Collaborative for Health and Home Baseline Evaluation Report

March 2019

CHH | Collaborative for Health and Home

Evaluation conducted with support from
Constellation Consulting Group

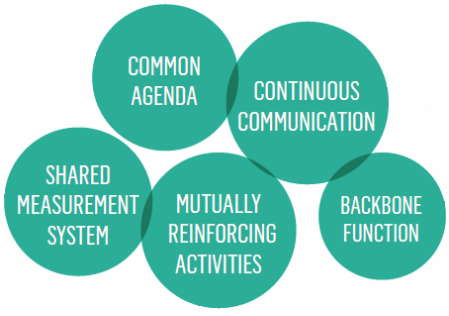
Contents

1.0 Introduction and Background

In the fall of 2014, consultations amongst 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 in Calgary, and that this was not a single-agency challenge, but rather a city-wide issue. Building on the conversations initiated in the fall of 2014, by February 2015 individuals from multiple sectors came forward to form the Calgary Recovery Services Taskforce. The goal of the Taskforce was to issue recommendations for action to advance the health and housing of chronically homeless individuals in Calgary. The Taskforce accomplished this goal and recommendations were presented in a Final Report in early 2017, which also included a summary of research that was conducted through the Cummings School of Medicine and sponsored by the Taskforce to better understand the need faced in the Calgary community.[1]

Based on the clear recommendations set out in the Taskforce's Final Report, three years of backbone support funding resourced through the Calgary Homeless Foundation (CHF) was secured to help advance progress towards desired outcomes related to the Taskforce's recommendations. In 2018 the Taskforce evolved into the Collaborative for Health and Home (CHH), which includes representation from 26 homeless-serving agencies, government, and related stakeholders. The CHH seeks to advance the Taskforce's recommendations and collaboratively respond to the complex health, housing, and support needs of people with chronic and/or complex experiences of homelessness in Calgary. Since individuals with complex and/or chronic experiences of homelessness often experience multiple complex issues that compound their experience of homelessness, including concurrent mental illness, substance abuse and physical health issues, the shared goal of the CHH is to create a coordinated system of care wherein this population can experience improved health, housing and overall well-being.

Collective impact occurs when a group of organizations and stakeholders from different sectors commit to a shared goal for addressing complex social situations or problems.[2] The key elements of a collective impact approach to complex change are: a common agenda, continuous communications, mutually reinforcing activities, backbone infrastructure, and commitment to shared measurement:[3]



[1] Available online at: http://calgarychh.ca/wp-content/uploads/2018/09/Calgary_Recovery_Services_Task_Force_Report.pdf
[2] Preskill, H., Parkhurst, M., & Juster Splansky, J. (2014). *Guide to Evaluating Collective Impact.* FSG and Collective Impact Forum.
[3] Image from Preskill, H., Parkhurst, M., & Juster Splansky, J. (2014). *Guide to Evaluating Collective Impact.*

The CHH is a clear example of a collective impact approach, with a collaboratively established common agenda, continuous communications, mutually reinforcing activities, backbone infrastructure, and commitment to understanding impact.

Collective impact emerges over time with different outcomes arising at different stages. As such, evaluation of collective impact initiatives must be responsive to this emergent process, recognizing that desired population-level change may not be evident in the early stages of collaboration. In particular, when collective impact initiatives are initially established, process outcomes, such as the establishment of a collaborative culture and the development of sector capacity for collaboration, are most likely to emerge. Over time, desired collective impact outcomes that affect clients and services may then begin to emerge, with evidence of this change not generally emerging until later years of the initiative.[4]

To ensure thoughtful evaluation of the CHH's collective impact work, in 2018 evaluation experts at Constellation Consulting Group were hired to develop a comprehensive evaluation framework setting out the anticipated methods for understanding the CHH's impact over time. The evaluation framework that was developed outlines the CHH's anticipated outcomes along with key data sources for understanding whether the CHH is fostering effective collaboration that can contribute to the achievement of outcomes. The framework was approved by the CHH Steering Committee in September 2018, with an understanding that it is to be treated as a 'living document' that should be changed and updated as the CHH evolves.

The current report presents initial findings from the implementation of the 2018 CHH Collective Impact Evaluation Framework. This initial implementation of the Evaluation Framework captures 'early stage' collective impact information focusing on the development of collaborative processes that can contribute to the creation of outcomes as well as initial movement towards desired outcomes. Initial findings are presented here with these findings intended to help establish a baseline for future comparison and understanding of CHH impact over time. While the baseline information outlined in this report does not represent a 'true baseline' for the CHH (since collaboration has been happening for some time) it is nevertheless essential for understanding movement towards change fostered by the CHH in the long-term. Future comparison against the current findings will ultimately highlight whether the CHH is effectively creating intended positive outcomes and moving towards its stated goal in the long-term.

[4] Preskill, H., Parkhurst, M., & Juster Splansky, J. (2014). *Guide to Evaluating Collective Impact.* FSG and Collective Impact Forum.

2.0 Evaluation Processes and Methods

The CHH Collective Impact Evaluation Framework, approved by the collaborative in September 2018, provides a guide for evaluating the collective impact of CHH. It outlines methods to begin to understand both the ***processes*** of collective impact as well as the ***outcomes*** of collaboration. For further information on evaluation questions and collective impact evaluation, please refer to the Framework.

2.1 Evaluation Methods

The CHH evaluation methods include qualitative and quantitative methods in order to garner robust results and involve multiple stakeholders. Having multiple sources/methods of data collection enables triangulation of results, though it is noted that limitations in the implementation of these methods nevertheless exist (see Section 2.2 for details). The following evaluation methods have been leveraged in the development of this baseline report:

1. CHH Collaboration Survey This survey includes both quantitative and qualitative questions and is based on the Wilder Collaboration Factors Inventory, which is a standardized tool designed for the measurement of collaboration.[5] The collaboration factors measured through the CHH Collaboration Survey include:
    - History of collaboration or cooperation in the community[6]
    - Unique purpose
    - Established informal relationships and communication links
    - Sufficient funds, staff, materials and time
    - Members see collaboration as in their self-interest
    - Open and frequent communication
    - Mutual respect, understanding and trust
    - Members share a stake in both process and outcome
    - Shared vision
    - Skilled leadership
    - Multiple layers of participation

    The survey was sent to members of the CHH Steering Committee and Working Groups to determine what progress has been made towards process and impact outcomes to date and to establish a baseline against which future evaluation results can be compared. It was sent to 71 individuals, with 41 individuals providing responses, representing a response rate of 58%. Individuals from all key contributing agencies involved in the CHH responded to the survey (see Appendix B for details).

[5] The Wilder Collaboration Factors Inventory has been tested for reliability: Derose, K. Pitkin, A., & Jackson, C. (2004). It is based on 20 'Collaboration Factors' and is available for free online at: https://wilderresearch.org/tools/cfi/. The tool has been adapted to fit with CHH evaluation, which may impact the internal validity of the tool.

[6] Information on this collaboration factor has not been reported as it will not be relevant for future comparison.

2. Survey for Former or Non-CHH Community Organizations/Services This brief qualitative survey was sent to individuals no longer participating in the CHH or who work within the homeless-serving sector but are not yet involved in the CHH. Data from this survey helps establish a baseline for understanding engagement with the CHH, barriers and challenges and possible gaps in collaboration. The survey was sent to 124 individuals, with 11 responding, representing a response rate of 9%. 45% of respondents had previously been involved with CHH and 55% had never been involved with CHH. The lower response rate on this survey is not surprising, given that individuals invited to participate are not currently actively involved with the CHH and may not see a clear connection between their work and the work of the CHH. Future iterations of the survey may require additional attention to survey participant recruitment, however the initial responses garnered during this baseline evaluation can nevertheless be useful for understanding CHH engagement and perceived systemic gaps that may be addressed by the CHH moving forward.

3. Frontline Staff Survey This survey includes both quantitative and qualitative questions and was administered to frontline staff within CHH member agencies. The questions collect staff perspectives on movement towards CHH outcomes and overall perceived changes and/or ongoing challenges in service access and navigation. A total of 21 frontline staff representing 6 CHH member organizations completed the survey for this baseline report. Since invitations to complete the survey were sent to staff via CHH member organizations, it is not possible to report on the total number of invitations sent or the response rate for this survey.

4. Experience Stories Experience stories were collected from frontline staff and individuals with lived experience of homelessness. These stories qualitatively describe the health and housing experiences of individuals who are homeless and those who seek to help them in order to paint a picture of health and housing successes and challenges experienced within the homeless system of care. Stories were provided by 12 individuals with lived experience and 11 frontline staff.

5. Calgary Homeless Foundation (CHF) Data The CHF collects data from individuals with complex and/or chronic experiences of homelessness who are entering CHF-funded Housing First programs. This 'move in' data includes information on whether individuals are entering housing from homelessness with treated or untreated mental and physical health conditions, including addictions. This information can help provide a snapshot of the services received by homeless individuals in the period prior to entering a Housing First program. While this information does not comprehensively capture what is happening in terms of health supports for chronically homeless individuals in Calgary, it can provide a small window of understanding around a segment of the population the CHH is attempting to impact. For the current baseline report, a random sample of 383

CHF move-in surveys gathered from October 1, 2017 to September 30, 2018 were analyzed. This sample of data enables the establishment of a baseline against which future move-in data can be compared to understand changes over time. It is recognized that this data is limited and thus any conclusions drawn from the analysis will be similarly limited. Section 2.2 discusses the specific limitations of this dataset.

6. <u>The Perceived Need for Health Services for Persons Experiencing Chronic Homelessness (PNHS) Study</u>
   The initial PNHS study was sponsored by the Calgary Recovery Services Taskforce in 2015 and conducted through the Cummings School of Medicine at the University of Calgary. This study facilitated 300 surveys with individuals who had been homeless for at least six months in the winter of 2015. The surveys consisted of 88 questions, 10 of which were from the Adverse Childhood Experiences survey (ACE) and were conducted in two emergency shelters and with a small group of rough sleepers. Data from this study provides a snapshot of the experience of chronically homeless Calgarians and can be used as baseline information as part of the CHH evaluation.

The current report has been developed based on a combination of the subjective and objective information gathered using the data sources described above. Future evaluation of the CHH can compare against the baseline established in this report to better understand the CHH's impact over time.

2.2 Limitations

It is recognized that within any research or evaluation efforts there will be limitations. Triangulation is a key technique that helps manage bias and facilitate validity of research. The current evaluation leverages multiple sources/methods of data collection allowing for the triangulation of results. Nevertheless, the following limitations have been identified and should be kept in mind when reading the results presented:

- The baselines presented in this report are being established at a point when members of the CHH have been officially collaborating since the creation of the Taskforce in 2015, and unofficially collaborating much longer. This means that collaboration in the sector has potentially already contributed to community change and the baseline presented in this report does not represent a 'true' baseline. In the absence of earlier baseline information, however, the information presented here can help foster understanding about the CHH's intentional contribution to desired outcomes moving forward. This report also highlights where initial movement towards outcomes has been observed and future evaluation can determine if this movement continues in positive directions.

- The CHF move-in survey data set analyzed as part of the CHH evaluation baseline only includes information on services that receive CHF funding for Housing First programming. As such, it may underrepresent the experiences of clients accessing services not funded

through the Foundation or not related to Housing First initiatives. Further, CHF data is self-reported by a client group that may have trouble remembering their service history and may feel pressure to report positive outcomes. The data also likely underrepresents Indigenous perspectives.
Further, while objective decreases in the number of individuals with untreated conditions can indicate changes in the service landscape experienced by homeless individuals, it is important to note that the CHH exists and seeks to create impact within a complex environment, and CHH actions and outcomes are inherently multi-dimensional in nature, with numerous influencing factors, and involving a myriad of interactions, synergies, and possible outcomes. Rather than seeking to attribute outcomes, in their entirety, to the CHH, future evaluation can leverage methods outlined in the CHH Evaluation Framework to understand the *contribution* the collaborative is making towards actions and the creation of positive social impact.

- Some questions in the original PNHS Survey were found to be difficult for clients to answer. For example, having clients remember a service they received a long time ago may be challenging. This may limit the validity of the baseline PNHS results.
- The baseline evaluation and the CHH Collective Impact Evaluation Framework lack specific culturally relevant evaluation methods for Indigenous service users. As Indigenous peoples are overrepresented amongst individuals with chronic and/or complex experiences of homelessness, the baseline evaluation results are limited and may not adequately represent their experiences. As future CHH evaluation unfolds, methods of data collection and evidence gathering should evolve with the support of Indigenous evaluation experts to more effectively capture experiences of Indigenous individuals. This can include seeking opportunities to evolve future iterations of the PNHS study to be more relevant for Indigenous stakeholders.
- Experience stories are not always an effective method for determining direct cause and effect relationships related to outcomes and may be subject to bias depending on who is contributing to the story. Nevertheless, these stories can provide some evidence towards understanding the impact of collaborative action in the absence of clear contribution or attribution lines.

Overall, subjective data sources included in the evaluation may skew results towards the positive while objective data sources are not comprehensive enough to draw definitive conclusions about impact. By combining multiple data sources, the validity of the evaluation findings are increased, however it is recognized that biases have not been eliminated using the chosen evaluation methods.

3.0 CHH 2018 Baseline Evaluation Results

3.1 Perspectives on Collaboration at Baseline

Since collective impact requires multiple contributions and pathways to change, and is a commitment to impact over the long term, evaluation of collective impact must take into consideration multiple perspectives and timeframes, and must be flexible to capture emerging and unanticipated outcomes that inevitably develop as contexts and issues change.[2] As such, the early years of collaborative work are most likely to realize process outcomes, such as the development of collaborative culture and collective capacity.

Perspectives on collaborative processes have been solicited from CHH Steering Committee and Working Group members to develop a baseline of understanding around how the CHH is currently working together to create collective impact. In the future, comparison with subsequent survey results can help foster understanding around whether the CHH is supporting effective collaborative processes within the homeless-serving sector that can ultimately contribute to community-wide change.

In total, 41 CHH Steering Committee and Working Group members provided responses to the CHH Collaboration Survey. The survey revealed that CHH Steering Committee and Working Groups had similar views on the collaborative's progress towards various collaboration factors, however it should be noted that Steering Committee members generally had slightly more negative perspectives than Working Group members. See Appendix C for a detailed breakdown of survey results.

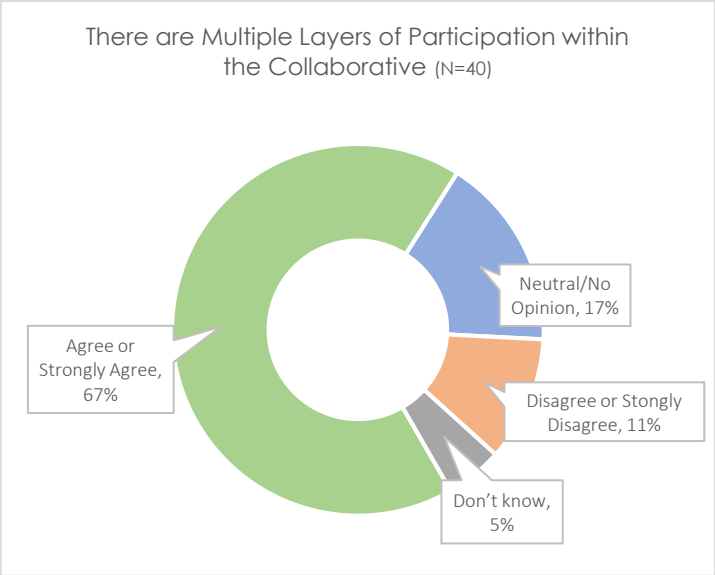
Strengths in Collaboration at Baseline

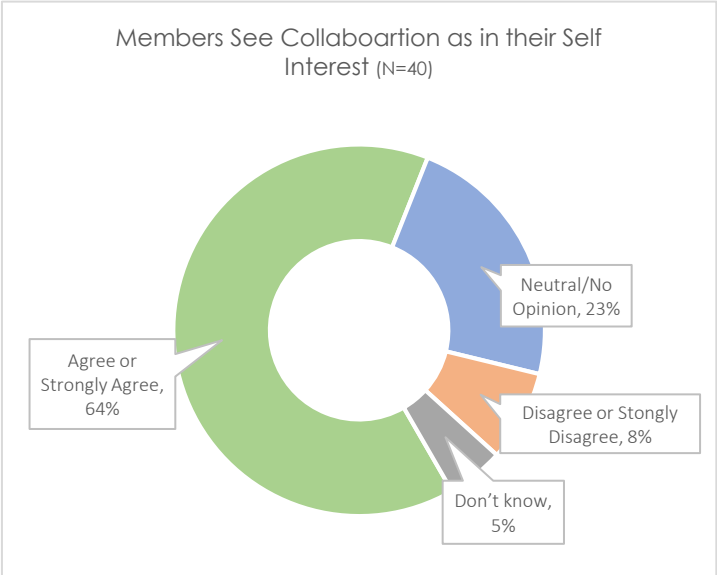
Overall, the survey suggested that **CHH Steering Committee and Working Group members feel cross-sector collaboration is happening to a greater degree because of the CHH**, with 78% of CHH members agreeing that cross-sector collaboration is happening to a greater degree because of the CHH, and 78% agreeing that individuals involved in the CHH communicate openly with one another. The survey also revealed that, because of the CHH, 86% of survey respondents feel they have learned more about what others in the sector are working on, and how this work can be supported through collaboration. The survey clearly indicated that CHH members are recognizing the need for the collaborative and that the collaborative is already helping to break down silos within the homeless-serving sector that may have existed in the past. In total:

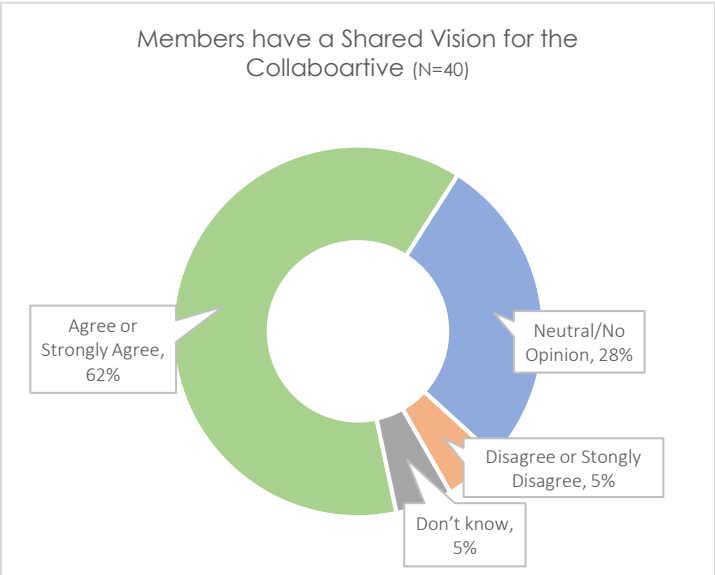
98% of survey respondents felt that what the CHH is trying to accomplish would be difficult for any single organization to accomplish by itself.

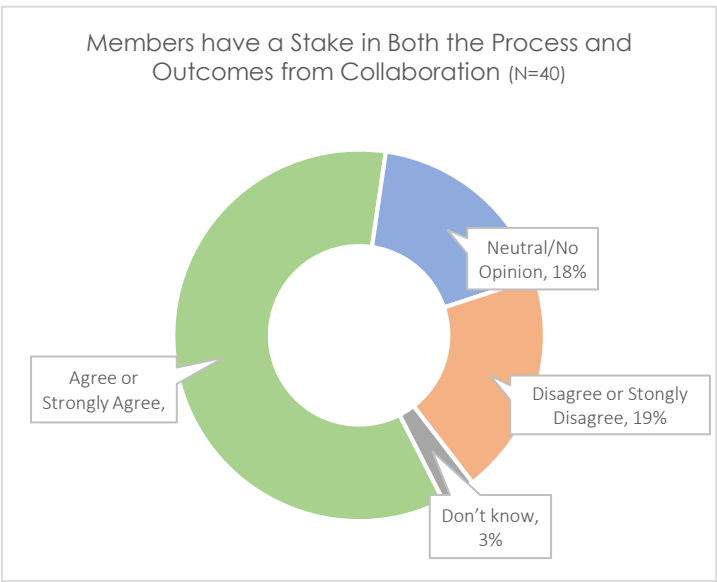
98% of survey respondents felt that the CHH has enabled *new* collaborative relationships to develop amongst stakeholders.

CHH Steering Committee and Working Group members also felt the CHH was demonstrating some strength with respect to four key collaboration factors:









While some strength has been recognized by survey respondents with respect to these four key collaboration factors, there is also room for growth. Overall, strength in these areas indicates that the collaborative is currently well-positioned to leverage the contributions of members (including Working Group members) towards the advancement of a shared vision and creation of desired outcomes. Moving forward, continued support for open communication and the advancement of Working Group objectives can further enhance the CHH's ability contribute to community-wide change. Ongoing efforts to maintain and grow member interest and commitment will be essential for ensuring the longevity of the collaborative.

Areas for Improvement in Collaboration at Baseline

The CHH Collaboration Survey also revealed that there were three key collaboration factors with

room for improvement: mutual respect, understanding and trust; skilled leadership; and sufficient funds, staff materials and time.

Mutual trust is a key component to any collaborative effort. The CHH Collaboration Survey results suggest that there is room to grow with respect to trust within the CHH, with just over half (52%) of respondents agreeing that people involved in the CHH always trust one another. This suggests that, while many members feel there is strong trust within the collaborative, ongoing efforts to build and model trusting relationships can help further enhance the collaborative's effectiveness.

Working to ensure that the effectiveness of the Steering Committee is maximized can also help increase commitment and trust within the collaborative. While 50% of survey respondents agreed that the CHH Steering Committee is effective in guiding the development and execution of the CHH's shared vision and strategic direction, there is room to grow with respect to Steering Committee effectiveness. Shortly after the baseline CHH Collaboration Survey was completed, a reconceptualizing of the Steering Committee's membership and role was undertaken and key changes have begun to be implemented. As the collaborative moves forward with a more clearly defined Steering Committee mandate, future evaluation can reveal whether the changes that have been made are helping the Steering Committee evolve towards even greater effectiveness.

Resourcing for the CHH was the area in which survey respondents felt there was the most room for improvement, with only 26% of respondents feeling that the collaborative has adequate resources to accomplish its goals at this time. Recognizing that most CHH members are contributing to the collaborative without additional resources to do so, and acknowledging the scale of what the CHH is seeking to accomplish, it is understandable that many members would feel the collaborative is under-resourced. Ongoing efforts to secure funds for CHH projects and find new ways to effectively leverage existing funds may help alleviate resource-related concerns.

Overall, assessment of the CHH's collaboration factors in late 2018 has suggested that the collaborative is already building key collaborative processes that can support the creation of outcomes over time. By building on the areas in which the CHH is already demonstrating strength in collaboration and identifying key areas for improvement, the collaborative can increase effectiveness moving forward, with future assessment of the CHH's collaboration compared to this 'baseline' to determine the extent to which effectiveness may be increasing.

3.2 Perspectives on Movement Toward Outcomes at Baseline

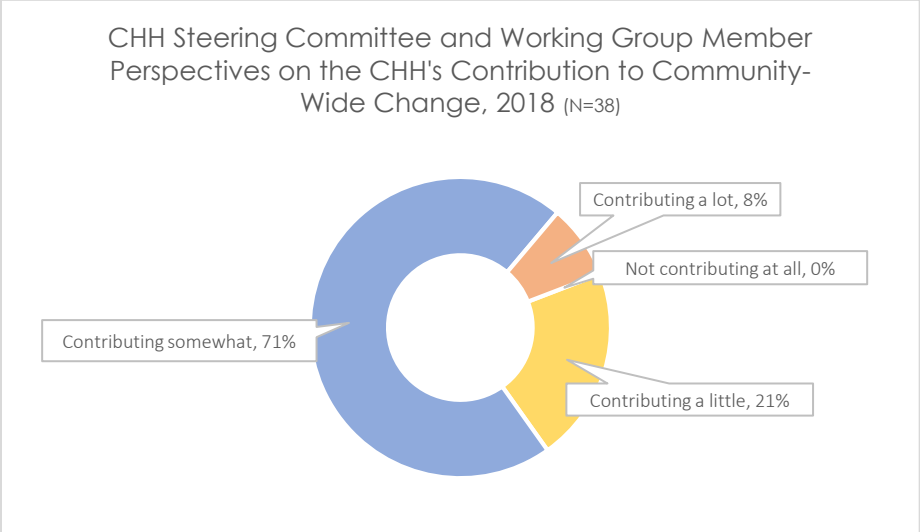
Since CHH members have been working together for some time, there is the potential that collective impact outcomes are beginning to emerge. At the same time, it is recognized that the CHH is still in its 'early years' as a collective impact initiative, meaning outcomes may not yet be clearly emerging. In the absence of objective comparative data on experiences of health and housing amongst individuals experiencing chronic/complex homelessness in Calgary at this time, subjective perspectives on outcomes were gathered from CHH Steering Committee members,

CHH Working Group members, frontline staff from CHH member agencies, and related community stakeholders to gain a broad perspective on where impact may be emerging. The current baseline evaluation report takes stock of key perspectives on the possible emergence of outcomes and seeks to establish a baseline against which future evidence can be measured to determine whether the CHH is making progress towards desired outcomes.

The CHH Collaboration and the Frontline Staff Surveys asked respondents to rate the extent to which they felt key CHH outcomes were happening (see Appendix C for a detailed breakdown of survey results and Appendix A for a list of anticipated CHH outcomes). In total, 41 CHH Steering Committee and Working Group members and 21 frontline staff from CHH member agencies provided responses. Overall:

71% of CHH Steering Committee and Working Group member respondents felt that the CHH has 'somewhat' contributed to community-wide change.

Notably, no respondents felt that the CHH is not contributing to community-wide change at all, suggesting that CHH members see value in the collaborative efforts of the CHH.



CHH Steering Committee and Working Group members were also asked about more specific outcomes from their work with the collaborative, and frontline staff were asked about CHH-related outcomes they may have observed in their day-to-day work. While most respondents indicated that some movement towards desired CHH outcomes has begun, there is still room to grow. The survey found:

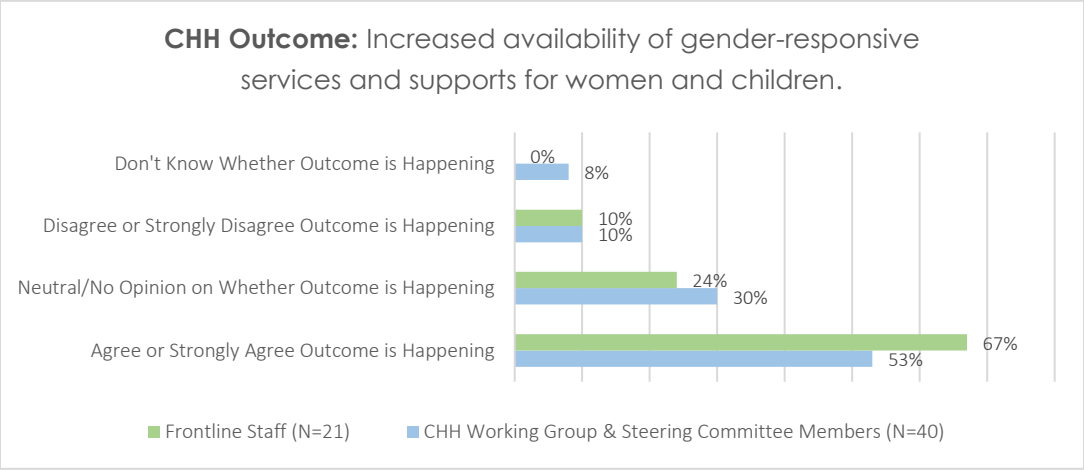
CHH Outcome: Increased choice and access to health and housing services for people with complex and/or chronic experiences of homelessness. While only 16% of Steering Committee and Working Group members felt this outcome is not yet happening, from the frontline staff perspective, 43% of survey respondents indicated that, at this time, they have not observed improved access to health and housing supports for the clients they serve. This suggests that on-the-ground experiences of this CHH outcome have yet to emerge in a

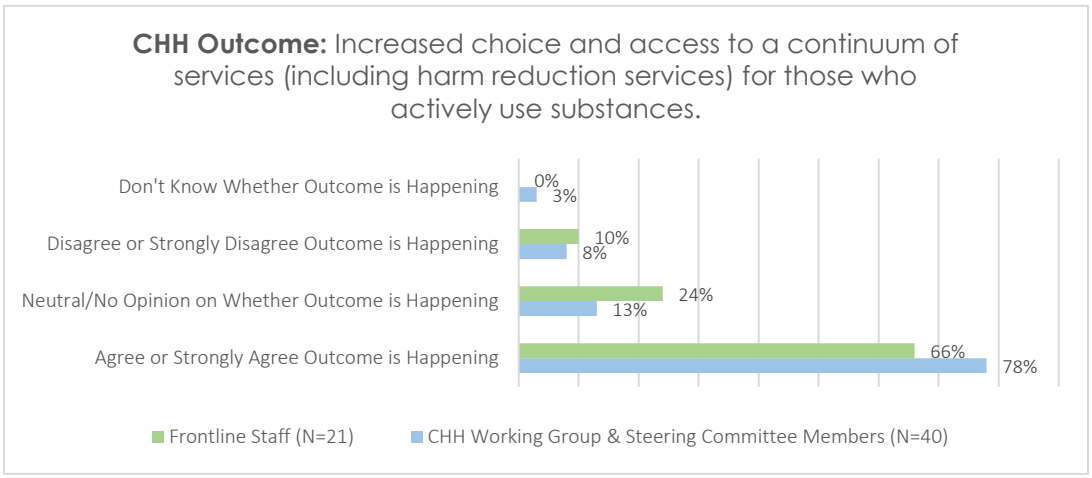
meaningful way and ongoing work towards this outcome will be needed to advance community-wide change.

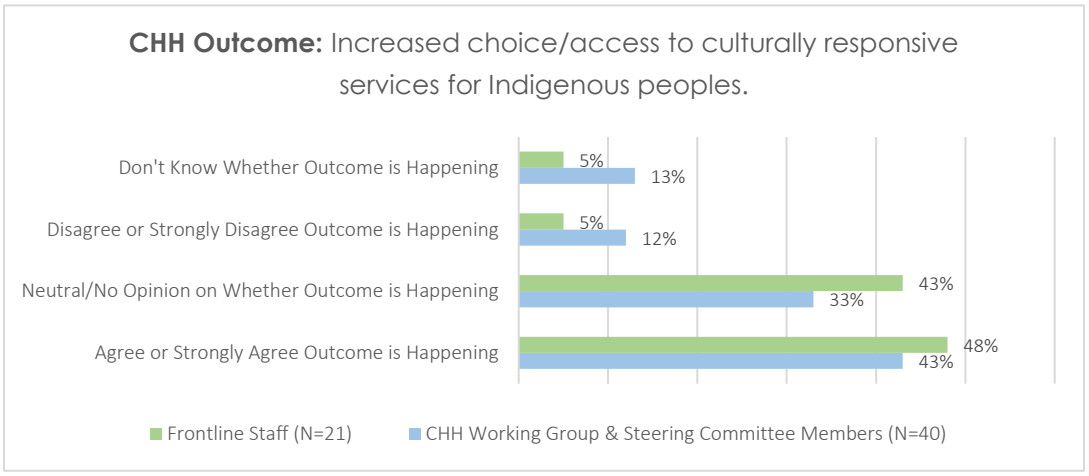
CHH Outcome: Maintained or improved health amongst people with complex and/or chronic experiences of homelessness, in shelter or newly housed. While only 13% of Steering Committee and Working Group members felt this outcome is not yet happening, from the frontline staff perspective, 71% of respondents felt that the health of individuals with complex and/or chronic experiences of homelessness has not improved in recent years. This suggests that the work of the CHH is not yet directly impacting the health and housing of individuals with complex and/or chronic experiences of homelessness. This is not surprising, given the complex nature of the issues the CHH is tackling and the typically slowly-emerging nature of population-wide collective impact. Leveraging collaborative processes and pursuing outcome goals with persistence, however, can help move communities further towards desired outcomes in the long term.

With ongoing CHH collaboration working towards creating community-wide outcomes, future evaluation results can be compared against these perspectives to understand whether subjective opinions about outcomes are becoming more positive over time as CHH members and frontline staff begin to witness the emergence of outcomes among clients and within their agencies/communities.

Understanding that, for sub-populations of individuals with chronic and/or complex experiences of homelessness outcomes may be at an even more nascent stage, where services must first be created before access and health can be improved, the CHH Collaboration and Frontline Staff Surveys asked respondents to share their perspectives on services for women and children, individuals actively using substances and Indigenous individuals. The survey indicated that members and frontline staff feel there has been some movement towards the following anticipated CHH outcomes, with greater movement towards increasing choice/access observed for women and active substance users than for Indigenous individuals at this time:







These results suggest that working towards outcomes for Indigenous individuals experiencing homelessness must begin with the creation of culturally responsive services that can best support their engagement in services. On the other hand, the survey results suggest that some progress has already been made towards creating gender-responsive services and a continuum of service for individuals actively using substances, opening opportunities to begin effectively impacting the health and housing of women and substance users who are experiencing homelessness.

Overall, perspectives from CHH members and frontline staff suggest that outcomes are being initiated, even while definitive community-wide change is slow to emerge.

Moving forward, the CHH can build on this initial progress to further advance desired objectives.

Community stakeholders who are not currently involved in the CHH also provided some feedback about perceived impact of the CHH. In total, 11 non-CHH members provided responses. Most non-member survey respondents were unsure whether the CHH is currently creating positive outcomes in the community, and one participant felt CHH was not creating

positive outcomes because of a lack of direction. Some positive changes participants felt they had seen in the community that could possibly be related to the work of the CHH were:

- Increased integration of health services for homeless clients
- Creation of new community dialogue and increased community awareness of issues related to homelessness
- Increased collaboration across the homeless-serving sector

These perspectives suggest that community stakeholders are beginning to observe the results from CHH efforts, whether or not they have intimate knowledge of the objectives of the CHH. Future surveying of community stakeholders can determine the extent to which the CHH is able to effectively build on this initial movement towards the creation of tangible community-wide outcomes.

3.3 Experience-Informed Key Themes

Understanding lived experiences with respect to the collaborative's work is important for understanding the ways in which the CHH is contributing to real change for the people it is seeking to impact. Experience stories can help inform the CHH about where desired outcomes are being advanced and can highlight the ways in which the collaborative is, or is not, meaningfully impacting the community.

For the current baseline evaluation, 12 homeless individuals and 11 homeless-serving frontline staff shared stories about their experiences with health and housing in the current service landscape. While many of the themes from the experience stories that were shared during the evaluation are already known to the CHH, by establishing these themes at baseline, future comparison of experience story themes will be possible and can contribute to understanding of the CHH's impact over time. Further, since the current baseline evaluation is happening at a time when the CHH has already possibly made progress towards outcomes, experience story themes can help highlight where movement towards CHH desired outcomes has already begun. Themes that emerged are based on staff and client perspectives and experiences; they have not been externally validated. Key themes emerging from experience stories collected during the CHH's baseline evaluation include:

Access to and Trust of Mental and Physical Health Services

Challenges with access to mental and physical health services was raised through multiple experience stories. In particular, the issue of missed appointments was highlighted. One person with lived experience described missing doctor appointments that subsequently limited their access to medical support. Those with lived experience of homelessness explained that doctor appointments get missed for many reasons including addictions, fear, transportation issues, or appointment conflicts. Having this tracked was perceived as creating barriers for future medical access.

Others described how mental health issues can be the reason why individuals experiencing homelessness may not access medical treatment. One respondent highlighted the impact of trauma and PTSD in creating barriers to service access. This individual described how PTSD and trauma prevented them from accessing support as they lacked trust and were very frightened of systems.

> *"When you have mental health issues –*
> *the way people treat you in services is so important."*

Experience stories also revealed that there are access issues in terms of communication of test results. According to one person, this is done by phone. For this person, this was very problematic as they do not use a phone and would prefer communication via email – something which was not permitted.

Further, stories suggested that, for some individuals experiencing homeless, there is a general mistrust and avoidance of the medical system, largely due to experiences of stigma and discrimination. People shared stories about their own experiences with judgement from the medical system, including paramedics, doctors, and hospital staff, as well as witnessing other homeless individuals being discriminated against. One individual shared an experience where they felt stigmatized and dismissed:

> *"I was waiting a long time [in the hospital]. I complained to the receptionist,*
> *who told me I should just be grateful for being warm."*

Participants discussed how relationships and trust are very important and, as such, many people experiencing homelessness prefer to receive treatment in shelters, where they feel accepted.

Some frontline staff indicated that in their experience, individuals who are homeless often do not "have the skills or knowledge to navigate the system or agencies". Peer support was identified as a possible way to fill this gap.

Inadequate Health Coverage, Including Coverage for Eye Care, Dental Care and Disability Services

Another theme emerging from the experience stories was inadequate health coverage for individuals experiencing homelessness. While respondents acknowledged that there is some coverage, it was emphasized that due to the heightened health-related vulnerability of individuals experiencing homelessness, this coverage is often significantly inadequate (including dental coverage):

"We have a higher rate of physical issues and our coverage is not enough. We are very vulnerable to disease and illness – need better access to paid for prescriptions."

"Alberta Works is inadequate – they give little coverage – only meds for one month. In many cases such as antibiotics, this is not enough."

Further, while experience stories suggest that individuals experiencing homelessness often require eye exams, eye glasses, and dental work many individuals said they do not know where to go for affordable or covered services. This was seen as a service gap that needs to be filled.

"A lot have eyesight problems and don't know where to get cheap glasses. I know don't know where to go…"

"Lots of people have dental problems but can't afford the dental work."

Individuals experiencing homelessness also often face difficulties accessing prosthetics when needed, as there is limited awareness of organizations that are willing and able to help, such as the War Amps.

Mental Health

Mental health was another common theme within the experience stories. Respondents suggested that when individuals are homeless they are often not open to connecting with doctors and many feel stigmatized and are "careful around the medical profession." As such, while service providers may make referrals to psychiatric services, many homeless individuals do not follow through on those referrals. Further, while clients may go to the Sheldon Chumir health centre for mental health services, many do not want to engage with the medical system in this way.

Those sharing experience stories expressed that there is a lack of available psychiatry services in Calgary to meet need/demand, resulting in significant waitlists. Staff stated there are mental health teams in the community, but that the mental health needs often surpass available supports. Others added that it is hard to get hospitalized for mental health due to waitlists:

"I tried to get hospitalized for my mental health issues. There was a 4-month waiting list."

Stories suggested, however, that when mental health supports are available, and are appropriately accessed, significant improvements in mental health can happen.

> *"My mental illness was misdiagnosed. When I got the correct diagnosis and the right treatment, I improved so quickly and am no longer homeless."*

Addictions

Stories about addiction services were also frequent. Several individuals described waitlists for addiction treatment faced by people experiencing homeless, and a lack of housing for those who are waiting for treatment. It was mentioned that when a person is in treatment and housing, wellbeing can be improved. Stories suggested that within the service community there may be varying levels of staff understanding/education related to addictions, limiting ability to be responsive when addiction is an issue experienced.

In particular, the opioid epidemic was highlighted as a significant challenge. According to some, shelters are seeing high numbers of overdoses on-site even while staff are trained in giving Naloxone and are able to respond. One respondent explained:

> *"I think people are using the shelter as a safe consumption site. Especially in the cold [weather] – they don't want to go to Chumir because then they need to return to the shelter afterwards. Here, they use, get treated, and then go to sleep."*

Long-term Medical and Hospice Care

One of the most common themes shared by both staff and clients was the need for long-term medical and hospice care for chronically homeless individuals. Some shared experiences of being discharged to the streets from the hospitals, and suggested that, from their perspective, there needs to be somewhere that people can go when they require medical needs such as homecare or hospice. A few stories within this theme involved individuals battling cancer while homeless. In these situations, stories suggested that individuals experiencing homelessness and cancer are faced with significant medical needs that may not be adequately addressed. In one case, a story emerged of a homeless individual who chose medically assisted dying rather than extensive cancer treatment partly because they could not receive the treatment after-care in a shelter. For those that require hospice care, the stories suggested that getting access can also be difficult. Respondents described how a doctor referral is needed to enter a hospice, however many homeless individuals are not connected to a doctor.

Those sharing stories who were aware of the service celebrated the newly developed Drop In Centre Medical Stepdown Homecare beds, but several individuals felt that this support is still limited compared to the need in the community.

Housing- Related Challenges

Housing-related challenges can intensify illness and addiction, according to the experience stories shared during the evaluation. One person explained that some housing only allows for short-term leases (i.e. 3 months) which "are not trauma-informed and can exasperate or create mental health conditions such as anxiety."

While many agreed that Housing First has created numerous positive stories, housing gaps continue. One individual mentioned that abstinence-only housing was the only option available for someone with an addiction. This person accepted that housing because they did not have another option, despite knowing that maintaining the housing would be very difficult for them.

Other perspectives of housing gaps identified included: individuals who are about to be homeless but don't qualify for housing because they are not yet homeless; individuals who are single and cannot find subsidized housing; and mothers who are in abusive situations who do not quality for supportive housing that exists connected to the homeless system of care.

Indigenous Individuals Experiencing Homelessness

While any homeless individual may experience significant stigma and discrimination within systems (including health and mental health systems), several respondents emphasized that this is more commonly experienced by Indigenous individuals due to Canada's colonial history and ongoing systemic racism. One Indigenous-identifying individual with lived experience of homelessness shared that they do not like to go to the hospital as they have been traumatized by systemic racism. Others added that Indigenous individuals experiencing homelessness are sometimes targeted by systems such as the police (individuals shared stories of witnessing encounters that have concerned them). There was also some concern expressed within the experience stories of possible mis-diagnosis of Fetal Alcohol Syndrome for Indigenous individuals due to "racial-bias."

Women Experiencing Homelessness

Within the group of individuals sharing their lived experiences of health and housing while homeless, four were women. These individuals shared experience stories that highlighted the reticence of women to engage with health services when homeless due to the fear of child apprehensions by Children's Services. One woman with lived experience shared that when she went to the hospital for mental health services while she was homeless, her children were ultimately apprehended as a result, deterring her from seeking help in the future.

> *"I went and got help at the hospital and mentioned my children. The doc assumed that my children were [young] and a report was put into child welfare. I didn't get the help I needed. They wouldn't help me at the time. My kids got apprehended. I don't know if I would ever go to the hospital again. If I started hearing voices again, I don't' think I would go into the hospital again."*

Staff stories added that sexual health issues for women such as unplanned pregnancies, using substances while pregnant and Sexually Transmitted Infections (STI) are common experiences for women while experiencing homelessness. They expressed concern that when women are pregnant and homeless Children's Services often becomes involved and apprehends children. When women who are pregnant and homeless can be safely housed however, there were stories of positive outcomes.

Conclusions from Baseline Experience Stories

Overall, the key themes emerging from the experience stories shared during the CHH baseline evaluation suggest that the CHH's goals and objectives are well-aligned with perceived and experienced needs in the community. Further, while progress is still emerging, key initiatives connected to the CHH, such as the Stepdown Medical Homecare beds at the Drop In Centre and support for safe consumption and addictions treatment options, are being highlighted by frontline staff and clients as positive changes in the service landscape. Future assessment of experience stories can help identify where key themes are being addressed by CHH initiatives and where evolving service needs and gaps may be emerging.

3.4 Data-Informed Baselines for Outcome Assessment

Building on the collaboration survey results and subjective information gathered through experience stories, objective data can help concretely measure changes in health and housing among chronically homeless Calgarians. While shared measurement is an element of collective impact and can contribute to the evaluation of collective impact achievements, Tamarack Institute Associate and collective impact thought leader Mark Cabaj warns that an over-emphasis on shared measurement systems can result in stalled action, limited strategic thinking, and the need for additional resources that may not be available to organizations creating collective impact.[7] With this in mind, the collective impact evaluation of the CHH seeks to build on *existing* measurement capacity of members rather than focusing on the development of a shared measurement system at this time. There are two key existing objective data sources that are being leveraged to establish a baseline for the evaluation of the CHH:

1. The Calgary Homeless Foundation's Housing First Move-In data, 2017-2018
2. The Perceived Need for Health Services for Persons Experiencing Chronic Homelessness (PNHS) Study conducted in 2015 with support from the CHH through the Cummings School of Medicine at the University of Calgary.

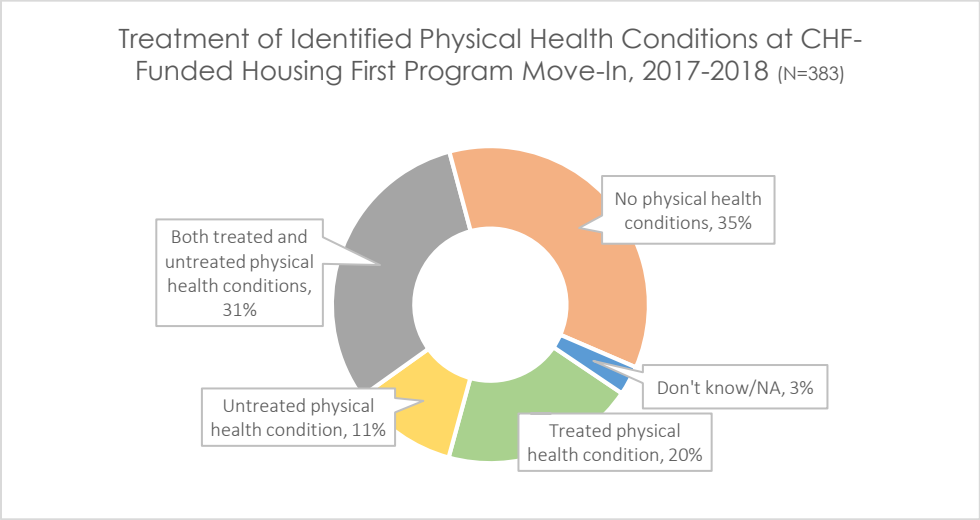
Calgary Homeless Foundation (CHF) Move-In Baseline Data

Move-in data from the CHF is provided by Housing First programs funded through the CHF. Understanding the treated versus untreated heath and health-related conditions of individuals upon move-in can help highlight whether or not individuals are receiving adequate health

[7] Cabaj, M. (2014). Evaluating Collective Impact: Five Simple Rules. *The Philanthropist, 26(1),* 109-124.

services while experiencing homelessness, and comparing the proportion of individuals with treated conditions over time can help indicate whether the CHH is contributing to increased access to key health services. While this information is not a perfect reflection of experiences in the community as it relies on self-reported information from individuals engaging with CHF-funded Housing First projects, it is nevertheless one potential indicator for understanding whether health conditions in the community are improving over time. See Section 2.2 for further discussion of limitations. At this time, a random sample of 383 CHF Move-In Surveys from October 1, 2017 to September 30, 2018 that were analyzed for the evaluation revealed:

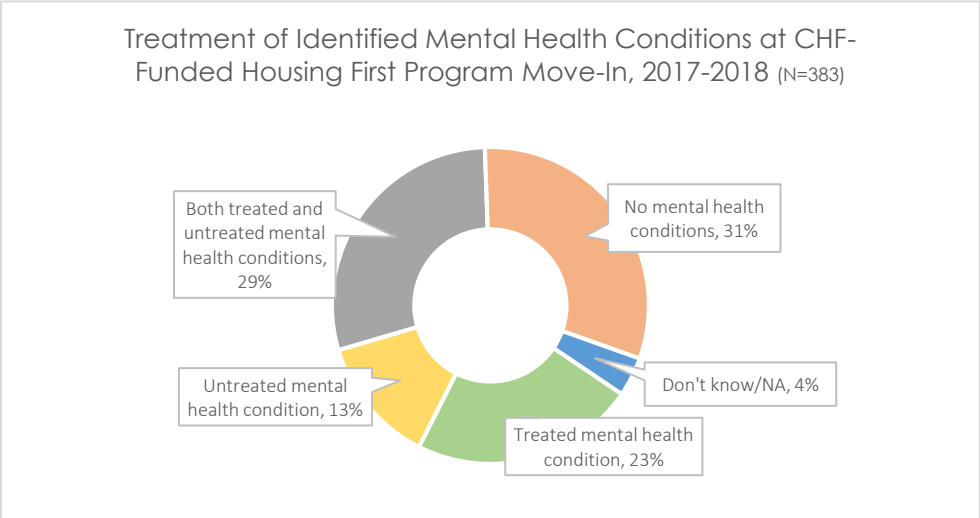
Physical Health Conditions:



Considering the move-in survey results broken out by gender and Indigenous identity, slight variations are observed. Overall, the same proportion of women were entering Housing First programs reporting untreated physical health conditions (11%), while the proportion of women reporting no physical health conditions was much higher (46%). This may suggest that among women there is less recognition of, or desire to report physical health conditions when accessing a Housing First program.

For Indigenous-identifying individuals, the proportion of those accessing Housing First programs reporting untreated physical health conditions was higher than the overall population (14%) as was the proportion of individuals reporting no physical health condition (42%). This may suggest that Indigenous individuals are less likely to be receiving needed treatment while at the same time being less likely to recognize, or to report physical health conditions.

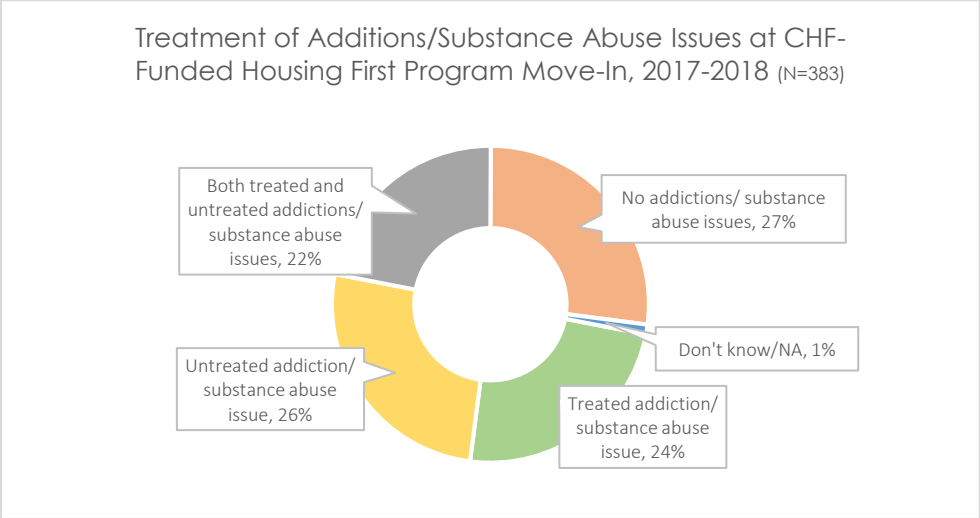
Mental Health Conditions:



Considering the move-in survey results broken out by gender and Indigenous identity, slight variations are observed. Overall, a slightly lower proportion of women (9%) are entering Housing First programs reporting untreated mental health conditions, while the proportion of women reporting untreated and treated conditions is approximately the same as the overall population (30%). This may suggest that women are more readily able to access mental health services in the community, or that, among women, there may be less recognition of, or desire to report mental health conditions that may need treatment when accessing a Housing First program.

For Indigenous-identifying individuals, the proportion of those accessing Housing First programs reporting untreated mental health conditions is approximately the same as the overall population (14%), while the proportion of individuals reporting both treated and untreated conditions is lower (22%). At the same time, the proportion of individuals reporting no mental health conditions is higher (37%) suggesting there may be less recognition of, or desire to report mental health conditions that may need treatment when accessing a Housing First program.

Substance Abuse Issues:



Considering the move-in survey results broken out by gender and Indigenous identity, slight variations are observed. Overall, a lower proportion of women (17%) entered Housing First programs reporting untreated (17%) or both treated and untreated (17%) addictions or substance abuse concerns, while the proportion of women reporting no addiction or substance abuse concern was higher at 39%. With a higher number of women reporting no substance use issues, these findings may suggest that women are experiencing fewer addictions/substance abuse issues or that there is less recognition of, or desire to report these issues when accessing a Housing First program. It may also indicate that there are barriers for women in reporting substance use issues and/or seeking treatment. In particular, fear of child apprehension and a lack of substance use treatment services that allowing children to live with their mothers while in treatment may create barriers for women to disclose substance abuse concerns or access treatment.

For Indigenous-identifying individuals, the proportion of those accessing Housing First programs reporting untreated addictions or substance abuse issues was slightly higher than the overall cohort (29%) while the proportion reporting both treated and untreated conditions was approximately the same (21%). Conversely, the proportion of Indigenous-identifying individuals reporting treated addictions or substance abuse issues at move-in was lower (22%) while the number reporting no issues was approximately the same (26%). With a higher number of Indigenous individuals reporting untreated substance use issues and a lower proportion of Indigenous individuals reporting treated substance use issues at move-in, these findings may suggest that Indigenous individuals are facing barriers to accessing treatment for addictions or substance abuse issues, including possible cultural barriers due to a lack of culturally relevant services available in the community.

Overall involvement with the health system while homeless: Though many individuals reported untreated conditions when moving into a Housing First program, the majority (66%) indicated that they had had involvement with the health system in the past year while they were homeless. This suggests that, while homeless individuals may be having encounters with the health system, their health needs are not always being addressed.

Overall, these baseline move-in survey results suggest that there is a need to provide greater treatment for mental health, physical health and substance use issues in the community while individuals are experiencing chronic and/or complex homelessness prior to entering housing through a Housing First program. Comparison of these baseline results to future samples of move-in surveys can help highlight whether access to treatment for various health conditions (including addiction) is increasing over time.

PNHS Study Baseline Data

As part of the journey towards the establishment of a common agenda, and in an effort to adhere to a client-centered approach focused on personal choice, the PNHS study was commissioned by the Calgary Recovery Services Taskforce (the precursor to the CHH) in 2015 to

explore the lived experiences of chronically homeless individuals living in Calgary.[8] The questions asked through the PNHS study were extensive, ranging from demographic information to an exploration of Adverse Childhood Experiences. Of particular relevance to the CHH evaluation, the study asked questions about the health and housing services received by study participants. The results from these questions can be used as a baseline against which future evaluation can assess CHH progress.[9] While this method can help highlight the ways in which the health and housing service experiences of chronically homeless Calgarians are changing over time, it is important to ensure comparative results are considered in terms of the *contribution* the CHH may be making rather than trying to attribute specific outcomes to the CHH.

Overall, the results from the PNHS survey conducted in 2015 highlight many of the same issues articulated by individuals through experience stories shared as part of the current evaluation. At the same time, experience stories suggested that progress is being made towards addressing specific needs, like end-of-life care in shelters. To objectively assess changes in health and housing experiences, however, it is recommended that relevant PNHS survey questions are replicated with a similar population of respondents experiencing homelessness today. See Section 2.2 for a discussion of the limitations of this approach. A list of questions from the PNHS survey that are relevant to the CHH evaluation is available in the CHH Evaluation Framework.

3.5 Identified CHH Accomplishments to Date

While the current report is the first CHH evaluation and is intended to establish a baseline against which future accomplishments can be measured, it is recognized that, since the CHH has been collaborating for some time, accomplishments have already begun to emerge.

CHH Steering Committee and Working Group Perspectives on Accomplishments

When asked about outcomes and accomplishments of the CHH to date, 31 Steering Committee and Working Group members provided responses, with four indicating they felt the CHH had not produced any outcomes or tangible results to-date and five indicating they felt unsure about what the CHH may have tangibly produced.

Members suggested that the CHH has been effective in advancing certain actions, programs and activities. The three most commonly identified accomplishments to-date were:

1. The creation of medical Step-Down Homecare beds at the Drop In Centre;
2. The development of supervised consumption options and movement towards mobile safe consumption; and
3. The advancement of a community of practice within the homeless-serving sector in Calgary.

[8] For details on findings see: 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*.
[9] For details on which PNHS questions are most relevant for the CHH evaluation, see the CHH Evaluation Framework.

Other cited accomplishments included:

- City Centre Team expansion and partnering with HIV Community Link
- Advancement of services for elderly individuals experiencing chronic homelessness
- Advancement of managed alcohol programs
- Creation of information kiosks at the DI
- Indirect impact on establishing the CCT community paramedics team (incl. PEAR UP partnership between AHS, EMS & HIV Community Link)
- Endorsement of ROOT proposal of the CCT
- Connection of CCT to supervised consumption managed alcohol procedures
- Advancement of peer-based programming
- GBA+ analysis
- MAP programming
- Collaborative development of funding opportunities (e.g. Health Services Working Group supported funding for suboxone treatment)

According to the Steering Committee and Working Group members, the CHH has also advanced shifts in perspectives, approaches and overall service delivery, including:

- Movement towards innovating new ideas for better health outcomes for individuals experiencing chronic homelessness
- Movement towards greater information sharing
- Greater access to homecare for clients
- Better access to health services on the frontline
- Sector-wide discussions of how to better serve people experiencing homelessness through programs that offer a continuity of care
- Increased focus on meeting the healthcare needs of women (including pregnant women and pregnant women with addictions) experiencing homelessness
- Streamlined advocacy and policy recommendations
- Less duplication of service (greater streamlining);
- Less duplication of funding asks
- Sharing of policies across agencies
- Community mapping
- Increased focus on ACEs as a cause of vulnerability
- Better alignment across the homeless-serving sector
- Creation of the CHH Working Groups and a forum to advance initiatives
- Development of a shared vision and strategic direction
- Creation of awareness
- Reduced feeling of 'working in silos'

In their own words, CHH Steering Committee and Working Group members said things like:

"The collaborative has reduced the feeling of working in silos and as a result has perhaps reduced redundancy in services/initiatives."

"I think CHH was vital in moving the [Homecare] beds forward by bringing the various parties together and strongly endorsing the project. CHH was also instrumental in bringing CCT the needed attention for its first expansion and has been equally so as CCT again seeks to increase services through collaboration."

"Being community-based and driven, with multi-sectoral engagement, makes CHH very unique and well-positioned to respond meaningfully to complex issues in the community, provided needed resources and timelines are provided."

Frontline Staff Perspectives on Accomplishments

The Frontline Staff Survey also asked about perceived accomplishments related to the CHH. While frontline staff may be unaware of the connection between observed changes in the community and the CHH, as a network of agencies working to change conditions for individuals experiencing chronic homelessness in Calgary, the on-the-ground experiences articulated by staff are essential for understanding where the CHH is achieving outcomes or needing greater focus. Of the responses given, the most common identified improvements staff had observed in recent years were:

- Better processes for linking services and creating system integration
- Increased implementation of harm reduction policies and the development of the supervised consumption site
- Coordinated Access and Assessment (CAA) (incl. increasing priority for high-needs homeless individuals and improving accountability from partnering organizations)
- The development and/or expansion of programs/services such as the DOAP Team, Connect to Care and Community Paramedics
- Improved housing options (incl. Housing First approaches, subsidized housing and harm reduction housing)

Only a couple of frontline staff stated that they had not seen any noticeable positive changes in health and housing for individuals with complex and/or chronic experiences of homelessness. One participant also noted the improvement in awareness of complex and chronic experiences of homelessness. In their own words, staff said things like:

"The DI has been collaborating with external organizations more. This has helped to connect institutionalized persons with needed supports and also share the workload associated with housing and support for these people."

"We have become somewhat better at linking services (i.e. health and housing), but we still have a long way to go to achieve integration across services, particularly between those that address the social determinants of health and those that primarily address addiction and mental health."

3.6 Identified Challenges and Impediments to CHH Progress

Collaborative work involving complex issues is a challenging undertaking that can take time and may face setbacks along the way. When asked what may be impeding the progress of the CHH in advancing actions and achieving outcomes, CHH Steering Committee and Working Group members had many thoughtful responses. In total, 34 members provided suggestions, with four indicating they felt unsure about what the impediments to CHH progress may be. The most commonly articulated challenges facing the CHH included:

- Lack of funding, staff
- Lack of accountability or evaluative measures built into action items and/or projects, lack of resources for evaluation of actions
- Different agencies still isolated/siloed
- Competitive funding environment
- Difficulty in defining Steering Committee role
- Lack of clarity around CHH purpose
- Collaborative action is a slow process, people may lose interest
- Lack of time amongst members (e.g. to come to meetings, engage with materials)
- Not all the appropriate agencies/organizations are involved (e.g. perceived lack of justice system involvement/commitment; perceived lack of health system involvement/commitment)
- Level of commitment amongst members (some not committed enough)

Other comments about impediments included:

- Steering Committee endorsement process for projects is too cumbersome and slows project advancement
- Difficulties in knowing how/when to contribute expertise; too much direction or control of projects from CHH
- Too many projects being advanced at once (some duplication occurring); issues with duplication of efforts
- Lack of realistic timelines for actions being pursued
- Failure to value volunteer time and energy from members
- Lack of willingness to take risks
- Difficulty ensuring the right individuals are at the Steering Committee table to advance objectives at an executive level
- Lack of clear direction within working groups; lack of working group member commitment to take on actions
- Disconnect between different working groups and their priorities
- Backbone organization (CHF) focusing on advancing CHF goals/objectives rather than CHH goals/objectives
- Lack of engagement with frontline staff to understand the issue and what solutions will be best
- Too much direction from the backbone to the CHH.

In their own words, members said things like:

"I think going forward, participation in CHH needs to entail meaningful/material support of projects, not just verbal endorsement. Future projects should undergo rigorous process of identifying how members will support a particular project before it proceeds. If it does not require, or members are not willing to, commit their support then that

project should be developed outside of CHH (if at all) and those projects that garner the requisite commitment should be vigorously pursued."

"The work is slow and frustrating, and the folks that I have seen make significant contributions (i.e. Street CCRED initiatives including [Homecare], CCT/PEAR-UP, the memorial project, research, educational projects including electives for health students) are sometimes felt to be undervalued however these are the initiatives that are moving forward towards producing CHH outcomes. We must continue to demand that health and social/human services continue to work together at the policy level."

Frontline staff from CHH member agencies also brought forward on-the-ground challenges and barriers they continue to face when supporting people with complex and/or chronic experiences of homelessness. Many frontline respondents mentioned barriers to housing, including:

- A lack of affordable housing in the community and long waitlists for housing does exist;
- A lack of housing for individuals not assessed as 'high' needs (such as single men and women with low income);
- A lack of mental health, trauma informed and harm reduction housing;
- Limited availability of seniors housing, especially for seniors with medical concerns or who need harm reduction.

Respondents also noted challenges that exist in working with specific populations, including: rough sleeping individuals who avoid services; people with mid- to low-level chronicity/acuity, individuals with ADHD, ASD, brain injury and developmental disabilities; Indigenous individuals leaving their communities; and individuals with comorbid mental health and addictions issues. Some other challenges and barriers mentioned by frontline staff included:

- Stigma and discrimination impacting access to services for more 'difficult' clients
- Limitations to health care coverage for clients
- Lack of communication and follow-up between services working with clients

Staff articulated different strategies they use to 'work around' the challenges they encounter, most prominently advocating on behalf of clients by writing letters of support and trying to influence the system. Another strategy that many frontline respondents suggested was using a client-centered care approach (e.g. collaborating with clients; prioritizing the needs of the client and helping them meet their goals; decreasing system dependence). Other strategies that were highlighted included: collaboration with colleagues and other agencies to share knowledge, troubleshooting and finding creative solutions; offering clients as many options and resources as possible; providing flexible program delivery to accommodate the needs of all individuals (including those who are intoxicated); and informing, educating and raising awareness.

Community stakeholders who were surveyed also articulated some current/ongoing challenges and barriers they felt the CHH faces:

- A need for increased accountability within health systems
- A need for more services for individuals who 'fall through the gaps' of service
- A need for more detox programs
- Gaps in services for victims of domestic violence and sexual exploitation
- Inefficient use of resources and/or duplication in services

Overall, understanding the challenges and barriers highlighted by various stakeholders can help inform CHH actions while also providing a baseline list of challenges against which future CHH progress can be assessed.

4.0 Strengths, Challenges & Learnings

The chart below provides a summary of learnings from the CHH baseline evaluation:

Strengths

- CHH members are seeing the value of undertaking collaborative efforts and have made a strong commitment to advancing the goal and intended outcomes of the CHH
- The CHH has enabled new collaborative relationships to form, is breaking down silos in the homeless-serving community and creating a community of practice across services and systems
- An evaluation framework and baseline evaluation information have been established to enable evaluation of the CHH's progress over time
- Frontline staff are strong advocates for collaborative action
- Outcomes have begun to emerge, including the creation of key services and the advancement of actions recommended by the Calgary Recovery Services Taskforce (the precursor to the CHH)

Challenges and Areas for Growth

- Collective impact takes time, meaning outcomes and evidence of outcomes may emerge slowly
- Continued systemic barriers (including stigma, racism and discrimination) within medical and housing systems, particularly for Indigenous individuals and women
- Perceived inadequacy of resources (e.g. time, financial) to accomplish CHH goals
- The CHH structure needs to reflect the collaborative's intended purpose such that it can best advance action that will contribute to desired outcomes and can ensure accountability is built into CHH projects
- Waitlists for key services (e.g. addictions, psychiatric) and ongoing service gaps; inadequate health care coverage for individuals experiencing chronic and/or complex homelessness (e.g. dental, eye)
- External factors like the opioid epidemic, political change, etc.
- Limited perceived change at the frontline

Learnings and Future Directions

- While collective impact takes time, an important evolution in people's mental models, from individual agencies seeking to create change to a collective approach to community-wide impact has begun, as evidenced by findings from the CHH Collaboration Survey and CHH accomplishments to date
- In the absence of new resources to support collaboratively-led action, the CHH and its members are prioritizing the leveraging of existing resources towards a more efficient and effective system of care.
- Our community is still struggling to provide the best care for Indigenous individuals with complex and/or chronic experiences of homelessness, however recognition of the need to create culturally relevant services and evaluate progress in a culturally responsive way has emerged, resulting in intended movement towards a more inclusive system of care
- In response to a desire to increase the effectiveness of the CHH structures, the CHH Steering Committee and Working Group structures have been revised to ensure alignment with purpose and ongoing effectiveness in advancing actions.
- While collective impact evaluation takes time due to slowly emerging outcomes, a plan for measurement and a baseline for CHH evaluation has been established.

5.0 Conclusions and Future Directions

The CHH is an important collective impact initiative seeking to positively impact the health and housing of individuals in Calgary who are experiencing complex and/or chronic homelessness and the vulnerabilities associated with that experience. Collective impact is a way of tackling society's most complex problems in a multi-dimensional way that engages multiple sectors, systems and stakeholders to create community-wide change. Outcomes from collective impact initiatives, however, often emerge slowly, with process outcomes, such as the establishment of a collaborative culture and the development of sector capacity for collaboration, emerging before community-wide outcomes that affect clients and services.[10]

To ensure thoughtful evaluation of the CHH's collective impact work, in 2018 evaluation experts at Constellation Consulting Group were hired to develop a comprehensive evaluation framework setting out the anticipated methods for understanding the CHH's impact over time. Implementation of this framework in late 2018 has enabled the establishment of a baseline for future comparison and has revealed that the CHH is beginning to move towards the creation of desired outcomes in the community. Specifically, the evaluation has found that the CHH is fostering a climate of collaboration within the homeless system of care that is likely to positively impact the health and housing of chronically homeless individuals over time.

While the baseline information outlined in this report does not represent a 'true baseline' for the CHH (since collaboration has been happening for some time) it is nevertheless essential for understanding movement towards change fostered by the CHH in the long-term. Future comparison against the current findings will ultimately highlight whether the CHH is effectively creating intended positive outcomes and moving towards its stated goal in the long-term.

Overall, the baseline evaluation results suggest that the CHH has made some significant progress towards desired actions and outcomes, with collaborative engagement resulting in the advancement of key initiatives and a culture of collaboration. Leveraging the accomplishments to-date, the CHH has the opportunity to move forward in positive directions. Identified future directions at this time include:

- Ongoing collaboration to advance desired goals and outcomes.
- Work to create culturally relevant services, systems and evaluation methods to work with Indigenous individuals from a place of cultural humility.
- New Steering Committee and Working Group structures to enhance the advancement of action.
- Leveraging of existing resources towards a more efficient and effective system of care.

[10] Preskill, H., Parkhurst, M., & Juster Splansky, J. (2014). *Guide to Evaluating Collective Impact.* FSG and Collective Impact Forum.

Appendix A: Anticipated Results from CHH Collaboration

Process Results:

The **process** of working together as a collaborative is expected to result in three **process results**:

1. Increased connection: Because of the CHH collaborative process, increased connection is expected to develop amongst members, between the CHH and the community, between the CHH and other systems, and amongst community members.
2. Increased coordination: Because of the CHH collaborative process, increased coordination of actions and resources is expected to emerge, increasing efficacy and/or efficiency.
3. Increased emergence of collaborative opportunities: Collaborative opportunities for knowledge sharing and action, both large and small, are expected to emerge as a result of CHH collaborative processes.

Outcomes from Action:

The **anticipated outcomes** from CHH collaborative **action** include:

4. Increased choice and access to health and housing services for people with complex and/or chronic experiences of homelessness.
5. Maintained or improved health amongst people with complex and/or chronic experiences of homelessness, in shelter or newly housed. *Based on movement towards outcome #1 (above) this outcome is expected to emerge over time.*
6. Increased availability of services and supports that are culturally responsive for Indigenous peoples with complex and/or chronic experiences of homelessness.
7. Increased choice and access to culturally responsive services for Indigenous peoples with complex and/or chronic experiences of homelessness. *Based on movement towards outcome #3 (above) this outcome is expected to emerge over time.*
8. Maintained or improved health amongst Indigenous peoples with complex and/or chronic experiences of homelessness. *Based on movement towards outcomes #3 and 4 (above) this outcome is expected to emerge over time.*
9. Increased availability of gender-responsive services and supports for women and children with complex and/or chronic experiences of homelessness.
10. Increased choice and access to gender-responsive services for women and children with complex and/or chronic experiences of homelessness. *Based on movement towards outcome #6 (above) this outcome is expected to emerge over time.*
11. Maintained or improved health amongst women and children with complex and/or chronic experiences of homelessness. *Based on movement towards outcomes #6 and #7 (above) this outcome is expected to emerge over time.*
12. Increased or maintained collaboration amongst services and systems at the intersection of health, housing and complex and/or chronic homelessness.
13. Increased choice and access to a continuum of services (including harm reduction services) to support health and wellbeing amongst people with complex and/or chronic experiences of homelessness who actively use substances.

Appendix B: CHH Collaboration and Frontline Staff Survey Participant Affiliations

CHH Collaboration Survey respondents represented 21 agencies involved with the CHH, either on the Steering Committee or through a CHH Working Group, including:

- Alberta Health Services
- The Alex
- Alpha House
- The Calgary Homeless Foundation
- The Calgary Immigrant Women's Association (CIWA)
- The Calgary Police Service
- The Calgary Women's Centre
- The City of Calgary
- Closer to Home
- CUPS
- Discovery House
- The Drop In Centre
- Elizabeth Fry Society
- The Government of Alberta
- HIV Community Link
- Inn from the Cold
- The Mustard Seed
- Sonshine
- The University of Calgary
- YWCA Calgary

CHH Frontline Staff Survey respondents represented five agencies involved with the CHH, including:

- The Calgary Homeless Foundation
- CUPS
- The Drop In Centre
- Elizabeth Fry Society
- HIV Community Link

Appendix C: Detailed Survey Results

Steering Committee and Working Group Collaboration Survey Results:

Collaboration Factor: History of collaboration or cooperation in the community

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree	Don't Know
Both (N:40)	13%	55%	10%	20%	0%	3%
Steering Committee (N:14)	7%	64%	7%	14%	0%	7%
Working Group (N:26)	15%	50%	12%	23%	0%	0%

Collaboration Factor: Unique purpose

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree	Don't Know
Both (N:40)	60%	38%	3%	0%	0%	0%
Steering Committee (N:14)	36%	64%	0%	0%	0%	0%
Working Group (N:26)	73%	23%	4%	0%	0%	0%

Collaboration Factor: Established informal relationships and communication links

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree	Don't Know
Both (N:40)	50%	48%	3%	0%	0%	0%
Steering Committee (N:14)	29%	71%	0%	0%	0%	0%
Working Group (N:26)	62%	35%	4%	0%	0%	0%

Collaboration Factor: Sufficient funds, staff, materials and time

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree	Don't Know
Both (N:40)	8%	18%	35%	33%	0%	8%
Steering Committee (N:14)	7%	21%	21%	50%	0%	0%
Working Group (N:26)	8%	15%	42%	23%	0%	12%

Collaboration Factor: Members see collaboration as in their self-interest

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree	Don't Know
Both (N:40)	20%	45%	23%	8%	0%	5%
Steering Committee (N:14)	21%	43%	29%	7%	0%	0%
Working Group (N:26)	19%	46%	19%	8%	0%	8%

Collaboration Factor: Open and frequent communication

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree	Don't Know
Both (N:40)	20%	58%	13%	5%	3%	3%
Steering Committee (N:14)	7%	50%	29%	0%	7%	7%
Working Group (N:26)	27%	62%	4%	8%	0%	0%

Collaboration Factor: Mutual respect, understanding and trust

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree	Don't Know
Both (N:39)	8%	44%	28%	10%	5%	5%
Steering Committee (N:13)	8%	38%	23%	15%	8%	8%
Working Group (N:26)	8%	46%	31%	8%	4%	4%

Collaboration Factor: Members share a stake in both process and outcome

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree	Don't Know
Both (N:40)	13%	48%	18%	15%	5%	3%
Steering Committee (N:14)	7%	36%	29%	21%	7%	0%
Working Group (N:26)	15%	54%	12%	12%	4%	4%

Collaboration Factor: Shared vision

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree	Don't Know
Both (N:40)	13%	50%	28%	5%	0%	5%
Steering Committee (N:14)	14%	29%	43%	7%	0%	7%
Working Group (N:26)	12%	62%	19%	4%	0%	4%

Collaboration Factor: Skilled leadership

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree	Don't Know
Both (N:40)	5%	45%	28%	10%	10%	3%
Steering Committee (N:14)	0%	43%	43%	7%	7%	0%
Working Group (N:26)	8%	46%	19%	12%	12%	4%

Collaboration Factor: Multiple layers of participation

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree	Don't Know
Both (N:40)	13%	55%	17%	10%	1%	5%
Steering Committee (N:14)	11%	47%	22%	14%	3%	3%

Working Group (N:26)	14%	60%	13%	8%	0%	6%

Outcome: Increased choice and access to health and housing services for people with complex and/or chronic experiences of homelessness.

As a collaborative I believe we have reduced the number of health and housing service gaps for those with complex and/or chronic experiences of homeless in Calgary

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree	Don't Know
Both (N:40)	5%	33%	43%	13%	0%	8%
Steering Committee (N:14)	0%	29%	43%	21%	0%	7%
Working Group (N:26)	8%	35%	42%	8%	0%	8%

I believe people with complex and/or chronic experiences of homeless have better access to health and housing services as a result of the work of the CHH

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree	Don't Know
Both (N:40)	5%	35%	33%	13%	3%	13%
Steering Committee (N:14)	0%	36%	29%	21%	7%	7%
Working Group	8%	35%	35%	8%	0%	15%

Outcome: Maintained or improved health amongst people with complex and/or chronic experiences of homelessness, in shelter or newly housed.

I believe people with complex and/or chronic experiences of homeless have improved health as a result of the work of the CHH

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree	Don't Know
Both (N:40)	3%	30%	43%	10%	3%	13%
Steering Committee (N:14)	0%	29%	36%	21%	7%	7%
Working Group (N:26)	4%	31%	46%	4%	0%	15%

Outcome: Increased availability of services and supports that are culturally responsive for Indigenous peoples with complex and/or chronic experiences of homelessness.

Organizations within the homeless-serving system are implementing culturally responsive services for Indigenous peoples.

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree	Don't Know
Both (N:40)	5%	38%	33%	8%	5%	13%
Steering Committee (N:14)	0%	29%	29%	21%	7%	14%
Working Group (N:26)	8%	42%	35%	0%	4%	12%

Outcome: Increased availability of gender-responsive services and supports for women and children with complex

and/or chronic experiences of homelessness.

Organizations within the homeless-serving system are implementing gender-responsive services for women.

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree	Don't Know
Both (N:40)	5%	48%	30%	10%	0%	8%
Steering Committee (N:14)	7%	50%	29%	7%	0%	7%
Working Group (N:26)	4%	46%	31%	12%	0%	8%

Outcome: Increased or maintained collaboration amongst services and systems at the intersection of health, housing and complex and/or chronic homelessness.

My involvement in the CHH has helped me learn more about what my colleagues are working on and ways I can support their work

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree	Don't Know
Both (N:40)	33%	53%	13%	3%	0%	0%
Steering Committee (N:14)	43%	50%	7%	0%	0%	0%
Working Group (N:26)	27%	54%	15%	4%	0%	0%

I believe cross-sector collaboration is happening to a greater degree because of the CHH

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree	Don't Know
Both (N:40)	25%	53%	15%	5%	0%	3%
Steering Committee (N:14)	7%	57%	29%	7%	0%	0%
Working Group (N:26)	35%	50%	8%	4%	0%	4%

I believe systems (such as health systems like Alberta Health Services) are improving with respect to health and housing because of the work of the CHH (e.g. better connections, more efficient processes, new processes)

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree	Don't Know
Both (N:40)	18%	53%	15%	5%	0%	10%
Steering Committee (N:14)	21%	57%	14%	0%	0%	7%
Working Group (N:26)	15%	50%	15%	8%	0%	12%

Outcome: Increased choice and access to a continuum of services (including harm reduction services) to support health and wellbeing amongst people with complex and/or chronic experiences of homelessness who actively use substances.

There is a continuum of services within the homeless-serving system to support the health and wellbeing of those actively using substances (e.g. harm reduction services).

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree	Don't Know

Both (N:40)	8%	70%	13%	8%	0%	3%
Steering Committee (N:14)	0%	79%	7%	14%	0%	0%
Working Group (N:26)	12%	65%	15%	4%	0%	4%

Overall movement towards outcomes:

In your view, how much has CHH contributed to community-wide change?

	A lot	Somewhat	A Little	Not At All
Both (N:38)	8%	71%	21%	0%
Steering Committee (N:14)	7%	64%	29%	0%
Working Group (N:24)	8%	75%	17%	0%

Frontline Staff Survey Results

I have observed that organizations serving homeless individuals in Calgary are implementing culturally responsive services for Indigenous peoples

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree
Frontline Staff (N:21)	5%	43%	43%	5%	5%

I have observed that organizations serving homeless individuals in Calgary are implementing gender-responsive services for women

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree
Frontline Staff (N:21)	0%	67%	24%	10%	0%

In Calgary, there is a continuum of services to support the health and wellbeing of homeless individuals actively using substances (e.g. harm reduction services)

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree
Frontline Staff (N:21)	14%	52%	24%	10%	0%

Recently, I've observed that people with complex and/or chronic experiences of homeless have better access to health services

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree
Frontline Staff (N:21)	0%	14%	33%	43%	10%

Recently, I've observed that people with complex and/or chronic experiences of homelessness have better access to housing services

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree
Frontline Staff (N:21)	5%	33%	19%	43%	0%

Recently, I've observed that people with complex and/or chronic experiences of homelessness have better health

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree
Frontline Staff (N:21)	5%	5%	19%	57%	14%

CHF Housing First Sample Move-In Survey Results (October 1, 2017 to September 30, 2018; N=383):

Do you have an ongoing mental health condition?

	All	Female	Indigenous
Yes - Treated	23%	27%	22%
Yes – Untreated	13%	9%	14%
Yes – Both treated and untreated	29%	30%	22%
No	31%	30%	37%
Don't know	3%	4%	3%
Declined to answer	1%	1%	1%
No response provided	0%	0%	1%

Do you have an ongoing physical health condition?

	All	Female	Indigenous
Yes - Treated	20%	16%	14%
Yes – Untreated	11%	11%	14%
Yes – Both treated and untreated	31%	24%	28%
No	36%	46%	42%
Don't know	2%	2%	0%
Declined to answer	1%	1%	1%
No response provided	0%	0%	1%

Do you have an addictions/substance abuse issue?

	All	Female	Indigenous
Yes - Treated	24%	26%	22%
Yes – Untreated	26%	17%	29%
Yes – Both treated and untreated	22%	17%	21%
No	27%	39%	26%
Don't know	0%	0%	0%

Declined to answer	1%	1%	1%
No response provided	0%	0%	1%

Have you had any involvement with the health system in the past 12 months while you were homeless?

	All	Female	Indigenous
Yes	66%	58%	62%
No	31%	40%	34%
Don't know	2%	1%	1%
Declined to answer	2%	1%	3%
No response provided	1%	1%	1%