RECOVER INTEGRATED REVIEW

Prepared for MaRS Discovery District

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- OVERVIEW -

The Recover project has the goal of promoting urban wellness in Edmonton. Specifically, the aim of the program is to improve urban wellness as it relates to five key indicator categories: 1) social capacity; 2) economic vitality; 3) safety and security; 4) physical and mental health; and 5) built and natural environments. These indicator categories were identified by the Recover team through consultation with community organizations, members of vulnerable population groups, and government officials in Edmonton to ensure best fit with the local context.

To summarize existing evidence and best practices, we have completed five mini-reviews of the academic literature of community interventions, services, initiatives, and programs related to the aforementioned five indicator categories. In the mini-reviews, we summarized the impact of these interventions for inner city communities, while drawing particular attention to the possible implications for very vulnerable populations (VVP). Integrated into each mini-review is an assessment of five political factors: **duration of intervention/assessment** (i.e., long-term or short-term); **governance and conflict resolution models**; **data-sharing processes**; **service delivery models** (i.e., centralized or dispersed); and **integration of a systems-level approach**.

As requested by MaRS Discovery District, the scope of the mini-reviews was limited to literature reporting on interventions (services, etc.) that: assessed or evaluated (qualitatively and/or quantitatively); focused on inner city/urban communities (i.e., excluding rural and suburban) in high-income countries; and were published in the previous 10 years (or key papers outside that time period) in English. The literature included in the mini-reviews primarily came from Canada, United States of America, United Kingdom, Australia, and New Zealand. We also reviewed and summarized local grey literature (e.g., descriptive, program impact, and policy reports from Edmonton-based organizations provided to us by MaRS Discovery District) according to the five wellness indicator categories. The aim of this integrated review is to provide a broad environmental scan and synthesize the local grey and academic literature.

Our examination of the programs/services reported in the mini-reviews and grey literature revealed connections not only to the established wellness indicator categories, but also to the social determinants of health (SDOH), which are:

> The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries[1, para.1].

Within a Canadian context, the SDOH include: Aboriginal status, disability, early life, education, employment and working conditions, food in/security, health services, gender, housing, income and income distribution, race, social exclusion, social safety net, unemployment, and job security[2]. Researchers examining the SDOH in Canada have found: "their effects are actually much stronger

than the ones associated with behaviours such as diet, physical activity, and even tobacco and excessive alcohol use"[2, p.9].

Here we present the information reported in the mini and grey literature reviews according to the relevant aspects of the SDOH. The information has also been organized according to two pathways for community-based intervention: 1) top-down (structural and political); and 2) bottom-up (community-initiated programs and services).

- Top Down Interventions -

Top-down interventions refer to policies, regulations, programs, or structural changes implemented based on authoritative decision. The key actors in top-down interventions are often described as 'decision-makers', 'policy-makers', or 'political figures'[3]. Top-down interventions generally mapped onto the following four SDOH: 1) housing; 2) health services; 3) income; and 4) food in/security. In addition, built and natural environments were often the focus of top-down interventions. Although these are not consistently described as SDOH, there are clear connections to the SDOH (e.g., social exclusion).

Housing

Housing as it relates to the SDOH includes three intersecting constructs: adequate housing conditions; affordability; and residential stability[4]. Housing represents a top-down approach to wellness intervention because it involves public policy and government responsibility to provide citizens with prerequisites for health[2]. We found housing-related interventions across **all five** wellness indicator categories as well as in the grey literature scan. In fact, programs focused on housing provision and assistance and/or people experiencing homelessness were the most common type of intervention discussed in the grey literature we were provided for review.

Top-down housing interventions found within the academic and grey literature include permanent supportive housing (i.e., programs amalgamating housing and social service support[4-14], housing mobility programs (i.e., provide incentives to move families out of unsafe inner city environments[15,16]), co-housing facilities (i.e., autonomous units with shared spaces[17]), housing voucher programs (i.e., financial assistance to ensure safe, sanitary housing[18]), and mixed-income housing developments[18,19]. In the local grey literature specifically, we found organizations focused on addressing housing needs among refugee and immigrant populations[20,21], youth[14,22], LGBTQ2S seniors[23] (36), individuals with addictions[12,24], victims of domestic violence[25], and people who are homeless/vulnerably housed[13,26,27].

The reported **impact** of these housing interventions has been mixed. Permanent supportive housing has increased security[28] and empowerment among residents[29]. It has also been successful at providing sustained housing tenure for homeless individuals with mental illness[6,7]. Programs to re/develop or improve social housing in inner cities have improved housing quality[30] and had a positive impact on health[4,11]. Co-housing programs have increased community connectedness by encouraging residents to socialize and care for one another[17]. However, when re/development efforts include mixed housing (i.e., low and high cost housing), relocation, or broader neighbourhood renewal, the outcome of these interventions is less straightforward[18,19]. For example, discrimination, segregation, and displacement have been reported in relation to mixed-income developments and neighbourhoods that have undergone substantial revitalization[18,31-33]. The

economic impacts of housing interventions have also been mixed. Despite research suggesting mixed-income housing developments can improve affordability[34-36], residents who have been re-housed in low-poverty neighbourhoods have reported an increase to their cost of living in addition to the loss of social connections[18,32]. Nevertheless, revitalization efforts are commonly based on the premises of local job creation, attracting new business, and increasing tax revenue[34,37]. These, however, do little to address the needs of VVP[33] or the underlying structural and cultural causes of housing insecurity among marginalized sub-segments of the population[38]. That said, examples from the local grey literature demonstrate that interdisciplinary and intensive case management has been successful in housing VVP[12,14,39]. For instance, the 24/7 *Mobile Assistance Program* initiative estimated that housing twenty-six clients experiencing homelessness resulted in a return on investment of $600,000 to $1.2 million[12]. The *Supportive Housing* initiative was also a successful strategy to support vulnerably housed teen families through subsidies and additional wraparound health and social support services[14].

Health Services: Access, Delivery, And Quality

The delivery, quality, and access to community health services are an essential SDOH and can greatly impact individual and population health status as well as overall urban wellness[2]. In Canada, health service provision primarily falls within the mandate of the provincial and territorial governments and therefore represents a top-down approach to intervention. We identified top-down interventions to improve health services in relation to wellness indicator categories **safety and security** and **physical and mental health**. Health services were also discussed within the local grey literature.

Top-down community health service interventions included harm reduction strategies (e.g., safe injection sites), service navigators, culturally appropriate pre-natal care, and community outreach and support (e.g., chronic disease prevention, immunization) and are often provided as part of a comprehensive program, which may also include housing – these were evident in both the academic[8,9,40-52] and grey[21,53] literatures. Interventions focused on harm reduction have included safe injection sites, substance exchanges, and education and therapy programs[32,54,55]. Other programs have provided immunizations, HIV screening, and sex education to inner city residents, children/families, and VVP[41-43]. Services for VVP have employed comprehensive approaches, combining outreach, emergency food, information and referral, counselling, and case management[9, 10,40,47,52]. Locally, initiatives such as the *Caring and Responding in Edmonton* (CARE) project have explored structural barriers to accessing health care services (e.g., transportation, lack of navigator/advocacy support, and poor cultural awareness) in order to improve supports and the overall experience[53].

With regards to **impact**, the use of case management (or patient navigators) has also been successful in reducing hospital re/admissions among VVP[51,52] and older adults[44]. Supportive housing models have had a similar impact with VVP[10,46,50] – these results have been noted in the local grey literature as well[12,13,24]. In recent years, health services have become increasing mobile[56] and successfully included 'telehealth' delivery[45]. In Edmonton, the *24/7 Mobile Assistance Program* was estimated to have increased the efficiency of the Edmonton Police Service and Emergency Medical Services by diverting 939 and 274 calls, respectively, through a crisis diversion and follow-up support model over a 2-year period[12].

Income and Employment

Income and economic status are important SDOH[2]. According to the World Health Organization[57], the greater the gap between the richest and poorest people, the greater the differences in health. Government policies have a strong influence on income and employment. We identified interventions to improve income and employment in relation to the wellness indicator category *economic vitality* from academic sources and also within the Edmonton-specific grey literature.

Top-down interventions that have addressed income inequality include universal basic income (UBI), living wage policies, increasing minimum wage, and implementing redistributive tax[26,58-62]. However, research examining the **impact** of these interventions has been inconclusive. For example, evaluation studies on the efficacy of UBI demonstrates neutral or modest declines in labour market participation, with many young people receiving UBI leaving the labour force to pursue additional education; however in the longer-term these policies may result in economic stability and growth[58,59]. Additionally, redistributive taxes and cash transfers interventions can be variable and difficult to measure[60]. Furthermore, despite the suggestion that increasing the minimum wage can help lift individuals out of poverty[61], researchers have suggested it is unlikely to improve income inequality[62]. Within Edmonton, a 2017 report to inform the *End Poverty Edmonton* initiative recommended that the City of Edmonton develop a living wage policy for city staff and contracted services[26]. In 2016, the living wage in Edmonton was calculated at $16.69/hour for a two-parent family with two children to live modestly with economic stability[26]. While the minimum wage is set to increase to $15/hour in Alberta on October 1st, 2018, the rate remains below the 2016 living wage[26].

Food In/security

Food in/security is a SDOH and contributes to poor health among vulnerable or disadvantaged peoples[2]. Differences in food distribution and access across socioeconomic status can reinforce inequalities in health[2] and are amenable to change through policy action. We identified interventions within the academic literature to improve food in/security in relation to the wellness indicator categories *economic vitality*, **safety and security**, **physical and mental health**, and **built and natural environments**. We did not come across any programs specific to food in/security within the local grey literature. Top-down interventions that have focused on improving food in/security primarily include food retail policies and regulations (e.g., policies permitting urban farmers markets, street vendor regulations, grocery store zoning and development[63-73]).

Policies that promote an improved food retail environment have had little **impact** on food in/security or health more broadly[63-65,74], although we noted a few exceptions[66,67]. Other programs such as farmers markets improved access to food and drove down the prices of similar products at local grocery stores[69].

Built and Natural Environments

Built and natural environments contribute to urban wellness in a myriad of ways, and often negatively in those public spaces where disadvantage and poor environmental quality coincide[75]. We identified top-down interventions to improve urban environments in relation to **all five** of the wellness indicator categories from across the academic and local grey literature.

Programs to improve built and natural environments within the academic and grey literature have primarily focused on neighbourhood revitalization (e.g., beautification, 'greening', safety measures). Specific activities have included repurposing vacant lots[76-82], installation of furniture and public art[81-83], the inclusion of pedestrian plazas[84,85], improvements in street lighting[81-83], traffic calming (e.g., reduced parking, speed limits, raised crosswalks[81-83,86]), incorporation of vegetation and landscaping[80,83,86], and the addition of closed-circuit television (CCTV)[32,80]. With the intention of increasing opportunities for physical activity, specific programs have focused on re/developing local playgrounds, parks, and/or green spaces[87-91] and walking paths[88,92]. Within the local grey literature we found neighbourhood revitalization strategies that were developed for Queen Mary Park and Central McDougall[81] and McCauley[82].

The reported **impact** of these changes to urban environments have included increases in physical activity and use of the park space[88-91,93], stress reduction[94], improved psychological wellbeing[76], positive perceptions about neighbourhood safety[93], decreases in vandalism[94], and reductions in gun assaults[94]. Despite these positive associations, however, revitalization efforts have also been linked to increased property values (i.e., gentrification), which can have negative impacts on low-income residents[76,77].

Relationship to Relevant Political Factors

Duration

With regards to **duration** of interventions, top-down approaches often target longer-term outcomes (e.g., providing permanent supportive housing, revitalizing neighbourhoods, food and income policies[4,11,26,93,95]). However, these interventions are infrequently assessed for their long-term impacts. As a result, researchers have suggested that longitudinal studies would provide more nuanced data about the long and short-term benefits and consequences of interventions[78,83]. Within the grey literature, we found many examples of strategies[26,95] making recommendations to target longer-term outcomes as opposed to impact evaluations of programs implemented these recommendations. However, the *24/7 Mobile Assistance Program,* previously described, did report on impacts over a 2-year period[12].

Governance and Conflict Resolution

In reference to **governance and conflict resolution models**, although top-down approaches are often driven by government officials, partnerships with the community were recommended to ensure shared decision-making, mutual benefit, and the effective use of community strengths and resources[31,85,93]. As such, participatory and collaborative approaches have been used to achieve buy-in from community members (particularly VVP), account for local needs, and promote capacity building and social justice[8,20-22,38,14,56,96,97,98]. However, lack of time and community leadership may create barriers to participatory approaches and collaboration[96].

Data-Sharing Processes

Data-sharing processes were not commonly reported in the literature on top-down interventions. However, some studies did include publically available data in their analyses (e.g., census data, national health survey data, tax records, police records, health records[94,99]). This highlights the importance of centralized databases and reinforces the need for better data sharing infrastructure[11,78], which was particularly evident in the grey literature[95,100]. For example, the *Senior*

Centres of the Future Strategy[100] and the *Community Strategy to End Youth Homelessness in Edmonton*[95] recommended establishing coordinated assessment strategies and processes for sharing information across organizations.

Service Delivery Models

Related to **service delivery models**, interventions focused on VVP were most effective when implemented locally and within inner city communities where people had existing social ties and access to culturally-appropriate services[20,21,35,53,70,101,102]. Common themes related to service delivery were integrated models, community relevance, interdisciplinary collaboration, system navigation, cultural alignment, and user satisfaction[10,12,13,39,46,56,101,102].

Systems-Level Approach

A number of the top-down interventions recognized the importance of adopting a **systems-level approach**. For example, several initiatives adopted a multi-level approach by integrating policies and community programs[71,103]. Additionally, funding for top-down interventions often came from multiple government and non-government sources including the private sector[34,37,70,76].

- Bottom-Up Interventions -

Bottom-up interventions refer to programs and activities that are implemented at the local, community level. The key actors in bottom-up interventions are community organizations. They react to the macro-level policies and plans by developing and implementing their own programs based on the needs and circumstances of their communities, clients, members or participants[104]. Bottom-up interventions mapped on to the following five SDOH: 1) early life; 2) education; 3) health services (community outreach); 4) food in/security (community programs); and 5) employment and income (social models).

Early Life

Early life (also commonly referred to as early childhood) is defined as the period from prenatal development to eight years of age and is considered the most important developmental phase of life[105]. Healthy early childhood includes cognitive, physical, social, and emotional development. We identified bottom-up interventions to improve early life in relation to the wellness indicator categories **economic vitality**, **safety and security**, and **physical and mental health** mini-reviews and also within the Edmonton-specific grey literature. Community-based programs focused on early childhood often take an outreach approach and include prenatal counselling[106], infant feeding[107-108], general parenting skills[109,110] and literacy development[11,112], and supports for teen families who are a particularly vulnerable group[14].

Overall, the literature revealed that these programs have had a positive **impact** on parenting practices, food choices and healthy eating practices, literacy, and development among children[109,110,112,113]. In the *Successful Families* initiative[14], which provided housing, social, and health service support using a community capacity building model, teen parents were able to raise their children in a stable and safe environment. Further, teen parents reported building relationships with their neighbours, which led to providing mutual support such as swapping baby-sitting services[14].

Education

Education is a critical SDOH[2] and is associated with improved health and wellbeing, employment, and income[114]. We identified bottom-up interventions to improve education in relation to the wellness indicator categories **economic vitality**, **safety and security**, **physical and mental health** across the academic and grey literature.

Education was the mandate of many programs focused on improving 'healthy behaviours' such as healthy eating and physical activity[106,107,113, 115-117] and in relation to public health activities (e.g., immunizations, infant feeding[107,108]). Adult education programs have included stress management training, literacy programs (numeracy, reading), and job search and training programs[118-121].

In terms of **impact**, stress management training and 'job club' interventions have reduced emotional distress and improved healthy coping mechanisms among job seekers[119,120]. Programs that address adult literacy have been linked to increases in self-esteem[121], greater income stability[122], and financial literacy (e.g., learning how to budget[14,123]). Despite these positive employability characteristics, however, there appears to be little or no effect on employment mobility (i.e., attaining higher employment status[121]). Early education interventions have reduced social welfare dependency by increasing educational attainment and earnings later in life[124], promoted literacy and development[111], and improved parenting practices and child development[109,110]. School recreational programs for children improved quality of life and community safety and reduced youth involvement with drugs and gangs[125,126].

Health Services: Community Outreach

Outreach programs provide services to populations who would not otherwise have access and are often initiated within the communities they serve. We identified bottom-up interventions to improve health services in relation to the wellness indicator categories **safety and security** and **physical and mental health** in the academic sources and within the Edmonton-specific grey literature.

Health service related community outreach programs provide a variety of resources and supports including education, therapy, harm reduction services, disease treatment and prevention, support groups, peer mentoring, as well as identifying vulnerable seniors and are often connected to housing supports[54,55,127-129]. Other health services outreach programs have targeted HIV prevention among inner city residents (e.g., condom provision[130]).

The **impact** of prevention-focused outreach programs have moved beyond health service provision and have proven successful at increasing social inclusion and family support among VVP[128,131]. For example, nurse and teacher training on the psychosocial health needs of very vulnerable children coupled with peer-to-peer support groups for the children improved resiliency and reduced depression among participants[132]. The *Finding Isolated, At Risk Seniors Project* identified different strategy to engage isolated seniors to increase access to supports and reduce isolation[129]. At-risk, isolated seniors tend to be women, live alone, be over the age of 85 years, have poor mobility and ill health, and live in urban areas[129]. This project found that the gatekeeper strategy (through family, friends, health and social service providers) was one of the most effective of identifying and engaging isolated seniors[129].

Food In/security: Community Programs

We identified bottom-up interventions to address food in/security in relation to the wellness indicator categories **social capacity** and **safety and security** in the academic literature, but there were not any reported in the local grey literature provided. Community interventions focused on increasing access to healthy food in disadvantaged populations via non-governmental food aid programs (e.g., food banks, food stamps, meal services[68,133-137]) and community gardens[138-146]. That said, the primary aim of a number of these programs was not to improve food security, but rather to develop other aspects of community such as *social capacity*[141-145], health and wellbeing[146], or reduce obesity among specific at-risk populations[138].

Food aid programs have had a positive **impact** on food security (e.g., access) and reduced social isolation[68,133,134-137]. Similarly, community gardens have provided a potentially sustainable option for improved food security and other health benefits[141,142,144,146]. One critique of community garden programs is that they can unintentionally support policies that reduce government social supports[142,147] and promote racial and social exclusion[139,140].

Employment and Social Exclusion: Social Models

Bottom-up initiatives to promote business investment have focused on a variety of strategies targeting the inner city. For example, social enterprises (i.e., businesses with primarily social objectives) can benefit local labour markets by providing paid employment to VVP in the community who may face barriers to employment[148,149]. We identified bottom-up interventions to improve employment and reduce social exclusion in relation to the wellness indicator categories **social capacity** and **economic vitality** in the academic literature and also within the Edmonton-specific grey sources.

The social enterprise model encourages the development of employable skills and connections to peer and community support, particularly among VVP[148,150,151]. With regards to **impact**, financial incentives (e.g., seed grants[152]), public-private partnerships (e.g., rent reduction for entrepreneurs[153,154]), and businesses co-owned by marginalized populations[155] also encourage the development of employment-related skills, foster community connections, and increase employment and revenue among inner city communities and VVP[149]. The *Providing Accessible Transit Here* (PATH) initiative in Edmonton helps to support social inclusion by providing free public transit passes for homeless/precariously housed people to support attendance at school, medical and social service appointments, and work opportunities[156].

Relationship to Relevant Political Factors

Duration

Bottom-up interventions were primarily short-term in **duration**. As such, with few exceptions[121,148] the majority were too short to report long-term impacts[115,157,158]. Bottom-up interventions are likely short-term because key actors are often community organizations with specific goals, resources, partners, and participants. For example, community youth and recreation initiatives were frequently developed and implemented in partnership with schools and other organizations according to the school calendar[152,159-161]. The duration of other initiatives were limited due to the type of intervention. For example, programs that focused on developing individual skills such as job training or coping skills to improve mental health were intended to end once individuals completed the program[115,120,157,158].

Governance and Conflict Resolution

Given that the key actors in bottom-up interventions are typically community organizations, participatory approaches and partnership development were commonly discussed in reference to **governance and conflict resolution models**. For example, interventions that adopted a community-based research approach stressed community ownership and involved members of the community in all phases of the research[142,145,150,159-161]. Other interventions stressed the importance of formal community partnerships with a diverse range of stakeholders (e.g., social services, health services, police, school boards, not-for-profit organizations[12,13,39,129,149,155,162,163]). Community involvement was important to ensure culturally appropriate interventions that meet the unique needs of minority and underserved populations[20,21,116]. These relationships were, however, not without challenges such as navigating existing hierarchies and power dynamics[148].

Data-Sharing Processes

Data-sharing processes did not appear to be an important facet of bottom-up interventions. A more common view appears to be that shared data may have limited application across populations and projects[164]. This view is consistent with community-based interventions that used local knowledge for decision-making, particularly knowledge from VVP[145,150,159,160].

Service Delivery Models

Given the nature of bottom-up interventions, the majority of literature referred to decentralized **service delivery models**. That is, the majority of programs and initiatives were offered in schools, community clinics, recreation facilities, or community centers[106,115,157,158]. By operating within these community facilities, programs and initiatives were able to best respond to local needs[127,159]. In regards to health services, the provision of service navigation support and community-based continuous care models were best able to meet the services and needs of VVP[127].

Systems-Level Approaches

To ensure sustainability of bottom-up community-led programs and initiatives, **systems-level approaches** are required. Specifically, a systems-level approach would allow for the development of multi-sectoral partnerships as well as ongoing government support[141,152,162].

KEY MESSAGES

- The Recover wellness indicator categories have clear connections to the SDOH – these links may prove helpful in the future to guide the measurement of Recover programs and initiatives and ground the evaluation process within rigourous, established techniques. Additionally, these connections will provide a platform from which to link Recover with urban wellness initiatives occurring across Canada and globally (e.g., to share knowledge).
- To achieve urban wellness, interventions and programs that take both top-down and bottom-up approaches are required. Essential to this process will be an understanding of the mechanisms that best connect these two different approaches to intervention and programming (i.e., conflict resolution and community governance, service delivery models, and the integration of a systems-level approach).
- Regardless of the approach to intervention (top-down or bottom-up), working in partnerships with communities (members and organizations) creates a pathway to address local needs in a way that is acceptable and appropriate to community residents. This is particularly important when creating interventions that have an impact on VVP.

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