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COMMITTEE REPORT

NO: P002 DATE: May 14, 2018

PUBLIC SAFETY COMMITTEE

TO: **Mayor & Council** DATE: **May 10, 2018**

FROM: **Assistant Commissioner, OIC - Surrey RCMP**
Director, Public Safety FILE: **7450-30**

SUBJECT: **Surrey Mobilization and Resiliency Table (SMART) Evaluation Update**

RECOMMENDATION

The Surrey RCMP and the Public Safety Division recommend that the Public Safety Committee receive this report for information.

INTENT

The purpose of this report is to provide the Public Safety Committee with an update on the Surrey Mobilization and Resiliency Table ("SMART") strategic initiative.

BACKGROUND

In 2015, concerned about the cost and impact of reactive policing and reports from citizens concerned about community safety the Surrey RCMP led the development of a multi-agency table to address developing community problems before they escalated to require police intervention. Surrey RCMP reviewed calls for service and found that 70% of calls dealt with social issues (poverty, homelessness, mental health and substance use) that were not chargeable offences. To develop a best practices response, the Surrey RCMP reviewed practices in other jurisdictions and found that "Hub" models, where community partners meet weekly to develop immediate interventions for clients facing elevated social risks, that had shown promise in Saskatchewan and Ontario. In many jurisdictions the term "situation table" is used to describe this approach.

SMART was launched as a pilot project by the Surrey RCMP in November 2015. SMART allows service professionals from a variety of disciplines to meet weekly and collaborate on intervention opportunities to address situations of acutely-elevated risk. SMART was presented to Public Safety Committee on April 11, 2016 and endorsed as a Strategic Initiative under the Public Safety Strategy when the Strategy was launched in October 2016. The Public Safety Division assumed operational responsibility for SMART in May 2017.

To date 209 individuals have been referred to SMART. As SMART is an immediate, not long-term intervention intended to lower the precipitating risks quickly, client outcomes are not tracked beyond the initial intervention. Of those individuals referred to SMART approximately half have had the risk factors that led to the referral lowered.

In July 2017, an independent evaluation (Appendix "I") of the SMART initiative was conducted by Dr. Julian Somers of Simon Fraser University. The evaluation included a literature review on the efficacy of HUB models, as well as interviews with partners and interviews with clients. The evaluation was completed in December 2017.

The Public Safety Division has been engaging with stakeholders and partners to leverage the lessons of SMART to inform the use of multi-agency situation tables on other public safety issues. This report provides an update on this work to the Public Safety Committee.

DISCUSSION

The SMART Model

SMART is a risk driven response model that works in collaboration with other service providers ("Appendix II") to proactively address developing community problems prior to police intervention and before they become police problems. The mission statement of SMART is to reduce the incidence of emergencies to persons, groups or places in Surrey and to strengthen the capacity of the Surrey community to sustain safety, security and wellness for all.

SMART is not an agency, department or program. It does not focus on long term solutions, chronic conditions, or case management. Rather, SMART focusses specifically on short-term immediate intervention for those in situations of acutely-elevated risk. After the risk is lowered to a more manageable level and the appropriate services take over, SMART does not continue to be involved. However, in many cases, agency partners continue to provide services under their mandate.

SMART clients are typically persons, families, groups or places that have an acutely-elevated risk for some form of crime, disorder or victimization. The anticipated outcomes and benefits include:

- At risk citizens and their families will gain the supports they need to build positive and healthy lives;
- Incidents of crime and social disorder will be reduced and prevented;
- Community safety, security and wellness in specific neighbourhoods of City Centre will be enhanced; and
- Collaborative partnerships amongst all stakeholders will be enhanced and sustained.

Implementation of the SMART model brought about many challenges. Firstly, individuals requiring SMART services are often difficult to reach and face many risks (Figure 1). End of year data for the SMART initiative shows that:

- 47% of clients receiving interventions, had an overall lowered level of risk;
- 20% refuse services or are uncooperative;
- 18% relocate or cannot be located; and
- 15% are not connected to services.

The challenges inherent in linking SMART clients to services are due to a number of underlying challenges related to chronic lack of suitable and sustainable housing, mental health and/or substance use issues. An additional challenge with SMART is that as it is an immediate

intervention, clients are not case managed over time. Therefore it is difficult to know the degree to which the intervention lowered the risk and if the lowered risk was sustained over time.

Clients present at SMART with a variety of challenges and have very diverse risk factors. Figure 1 shows the top ten risk factors for SMART clients that increase their level of risk as identified in the SFU evaluation. At that time SMART had reviewed 186 cases. To date SMART has intervened in 208 cases. Of those, 25% experience housing insecurity and about 20% associate with peers that contributes to negative outcomes in their lives. It is important to note that most clients present with more than one of these risk factors hence the data below are presented as raw numbers rather than percentages.

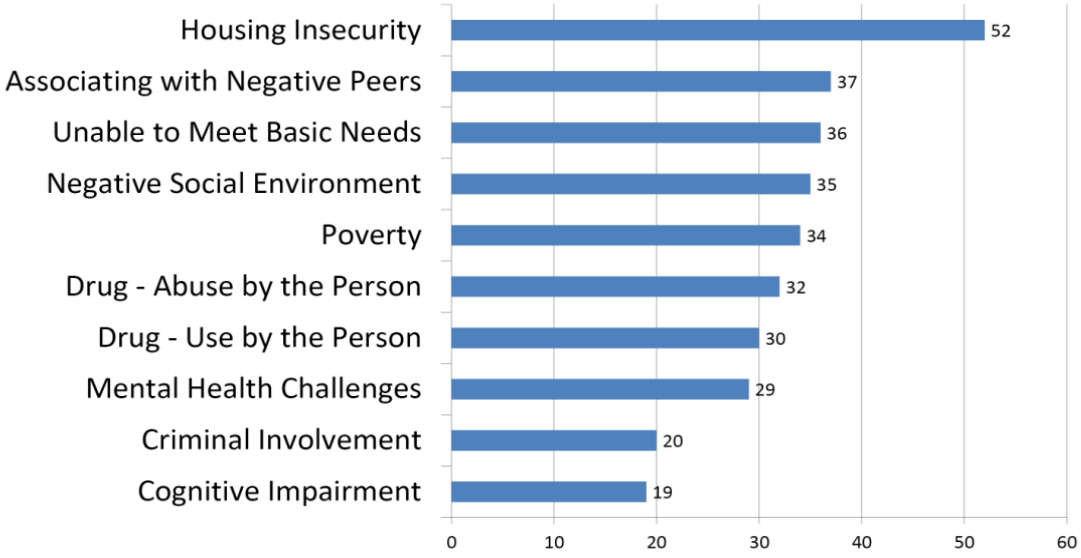

Figure 1 – Top Ten SMART Client Risk Factors as identified in SFU evaluation (186 cases)

Evaluation Findings

The evaluation team spoke to members of the frontline staff that meet weekly at SMART, and with senior leaders of partner agencies. As well, they conducted a literature review to assess SMART relative to other HUB models and situation tables. Finally, they completed in person interviews with individual SMART clients (both youth and adults) and with client families. In total 16 clients were interviewed for the evaluation.

There were several key findings from the evaluation regarding client experience.

- Clients reported two primary sources of benefit from their encounters with SMART
    - Provision of resources to meet their immediate need (e.g., income support, housing etc.)
    - Receiving attention and opportunities they otherwise would not have received. In some cases SMART was described as the first service they had experienced to offer meaningful assistance.

- Clients reported being more "hopeful" after their encounter with SMART and individuals were appreciative of the "care and concern" shown by table members.
- Client needs were most commonly focused on housing, personal safety and substance dependence. As well, they noted that SMART members helped reduce barriers to connecting with service providers.
- One of the most impactful SMART interventions was advocacy and liaison to allow clients to secure housing with landlords reluctant to rent to SMART clients, and for SMART clients experiencing problems with their existing landlords.
- Clients noted that intervention by SMART was a catalyst for positive change in their life trajectory.

The following quote from the evaluation sums up the case for SMART.

> *"Our current findings support the role of brief interventions like SMART in the identification of high risk cases, successful diversion from acute risk, and positive rapport building with extremely vulnerable and marginalized people…Economic costs of the status quo have been estimated by separate studies at approximately $55,000 per person, per year."*
>
> - *SMART Evaluation Report p. 26*

Review of the literature and discussion with SMART members also revealed several key insights for the evaluation. Canada is a leader in effective interventions for people experiencing complex co-occurring challenges including homelessness. However, the de-escalation of imminent risk of harm is not sufficient as a stand-alone solution to complex social problems in fast growing cities such as Surrey. The evaluation report recommends that SMART is seen as a gateway to more intensive and enduring services. These must be delivered in a coordinated manner and be supported by policies and procedures (e.g., sharing of confidential client information) that encourage a client-centred approach to care.

The evaluation also recommended further actions:

1. Research the life trajectories leading to situations of acute elevated risk;
2. Review the impact of discrete HUB interventions when paired with comprehensive and coordinated supports over time;
3. Expand the quality of tracking of clients in the SMART database;
4. Improve the reach of SMART (i.e., increase the number of cases per year that can be closed);
5. Empower SMART agency representatives with the authority to accelerate action in cases of elevated (urgent) risk; and
6. Leverage the lessons of the SMART model to create issue-specific situation tables.

Next Steps

Following the completion of the evaluation report the Public Safety Division and members of SMART have been investigating opportunities to build on the findings and recommendations from the SMART evaluation.

On May 10, 2018, the City of Surrey hosted "*Getting SMARTer: a workshop on the evolution of situation tables*". The session received funding support from the Ministry of Public Safety and Solicitor General and the Canadian Municipal Network for Crime Prevention. Over 50 public safety practitioners from across Canada came together to review the findings from the SMART evaluation and discuss how the initiative could evolve. As well, the group heard from the Ministry of Community Safety and Corrections in Ontario who presented on their use of situation tables and provided resources and tools that other municipalities can adopt for deployment of multi-agency solutions. The City of Toronto, also presented on how that city is taking a neighbourhood approach to safety and wellbeing and how they use HUB tables to implement grassroots solutions. Finally the perspective of the Ontario Provincial Police provided insight into how law enforcement can work with community based and municipal partners to engage effectively on situation tables.

The Public Safety Division also co-hosted a staff workshop in partnership with the General Manager of the Parks, Recreation & Culture to look at data driven approaches to neighbourhood safety planning and place-making activities. Scott McKean, Manager, Community Safety & Wellbeing, from the City of Toronto shared insights into their approach to neighbourhood data tracking at this session.

City of Surrey staff have also been working on strengthening the use of situation tables for other risks, particularly related to the opioid crisis. Building on grant funding, staff are exploring how to use the SMART model to deal with individuals overdosing from opioids. This is linked to a variety of activities related to opioids and will be the subject of an upcoming report to Council.

SMART provides an important and immediate intervention. As stated, however it is not intended or designed to provide ongoing case management. To address that need City staff are currently working with partners to develop and implement a complimentary enhanced integrated services model. This initiative will also be the subject of an upcoming report to Council.

SUSTAINABILITY CONSIDERATIONS

This initiative assists in achieving objectives related to two themes in the Sustainability Charter 2.0 – Public Safety and Health and Wellness. More specifically, it supports the following Desired Outcomes (DO):

- Public Safety DO3: There are minimal community safety issues in the city, and the public is fully engaged in preventing and reducing crime.
- Public Safety DO4: Local residents and businesses are connected and engaged within their neighbourhoods and with the broader community - including police, public safety partners and social service agencies - to enhance safety.
- Public Safety DO5: Surrey is recognized and perceived as a leader in establishing and maintaining collaborative partnerships for community safety and well-being.
- Health and Wellness DO5: Services and programs are responsive to shifting health and social needs, and local and external factors.

CONCLUSION

Based on the above discussion, it is recommended that the Public Safety Committee receive this report for information.

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Assistant Commissioner, OIC – Surrey RCMP

Terry Waterhouse
Director, Public Safety

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Appendix "I" – Evaluation of the SMART Program
Appendix "II" – SMART Participation List

Appendix "I"

SFU
SIMON FRASER UNIVERSITY
ENGAGING THE WORLD

A Hub intervention in Surrey, Canada: learning from people at risk

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Executive Summary

Co-occurring health and public safety concerns involving mental illness, substance use, and homelessness are increasingly prevalent challenges for policymakers in cities worldwide. The Hub model is a roundtable process where the combined resources of diverse agencies are used to mitigate urgent risk of crime, victimization, illness and death by establishing immediate connections with appropriate services and supports. Initiated in Scotland, the model has been replicated in more than 60 communities across Canada since 2012. In November 2105, the Surrey Mobilization and Resiliency Table (SMART) became the first Hub in British Columbia.

No peer-reviewed research has examined the impact of Hub interventions from a client perspective. We conducted semi-structured interviews with 16 SMART clients, and analysed their responses thematically. We also examined demographic and intervention-related characteristics reported in the SMART database. Participants described positive experiences with SMART service providers, and that the intervention was effective at meeting relatively circumscribed needs. However, most clients reported complex and mutually exacerbating health and social conditions, and expressed the need for ongoing structured support (e.g., Assertive Community Treatment). Our results emphasize the beneficial role played by SMART's coordinated, real-time approach. They also indicate demand for social policies that include substantial and enduring forms of support to prevent crises and promote community safety.

Background

Despite more than 2 decades of consistent decline in Canadian crime rates, (Statistics Canada, 2016), law enforcement costs in Canada are on the rise (Di Matteo, 2014; Leuprecht, 2014). Police, courts, and departments of corrections are increasingly being called upon to respond to complex, co-occurring and mutually exacerbating health and public safety issues involving mental illness, substance use, and homelessness (Fazel and Danesh, 2008; Rezansoff *et al*., 2013; Somers *et al*., 2012; Somers *et al*., 2014).

Co-occurring mental and substance use disorders are strongly predictive of criminal recidivism (Rezansoff *et al.,* 2013), and require coordinated response (Priester *et al*., 2016). Similarly, long-term homelessness is associated with diverse harms including involvement with the justice system (Somers *et al*., 2013), and results in extremely high public costs (Latimer *et al*., 2017). These findings correspond with research demonstrating that a disproportionate amount of crime is committed by a subset of individuals who are entrenched in an ineffective and costly revolving door involving corrections, health and social welfare services (Somers *et al*., 2015b). Offenders in this subgroup have previously been described as having 'complex co-occurring disorders' (CCD) (Somers *et al*., 2015a).

Research in the Canadian context has shown that the highest per capita rates of CCD are observed in rural and relatively remote geographical locations, where relevant services are often scarce or unavailable (Somers *et al*., 2016). Lack of appropriate supports in these communities may influence the migration of

people with CCD to urban areas where services for homeless and marginalized populations are concentrated (Somers *et al*., 2016). As a consequence, policing agencies across the country report that resources are increasingly being diverted from their core responsibilities for public safety (e.g., Szkopec-Szkopowski, 2013; Thompson, 2014; Wilson-Bates, 2008).

The Hub Model

A growing policy response to these pressures is the implementation of multi-disciplinary, risk-driven and community-centric approaches to public safety and wellbeing. One such initiative gaining traction in Canada is known as the *Hub* model or *Situation Table,*[1] where the combined resources of multi-sectoral agencies (e.g., policing, mental health, addictions, housing, education and corrections) are used to identify and respond in a timely manner to situations of acutely elevated risk (AER)[2] of harm to individual and/or public health and safety.

Modelled after Scotland's Govanhill Operational Hub (see Ekos Limited, 2011), and introduced in the Canadian context (Saskatchewan) in 2011 (see Sawatsky *et al*., 2017), there are currently more than 60 active Situation Tables throughout the country (Global Network for Community Safety, 2016).The overall goal of these initiatives is to mitigate risk of criminal offending, victimization,

[1] Referring to the formalized process of information sharing between table discussants from social, health and housing agencies, community stakeholders and police during regularly scheduled meetings. The terms Hub and Situation Table are used interchangeably in extant reports and the current document.
[2] Defined by 4 criteria (from McFee and Taylor, 2014, p.10): a) significant community interest at stake; b) clear probability of harm; c) severe intensity of harm predicted; and d) multidisciplinary nature to elevated risk factors.

illness, and death, by facilitating rapid client engagement with appropriate services and supports (Bhayani and Thompson, 2016).

Multiagency, collaborative and problem-oriented policing initiatives have been studied extensively (e.g., Weisburd *et al*., 2010). Many of these have taken a comparatively specific focus such as gang-related crime and gun violence (see Braga *et al*., 2001) or drug-related crime (see Corsaro *et al*., 2013). In contrast, Situation Tables respond to clients with a wide spectrum of risk factors, (including addiction, mental illness and homelessness), and interaction with the justice system is not a necessary criterion for referral.

Moreover, applications of the Hub model in Canada do not represent separate or stand-alone "programs". Instead, they function as forums where representatives from various existing agencies convene for time-limited and highly focused discussions of high-risk situations requiring immediate and coordinated action. Finally, Hub interventions are limited to basic triage, and do not include sustained support such as case management or Assertive Community Treatment.

The Surrey Mobilization and Resiliency Table

Implemented in November 2015, the Surrey Mobilization and Resiliency Table (SMART) is the first application of the Hub model in the province of British Columbia. Details concerning SMART (implementation, operational practices, etc.) have been previously published (see Bhayani and Thompson, 2016).

For further context on how SMART identifies and mitigates cases of AER while protecting client privacy, the following details[3] of the 'Four Filter' Hub discussion process are excerpted and abbreviated from the Situation Table Guidance Manual (Russell, 2016, pp. 51-53).

> *Filter 1: Internal agency/organization screening:* … [an individual] agency representative decides whether or not to take a particular situation to the Table … determin[ing] that the sharing of personal information is necessary to mitigate risks …
>
> *Filter 2: De-identified discussion with Situation Table agencies:* The situation is presented to the Table, using de-identified data. All participants … are asked if they agree that this situation meets the threshold of AER. If they decide it does not, then the discussion of the situation ceases. If they reach consensus on the situation meeting the threshold of AER, then they … determine which agencies should participate, relative to the identified risks, in a planned intervention …
>
> *Filter 3: Limited identif[ying] information:* … having established that the threshold … has been met, limited identif[ying] information is shared: name, address and date of birth. [Use of] this information [is] limited to determining if agencies are already engaged and which agencies need to be involved with the intervention. … only those agencies with a role to play

[3] Identified as current best practice across Ontario.

shall collect any personal information. Any notes taken by agencies who will not be involved are destroyed. If at any point it becomes apparent that the risks are being mitigated by an involved agency all discussion [ceases]. The Filter 4 planning intervention discussion … take[s] place with the involved agencies at the end of the Situation Table meeting, after all situations have been addressed.

Filter 4: Intervention planning: Agencies identified in Filter 3 … meet to plan the best intervention for the person(s) at risk. Disclosure of personal information [is] limited to [that] necessary to assess the situation and determine the most appropriate actions to mitigate AER. Once the intervention plan is set the agencies best determined to conduct the intervention will do so within 24-48 hours of the meeting. At the intervention it is imperative, if consent was not provided at *Filter 1*, that consent to permit any further sharing of personal information in support of providing services from the agencies involved be obtained. If the individual refuses or declines services, then no further action [is] taken by the agencies.

Report Back: The agency determined to be lead for the intervention [reports] back to the Situation Table at the meeting, limited to the status of AER and whether the situation can now be closed or whether it requires additional actions.

Research to date

Initial evaluations of the Hub model report promising results, including reductions in police-related incidents (Brown and Newberry, 2015), improved communication between participating agencies (Babayan *et al*., 2015), and lower rates of property and violent crime (Sawatsky *et al*., 2017), although this literature is largely limited to trade journals and reports for government.

Very little is known about client perspectives and experiences of Hub interventions across Canada. This gap has been identified as a critical omission in existing literature (Ng and Nerad, 2015; Nilson, 2016). However, some authors have noted that ascertaining information directly from clients can present methodological challenges (Babayan *et al*., 2015; Newberry and Brown, 2015). Several grey literature reports are based on the results of focus groups and surveys with service providers, and describe client-related benefits including better understanding of individual needs (Babayan *et al*., 2015) and improved access to services (Brown and Newberry, 2015; Nilson 2014).

At the time of writing, a single grey literature study has reported data collected from 11 Hub clients (Nilson, 2017) using surveys distributed by service providers to clients who were relatively stable (i.e., clients deemed to be in crisis were excluded). The report concludes that the majority of clients were "satisfied" with the intervention. To date, no study has reported findings from narrative

interviews with clients, and very little research has characterized clients' needs or the enduring effects of Hub interventions.

Given continued proliferation of the Hub model in Canada, there is a compelling need for peer-reviewed research[4] focusing on client-level experience of Situation Table interventions, including elements that appear to be operating effectively, as well as areas of service requiring further attention. Indeed, "researchers, evaluators, analysts, and human service professionals [have been called on] to work together in identifying opportunities for data to be gathered from the actual subjects of collaborative risk-driven interventions" (Nilson 2016, p.59). The current study responds to this research need by combining client demographic and intervention-related data with client narratives to investigate client needs, their experiences with SMART, and factors that enable or impede lasting positive change.

Approach

The approach used in this study was developed in collaboration with SMART agency representatives and their respective executive members. This collaboration involved all aspects of the study including: selection of data sources; interview design; interpretation of results and development of implications. Initial (in-person) meetings with team members were followed by email correspondence and

[4] Findings presented in the current report have been prepared for submission to a peer-reviewed journal.

telephone discussion. Front-line staff and executive leaders were re-convened to review study findings and generate interpretations reflected in this report.

Data sources

The SMART database

SMART maintains a de-identified client database modelled on Saskatchewan's flagship Hub (see Nilson, 2014) to monitor the intervention process. Recorded data include client socio-demographic characteristics and categories of risk, agency involvement, services mobilized, intervention outcomes and length of client engagement with SMART. These data were tabulated and analysed to produce means and standard deviations (e.g., "duration of intervention" in days) or frequencies, (e.g., gender), as appropriate.

Narrative interviews

Interview eligibility was based on current or former SMART client status, regardless of the extent of client engagement with services. Recruitment was facilitated by SMART service providers affiliated with police, income assistance, housing, health care, corrections, education and civic government. A goal of interview recruitment was to identify clients whose needs were representative of those in the overall population served by SMART. Table members drew on their knowledge of clients' whereabouts to arrange for contact with members of the research team and completion of informed consent. Study participation was voluntary and did not affect service provision or future eligibility for services and supports.

Consenting participants met with a trained interviewer who explained study objectives and obtained permission for interviews to be recorded and transcribed. A semi-structured interview was conducted to elicit responses addressing three primary domains: a) immediate client needs; b) experience with the SMART intervention; and c) barriers/contributors to changes initiated by SMART. Meetings took place in agency offices, custody centres and street settings. Interviews lasted from 15 to 30 minutes, and cash honoria of $25.00 CDN were provided.

Interviews were transcribed and anonymized. Transcripts were reviewed independently by SY and SNR, and recurring themes for each domain were identified. A coding frame was developed to facilitate the coding of interview transcripts using NVivo (Version 11.0). Final identification of themes was based on consensus between three authors (SY, JMS and SNR). Participant pseudonyms were created for reporting purposes.

Findings

Client characteristics

Demographic and intervention-related client characteristics (n=161) extending from SMART inception to time of writing (November 2015 - August 2017) are presented in Table 1.

Table 1: Socio-demographic and intervention-related characteristics of SMART clients (n=161[5])

	Individual (youth) n=51[6]	Individual (adult) n=96	Family n=12
Age			
<25 years	51 (100)	0 (0.0)	
25-49 years	0 (0.0)	74 (77.1)	
≥50 years	0 (0.0)	22 (22.9)	N/A
Gender			
Female	33 (64.7)	39 (40.6)	
Male	18 (35.3)	57 (59.4)	N/A
Originating agency			
Education - school district	8 (15.7)	0 (0.0)	4 (33.3)
Local health authority	2 (3.9)	7 (7.3)	1 (8.3)
Housing & outreach	10 (19.6)	29 (30.2)	3 (25.0)
Income assistance	1 (2)	4 (4.2)	0 (0.0)
Community services	1 (2.0)	1 (1.0)	0 (0.0)
Police	22 (43.1)	36 (37.5)	2 (16.7)
Probation - Adult	5 (9.8)	17 (17.7)	0 (0.0)
Social services	2 (3.9)	2 (2.1)	2 (16.7)
Duration of intervention[7]			
Mean (SD)	17.8 (13.0)	16.3 (11.9)	21.0 (7.3)
Median (min, max)	14 (0, 49)	14 (0, 56)	21 (7, 28)
# of repeating clients	3 (5.9)	6 (6.2)	0 (0.0)

[5] Nine individuals were repeat clients. Information was missing for two clients.
[6] Individuals were categorized into two age groups: < 25 years (youth), and ≥25 years (adult).
[7] For repeat clients, duration of first episode was considered.

The majority of cases involved single clients (93%) between the ages of 25 and 49 (77%). Although gender was evenly divided across the population, individuals under the age of 25 were more likely to be female (65%). Cases originated most frequently from police, probation and housing outreach services, and were resolved within a mean period of 2-3 weeks. Half of all case closings were attributed to client engagement with appropriate services and supports. A minority (14%) of individuals and one family refused services. Nine (individual) client cases (6%) were re-opened at least once during the study period.

Categories of risk for the client population as assessed by SMART representatives are presented in Table 2. The most prevalent category of risk among participants was a high level of unmet basic need (e.g., housing, activities of daily living; 51%), followed by exposure to negative environment (e.g., physical or emotional abuse; 16%), and substance use (alcohol or other drugs; 14%). Crime (gang involvement or other criminal behaviour) and mental/physical health (disability, diagnosed disorder) were noted as risk factors in 10% and 8% of cases, respectively.

Table 2: Assessed categories of risk among SMART clients (n=161[8])

	Individual (youth) n=51	Individual (adult) n=96	Family n=12
Primary risk category			
Basic needs	26 (51)	47 (49)	8 (66.7)
Crime & public safety	3 (5.9)	11 (11.5)	2 (16.7)
Alcohol/drugs	9 (17.6)	13 (13.5)	1 (8.3)
Mental health	5 (9.8)	4 (4.2)	0 (0)
Negative environment	8 (15.7)	17 (17.7)	1 (8.3)
Physical health	0 (0)	4 (4.2)	0 (0)

Narrative interview sample

Of 28 individuals who were approached for an interview, 16 provided informed consent (10 elected not to participate, 2 were deemed by the investigators to be unable to consent). Self-reported characteristics of the interview sample were broadly similar to those of the larger client population, and are presented in Table 3. The majority of participants were White (n=9) and male (n=10), with a mean age of 36 years. Six participants claimed Indigenous ethnicity. More than half were homeless and reported diagnosed mental disorder, current substance use and chronic physical illness/injury. Five individuals had children under the age of 18, and one participant was pregnant.

[8] Nine individuals were repeat clients. Information was missing for two clients.

Table 3: Self-reported socio-demographic, health, and related characteristics of SMART interviewees (n=16)

Variable	n (%)
Age	36 years; (SD=14)
Gender (M)	10 (63)
Ethnicity	
-Indigenous	6 (38)
-White	9 (56)
-Other	1 (6)
Dx physical illness	8 (50)
Dx mental disorder	10 (63)
Current substance use	12 (75)
Currently homeless	10 (63)
Dependent children	1 (6)
Children in foster care	4 (25)
Currently pregnant	1 (6)

Interview findings

Narrative results are organized under the primary domains examined: client needs; experience with the SMART intervention; and barriers/contributors to positive change. Subheadings refer to dominant themes identified in the analysis of transcripts, prominently involving shelter/housing; substance use; coordination across sectors; and longer-term support.

1. *Client Needs*

Self-described needs converged on the following points: *housing, personal safety, and substance dependence*. Housing affordability and accessibility were frequently described. For example, Mary – a single Indigenous woman recently released from hospital following the birth of her son - faced multiple challenges trying to secure an apartment:

I need affordable housing first of all. Rent is too high, landlords are restricting, and they're somewhat prejudiced too … about your background or what you do for a living.

In many cases clients described ways in which their needs were interdependent (e.g., housing linked to drug treatment). For example, Josh and his partner had been placed in a shelter, but were subsequently evicted for drug use:

It was a good place for us, but it just didn't work … we fucked up and got the boot. A recovery house, or something like that, would have been better.

Josh explained how renting an apartment was financially impossible for them, despite their combined resources:

It's hard. It's really hard. Even with both our incomes it's hard to find a place in Surrey. Both our whole cheques would go to them, and we'd get like, what, thirty bucks or something to eat for the month, right?

Descriptions of threats to personal safety often highlighted the interactions between drug use and sleeping rough. Fifty-year old Suzanne described an attack she experienced in the previous year:

It was one of the young guys on the strip that deals and stuff, and he was high and drunk … he ripped open the zipper to the tent, grabbed the propane tank [next to me] and started swinging, you know? Broke my nose, fractured my orbital bone and all kinds of stuff … It's dangerous out there. And you have to look after yourself… Especially for ladies and the older guys.

Jenny was 5 months pregnant at the time of the interview, and described her circumstances sleeping in a tent on the street:

I'm so tired … [I can't sleep during the day]. We have to [collapse] our tents down by 9 o'clock in the morning … If you sleep inside the tent during the day you suffocate in the sun. It's really hot in the tent – you're basically, like, in a greenhouse … No, I don't want to be there … I hate it down there, I do … I hate it. There's lots of rats. They like, chew through your tents and everything. So gross.

Participants spoke urgently and desperately of their need to curtail substance use, and their frustrated attempts to access treatment either initially or after a prior episode:

Ever since 2006 I've been using crystal meth and it's just such a shit show. I've lost lots, right? I tried Suboxone … I had another puff and I was right back into it. Like, I've never used intravenous, and I never will. Knock on wood or whatever, right? But you know, I feel that it's only getting closer and closer, and I don't want to go there… Yeah man. I gotta get the fuck outta here man.

2. *Experience with the SMART intervention*

Participants described benefits derived from their encounters with SMART. These benefits included essential advocacy and liaison with landlords in order to secure housing. Rob, a 46-year-old Indigenous man described why he thought landlords were reluctant to rent him an apartment:

> Housing I could never get by myself. I just, you know, just...maybe I'm a visible minority or something, I don't know. Like even if I clean myself up it seems like, I don't get through, eh? It's hard if you don't have references too, right? You know. So yeah…it was helpful.

Some participants had relatively discrete needs, and derived a significant benefit from a specific form of assistance. Paul described how he and his 5-year-old son had been precariously housed immediately after arriving in Vancouver, and how help navigating an application for income assistance allowed him to rectify the situation:

> I didn't need anything else – just help getting back on my feet and making a home for my son. We were living in a motel, and the ministry was going to take him away, but once I had some money I was able to find us a place on my own. Now I can start looking for work and we can get on with things.

Other participants described changes that appeared to reflect having received encouragement or motivation through their encounters with SMART. Eighteen-year-old James explained how he was frequently arrested for fighting

prior to connecting with service providers; behaviour that he attributed to poor medication adherence:

> They talked me into taking my meds again, and I'm fighting way less … And they showed me the clinic for my Narcan kit. I'm there once a week now."

3. *Barriers/contributors to change*

Participants consistently valued the attention that they received from front line staff representing SMART, and described this as an important contributor to change. The qualities of persistence and caring often stood out:

> It felt really good to get help from Dan [police officer]. I'm grateful. He was ok to talk to and he kept everything confidential … He stuck with me. I can still talk to him … They tried to help me right away, and I pushed them away, but they just came trying to help me again.

Participants singled out police representatives of SMART, describing their approach as fundamentally different from their previous experiences with law enforcement. In some cases, this was expressed with considerable affection:

> It was cool. I never met a cop that would go that far, you know what I mean? Like, he seemed to take it a bit personal. And it was cool because, like, I don't know, he took a shine to me too – I swear … even came off-shift to see me in the hospital, right? Like, it was just cool – they took it a bit further than the street, right? Took it home with them almost. It was like, it was a really cool feeling … it was motivating.

Respondents also emphasized that their experience with SMART had made them more willing to engage with service providers, and more motivated to make the most of opportunities that are presented to them in the future:

The tunnel seems a lot less … long. You know what I mean? The light's like, right there! Just now I gotta make the next step, right? I was there for a minute and I liked it, and I need to go back, man.

Barriers to change centred on clients' experiences with services and supports. Needed services were often not available, or were only available under specific circumstances (e.g., abstinence-based housing without conjoint drug treatment). Forty-eight-year-old Bert spoke highly of the worker who assisted with his placement in emergency shelter, but expressed remorse over how issues related to heroin dependence compromised that opportunity:

She was really good … she got me into Hyland House but it didn't work out due to the fact uh...with the curfew and stuff. I just kind of screwed that up, cause like I said … I was using quite a bit at that time. But she did a lot to help me - I'll tell you that. She could have done a lot more for me if I hadn't been so...like, you know. I was doing a lot of drugs then, right? It's kind of embarrassing but, I probably should have stuck more with her, you know what I mean? And I didn't and I regret that.

Housing was sometimes provided in locations that made it impractical to address other essential responsibilities. Danielle - an elderly diabetic - explained

why she eventually left the apartment in which she had been placed and returned to the street:

> They put me in a place – a sort of transit never-never land. It took me an hour to walk to Newton. Sometimes you just can't...that was a huge problem for me with my cellulitis, right? … I was supposed to go to the Dr's office for IV treatment, 3 hours a day. But I couldn't get there - I couldn't walk to Skytrain because um, my legs were...right? And so the ambulance guys - the EMTs that are on the strip now - they insisted on taking me, like every 3 days.

Despite describing benefits arising from their contact with SMART, the vast majority reported that it was insufficient to meet ongoing challenges. Tony, a 50-year-old homeless woman with chronic health issues and heroin dependence had a very clear idea of her long-term support needs:

> I need an ACT team. I need a proper worker to sit down and remain ... to constantly communicate with me and - <u>what I need is not that hard!</u> [Crying] I need a contact number, a contact person, you know? I need supportive housing and I need to get on the methadone program - really bad.

Discussion

This study is the first to combine demographic and intervention-related data with client narratives to examine the impact, strengths and weaknesses of the Hub model. The results characterise the needs of a growing population of marginalized individuals in communities throughout the country, and the urgent challenge this presents to social policy makers.

Overall, participants' self-reported priorities involving homelessness, substance use, personal safety and unmet basic needs were consistent with the primary risk categories identified by SMART representatives and listed in the client database. Nearly all clients reported needs spanning multiple domains of service (e.g., housing, healthcare, income support). Notably, participant self-reported substance use (75%) was much higher than the level of substance use identified in the SMART database (14%). This discrepancy may arise from the fact that SMART does not undertake client clinical assessments.

Housing emerged as the paramount need expressed by SMART clients. Typically, housing was linked to additional needs, such as transit or addiction treatment. Some clients reported having lost housing due to barriers or rules (e.g., curfews, abstinence requirements) that they were unable to comply with. Conversely, few participants emphasized needs related to their mental or physical health. It is unclear whether participants were unaware of their health status (e.g., infection positivity, mental illness symptoms, etc.), regarded their physical and mental health as lower priorities, or lacked positive and therapeutic experiences with relevant health professionals. People claiming Indigenous ethnicity comprised 38% of the sample. Culturally appropriate services are urgently indicated.

SMART Benefits

Participants reported two primary sources of benefit from their encounters with SMART. The first type of benefit was the provision of resources that enabled other

positive changes to take place. This occurred when clients had relatively circumscribed needs (e.g., to initiate receipt of income assistance). Once their urgent and specific requirements were met, these participants reported feeling less distressed and more able to address other challenges. However, it is important to emphasize that while many clients confirmed that SMART facilitated their access to existing services, the vast majority stated that the services and supports they required were unavailable (e.g., substance use treatment, affordable housing).

The second type of benefit was associated with clients' interpersonal experiences with SMART representatives. Clients described SMART as having provided them with attention and opportunities that they would not otherwise have received. In some cases, SMART was described as the first service to offer meaningful assistance. Clients articulated feeling more hopeful following their encounters with SMART, and appreciative of the care and concern shown by table members. Many participants reported that they valued ongoing relationships with team members after their cases were closed, and that they missed the level of support they received as active clients. Expressions of gratitude and hope were prevalent among interviewees who remained homeless and at risk.

Risk Identification

Results show that SMART clients share a number of characteristics with their counterparts receiving Hub services throughout the country (e.g., see Babayan *et al.*, 2015; Bown and Newberry, 2015; Lamontagne, 2015). Age and gender

distributions are similar to those reported by existing Hub evaluators, and clients are predominantly designated as having 'individual' (versus family) status. A number of intervention-related details are also similar between Hubs: most cases originate from policing agencies and are resolved within 2-3 weeks, with clients connected to services deemed appropriate to their respective situations.

There are, however, some notable differences with respect to the relative priority of risks and needs faced by clients across sites. While housing and basic needs emerged as paramount among SMART clients in Surrey, mental health issues were - overwhelmingly - the most prevalent risk factor reported in other sites across the country. This discrepancy is difficult to interpret due to the multi-dimensional challenges faced by Hub clients and the absence of rigorous and standardized differential diagnoses and assessments across sites. Given the absence of standardized assessment instruments and protocols between Hubs, reported differences in observed client risk factors may – at least in part - arise from the settings in which clients are identified. In the City of Surrey, the vast majority of clients were identified in a homeless encampment, and thus were more likely to illicit concerns about homelessness. Accordingly, presenting risk factors are likely a strong reflection of the local context in which individual Hubs operate.

Next Steps in Practice and Research

Before addressing the implications of this research, it is important to place the SMART intervention in context. A rising tide of homelessness, mental illness,

substance use, and public disorder constitutes an emergency in many communities. Hubs like SMART are positioned to identify the most urgent cases of risk (e.g., immediate threat of harm to oneself or another) and intervene. They are crucial and potentially life-saving interventions. But they are not designed or resourced to provide long-term solutions to their clients' problems, nor are they capable of addressing the needs of homeless individuals who may have concurrent needs but are not currently in crisis.

There are examples of programs that aim to deliver long-term support for people exiting homelessness and who are experiencing complex challenges including addiction, mental illness, and recurrent involvement with the justice system. The largest public health experiment in Canadian history investigated long-term recovery for people who were both homeless and mentally ill (Goering *et al*., 2011), with results demonstrating housing stability (Aubry *et al*. 2016), improvements in quality of life (Patterson *et al*., 2013), reductions in emergency department admissions (Russolillo *et al*., 2014), decreased criminal offending (Somers *et al*., 2013), and greatly improved participation in psychiatric treatment (e.g., Rezansoff *et al*., 2017). These results resoundingly demonstrate that profound positive changes are achievable with specific combinations of housing, support, and an appropriate clinical style.

Additional research has examined long-term outcomes for people who do not receive advanced evidence-based interventions. The status quo for Canadians who experience homelessness alongside other serious challenges involves a

revolving door of extremely costly services (Latimer *et al*., 2017; Somers *et al*., 2015), notably associated with health emergencies, victimization, and exposure to crime. Many rural and remote communities lack appropriate services and supports, which may contribute to migration by individuals with complex and co-occurring disorders to locations where resources are concentrated (e.g., Somers *et al*., 2016). Some empirically supported interventions have been successfully adapted to rural communities, including Assertive Community Treatment (Pope and Harris, 2014), and Housing First (Stefancic *et al.,* 2013), and the broader implementation of these programs may help reduce the concentration of complex and marginalized people in urban settings.

Our current findings support the role of brief interventions like SMART in the identification of high-risk cases, successful diversion from acute risk, and positive rapport building with extremely vulnerable and marginalized people. These are critically important facets of a comprehensive solution. However, the obvious implications from this research and from the relevant empirical literature are that Hub interventions must be closely affiliated with services that integrate market housing and supports, with a mandate to achieve long-term stability among clients with significant health and social needs. In the absence of empirically supported services, (e.g., case management, ACT), they will likely remain in a dangerous and costly cycle of unmet need. Economic costs of the status quo have been estimated by separate studies at approximately $55,000 per person per year (Latimer *et al*., 2017; Somers et al., 2015b).

Canada has led the world in the scientific development of effective interventions for people experiencing complex co-occurring challenges including homelessness. It is an apparent violation of Canadians' rights, values and commitments that it is possible to find a young woman, pregnant, injecting drugs and abandoned to poor nutrition, sleeping in a tent, and otherwise unsupported. Appropriate and effective interventions are now well established through research and should be the standard of practice.

The de-escalation of imminent risk of harm, although necessary and often life saving, is not a stand-alone solution to the longstanding and complex social problems present in today's rapidly growing urban centres (such as Surrey, BC). Rather, SMART can be seen as a gateway to more intensive and enduring services, delivered - as needed - in a coordinated manner and supported by policies and procedures (e.g., information sharing) that encourage client-centered care.

The current study contributes some of the first evidence concerning clients' experiences with Hub interventions, augmented with descriptive data collected by SMART. Although table discussants attested to the representativeness of the study sample, we are unable to confirm this quantitatively. Neither the data provided by the SMART database nor self-reported details provided by participants could be corroborated or validated by comparison with alternate (e.g., administrative) data. A further potential limitation of this research concerns the generalizability of our findings to other communities.

Several research questions addressing the Hub model require investigation, including details of the life trajectories leading to situations of AER, and the effectiveness of Hub interventions when paired with a comprehensive standard of support (e.g., Assertive Community Treatment). The study of long-term outcomes for clients of Hub interventions (e.g., using linked, longitudinal administrative data) is also required. This type of research would describe the patterns (and costs) of service use preceding clients' engagement with Hub services, identify the conditions required to successfully divert individuals from acute risk, and establish the resources needed to achieve long-term recovery. Particular emphasis is needed on the identification of people who may be at risk for street homelessness so that they can be supported in place, thereby preventing the growing demand for Hub interventions. Answers to these and other questions will substantially advance the field in its quest for evidence-based practice.

Conclusions

This study set out to learn from people who are at risk, and found that the SMART intervention effectively attenuates acute crises, establishes rapport, and inspires hope among highly marginalized people. Also, SMART appears to effectively triage cases based on acuity of risk. Less clear is where SMART will refer people who require evidence-based housing and support. A robust body of evidence details the types of services that are effective, and develops the business case for their

implementation. Scaling up these services to meet demand is now a matter to be resolved by elected officials and the public servants who support them.

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Appendix "II"

Surrey Mobilization and Resiliency Table (SMART) Participant List

May 2018

Name	Agency
Terry Waterhouse	City of Surrey
Chuck Crossfield	Corrections BC (Adult Probation)
Elena Henriksson	Corrections BC (Adult Probation)
Hilary Espezel	Fraser Health Authority
Inder Dosanjh	Fraser Health Authority
Kuda Mabiza	Fraser Health Authority
Raj Sidhu	Fraser Health Authority
Rohit Kambo	Fraser Health Authority
Jennifer Wishinski	Lookout Housing and Health Society
Leonard Levy	Lookout Housing and Health Society
Liz Campbell	Lookout Housing and Health Society
Megan Kriger	Lookout Housing and Health Society
Chelsea Parman	Ministry of Social Development and Poverty Reduction
Heather Ellioti	Ministry of Social Development and Poverty Reduction
Ingrid Willis	Ministry of Social Development and Poverty Reduction
Leah Campo	Ministry of Social Development and Poverty Reduction
Morten Bisgaard	Ministry of Social Development and Poverty Reduction
Natalie Harper	Ministry of Children and Family Development
Erick Parmiter	Options Community Outreach Services Society
Jaskarn Dhillon	Options Community Outreach Services Society
Lara Isaksch	Options Community Outreach Services Society
Reena Nand	Options Community Outreach Services Society
Erin Harvie	Pacific Community Resources Society
Tyler Lee	Pacific Community Resources Society
Val Clement	Pacific Community Resources Society
Pam Esplen	Surrey RCMP
Tanya Wong	Surrey RCMP
Carl Garlinski	Surrey RCMP
Jon Ross	Surrey School District
Sarah McKay	Surrey School District
Sharon Jackson	Surrey School District