during the pandemic for many shelters, would allow the community to observe outcomes and alter the services to better fit their unique populations. The House of Friendship ShelterCare program in Waterloo, Ontario had a similar trajectory which was essential for its success. Although the pandemic was its window of opportunity as congregate shelter options were high-risk for COVID-19 infection (Chapman et al., 2021), a similar model of change could be applied now that preliminary results from these programs have surfaced. In their program, the beginning of the pandemic was spent in a local hotel with medical and social supports on-site which demonstrated enhanced care provision (Elliott et al., 2022). When broad health and social benefits were being observed after a few months, participant stories were shared publicly and connection with other community partners was prioritized. Their efforts were well-received as they achieved a 1-year agreement with another local hotel to move their program and continue developing the program further than it could be envisioned in their current space. Although they encountered a few unforeseen hurdles, the evidence they gathered was effectively communicated to decision-makers and they were able to buy a permanent location for ShelterCare, purchasing a hotel in the area and renovating the space to better suit the

clientele in Waterloo Region. A medical clinic, housing hub, safer use program with consumption and treatment services site, a dining hall, as well as fully accessible rooms were developed all renovated utilizing trauma-informed design (Olusola Alabi et al., 2022). Involvement of various community services are therefore required to make this program effective. Local organizations that have an in-depth understanding of the population and community needs would lead to more comprehensive care and improved outcomes. For example, the health clinic integrated into the Waterloo Region shelter was operated by a community health clinic partner providing RPNs with extensive expertise in poverty medicine and strong rapport with the homeless population. This was invaluable to the program as it has been found that primary care programs specialized for these populations are more effective than standard care, and practitioners with experience applying anti-oppressive and trauma-informed care principles can promote acceptance, equitability, and effectiveness of care for marginalized populations previously subjected to dehumanization and structural violence within health institutions (Magwood et al., 2019). Studies reviewing this relationship found significant decreases in overdose events, emergency service calls, emergency department visits, hospital admissions, and psychiatric-related emergency events (Fleming et al., 2022), benefiting the entire community.

These results highlight the plasticity of this model and ability to integrate local services that are impactful for the unique populations across Canada. This example made intersectoral partnerships with community health organizations, pharmacists that dispense opioid agonist treatments, ID specialists, housing and employment services, and addictions services, along with hairdressers, music therapists, and acquired brain injury specialists. In communities with higher levels of Indigenous populations, these services could be personalized to include traditional medicine and services that work with Indigenous cultural values and languages, better supporting their clients (ESDC, 2018). In communities without withdrawal management services available or safe consumption sites, these programs could be implemented into the ShelterCare program and address issues at a local level. The pilot portion of this project is therefore crucial to ensure the solution will fit the audience, community, and social system it is

being applied to, similar to how the Waterloo Region's model was implemented and then altered as needed.

Evaluation

Once the program is established and adapted to support its community needs, consistent evaluation and evidence-informed practice needs to be implemented to assess the impact of the program and revise the framework as needed. The overarching goal of the ShelterCare program is to improve the health and wellbeing of individuals experiencing houselessness, and to address the plenitude of systemic barriers that perpetuate the cycle of homelessness (Olusola Alabi et al., 2022). One of the key philosophies outlined by community researchers is to highly value the voices of people with direct service and/or lived experience to ensure the program adequately addresses the needs of service users. Applying the community based participatory research framework, the research methodologies, identification of needs, intervention design, measures of effectiveness, and target outcomes are produced collaboratively with stakeholders (Franco et al., 2021). Key stakeholders would first be established through a literature review, and then extended through consultation with gatekeepers including community leaders, health administrators, related non-profit organization leaders, and other local change agents identified by the advisory councils. Annual semi-structured interviews one-on-one with each stakeholder would be conducted to assess outcomes and identify gaps in the current program. Written surveys could be conducted annually amongst shelter users which case management workers would execute to ensure understanding of the survey and that it is accessible to all participants. This will result in lower quality data but will provide the opportunity for residents to give honest feedback that can be utilized for future interim reports. Standardized surveys across all pilot projects will increase the quality of evidence due to the greater sample size and diverse perspectives collected. These routine stakeholder engagement strategies will continue to keep stakeholders actively involved and ensure that all involved parties are aligned in the direction of the program (Macnaughton et al., 2017). Communication throughout the process with appropriate adjustments to the

intervention fosters a relationship between service providers and decision-makers, improving sustainability of the pilot project long-term.

Stakeholder engagement must also be coupled with standard measurable outcomes to quantitatively assess effectiveness of the program. Participant surveys would provide some measurable outcomes on self-reported wellbeing, perceived access to services, and overall quality of life. Housing outcomes will also be fundamental to program evaluation including enumeration of clients becoming permanently housed, length of stay in the program, returning service users, and engagement with housing supports (Olusola Alabi et al., 2022). If successful, the number of clients securing permanent housing should increase and a reduction in returning clients and housing loss of past participants. The length of stay is less straightforward, as stated earlier, a modest increase in shelter stay in comparison to standard shelter programs can still be a success if it results in more stable permanent housing outcomes.

Due to the program's key goal in improving the health of its users, various measures of health should be routinely measured. Hospital admissions, drug overdose fatalities, emergency department visits, calls to emergency services, pharmaceutical adherence, and greater engagement with health care support are all measures that can evaluate the impact of the program on health of clients. All of these measurements can be translated to cost savings due to reduced emergency service use, prevention of future costly health complications, and reduced reliance on acute health services with access to primary health care services. Data collection throughout the entirety of the pilot programs must therefore be prioritized as future funding and sustainability of the program relies upon the evidence basis collected. There are already established data collection systems in place for housing interventions with the key program being HIFIS, or the Homeless Individuals and Families Information System. This program is accessible to all community service providers for better integration and collaboration of care, and directly reports daily operations and case management data to the federal government (Infrastructure Canada, 2019). This data is also critical to understanding the population being served. For example, the homeless population in the Waterloo Region is predominantly Caucasian males, making their ShelterCare program a strictly men's shelter. In contrast, the homeless population being served by Shepherds of Good Hope in Ottawa is much

more diverse and therefore serves all genders and must account for Indigenous client needs as well. Annually, the community population should also be evaluated to ensure the ShelterCare program is serving the populations in need and will make necessary adjustments if the population needs shift over time. Cyclical assessment of the program should therefore be established from the beginning, realigning researchers, policymakers, shelter management, frontline staff, intersectoral partners, and clients. Conducting formal interviews and surveys allows those involved to express their opinions candidly and obtain higher quality results that can lead to alterations in programming and improve outcomes.

By evaluating the program qualitatively and quantitatively on an annual basis, preliminary results and interim reports can be produced supporting the ShelterCare program as an evidence-based intervention for homelessness. Framing the results to best communicate to policymakers and funders is critical to future programming, sustaining the shelter model past the pilot stage. In the long-term, the best-case scenario of this intervention is significantly reducing the rate of houselessness until the cycle of chronic homelessness is terminated. This end goal is of importance to propagation of the intervention, as there is also substantial need for supportive housing and affordable housing units. If implemented effectively across Canada, these facilities could later be converted to supportive housing programs and/or utilized for affordable housing that could contribute to Housing First programs. The initial investment will then appear more productive with the ability to utilize the spaces and integrated community programs even after ShelterCare completes its desired outcome and ends the cycle of chronic homelessness.

Conclusions

ShelterCare is a housing intervention that was originally thought to be a utopian model for ending chronic homelessness but was given the opportunity to demonstrate its potential as an incredibly impactful evidence-based intervention due to the COVID-19 pandemic. These pilot projects have exemplified the need for the program to address systemic barriers to housing for homeless populations and drastically improve the health of marginalized individuals. Demonstrating similar positive outcomes to other evidence-based housing interventions like

Housing First, but while considering the state of housing and escalating opioid crisis, this model can fill significant gaps and better support individuals who have experienced chronic homelessness to secure and maintain permanent housing. By employing similar pilot projects to the At Home/Chez Soi project, ShelterCare can be implemented to a diverse variety of communities in need across Canada in four-year pilot projects, producing interim results to support further dissemination of the program. Local advisory councils and a governing national council should be recruited to be involved in every phase of the change management approach. Engagement with key stakeholders is crucial from inception of the framework to ensure sustainability of the program past the pilot phase and establishment as an evidence-based intervention to be disseminated nationally. Involvement of third-party knowledge institutes should also be prioritized to accurately collect, and frame gathered results and communicate outcomes in a government-appropriate context. Media should be utilized to foster an emotional response and create a greater impact socially. Social media outputs, podcasts, and website material would effectively share positive outcomes of the program throughout the pilot and share stories of clients. Establishing the ShelterCare program in various communities by applying a standard ShelterCare Model Framework package allow local decision-makers to integrate services best-suited for their populations and adapt the framework accordingly. Annual interviews, surveys, and quantitative measurements need to be collected to assess success of the program and adjust as necessary. The cycle of program specialization per unique population needs and annual analysis of the model for each community will make the program produce better housing and health outcomes, progressing towards the goal of eliminating chronic and episodic homelessness across Canada. If successfully implemented and this result is achieved, the programs can be repurposed as supportive housing and/or affordable housing units available for Housing First interventions and to prevent houselessness at large.

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