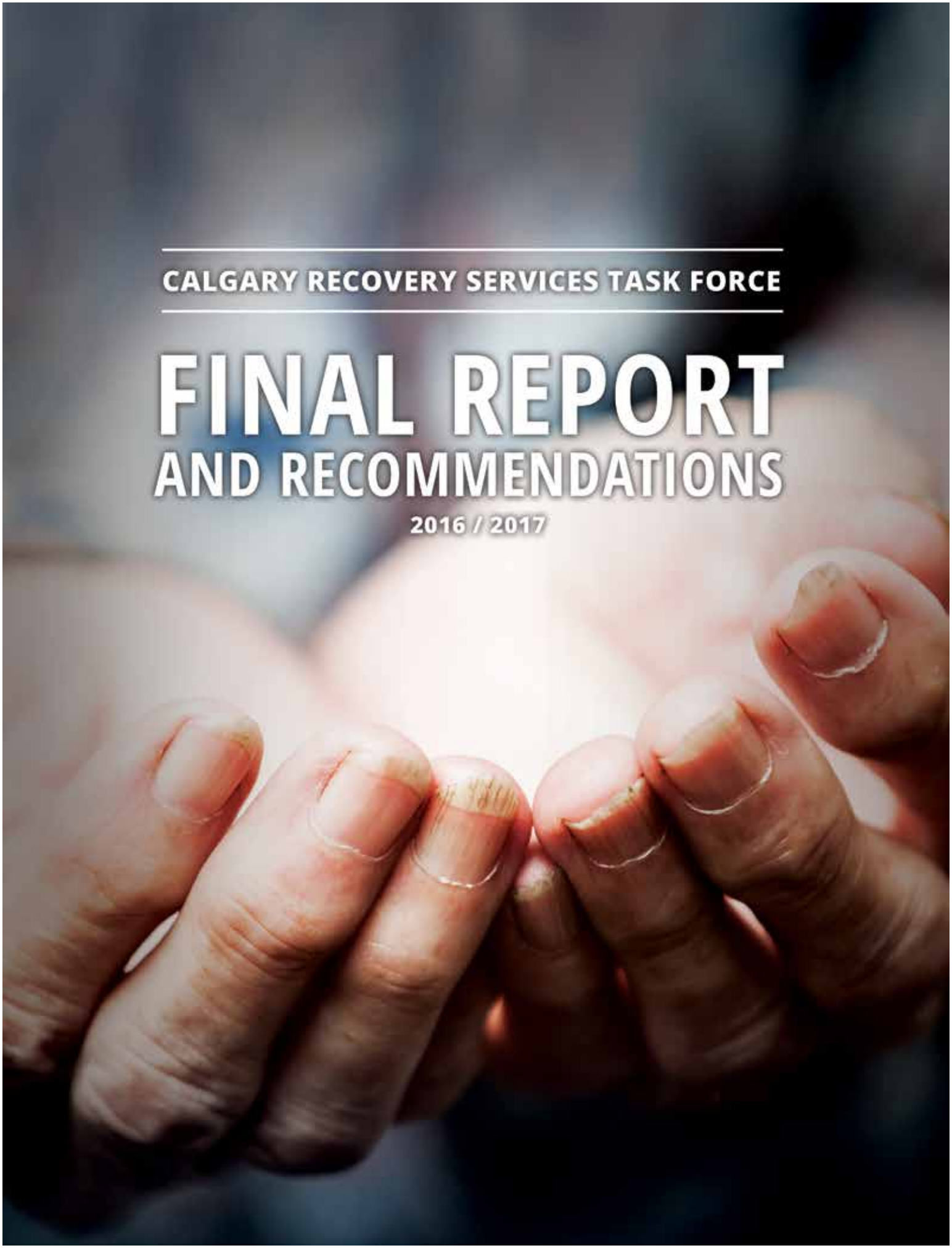

CALGARY RECOVERY SERVICES TASK FORCE

FINAL REPORT AND RECOMMENDATIONS

2016 / 2017

Executive Summary

In a city like Calgary, we each have important social, civic, and economic roles which can support the well-being of the community. What affects one part of the community affects us all, so it is imperative that we work together to support our most vulnerable citizens.

The Calgary Recovery Services Task Force is a committee of individuals from homeless-serving agencies, government, and interested stakeholders who have come together to consider ways of collaboratively responding to the complex health, housing, and supports needed for homeless individuals in Calgary. The Task Force also included systems representatives such as Alberta Health Services, Human Services, the Calgary Homeless Foundation, and members of government. This wide-ranging collaboration empowered the Task Force to take a strategic look at not only the current provision of services, but more effective ways to work together in order to better serve the most vulnerable. While there are numerous services for homeless individuals, and significant progress has been made towards the goal of ending homelessness in our city, the Task Force formed in February 2015 in recognition that current systems and services are sometimes unable to provide the right coordinated support to ensure homeless individuals with complex needs receive appropriate care.

The Task Force included representation from 26 organizations, working towards a shared goal of improving health outcomes and housing supports for vulnerable homeless individuals in Calgary. We were also guided by a collectively developed set of 12 guiding principles.

Over the last two years, the Task Force has collaboratively moved from identifying a need for better city-wide, multi-agency coordinated care for homeless individuals to commissioning a research study through the Cumming School of Medicine and finally producing Seven Key Recommendations for action moving forward.

Our commissioned research study explored the lived experiences of 300 homeless Calgarians with complex health experiences and has provided a person-centered foundation upon which our recommendations for action are based. It revealed that homeless Calgarians are interacting with numerous systems and have complex experiences of mental and physical health as well as addictions. Despite the progress being made using a 'housing first' approach, some individuals still struggle with health issues and access to services. This negatively impacts their well-being and ability to move out of homelessness.

Supporting the well-being of these complex individuals is like building a strong house; it is a process, not an event, requiring a team of specialists and many different types of materials. Bringing together the right mix of community resources, practitioners, and opportunities ensures that vulnerable people and communities can weather life's storms.

> "Calgary, like other major centres in Canada, is at a critical cross roads in caring for its homeless community. Unlike other cities however, Calgary is well positioned to make a lasting impact through high quality cohesive leadership, important existing resources and unified support from all sectors through the Calgary Recovery Services Task Force. This report and its subsequent recommendations chart a path forward that will seriously address this important social issue and I am confident that Calgary will be a leader for other centres to follow."
>
> Dr. Jeffrey Turnbull
> Medical Director of Ottawa Inner City Health:

SEVEN KEY RECOMMENDATIONS

1. **Better Access to Health Services on Front Lines**
   Access to health services should be available through the entire homeless system of care including shelter, supportive housing, and mobile outreach.

2. **Case Management During Transition to Housing**
   Ensure access to intensive case management and health supports as homeless Calgarians transition into supportive housing.

3. **Recognize Homeless Calgarians' Choice in Recovery Services**
   Integrate harm reduction approaches into the continuum of recovery services in recognition of homeless Calgarians' choice.

4. **Responsive Approaches for Indigenous Populations**
   Develop housing and health approaches that are responsive to homeless Indigenous populations.

5. **Open Communication within Homelessness Sector**
   Ensure open communication and access to information amongst organizations and agencies serving homeless Calgarians.

6. **Specialized Responses for Women and Children**
   Develop specialized responses for homeless women and children.

7. **Advance Governance Structure**
   Advance the development of a steering committee/governance structure to provide leadership and oversight for moving forward.

The current report presents detailed highlights from our commissioned research study along with specific research evidence and actions related to our Seven Key Recommendations. The Task Force believes that progress on these Seven Key Recommendations will contribute to positive changes in the health, housing status, and overall well-being of homeless individuals in Calgary. The Recommendations also suggest ways that public funds can be used more efficiently to support government policy and ending homelessness in our community. It is our intention that this report can inform both the community and policy makers, increasing their awareness and desire for action to ensure that chronically homeless individuals in Calgary experience the shared goal of improved health supports and outcomes. This document presents a proactive and collaborative road map for change and system transformation, which includes solutions and actions that can be taken with relative ease to achieve better health and housing outcomes for homeless individuals.


Calgary Recovery Services Task Force
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Alberta
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the alex.
ALPHAHOUSE
Calgary Homeless FOUNDATION
CALGARY POLICE SERVICE
cc4ms
Calgary
CJHS
CUPS
efry The Elizabeth Fry Society of Calgary
FRESH START
HindSight
Inn from the Cold
THE MUSTARD SEED
SHARP foundation
SORCe
United Way
UNIVERSITY OF CALGARY
UNIVERSITY OF CALGARY CUMMING SCHOOL OF MEDICINE
YW
Photo Credit: Davesbloggs007 Link: https://www.flickr.com/photos/davebloggs007/

Acknowledgments

The Calgary Recovery Services Task Force would like to thank all Task Force Members and supporters for their ongoing collaborative efforts and contribution to the current research and recommendations. In particular, we would like to thank: All of the research study participants who shared their experiences with us; Anne Miller, Dr. Sue McIntyre, and Darryn Werth, who wrote this document, along with the Task Force Writing Committee, who provided incredibly valuable insight and direction each step of the way.

We also want to give special thanks to Randal Bell (Alberta Health Services Provincial Initiatives Consultant – Indigenous Populations), Scott Calling Last (Alberta Health Services Street Outreach Worker, Elbow River Healing Lodge), and Katelyn Lucas (Elizabeth Fry Society of Calgary, Executive Director, and Chair of the Calgary Aboriginal Standing Committee on Housing and Homelessness) for their advice and contributions related to working with Indigenous individuals.

The Calgary Recovery Services Task Force would also like to thank the provincial government of Alberta, along with the City of Calgary for their continual support throughout the Task Force process.

The Recommendations in this document are based on the extensive Research Study conducted by Dr. Katrina Milaney from the Cumming School of Medicine at the University of Calgary. This Research Study was funded by the generous financial support of key Task Force partners, including the Calgary Health Trust, Alpha House, the Calgary Drop-In & Rehab Centre Society, the Calgary Homeless Foundation, Inn From The Cold, the United Way of Calgary & Area, the School of Public Policy at the University of Calgary, and Dr. Katrina Milaney. The Calgary Recovery Services Task Force is deeply grateful for the generous financial contributions of our partners who helped make our collaboration significant.

Lastly, the Calgary Recovery Services Task Force would like to thank the vibrant citizens of Calgary and Alberta, whose people have shown time and again their capacity to effectively and compassionately meet the needs of the most vulnerable. Calgarians have a deep capacity to support and care for one another, and the work of our Task Force has been so well received because of that.

For more information on the Calgary Recovery Services Task Force, please contact Debbie Newman (DebbieN@TheDi.ca / 403-699-8270), or Natalie Noble (natalie@calgaryhomeless.com).

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> “The Task Force was an opportunity for coordinated systemic change to help a particularly vulnerable part of our community.
>
> The positive outcome is the combination of added detox capacity combined with tailored supportive housing. This will greatly compliment already existing parts of the continuum of addictions treatment.”
>
> Hugh (Hubert) Colohan
> M.B., B.A.O., B.Ch.,
> LMCC, FRCPC, DABAM, FAPA, ASAM, CCSAM, MRO
> Addictions & Claresholm Clinical Section Chief
> Department of Psychiatry, Calgary Zone
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23 **Recommendation 6 - Specialized Responses for Women and Children**
Develop specialized responses for homeless women and children.

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Advance the development of a steering committee/governance structure to provide leadership and oversight for moving forward

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1.0 Who We Are and Why We've Come Together

In a city like Calgary, we each have important social, civic, and economic roles which can support the well-being of the community. What affects one part of the community affects us all, so it is imperative that we work together to support our most vulnerable citizens.

The Calgary Recovery Services Task Force is a committee of individuals from homeless-serving agencies, government, and interested stakeholders who have come together to consider ways of collaboratively responding to the complex needs of homeless individuals in Calgary. The Task Force also included systems representatives such as Alberta Health Services, Human Services and members of government. This wide-ranging collaboration empowered the Task Force to take a strategic look at not only the current provision of services, but more effective ways to work together in order to better serve the most vulnerable. While there are numerous services for homeless individuals, and significant progress has been made towards the goal of ending homelessness in our city, the Task Force formed in recognition that current systems and services are sometimes unable to provide the right coordinated support to ensure homeless individuals with complex needs receive appropriate care.

The need among homeless Calgarians can be traced back to policies dating back to the mid-nineties. At that time, many hospitals and mental health facilities were downsized or closed in Alberta, resulting in diminished support for individuals with concurrent mental illness, physical health issues, and/or addictions. These conditions contribute to, and exacerbate experiences of homelessness. In recent years, municipal and provincial homelessness strategies have focused on a 'housing first' approach. Despite the progress being made using a 'housing first' approach, some individuals still struggle with health issues and access to services. This negatively impacts their well-being and ability to move out of homelessness.

Numerous research studies have highlighted the systems cost of prolonged homelessness due to poor health, frequent use of hospital emergency departments for medical care, and a higher frequency of hospital admissions.[1] At the same time, for well over a decade, service providers for vulnerable populations, along with the Calgary Police Service, have recognized the need for coordinated wrap-around health services and supports for homeless Calgarians. In the fall of 2014, consultations between the Calgary Police Service, health providers, and homeless-serving agencies made it clear that there was a collectively perceived need for better coordinated care for high-acuity, chronically homeless individuals and that this was not a single-agency challenge, but rather a city-wide issue.

At a meeting on September 14, 2014, the Mayor's Office expressed support for hosting a collaborative conversation with key stakeholders on the need to address continuing poor health outcomes for the high-acuity, chronically homeless population. Subsequently, a collaborative conversation event was held on October 22, 2014. The event was facilitated by Lucy Miller, CEO of the United Way of Calgary, and attracted over 50 people from the addictions and mental health sector, the homeless-serving sector, the health sector, and government. Following the meeting, it was proposed that a Task Force be established to examine the needs of homeless Calgarians in more detail and make recommendations on how to improve health outcomes. Individuals from multiple sectors readily came forward to support the initiative, and the Task Force began meeting monthly in February 2015, with the goal of issuing its recommendations in late 2016 or early 2017.

[1] See for example: Nyamathi, *et al* (2015), Fuehrlein, *et al.* (2015), Forchuk *et al* (2015), Currie, Moniruzzaman, Patterson & Somers (2014), Geurts., Palatnick, . & Weldon (2012), Holtgrave, *et al.* (2012), Culhane, Park & Metraux (2011), Ku, Scott, Kertesz & Pitts (2010), Larmier *et al.* (2009), Patterson *et al* (2008), Pomeroy (2005), and British Columbia Ministry of Social Development and Economic Security (2001)

The Calgary Recovery Services Task Force has representation from 26 organizations, including:

- Alberta Health Services – Community, Rural, and Mental Health; Provincial Planning and Capacity Management; Indigenous Health Program
- Alberta Human Services – Housing and Homeless Supports
- The Alex Community Health Centre
- Alpha House Society
- The Calgary Drop-In & Rehab Centre Society
- The Calgary Homeless Foundation
- The Calgary John Howard Society
- Calgary Police Service
- The Canadian Centre for Male Survivors of Child Sexual Abuse
- Canadian Mental Health Association, Calgary
- The City of Calgary
- The Cumming School of Medicine, University of Calgary
- CUPS (Calgary Urban Project Society)
- The Elizabeth Fry Society of Calgary
- EMS – Community Paramedics
- ER Physicians, Foothills Medical Centre
- Fresh Start Recovery Centre
- The Hindsight Group
- HIV Community Link Calgary
- Inn From The Cold
- The Mustard Seed
- The Sharp Foundation
- SORCe
- Street CCRED
- The United Way of Calgary & Area
- The YW of Calgary

Maintaining collaborative dialogue between 26 different organizations with different mandates and perspectives over 18 months has been a complex challenge. Using a collective impact approach, our focus has consistently been collaboration, a common agenda, shared measurement, mutually reinforcing activities, and continuous communication. Every participant felt that their input was valued, and in the end, our collaboration has been successful in bringing stakeholders together, and in beginning to establish a backbone organization to take the vision of better health care for homeless Calgarians forward.

A key element to maintaining collaborative dialogue within the Task Force has been our shared vision for change. We have collectively established a goal of improving health outcomes and housing supports for vulnerable homeless individuals in Calgary, and have agreed that this should happen through collaborative decision-making and service delivery that seeks to align with government policy and use public funds efficiently.

Underpinning our actions and guiding our path forward are our collectively-developed Guiding Principles. All members of the Task Force had input in developing these principles and have agreed to work collaboratively towards maintaining the intent behind them. Going forward, the guiding principles will act as a compass for our actions and will support the maintenance of our collaborative approach.

Our Guiding Principles and Shared Philosophies

1. **Health Equity**
   Health Equity is achieved when the most marginalized Calgarians have the opportunity to reach their full health potential and receive high quality care that is appropriate, regardless of where they live or who they are. This means the right care at the right time, in the right place, by the right provider, for the right person.

2. **Alignment with Relevant Government Policies and Initiatives**
   The provincial government recognizes the need for changes in the delivery of health and housing services to improve outcomes for those experiencing homelessness. We see this here: Alberta Health Business Plan 2016-2019; AHS Health Plan & Business Plan 2015-2018; Valuing Mental Health: Report of the Alberta Mental Health Review Committee 2015 (Chaired by Dr. David Swann and the Honorable Danielle Larivee); 2014 Gap Analysis of Public Mental Health and Addictions Program; Calgary's Updated Plan to End Homelessness; the 2015 Final Report of the Truth and Reconciliation Commission; and Alberta's Information Sharing Strategy (See full references and links to online documents in Appendix A).

3. **System Integration**
   Increased communication, multi-sectoral response, and shared resources between each system and community which impacts the homeless at every level of planning and care, such as Housing, Health, Human Services, Justice, and Seniors.

4. **Client-Centered Approach Focused on Client Choice**
   This approach will extend, but not be limited to, Indigenous communities, women, children, individuals from diverse cultures, and LGBTQ2S communities. We must develop approaches that are responsive to Indigenous populations, which are over-represented within the homeless population, and more broadly, multi-cultural and inclusive, that respect client choice.

5. **Diversity**
   Led by client choice and need, we respect Agency diversity in philosophy and in the delivery of programs and services. We are committed to developing an integrated and gender-responsive system of care that optimizes the mandate of each Agency, and is responsive to the continuum of client needs.

6. **Upstream Focus On Prevention and Early Intervention**
   The Social Determinants of Health must be prioritized in systems changes. Health issues should be addressed as soon as possible to improve health outcomes for people and the system, along with poverty, housing, employment, community connection, and a deep sense of belonging.

7. **Housing**
   Appropriate resources and support for the entire housing spectrum; housing-first programs, shelters, outreach, and support for those whose housing is at risk.

8. **Family Health and Supporting the Optimization of Natural Supports**
   Our focus is supporting the communities of care and community networks of this population, and normalizing new types of communities and families. We also seek to build a network of family and community health supports.

9. **A Compassionate Culture of Care Focused on Harm Reduction and Trauma-Informed Practice**
   We will evaluate decisions and build initiatives that are grounded in principles of harm reduction, recovery and trauma-informed practice.

10. **Cultural Safety**
    We will adopt an Indigenous lens for all of our policies, services, and program delivery, along with a lens focused on the unique health needs of new Canadians.

11. **Systemic Transformation**
    Our focus is fixing systems, not people. We are committed to the transformation of Public Systems to improve health and housing outcomes for the target population, and ensuring functional accountability as we pursue this goal. This transformation of Public Systems includes, but is not limited to the provincial ministries of Health, Human Services, Justice, Municipal Affairs, and Seniors and Housing.

12. **Evidence-Based, Best Practice Focus**
    We are committed to ensuring that service delivery approaches are innovative, evidence-based, and capitalise on best practices. We will build a culture of measurement and better health outcomes for the target population, and seek to balance an evidence-based focus with an innovation-based focus.

Over the past 18 months, the Task Force has collaboratively moved from identifying a need for better city-wide, multi-agency coordinated care for chronically homeless individuals to producing the concrete recommendations presented in this report. As part of the journey towards the establishment of a common agenda, and in consideration of our guiding principle of adhering to a client-centered approach focused on personal choice, a research study through the Cumming School of Medicine at the University of Calgary was commissioned to explore the lived experiences of chronically homeless individuals living in our city. The study included 300 homeless Calgarians with complex experiences and has provided a person-centered foundation upon which our recommendations for action are based.[2]

The current report presents findings from our commissioned research study along with our Seven Key Recommendations for more effective management of health care for homeless Calgarians. It is our intention that this report can inform both the community and policy makers, increasing their awareness and desire for action to ensure chronically homeless individuals in Calgary receive high quality and appropriate care.

[2] The research can be cited as: Williams, N., Kamran, H., and Milaney, K. (2016). *Perceived need for health services for persons experiencing chronic homelessness: A Research report for the Calgary Recovery Services Task Force.*

2.0 What Are Homeless Calgarians Experiencing?

In order to better understand the complex experiences of homeless Calgarians, the Calgary Recovery Services Task Force commissioned an academic research study through the Cumming School of Medicine at the University of Calgary that was completed in 2015.[3] In particular, we wanted to know how homeless Calgarians currently access systems of care, and whether these systems adequately support those who experience concurrent mental illness, substance abuse, physical health issues. We wanted to hear from individuals with lived-experience of homelessness to enable the collaborative co-creation of new care designs that are person-centered, equitable, and effective.

Based on the best available data, the total number of chronically homeless Calgarians is approximately 900.[4] Calgary Homeless Foundation data suggests that the proportion of chronically homeless individuals with complex health situations (concurrent disorders) is approximately 62%, suggesting there are approximately 550 individuals having this experience.

Our commissioned research involved 303 Calgarians who have complex and ongoing experiences of homelessness. Each participant was asked 88 questions via a paper-based survey administered by a trained research assistant with homeless-sector experience. The final number of survey respondents with unique and complete surveys was 300. The survey questions were developed by researchers at the University of Calgary, and were vetted by Calgary Recovery Services Task Force members (survey questions available upon request).

The survey included demographic questions followed by questions about current drug and alcohol use, mental and physical health conditions, and safety amongst participants in order to develop a picture of the complex health needs of homeless Calgarians. It then asked about experiences with health, justice, and social support systems to garner information about respondents' experiences accessing care within established systems.

Ten questions from the Adverse Childhood Experiences (ACE) Study were also included as part of the survey in order to begin to gain understanding around the links between experiences in childhood and later experiences of homelessness. Five of the ACE Study questions ask about personal trauma, including verbal, physical and sexual abuse, and physical and emotional neglect. The other five ACE Study questions ask about family situations, including family members who are addicted to drugs and/or alcohol, mothers being a victim of domestic violence, family members diagnosed with a mental illness or being incarcerated, and separation from a parent through death, divorce, or abandonment. The ACE Study has resulted in more than 50 published articles and has revealed that Adverse Childhood Experiences like abuse, neglect, and household dysfunction (e.g. drug use, mental illness, incarceration, domestic violence), are linked to risky behaviours and chronic health conditions later in life (see Appendix C for more details).[5]

Our research study was approved through the University of Calgary Conjoint Health Research Ethics Board and required signed consent from all survey respondents. Individuals participating in the study were provided a $25 honorarium for their participation in the research.

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[3] Williams, N., Kamran, H., and Milaney, K. (2016). *Perceived need for health services for persons experiencing chronic homelessness: A Research report for the Calgary Recovery Services Task Force.*

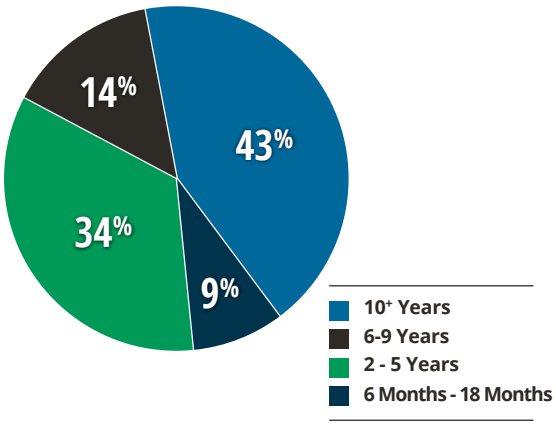
[4] Kneebone, R., Bell, M., Jackson, N., & Jadidzadeh, A. (2015). Who are the Homeless? Numbers, Trends, and Characteristics of Those without Homes in Calgary. *University of Calgary School of Public Policy SPP Research Papers, 8:11,* Page 2.

[5] For more information on the ACE Study, including a list of published journal articles, visit: https://www.cdc.gov/violenceprevention/acestudy/

Who Did We Talk To?

Our research study sought participants with lengthy (over one year) and complex experiences of homelessness. In total, 43% of the participants had been homeless ten years or more over the course of their lives, and 73% had been homeless four years or more.

Length of Homelessness Experienced Over The Lifetime



Respondents included 217 men (72%), 81 women (27%) and two individuals identifying as either transgender or two-spirited. Most respondents (57%) indicated that they had children. Of those with children, 4% indicated their children were in their care.

Most respondents (62%) had lived in Calgary for more than 10 years, and 12% had lived in Calgary their entire life. Their average age was 47.

Nearly one third (30%) of the respondents identified as Indigenous (First Nations, Aboriginal, Inuit, or Metis). Of those identifying as Indigenous, 20% had attended a residential school, while another 63% had family members who had attended a residential school.[6]

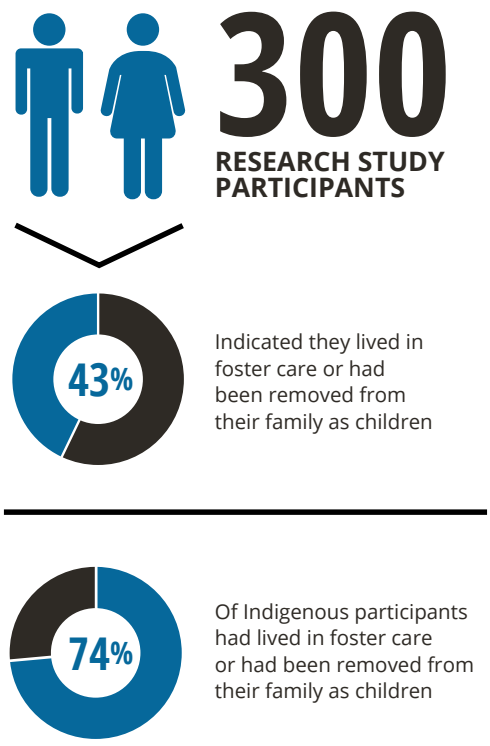
> People moving out of chronic homelessness into permanent housing with appropriate supports, including community-based medical care from a health team they know and trust, assistance with finding and maintaining employment and meaningful community activities, increases options for addressing addictions in a more timely and responsive way.
>
> Julie Kerr
> Senior Operating Officer
> Community Rural & Mental Health
> Calgary Zone, Alberta Health Services

[6] Note: Residential schools were government-funded, church-run schools set up to eliminate parental involvement in the intellectual, cultural, and spiritual development of Indigenous children. The schools were located across the country, starting around the 1870s, and the last school closed in 1996. For more information about residential schools and their impact on Indigenous peoples in Canada, see the Truth and Reconciliation Commission of Canada's Final Report, available online at: http://www.myrobust.com/websites/trcinstitution/File/Reports/Executive_Summary_English_Web.pdf

Childhood Experiences

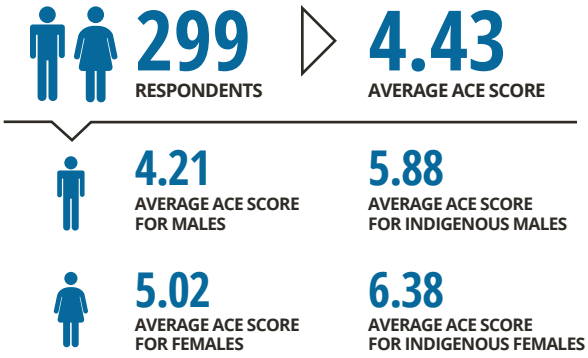
Past research has shown that adverse experiences in childhood, like trauma and abuse, are strong direct risk factors for homelessness later in life.[7] In order to better understand the pathways to complex homelessness, we asked respondents about their experiences in childhood.

Of the 300 research study participants, 43% indicated they had lived in foster care or had been removed from their family as children. Nearly three quarters (74%) of Indigenous participants had lived in foster care or had been removed from their family as children.



The ACE Study questions were used to ask about childhood experiences. These questions produce an ACE score[8] that assesses cumulative childhood stress. Past academic research has repeatedly shown that higher ACE scores are associated with increased risk of alcoholism, smoking, illicit drug use, financial stress, poor work performance, intimate partner violence, adolescent pregnancy, sexual violence, poor academic achievement, depression/suicide attempts, and a host of physical health issues throughout life (e.g. liver disease, heart, disease, etc.).[9] ACE scores of four or higher are associated with significant risk for a number of these poor health and well-being outcomes[10] (see Appendix C for more details).

In total, 299 participants in our research study completed the ACE Study questions. The average ACE score across all respondents was 4.43, with male respondents reporting an average ACE score of 4.21 and female respondents reporting an average ACE score of 5.02. The average ACE score of Indigenous respondents was 6.07, with Indigenous male respondents reporting an average ACE score of 5.88 and Indigenous female respondents reporting an average ACE score of 6.38.



This means that overall, on average, respondents experienced between four and five traumatic or disruptive situations in childhood (before the age of 18), while Indigenous respondents experienced an average of six traumatic or disruptive situations.

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[7] See for example: Roos, L. E., Mota, N., Afifi, T. O., Katz, L. Y., Distasio, J., & Sareen, J. (2013). Relationship Between Adverse Childhood Experiences and Homelessness and the Impact of Axis I and II Disorders. *American Journal of Public Health, 103(S2),* S275-S281.
Herman, D. B., Susser, E. S., , E. L., & Link, B. L. (1997). Adverse childhood experiences: Are they risk factors for adult homelessness? *American Journal of Public Health, 87(2),* 249-255.

[8] The ACE score is the total sum of the different categories of ACEs reported by participants, where a category is worth 1 if a survey respondent indicates they have experienced it in childhood.

[9] Note, this list is not exhaustive. See the Centre for Disease Control and Prevention's website for a list of published studies using ACE Scores: https://www.cdc.gov/violenceprevention/acestudy/journal.html

[10] TED. (2014, September). Nadine Burke Harris: How childhood trauma affects health across a lifetime [Video file]. Retrieved from: https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime

Current Physical Health

In order to better understand the complex health experiences and needs of homeless Calgarians, we asked survey respondents to tell us about their physical health issues.

Nearly all participants (91%) indicated they have been diagnosed with a physical health condition, with 62% indicating they had recurring/ongoing physical health issues directly related to their homelessness. Respondents reported an average of four diagnoses per individual.

The most commonly reported diagnoses were dental problems (56%), chronic pain (38%), skin/foot problems (37%), mobility issues (37%), and arthritis (34%).

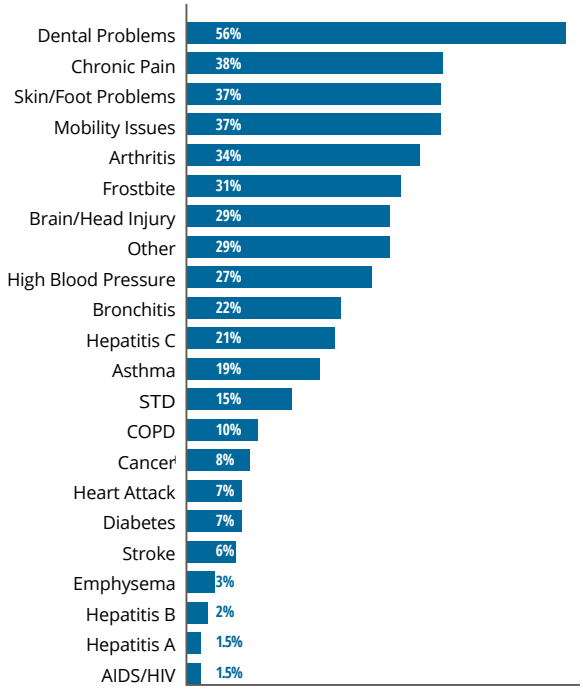
Current Mental Health

In order to further understand the complex health experiences and needs of homeless Calgarians, we asked survey respondents to tell us about their mental health challenges.

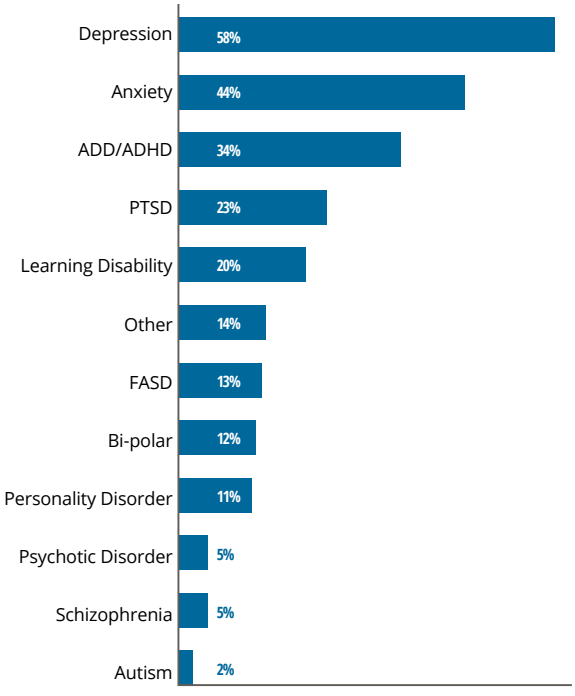
Nearly half (44%) of all participants indicated they have been diagnosed with a disability and/or mental illness. Respondents reported an average of two diagnoses per individual, however nearly half (46%) of participants who reported they had a diagnosed disability/mental illness felt that they also had another, undiagnosed, mental health condition. Of the respondents who were not diagnosed with a disability and/or mental illness, 42% felt they had an undiagnosed disability and/or mental illness.

The most commonly reported diagnoses were depression (58%), anxiety (44%), ADD/ADHD (34%), PTSD (23%), and learning disability (20%).

Current Physical Health Diagnoses



Current Mental Health Diagnoses



Drug and Alcohol Use

While not all homeless individuals are substance users, research has shown that substance use/abuse is linked to homelessness as both an antecedent and a consequence of homelessness.[11] Approximately one third (32%) of respondents in our research indicated that they drink alcohol daily or almost daily. When alcohol is not available, 15% of all respondents indicated that they use potentially dangerous non-beverage alcohols such as mouthwash, alcohol-based antifreeze, antiseptics, aftershave, and other alcohol-based substances. While most respondents (82%) stated that they use alcohol to some degree, 17% of participants noted that they never use alcohol.

Approximately one third (34%) of respondents indicated that they use drugs other than alcohol daily or almost daily, and 12% of respondents indicated that, on a daily or almost daily basis, they use drugs and alcohol at the same time.

The most frequently reported substance used was alcohol, and 81% of respondents indicated they had consumed alcohol in the six months prior to the survey. In the six months prior to the survey respondents also reported having used marijuana (53%), crack (31%), cocaine (25%), methamphetamine (22%), hashish (13%), OxyContin (12%), and amphetamine (11%).

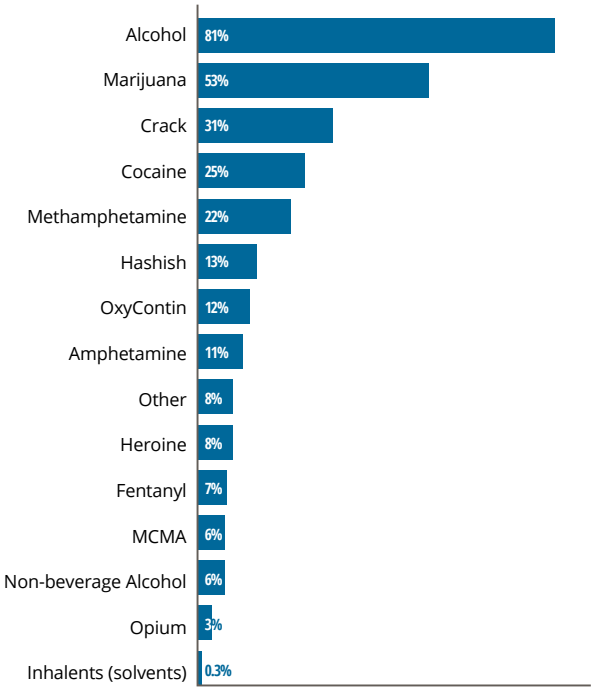
Most respondents (59%) said that using alcohol or drugs was one of the ways they deal with stress. Approximately half (51%) of all respondents reported they had been diagnosed with an addiction by a medical professional. The most common diagnosed addiction was alcohol addiction (62%).

Long-term and/or heavy alcohol and drug consumption can cause serious harm to users' health and well-being, particularly if they use/live on the streets.[12] In the previous 12 months, approximately a quarter (26%) of participants indicated they had experienced health issues as a result of their drinking or drug use.

Past research has revealed that the majority of criminal offenders show evidence of some kind of substance abuse problem, and Canadian national prevalence data indicates that at least 7 of 10 offenders in the federal correctional system have engaged in problematic substance use during the one-year period prior to their incarceration.[13] Research has shown that 97% of offenders with severe substance use issues reported using substances on the day of their offence; and 87% reported that substance abuse was associated with their crimes over the course of their criminal history. Often, society's most marginalized people enter a criminal justice system that cannot address the underlying systemic issues driving their behavior, including mental health and addiction. It has been said that these individuals serve life sentences one month at a time.

In total 34% of respondents from our research indicated they were having legal difficulties resulting from their substance use.

Substances Used In The Last Six Months



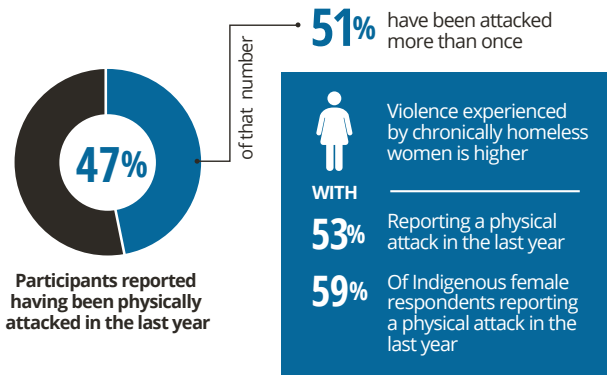
[11] Johnson, G., & Chamberlain, C. (2008). Homelessness and Substance Abuse: Which Comes First? *Australian Social Work, 61(4)*, 342-356.

[12] Wright, N., & Tompkins, C. (2006). How Can Health Services Effectively Meet the Health Needs of Homeless People? *British Journal of General Practice, 56 (525),* 286-293.

[13] Canadian Centre on Substance Abuse (CCSA).(2004). *Substance Abuse in Corrections: FAQs*. Available online at: http://www.ccsa.ca/Resource%20Library/ccsa-011058-2004.pdf

Experiences of Harm and Violence

Past research has shown that homeless individuals are at high risk of experiencing violence,[14] and the longer an individual is homeless, the greater their risk of experiencing violent victimization. Gender and age have also been shown to increase the risk of experiencing violence, with women and older individuals experiencing more instances and greater degrees of violence when living on the streets.[15]



Nearly half (47%) of all participants reported having been physically attacked in the last year. Of those who had been attacked, approximately half (51%) had been attacked more than once.

The level of violence experienced by chronically homeless women is higher, with 53% of female respondents reporting a physical attack in the last year, and 59% of Indigenous female respondents reporting a physical attack in the last year.

Beyond violence experienced at the hands of others, respondents reported having engaged in a variety of intentional self-harming behaviours in their lifetimes including cutting, burning, scratching, and hitting themselves. Most respondents (62%) had thoughts of suicide, and one in four respondents had attempted suicide at some point.

Experiences with Harm Reduction

'Harm reduction' approaches include policies, programs, and practices that seek to reduce the adverse health, social, and economic consequences of risky behaviours, while recognizing that the behavior may continue despite the risks.[16] Harm reduction approaches are most often applied to substance use behaviour, with strategies ranging from safer substance use (e.g. safe injection sites), to managed substance use (e.g. reducing the amount or type of substance used) to abstinence from substance use. This enables supporters and service-providers to meet substance users 'where they're at', potentially reducing harm caused by substance use while 'opening doors' for recovery.[17]

Our research revealed that only 36% of respondents felt they had received harm reduction services in the past year. Respondents who indicated they had received harm reduction services had done so primarily through shelters (63%). Many respondents also indicated they had received harm reduction through community service agencies (23%), outreach workers (17%), and detox services (13%).[18]

Across respondents, substance use issues are prevalent with half (51%) of all respondents reported having been diagnosed with an addiction by a medical professional and 30% indicating they felt they had an addiction that had not been diagnosed. Despite the high prevalence of addiction amongst respondents, many individuals indicated they had not accessed services designed to address substance use or addiction because they were not ready to get help (40% of respondents had not accessed detox services because they felt they were not ready, and 23% had not accessed residential treatment services because they were not ready). Harm reduction approaches can provide opportunities to meet substance users 'where they are at' to create opportunities to move towards full recovery while mitigating the potential harm caused by substance use.

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[14] Lee, B. (2005). Danger on the Streets: Marginality and Victimization Among Homeless People. *American Behavioral Scientist, 48(8),* 1055-1081.

[15] Meinbresse, M., Brinkley-Rubinstein, L., Grassette, A., Benson, J., Hamilton, R., Malott, M., & Jenkins, D. (2014). Exploring the Experiences of Violence Among Individuals Who Are Homeless Using a Consumer-Led Approach. *Violence and Victims Violence, 29(1),* 122-136.

[16] Calgary Homeless Foundation. (2015). *Calgary's Updated Plan to End Homelessness: People First in Housing First.* Calgary, AB: Calgary Homeless Foundation.

[17] For more information see the Harm Reduction Coalition's website at: http://harmreduction.org

[18] Note: Respondents may have reported receiving harm reduction services through multiple sources.

Social Supports

Social supports, like friends and family, are important for maintaining physical and mental health.[19] Among homeless individuals, research suggests that social supports are related to both better physical and mental health status and lower likelihood of victimization.[20]

Approximately two thirds (68%) of survey respondents indicated that they feel they have some form of social supports. Of those who felt they did not have social supports, most wished they had some (65%)

Of the respondents who indicated they have social supports, most said that they are supported by friends on the street (69%) and family (53%). Respondents also identified their housed friends as social supports (52%).

Respondents suggested that their social supports help them most often by talking through problems and providing emotional support. Social supports have also helped respondents with basic needs such as food, housing, and transportation. Some respondents indicated that their social supports help them with systems navigation/access including accessing counselling, health care, legal services, and/or detox.

Most respondents were accessing their social supports frequently with 36% relying on social supports daily or almost daily and 23% engaging with social supports weekly.

Experiences with Systems

The Calgary Recovery Services Task Force came together with an underlying belief that systems could work more collaboratively to provide better person-centered care for homeless Calgarians with complex physical and mental health needs. In order to better understand what is currently working or not working within our systems, we asked our research participants about their experiences with those different systems.

Experiences with Health Services

Past research has shown that homeless individuals often face significant barriers to accessing health and addictions supports[21], and accessing/adhering to treatments (or medications) when they are prescribed.[22] Homeless individuals also often feel unwelcome in health service settings, which may decrease their desire to seek support when needed, exacerbating many health issues.[23]

In our study, we were curious about homeless Calgarian's use of different health services, the reasons why they don't or can't use different health services, and their experience and satisfaction with health service use. First we asked respondents about the health services they may have received in the last year, including hospital services, detox services, residential treatment services, outpatient services, and medications/ treatments for mental and physical health issues.

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[19] See for example: Ozbay, F., Johnson, D., Dimoulas, E., Morgan, C., Charney, D., & Southwick, S. (2007). Social Support and Resilience to Stress: From Neurobiology to Clinical Practice. *Psychiatry, 4(5),* 35-40.

[20] Hwang, S., Kirst, M., Chiu, S., Tolomiczenko, G., Kiss, A., Cowan, L., & Levinson, W. (2009). Multidimensional Social Support and the Health of Homeless Individuals. *Journal of Urban Health, 86(5),* 791-803.

[21] Bonin, J., Fournier, L., & Blais, R. (2007). Predictors of Mental Health Service Utilization by People Using Resources for Homeless People in Canada. *Psychiatric Services, 58(7),* 936-941.;
Palepu, A., Gadermann, A., Hubley, A., Farrell, S., Gogosis, E., Aubry, T., & Hwang, S. (2013). Substance Use and Access to Health Care and Addiction Treatment among Homeless and Vulnerably Housed Persons in Three Canadian Cities. PLoS ONE, 8(10).

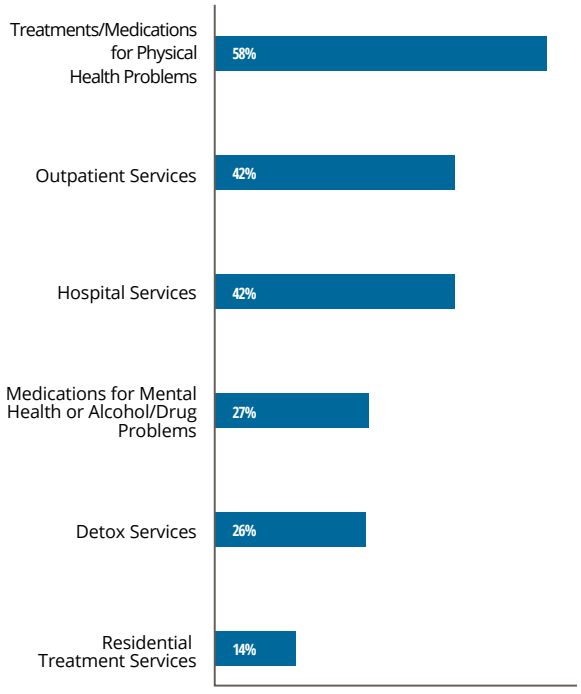
[22] Hunter, C., Palepu, A., Farrell, S., Gogosis, E., O'brien, K., & Hwang, S. (2014). Barriers to Prescription Medication Adherence Among Homeless and Vulnerably Housed Adults in Three Canadian Cities. *Journal of Primary Care & Community Health, 6(3),* 154-161.

[23] Wen, C., Hudak, P., & Hwang, S. (2007). Homeless People's Perceptions of Welcomeness and Unwelcomeness in Healthcare Encounters. *Journal of General Internal Medicine, 22(7),* 1011-1017.

Our research revealed that in the last year:

- 58% of respondents had received treatments/ medications to address physical health issues;
- 42% of respondents had used outpatient services;
- 42% of respondents had spent time in the hospital due to physical, mental, or substance use issues;
- 27% of respondents had received medications (or tablets) to address emotional, mental health, or alcohol/drug use issues.
- 26% of respondents had used detox services; and
- 14% of respondents had attended residential treatment services.

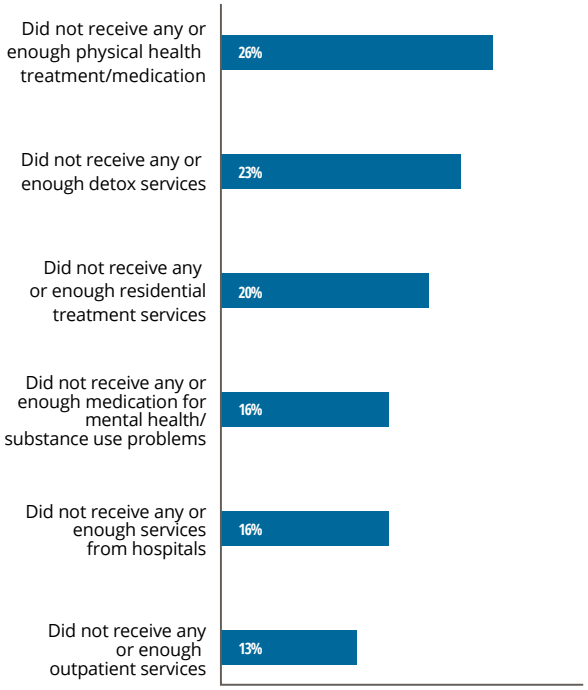
Health Services Used In The Last Year



If respondents indicated they had not accessed a health service, we asked them to indicate whether they had not accessed the service because they did not need it, or whether they felt they had needed the service and were not able to access it. If respondents indicated they had accessed a health service, we asked if they had received enough of the service. In total:

- 26% of respondents felt they had not received the treatment/medication they needed for their physical health issues or had not received enough treatment/medication;
- 23% of respondents felt they needed detox services and had not received them, or had not received enough support from the detox services they accessed;
- 20% of respondents felt they needed residential treatment services and had not received them, or had not received enough from the residential treatment services they accessed;
- 16% of respondents felt they had not received the medication they needed for their mental health or alcohol/drug issues or had not received enough medication;
- 16% of respondents felt they had not spent time in the hospital when they needed to, or had not received enough care when they were in the hospital; and
- 13% of respondents felt they needed outpatient services and had not received them, or had not received enough outpatient services.

Unmet Health Services Needs



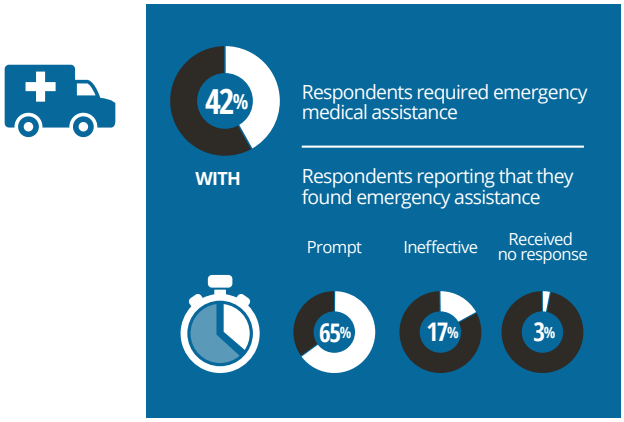
The reasons respondents did not receive any or enough of the health services they needed varied from service to service.[24] Often, respondents indicated that they preferred to manage the issue themselves, and some felt that nothing would help them so they did not access services. For services such as hospital, residential treatment services, and outpatient services long wait lists were a common reason why respondents had not received adequate care. Nearly a third[25] of respondents indicated that they couldn't afford hospital stays, medications, and/or treatments for their health issues. In total, 52% of respondents indicated that they had asked for help through hospital services but had not received it.

Overall, however, respondents indicated satisfaction around health services and health service actions. Three quarters (75%) of respondents felt that health services were easy or relatively easy for them to access and 55% of respondents often or always found health care practitioners caring and compassionate. Overall, three quarters (75%) of respondents were satisfied or very satisfied with health services. At the same time, 22% of respondents found health services difficult or very difficult to access, and 19% were unsatisfied or very unsatisfied with these services.

Experiences with Emergency Services

Due to higher rates of violent victimization and serious health issues, individuals living on the streets are often high users of emergency systems.[26] The Calgary Police Service responds to over 100,000 social disorder calls for service every year, often related to mental health and/or substance use issues.

In the last year, 29% of respondents required police assistance and contacted the police, while 5% of respondents required police assistance but did not contact the police. Of those requiring police assistance, only approximately half[27] found it prompt and/or effective while 31% felt it was ineffective. 7% of respondents who required police assistance did not receive it.



In the last year, 42% of respondents required emergency medical assistance. Most respondents (over 65%) reported that they found the emergency medical assistance prompt and/or effective, although 17% found it ineffective and 3% received no response.

[24] Note: participants could cite multiple reasons.

[25] 27% indicated they could not afford hospital stays; 27% indicated they could not afford medications for problems with emotions, mental health, or substance use; 33% indicated they could not afford medications or treatments for physical health conditions.

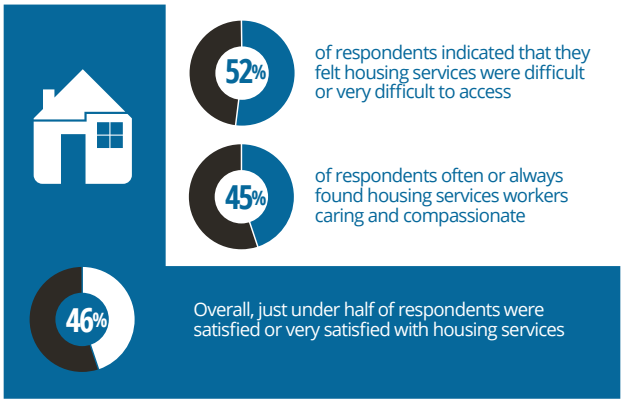
[26] Kushel, M. B., Perry, S., Bangsberg, D., Clark, R., & Moss, A. R. (2002). Emergency Department Use Among the Homeless and Marginally Housed: Results From a Community-Based Study. *American Journal of Public Health, 92(5)*, 778-784.
See also: Lee, B. (2005). Danger on the Streets: Marginality and Victimization Among Homeless People. *American Behavioral Scientist, 48(8)*, 1055-1081.
Wright, N., & Tompkins, C. (2006). How Can Health Services Effectively Meet the Health Needs of Homeless People? *British Journal of General Practice, 56 (525)*, 286-293.

[27] 52% of respondents found the response prompt; 50% of respondents found the response effective.

Experiences with Social Services

Beyond the health/emergency services that individuals access when they're homeless, specific social services are targeted towards homeless individuals with the intention of supporting their well-being and mitigating the impacts and length of homelessness.

Approximately three quarters (76%) of all respondents indicated that they had accessed social interventions in the last year in response to their homelessness. By far the most accessed service reported by respondents was shelters (81%).

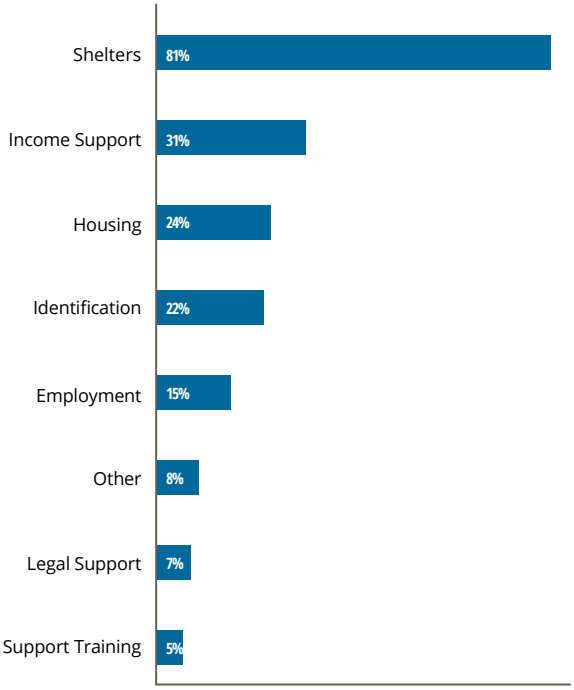


Despite the proportion of individuals indicating they had accessed shelters or housing, approximately half (52%) of respondents indicated that they felt housing services were difficult or very difficult to access and only 45% of respondents often or always found housing services workers caring and compassionate. Overall, just under half (46%) of respondents were satisfied or very satisfied with housing services.

Respondents were asked about their (outside of hospital) counselling service use separately from their social service use. In the last year, just over a third (37%) of respondents accessed counselling for physical/mental health or alcohol/drug use. Counselling was received through shelters (49%), community service agencies (35%), and non-hospital health clinics (14%).

In total, 42% of respondents felt they had not received the social interventions that they needed or had not received enough of the services that they needed. For these individuals, the most commonly cited reasons for not receiving any or enough services were long wait lists, asking for help but not receiving it, and not qualifying for supports.[28]

Social Services Accessed In The Last Year In Relation To Homelessness



[28] Note: participants could cite multiple reasons.

3.0 Where Do We Go From Here?

Supporting the well-being of vulnerable and complex individuals is like building a strong house; it is a process, not an event, requiring a team of specialists and many different types of materials. Bringing together the right mix of community resources, practitioners, and opportunities ensures that people and communities can weather life's storms.

Based on research, investigation, and significant homeless-sector experience, the Calgary Recovery Services Task Force has collaboratively developed Seven Key Recommendations to move Calgary forward. These recommendations seek to highlight specific actions that the Task Force believes will contribute to positive changes in the health and well-being of homeless individuals in Calgary. The recommendations also suggest ways that public funds can be used efficiently to support government policy and the ending of homelessness in our community.

Recommendation 1

Better Access to Health Services on Front Lines

Access to health services should be available through the entire homeless system of care including shelter, supportive housing, and mobile outreach.

Recommendation 2

Case Management During Transition to Housing

Ensure access to intensive case management and health supports as homeless Calgarians transition into supportive housing.

Recommendation 3

Recognize Homeless Calgarians' Choice in Recovery Services

Integrate harm reduction approaches into the continuum of recovery services in recognition of homeless Calgarians' choice.

Recommendation 4

Responsive Approaches for Indigenous Populations

Develop housing and health approaches that are responsive to homeless Indigenous populations.

Recommendation 5

Open Communication within Homelessness Sector

Ensure open communication and access to information amongst organizations and agencies serving homeless Calgarians.

Recommendation 6

Specialized Responses for Women and Children

Develop specialized responses for homeless women and children.

Recommendation 7

Advance Governance Structure

Advance the development of a steering committee/ governance structure to provide leadership and oversight for moving forward.

Recommendation 1 – Better Access to Health Services on Front Lines

Access to health services should be available through the entire homeless system of care including shelters, supportive housing, and mobile outreach.

Our research has shown that homeless Calgarians face complex mental and physical health needs. 91% of survey respondents indicated that they have a diagnosed physical health condition and 44% of survey respondents indicated that they have a diagnosed disability and/or mental illness. A further 42% of respondents indicated that they felt they had a disability and/or mental illness that had not been diagnosed. For each diagnosed individual an average of four physical health conditions and two mental health conditions have been diagnosed. These individuals are accessing multiple formal and informal systems of care as they seek to address their health issues, which are often exacerbated by their homelessness.

Our research has also shown that most homeless Calgarians (81%) are accessing shelters, and that shelters are a key source of information on physical/mental health and addictions services for homeless Calgarians. Past research has shown that providing health services to homeless individuals within the homeless system of care can be less costly and more client-centered than having homeless individuals access health services through emergency departments and hospitals.[29] Providing better access to primary care in places where vulnerable patients are comfortable accessing services may prevent many acute care encounters and escalation of health issues.[30]

We recognize that, in parallel to the general population, the homeless population is aging. The average age of participants in our research study was 47 and past research has shown that the aging process is accelerated by homelessness, increasing the complexity of the health needs of older homeless individuals.[31] As these individuals reach a point of needing palliative and end-of-life care, they often face barriers to access due to their lack of housing. In particular, many policies and programs emphasize the importance of "dying at home" and family supports, which assume individuals have homes and supportive families, which many homeless individuals do not.[32] These individuals may require specialized supports to increase effectiveness of advance care planning, palliative care, and end-of-life care interventions.[33]

Given these findings from our research, we recommend that wrap-around health resources and programs (including palliative care) are made available through the entire homeless system of care, including shelters, supportive housing, and mobile outreach. This should be an integrated response using shared resources.

Through the realignment and sharing of resources, this responsive continuity of care could include:

- Sustainable funding for multi-disciplinary health teams integrated into shelters, housing, and correctional services;
- Increased capacity for health and medical supports in shelters and mobile outreach for homeless Calgarians awaiting transition to housing;
- Increased capacity for mobile medical and dental supports, including mobile palliative care programming;
- Establishing a discharge planning process with Alberta Health Services, local hospitals, justice, and local shelters, and piloting step-down care for homeless Calgarians;
- The re-purposing of existing long-term care facilities or shelters for end of life care and/or transitional care;
- Support for a community health centre model in shelters that provides team-based care and addresses the social barriers to health faced by homeless individuals;
- Increased efforts to attach homeless individuals to a 'health home' to increase continuity of care, in alignment with the Alberta Primary Health Care Strategy.

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[29] See for example Kuehn (2012); Pomeroy (2005)

[30] Mccusker, J., Tousignant, P., Silva, R. B., Ciampi, A., Levesque, J., Vadeboncoeur, A., & Sanche, S. (2012). Factors predicting patient use of the emergency department: A retrospective cohort study. *Canadian Medical Association Journal,* 184(6), E307-316; Wang *et al* (2015). The Role of Charity Care and Primary Care Physician Assignment on ED Use in Homeless Patients. *The American Journal of Emergency Medicine, 33(8)*, 1006-1011.

[31] Grenier, A., Barken, R., Sussman, T., Rothwell, D., Bourgeois-Guérin, V., & Lavoie, J. (2016). A Literature Review of Homelessness and Aging: Suggestions for a Policy and Practice-Relevant Research Agenda. *Canadian Journal on Aging, 35(01)*, 28-41.

[32] Huynh, L., Henry, B., & Dosani, N. (2015). Minding the gap: Access to palliative care and the homeless. *BMC Palliative Care, 14(1)*, 1-4.

[33] Sumalinog, R., Harrington, K., Dosani, N., & Hwang, S. (2016). Advance care planning, palliative care, and end-of-life care interventions for homeless people: A systematic review. *Palliative Medicine*, 1-11.

Recommendation 2 - Case Management During Transition to Housing

Ensure access to intensive case management and health supports as homeless Calgarians transition into supportive housing.

Our research has shown that homeless Calgarians have complex mental/physical health issues, many of which are exacerbated by their experience of homelessness. In total, 62% of the participants in our research indicated that their physical health issues were directly related to their homelessness, and 59% indicated that they use drugs and/or alcohol to deal with the stress they experience in their lives.

While residential stability is associated with fewer unmet physical health care needs and lower emergency department utilization by formerly homeless individuals,[34] health issues developed during years of living on the streets can persist despite access to stable housing.[35] Past research has also shown that providing health services for recently housed, formerly homeless individuals is a cost efficient approach.[36] In consideration of this, we recommend ensuring that those who move from shelter into housing have medically supported housing with case management to support their wide range of physical and mental health needs. We believe that this will lead to better health outcomes, as well as better housing outcomes in the long-term.

We suggest that this can be achieved by:

- Increasing capacity in medically supported permanent supportive housing;
- Piloting alternative housing models for complex and high acuity clients using multiple systems;
- Building on integrated service delivery models currently being implemented in Human Services;
- Increasing capacity in medically supported permanent supportive housing for seniors and homeless individuals with mobility challenges.

> “Collaborative work with Alberta Health Services, Government, and Community Partners to develop and implement strategies, treatments, education, and policies that aim to directly mitigate the growing opioid overuse/misuse and fentanyl crisis is critically important.”
>
> Dr. Van Nguyen, MD CCFP
> Health Director
> CUPS

[34] Jaworsky, D., et al. (2016). Residential Stability Reduces Unmet Health Care Needs and Emergency Department Utilization among a Cohort of Homeless and Vulnerably Housed Persons in Canada. *Journal of Urban Health, 93(4)*, 666-681.

[35] Fuehrlein, B., Cowell, A., Pollio, D., Cupps, L., Balfour, M., & North, C. (2015). A Prospective Study of the Associations Among Housing Status and Costs of Services in a Homeless Population. *Psychiatric Services, 66(1)*, 27-32.

[36] See for example Kuehn (2012); Pomeroy (2005)

Recommendation 3 - Recognize Homeless Calgarians' Choice in Recovery Services

Integrate harm reduction approaches into the continuum of recovery services in recognition of homeless Calgarians' choice.

'Harm reduction' approaches include policies, programs, and practices that seek to reduce the adverse health, social, and economic consequences of risky behaviours, while recognizing that the behavior may continue despite the risks.[37] Harm reduction approaches are most often applied to substance use behaviour, with strategies ranging from safer substance use (e.g. safe injection sites), to managed substance use (e.g. reducing the amount or type of substance used) to abstinence from substance use. This enables supporters and service-providers to meet substance users 'where they're at', potentially reducing harm caused by substance use while 'opening doors' for recovery.[38] Research suggests that harm reduction strategies are effective for mitigating some of the most dire consequences of risky behaviours and that these strategies are cost effective.[39]

Our research shows that only 36% of complex homeless Calgarians have experienced harm reduction services. At the same time, half (51%) of all participants reporting having been diagnosed with an addiction by a medical professional and 30% felt they had an addiction that had not been diagnosed. Despite the high prevalence of addiction amongst respondents, many individuals indicated they had not accessed services designed to address substance use or addiction because they were not ready to get help (40% of respondents had not accessed detox services because they felt they were not ready, and 23% had not accessed residential treatment services because they were not ready).

Harm reduction approaches provide opportunities for individuals who are not ready for abstinence-based or sobriety-based solutions to engage with important supports that can mitigate some of the most dire consequences of harmful behaviours. These approaches can work in parallel with opportunities for recovery, and can open doors for individuals to move towards full recovery.

Given the documented effectiveness and cost efficiency of harm reduction approaches, we recommend a harm reduction philosophy and innovative approaches for medically complex clients who struggle with chronic addictions. This includes the implementation of harm reduction programming in housing and shelters that support medically complex clients, such as palliative care or long-term care clients, who may be excluded from services due to their substance use or risky behaviours.[40] Harm reduction programming is not intended to take away from programs supporting full recovery from active addiction, and we recommend that recovery programs be adequately resourced and supported.

Overall, we recommend an innovative approach and new types of services delivery models such as:

- Using existing buildings to add detox capacity and other health programs;
- Developing Managed Alcohol Programs that will fit within a supportive housing or shelter model;
- Evolving palliative care systems to more effectively reflect the health needs and circumstances of homeless individuals, increasing equity in the end-of-life care system for this population;
- Exploring new types of delivery models that support community resources that can build a context of understanding and self-determination that can facilitate the healing and recovery process for individuals;
- Enhancing the capacity of treatment programs for homeless Calgarians with addiction and/or concurrent disorder;
- Exploring safe consumption programs and adding capacity to replacement therapy programs.

While harm reduction and abstinence approaches for the management and resolution of addictions have sometimes been presented as binary, mutually exclusive, choices, considering addictions recovery as a continuum of services that can include, but is not limited to either harm reduction or abstinence programming, "may be particularly well-suited for individuals and families who have been difficult to reach, engage, treat, and reintegrate into mainstream community life through traditional service programs." (Page 35, Evans, White & Lamb, 2013)

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[37] Calgary Homeless Foundation. (2015). *Calgary's Updated Plan to End Homelessness: People First in Housing First.* Calgary, AB: Calgary Homeless Foundation.

[38] For more information see the Harm Reduction Coalition's website at: http://harmreduction.org

[39] See for example: Ritter, A., & Cameron, J. (2006). A Review of the Efficacy and Effectiveness of Harm Reduction Strategies for Alcohol, Tobacco, and Illicit Drugs. *Drug Alcohol Review, 25(26)*, 611-624.

[40] McNeil, R., Guirguis-Younger, M., & Dilley, L. (2012). Recommendations for Improving the End-Of-Life Care System for Homeless Populations: A Qualitative Study of the Views of Canadian Health and Social Services Professionals. *BMC Palliative Care, 11(14)*, 1-8.

Recommendation 4 - Responsive Approaches for Indigenous Populations

Develop housing and health approaches that are responsive to homeless Indigenous populations.

Residential schools were government-funded, church-run schools set up to eliminate parental involvement in the intellectual, cultural, and spiritual development of Indigenous children. The schools were located across the country, and the last school closed in 1996.[41] The Truth and Reconciliation Commission of Canada was established with a mandate to learn the truth about what happened in Canada's residential schools and to inform all Canadians. In their final report, the Truth and Reconciliation Commission of Canada stated that:

> *"For over a century, the central goals of Canada's Aboriginal policy were to eliminate Aboriginal governments; ignore Aboriginal rights; terminate the Treaties; and, through a process of assimilation, cause Aboriginal peoples to cease to exist as distinct legal, social, cultural, religious, and racial entities in Canada. The establishment and operation of residential schools were a central element of this policy, which can best be described as "cultural genocide.""*[42]

Our research included 91 homeless individuals who identified as Indigenous, 46% of whom had experienced a total of ten years or more of homelessness, and 77% of whom had experienced a total of four year or more of homelessness. Indigenous participants in our study reported higher rates of foster care system involvement and had, on average, experienced more Adverse Childhood Experiences than respondents overall (see Appendix C for more information about the impacts of Adverse Childhood Experiences). Indigenous respondents also indicated that, on average, they had experienced more frequent incidents of violent victimization in the last year.

In total, 20% of Indigenous respondents had attended a residential school, while another 63% had family members who had attended a residential school. Regardless of attendance at a residential school, all Indigenous peoples in Canada have been impacted by cultural assimilation policies that have "left ongoing and devastating impacts on the health and well-being of individuals, families, and communities".[43] Individual and cultural traumas, such as residential schools and other cultural assimilation policies, have lasting and intergenerational impacts, described as intergenerational trauma.[44]

Given the unique experiences of Indigenous people, and the ongoing and historical intergenerational trauma and impacts of colonization they experience, we believe that our approaches to health and housing need to be more responsive and relevant for Indigenous individuals.

We recommend:

- Incorporating trauma-informed practice and training into services that support homeless Indigenous individuals in recognition of their experiences of personal and intergenerational trauma;
- Integrating harm reduction approaches into services used by homeless Indigenous individuals to adhere to a person-centered approach and begin to create safer spaces for individuals to pursue recovery in their own way;

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[41] Truth and Reconciliation Commission of Canada. (2015). *About Us: Truth and Reconciliation Commission of Canada (TRC).* Retrieved August 26, 2016, from http://www.trc.ca/websites/trcinstitution/index.php?p=4
More information about the Commission available online.

[42] Truth and Reconciliation Commission of Canada. (2015). Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada. Ottawa: Library Archives Canada Cataloging in Publication. Page 1.

[43] Aguir, W., & Halseth, R. (2015). *Aboriginal Peoples and Historical Trauma: The Process of Intergenerational Transmission.* Prince George, B.C.: National Collaborating Centre for Aboriginal Health (NCCAH).

[44] See for example: Bombay, A., Matheson, K., & Ainsman, H. (2009). Intergenerational Trauma: Convergence of Multiple Processes Among First Nations Peoples in Canada. *Journal of Aboriginal Health, 5(3)*, 6-47.

- Piloting projects for the strategic placement of service navigator staff in community-based organizations to support homeless Indigenous individuals with service navigation and getting the support they need, recognizing that current systems and services have likely been designed outside Indigenous paradigms and with little input from Indigenous peoples[45;]
- Providing supports for Indigenous individuals as they transition from homelessness to housing, or between services (e.g. provide step-down care geared towards Indigenous service users);
- Providing dedicated resourcing for shelters and permanent supportive housing to better support Indigenous individuals;
- Providing spaces that support traditional activities, teachings, and ceremonies to engage healing (e.g. a sacred space will be created to have ceremonies ; a sweat lodge);
- Integrating elders and cultural resources that support access to traditional teachings and Indigenous ceremonies.
- Working together with the Aboriginal Standing Committee on Housing and Homelessness (ASCHH), and other Indigenous health and social agencies, to determine ways to increase the cultural relevance of shelter, health, and housing services, recognizing that there are many different Indigenous cultures that may have different perspectives;

Katelyn Lucas (current chair of the ASCHH), Scott Calling Last (previous co-chair), and Randal Bell (author, The Indigenous Patient Journey Report, AHS) are members of the Calgary Recovery Services Task Force Governance Committee, and provided support in making these recommendations.

[45] For more information on Indigenous experiences of the health system in Alberta, see: Bell, R. (2016). *The Indigenous Patient Journey Report.* Calgary, AB: Alberta Health Services.

Recommendation 5 - Open Communication within Homelessness Sector

Ensure open communication and access to information amongst organizations and agencies serving homeless Calgarians.

An essential component of providing integrated care to vulnerable populations is the involvement of practitioners from multiple disciplines. This team-based approach crosses agencies, organizations, and service systems, to provide continuity of care. A key element in coordinating the care of multiple practitioners from multiple organizations is effective communication and information-sharing.

Our research revealed that 58% of complex homeless Calgarians access treatments or medications for their physical health issues from a wide variety of sources that include community health clinics, community service agencies, and shelters in addition to hospitals and associated emergency rooms. In addition, 45% access information and 27% access medication, for their emotional, mental health, or substance use issues from these same sources. Unfortunately, as individuals access different services there is often little communication between these services, potentially leading to confusion for service users.

One of the researchers involved in the project commented, "One of the things that really stood out to me was the number of people who felt as though they had shared their stories countless numbers of times and were really resigned to the fact that they would have to continue to share their life story many times. Most attributed this to the lack of continuity across service delivery and the disconnectedness of the many sectors that they interact with."

Sharing information between organizations serving the same individual can help increase the continuity of care that individual receives, reducing the number of times they have to reiterate their needs and decreasing the possibility that they will experience negative outcomes because of a lack of coordination.

Recognizing the need to strike a balance between access to information for the benefit of clients and clients' right to privacy, we recommend the formation of a working group to conduct an environmental scan of information-sharing frameworks, options, and barriers. The scan should include particular focus on *Alberta's Information Sharing Strategy: Supporting Human Services Delivery* developed by Alberta Human Services. It should also draw from learnings in other sectors, such as the children's sector where the Children First Act (CFA) has been established to guide and support information sharing between individuals and organizations that plan or provide critical programs and services for Alberta's children.[46] The working group should have a specified timeline in which to accomplish the scan to ensure their recommendations are relevant to the most current legislation and to ensure the collaborative momentum created by the Task Force is not lost.

Overall, we recommend broad information and data sharing between sectors and agencies, where clients extend permission. In practice, this likely means that all Calgary shelters will adopt the Homeless Management Information System (HMIS), and opportunities will be thoroughly examined for information sharing across sectors, building on the work of Government of Alberta Information Sharing Strategy.

[46] Available online at: http://www.humanservices.alberta.ca/16594.html

Recommendation 6 - Specialized Responses for Women and Children

Develop specialized responses for homeless women and children.

In 2008, Susan Scott worked with homeless women in Canada to support the articulation of their unique stories and experiences of homelessness. One repeatedly emerging theme was the challenge faced by women as they seek to access currently available services. Homeless women often have difficulties with mixed shelter and service settings due to past traumatic experiences involving men (e.g. sexual exploitation, domestic violence), concerns for safety, a desire for privacy, and need dedicated health services geared specifically towards women (e.g. sanitary supplies, STI treatment, support with pregnancy, etc.).

Our research included 91 homeless individuals who identified female, 37% of whom had experienced a total of ten years or more of homelessness, and 65% of whom had experienced a total of four year or more of homelessness. The women who participated in the study were more likely to have children in their care than the men, and female respondents reported a greater number of Adverse Childhood Experiences, on average, than their male counterparts.

The Task Force recognizes that homeless women and children often experience greater vulnerability, risk, and disadvantage, such that a gender-responsive approach must be central in supporting their positive health and well-being. This includes ensuring there is a gender-responsive approach in research, planning, and policy/practice decision-making.

Further, being responsive to the needs of vulnerable children can potentially optimize their early childhood development, preventing Adverse Childhood Experiences and associated future negative outcomes (See Appendix C for more details on Adverse Childhood Experiences).

Recommended actions to support a specialized response to homelessness for women and children include:

- Focusing on female long-term shelter residents, and piloting intensive case management approaches to assist them with moving toward a more permanent housing solution, using a gender-responsive lens;
- Researching the relative cost/resourcing required to provide dedicated services for women and women with children in comparison to services for single men;
- Designing, piloting, and resourcing housing models that are committed to preventing family splitting (e.g. foster care models that support the whole family together in residence);
- Focusing on research and planning for lifespan healthcare for women experiencing homelessness;
- Coordinating service delivery for homeless women and children through an established Steering Committee (see Recommendation 7).

[47] Gelberg, L., Browner, C., Lejano, E., & Arangua, L. (2004). Access to Women's Health Care: A Qualitative Study of Barriers Perceived by Homeless Women. *Women & Health, 40(2)*, 87-100.

Recommendation 7 - Advance Governance Structure

Advance the development of a steering committee/governance structure to provide leadership and oversight for moving forward.

The Calgary Recovery Services Task Force has laid the groundwork for moving towards better integrated health and recovery services for homeless individuals with complex health needs. In order to continue this important momentum, we recommend and have begun, a Governance Committee with the goal to provide leadership and oversight to a strengthened integrated system of care and response for homeless Calgarians, ensuring linkages to key strategic priorities.

Using the collective impact model of a backbone organization to fulfill the vision of our Seven Recommendations, this Governance Committee will seek to:

- Guide vision and strategy;
- Support and coordinate aligned activities between agencies and government;
- Work to establish shared measurement practices;
- Build public will and support;
- Advance policy; and
- At times, mobilize funding to improve the health care outcomes for homeless Calgarians.

This Governance Committee will support the goal of improved health care outcomes for homeless Calgarians by aligning with existing mandates and supporting the work of collaboration. Membership consists of decision-makers from Human Services, Alberta Health Services, the Calgary Homeless Foundation, the Calgary Police Service, EMS, and partner Agencies, along with Indigenous elders and clients.

A primary role of the Governance Committee will be to serve as a "convener", and so much of its work will involve building partnerships and collaboration between a diverse set of stakeholders around common vision and goals. As a result, it will work hard to foster consensus, identify shared principles and opportunities for coordinated response, and develop mutually-reinforcing activities.

In practice, this Governance Committee aligns well with many existing government initiatives, and will seek representation at leadership committee tables which the Province strikes so that we can ensure alignment of our work with theirs. In the future, this Governance Committee could assume a greater role with respect to frameworks for the implementation of government policies that address the intersection of health and homelessness. With the knowledge and cross-sectoral expertise brought together by this structure, the Governance Committee can be well-positioned to act as a homeless issues/policies reference group for government.

Examples include:

- Ottawa Inner City Health Model http://ottawainnercityhealth.ca/Home
- Boston Health Care for the Homeless Program https://www.chchp.org

The Governance Committee has not yet fully defined its role, but sees its primary focus as supporting the implementation of the 7 Recommendations of the Calgary Recovery Services Task Force, and as this process unfolds collaboratively, more information will be made available.

[46] Available online at: http://www.humanservices.alberta.ca/16594.html

> I am confident that if the Task Force recommendations are fully supported at relevant levels of government and agency policy and process, as well as reflected in front-line daily interactions, that the health and quality of life of countless Calgarians will improve markedly. I believe our communities will similarly benefit. These recommendations support very high level, evidence-informed, and principled collaboration and can be expected to contribute to optimization of current resource use and cost containment.
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> Lara Nixon MD CCFP FCFP
> Director, Enhanced Skills Residency Program
> Assistant Professor, Dept of Family Medicine
> Cumming School of Medicine
> University of Calgary

4.0 Moving Forward Together

In the last two years, using a collective impact model, the Task Force has been successful in developing dialogue around a common agenda, shared measurement, mutually reinforcing activities, and continuous communication towards the goal of improving medical supports and outcomes for vulnerable homeless individuals in Calgary. As a result of this collaborative effort we now have more information about the experiences and needs of homeless Calgarians, a set of mutually agreed upon guiding principles, and the beginnings of a backbone organization committed to taking the vision of better health care for homeless Calgarians forward.

Perhaps most importantly, the Task Force has collaboratively moved from identifying a need for better city-wide, multi-agency coordinated care for chronically homeless individuals to producing a set of seven concrete recommendations for action.

The Task Force is an excellent example of what can be accomplished when partners with diverse mandates from different systems come together towards a common goal. It is important to highlight examples of program improvements, partnerships and collaborative projects created as a result of the relationships, information-sharing and trust forged throughout the entire process of the Calgary Recovery Services Task Force. Action has already begun in a number of areas:

- **Directly attributable to the Task Force: The Street CCRED collaborative (Street Community, Clinical, Capacity, Research, Education, and Development collaborative),**
  has received catalyst funding from the University of Calgary Cumming School of Medicine to develop a Managed Alcohol Program model and a Palliative Outreach model. Street CCRED is an inter-disciplinary, grassroots community of practice that strives to organize and provide clinical care to people living with homelessness, poverty, increased risk of suffering, frequent system contact, and poor health outcomes. The pilot development of a Managed Alcohol Program model and Palliative Outreach model have been explicitly recommended by the Task Force (Recommendation 3) and will benefit from the co-ordinated and collaborative support of the Task Force moving forward.

- **The Alberta Association of Community Health Centres (AACHC)**
  is also moving the Task Force's vision forward. AACHC is an emerging association of Community Health Centres (CHCs) in the province of Alberta that began formation in the Spring of 2016. AACHC's goals are to: improve access to community-oriented, team-based primary health care throughout Alberta; improve the health and well-being of our population, in its diversity; and increase the effectiveness and sustainability of our health system. Some of the AACHC members are a part of the Task Force and already provide team-based primary care to vulnerable Calgarians who face significant barriers to accessing healthcare services. Development of the AACHC will provide a broader platform to support many of the recommendations of the Task Force.

- **The CUPS' Coordinated Care Team (CCT)**
  is also currently moving forward with the Task Force's recommendation to increase access around mobile health services. The CCT is a mobile outreach team that provides intensive case management and transitional health care to vulnerable, low-income individuals presenting to the emergency department (ED) or acute care unit at any Calgary-area hospital. The goals of the CCT are to improve transition of care between acute and community care, reduce inappropriate ED use, and reduce the length of in-patient stays. The Team simultaneously builds knowledge and collaboration between patients, primary and acute healthcare, and social agencies. Ultimately, work of the CCT aims to improve the patient experience for a population that faces social stigma and isolation. CUPS is partnering with Alpha House to expand the reach of the program all Calgary hospitals over the next three years.

- **The Community Paramedics Program**
  The Community Paramedics Program is operated by Calgary EMS to make a far wider range of mobile medical supports available, including mental health supports. Due to the work of the Calgary Recovery Services Task Force, we have seen increased capacity of EMS mobile services with case management in shelters through the Community Paramedics Program.

- **Integration of Home Care services into Permanent Supportive Housing Programs**
  Where appropriate, new Permanent Supportive Housing Programs will include Home Care Services delivered on-site, specifically for seniors and those who live with mobility challenges. Alberta Health Services has committed to ensuring Home Care services are delivered using the Task Force's Guiding Principles.

- **Harm Reduction and Managed Alcohol Programming Pilots**
  Where appropriate and medically supported, Managed Alcohol Programs will be incorporated into Permanent Supportive Housing Programs within Calgary. Alberta Health Services is providing clinical supports integrated in harm reduction supportive housing programs within Calgary.

- **Increased Participation of Shelters into the Supportive Housing System of Care and Coordinated Access and Assessment (CAA) Program**
  The CAA Program is a central group where all Calgary Homeless Foundation funded housing programs are accessed. In the past several months through the work of the Task Force, all shelters in Calgary are now part of this collaborative, and it has led to many people being housed in medically-supported permanent supportive housing programs.

> "The Calgary Recovery Services Task Force has provided excellent leadership in engaging and mobilizing the Calgary community. The commitment and engagement demonstrated by the Task Force is a testimony to the passion and leadership shown by Task Force participants around better serving chronically homeless Calgarians. The research project we completed on chronically homeless Calgarians and the consultative process itself contributed to the commitment of all the members of the Task Force. This process created an opportunity for each participating organization of the Task Force to play a meaningful role in the recovery journey of the chronically homeless in Calgary."
>
> Yared Belayneh, Community Impact Planner
> The United Way of Calgary & Area

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Appendix B: Key Concepts and Terms

Absolute Homelessness
Those living on the street with no physical shelter of their own, including those who spend their nights in emergency shelters. (Calgary Homeless Foundation. (2015). *Calgary's Updated Plan to End Homelessness: People First in Housing First.* Calgary, AB: Calgary Homeless Foundation.)

Acuity
An assessment of the level of complexity of a homeless experience. Acuity is used to determine the appropriate level, intensity, duration, and frequency of supports to sustainably end a person's or family's homelessness. 'High acuity' means highly complex. (Calgary Homeless Foundation. (2015). *Calgary's Updated Plan to End Homelessness: People First in Housing First*. Calgary, AB: Calgary Homeless Foundation.)

Chronic Homelessness
Those who have either been continuously homeless for a year or more, or have had at least four episodes of absolute homelessness in the past three years. (Calgary Homeless Foundation. (2015). *Calgary's Updated Plan to End Homelessness: People First in Housing First*. Calgary, AB: Calgary Homeless Foundation.)

Concurrent Disorders
Any combination of mental health and substance use disorders. Because there are a large number of mental health issues and types of substances to which one may become addicted, there are many potential combinations represented within this definition. Also referred to as co-occurring disorders (or "COD"). (Alberta Health Services; Zuidhof-Knoop, E. (2011). *Integrating Addiction and Mental Health Services in Alberta.* Athabasca: Athabasca University; and Winn, L. (2010). Co-Occurring Disorders 101: A Common Language for Better Care. Retrieved August 16, 2016, from http://www.homelesshub.ca/resource/co-occurring-disorders-101-common-language-better-care; SAMHSA)

Detoxification (Detox) Services
Around the clock services that provide assistance with the detoxification from alcohol and other drugs in a safe and controlled setting. Services may include: stabilizing health, assessment, information sessions, introduction to self-help groups, addiction treatment planning, discharge planning, and/or referral. Because detoxification is often accompanied by unpleasant and potentially fatal side effects stemming from withdrawal, detoxification is often managed with medications administered by a physician in an inpatient or outpatient setting; therefore, it is referred to as "medically managed withdrawal." (Alberta Health Services. (2016). *Addiction Services – Adult Detoxification.* Retrieved August 24, 2016, from http://www.albertahealthservices.ca/Info/service.aspx?id=1060416 ; and National Institute on Drug Abuse (2012). *Principles of Drug Addiction Treatment: A Research-Based Guide* (Third Edition) Washington, D.C.: NIH Publication No. 12–4180)

Episodic Homelessness
A person who experiences absolute homelessness for less than a year and has fewer than four episodes of absolute homelessness in the past three years. (Calgary Homeless Foundation. (2015). *Calgary's Updated Plan to End Homelessness: People First in Housing First.* Calgary, AB: Calgary Homeless Foundation.)

Equitable Access
The opportunity for patients to obtain appropriate health care services based on their perceived need for care. This necessitates consideration of not only availability of services but quality of care as well. (Canadian Medical Association. (2013). *CMA Position Statement: Ensuring Equitable Access to Care: Strategies for Governments, Health System Planners, and the Medical Profession.* Available online at: https://www.cma.ca/Assets/assets-library/document/en/advocacy/PD14-04-e.pdf)

Full Recovery
Full recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life. (National Council on Alcoholism and Drug Dependence (NCADD). (2015, July 24) *Definition of Recovery*. New York, NY: NCADD. https://www.ncadd.org/people-in-recovery/recovery-definition/definition-of-recovery

Appendix B: Continued

Harm Reduction
Policies, programs, and practices that seek to reduce the adverse health, social, and economic consequences of risky behaviours, such as the use of legal and illegal substances and risky sexual activity. Harm reduction is a pragmatic response that focuses on keeping people safe and minimizing death, disease and injury associated with higher risk behavior, while recognizing that the behavior may continue despite the risks. (Calgary Homeless Foundation. (2015). *Calgary's Updated Plan to End Homelessness: People First in Housing First.* Calgary, AB: Calgary Homeless Foundation.)

Health Home
A 'health home' is an individual's home base within the health care system, where they can access primary health care services and be connected to other needed health and social services. (Alberta Health Services. (2016). *Primary Care Networks: Review.* Edmonton, AB: Government of Alberta).

Housing First
An approach to housing supports where permanent housing is provided directly from homelessness, along with needed support services, without the requirement of a transition period of sobriety or abstinence. (Calgary Homeless Foundation. (2015). *Calgary's Updated Plan to End Homelessness: People First in Housing First.* Calgary, AB: Calgary Homeless Foundation.)

Indigenous
A term encompassing the cultural groups known as the 'Inuit', the 'Métis ' and 'First Nations' in Canada. Each of these three groups of people has its own unique history, culture and spirituality. And further, for example, within the 'First Nations' of Alberta there are 45 distinct nations in three different Treaty territories, each with their own unique history, culture and spirituality. (Alberta Health Services. (n.d.) *Aboriginal Myths and Misconceptions*. Available online at: http://www.albertahealthservices.ca/assets/info/ihp/if-ihp-fact-sheet-terminology.pdf)

Lived Experience
Personal knowledge about the world gained through direct, first-hand involvement. (Oxford Dictionary definition)

Person-Centred Approach
An approach that recognizes people rather than labels or presenting issues and aims to build on each person's unique strengths and capacities in the context of community life rather than depending on systems or service providers. This approach inherently values the voice of the person in accounting for their history, present circumstances, and desirable changes. Person-centeredness recognizes that the individual is the expert on their life experience and needs. (Calgary Homeless Foundation. (2015). *Calgary's Updated Plan to End Homelessness: People First in Housing First.* Calgary, AB: Calgary Homeless Foundation.)

Residential Treatment Services
Treatment of addictions (or mental health issues) in a non-hospital live-in setting with 24 hour care that goes beyond detoxification or medically managed withdrawal (see 'Detoxification (Detox) Services'). Treatment is highly structured and can be confrontational at times, with activities designed to help residents examine damaging beliefs, self-concepts, and destructive patterns of behavior and adopt new, more harmonious and constructive ways to interact with others. (National Institute on Drug Abuse (2012). *Principles of Drug Addiction Treatment: A Research-Based Guide* (Third Edition) Washington, D.C.: NIH Publication No. 12–4180)

Step-Down Care
Health supports for individuals who are preparing for discharge from an inpatient unit, as a transitional service to support them as they prepare to return to living in the community. (Thomas, K., Rickwood, D., Bussenschutt, G. (2015). Adult Step-Up Step-Down: A Sub-Acute Short-Term Residential Mental Health Service. *International Journal of Psychosocial Rehabilitation*, 19(1), 13-21.)

Step-Up Care
Service for individuals who are experiencing an escalation in health condition symptoms, where a short stay in a residential rehabilitation program may avoid hospitalization. (Thomas, K., Rickwood, D., Bussenschutt, G. (2015). Adult Step-Up Step-Down: A Sub-Acute Short-Term Residential Mental Health Service. *International Journal of Psychosocial Rehabilitation,* 19(1), 13-21.)

Transitional Homelessness
A person experiencing absolute homelessness for the first time (usually for less than three months) or has had less than two episodes in the past three years. (Calgary Homeless Foundation. (2015). *Calgary's Updated Plan to End Homelessness: People First in Housing First.* Calgary, AB: Calgary Homeless Foundation.)

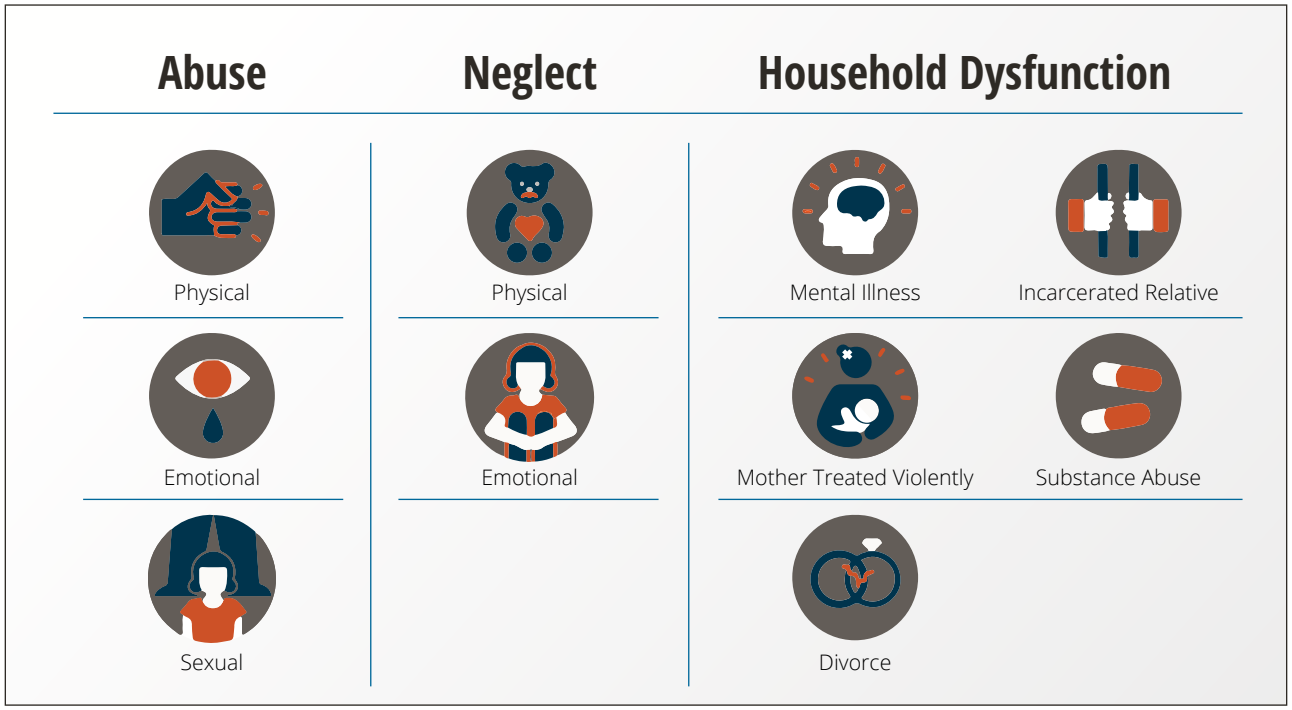
Tri-Morbidity
Tri-morbidity refers to individuals who exhibit concurrent psychiatric, substance abuse and chronic medical conditions that increase risk of death. (Calgary Homeless Foundation. *Rehousing Triage and Assessment Survey Toolkit.* Calgary, AB: Calgary Homeless Foundation; see also: Hewitt, N., Halligan, A., & Boyce, T. (2012). A General Practitioner and Nurse Led Approach to Improving Hospital Care for Homeless People. British Journal of Medicine, 345)

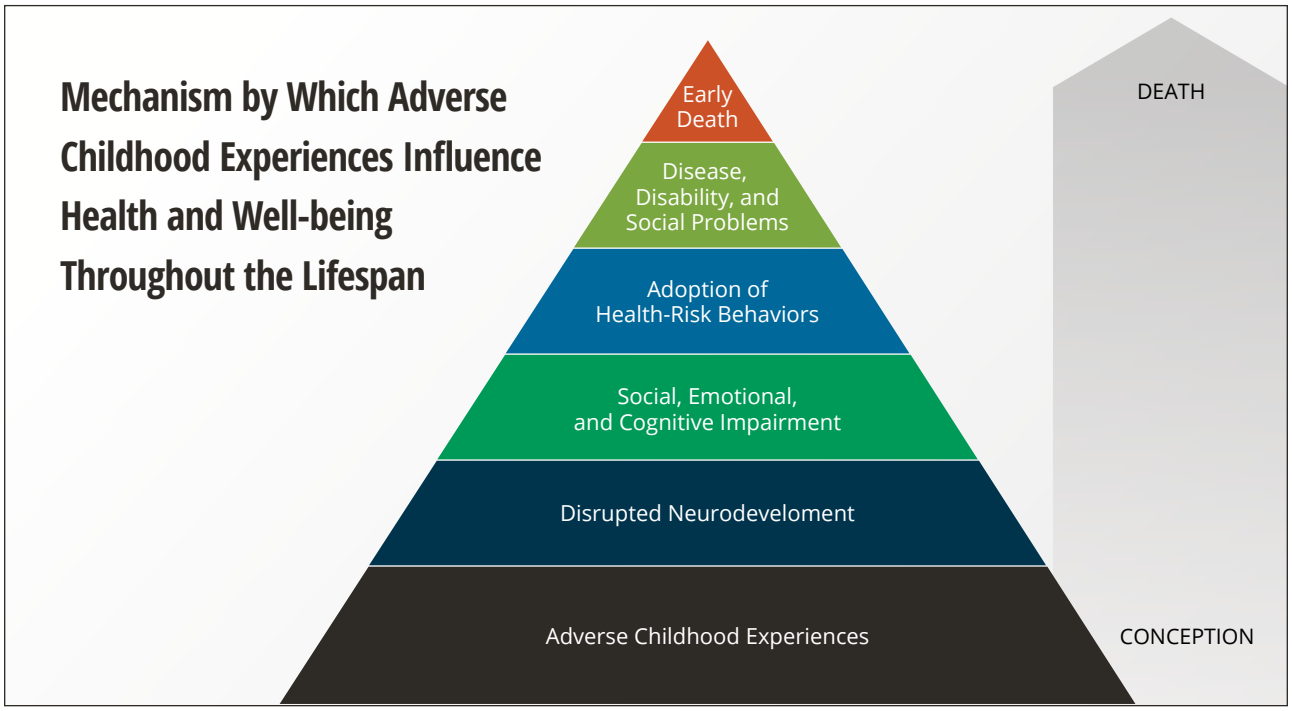
Wrap-Around Services
Services that help address a homeless individual's underlying causes of homelessness. These support services include medical and psychiatric case management, life skills training, landlord liaison assistance, and addictions counseling (Calgary Homeless Foundation. (2014). *System Planning Framework.* Calgary, AB: Calgary Homeless Foundation.)

> The Calgary Recovery Services Task Force was an incredible exercise in collective impact, collaboration, and community conversation. Communities heal as they begin to have conversations and solve problems together. The challenge of offering wrap-around health services to homeless and vulnerable people is significant, and there is no way we can solve this in silos. The Calgary Recovery Services Task Force is a shining example of leaders coming together, representing community together, and shelving individual impact for the needs of the people we serve. Moving forward together, we will see significant changes in the way homeless and vulnerable people receive health services in the city of Calgary, and this is something we should all celebrate.
>
> Abe Brown, MBA
> Executive Director, Inn From The Cold

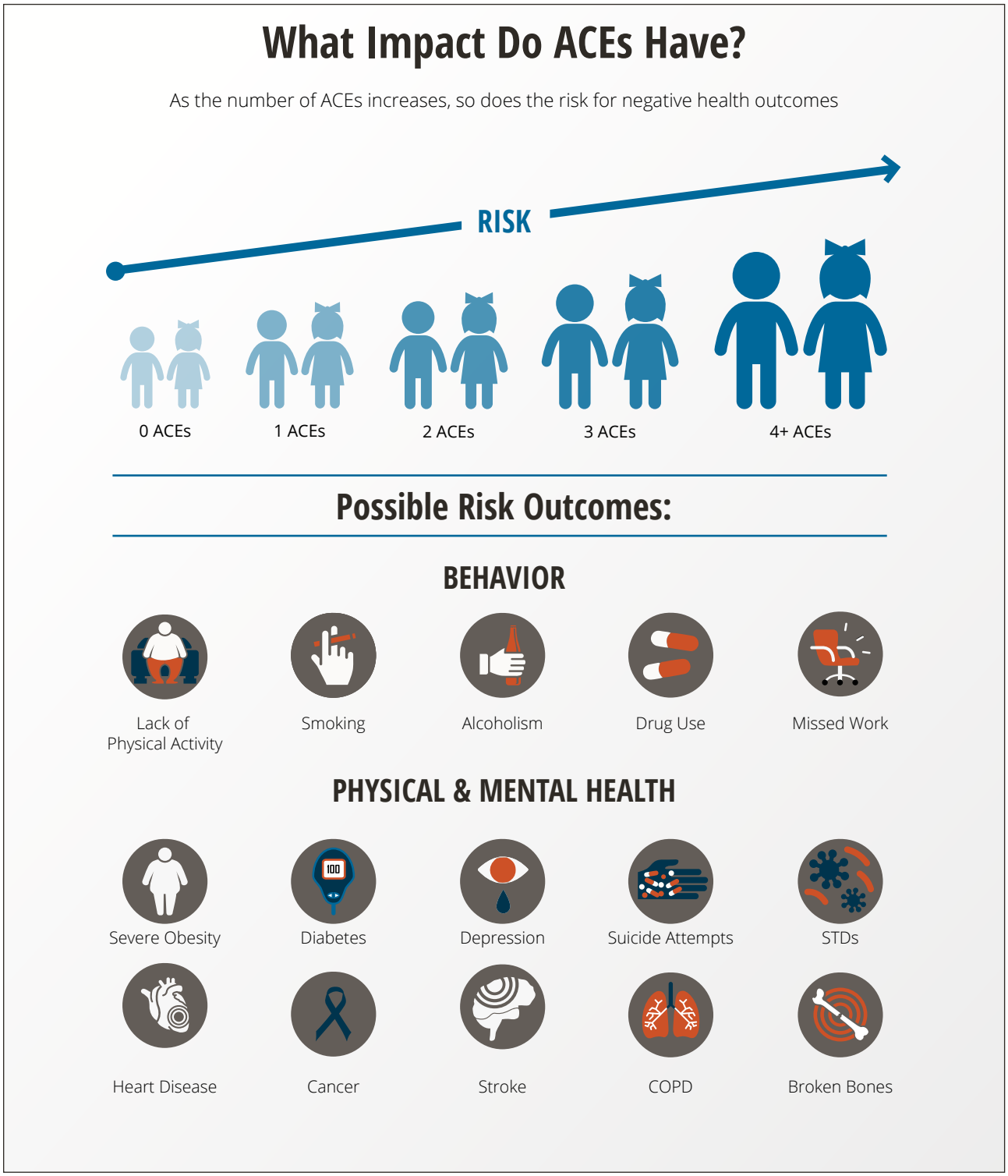
Appendix C: Adverse Childhood Experiences Study

Adverse Childhood Experiences Include:





Appendix C: Continued



See: The Robert Wood Johnson Foundation Explanation of ACEs at:
http://www.rwjf.org/en/library/collections/aces.html

See the Centre for Disease Prevention and Control's ACE Study at:
https://www.cdc.gov/violenceprevention/acestudy/

Appendix D: "One Doctor's View"

Dr. Bonnie Larson is a family physician in Calgary.
She works collaboratively with CUPS, the EMS Community Paramedic City Centre Team, and Street CCRED.

As a family physician working with Calgary's homeless population, I am often confronted with the shortcomings of our healthcare system. Over the past while, however, I have seen a few glimmers of hope.

The usual struggles to get the right health care, for the right person, at the right time, by the right provider, are ever-present, but I find myself inspired by these following anecdotes that illustrate how things are changing.

What's more, these represent real, rather than rhetorical, health equity and community-driven, person-focused care.

One elderly gentleman, after dwelling outside for almost 10 years, has been housed and is engaging in much-needed health care.

A young man was finally admitted to hospital for urgent treatment of cancer. Several prior attempts to coordinate care had ended with him being back on the streets or shelter, untreated.

One severely mentally ill woman who was too fearful to go to a shelter or seek help, is now connected with an extraordinary team of health care providers and is settling into a small apartment.

A schizophrenic homeless man is getting the help he has needed for decades, providing him dignity and a reduction of his suffering, near the end of his very difficult life.

A few glimmers. What has changed?

There is evidence that Alberta Health Services and our elected decision makers are actively listening to, and engaging with, the front line providers to our most vulnerable populations. Many of whom have been fighting so fiercely to bring adequate care to our communities that they sometimes put their own health at risk.

At least now there is hope for relief and reinforcement.

An inner city nurse finds a patient in distress at the C-train platform early on a cold and rainy morning. After sharing a healthy breakfast at a nearby restaurant, she accompanies him to a safe shelter, goes on to work a full day, and follows up later that day to make sure he is alright.

A paramedic pauses in the middle of a demanding day to change the dressings on a homeless man's wounds.

She does this week after week, until he is able to trust her and her team enough to allow them to bring him to more definitive care.

Three physicians spend hundreds of hours late at night after caring for their patients and then putting their own kids to bed, developing a proposal to have outreach nurses advocate for patients so that they are less likely to have to return over and over again to the emergency department. They are rewarded for their efforts with funding, and the program starts to decrease expensive emergency room visits.

After an ill patient is discharged back to homelessness despite urgent need of treatment, a community physician takes her back to hospital and waits with her for four hours, ensuring her admission.

A group of committed individuals from Calgary's diverse (and sometimes competitive) non-profit sector gather persistently for two years, to put their differences aside and painstakingly reach a collaborative set of recommendations on how to best serve our community's most vulnerable individuals.

There is a famous quote, often attributed to Gandhi that says, "the true measure of society is in how it treats its most vulnerable".

We are most certainly doing better on this path than we have in recent history. But things are far from perfect. The strengths in the stories above have to do with building resilience; not only in our patients but also in those who are caring for them — strengthening the entire community.

Without adequate and sustained support, breakfast-buying nurses burn out and community paramedic programs lose their funding and momentum, which ultimately increases costs to our entire society.

Now is the time to challenge our provincial government and other stakeholders to hold the course. We are on the cusp of both a systemic and cultural shift that will bring better health for all. We should also challenge each other, as citizens, to support bold movement towards a healthier society; one that represents Canadian compassion and values for everyone who calls our country home.

Endorsements and Support:

The current report has been endorsed by the following supporters:

The Calgary Recovery Services Task Force is an extraordinary effort and commitment to the most challenging citizens in our communities. I am inspired by the openness and wisdom that has come from this important work and believe it will save lives and healthcare dollars.

The Task Force's interdisciplinary work combines all the key principles identified in optimizing mental health and addiction services. Support for the Task Force and their report will go a long way in achieving a number of the recommendations of the recently released Valuing Mental Health Report of the Alberta Mental health and Addictions Review Committee.

David Swann, MD
MLA for Calgary Mountain View

Only by working collaboratively can we hope to address the underlying systemic issues.

Superintendent Tam Pozzobon, MA
EdD Candidate
Integrated Partnership Division
Calgary Police Service

So many have given up on these people; we as service providers must not—and we must do better collectively to meet the needs.

Julie Kerr
Senior Operating Officer
Community Rural & Mental Health, Calgary Zone
Alberta Health Services

Participating in the Recovery Task Force was an incredibly valuable experience. Through ongoing conversations and relationship development, successful partnerships were formed resulting in immediate action towards our goal of ending homelessness in our city.

Natalie Noble
Director, System Planning
Calgary Homeless Foundation

The Task Force added great value in its collaborative city-wide and multi-sectoral approach to homelessness. I feel we are beginning down the right path at the right time.

Carrie Collier MSW, RSW
Area Manager, Community Prenatal Programs
East Calgary Health Centre

The commitment to inclusivity in this Task Force's work reflects a deep awareness of the value of a multifaceted system of approaches, reflective of the diversity of the populations we seek to serve.

The Task Force recommendations support very high level, evidence-informed, and principled collaboration and can be expected to contribute to optimization of current resource use and cost containment. I'm very optimistic that these recommendations will provide very relevant and helpful direction for those involved in policy and programming for marginalized Calgarians.

Lara Nixon MD CCFP FCFP
Director, Enhanced Skills Residency Program and Assistant Professor
Cumming School of Medicine, University of Calgary

The commitment and engagement demonstrated by the Recovery Task Force is a testimony to excellent leadership in engaging and mobilizing the Calgary community. This process created an opportunity for each participating organization of the Task Force to play a meaningful role in the recovery journey of the chronically homeless in Calgary.

Yared Belayneh, Community Impact Planner
The United Way of Calgary & Area

Having watched the work of the Calgary Recovery Services Task Force, I absolutely support AHS' continued involvement in the work of the Recovery Services Task Force and in pursuing the recommendations contained within the report.

Dr. Verna Yiu, CEO
Alberta Health Services

I believe that investing in prevention and treatment programs benefits our most vulnerable citizens. Early intervention leads to less crime associated with addiction and therefore less police involvement, which is money well spent. I believe that the Recommendations of the Calgary Recovery Services Task Force, if implemented, will lead to more prevention and treatment for the most vulnerable.

Chief Constable Roger Chaffin
Calgary Police Service

CHF, as an active stakeholder on the Recovery Services Task Force and Steering/Governance committee, is supportive of and aligned with the guiding principles, shared philosophies and 7 Recommendations of the Calgary Recovery Services Task Force.

Diana Krecsy RN, BN, M.Ed, President & CEO
Calgary Homeless Foundation

The Final Report of the Calgary Recovery Services Task Force is clearly heavily supported by the science of building brains and resiliency. It encourages integration of services, a way of working that better understands and responds to the complexities of the lives of those who have experienced the poverty and trauma that has led to homelessness, as well as better supports all Calgarians to reach stability and self-sufficiency. CUPS looks forward to the role we will take in bringing the Recovery Services Task Force recommendations to life.

Carlene Donnelly, Executive Director
CUPS

Alpha House is proud to be a member and supporter of the Calgary Recovery Task Force and the ongoing collaborative work accomplished towards improving health outcomes for vulnerable Calgarians.

Kathy Christiansen, Executive Director,
Alpha House

The final report of the Calgary Recovery Services Task Force clearly articulates the complex health needs of the chronically homeless population in Calgary. These are among the most vulnerable Calgarians, and the Calgary Drop-In Centre exists to serve them. The Task Force enthusiastically facilitated completion of the research project, community consultation and engagement process, all of which has informed the report and its Recommendations. The 7 recommendations of the Task Force represent a viable, practical and well-coordinated community response to complex issues participants have long been wrestling with. The Calgary Drop-In & Rehab Centre Society proudly supports the 7 recommendations and the continuing work of the Calgary Recovery Services Task Force.

Debbie Newman, Executive Director
The Calgary Drop-In & Rehab Centre Society

The work of the Calgary Recovery Services Task Force reinforces and builds upon our belief women's experiences with chronic homelessness demand coordinated responses which are tailored. Abuse, poor health, substance use and motherhood can and do co-exist and supports must honour that reality.

Sue Tomney, CEO
YW Calgary

We at the Mustard Seed recognize the value and impact the Calgary Recovery Services Task Force is having in building understand of homelessness and providing collaborative opportunities to address this important need. The final document of the Task Force provides empirical data to build a cogent response to chronic homelessness.

Dr. Stephen Wile, Chief Executive Officer
The Mustard Seed

Endorsements and Support Continued:

Inn from the Cold is honoured to be involved with the Calgary Recovery Services Task Force. This is an innovative community collaboration, the first of its kind, and involves senior leadership from over 26 organizations who serve our most vulnerable Calgarians. We believe if the seven recommendations are executed we will significantly improve the health outcomes, and life trajectories, of homeless children and their families.

Neil Smith, Chair
Inn From the Cold

The Calgary Recovery Services Task Force has embodied the idea of community planning in the shared visions of their report. I am excited to continue to participate in the ongoing improvement of services that impact the lives of Calgary's most vulnerable populations. We are better together.

Tanya L. Gaskell
Provincial Planning and Capacity Management
Community, Seniors and Addiction & Mental Health

Addiction and mental health impact all of us, across every sector. If you do not think you are affected, you are mistaken. I have attended over 300 addiction related funerals during my career thus far; it never gets easier. The ripple effects on both the positive and negative sides of this global health crisis for all of us are astonishing.

So, if I were to ask you if you could be involved with an initiative that would help heal the community and avoid more absent mothers and fathers and lost sons and daughters, I know what the answer would be. Of course you would. I believe this initiative and Final Report of the Calgary Recovery Services Task Force has the ability to produce exponential results on both the business and human case outcomes. This is good for all of us, so let's then now give it some legs!

Mr. Stacey Petersen RSW, Executive Director
Fresh Start Recovery Centre

The Calgary Recovery Services Task Force has done strong work to identify a number of key issues that need to be addressed with regard to the health and well-being of our homeless population. I support moving forward on their recommendations because this will ultimately reduce the use of Emergency Departments in Calgary by the homeless, and more importantly provide better care for them.

Dr. Scott Farquharson,
Department of Emergency Medicine
Alberta Health Services, Calgary Health Zone
University of Calgary Clinical Lecturer

As a member of the Calgary Recovery Services Task Force, HIV Community Link values and supports the shared vision to collaboratively respond to the complex health needs of people experiencing homelessness in Calgary. We believe that the recommendations will lead to improved health supports and outcomes for some of the most vulnerable members of our community.

Leslie Hill, Executive Director
HIV Community Link

I'm pleased to see the Final Report of the Calgary Recovery Services Task Force. I'm equally pleased to see that the Task Force has adopted many of the recommendations made through our Indigenous Patient Journey Project. It's great to see a community initiative progress with such collaboration and shared vision. We look forward to supporting this great work in any way we can.

Randal Bell, Provincial Initiatives Consultant – Indigenous Populations
Provincial Planning and Capacity Management
Community, Seniors and Addiction & Mental Health,
Alberta Health Services

The Task Force provided an opportunity for EMS to meet, discuss and collaboratively develop strategies with our community partners in order to improve health outcomes for vulnerable homeless individuals in Calgary. The venue enabled multiple agencies to come together with a common vision and purpose, and EMS is proud be part of the final report and recommendations.

Ryan Kozicky, Manager - Alberta Health Services Emergency Medical Services - Community Paramedicine, Calgary EMS Statement

The Alex salutes the work of the Calgary Recovery Services Task Force, in particular with the development of the seven powerful recommendations. We are committed to continue our support for the chronically homeless in Calgary.

The Guiding Principles and Shared Philosophies speak to the foundational strength of the organizations that make up the Task Force. The research study through the Cumming School of Medicine provided invaluable insights into the accessibility of established health, justice and social supports systems in Calgary. The Alex looks forward to continuing work with the other Task Force members to address gaps in service for our vulnerable Calgarians, the work to-date by the Task Force has provided immeasurable data for those of us on-the-ground.

Shelley Heartwell, CEO
The Alex

I am very impressed with the Final Report of the Calgary Recovery Services Task Force, and greatly appreciate the opportunity of being part of this collaboration. This work validates the model of care that SHARP has been trying to build over the past few years, but it also inspires us to do better in serving people living with complex health and social needs. We recognize that there is still a great deal of work to do, and we look forward to continue this journey in collaboration with the people we serve and our partners to create the best, most inclusive community for everyone. My hope is that we maintain the momentum that has been created through this work as the need is urgent.

Floyd Visser, Executive Director
The SHARP Foundation

The final report of the Calgary Recovery Task Force has clearly articulated the complex health needs of the chronically homeless population in Calgary. This includes recommendations to create a well-coordinated, viable community response. The Calgary Drop-in Center has played a significant and commendable role in facilitating the completion of the research project, community consultation and engagement process that informed the report and its recommendations.

Diane Altwasser, Manager for Community Impact
The United Way of Calgary & Area