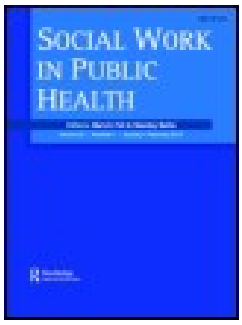

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At the Intersection of Homeless Encampments and Heroin Addiction: Service Use Barriers, Facilitators, and Recommendations from the City of Philadelphia's Encampment Resolution Pilot

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ABSTRACT

We provide an overview of the pilot and evaluation measures used for an independent evaluation of the Encampment Resolution Pilot (ERP) wherein the City of Philadelphia closed two homeless encampments in May 2018 and sought to assist those displaced by the closures with housing and treatment services. The evaluation used the Rapid Assessment, Response, and Evaluation method to collect qualitative findings on service use barriers and facilitators from open-ended interviews with people staying in the encampments (N = 27) and service providers (N = 10). We assessed how the ERP allowed providers to "push the system" by removing access barriers, and providing amenable, effective, and accessible housing and drug treatment services that led to more widely adopted best practices. However, there was a clear need for additional supportive services and aftercare for those exiting treatment. Providers also cited a need for more integrated medical and mental health services.

KEYWORDS

Homeless; encampments; opioid use disorder

On a single night in January 2018, over half a million people (552,830) experienced homelessness in the United States; over one-third (35%, 194,467) were staying outdoors, in abandoned buildings, or other locations not suitable for human habitation. Despite a 13% overall reduction in the number of people experiencing homelessness nationally since 2010, recent increases in homelessness have been driven by a rise in the number of individuals staying in unsheltered locations. (Henry et al., 2018)

Scholars have recognized new growth in the phenomenon of homeless encampments or "tent cities" across the country (National Coalition for the Homeless, 2010). Homeless camps can be traced from the latter half of the 19th century, proliferating during the Great Depression, and declining during World War II and the postwar boom (Herring, 2015). Herring and Lutz (2015, p. 690) postulate that contemporary encampments are, "first and foremost creatures of urban policy: reactions and partial solutions to multiple crises of ongoing penal and welfare restructuring of the local state dating back to the early 1980s." A media survey of news reports between 2008 and 2013 documented over 100 large tent communities in 46 states and the District of Columbia (Hunter, Linden-Retek, Shebaya, & Halpert, 2014). Homeless encampments reflect not just inadequate housing stock, but also a service system that does not meet the immediate or long-term needs of homeless individuals (Hunter

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et al., 2014). For those on the margins of society whose needs are not being met through formal systems, encampments can offer autonomy, community, and security (Hunter et al., 2014; Lutz, 2015).

At the same time, researchers have been tracking a growing heroin epidemic and corresponding increases in heroin-related overdose deaths (Center for Disease Control [CDC], 2015). Between 2010 and 2017, the rate of heroin-related overdose deaths increased by almost 400% (Hedegaard, Miniño, & Warner, 2018). Homelessness is significantly associated with injection drug use and injection-related risk behavior and relapse (Linton, Celentano, Kirk, & Mehta, 2013), and people experiencing homelessness appear at greater risk for overdose than those who are housed (Seal et al., 2001). In response, the federal government has increased access to substance use treatment services and expanded the use of Medication-Assisted Treatment (MAT) for people suffering from opioid addiction (CDC, 2015).

While research denotes a link between homelessness and substance abuse, understanding of the relationship between the two remains unclear (Briggs et al., 2009; Fitzpatrick, Kemp, & Klinker, 2000; Johnson, Freels, Parsons, & Vangeest, 1997). What is known is that a successful policy response to ending homelessness must incorporate housing access and affordability, as well as services for substance use and mental health issues and efforts to address unemployment and poverty (City Policy Associates, 2014). Amidst concerns about homeless encampments and heroin abuse and its related mortality, it is crucial to identify appropriate policy and service responses.

This paper explores the intersection of homelessness and heroin addiction from a pilot project and evaluation that took place during the closure of two homeless encampments in the City of Philadelphia (hereafter, City). In these encampments, homelessness and substance abuse had become integrated to the point where they were no longer distinct problems. The integration of the pilot implementation with an independent evaluation provided a unique opportunity to build knowledge to inform ongoing work in these communities. Here, we describe the initial pilot and evaluation measures. We then incorporate the perspectives from people staying in these homeless encampments and providers to bring attention to service use barriers and facilitators and offer recommendations for future efforts aimed at serving the vulnerable population at the intersection of these two issues.

Background

On a single night in January 2019, 1,139 people were identified as sleeping on Philadelphia's streets through the annual Point-in-Time (PIT) count, a 56-person, or 5%, increase from the previous year. Taken over time, the City had seen reductions in the overall growth of homelessness, yet the PIT showed a 36% increase in unsheltered homelessness in 2017, followed by a 13% increase in 2018. In response, Liz Hersh, the Director of the City's Office of Homeless Services emphasized, "We need to slow the train before we can eventually stop it, and the momentum right now is in our favor. It's critical that we continue to do everything we can to keep progress going. The fact that, despite all the work going on, we're still seeing even small increases in our totals shows the inordinate amount of pressure our partners and our neighborhoods are under" (City of Philadelphia Office of Homeless Services, 2019). Part of the pressure described by Hersh related to growth in opioid-linked homelessness specific to the Kensington section of the City where heroin is cheap and easy to access. Between 2017 and 2018, Kensington saw its PIT counts leap from 271 to 703, accounting for more than half of the City's unsheltered homeless. This spike occurred despite the closure of several homeless encampments in the neighborhood, leading the City to consider a new approach in dealing with the four remaining encampments (Whelan, 2018).

Encampment resolution

Between August 2016 and July 2017, the City of San Francisco closed 17 encampments through an approach known as "encampment resolution" that sought to connect people sleeping in encampments with housing and services prior to encampment closure. This approach starts by setting a deadline for removing the encampments, creating an urgency for people sleeping in encampments to accept housing, treatment, and other services as an alternative to displacement, and then subsequently

focuses outreach efforts on this population (Department of Homelessness and Supportive Housing, n. d.; San Francisco Public Works, 2019).

In April 2018, Philadelphia adapted the encampment resolution process to close two of the Kensington encampments—one on Kensington Avenue and the other on Tulip Street, parallel cross streets a half mile apart under a set of active railroad tracks—by the end of May. As was the case with San Francisco, Philadelphia's emerging Encampment Resolution Pilot (ERP) plan prioritized both the physical clearance of the encampments and making available housing, substance use, and other services for those facing displacement from the encampments. (Department of Behavioral and Intellectual Disabilities, 2018)

Rapid assessment, response, and evaluation

As part of the ERP, the City commissioned an independent evaluation of the ERP through academic partners. The evaluation comprised four primary activities, in a modified application of the RARE method (Rapid Assessment, Response, and Evaluation; Trotter, Needle, Goosby, Bates, & Singer, 2001). These activities provided a timely, multifaceted assessment of the closure and resettlement process. The evaluation also sought to assess the impact on those displaced by the initiative and the surrounding communities. They included:

(1) An Outreach Encampment Survey conducted by outreach workers that provided an initial profile of people staying in the encampments (i.e., target population);
(2) Survey data linked with City administrative data that provided additional service history context, a baseline for assessing changes in services use that may have resulted from the intervention, and an opportunity for continued monitoring and engagement of the target population;
(3) An ethnographic component that examined the impact of the closure and resettlement through direct observation and interviews with people staying in encampments, people who accessed services through the ERP, community members, City representatives, and service providers; and
(4) A process evaluation that documented the history of the intervention development, the implementation process, and the relative efficacy of the project.

Service use history. Outreach Encampment Survey data and linked City administrative data suggested near ubiquity of substance use, and particularly opioid use, among the 169 people identified as staying in the encampments. The population also had an extensive history of utilizing homeless services, substance use treatment, and other services available through the City. Quantitative findings from the evaluation related to service use are outlined below (see also Metraux, Cusack, Graham, Metzger, & Culhane, 2019).

Homeless services. A little more than half of survey respondents had used and/or were willing to go to a shelter, and more than 9 in 10 expressed willingness to go to a shelter with minimal rules. City data indicate that a smaller proportion had a record of a shelter stay prior to ERP implementation with substantial increases following ERP implementation, when low-demand respite housing was offered through the initiative.

Substance use treatment. Nearly all survey respondents reported current drug use, with opioid use being the most prevalent. About three-quarters said they had previously been in substance use treatment, with an equal number expressing interest in getting treatment for substance use at the time of the survey. MAT and long-term treatment that could lead to permanent supportive housing was of particular interest. City data supported these claims: over half had a record of receiving rehabilitation services and/or outpatient substance use treatment services, with first engagement primarily occurring prior to ERP implementation. About one-quarter received treatment during ERP implementation and sustainment.

Additional services. Over half of survey respondents reported mental health challenges. Those who reported receiving help for mental health challenges amounted to less than half the proportion who affirmed interest in such assistance. City data indicate that the majority of people staying in the encampments had received at least one mental health service, with just over half receiving inpatient services, and just under half receiving crisis or emergency services prior to the ERP. Minimal changes were reported in use of these services during the ERP. The majority of survey respondents also reported interest in employment assistance; data on employment services were not available through the City.

Study aims

Findings presented here were collected as part of the ethnographic and process evaluation components of the ERP evaluation described above. Given quantitative findings on the ubiquity of substance use and extensive history of utilizing services among those staying in the encampments, we explored qualitative data collected through interviews with people staying in the encampments and providers affiliated with the initiative to provide context on the service needs and preferences of those staying in the encampments. Our aim is to identify the barriers and facilitators to accessing and using services, as well as additional service needs, and to highlight specific recommendations for future efforts to connect people staying in homeless encampments with services that can best promote their long-term stability.

Materials and methods

To understand more about the service needs and preferences of people staying in the encampments, members of the research team conducted interviews with a convenience sample of people at the Kensington Avenue (n = 11) and Tulip Street (n = 16) encampments during the two weeks leading up to the encampment closures (May 16–29, 2018; N = 27). As part of the ethnographic observation for the evaluation, research staff shadowed outreach workers at both encampments during the implementation phase. Research staff then initiated conversations with individuals at the encampments and asked if they would be interested in sharing their perspectives on the encampment closures, emphasizing that they were unaffiliated with the ERP. Interviewers used an open-ended interview guide to elicit information on willing participants' living situation, typical day, background and service use, and perspectives on encampment closures (see Table 1). Interviewers also collected field and interview notes describing the setting and participants' responses.

Table 1. Sample questions from interview guide with people staying in encampments.

BACKGROUND AND SERVICE USE
• Tell me about any services you currently use or have used in the past.
• [Depending on how participant responds, prompt with additional service types] What about … substance use treatment, mental health, emergency, shelter/housing, HIV, employment, case management … services?
• Tell me about any plans you have to access services or get into treatment.
• Can you tell me more about any barriers or challenges (e.g., personal [mental health, trauma] or programmatic [eligibility, requirements]) you've faced getting your needs met?
• What, if anything, has been helpful in getting your needs met?
CAMP CLOSURE
• How did you first learn that the encampment would be closing? What were your first thoughts? What are your thoughts now?
• Where do you plan to go when the encampment closes? What are some of your concerns?
• Have you spoken with anyone from the City helping with the initiative (i.e., "orange shirts")? How did that go?
• What do you think should be done about the encampments? What are your suggestions for what the City should do to improve conditions and access to services?
• What do you think about the respite centers that have opened to connect encampment residents to services?
• What do you think about the possibility of a supervised injection facility with services on-site? Would you be likely to go to a supervised injection facility? Why or why not?
• What do you think about mobile treatment options (i.e., mobile suboxone van)?

Table 2. Sample questions from interview guide with providers.

AVAILABLE SERVICES
• What types of services are available in this area? Which services do people staying in encampments most frequently access? How do people feel about these services?
• [Depending on how participant responds, prompt with additional service types] What about … substance use treatment, mental health, emergency, shelter/housing, HIV, employment, case management … services?
• Can you tell me more about any barriers or challenges (e.g., personal [mental health, trauma] or programmatic [eligibility, requirements]) residents face in getting their needs met?
• What has been helpful in getting residents' needs met?
CAMP CLOSURE
• What do you think should be done about the encampments? What are your suggestions for what the city should do to improve conditions and access to services?
• What do you think about the respite centers that have opened to connect encampment residents to services?
• What do you think about the possibility of a supervised injection facility with services on-site? Would encampment residents be likely to go to a supervised injection facility? Why or why not?
• What do you think about mobile treatment options (i.e., mobile suboxone van)?

To explore available services and assess additional service needs from a system perspective, members of the research team conducted interviews with providers affiliated with the ERP at both the City government (i.e., Community Behavioral Health [CBH], Department of Behavioral Health and Intellectual Disabilities [DBHiDS], and Office of Homeless Services [OHS]; n = 5) and community levels (i.e., three local nonprofits: Prevention Point Philadelphia [PPP], One Day at a Time [ODAAT], and the Northeast Treatment [NET] Assessment Center; n = 5). Interviews were conducted during ERP implementation and sustainment (May through August 2018). As part of the process evaluation, research staff connected with the providers tasked with carrying out the ERP, measuring outcomes, and adapting processes to be more responsive to changing conditions. Interviewers used an open-ended interview guide to elicit information on providers' backgrounds, available services, and perspectives on the encampment closures (see Table 2). Interviewers conducted interviews in-person or over the phone and collected interview notes detailing participants' responses.

Field and interview notes were analyzed using a template analysis approach (Patton, 2002). One member of the research team organized interview data from both stakeholder groups (i.e., people staying in the encampments and providers affiliated with the ERP) by the interview guide domains described above. Data were then divided into related themes within each domain.

Results

The results detailed below include barriers to housing, substance use treatment, and other services as identified by people staying in the encampments and providers as well as measures taken to facilitate service access and use during the ERP. Recommendations are highlighted that were offered by the stakeholder groups to inform future encampment closure efforts (see Table 3).

Housing

Through engagement efforts specific to the ERP, respite housing was ostensibly offered to all of the people staying in the encampments. Though several individuals reported that they were staying in these respites at the time of the interview, the majority were not. In addition, several reported prior use of the City's homeless shelter system.

Low utilization of housing services is reflective of the primary barriers to entering temporary housing described by interview participants: inability for couples to stay together, no allowance for pets, daytime closures and curfews, and other rules. They also expressed concerns about temporary shelters, such as fear of theft and sexual assault, as well as the location of available shelters since most City shelters were quite removed from where they bought and used drugs. People staying in the

Table 3. Barriers and facilitators to services.

Category	Barriers	Facilitators
Housing	• Shelter restrictions (e.g., inability to serve couples, no pets, daytime closures and curfews, rules); security (e.g., fear of theft and sexual assault); and lack of autonomy • Shelters located far from areas where people bought and used drugs • Lack of availability of both transitional and long-term housing	• Low-demand respite housing (e.g., no sobriety requirement, accommodated couples and pets, entry and exit at will during operating hours) brought online • One respite shelter was located proximal to the encampment locations
Substance use treatment	• Difficulty navigating the system • Lack of identification • Difficulty getting identification • Lack of availability • Limitations on treatment access • Lack of timely admission • Lack of after-care • "Readiness" • Need for more evidence-based best practices	• Assistance obtaining identification (e.g., transportation, financial assistance) • Identification waivers • Pre-authorization waivers • Treatment beds set aside • Mobile suboxone treatment
Additional services	• Need for additional supportive services (e.g., employment, family reunification) • Need for integrated medical and mental health services	• Case management services offered through community providers • Wrap-around services (though variable) through housing and substance use treatment programs

encampments further described feeling a loss of autonomy when accessing available housing options whereas they felt a sense of community and security in the encampments.

Aware of these concerns, the respite housing offered through the ERP was considered low-demand in that it did not require sobriety, attempted to accommodate couples and pets, and allowed for exit and entry at will during operating hours (respites were still closed during the day). Given that the respites were opened specifically for the ERP, they also enabled people who felt a sense of community in the encampments to stay in the shelter together. One of the respite sites was near the encampment locations. However, the second site was further away and ended up serving very few of the individuals targeted for services.

Encampment residents also stressed that there was not enough housing for everyone staying in the encampments. Several suggested that the initiative was simply a way to "put them out of sight" and did not offer any meaningful long-term housing solutions. Providers echoed that while the ERP provided additional shelter beds specifically for the initiative, there were still simply not enough beds to accommodate everyone experiencing homelessness across the City. Though people staying in the encampments were prioritized for the low-demand respite housing offered through the ERP, given that many refused to go to the site located further away, the lack of beds remained a challenge. Additionally, lack of long-term housing options made it difficult to transition people from respite housing, which was meant to be temporary until people connected with needed resources, thus limiting the turnover of respite beds. In particular, providers cited a need for more recovery or sober housing options to support long-term recovery.

Substance use treatment

All but four of the people staying in the encampments reported receiving substance use treatment at some point in their lives, and most described familiarity with the treatment system, including how to access treatment, the types of treatment available, and their reasons for discontinuing treatment (only three reported current engagement in treatment). Chief among their complaints were: difficulty navigating the system; lack of identification (e.g., license, birth certification, social security card) and issues around accessing it, such as the cost, process, and residency requirements; lack of availability

and limitations on treatment access; drawn out admission procedures and feeling as though providers "blow you off;" getting pushed out of treatment and/or failing to receive appropriate after-care; and simply lacking "readiness" to enter treatment at the time of the interview.

Providers were cognizant of many of these issues prior to implementing the ERP and used the initiative to pilot strategies to improve treatment access. During ERP implementation, outreach workers assisted people staying in the encampments with obtaining identification, including providing transportation and financial assistance for locals (people with residency outside of the City faced ongoing difficulties), which also served to promote trust toward outreach workers and provided an opportunity to discuss other service options with people staying in the encampments. At the same time, identification requirements for substance use treatment were waived for people targeted for services through the ERP (though providers reported that this was not uniformly implemented and continued to be a challenge throughout the ERP). The initiative also "pushed the system" to reevaluate processes for denials and pre-authorizations for treatment, meaning an individual could no longer be denied treatment for chronic substance misuse or the ineffectiveness of treatment, allowing for "treatment on demand." There were time limitations to the pre-authorizations, however, and providers expressed concern over engaging people in treatment at a level of care that they could be denied the following week. Treatment beds were also set aside for people targeted for services through the ERP, meaning that no one would be turned away for lack of available treatment options. Despite these measures, providers were uniformly surprised by how few individuals entered treatment through the ERP.

In addition to traditional treatment options, a mobile suboxone treatment option was piloted in Kensington simultaneous to the ERP. People staying in the encampments had mixed feelings about the mobile treatment option; while several thought it was a good idea, others suggested that it could be misused (i.e., utilized for the "boosting affect" experienced when used in combination with other drugs) or that MAT simply substituted one addiction for another (i.e., offered a "replacement high"). Several providers expressed similar concerns around MAT generally, though the majority of providers supported MAT as an evidence-based best practice and believed that a mobile option made treatment more accessible to those who wanted it.

There was a sense from providers that standards of care were going through a period of growth and change as people realize that the standards that have been used for decades did not necessarily apply to the opioid crisis. They reported that twenty-eight-day treatment was meant for alcoholics and that more research is needed to understand evidence-based best practices for the current opioid epidemic. At the very least, one provider suggested, withdrawal management should be extended from five to 10 or 15 days.

Additional services

Although the focus of the ERP was on housing and substance use treatment provision, people staying in the encampments reported needing other types of assistance, too. Several described goals related to employment and family reunification. Providers similarly highlighted a need for additional supportive services. Though people who accessed respite centers were encouraged to connect with a case manager during the day, these services were not required and were only offered on-site at the respite center few people accessed. Some treatment programs offered vocational rehabilitation, job training, and family reunification, but providers reported variability in the inclusion of other modalities of care with substance use treatment. While some wanted to offer more, given the short timeframe during which people engage with substance use treatment, people were more often linked with other programs or services for this type of support.

Finally, although few people staying in the encampments discussed medical or mental health issues or service needs during interviews, providers emphasized the need to recognize the complexity and interrelated issues and needs of people staying in the encampments. They reported that it could be difficult to place people with medical issues in treatment (e.g., people who can't ambulate are

considered a "fall risk" and won't be accepted) and many programs won't accept patients who actively exhibit severe mental health symptoms. Similarly, providers reported that in addition to identification, it could be difficult to access psychiatric evaluations for those who needed them to access treatment. Moreover, while some recognized that the number of providers who have the skills to treat co-occurring disorders is growing, systems of care often lack coordination for patients with dual disorders.

Stakeholder recommendations

People staying in the encampments and providers alike pointed out the need for enough low-demand shelter beds for people who want them, and that they should be accessible 24/7. People staying in the encampments suggested that transitioning from living on the street to a structured environment can be jarring and difficult and that flexibility is essential for success. The two groups also agreed on the importance of having available true treatment on demand and long-term affordable housing options. Providers suggested that housing should be available to align with where people are on the continuum of recovery (i.e., from actively using to being in recovery and all points in-between).

Beyond simply having enough housing and treatment resources, both groups proposed improving aftercare planning and support. As one provider described, people who have been living in chaos with their addiction need support when they leave treatment and begin facing sobriety and thinking logically. Indeed, providers underscored that treating substance misuse is only addressing one symptom of much larger issues (e.g., mental health, social capacity, unemployment, poverty). Providers felt that current treatment is too often disconnected from life skills and housing related issues and recommended that the continuum of service be expanded to incorporate employment opportunities and family reunification given the meaningful impact that social support and a stable home can have on people's lives. They proposed a more holistic approach to support successful housing and recovery outcomes, one where housing, treatment, and supportive services "talk to each other" to address the multiple needs of these individuals. Additionally, Safe Injection Facilities (SIFs), currently illegal in the U.S., were viewed as a potential mechanism to reduce fatal overdoses and disease while simultaneously serving as an entry to housing, substance use treatment, and related services.

Discussion

This paper explores the intersection of homeless encampments and heroin addiction from the perspectives of people experiencing homelessness and substance abuse and the providers tasked with connecting these individuals with housing, substance use treatment, and related services through a pilot initiative that offered opportunities to innovate and change policy. The RARE method allowed our team to fill in the gaps between survey and administrative data and increased the utility of what could be learned from a pilot that aimed to "push the system." Below, we describe the integration of implementation and evaluation efforts and recommendations for service delivery that the pilot evaluation uncovered.

Integration of encampment resolution and RARE

Philadelphia recognized that conditions in Kensington were becoming increasingly untenable. Through the ERP, the City leveraged an existing academic partnership to use the pilot as an opportunity to test innovative strategies alongside an evaluation to inform future efforts. Adapted from San Francisco's model that combined services with encampment closure, the ERP benefited from effective coordination between participating entities that pitted the limited resources of a pilot project against the twin public health crises of homelessness and opioids.

The ERP and evaluation both benefitted from the collection and accessibility of data. Outreach Encampment Survey data helped identify the encampments as both a homelessness-related problem, demonstrating that those staying in the encampments were not simply homeless "by choice" in order to facilitate their substance use, as well as an opioid-related problem, making substance use services a critical component of the ERP. Survey data also provided evidence that homelessness in Kensington is a Philadelphia problem requiring local solutions.

The ethnographic component also added value to evaluative efforts. Unfortunately, people experiencing homelessness in Kensington were difficult to engage in a participatory process on resolving the encampments through the pilot itself. Efforts to include these voices in planning efforts may help to balance their interests with those of other community members in the future. Closing the encampments themselves was the easiest part of this process.

While most of the individuals staying in the encampments had a history of involvement with City services, effective service provision required removing access barriers. Providing amenable, effective and accessible housing and drug treatment services under the ERP led to more widely adopted best practices.

Among the individuals targeted for services through the ERP (a total of 189, less 12 who were unable to access placements due to either death or incarceration), by October 15, 2018, 36 (20.3%) received long-term housing or recovery services through the ERP; 72 (40.7%) received at least temporary housing or treatment services after ERP engagement; and 109 (61.6%) interacted with outreach workers to some degree and thereby had a direct opportunity to engage in services (see also Metraux et al., 2019).

Implications for service delivery

Overall, the perspectives of stakeholders reflect the "multiple crises" that Philadelphia and other cities are currently experiencing as hypothesized by Herring and Lutz (2015, p. 690). Given that the population studied were already high utilizers of City services, our findings provide support for more integrated care models.

Housing

Nationally, the availability of emergency shelter and transitional housing beds is insufficient to house all of the people lacking accommodation (United States Conference of Mayors, 2016), and even if enough beds were available, many people experiencing homelessness refuse to access them due to poor conditions (Neale, 2001). The people staying in encampments who we interviewed emphasized these concerns. In particular, people experiencing heroin addiction feared staying too far from their drug source and in accommodation that wouldn't enable them to leave at will. When low-demand respite housing was opened as part of the ERP, people were willing to go to the respite close to the encampment locations but did not readily accept accommodation further away, underscoring the need for local, low-barrier options where people could connect with additional services.

Furthermore, according to a recent HUD report, "the unmet need for decent, safe, and affordable rental housing continues to outpace the ability of federal, state, and local governments to supply housing assistance and facilitate affordable housing production" (Watson, Steffen, Martin, & Vandenbroucke, 2017, p. ix). The waitlist for the Philadelphia Housing Authority's (PHA, 2013) Housing Choice Voucher Program, a federal rental assistance program for low-income individuals and families, is currently closed to applicants (PHA, n.d.), and those on the waitlist are not expected to reach the top for ten years or more due to low turnover (PHA, 2013). Even if vouchers were available, many Philadelphia landlords refuse to accept them, preferring to rent on the open market (Terruso, 2018). As such, 42.4% of renters with very low incomes in Philadelphia who do not receive rental assistance either pay more than one-half of their income for rent, live in severely inadequate conditions, or both (Watson et al., 2017), making a dramatic case for more options, particularly for individuals in recovery.

Opioid users assert that addressing their substance abuse while homeless is virtually impossible (Neale, 2001). The role of housing in recovery and successful rehabilitation has been well-established through Housing First literature which demonstrates significantly lower rates of substance use compared to the "treatment first" philosophy (Davidson et al., 2014; Padgett, Stanhope, Henwood, & Stefancic, 2011). Yet, given the limited supply of long-term treatment and housing options, providers were often unable to create flow from respite housing to permanent housing.

Substance use treatment

Relapse was commonly reported among both people staying in encampments who had previously participated in treatment programs and providers. Similarly, Smyth, Barry, Keenan, and Ducray (2010) reported relapse among 91% of opiate dependent patients admitted to residential addiction treatment services, with the majority (59%) of relapses occurring within one week following discharge. Differential outcomes pointed to the need for providers to better prepare users for detoxification admission, to strive to retain them in treatment for the full admission period, and to support their entry into appropriate aftercare.

The providers we interviewed expressed surprise at how few people staying in the encampments accessed substance use treatment despite attempts to minimize barriers to treatment and improve access. Previous drug treatment and homelessness are predictive of trying but being unable to get into treatment, suggesting that including support for personal planning that make navigating complex systems and following through with appointments easier may be an important strategy to encourage future access (Fisher, Reynolds, D'Anna, Hosmer, & Hardan-Khalil, 2017).

Research into the prevalence and consequences of dropping out of treatment has uncovered a myriad number of factors that lead to poor recovery outcomes, including participant and treatment factors. No clear profile (e.g., age, gender, co-morbidities) has emerged of individuals who are likely to have poor treatment outcomes; and while some research has attempted to measure the role of client motivation and expectations, such measures are difficult to quantify (Stark, 1992). Yet, in a systematic review of risk factors for dropping-out of addiction treatment, Brorson, Arnevik, Rand-Hendriksen, and Duckert (2013) found that the vast majority of research focused on participant factors; only 4% of studies considered risk factors associated with treatment programs, such as method and treatment duration. The authors suggested that understanding the role of treatment factors and processes, and their interactions with participants' characteristics, may benefit the field and lead to better treatment retention. Others suggest that the quality of participant interactions with providers should also be an area of inquiry (Simpson, Joe, Rowan-Szal, & Greener, 1997; Walker, 2009).

MAT was considered a best practice by the providers we interviewed and there is growing evidence to support its use (Chalana, Sachdeva, Kundal, Malhari, & Choudhary, 2015; Johansson, Berglund, & Lindgren, 2007; Lee et al., 2016). People staying in the encampments reported mixed levels of support for MAT, making it important to provide individualized treatment plans. Service retention plays a key role in MAT outcomes as well (Johansson, Berglund, & Lindgren, 2006) and research shows that positive outcomes can be maximized through a combination of MAT and psychosocial services (McLellan, Arndt, Metzger, Woody, & O'Brlen, 1993).

Finally, connecting individuals with aftercare following treatment is essential. People staying in encampments identified lack of aftercare planning as a major challenge to their recovery. Kertesz, Horton, Friedmann, Saitz, and Samet (2003) demonstrated that among detoxification patients, people experiencing homelessness who did not use a post-detoxification stabilization program experienced the highest risk of returning to substance use.

Additional services

Services related to medical and mental health needs, employment, and family reunification were identified by people staying in the encampments and providers as needed, but these services were not prioritized by the ERP or local treatment programs. While it has been suggested that substance use treatment should be integrated into the mainstream of general healthcare (Buck, 2011), this was not

the experience of people staying in the encampments at the time of the ERP. Research has demonstrated that providing employment, family, and/or mental health services alongside treatment are clinically and administratively practical and attractive to participants, leading to longer treatment stays, higher completion rates, and greater effectiveness of treatment (McLellan et al., 1997; Siegal et al., 1996). Involving supportive family in the recovery process may also help facilitate recovery (Tucker, Wenzel, Golinelli, Zhou, & Green, 2011). Our data emphasize the need to include additional services in combination with treatment to support recovery.

Ongoing engagement efforts

In October 2018, Philadelphia Mayor Jim Kenney signed an executive order establishing an emergency response to combat the City's opioid epidemic, calling on 35 City departments, agencies, and offices to come together to implement the Philadelphia Resilience Project. The order came in recognition of the extreme challenges that Kensington and the surrounding neighborhoods continued to face. Similar to the work promoted through the ERP, the Resilience Project "called for departments to break down silos, try new things, and accelerate the speed of current initiatives already proven to be successful" (Philadelphia Resilience Project, 2019, p. 5). This allowed additional resources to be deployed to address key issues: (a) clearing the remaining two encampments; (b) reducing criminal activity; (c) reducing the number of unsheltered homeless; (d) reducing trash and litter; (e) reducing overdoses and the spread of infectious diseases; (f) increasing treatment options; and (g) mobilizing community resources. This important work is ongoing and can serve as a call to other communities faced with similar challenges. (Philadelphia Resilience Project, 2019)

Limitations and future research

While there were benefits to using a RARE approach in the evaluation of the ERP, there were also limitations. Interviews with people staying in the encampments, conducted during ethnographic observation, were not recorded and field and interview notes were used for analysis. Additionally, the data analyzed was time-limited and, for the most part, does not include the perspectives of people who had engaged with services through the ERP. Interviews with providers were also not recorded. While this afforded providers a greater sense of confidentiality and may have promoted more honest responses, interview notes were used for analysis. These interviews also took place at different points in the ERP implementation and sustainment phases and, therefore, may not reflect providers' overall reflections on the challenges and successes of the initiative.

People staying in the encampments felt that the ERP was simply a way to "put them out of sight." This criticism makes sense considering the lack of transitional and affordable permanent housing options and integrated care. Yet, the City of Philadelphia's commitment to serving this population and adapt as needed is a powerful precedent for a new paradigm for cities dealing with multiple crises at once. Future research is needed to understand the long-term housing and treatment outcomes for people staying in encampments who receive services as well as the treatment dynamics (e.g., treatment factors, processes, participant-provider interactions) that can best support recovery.

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