Inter-sectoral Collaborations

3.8

VIGNETTE: ADDRESSING HOMELESSNESS AMONG CANADIAN VETERANS

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ADDRESSING HOMELESSNESS AMONG CANADIAN VETERANS

The range of experiences and differing needs among specific homeless subgroups is not well understood. This is especially true for Canadian veterans – a subpopulation gaining increasing recognition among homeless communities across Canada. While it is clear that the needs of Canadian veterans who are homeless differ from the general homeless population, there is little research within the Canadian context to guide housing interventions and related support for this group. Furthermore, individuals may not self-identify as veterans for a variety of reasons and, thus, innovative approaches are necessary to reach this target population.

The Canadian Model for Housing and Support for Veterans Experiencing Homelessness was a two-year evaluation project (2012–2014) funded through the federal Homelessness Partnering Strategy, with in-kind support from Veterans Affairs Canada (VAC) and the City of London and housing through support agencies across four Canadian cities. This participatory action research project developed and evaluated a model of housing and individualized programming to best meet the unique needs of Canadian veterans experiencing homelessness. The project used principles identified previously by veterans who were homeless (Milroy, 2009; Ray & Forchuk, 2011), such as peer support from someone with experience in the military and support for alcohol abuse and related issues. Local community partners experienced in working within the homeless-serving sector collaborated with federal partners, veteran specific organizations (the Royal Canadian Legion, Operational Stress Injury Clinic [OSIC] and Operational Stress Injury Support Services [OSISS]) and other community-based services to provide 56 units of housing with support to veterans who were experiencing homeless. Each site adhered to similar principles with emphasis on providing veteran-specific support and worked to enable pathways that support long-term housing-with-support solutions. Housing models differed across sites and included varying levels of on-site case management, clinical support and peer mentorship, allowing for examination of the strengths and limitations of each approach and an opportunity to compare unique adaptations that evolved within each community.

TABLE 1 *Overview of the Four Housing First Providers*

Location	Capacity	Staffing	Housing Model	Housing & Supports	Peer Support
Toronto	20	Weekday support plus 24/7 on call	Two-bedroom units in one building owned and operated by site	Combined landlord and programs	Mental Health Peer Support
London	10	Seven-day daily support plus 24/7 on call	Scattered sites: private sector apartments	Private landlord and supports by program	OSSIS
Calgary	15	On site 24/7	One-bedroom units in one building owned and operated by site	Combined landlord and programs	Informal
Victoria	11	Weekday volunteer support, no paid staff	Shared accommodations and some private sector	Combined landlord and programs	Veteran volunteers; OSSIS

Housing Model and Housing Specific Supports

One site offered transitional housing though allowed flexibility as to the length of stay, whereas the remaining three sites provided permanent housing. Tenants were able to come and go freely at three of the four sites while one site maintained a controlled entry model where tenants/guests checked in with staff as they entered or left the building. Staffing levels varied by site from daily with or without after-hours on-call support to a 24/7 staffing presence. Across sites, housing staff served as the primary case manager while working closely in partnership with a locally appointed Veteran Affairs Canada case manager, OSIC clinician and peer support counselor(s) to ensure that each veteran's housing, social, cultural and health-related needs were seamlessly addressed. The exception to this was Victoria, where the overall approach was similar; however, supports were overseen and delivered by peer veteran volunteers. Support was individualized such that veteran-identified needs (social and health) were considered a priority.

Key Principles

The following principles based on the work of Milroy (2009) and Ray and Forchuk (2011) formed the basis of the Evaluation Project. Each project site was consistent in applying these principles while creating strategies to match local conditions and variability:

TABLE 2 *Key Principles for Addressing Homelessness Among Canadian Veterans*

• Providing housing with support
• Peer support: by vets for vets
• Provision of services separate from the general shelter/homeless population
• Emphasis on promoting self-respect
• Providing structure through the day
• Addressing co-occurring mental illness, addiction and trauma-related issues
• Providing a transition process to housing

Veteran Specific Supports

Once enrolled in veteran specific housing, veterans were assigned a local Veteran Affairs Canada (VAC) case manager for assistance and support regarding service-related benefits. An OSIC clinician addressed care for mental health, addictions and/or medical concerns arising as a result of military service. Following assessment by VAC/OSIC, veterans dealing with health or social issues that did not relate to military service were formally referred by way of a warm transfer process to appropriate community-based services and supports within public and non-profit sectors. The VAC case manager and OSIC clinician collaborated with housing staff to ensure that recommendations regarding social and health-related needs aligned with housing-specific goals and housing support staff then provided ongoing support that allowed veterans to initiate and maintain a connection to community-based treatment programs.

Peer Support

Efforts to link veterans with peer support services were made at all sites. In some cases, this involved formal peer support through veteran-affiliated organizations (e.g. OSISS, Royal Canadian Legion). Community volunteers who had served in the military offered informal peer support at one site; these individuals were not affiliated with any specific agency and had not received formal training yet shared an interest in supporting this population. One site employed a mental health peer support worker as staff.

Housing First and Harm Reduction

A Housing First approach served as the cornerstone of this project; along with provisions to support attainment of permanent housing, veterans were offered intensive case planning and support aimed at improving health, independent living skills, well-being and social interests. This was based on the foundational principle that individuals experiencing homelessness are better able to address addiction, mental health, trauma and other health issues from the stability of their own home (Mead, 2003).

Harm reduction practices were observed and combined with assessment and safety planning. Frequent in-home visits by qualified staff and peers were integrated within the housing support model across sites. In-home visits are a key element of a Housing First approach and in this context offered a more accurate assessment of housing stability and an opportunity to negotiate "in the moment" solutions to issues that arose. As well, staff and peers were better able to engage with veterans

on a more personal level, to advocate (where necessary) and to provide a wraparound service able to mitigate system navigation issues as well as generally support veterans in working toward their individualized goals as they made the transition from street life to home life. Veterans were not required to observe abstinence rules within their own housing unit at three sites; however, substance use was prohibited in communal areas (shared patio, hallways or lounge) in order to respect fellow residents who may be in different stages of recovery. In Victoria, veterans were discouraged from using substances on site, this was largely due to the absence of paid staff or after-hours support. Housing tenure for veterans struggling with addiction at this site frequently relied on active involvement with addiction counseling and/or rehabilitation.

RESEARCH FINDINGS

Evaluation of this project included a mixed-methods approach. Quantitative analysis was derived from a standardized set of valid reliable questionnaires administered to veterans at baseline, three, nine and 15 months. Questionnaires included demographic and housing histories, Quality of Life Enjoyment and Satisfaction – Short Form (Endicott, 1993), and the Health, Social, Justice Service Use form. Qualitative analysis was based on three cycles of focus group interviews conducted with veterans, staff and stakeholders at each site (2012–2014).

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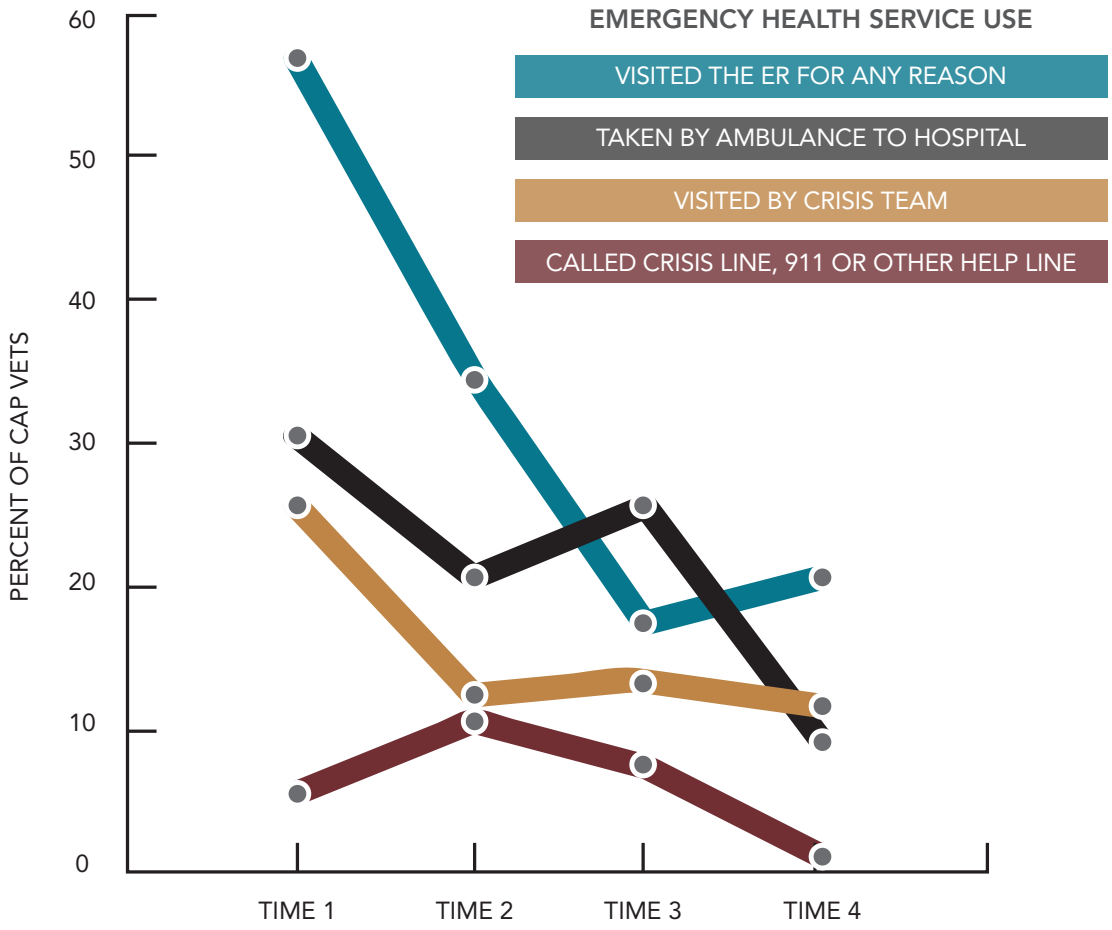
Analysis revealed a pattern of chronic homelessness with tremendous physical and mental health consequences occurring many years following release from active military service. The majority of participants were white English Canadian (79%) and male (92.1%) with an average age of 52.8 years. Only 9.7% were Aboriginal or Métis. While 66% of the sample reported having children, the pilot study housed only one single parent family. The average total time spent homeless for veterans in this study was 5.8 years (range 0–30 years). At enrolment 69.8% of participants reported situations of absolute homelessness while the remainder were at imminent risk of homelessness. The average number of years served in the Canadian Forces was 8.1 years with 39.7% having served in overseas deployments. Participants reported an average of 28.4 years since release from military service. The total time-lapse since first episode of homelessness averaged 9.7 years prior to enrolment (range 0–47 years) suggesting that for many veterans, homelessness followed a period of prolonged destabilization.

Veterans consistently voiced a desire to re-engage with military culture. Peer support services afforded many veterans an opportunity to reconnect with the camaraderie and sense of pride they once felt while serving their country. However, not all participants regarded their military experiences in a positive light and, therefore, the majority's preference was to access veteran peer support on their own terms and at their own pace. The level of street entrenchment and ongoing substance use among participants proved challenging for veteran peer supporters at one site. Sites where peer support staff and/or volunteers had more experience in working with homeless populations were better able to integrate peer support as a consistent and ongoing aspect of housing with support.

Shifting Needs Once Housed

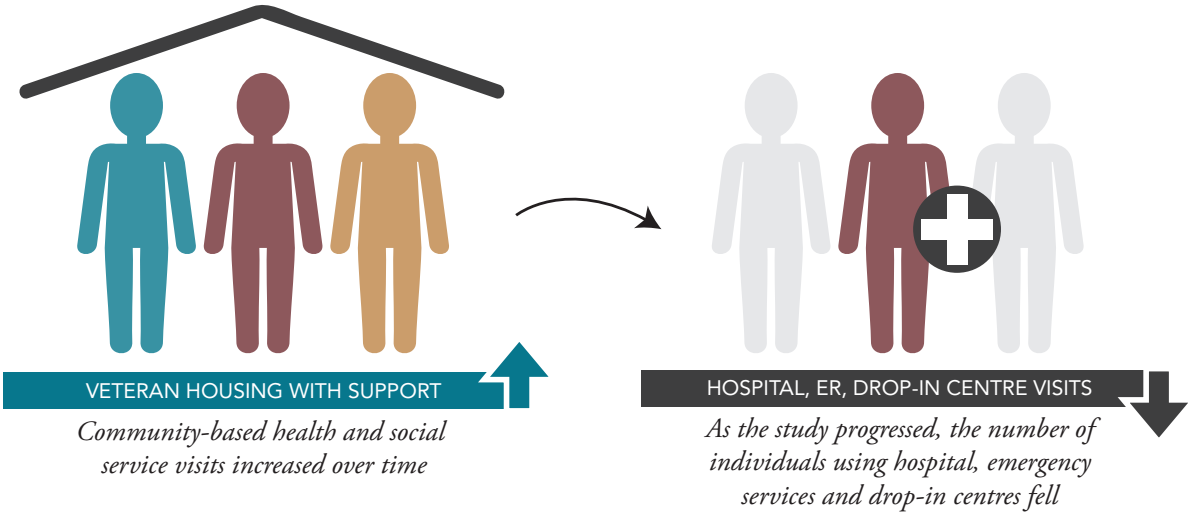
The sample size of this pilot project was insufficient to support formal analysis of service-use patterns over time. A general trend toward increased community-based care (social service and health) was observed, along with decreased hospital and emergency-room visits.

FIGURE 1 *Service-Utilization Across Data Collection Points (0,3,9 and 15 months)*



Food bank use increased over the period of study while drop-in centre visits decreased overall.

FIGURE 2 *Shift Toward Community-Based Preventative Care*



These service-use trends resulted in cost savings to the system and suggest a shift in the manner in which the veterans were able to respond to challenges from a crisis and emergency response toward more preventative supports. The provision of permanent stable housing and support contributed to cost savings of up to $536,600 in the first year following enrolment into veteran-specific housing; this figure is based on reduced reliance on emergency shelter and drop-in centre services. The immediate costs of emergency housing and related services far exceed the costs of permanent supportive housing (Calgary Homeless Foundation, 2008; Gaetz, 2012; Pomeroy, 2005); continued cost savings are therefore anticipated over time in light of the chronicity of homelessness observed among veterans involved in this study sample. Comprehensive tracking and accounting processes are integral to supporting meaningful cost-benefit analyses that illustrate how increased expenditures in one sector – in this case, a housing intervention with support – translates into significant cost savings in other sectors. Such processes should therefore be integrated as a component of program evaluation for evolving interventions that seek to address the issue of homelessness, particularly those targeted at specific subpopulations of the homeless, as this will enhance overall understanding of the true impact of targeted interventions across various systems and sectors.

Local System Collaboration and Networking

Collaboration at the local level between a range of sectors and service providers allowed for insight into site-specific strengths and challenges as veterans transitioned from a state of homelessness to being housed. All sites agreed that a concerted effort to establish regular meetings and case conferences to support individual veteran needs was important and provided a forum to address ongoing issues or conflicts. The success of outreach efforts to identify participants often depended upon the knowledge of street-level/ homeless-serving programs and other community-based mental health or addiction programs. Once established within the housing program, veteran services and other community support services were instrumental in supporting continued success. The local Housing First agency served as the primary case manager responsible for coordinating services; these agencies were familiar with the housing/homeless-serving sector and were well established in their relationships with community services, mental health and addiction treatment programs thus enhancing access to community-based resources if/when these were deemed a necessary component of veteran-specific care. Regular teleconference meetings between housing supports, VAC, OSIC and peer supports provided an opportunity to consider site-specific obstacles, identify common challenges and develop shared problem solving strategies. Sharing of information and ideas improved consistency across sites, thus improving timely access to housing and service delivery generally.

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KEY AREAS OF CONSIDERATION FOR PROVIDING HOUSING WITH SUPPORT FOR CANADIAN VETERANS:

- Veterans have unique needs within the broader homeless population;
- Structure and routine, including leisure, are important;
- Peer support requires an understanding of both military service and homelessness-related issues;
- Collaboration includes an integrated and shared response with both homeless-serving and veteran-serving organizations;
- Permanent long-term housing solutions with support are preferred over transitional housing models;
- Housing First and harm reduction philosophies and interventions must drive programming;
- Choice in housing and living arrangements is important. In particular, the needs of women and families are unlikely to be met by single-site housing models; and
- Programs need to be outcome-focused with housing stability a primary goal. Secondary goals include diversion from emergency services such as shelters, police and emergency departments.

CONCLUSION

By providing veteran-specific housing and support to homeless veterans, this Canadian Evaluation Project created an opportunity for veterans, many of whom had spent years on the streets or on the verge of homelessness, to achieve new stability in their lives. This required coordinated and intensive efforts on the part of participating organizations within housing/homelessness- and veteran-serving sectors. This encompassed development of formal service agreements between agencies and a clear understanding of organizational mandates that govern service delivery. At times, this also required a shift in care delivery to conform to the primary housing agency's core philosophy or approach (i.e. adopting a harm reduction approach to support a Housing First mandate). The initial key principles for addressing homelessness among Canadian veterans remained relevant and were supported throughout the study. However, the depth and scope pertaining to the understanding of these principles increased in complexity over time. The exception from the original list of principles is that permanent rather than transitional housing is needed.

For the veterans who were housed as part of this study, this integrated approach improved access to much needed resources including income supports, medical, mental health and addiction treatments and provided an opportunity for psychosocial healing and reconnection to military culture and family supports. Ensuring pathways for open and clear communication between partner organizations serving the homeless veteran population was critical to the success of the program. Mutual problem solving required all parties keep an open mind in the face of conflict or tension and be prepared to listen, explain and/or compromise to ensure the ultimate goals of providing safe, affordable and stable housing in accordance with the core philosophies. Continued collaboration between sectors and between organizations serving the veteran population is needed, along with further research to validate long-term benefits and impacts associated with veteran-specific housing and support programs such as these.

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