

*Program and Service-level  
Collaboration*

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## **COORDINATED ACCESS AND ASSESSMENT: CALGARY, ALBERTA**

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### **INTRODUCTION**

Since its inception in 1998, one of the primary goals of the Calgary Homeless Foundation (CHF) has been to create an umbrella system for relevant programs and services and create a single point of entry for Calgarians experiencing homelessness (Scott, 2012). Building a homeless-serving system was identified as Phase 2 of Calgary's 10 Year Plan to End Homelessness (the Plan), originally launched in January 2008. This phase was scheduled to take place from 2011–2014 following the first phase of the Plan, which was focused on injecting new resources into the homeless-serving sector. Phase 2 was recognized as the most labour-intensive and difficult phase, and included creating a standardized assessment process, coordinating intake for housing programs and services, filling in gaps in service and working with large systems.

The Coordinated Access and Assessment (CAA) program is an intake program for all CHF-funded Housing First programs – a single point of entry for Calgarians experiencing homelessness. It was launched in June 2013, just days before a great flood displaced thousands of Calgarians and several homeless-serving agencies and programs, including the storefront CAA program located

at the Safe communities Opportunities and Resource Centre (SORCe). The program was up and running again in the fall of that year, and was in operation for a year when the writing of this report began in 2014.

This report was prepared at a critical time in the history of the CHF. The clock was ticking on the Plan's countdown to ending homelessness – less than four years were left on the countdown to the 10-year anniversary of the Plan being launched. The CHF had undergone significant changes in its senior leadership, and it was increasingly difficult for Calgarians to find housing – affordable or otherwise – due to a strong economy and significant population growth. The flood of 2013 further reduced Calgary's vacancy rate as people were displaced from their inner city homes. Despite these challenges, the CHF managed to keep moving toward its goal of further developing a coordinated intake and assessment program to anchor its system of care and end homelessness.

The observations documented in this report took place over the course of eight months, between May and December of 2014. The purpose was to document

and provide information about the CAA program's formative process, and to inform the ongoing development of the CAA program in Calgary. Data collection included participant observation at CAA's storefront location at SORCe, in relevant internal meetings at CHF and at Placement Committee Meetings (PCMs) where clients who have been assessed are matched to programs. It included an extensive review of internal policy and procedural CHF and CAA documents and of the literature regarding Housing First and coordinated intake programs.

## **BACKGROUND**

There are several contextual factors that have influenced the state of homelessness in Calgary and efforts to end homelessness in this city. Prior to the launch of the CAA, the CHF engaged the community in its 10 Year Plan to End Homelessness, implemented the Homeless Management Information System and consulted the community in regard to the development of a coordinated intake program for Calgarians experiencing homelessness.

### **Environmental Scan**

Alberta's 'boom and bust' economy has direct and indirect impacts on the state of homelessness in the province. When booming, the province's resource-based economy creates more jobs than there are people to fill them. Calgary's most recent civic census data indicates that the city experienced a record-breaking population growth of 3.33%, or 38,508 residents, from 2013 to 2014 (Election and Information Services, 2014). Alberta's growth rate was the highest in Canada at 0.34% in the last quarter of 2014 (Ferguson, 2015). The CAA team at SORCe reports that in boom times like these many individuals and families come to Calgary to find work, without a full understanding of the high cost of living or a social network to rely on during difficult times. Almost one-fifth (18%) of Calgarians experiencing homelessness migrated to Calgary in the past year, compared to about 6% of Calgary's population as a whole (CHF, 2015). Safe and affordable housing is difficult to find due to Calgary's exponential population growth – in 2012, Calgary's vacancy rate was the lowest in Canada at 1.3% (Employment and Social Development Canada, 2014). Excessive demand for housing and increasing property values leave few safe and affordable housing options. The flood of 2013 placed further pressure on Calgary's minimal rental unit vacancy rate.

## Calgary's 10 Year Plan to End Homelessness

Calgary's Updated Plan to End Homelessness (The Plan, CHF, 2015) is based on Housing First values and principles. It was created in 2008 using a model applied in over 300 American cities but was the first plan of its kind in Canada. The most recent version of the Plan emphasizes a person-centred approach and community ownership and collaboration. The Plan guides CHF in all of its work, and the 2015 update maintained the core principles defined in the original Plan:

- The Plan will aim to help people move to self-reliance and independence.
- All people experiencing homelessness are ready for permanent housing with supports, as necessary.
- The first objective of homeless-serving systems, agencies, programs and funding is to help people experiencing homelessness gain and maintain permanent housing (Housing First).
- The most vulnerable populations experiencing homelessness need to be prioritized.
- The selection of affordable housing and the provision of services should be guided by consumer choices.
- Resources will be concentrated on programs that offer measurable results.
- Affordable housing is safe, decent and readily attainable. Diverse, integrated, scattered site affordable housing, close to services, is preferred.
- Plan funding should be diverse and sustainable.
- The use of markets will be maximized by involving the private sector in the implementation of the Plan.
- The economic cost of homelessness will be reduced.
- A well-educated, well-trained and adequately funded non-profit sector is central to the success of the Plan (CHF, 2015: 1).

### State of the System of Care

Prior to the implementation of the CAA program in 2013, the numerous homeless-serving agencies and programs in Calgary were operating relatively independently of one another, with little coordination regarding client intake or shared clients. Agencies and programs in the system of care included emergency shelters and programs offering transitional housing, permanent housing, rapid rehousing, prevention, outreach, affordable housing and support services. Combined, they did not resemble a system, but rather a fragmented collection of agencies and programs; historically, the Plan has used a 'traffic system' analogy, one with no established traffic flow or clear rules of the road. Homeless individuals were often being served by multiple agencies and sat on multiple waitlists for housing, each of which was accessible only through the program itself.

Not only was this fragmented system difficult for clients to navigate – and potentially re-traumatizing because it required them to tell their story over and over again – but agency and program accountability was also lacking. Agencies had the ability to refuse to serve clients based on their own assessment of programmatic fit, or if the client's needs were too complex. This practice is known in the homeless-serving sector as 'cherry-picking' or 'cream-skimming,' i.e. picking clients who are easier to serve and thus more likely to be successful in agency programs and produce more positive outcomes. Agencies could assume that another agency or program would serve the client, but this left many clients under-served when in fact they were the clients requiring the most support.

Furthermore, several examples emerged of people without a history of homelessness being housed in homeless-serving programs at PCMs – one in a housing program for those with physical health requirements and others in a housing program for clients struggling with substance abuse.

## HMIS and System Planning Framework

In 2011, the Homeless Management Information System (HMIS) was implemented as the first system of its kind in Canada. It is a database and case management tool used by CHF-funded programs. If a client agrees to share their information, HMIS allows case workers from different programs to see the client's history, improving their understanding of the client's situation and needs. It is meant to ensure that clients experiencing homelessness do not fall through the cracks. The information within HMIS has also informed and influenced CHF policy and program design and helped identify gaps within the system of care. It has been called “the backbone of the system of care” by CHF's HMIS Manager Chantal Hansen (Fletcher, 2012). The CHF's System Planning Framework is guided by data collected in Calgary's HMIS program.

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Key elements of a System Planning Framework include:

- Defining the key program types that are responsive to diverse client populations and their respective needs;
- Ensuring programs have clear, consistent and transparent eligibility and prioritization processes to support right matching of services for clients;
- Using a common assessment tool to determine acuity or need, direct client placement and track client progress;
- Having clear and appropriate performance measurement indicators and quality assurance expectations at the program and system level to monitor and evaluate outcomes;
- Using data to direct strategies and assess program and system impact in real time (i.e. a HMIS); and
- Promoting information sharing across programs (CHF, 2014: 2).

The CAA team at SORCe is the primary administrator of the 'common assessment tool' – the Service Prioritization Decision Assessment Tool (SPDAT). CAA plays a role in many of the points above by bringing CHF-funded agencies together each week at PCMs. At each PCM, the CAA program and CHF-funded agencies collaboratively match clients to programs and share information across programs. The CAA has been instrumental in not only coordinating access to homeless-serving programs, but in coordinating the entire system of care and increasing the level of accountability in regard to triaging and accepting clients at PCMs. By implementing CAA (along with HMIS) and participating in the collective discussion that takes place at PCMs, homeless-serving organizations are able to more clearly identify the needs of clients and the programs that best meet those needs.

## Establishing CAA

The CHF is dedicated to collaboration and community consultation, and has demonstrated this commitment through the creation and subsequent updates of the 10 Year Plan to End Homelessness. Prior to the implementation of CAA, CHF engaged in community consultation including surveying community agencies and community system planning meetings, the creation of Client and Youth Advisory and Request For Proposal Advisory Committees, an agency advisory strategic planning day and individual meetings with every CHF-funded agency. Based on feedback specifying that community agencies wanted input on the clients they were accepting, PCMs were established so that CHF-funded programs taking clients from CAA could collectively match clients to programs. Quarterly Advisory Committee and community information and feedback meetings continue to take place to guide the ongoing development of CAA.

The level of collaboration and coordination among such a large group of community organizations is impressive and unprecedented in the local context. The decision to conduct PCMs to assign clients to

programs was an additional step taken to ensure buy-in from homeless-serving agencies and programs in Calgary. Programs would not be told which clients they were assigned by a centralized CAA service, as happens in other cities with coordinated access programs across North America, but would have direct input into the capacity of their programs and whether or not any one particular client was a good fit for their program.

Distress Centre Calgary (DCC) was chosen to deliver service through CAA's storefront location at SORCe. The delivery of information and referral is the business of DCC's 211 program, which connects people in need with government, social and community services. DCC was well equipped to prevent clients from entering homelessness and divert them from the homelessness system of care, which is a key role of the CAA team at SORCe. Several coordinated access programs for shelter and housing in the United States are connected to the local 211 service, including those in King County (Washington), Orange County (California) and the state of Arizona.

## COORDINATED ACCESS AND ASSESSMENT

There are key characteristics and activities of the CAA program that help improve service to clients and programs participating in the common intake process. These include a centralized location, the administration of the assessment tool, PCMs, and a flexible, organic decision-making process.

### Centralized Location

CAA's storefront location at SORCe is located near Calgary's emergency shelters and steps away from a Calgary Transit Light Rail Transit (LRT) station. SORCe is a Calgary Police Service initiative and is intended to support Calgary's downtown homeless population. It is a multi-service site where 14 homeless-serving agencies provide a variety of services that people experiencing homelessness may require, including prevention and diversion from the system of care through information and referral, income support, addiction and mental health services, and outreach services.

In implementing CAA, it was determined that it would be best to enlist several ‘door agencies,’ agencies who have trained staff to conduct an assessment for access into CAA, to provide services in addition to establishing a centrally located storefront operation. This established a ‘no wrong door’ approach for Calgarians experiencing homelessness; they could receive service at an easily

accessible location in downtown Calgary or sit down with workers at the emergency shelter or hospital or treatment or correctional facility in which they were staying. This created ease of access for clients as well as a more seamless delivery of services, and enabled a more client-centred approach.

## Assessment Tool

SPDAT was chosen by Alberta’s 7 Cities on Housing and Homelessness and approved by their largest supporter, the Government of Alberta’s Human Services, prior to the implementation of CAA in Calgary. It is a detailed assessment measuring an individual’s or family’s acuity for the purpose of triaging and prioritizing service delivery. It uses 15 measures to calculate a score out of 60 for individuals experiencing homelessness. The 15 measures include:

- Self-care and Daily Living Skills;
- Social Relationships and Networks;
- Managing Daily Activities;
- Personal Administration and Money Management;
- Managing Tenancy;
- Physical Health and Wellness;
- Mental Health and Wellness and Cognitive Functioning;
- Medication;
- Interaction with Emergency Services;
- Involvement in High Risk and/or Exploitative Situations;
- Substance Use;
- Abuse and Trauma;
- Risk of Personal Harm and Harm to Others;
- Legal; and
- History of Homelessness and Housing.

*OrgCode Consulting, the creator of the SPDAT tool, was brought to Calgary to train staff who were going to be conducting the assessments at door agencies and at SORCe, and also to train trainers to continue training new staff on the administration of the SPDAT.*

Clients are given a score of 0–4 in each category, with a higher number indicating a higher acuity, or higher risk. It also identifies what services are most appropriate for clients based on their score – Housing First, Rapid Rehousing, or Prevention and Diversion. OrgCode Consulting, the creator of the SPDAT tool, was brought to Calgary to train staff who were going to be conducting the assessments at door agencies and at SORCe, and also to train trainers to continue training new staff on

the administration of the SPDAT. The tool is in use in over 100 communities across North America. Along with the use of the SPDAT tool for all clients entering CHF's system of care, standardized prevention and diversion questions were employed to ensure as many people as possible are diverted from the system of care.

The SPDAT assessment is deficit-focused, which is a concern for program staff as it has the potential to leave vulnerable clients feeling poorly about, or responsible for, their current situation. At PCMs, positive ways in which to reframe the SPDAT assessment and score have been discussed. Examples involved focusing on an individual's strengths at the end of the SPDAT, e.g. asking the client to identify what they see as their biggest strength, and working with clients who are unlikely to get placed due to their score to see their strengths and how they can leverage those strengths to find housing independently.

*The SPDAT training emphasizes that as little information as possible should be collected to assess the client in order to prevent re-traumatization.*

Consistency or 'inter-rater reliability' of the SPDAT assessment was identified as a concern early in the research process. Over several months, measures were taken to improve the consistency among those conducting the SPDAT assessment, including the introduction of a SPDAT-trained staff registry, a shadowing and mentorship process, and spot-checking of SPDAT assessments by senior staff with Distress Centre's CAA team at SORCe. Documentation was also identified as a concern, in particular regarding what should/should not be included in the SPDAT assessment. The SPDAT training emphasizes that as little information as possible should be collected to assess the client in order to prevent re-traumatization. The purpose of the SPDAT is prioritization, not case management; therefore very little information is required to support the score given. Continued emphasis on training and communication will address many of these issues over time.

## PLACEMENT COMMITTEE MEETINGS (PCMS)

Four PCMs were created for CHF-funded housing program staff, CAA staff and CHF staff to meet and collectively match clients to programs. The four meetings include those to discuss and place high-acuity singles (clients with a SPDAT score over 44), mid-acuity singles (clients with a SPDAT score under 44), families and youth. PCMs generally take place once a week at a regularly scheduled time and place. The amount of client information shared within CAA and at PCMs is very high. Clients sign a Release of Information granting permission to share information with and gather information from a relatively long list of agencies and programs, with the option for the client to exclude any one of them. If clients do not wish to share their information, they can either choose to be anonymous or, alternatively, there are a handful of non-CAA participating agencies that they can contact independently in their search for housing.

The primary purpose of PCMs is to collectively match clients to programs, but there is much more to PCMs than reviewing the triage list and assigning clients to programs. Some benefits of holding PCMs include constant renewal of the groups' commitment to the Housing First philosophy, a very high level of inter-program collaboration, collective decision making and increased accountability of programs.

## HOUSING FIRST

The Housing First philosophy has been adopted by the CHF and commitment to this philosophy is regularly renewed at PCMs. There were times when program staff appeared reluctant to accept clients at the top of the list based on their history of substance abuse. In such instances, the meetings' chairs emphasized that substance use should not be a 'screen-out,' and that it is possible or even likely that clients' substance use would decrease after being housed; it is common for clients to use substances as a way to cope with being homeless. The group as a whole appeared to struggle with the Housing First philosophy in regard to clients with violent criminal histories. On several occasions program staff were reluctant to take clients due to concerns about their ability to remain safe while working with the client, regardless of whether or not they were at the top of the triage list.

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### Client Choice

Client choice, when stated, was always respected, including preferences related to housing location, roommates, sober living versus harm reduction, family reunification, etc. At times, client choice may limit the options available and increase the length of time spent waiting for housing; e.g. if the client did not want a roommate but there was only housing with roommates available. However it was recognized that respecting client choice increases the chance that a client will be successful in a program and not end up back on the streets.

### Collaboration

There was a very high level of collaboration observed at PCMs, particularly regarding very high-acuity and/or complex clients. Program staff were willing to share their expertise and support and make recommendations in regard to complex clients. On more than one occasion, a client was presented at PCM with the goal of transferring the client to another program. With the support and recommendations provided at the table, the client was able to remain in their current program and avoid being bounced from program to program or, worse, discharged into homelessness. Dual programming was also put in place for some clients; i.e. two programs were enlisted to support a client with complex needs. Furthermore, CHF's policies regarding dual programming were subsequently modified and relaxed in order to accommodate such arrangements for complex clients. CHF's awareness of the resources and programs required to house and support complex clients increased as a result of CAA and PCMs, resulting in policy changes benefitting both clients and program staff.



## Mutual Trust and Respect

While it is specified in CAA's operating manual that Shelter Point (a database tracking the number of spaces available in CHF-funded programs) is to be used to identify the number of spaces available in each program, it is common practice at PCMs for programs to self-identify the number of spaces they have available. It is recognized by each PCM chair and the CHF that program capacity is not black and white with regard to how many spaces are available in each program; i.e. the number of spaces available may be impacted by the amount of support required by clients (e.g. complex clients), unfilled case worker positions and the level of skill and experience of the case workers who are available to take clients. This ad-hoc process is empowering to program staff and respectful of their expertise regarding what is happening in their programs, and builds trust between programs and the CHF at the PCM tables.

When a discrepancy between the number of spaces available in Shelter Point and those being identified at PCMs was raised (from a place of respect and open curiosity), program staff identified lack of housing and open case manager positions as the major issues impacting their capacity. Not only is there a lack of appropriate housing, but landlords are often reluctant to work with programs serving homeless clients.

## Agency Accountability

The triage model is one that the community has collectively agreed to, and it is useful when working with limited resources. On several occasions at PCMs program staff appeared reluctant to accept particular clients, despite the client being next on the triage list as well as a suggested program match. While everyone at the PCM tables is respectful of programs self-identifying their capacity, there were times when it appeared that program staff accepted particularly challenging clients because they were held accountable by those at the PCM table – not only by a CHF representative, but also by their peers. There was a process in which the client's situation was discussed, including the reasons they were at the top of the triage list, and it was made clear why it was critical that the client be placed. If the program staff remained reluctant to accept the client, they were reminded that they could return the client to the triage list if after meeting with them it was determined that they were not a programmatic fit.

Despite the benefits of the process described above, some CAA program staff appeared to feel pressured to take particular clients. PCM chairs may wish to remind CAA program representatives that they retain the ability to return the client to the triage list after they have met with the client if the client is determined not to be a good fit with their program. There must be a justifiable rationale and CAA members are accountable to all other members of the group, but this encouragement may help program staff feel empowered and less reluctant to give the client an opportunity in their program.

There are many examples of collective decision making at PCM tables. When deciding whether or not to hold a bed for a client, for example, it was stated "it's up to the committee." On another occasion, regarding a transfer, one program staff stated "as long as the committee is okay with it." There is a delicate balance of program autonomy and collective decision making that must be maintained to ensure the active and willing participation and engagement of program staff.

## FLEXIBILITY IN PROCESS

There have been many additions and modifications to the common intake process that are specific to the Calgary context, likely because a funder, rather than a service provider, has led the implementation and operation of the program. CHF has the ability to make decisions based on both its observations and the recommendations of community agencies participating in CAA. This has allowed for slight changes to the SPDAT assessment, including the use of baseline scores for SPDATs for clients who have been institutionalized (i.e. scores prior to being in hospital or incarcerated), vulnerability scores (calculated using scores from the Physical Health, Mental Health, Interaction with Emergency Services, Risk of Personal Harm and Harm to Others, and History of Homelessness and Housing fields from the SPDAT assessment), a pregnancy calculator for the family sector, and an FASD (Fetal Alcohol Spectrum Disorder) toolkit to assist program staff in completing SPDAT assessments of clients who have FASD. It has also allowed for changes in processes to improve CHF's understanding of Shelter Point data and create a clearer picture of what is happening within community agencies; such changes include the CHF policy regarding 'dual programming' and new procedures regarding how to 'ramp up' caseloads for new case managers.

The process for change within CAA could be described as 'organic' – that is, change happens as needed, when issues arise and are identified within the programs and at PCM tables. Through the writing of this report, it was identified that processes for change should be outlined more clearly within CHF. A governance structure was suggested, dividing oversight of the program into strategic and operational realms, with the strategic oversight being the responsibility of a steering committee consisting of CHF and community agency leadership, and the operational oversight being the responsibility of CHF's System Planners and CAA-participating agencies and staff, primarily at PCM tables. While clear processes and communication will be helpful for the continued development of CAA, the ability to react quickly and adapt to community and client needs is a strength of not-for-profit and non-governmental organizations, one that has been identified by the Government of Alberta (2013) and should not be lost.

## SYSTEM OF CARE

### Gaps in the System of Care

Throughout the research process, several gaps in the system of care were observed at PCMs:

#### **Harm Reduction:**

On several occasions it was observed that the majority of spots available at both high- and mid-acuity PCMs were available only to clients interested in or already maintaining sobriety from drugs and alcohol. While it is important that clients interested in sobriety have a safe and 'dry' home environment, the vast majority of clients on the triage list are in need of harm reduction program placements, i.e. programs that are willing to work with individuals who are actively engaged in their addiction. This imbalance in the amount of sober housing and the relatively low number of clients interested in sobriety meant that much lower acuity clients interested in sobriety received placement above those who were higher in acuity and in greater need of housing according to the triage model. This imbalance was further exacerbated by the introduction of a sober living apartment tower in Calgary's beltline. CAA participating programs had a difficult time filling the units they held in this tower, as it was not easy to match clients to their program who were also clean and sober. The excess of sober housing sends an implicit message to clients that people who are clean and sober are more deserving of housing, in direct opposition to Housing First principles. CAA provides data that should be used to make funding decisions based on the needs of the population being served. From the Waterloo Social Planning, Policy and Program Administration (2013):

*As part of the... process, communities should establish a feedback loop that involves using the information gained from these assessments to make any necessary adjustments to the system. For example, if families are being referred to the right program, but that program cannot serve them due to capacity issues while other program types have an increasing number of empty beds, it may be time to make system-wide shifts in the types of programs and services offered. Communities with a coordinated entry system tracking all their data have a centralized source of information on who is entering their system, who is on a wait list, what their needs are, and how those needs match with what's currently available. (p. 21)*

Using data to inform CHF-funded programming and services for Calgarians experiencing homelessness is one of the key shifts from the previous Plan identified in the Updated Plan (CHF, 2015). A systemic shift of this significance in the homelessness-serving system as a whole, however, requires working with other systems to ensure that all programming and services are informed by data and the needs of the population. Fortunately this is also a clearly identified priority in the Updated Plan.

**Couples:**

There are very few programs willing to take couples, either because it is not the mandate of their program and/or because of the risk of domestic violence and the subsequent risk to housing stability.

**Non-English Speaking Clients:**

There appeared to be little capacity for programs to work with clients who have limited English-language skills – any capacity was dependent on the program staff's ability to speak other languages. Subsequently, throughout the research process program staff were instructed to access a language line for tele-interpretation through Distress Centre's 211 service as needed.

**Transitional Housing:**

There is a lack of housing for transitions from systems like corrections or for those with physical health needs upon being discharged from hospital. Clients are routinely discharged from hospital or corrections into homelessness, despite it being against Alberta Health Services' (AHS') policies to do so.

**Clients with a Violent History:**

These clients may pose a safety concern to program staff, other residents if in place-based housing and the community in which they are placed. As such, CAA-participating programs were reluctant to take on clients with a violent history within their existing resources.

**Complex Clients:**

Complex clients are those clients for whom there is no program match, often due to high needs in multiple areas of the SPDAT assessment (e.g. addictions, mental health, risk of harm to self or others, legal, etc.). 'Dual programming,' i.e. assigning more than one program to the client, can address complex clients' needs only a fraction of the time. A Complex Case Review Committee was created

to discuss complex cases and develop potential strategies regarding how to house and support these clients. One recommendation is to assign a case manager to complex clients in homelessness until the client can be housed either by the program with which the client is engaged, or with the program best suited to meet some of the client's needs.

Some clients are deemed complex because there is no program able or willing to serve clients with an extensive history of violence. The CAA program has outlined safety procedures in its operating manual, and it is expected that all housing programs have safety procedures in place. If clients cannot be supported safely within the parameters of any program's safety procedures, the client is deemed complex. Ideally, the resources required to safely support that client are identified at the Complex Case Review Committee meeting and provided to the program willing to support the client, similar to a fee-for-service model. The alternative is to direct these clients back to AHS, where there may be more resources to adequately and safely support such clients (e.g. Assertive Community Treatment Team or locked-down, place-based housing). That being said, it is clear that all such systems are operating at or over capacity. Currently there is no clear process in place to get the needs of complex clients met in a sector that has little to no capacity.

Upon review of the complex clients' SPDAT assessments, what stood out was the extensive history of significant trauma experienced by these clients and the impact it was having on the clients' current life and experience of homelessness. Clients reported witnessing and experiencing physical, financial, emotional and sexual abuse, and violence as children, as adults, and as adults experiencing homelessness. Clients reported being repeatedly institutionalized in foster homes and in correctional facilities. Trauma-informed care within CHF's System of Care is critical for such clients.

## OUTSIDE OF CHF'S SYSTEM OF CARE: ENGAGING SYSTEMS AND NON-CHF-FUNDED AGENCIES

The high level of coordination and collaboration within CAA and CHF's system of care is unprecedented within any other system serving particular populations in Calgary. Having a relatively comprehensive list of clients requiring housing made it apparent that many clients waiting for housing were eligible for supports from other systems, most of which have a larger pool of resources than CHF's system of care. CHF's System Planner worked to connect clients on CAA's triage list to supports from other, larger systems, including the Government of Alberta's Persons with Developmental Disabilities, AHS' Regional Housing and Corrections Transition Team and Child Welfare. It was recognized that all systems supporting homeless clients are under-resourced, and in some cases programs from different systems would agree to work together to ensure clients received the support they needed. This level of advocacy created increased communication and coordination between systems, and will benefit shared clients. It also created more positive transitions from systems to housing, particularly for homeless clients transitioning out of correctional facilities or hospitals.

*It was recognized that all systems supporting homeless clients are under-resourced, and in some cases programs from different systems would agree to work together to ensure clients received the support they needed.*

### Recommendations

#### ***Lack of Strategic Direction***

The process of implementing CAA has been described by CHF staff as “flying the plane as it is being built.” The pressure created by the timelines in the 10 Year Plan may have been related to decisions being made without clear vision regarding what CAA should look like, and what CHF's role would be in the future. There was confusion regarding who was primarily responsible for CAA. Was it CHF as the funder leading the implementation? Was it Distress Centre, chosen to operate the storefront location of CAA at SORCe and play a key role in Placement Committees? Was it the community of homeless-serving programs and agencies under the umbrella of CAA? These questions have yet to be answered. As CHF endeavours to engage the community in systems-level decision making and ending homelessness in Calgary, it would be advisable to involve the community in the ongoing development of CAA as much as possible.

Until this research process, a program logic model and the evaluation of the program had not been discussed. CHF was reluctant to create a logic model and evaluation framework for CAA, as it was considered counter-intuitive to their goal of collective ownership of both the 10 Year Plan and of CAA. The first logical step moving forward is to establish a governance model and strategic oversight and goals for the program. A steering committee is currently being established and will ultimately set a strategic direction for CAA, after which a program logic model can be created and a program evaluation framework begun.

## Outcome Measures

The introduction of CAA has caused a shift from program-centred to client-centred care. Looking ahead, it will be important to measure the outcomes that are hoped for with the introduction of diversion processes and common intake, as outlined in Social Planning, Policy and Program Administration (2013):

- Outcomes related to common intake (streamlined intake and program matching):
  - » Shorter time from system entry to permanent housing;
  - » Fewer interactions with different agencies;
  - » Reducing length of stay in shelter; and
  - » Reducing repeat episodes of homelessness.
- Outcome related to diversion:
  - » Reducing new entries into homelessness.
- Program occupancy (although true program capacity is difficult to measure due to the influence of staffing levels and availability of housing);
- Positive destinations at exit from program;
- Fewer clients returning to shelter/rough sleeping; and
- Less frequent discharge from public institutions into homelessness due to engaging large systems through CAA.

Missing from this report, and from the CAA in general, is client feedback on the common intake process. Feedback should be collected, primarily from clients who are housed as those who are still waiting on the list would have an inherent bias.

Other measures identified in the research process as useful in measuring the success of CAA's coordinated intake and program matching include:

## Remaining Questions

There are clear indications that CHF and CAA are achieving success in the work being done in Calgary's homelessness sector. Despite Calgary's rapid growth, the city's homeless population has remained stable in recent years. In addition, CHF's system of care is currently at 95% capacity – programs are full and any empty spaces are filled quickly and efficiently. One of the most significant questions begging to be answered is regarding continuing to assess clients, considering the likelihood of them being housed is currently extremely low. Should CAA continue to SPDAT clients? If the program operates on a triage model, should CAA be conducting SPDATs within emergency shelters to reach only the highest acuity clients? Should the system remain a triage model? These are questions that I believe need to be answered by a steering committee, with an eye on the strategic direction of the program.

## CONCLUSION

The CHF, along with its funded agencies, has managed to complete the most challenging phase of Calgary's 10 Year Plan to End Homelessness. They have chosen a standardized assessment process (the SPDAT assessment), developed a coordinated intake team and process, and have begun working with large systems to ensure that Calgarians experiencing homelessness are receiving the most appropriate care. Work remains to be done around using the data collected in HMIS to inform resource allocation within the system of care, as demonstrated by the over-abundance of sober housing in a system that requires more programs working with clients who require harm reduction.

Despite the challenges posed by changes in leadership at CHF and Calgary's 'boom and bust economy,' Calgary has managed to slow the rate of homelessness in Canada's fastest growing city. The CHF has introduced key infrastructure to coordinate and anchor its system of care. Further coordination surrounding the strategic direction, logic model and an evaluation framework is required. With these guiding frameworks in place, the CAA program in Calgary will serve as a pillar in this city's goal to end homelessness.

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## REFERENCES

- Calgary Homeless Foundation. (2015, March). *Calgary's updated plan to end homelessness: People first in housing first*. Calgary: Author. Retrieved from: <http://www.ihearthomeyyc.com/the-plan/>.
- Calgary Homeless Foundation. (2014). *System planning framework*. Calgary: Author. Retrieved from: <http://calgaryhomeless.com/wp-content/uploads/2014/05/System-Planning-Framework-May-2014.pdf>.
- Clegg & Associates, Inc. (2007). *King County Committee to End Homelessness: Coordinated entry for housing and homeless services*. King County, WA: Committee to End Homelessness.
- Election and Information Services. (2014). *2014 Civic Census Results*. Calgary: The City of Calgary. Retrieved from: <http://www.calgary.ca/CA/city-clerks/Pages/Election-and-information-services/Civic-Census/2014-Results.aspx>.
- Employment and Social Development Canada. (2014). *Indicators of well-being in Canada*. Ottawa: Author. Retrieved from: <http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=43>.

- Ferguson, E. (2015, March 15). Alberta's population growth slows, but continues to lead nation. *Calgary Herald*. Retrieved from: <http://calgaryherald.com/news/local-news/albertas-population-growth-slows-but-continues-to-lead-nation>.
- Fletcher, R. (2014, August 12). Homeless Management Information System “a godsend” for front-line Calgary workers. *Metro News Calgary*. Retrieved from: <http://metronews.ca/news/calgary/1123573/homeless-management-information-system-a-godsend-for-front-line-calgary-workers/>.
- Government of Alberta. (2013). *Alberta's social policy framework*. Edmonton: Author. Retrieved from: [http://socialpolicyframework.alberta.ca/Document/Albertas\\_Social\\_Policy\\_Framework](http://socialpolicyframework.alberta.ca/Document/Albertas_Social_Policy_Framework).
- Scott, S. (2012). *The beginning of the end: The story of the Calgary Homeless Foundation and one community's drive to end homelessness*. Calgary: Calgary Homeless Foundation.
- Social Planning, Policy and Program Administration. (2013). *What is Diversion? An overview of emergency shelter diversion as a practice and the local context in Waterloo Region*. Waterloo, ON: Regional Municipality of Waterloo. Retrieved from: [http://www.homelesshub.ca/ResourceFiles/Diversion\\_Report\\_Final.pdf](http://www.homelesshub.ca/ResourceFiles/Diversion_Report_Final.pdf).
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Distress Centre plays a key role in the Coordinated Access and Assessment (CAA) program, providing assessments and information and referral to homeless individuals, families, and youth at the Safe communities Opportunities and Resource Centre (SORCe). Jerilyn completed her Masters in Social Work, with a specialization in Leadership in the Human Services, at the University of Calgary in 2015.