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BRINGING IT ALL TOGETHER: INTEGRATING SERVICES TO ADDRESS HOMELESSNESS

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SUMMARY

In Canada, approximately $27 billion is spent annually to fund services that deal with homelessness, including the related issues of poverty, mental illness, addiction, domestic violence, poor health and childhood trauma. Another $6.5 billion annually is spent on social assistance programs, health care, and the police and justice systems when their roles intersect with homelessness. Thus, $33.5 billion is spent each year on an array of 167,000 fragmented services provided by both government and non-profit organizations across the country. Ontario alone has some 60,000 social and community services in operation, while Alberta has 20,000. There must be a better, more cost-effective way to achieve results through co-ordinating this confusing jumble of services.

Integrating services for cost-effectiveness and streamlining to clients must be done properly or it risks simply adding more layers of bureaucracy. When considering how best to integrate and consolidate services, the focus must remain on the clients and not on the systems involved. Nor does integration necessarily equate to more positive outcomes. Integration should not be considered a cure-all for what ails the system; rather, it would be more realistic to take a transformative and deliberate approach to collaboration and change. This paper examines methods and proposes tenets by which services can be integrated, yet still deliver efficient and effective assistance to homeless Canadians.

Moving towards integration entails examination of the primary objective, the systems involved, the target population of clients, development of an integration strategy and activities, a timeline, a list of participant organizations, regional scope and client impact, to name a few of the variables. The idea is to develop mechanisms to share, link and leverage the various stakeholders' realms more strategically. The work requires co-operation and co-ordination among organizations that may have different commitments and thinking, with the aim of creating mutual trust and effective relationships.

The best way to think about integration is to picture a network and nodes of activity, interests, people and resources as being parts of all the systems that provide services to the homeless. The key then is to focus on which nodes offer clients the best outcomes. These nodes include social services, education, justice, housing, health, children's services and income supports.

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The cost to end homelessness has been estimated at $3.8 billion a year. Unfortunately, no clear line of sight exists between the $33.5 billion annual investment and the current client and population outcomes. The array of resources needs to be sorted out and integrated where deemed beneficial, to create maximum impact and value for Canadians. Amalgamation may be the answer in some cases, but so too may be the shutting down of some services whose roles are blurry or poorly defined. In the end, integration will not be about cutting back on funding, but rather using the existing funding more wisely, strategically and transparently.

Integration is so much more than piecemeal strategies aimed at repairing a broken system; it is a full-scale transformation of that system. The work needs to begin.

INTRODUCTION

Complex social issues like homelessness, domestic violence and poverty are cross-cutting whether we consider them through the lens of a government jurisdiction, department or service delivery approach. One of the oft-cited root causes behind the persistence of such social issues – despite significant investments and efforts to address them – is the lack of integration among stakeholders, policies, government, community members, agencies and other service providers (Mental Health Commission, 2011). The poor, the homeless, the mentally ill and other marginalized people are the victims of "gaps in the social safety net": they "fall through the cracks". While not the sole factor in these dynamics, the way the network of services and organizations relate to one another (or fail to) indeed impacts their cumulative effect on these issues.

Integration is a concept that refers to individuals, groups, organizations, etc. working together more effectively towards common objectives. Admittedly, understanding how integration differs from collaboration or co-ordination in practice is muddy despite attempts at defining these terms in literature.

Defining what successful integration is and is not is further complicated: does enhanced integration lead to increased individual or population-level positive outcomes? In fact, there is evidence that puts into question the entire assumption that integration automatically equals positive change (Morse, 2017a). There are instances where integration efforts seem to have the exact opposite effect on system efficiency and cost, and importantly, client outcomes (Centre for Health Economics, 2014; HC Health Committee, 2014; Local Government Association, 2013; Nuffield Trust, 2013; RAND Europe, 2012).

To shed light on these issues, this paper will provide a discussion on systems integration efforts related to homelessness. This paper will be particularly relevant to integration efforts among multiple large systems aiming to achieve a co-ordinated enterprise. As a foundational document, it will discuss key considerations of when and how integration can be a useful approach to addressing complex social issues such as homelessness.

We present analysis on the tens of thousands of services involved from government and non-profits in addressing homelessness, noting the potential benefits of leveraging the $33.5 billion annual investment for better impact. Our conclusions suggest that while efforts to enhance integration remain important, they are not a silver bullet to homelessness. In light of these considerations, we propose a framework through which decisions about integration can be considered to maximize the desired impact.

DEFINING INTEGRATION

Overview and Approach

Homelessness is an apt example of individuals interacting with varying organizational levels of government and non-profit stakeholders involved in the delivery of health, income assistance, shelter, corrections and child intervention services (to name a few). Where diverse services are aligned to support the client, benefits are realized – as demonstrated by positive client outcomes and cost savings gained through Housing First interventions for corrections and health (Calgary Homeless Foundation, 2014; Culhane, 2008; Ly and Latimer, 2015). Alternatively, the lack of access to appropriate services and benefits can contribute to client

instability, which is further associated with higher interactions of health, corrections, child intervention, income assistance and shelters (Culhane et al., 2002; Eberle, Kraus, Pomeroy et al., 2001; Gladwell, 2006; Richter, 2008).

The fragmentation and duplication of supports and services, complicated by confusing and ever-changing criteria, make access to the right help at the right time one of the most cited examples of systems failures by those with lived experience, service providers, researchers and policy-makers. This fragmentation is evident at the service, organizational, funding and policy levels and in turn contributes to inequities and poor social outcomes.

Not surprisingly, the drive to discern order from this complicated network of services has in part spurred the push towards integration. To this end, this section synthesizes the literature on integration to discern definitions and characteristics that can be applied to homelessness further.

The academic literature review search began with a review of the common databases that would normally include articles on the intersection of issues focused on integration perspective: PsychInfo, Medline, SocIndex, Urban Studies Abstracts, Family & Society Studies Worldwide, Academic Search Premier. Terms used included "homeless"*, "housing", "substance abuse", "substance use", "addiction", "discharge system use" *, "complex clients/patients", "child welfare", "criminal justice", "education, combined with integration", * co-ordination, system"* (* denotes variations of the word) to examine these databases. The result generated approximately 50 sources of particular relevance to develop the literature review that served as the basis for this discussion paper.

Emergence of Integration Literature

As noted above, the notion of integration is essentially about working together in various ways to improve results (Corbett and Noyes, 2008a; Gold and Dragicevic, 2013a; Grdisa, 2009a; Konrad, 1996a; Nelson, Sylvestre, Aubry et al., 2007; Mays, Scutchfield, Bhandari and Smith, 2010). Integration as a discourse in public policy and academic literature gained popularity during the 1960s and 1970s, particularly in the U.S., on the heels of structural changes to governmental approaches to service delivery and the emergence of non-profit organizations as contracted delivery agents on the state's behalf (Randolph, 1995a; Rowe, Hoge and Fisk, 1998a).

A similar trend is seen in Canada, where it coincided with increasing fragmentation of support services contracted by diverse government levels and departments with overlapping yet complicated objectives and procedural expectations (Hulchanski, Campsie, Chau, Hwang and Paradis, 2009). In this context, integration was proposed as a solution to enhance a continuum of care by "establishing linkages with agencies within a system and across multiple systems to facilitate the provision of services at the local level" (Randolph, 1995b, 2). The assumption was that integration at the service provider level would lead to better client outcomes and improved cost-effectiveness in delivery (Rowe et al., 1998b).

Differentiating Integration

Considerable efforts have been made to taxonomize aspects of integration. In fact, much of the academic literature on the topic concentrated on presenting various ways of assessing the intensity, type, strategy or level of integration at play as a general working framework for analysis. For instance, Ellen Konrad (1996b) discusses the continuum of integration moving

from fragmentation of service delivery by autonomous agencies toward full integration where services are consolidated under one umbrella organization's leadership.

Konrad describes the various levels of integration across key dimensions further along a continuum ranging from informal to the formal levels of integration intensity – as illustrated in Figure 1. This would imply that integration is something much more intentional than collaboration or even consolidation: it suggests the immersion of diverse services into a new model entirely.

FIGURE 1 INTENSITY OF INTEGRATION (ADAPTED FROM KONRAD, 1996C)

Konrad's continuum ends in integration under a single authority overseeing a system that is:

- Comprehensive in scope, operates collectively, addresses client needs in an individualized fashion, and is multipurpose and cross-cutting.
- Categorical lines are transparent, activities are fully blended and funding is pooled.
- Eligibility requirements for all services are simple and uniform.
- Clients' problems are treated as a whole and individuals are treated as part of family and community systems (Konrad, 1996d, 11).

Rowe et al., (1998c) also write about the value of "street-level integration" delivered directly to clients by networks of outreach case managers who are able to effectively engage with complex, vulnerable groups, push boundaries to meet their needs, and develop networks with other providers across systems to improve client outcomes. In this manner, street-level work can produce both service and systems integration.

Assessing Integration Levels and Dimensions

Gina Browne et al., (2007a) outlined a typology of integration at multiple levels addressing the concepts of structure, process and outcome in evaluation through their work on integrated human service organizations. The various dimensions of human service network integration were conceptualized as follows:

1. Observed **structural inputs**, or the mix of organizations that comprise the service network (e.g., extent, scope, depth, congruence within an organization and reciprocity among organizations);

2. **Functioning of the network** both in terms of the quality of the network or partnership functioning and ingredients of the integration of the networks' working arrangements and range of human services provided;

3. **Network outputs** in terms of network capacity (e.g., what is accomplished, for how many and how quickly, given the local demand) measured from dual perspectives of the agency and the family (Browne et al., 2007b, 4-5).

Here, a much more comprehensive understanding of integration at the front-line service delivery level is presented, with quality and impact measures and standards proposed from the perspectives of funders, service providers and population served. The notion presented is that of an integrated network of supports made up of key component parts delivering services as part of a functioning whole wrapped around the needs of the individual or family.

Valerie Grdisa (2009b) ventured further to discern the varying dimensions at which integration can occur at multiple levels: within or among teams, organizations, sectors, regional levels and systems. This points to the need to understand integration initiatives from various vantage points, rather than solely focusing on the service network levels under the premise that the full context requires careful consideration, given interconnections among components and organization levels at play. Grdisa suggests four main dimensions for consideration in any integration efforts:

- *Structure* refers to the nature, patterns and relations of entities such as individuals, teams, service or community support providers, educators, regional programs or systems.
- *Process* refers to the procedures, activities, methods and actions that entities such as individuals, teams, service or community support providers, educators, regional programs or systems implement for service provision.
- *Leadership* refers to a process of social influence to engage, organize and motivate others at multiple levels to accomplish common goals or responsibilities and meet expected outcomes/outputs.
- *Collaboration* refers to the interpersonal process by which two or more individuals work together to solve a problem or deliver services (Grdisa, 2009c, 9)

Specifically related to homelessness, Burt et al., for Housing and Urban Development (2000a) published an evaluation of homeless-serving systems in the U.S., which examined how successful integration could be achieved particularly in relation to the health, justice and child welfare systems. Findings indicate the integration of the homeless-serving system with these systems was most effective when the following strategies were applied: common policies and protocols, shared information, co-ordinated service delivery and training. The report recommends a number of elements for successful integration:

- Having staff with the responsibility to promote systems/service integration;
- Creating a local interagency co-ordinating body;
- Having a centralized authority for the homeless assistance system;
- Co-locating mainstream services within homeless-specific agencies and programs;
- Adopting and using an interagency management information system (Burt et al., 2000b, 73).

More specific analysis has also been undertaken to analyze the point of discharge from public systems into the homeless-serving system as a key opportunity for integration efforts (Backer, Howard and Moran, 2007; Barr, 1999; Christ and Hayden, 1989; Conly, 1999; Harrison et al., 2008). In a sense, discharge planning can be construed as a form of system integration specific to the transition of clients of one service delivery system to another. Key service systems identified to have considerable intersection with homeless services include addictions, mental health, hospitals, child intervention, jails and prisons (Baron et al., 2008; Kertesz et al., 2009; Moss et al., 2002; Sun, 2012).

Assessing the Impact of Integration

As empirical and experiential evidence from front-line integration efforts around homelessness emerged, researchers suggested that service integration closest to the front-line interaction with the client was correlated to improved client outcomes (Greenberg and Rosenheck, 2010a; Hambrick and Rog, 2000a; Mares, Greenberg and Rosenheck, 2008a). The implication here was that even if a high intensity of integration was achieved at policy levels, it was not until this was present among front-line supports interacting with the target population that positive outcomes for those being served were realized:

> High levels of provider integration do not necessarily result in high levels of user integration or vice versa. User integration requires that clients experience a seamless system of care and that may not occur even with high levels of provider integration (Flatau et al., 2013a, 17).

These studies suggested that service co-ordination closest to the individual served is more effective than broader top-down structural integration measures in terms of housing and health outcomes (Hambrick and Rog, 2000b). For integration efforts to be successful for the individual and population served, strategies must be aligned to this goal. This does not suggest that structural measures at the organizational or policy levels are not important, but rather that we ensure a clear line of sight to positive client-level results. This emerges in papers by Greenberg and Rosenheck (2010b), Mares, Greenberg and Rosenheck (2008b) and Flatau et al., (2013b).

Further, any integration initiative is limited in its impact by the broader social context in which it operates. For instance, one cannot expect a collaborative service delivery model targeted on complex clients in one locality to overcome structural issues like systemic poverty, lack

of affordable housing or discrimination (Boardman, 2006; Gordon, 2007). Building on this layered approach, integration strategies presented by Evans et al., (2011, 30) were further nuanced and articulated at various service and organizational levels to better discern which and in what combination and context these resulted in positive client and system outcomes.

In a landmark study, Flatau et al., (2013c) delved deeper into service integration at the front-line staff levels in the homeless, mental health and addictions sectors to discern approaches that maximized impact for dual-diagnosis chronically homeless clients in Australia. Their analysis proposed the following integration strategies between the health and homeless-serving systems to improve complex client outcomes:

TABLE 1 HEALTH & HOMELESSNESS INTEGRATION STRATEGIES FOR COMPLEX CLIENTS (FROM FLATAU ET AL., 2013D)

Streamlined assessments
• Single entry point, or multiple entry points linked to efficient referral system • Assessments that follow a client through the system • Multi-disciplinary assessments; for example, psychologist and psychiatrist assessing a client together • Formal arrangements (e.g., MOUs) for the acceptance of assessments from referring agencies; for example, suicide risk
Facilitated referrals
• On-the-spot referrals in the client's presence • Transporting clients to referrals (predominantly between agencies but also walking a client from one service to another within an agency) • Attending initial appointments with clients (particularly within mainstream health settings) • Preparing the client about the referral (e.g., assessment processes of service being referred to, reason for referral) and following up with the client afterwards regarding the referral's outcome • Negotiating the referral on behalf of the client; minimally, this involves researching referral options and establishing the eligibility criteria and assessment processes with services before referring a client • Assertive referral of clients back to the referring agency at the end of an episode of care (e.g., post-treatment care plans, discharge summaries)
Case review and supervision
• Secondary consultation to staff from outside own area of expertise • Regular case/clinical review meetings involving multi-disciplinary or multi-sectoral staff (e.g., mental health clinician attending the weekly case review meeting of homelessness support workers) • Seeking advice from others, including consulting with expert partners within a partnership or consulting with staff from co-located teams or services • Shared knowledge of how to work with a client (e.g., impact of mental health disorder on capacity to engage)
Flexible and supportive governance
• Ability to revise model parameters or approaches based on ongoing assessment of the program/service in meeting the target population's needs • Management support staff to undertake their role in such a way that enables them to meet client needs (e.g., flexible work hours to accommodate after-hours support for clients)
Relationships and communication
• Developing knowledge within the team, including the exchange of knowledge from one sector to another • Developing awareness and understanding of client need and service/program objectives across sectors or specialty areas • Two-way accountability of relationships • Collaborative approach to working with others (involves trust and respect among partners) • Division of roles within a partnership to avoid ethical conflicts (e.g., housing support versus tenancy management) • Multiple mechanisms for communication including formal meetings, electronic information exchange and informal as-needed conversations • Established protocols for the protection of client privacy and shared understanding of confidentiality

Staffing
• Recruitment of the "right kind" of people – committed, passionate, genuine • Low staff turnover • Adequate staffing for the workload • Expertise and experience built up over time, including established relationships and knowledge of the broader service landscape
Model integrity
• Alignment of values and philosophies among partner agencies • Intensity of integration mapped to complexity of client need • Clearly articulated goals for the partnership • Governance structure including mechanisms for resolving conflicts • Shared approach to working with clients (e.g., adoption of a particular case management model or therapeutic approach) • Linkages appropriate for the physical location of services, e.g., on-site clinics, satellite sites, co-location of services

Flatau et al.'s findings (2013e) echo those of other authors calling for increased focus on service-level integration to address homelessness (Cornes et al., 2014; Fisher and Elnitsky, 2012; Guerrero and Wenzel, 2014). As integration has gained momentum in public policy and practice networks, an enhanced focus has emerged on case study examples and learning.

In a comprehensive review of integration at various organizational levels and diverse issues related to the human services sector, KPMG (2013a) builds on various typologies on integration levels to develop a business case for support, or "integration imperative". The report goes on to suggest a number of benefits at the system (government/non-profits primarily) and client levels.

TABLE 2 INTEGRATION IMPERATIVE (KPMG, 2013B)

System Benefits	Client Benefits
Increased capacity and value for money, reduction in duplicated administrative processes Improved strategic planning and system integrity, sharing of information between different agencies and program areas Swifter and more co-ordinated assistance can help stabilize clients' conditions, limit need for high-cost crisis interventions (e.g., ER)	Simplified, co-ordinated access to supports and services Holistic, person-centred supports Faster response time Improved outcomes and user experience

Integration at Work

Corbett and Noyes (2008b) looked at what constitutes integration. Building on lessons learned from the field, the authors conclude that although it is not possible to create one all-encompassing definition of the concept, it is possible to develop an overarching, conceptual framework for understanding and analyzing the essential process involved in such efforts to simplify and transform the service experience of target populations. Their paper identifies the heterogeneity that exists across these efforts and from it develops a set of organizing principles and constructs for planning a service integration initiative. First, it elaborates on two key dimensions – relationship intensity and institutional similarity – critical for understanding any particular integration effort. Second, it proposes a strategy for framing integration efforts based on these two dimensions. Third, it considers the implications of this framework for developing an integration agenda. Finally, it identifies the basic components of all integration efforts within the context of a dynamic, rather than a static, operating environment.

The Mowat Centre and their Integration Imperative report (Gold and Dragicevic, 2013b) presents the results of a global survey undertaken to review active integration schemes across 22 jurisdictions. The authors spoke directly to the government leaders spearheading these

initiatives as well as a number of thought leaders. Drawing upon their valuable experience, the report examines the characteristics of current integration initiatives: the main drivers, types of integration, key enablers and conditions necessary for reforms to succeed. It also identifies where the integration agenda is heading: the key trends in the trajectory of integrated services provision (client pathways, focus on outcomes, inter-governmental integration, inter-sectoral integration and place-based integration), the lessons that early movers offer, and the implications of these trends for governments, clients and providers from the private and not-for-profit sectors.

Focusing on homelessness, Smelson et al., (2016) conducted a pilot study to examine the feasibility and preliminary outcomes of systematically integrating permanent supportive housing and an evidence-based co-occurring disorders intervention called Maintaining Independence and Sobriety Through Systems Integration, Outreach and Networking (MISSION). The results show overall retention was high, with 86 per cent remaining in MISSION treatment until the end of the study. While there were no significant changes in re-hospitalization, service utilization or substance use, there were modest significant mental health symptom improvements from baseline to program completion. The findings suggest that co-occurring disorder interventions like MISSION are feasible to integrate with permanent supportive housing, despite the somewhat differing philosophies. Preliminary data suggested substantial improvements in housing and modest improvements in mental health symptoms. While caution is warranted given the lack of a comparison group, these findings are consistent with other rigorous studies using MISSION among homeless individuals who did not receive permanent supportive housing.

THE CALGARY CASE STUDY

Despite the diverse understandings of integration in the literature, the concept has spurred considerable activity across Canadian communities struggling to respond to homelessness, including Calgary. Various task forces, committees, pilot programs, etc., have emerged in recent years in Calgary to address complex social issues as a means of improving system efficiency and client or population-level outcomes. Non-profit and government funders expect that service providers work together in effective ways, and these expectations are reflected in calls for proposals, funding contracts and performance monitoring.

No Shortage of Services and No Shortage of Confusion

By no means unique, Calgary is home to a dizzying array of social services. While no accurate assessment exists, the City of Calgary Community Services Guide (2018a, 62), is particularly relevant to assess the service landscape available to those at risk of, or experiencing, homelessness. Approximately 100 organizational listings are available; about 10 services or supports per organization are listed ranging from writing resumes or cover letters, to providing meals and shelter. This represents a dizzying number of services (over 1,000) in this guide alone – which is one of eight available on the city's website. While a lot of overlap is very likely, that still puts the Calgary network of services in the thousands (City of Calgary, 2018b, 63). Surely, in this case, integration would be extremely difficult in light of competing interests, organizational approaches and funder expectations.

Not surprisingly, to support complex clients experiencing homelessness, diverse integration initiatives emerged in recent years. In fact, there were 21 such efforts at various levels, as

illustrated in Figure 2. These were not existing services or organizations; rather, they were initiatives specifically developed to address the current fragmentation through integrative strategies. Some of these are described as front-line pilots; others are task forces, committees or networks. They occur at diverse levels in and across organizations and aim in some way to address complex clients or issues related to them, albeit with varying slants and definitions.

The integration initiatives active in the city were concurrent with thousands of services already in place. Of course, the levels or strategies used to achieve integration varied across these efforts and some had a front-line co-ordinated case management focus, while others were internal to a system (health, corrections, etc.). Some were occurring at the front-line or manager levels, while others had a mix of positions and organizations involved.

FIGURE 2 CALGARY COMPLEX CLIENT INITIATIVES

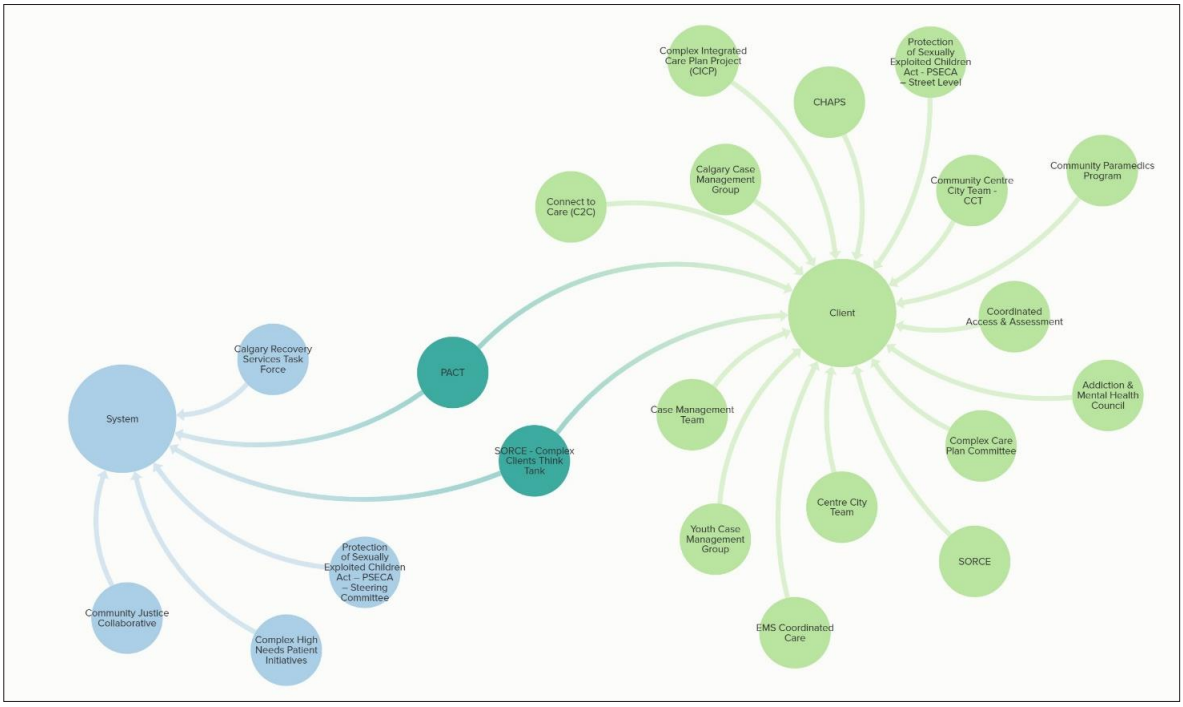


TABLE 3 COMPLEX CLIENT INITIATIVES IN CALGARY OPERATING IN 2016-2017

Initiative Name	Focus	Lead Agency/Group	Operations	Known Focus
1. Addiction & Mental Health Council	Client	Addiction services, AHS-funded agencies	Committee of diverse system and agency partners (executive level)	Complex clients, addictions, mental health, housing instability
2. Calgary Case Management Group	Client	Alpha House	Committee of diverse system and agency partners (front-line)	Complex clients, high EMS, transit, CPS, ER users, homeless
3. Case Management Team	Client	Alberta Health Services	Alberta Health Services staff	Complex clients, health
4. Centre City Team	Client	Emergency Medical Services	Alberta Health Services staff	Complex clients, high system users
5. CHAPS	Client	Emergency Medical Services	Alberta Health Services staff	Complex clients, high EMS users
6. Community Centre City Team - CCT	Client	Emergency Medical Services	Alberta Health Services staff	Complex clients, high health-system users

Initiative Name	Focus	Lead Agency/Group	Operations	Known Focus
7. Community Paramedics Program	Client	Emergency Medical Services	Alberta Health Services staff	Complex clients, high EMS users
8. Complex Care Plan Committee	Client	Alberta Health Services	Alberta Health Services staff	Complex clients, high EMS users
9. Co-ordinated Access & Assessment	Client	Calgary Homeless Foundation	Committee of diverse system and agency partners (manager-level)	Homeless clients (acuity considers system interactions)
10. *Protection of Sexually Exploited Children Act* - PSECA – street level	Client	Youth-serving agencies, child intervention (McMan, BGCC, Hull)	Youth-serving agencies, child intervention services (front-line)	Complex youth clients at risk of/or experiencing sexual exploitation
11. Connect to Care (C2C)	Client	Alpha House/CUPS	Alpha House/CUPS staff	Complex clients, health
12. Complex Integrated Care Plan Project (CICP)	Client	Alberta Health Services	Alberta Health Services staff	Complex clients, health
13. EMS Co-ordinated Care	Client	Alberta Health Services	Alberta Health Services staff	Complex clients, health
14. Youth Case Management Group	Client	Boys & Girls Club, The Alex, City of Calgary	Committee of diverse system and agency partners (front-line)	Complex youth clients
15. SORCE	Client	SORCE	Front-line staff co-located	Complex clients, addictions, mental health, housing instability
16. PACT	Client/ system	Alberta Health Services/ Calgary Police Service	Alberta Health Services/Calgary Police Service staff	Complex clients, CPS, health, homelessness issues
17. SORCE - Complex clients think tank	Client/ system	SORCE	Internal committee	Complex clients, homeless, addiction/mental health, high system users for health, CPS, justice, health
18. Calgary Recovery Services Task Force	System	Various partners (AHS, CHF, agencies, CPS)	Committee of diverse system and agency partners (executive level)	Complex clients, shelter stayers, chronic homeless, addiction/mental health, high system users for health, CPS, justice, health
19. Complex high-needs patient Initiatives	System	Alberta Health Services	Alberta Health Services - policy level	Complex clients, health
20. *Protection of Sexually Exploited Children Act* – PSECA – Steering Committee	System	Youth-serving agencies, child intervention (McMan, BGCC, Hull)	Youth-serving agencies, child intervention services (executive levels)	Complex youth clients at risk of/or experiencing sexual exploitation
21. Community Justice Collaborative	System	Calgary Police Service	Committee of diverse system and agency partners (executive level)	Complex clients (mental health, addictions, justice-involved), high system users

We are not making the case that these efforts are not worthwhile or not effective; we are simply pointing out that at the highest strategic levels, these 21 initiatives were not co-ordinated. It is also unclear how these integration efforts worked to address the complex and fragmented service landscape in the thousands noted above. In fact, there was no assessment evident to understand who did what, to what end, and how they worked with one another and existing services. Without this strategic analysis and direction-setting, good intentions may have inadvertently added yet another layer of organization cum integration that clients, staff and policy-makers need to navigate.

The point is not that these initiatives are not important; rather, that close attention is needed to ensure these efforts are getting the desired outcomes. It also points to a spinning of wheels among the array of already existing services to make sense of them, by adding yet

more complexity. Here again, the initiatives analyzed vary in their intent as well. With respect to system outcomes, some propose to reduce inappropriate system use (for instance, hospitalization or ambulatory care, jail, arrests, shelter stays, etc.), which would result in decreased costs, or at least a more appropriate use of resources. With respect to individual or population outcomes, these depend on the target group or issue, but may be increasing housing stability, improving mental health and wellbeing, increasing income and employment, etc. Again, without clear outcomes it becomes difficult to ascertain the line of sight of these efforts.

The Calgary Case Management Group Example

While difficult to draw a clear connection between these integration activities and client or population outcomes, in some instances this is certainly appropriate. The Calgary Case Management Group (CCMG) was established in 2007 to develop a co-ordinated service delivery response between front-line health, homelessness and corrections to Calgary's highest system users.

Representatives from diverse government and non-profit organizations meet monthly to develop integrated case plans which include housing, access to mental health and addictions supports, medical services, etc. Clients served have extremely complex profiles and evidence from diverse systems is used to assess their levels of interaction with Alberta Health Services, Calgary Police Service, Calgary Transit, etc., as part of the case-planning process. Updates are shared and providers adjust plans in real time, with updates coming back to the CCMG regularly.

In an evaluation supported by the Calgary Homeless Foundation and Alberta Health Services in 2016, AHS analysis of system interaction pre-, during and post-CCMG confirms clients are indeed high system users with corrections, health and homeless systems; further, that after CCMG involvement there is a notable decrease in system use and enhanced housing stability. In conjunction with case studies compiled of 11 clients, service providers on client trajectories provide context to confirm that involvement with CCMG resulted in positive individual outcomes and system benefits (Turner, 2016).

However, the evaluation also points out that the declines in system use may have more to do with the access to housing and supports that CCMG helped facilitate, as opposed to attributing these changes directly to CCMG itself. In other words, CCMG is an effective approach to engaging and connecting very complex clients to services, including housing, which resulted in positive outcomes at the client and system levels. Thus, the Housing First scattered-site and supportive housing interventions, to which CCMG helped clients connect, may be where the individual and system gains were made. This is by no means a critique of CCMG; rather, it clarifies the supporting or facilitative role such service integration approaches play in a broader response that still requires quality front-line case management, affordable and appropriate housing, and connection to treatment, medical and community-based supports long-term.

Housing First as Integration

From this lens, the system-use reductions and housing stabilizations of CCMG clients are consistent with reported Housing First outcomes in Calgary, Alberta and nationally. The basic idea behind Housing First is simple: provide a person experiencing homelessness with housing, and simultaneously offer him or her supports to address other issues that he or she may be facing. Rather than requiring someone to prove their worthiness for housing, such as being sober or getting a job, Housing First considers access to housing as an essential first step to

recovery and inclusion. A main argument reinforcing the approach's value in efforts to address homelessness relies on proving cost savings realized. Numerous studies have provided evidence whereby Housing First interventions are considerably more cost-efficient than relying on emergency responses (Turner, 2014).

Around 2006 many working in the homelessness sector began hearing about the concept of a 10-year plan to end homelessness and the success these plans were having in many communities in the United States. One of the components was the importance of integrating a Housing First systems approach into the plan and to adopt Housing First as a core philosophy guiding the success of the plan's approach. Housing First was then delivered through a number of programs targeting priority populations.

The outcomes of the application of Housing First in Calgary are impressive. For example, in 2016/2017, the Calgary Homeless Foundation reported 8,482 people had been housed over eight years (Calgary Homeless Foundation, 2017a, 8). The success of the Housing First programs contributed to a 26 per cent per capita reduction in people experiencing homelessness in 2017 compared with 2008 (Calgary Homeless Foundation, 2018).

In many ways, Housing First is an apt example of effective integration in practice. As a programmatic response, Housing First in its purest form refers to services targeting single men and women experiencing chronic homelessness with co-current mental health and addiction diagnoses who have lived in absolute homelessness for very long periods of time. The program uses rent subsidies to place individuals in market housing, and then a team of clinicians — including psychiatrists, doctors, social workers, occupational therapists and social-integration experts — assists them in addressing the underlying issues that put them at risk of losing housing in the first place (Alberta Human Services, 2012; Gaetz, 2014; Schiff and Turner, 2014; Tsemberis, Gulcur and Nakae, 2004). The tailoring of Housing First programs to youth, families and women fleeing domestic violence is an ongoing endeavour that is broadening the scope beyond this initial target group.

Since 2008, Calgary's homeless-serving system of care and the individuals who are committed to a shared vision of ending homelessness have housed over 9,500 individuals and added over 500 permanent supportive housing units to the sector – while maintaining a client/resident housing stability rate of 92 per cent.

A recent study from the Calgary Homeless Foundation investigates the impact of supportive housing programs on public service utilization for people experiencing homelessness. CHF employed data on 2,621 clients placed in supportive housing programs between 2012 to 2015 fiscal years, and assessed the interaction of each client with health and justice systems before and after joining the programs.

The following health-system utilization reductions are noted:

TABLE 4 CALGARY HOMELESS FOUNDATION PROGRAM IMPACT ON SYSTEM USE 2012-2015 (N=2,621)

	First 3 months	45 Months
Hospital days	-64%	-64%
Hospital times	-16%	-30%
Emergency room times	-7%	-22%
EMS times	1%	-14%

(Calgary Homeless Foundation, 2017b)

Increasingly, Housing First has become intimately tied to broader ending-homelessness movements in the U.S., Europe and Canada. In Calgary, and Alberta's other six cities, Housing First is a core principle in the local plan to end homelessness, which lays the foundation for an integrated community response to the issue. Here, the connection between front-line client-level integration in service delivery is made to public policy co-ordination to support the objectives of preventing and ending homelessness, as well as systems integration around discharge planning, strategic resource allocation and information sharing (Calgary Homeless Foundation, 2015).

Considering these results, the integration activities may indeed be part of this broader community mobilization around shared goals. Yet some critical questions remain unanswered:

- Can a clear line of sight to improved client outcomes be drawn from these initiatives?
- Is this the best way to get to the desired outcome?
- What would investing resources in front-line client level support achieve compared to the integration initiative?
- What are potential negative effects of the integration effort in a particular case, or related to one another and the broader system?
- When is integration not desirable, ethical or appropriate?

CHALLENGING INTEGRATION

It is important to consistently probe the assumption that integration will increase efficiency and reduce costs, which in turn will create better individual and population-level outcomes. While this assumption might pass as valuable at first glance, we cannot assume integration strategies will automatically improve efficiency for government or non-profit organizations; second, we cannot assume that more integration equals better outcomes for clients or populations; and third, system efficiency does not automatically result in positive client outcomes. The simplest example would be cutting staff to improve internal operations and costs, while clients don't have the same access to services. Similarly, integrating health and social supports would seem to make sense: we want nurses and social workers to collaborate closely across departments, programs, etc. This might bring focus to developing better information sharing, joint planning and training, etc. Yet these activities require work on the part of front-line staff, on top of client-related and administrative duties. When presented as a cost-saving measure, such integration efforts can not only add to workloads, but may be translated as justification for the cutting of front-line positions or increased expectations out of current resources. This is

because in certain instances, system decision-makers driving integration assume it leads to efficiencies and cost-savings without fully understanding the work involved on the ground.

We also have the challenge of integration becoming an end in itself. Increased time spent on various integration initiatives costs resources: when limited resources become diverted, there are implications. When front-line staff are tasked to take on integration-related work, such as developing joint task groups across departments on a common issue or shifting procedural approaches to implement an integrated case management approach, they do not automatically get back-up to manage ongoing job demands to take on these new demands. On this point, as integration initiatives move through various planning and implementation stages, they often land on the conclusion that despite co-ordination efforts introduced, there remains a lack of housing, income assistance, counselling, health services, etc.; these are capacity issues that integration efforts may not resolve to begin with.

We must challenge implicit assumptions that somehow, if we squeeze existing resources hard enough, there is enough capacity to end homelessness. In other words, if we could just get better at co-ordinating and become more efficient, we could resolve complex social issues. There is no doubt that more effective delivery is needed and that improved co-ordination across agencies, systems, policies, etc., can deliver on this goal; however, this cannot be taken as a given rationale for any integration exercise – we simultaneously need to consider that demand may outstrip supply as well, no matter how efficiently delivered the latter might be.

Cautionary Tales

Case in point: the sophisticated approaches being developed to co-ordinate and streamline access to the homeless-serving systems – Calgary Co-ordinated Access and Assessment. Here, agencies work together to pool case management, rent supports and supportive housing resources, and use common processes to assess and match clients to these. Calgary implemented this process in 2014/2015 along with many Canadian and U.S. cities. It has also matched this process alignment effort with the creation of a one-stop shop – the Safe Communities Opportunity and Resource Centre, or SCORCe – where a number of agencies co-locate to offer better access from a central location to populations experiencing homelessness. While such efforts are important and part of an integrated approach to addressing homelessness, these measures will not resolve the challenge of inadequate capacity on the back end of the referral process. In other words, no matter how sophisticated and efficient the front end of services is in terms of processing client intakes, making referrals and providing information and assessments, if there is nowhere for clients to go, they are still homeless. Having clarity about the link between the strategy and the actual issue at play can help manage expectations and point to where efforts need to be ramped up further. No assessment tool or co-ordinated access approach, etc., will resolve the lack of affordable and supportive housing options.

To this end, a cautionary tale as Calgary continues to evolve its system integration work in relation to homelessness comes from a U.K. nation-wide example: a report published in 2017 by England's Comptroller and Auditor General examined the progress and systems involved in the integration of health and social systems in the U.K. (Morse, 2017b). In 2013, the Department of Health launched the Integrated Care and Support Pioneers Programme to make co-ordinated health and care the norm by 2018. The main thrust of this decision was the full-scale integration of health and social services across communities to improve system and

client outcome. The approach was to effectively merge the two systems of care into one local integration council, presuming this would improve access to care and create efficiencies.

In their assessment of the evidence, the Comptroller and Auditor General's findings conclude:

> There is no compelling evidence to show that integration in England leads to sustainable financial savings or reduced hospital activity. While there are some positive examples of integration at the local level, evaluations of initiatives to date have found no evidence of systematic, sustainable reductions in the cost of care arising from integration. Evaluations have been inhibited by a lack of comparable cost data across different care settings, and the difficulty of tracking patients through different care settings (Morse, 2017c, 8).

Some of the challenges faced with implementing system integration have been "misaligned financial incentives, workforce challenges and reticence over information-sharing" (Morse, 2017d, 10) and variable engagement of local authorities in planning and decision-making. Overall, the National Audit Office (2017a) notes that the governance and oversight of these various integration initiatives are poor, leading to less than optimal outcomes.

The National Audit Office (2017b) points to the negative impacts of recent efforts to integrate health and social care, which "has not delivered all of the expected benefits for patients, the NHS or local authorities". In fact, rates of emergency admissions "increased by 87,000 against a planned reduction of 106,000, costing £311 million more than planned" in 2015-2016 compared to the previous year. There was improvement in incentivizing local areas to collaborate, as indicated by the more than 90 per cent who agreed or strongly agreed to this impact. Nationally, reductions in permanent admissions of people aged 65 were achieved alongside appropriate alternative care upon discharge from hospital.

In a U.S. example, the five-year federal study of the federal Access to Community Care and Effective Services and Supports demonstration program, which sought to enhance integration of service delivery systems for homeless persons with serious mental illness in 15 cities, showed that despite being successful in terms of project-centred integration, efforts were limited in terms of overall system integration (Morrissey, 2002).

TENETS OF AN INTEGRATION FRAMEWORK

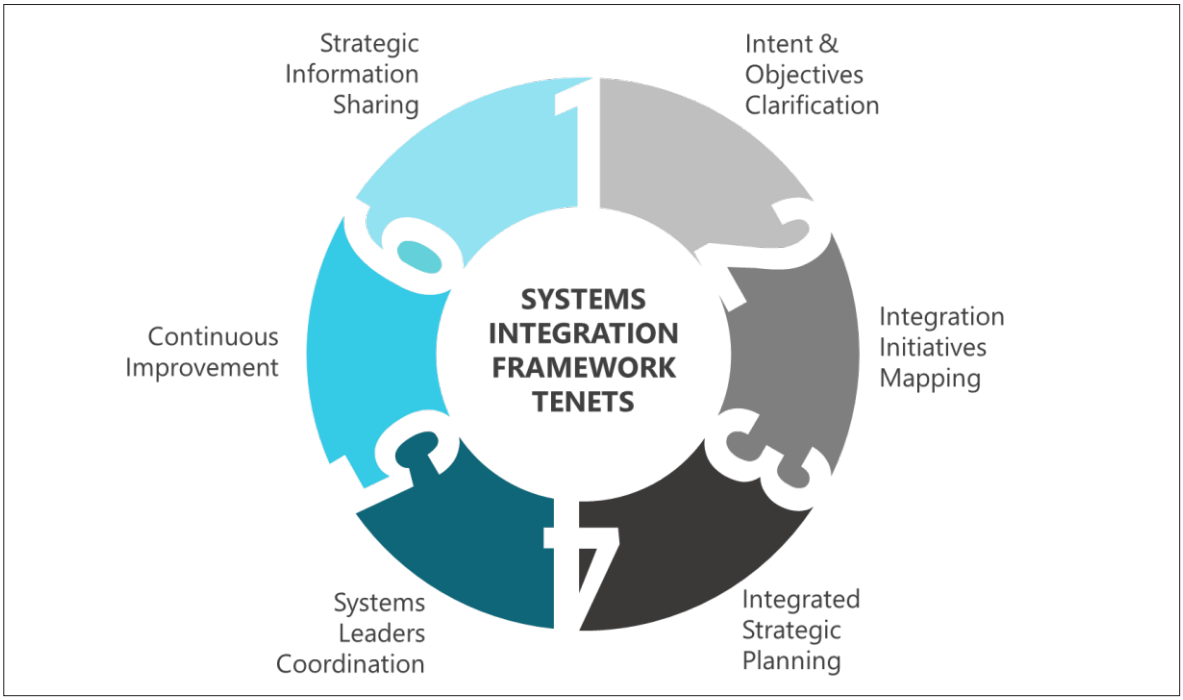
With all these considerations on the learnings we have had to date, and the practical experiences we have gained in our work to address homelessness, where and how does integration fit? We have ourselves declared that the "homeless-serving sector will never end homelessness on its own; we need to move towards a systems approach with justice, health, child welfare, etc." This points to looking at the issue from an eco-system lens as focused on integration. This would be embedded in strategies and plans to prevent and end homelessness, including the proposed national definition on what ending homelessness entails (Turner, Albanese and Pakeman, 2017).

We have argued that integration is in fact the modus operandum in many homeless-serving systems. Programs, service providers (government and non-profit), funders, policy-makers and researchers are interconnected to various extents. In some cases, we may want less integration, rather than more. In certain cases, a task force or committee cannot solve service fragmentation. Before we jump to provide a checklist of strategies on how to make systems

more integrated, we propose some considerations to help communities think through and critically examine what exactly they are integrating, and to what end.

These considerations are summarized in Figure 3 as key tenets of any systems integration framework.

FIGURE 3 SYSTEMS INTEGRATION TENETS



This section will flesh out each of these tenets in more detail to describe a systematic process through which service providers, funders, policy-makers and researchers can think about integration and homelessness from a practical perspective.

We suggest that integration is an ongoing process of making sense out of a relatively dizzying collection of programs, organizations and resources that span diverse public and non-profit systems. To assume full consolidation into a new person-centred social service system overnight is unrealistic. It is further unclear that such an approach is even desirable, given the U.K. experience integrating health and social services recently. Nonetheless, we can agree that a more transformative and deliberate approach to existing stakeholder collaboration is realistic and desirable in certain circumstances. To assist communities and stakeholders to determine how best to address integration, we propose a number of tenets for consideration.

1. Intent and Objectives Clarification

Here we need to return to the core motive behind any initiative, which is improving individual and population outcomes. Integrating to save money or reduce duplication cannot be the primary or sole goal of the exercise; if it so happens that cost avoidances are realized while improving client outcomes, that is of note, but it cannot suppress the primary objective. This might seem obvious, yet the merits need restating.

To this end, this first consideration probes: **What is the motive driving integration**? Is the primary beneficiary the client or the system? If a direct line to improved client outcomes cannot be drawn during the initial conceptualization of the effort, this will likely be the case during implementation and evaluation phases as well. The inability of an integration project, task force, pilot, etc., to demonstrate what impact is being made at the client level suggests the potential need for course correction.

We are not arguing that only initiatives that can demonstrate client impact should be supported; rather that if the objective of the integration is to "increase complex client wellbeing across systems", or "help vulnerable populations access services", etc., then it is reasonable to expect over the course of the initiative some indication that this is indeed being achieved, and where it is not, have an opportunity to probe why and adjust accordingly. Again, these suggestions of continuous improvement, performance management and evaluation are by no means novel; however, when it comes to integration activities, they may not be built into the approach despite the considerable investments being made to take on complex work between systems.

Another consideration is the **level of priority** an integration effort has in each participating system. If – hypothetically - the police initiated a complex client table to address the over-ticketing of publicly intoxicated homeless individuals at a chief's request, the staff of health and homeless-serving systems participating in the integration table may be assigned or self-select to participate, with relatively limited capacity to enact many of the recommendations that may emerge from discussions. It may be that their respective decision-makers are not even aware front-line staff are engaging in these discussions, and even if they are, they may not necessarily agree that the issue is relevant to their system. In other cases, homeless-serving agencies, police, justice and health entities may be developing solutions without engaging key departments within their own systems. In still other cases, similar tables run parallel without fully understanding one another's role, and how they relate or duplicate their mandate.

2. Integration Initiatives Mapping

To this issue, it is essential that a fulsome **"systems integration initiatives"** mapping be in place to simply catalogue even the most basic information about these efforts and locate a new initiative relative to pre-existing ones. A simple matrix like the one below illustrates some information that could be captured as part of any due diligence work for any integration initiatives. It would be important to understand what's already at play in communities before another approach is introduced. This may also assist with leveraging efforts, but also with identifying potential barriers to client impact. For instance, if the authority levels are not appropriate for the decisions that are being proposed, or the link to the right authority that is supportive of this work is not in place, the initiative may stall out or only make marginal impacts despite best efforts and resources invested.

We have to understand how integration initiatives fit into existing networks of services and supports. In other words, is the issue a lack of integration or lack of logic and order among available resources and actors?

TABLE 5 INTEGRATION INITIATIVES MAPPING EXAMPLE

Integration Initiative Name	High System User Table		
Primary objective	Increase effectiveness of integrated response across providers		
Convenor organization/ system	Police (public/government) & main local shelter (non-profit)		
Target population/s	Complex clients with addiction, mental health and homelessness histories with high levels of integration with police, health shelters		
Integration strategy	Co-location; meetings, joint case management, information sharing		
Activities	Meetings every 2 weeks formally to discuss issues, research commissioned to scope target population, aim to develop proposal for potential pilot		
Timelines	Have been meeting since 2015; no end date at this time.		
Contact	Key contact: Chair		
	Systems Analysis		
	Health	**Police**	**Homeless-Serving**
Participant organizations/ departments/systems	ER, EMS	Downtown district	Shelter providers Shelter funders
Regional scope	Downtown facilities delivering health care (ER, EMS, mental health unit)	Downtown district only	Shelters within city boundaries Federal, provincial, local, private with investments in participating shelters
Authority levels of representatives	Front-line nurses (ER) EMS team leads ER physician	Staff sergeants	Shelter team leads/managers Contract managers from funders
Decision-maker support/ priority	Unknown	Chief endorsement, high strategic priority	Shelters: unknown Funders: mixed
System leader interests	Unknown, executives not engaged	Reduce burden on patrol due to public intoxication; reduce social disorder calls	Potential to reduce high shelter users
Client impact	Unknown; too early; reported changes in attitudes re: homelessness by police officers on committee but not evaluated formally.		

The expertise of concept-mapping integration may reveal that there is limited consensus at the executive or operational levels on what a particular organization's objectives are in a particular initiative. Health services may not be fully informed on what the pressure points for the homeless-serving organizations are, and where long-term goals might be. While links to available public documents are a first step in developing an understanding of this and areas of alignment or divergence relative to a particular issue, the strategic plans of systems involving diverse government and non-profit stakeholders are not always easily discerned even for insiders.

This intentional classification of integration efforts may also help discern common strategies and link these to outcomes assessments to discern effective practice. For instance, co-location can be tested in health and social supports compared to joint case management. This can inform how the systems can better develop integration strategies to deliver on desired outcomes.

3. Integrated Strategic Planning

To this end, the engagement of leaders in the systems level **strategic planning around integration** is essential. We are not expecting the diverse interests of these systems to become fully aligned around homelessness. In fact, for some, the interest in homelessness or the issue's priority may be dwarfed relative to other pressures and priorities. Yet, at the highest strategy development levels, decision-makers need to have conversations about systems planning at the

same table. This in turn helps set the direction and tone in their respective networks of services, and ensures they are aware of the moving parts in each other's portfolios and how they relate to one another. For instance, having a major defunding of mental health services because a funding organization changes priority will have ramifications for police, child intervention, health, etc. If the opportunity never presents itself for these conversations to occur, how can systems have a full view of impacts and considerations for such shifts?

Again, the proposed model does not require a system to seek permission; rather, to develop mechanisms to share, link and leverage each other's spheres more strategically. This engages decision-makers at the system levels in a profound consideration of integrated systems planning at the highest levels, which can be reinforced in the implementation of direction through their organizations and networks of services they influence or fund. This may also help executives better understand when and how integration initiatives fit or don't fit as part of the broader eco-system work they are engaged in, and can act as the table where decisions around changes can be brought from these activities.

It may also help systems develop strategies to invest resources, including funding, in a co-ordinated fashion that considers a systems perspective, rather than one's own aims only. Blind spots and unintended consequences could potentially be avoided if a more holistic approach were applied at the front end of systems planning.

4. Systems Leaders Co-ordination

It may also emerge that with the highest levels of decision-makers at the table, the efforts required to shuffle issues up the ladder from various organizations, staff levels and clients can be mitigated as well. As such, the various integration efforts occurring within and across systems can have **clear links at all organizational levels**, to ensure alignment with strategic systems directions. Making these relationships transparent and intentional can help the decision-making that may occur at a systems integration table be informed and in turn informing of the various integration initiatives on the ground. This can help draw into key systems-level conversations common threads and recommendations emerging from the front lines and client levels that can be implemented with the commensurate level of due diligence and urgency. The approach may better enable the identification of high-leverage activities that can act as a tipping point generating change and better outcomes.

In sum, a systems integration table can act to:

- Identify and understand existing activities within and across systems relevant to preventing and ending homelessness;
- Inform and support cross-systems strategic planning and implementation;
- Participate in key integration initiatives and tables and bring back information as appropriate;
- Identify and influence system barriers and work collaboratively with community and government partners to swiftly resolve these;
- Identify potential tipping points across and within systems that can generate transformational changes;
- Co-ordinate and leverage existing initiatives/committees that align with the goals;

- Advance strategic investments across systems toward common objectives;
- Develop flagship integration initiatives and support their implementation in participating systems.

5. Continuous Improvement

With respect to impact, the assessment of effectiveness for integration measures will need to be considered carefully as well to ensure **continuous improvement**. Rather than focusing on the degree of intensity or the number of connections or meetings between systems or organizations, we propose an equal if not more intense evaluation focus on what impact has been achieved relative to clients. Performance management for integration initiatives cannot solely focus on process indicators relevant to the functioning of the initiative itself; a link to individual and population impact must be articulated and demonstrated.

If the link to beneficial client outcomes is correlative rather than direct, this should be documented formally, benchmarked and monitored on an ongoing basis as well. It may be that among particular populations or across particular systems/organizational levels, some integration strategies achieve differential outcomes. We need to develop frameworks to assess these impacts and link performance management further to continuous improvement.

This continuous improvement is reinforced and supported through training and capacity building across systems as relevant and appropriate to support the development of working relationships, common definitions and informal networks among staff at various organizational levels.

6. Strategic Information Sharing

This brings forth a pervasive challenge to integration work in practice, including the evaluation of activities: **information and data sharing**. It is imperative that integration initiatives have the data and information-sharing protocols and infrastructure in place across stakeholders involved to enable the effort, to begin with. If the strategy is hampered by the inability to even share the information needed to do the work, we may consider whether the effort will ultimately falter as a result. The sharing of information may be a critical tipping point as well, unlocking the potential of front-line efforts across departments and systems.

The sharing of information in practice is not simply the movement of all front-line workers onto the same information management platform. At various levels in the systems, access to appropriate information to deliver an integrated approach to care should drive how decisions and processes around data sharing are built out. We cannot simply expect that data will solve systemic issues without linking it into a broader integration strategy.

Privacy laws are necessary to protect the personal information of all members of society and more specifically vulnerable persons, including persons with mental health issues, addictions and children at risk. The overly broad application of privacy laws can limit appropriate information sharing between government agencies and service providers. In addition, the lack of training and information-sharing protocols within government agencies and service providers can impede the effective delivery of services to persons at risk, as well as increase the potential risk of harm to vulnerable persons.

Thus, the ability of service providers, multi-disciplinary teams, police officers and health professionals to respond in the most appropriate and beneficial manner to individuals in

need requires appropriate information sharing. We need to develop workable and effective changes to legislative information-sharing provisions and protocols, as well as more effective information-sharing training and leadership within government agencies and service providers to improve the services provided to, and level of safety of, vulnerable persons including persons with mental health issues, addictions and children at risk.

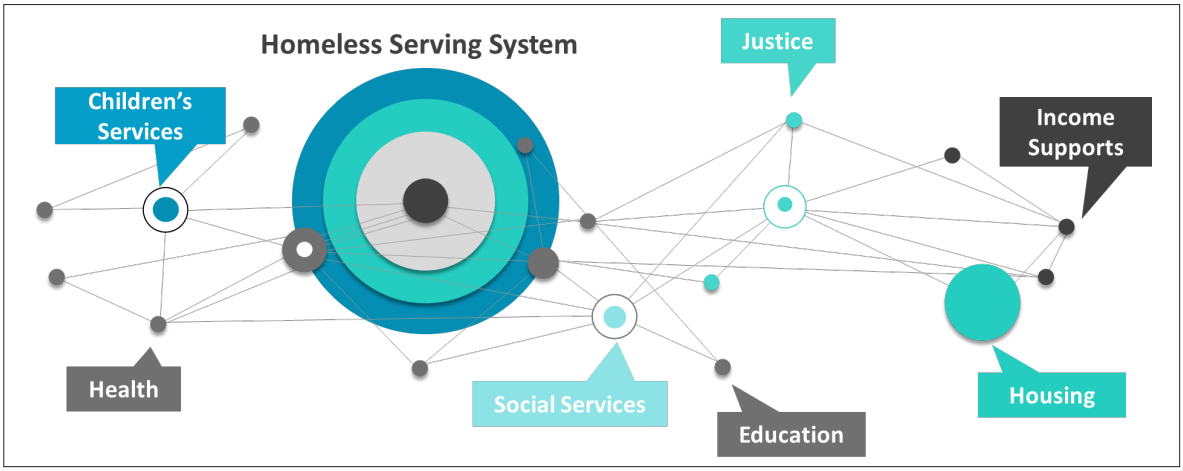
IMPLICATIONS

The effort to articulate how best to move multiple and complex service networks involved in homelessness as a co-ordinated enterprise is no easy task: it will require agents within respective organizations working towards common aspirations, which may challenge the way things are done and commonly accepted. This work asks for different commitment, thinking, mutual trust, relationships and time. It brings new risks and challenges to individual and organizational stakeholders.

Our current approach has been to focus on the interconnectedness of the homeless-serving system with health, justice, child intervention, etc. We know that the needs of individuals who may be in a shelter are not limited to one system's services, funding or policies. This has been a common way of understanding homelessness and systems integration. However, this implies that there are such things as concrete, bounded systems to start with.

In practice, as illustrated in Figure 4, the reality is more akin to a network and nodes of activity, interests, people and resources that are discernible to various extents as being parts of systems (health, justice, etc.) involving government, non-profits, private and voluntary stakeholders. This implies that integration is about identifying the nodes with the greatest promise of delivering positive outcomes at the client and population levels.

FIGURE 4 INTERCONNECTIONS ACROSS SYSTEMS OF CARE



There is no roadmap to integration, nor can we Google our way to it. While interesting work is being done on the minutiae of what is best described as integration activities among systems (i.e., system navigators, integration committees, one-stop shops, etc.), there is little to tell us how system leaders and strategy influencers are supposed to work together towards transformational changes across respective organizations and service networks.

What has also emerged quite clearly is that the dizzying array of social services is simply too complicated to manage or integrate. Ontario's social service network is 60,000 community- and social services-deep, delivered by diverse organizations (Ontario 211, 2018[1]); assuming similar rates, Alberta's figure would be around 20,000. Using this ratio per population (4.6 services per 1,000), the estimated total number of services would be just over 167,000 – each with its own processes, criteria, hours of operation, service model, etc. This does not include the tens of thousands of other government services provided directly through health, income assistance or correctional departments.[2] Given the evident lack of coherence and order, how exactly would an integration committee or a pilot program hope to address this? It is not surprising to hear about the need for better co-ordination of service in most if not all plans to address homelessness, especially echoing the input of those in actual need of help.

There is no doubt that this service network leverages considerable resources to benefit Canadians. Non-profit yearly revenues in 2003 totalled $75 billion; assuming a similar level of revenues per capita in 2017, the total estimated revenue would be $86 billion.[3] Statistics Canada estimated that social services, development and housing made up 31 per cent of the core non-profit sector's primary activity areas. In 2007, non-profits

> "generated 20% more value added than the entire accommodation and food services industry, more than 2.5 times that of agriculture, and generated nearly six times as much value added as the motor vehicle manufacturing industry" (Statistics Canada, 2007, 10).

Assuming that about one-third of the $86 billion in non-profit revenues went to the social service and housing sector, most likely to interact with those who are homeless and at risk of homelessness, this would result in about $27 billion going into these services, notwithstanding services that government delivers directly such as health, income assistance, police, etc., that have been estimated to cost Canadians another $6.5 billion annually for homelessness directly.[4] **In other words, we have a $33.5 billion/year industry we can leverage to prevent and end homelessness.**

Note that Canada recently announced a $40 billion national housing strategy, adding about $4 billion annually to this figure over 10 years. To put this in perspective, ending homelessness has been estimated to cost about $3.8 billion per year (Gaetz, Gulliver and Richter, 2014a) – which would roughly equal 10 per cent of the total revenue of the sectors concerned. Surely, before we add further chaos to this confusion through new investments and services, we should sort out the existing resources to maximize value and impact for Canadians. Note that the per capita government transfers directly to individuals in disability and income assistance payments or exemption are not included in this calculation.

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1 See also: Ontario Non-Profit Sector. 2011. Infographic online https://theonn.ca/wp-content/uploads/2011/08/Infographic.Nonprofit.Sector.pdf.

2 See resource listing from Alberta Health Services: https://www.albertahealthservices.ca/findhealth/Default.aspx

3 The figure excludes non-profit hospitals, universities and colleges. Calculated using data pro-rated per capita for 2017 using Hall, 2005. "Cornerstones of Community: Highlights of the National Survey of Non-Profit and Voluntary Organizations," 2003 revised. Available at http://sectorsource.ca/sites/default/files/nsnvo_report_english.pdf

4 Gaetz, Gulliver and Richter (2014b) estimate the cost of homelessness to be $7 billion annually including health, corrections and emergency shelters. As emergency shelters are already accounted for in the non-profit sector revenues, we subtracted $0.5 billion accordingly (15,810 shelter beds reported in 2016 at $85 per night in 2016 by Statistics Canada, Table: 14-10-0353-01 Available at https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1410035301.

Clearly, much deeper structural challenges are needed to transform our approach to homelessness. First and foremost, having such a considerable investment in social issues without transparency on how tens of thousands of services intersect and integrate into a coherent, navigable whole for clients is simply not good enough. A step further: It is not surprising that no clear line of sight between the $33.5 billion annual investment to client and population outcomes exists.

Transforming our approach to social services is essential; we will necessarily have to consider service and organizational amalgamations to enhance alignment. In some cases, we simply may have to let some services or organizations go when the line of sight to client and population outcomes is blurry or non-existent. This is not about clawing back funds; rather, it is about using what we already spend in a deliberate fashion, transparent to Canadians. These are policy and funding decisions that our system leaders need to step up to make from an integrated lens on common outcomes. It's no longer sufficient to care about one's own organizational mandate without recognizing the ricochet impacts decisions in health have on police, homelessness, etc., and vice versa. In this sense, integration is much more than incremental strategies at piecing together a broken system; it is a full-scale transformation of that system.

We are not proposing that we know the answers; what we are committing to is starting the work. In Calgary, the Community Systems Integration (CSI) Table is beginning this work in earnest as the vehicle for integrated strategic planning and co-ordination among systems leaders. The CSI Table was convened to bring decision-makers together to provide systems leadership that advances innovative solutions, policy and systems change to address the needs of vulnerable populations in Calgary. Recognizing transformational change is needed across and within systems, the CSI Table is working to synchronize strategic planning efforts at the systems level to identify high-leverage activities, anticipate needs and decision impacts on the target population, and generate tipping points through these efforts. The journey has just begun for Calgary; we will learn as we implement, and critically evaluate our efforts through a lens of putting people first. We invite our fellow Albertans and Canadians to join this journey with us.

REFERENCES

Backer, T.E., E.A. Howard, and G.E. Moran. 2007. "The Role of Effective Discharge Planning in Preventing Homelessness," *The Journal of Primary Prevention*, 28(3-4): 229-243.

Baron, M., B. Erlenbusch, C.F. Moran, K. O'Connor, K. Rice, and J. Rodriguez. 2008. *Best Practices Manual for Discharge Planning: Mental Health & Substance Abuse Facilities, Hospitals, Foster Care, Prisons and Jails*. Available at http://homelesshub.ca/resource/best-practices-manual-discharge-planning-mental-health-substance-abuse-facilities-hospitals

Barr, H. 1999. *Prisons and Jails: Hospitals of Last Resort. The Need for Diversion and Discharge Planning for Incarcerated People with Mental Illness in New York*. New York: Correctional Association of New York and Urban Justice Center.

Boardman, J.B. 2006. "Health Access and Integration for Adults with Serious and Persistent Mental Illness," *Families, Systems, & Health*, 24(1): 3-18.

Browne, G., D. Kingston, V. Grdisa, and M. Markle-Reid. 2007. "Conceptualization and Measurement of Integrated Human Service Networks for Evaluation," *International Journal of Integrated Care*, October-December; e51.

Burt, M., D. Pollock, A. Sosland, K. Mikelson, E. Drapa, K. Greenwait, and P. Sharkey. 2002. "Evaluation of Continuums of Care for Homeless People," U.S. Department of Housing and Urban Development Office of Policy Development and Research.

Calgary Homelessness Foundation. 2014. "The Cost Benefits of Housing First." Available at http://calgaryhomeless.com/wp-content/uploads/2014/06/The-CostBenefits-of-Housing-First.pdf.

Calgary Homeless Foundation. 2015. "Calgary's Updated Plan to End Homelessness: People First in Housing First." Available at http://www.ihearthomeyyc.com/content/uploads/Update_to_Calgary_Plan_March_4.pdf

Calgary Homeless Foundation. 2017. "Data that Makes a Difference," 2nd Annual Canadian Homelessness Data Sharing Initiative. Available at http://calgaryhomeless.com/content/uploads/Data-Sharing-Minutes-May-18-Final-Version-12jun2017.pdf

Calgary Homeless Foundation. 2017. "I am Home: Calgary Homeless Foundation 2017 Report on Progress." Available at http://calgaryhomeless.com/content/uploads/CHF-2017-Annual-Report_WEB.pdf

Calgary Homeless Foundation. 2018. "Calgary's 10 Year Plan to End Homelessness Enters its Final Year." Available at http://newsroom.calgaryhomeless.com/press-releases/calgarys-10-year-plan-to-end-homelessness-enters-its-final-year-gnw_2033199_001

Centre for Health Economics. 2014. "Financial Mechanisms for Integrating Funds for Health and Social Care: An Evidence Review." University of York, Economics of Social and Health Care Research Unit. Available at: www.york.ac.uk

Christ, W.R., and S.L. Hayden. 1989. "Discharge Planning Strategies for Acutely Homeless Inpatients," *Social Work in Health Care*, 14(1): 33-45.

City of Calgary. 2018. “Calgary Community Services Guide.” Available at http://www.calgary.ca/CSPS/CNS/Documents/Calgary_Community_Services_Guide.pdf

City of Calgary. 2018. “Resource Guides and Online Directories.” Available at http://www.calgary.ca/CSPS/CNS/Pages/Publications-guides-and-directories/Publications-Guides-Directories.aspx

Conly, C. 1999. “Coordinating Community Services for Mentally Ill Offenders: Maryland’s Community Criminal Justice Treatment Program,” *American Jails*, 13(1): 9-114.

Corbett, T., and J. Noyes. 2008. *Human Services Systems Integration: A Conceptual Framework*. Paper prepared for the Annual Meeting of the Association for Public Policy Analysis and Management, Washington, D.C., Nov. 8-10, 2007.

Cornes, M., J. Manthorpe, C. Hennessy, S. Anderson, M. Clark, and C. Scanlon. 2014. “Not Just a Talking Shop: Practitioner Perspectives on How Communities of Practice Work to Improve Outcomes for People Experiencing Multiple Exclusion Homelessness,” *Journal of Interprofessional Care*, 28(6): 541-546.

Culhane, D.P. 2008. “The Cost of Homelessness: A Perspective from the United States,” *European Journal of Homelessness* 2(1):97-114.

Culhane D.P., S. Metreaux, and T. Hadley. 2002. LDI Issue Brief. February, 7(5):1-4.

Eberle M., D. Kraus, S. Pomeroy et al. 2001. “The Cost of Homelessness in British Columbia,” [Internet] In: *Office of Housing and Construction Standards*, editor. Ministry of Natural Gas Development and Responsible for Housing of British Columbia. Homelessness-causes and effects reports. 1-5. Victoria B.C.: Office of Housing and Construction Standards.

Erick G., B.H. Guerrero, and Suzanne L. Wenzel. 2014. “Service Integration to Reduce Homelessness in Los Angeles County: Multiple Stakeholder Perspectives,” *Human Service Organizations: Management, Leadership & Governance*, 38, 44-54.

Evans, T., K. Neale, J. Buultjens, and T. Davies. 2011. “Service Integration in a Regional Homelessness Service System.” Available at http://socialfutures.org.au/wp-content/uploads/2015/11/Service-Integration-in-a-Regional-Homelessness-Service-system-Nov-2011.pdf

Fisher, M.P., and C. Elnitsky. 2012. “Health and Social Services Integration: A Review of Concepts and Models,” *Social Work in Public Health*, 27, 441-468.

Flatau, P., E. Conroy, M. Thielking, A. Clear, S. Hall, A. Bauskis et al. 2013. *How Integrated are Homelessness, Mental Health and Drug and Alcohol Services in Australia?* Melbourne: Australian Housing and Urban Research Institute.

Gaetz, S. 2014. *Coming of Age: Reimagining the Response to Youth Homelessness* (Homeless Hub).

Gaetz, S., F. Scott, and T. Gulliver. 2013. *3.1 Calgary, Alberta: Calgary Homeless Foundation. Housing First in Canada: Supporting Communities to End Homelessness*. Canadian Observatory on Homelessness.

GGI Consultants. 2015. "Evaluation of the NAVNET Initiative." Prepared for the NAVNET Steering Committee. Available at http://navnetnl.ca/wp-content/uploads/2013/09/NAVNET-Evaluation-Summary-Report-July-3-2013.pdf

Gladwell, M. 2006. "Million-Dollar Murray: Why Problems Like Homelessness May be Easier to Solve than to Manage," The New Yorker. Feb. 13, 96.

Gold, J., and N. Dragicevic. 2013. *Integration Imperative*. The Mowat Centre. Available at https://mowatcentre.ca/the-integration-imperative/

Gordon, A.J., M.L. Montlack, P. Freyder, D. Johnson, T. Bui, J. Williams, and Aim-High Team. 2007. "The Allegheny Initiative for Mental Health Integration for the Homeless: Integrating Heterogeneous Health Services for Homeless Persons," *American Journal of Public Health* 97(3): 401-405.

Grdisa, V. 2009. "Conceptualizing & Measuring Integration: Tools & Resources for System Leaders." Available at http://www.nhlc-cnls.ca/assets/grdisa%20presentation.pdf

Greenberg, G., and R. Rosenheck. 2010. "An Evaluation of an Initiative to Improve Coordination and Service Delivery of Homeless Services Networks," *The Journal of Behavioral Health Services & Research* 37(2): 184-196.

Hall, M. 2005. *Cornerstones of Community: Highlights of the National Survey of Non-Profit and Voluntary Organizations*, 2003 revised. Available at http://sectorsource.ca/sites/default/files/nsnvo_report_english.pdf

Hambrick, R., and D. Rog. 2000. "The Pursuit of Coordination: The Organizational Dimension in the Response to Homelessness," *Policy Studies Journal* 28(2): 353-364.

Harrison, M.L., K.A. Moore, M.S. Young, D. Flink, and E. Ochshorn. 2008. "Implementing the Comprehensive, Continuous, Integrated System of Care Model for Individuals with Co-Occurring Disorders: Preliminary Findings from a Residential Facility Serving Homeless Individuals," *Journal of Dual Diagnosis* 4(3): 238-259.

HC Health Committee. 2014. "Managing the Care of People with Long-Term Conditions." Second Report of Session 2014-15, HC 401, July.

Hulchanski, D., P. Campsie, S. Chau, S. Hwang, and E. Paradis. 2009. *Finding Home: Policy Options for Addressing Homelessness in Canada*. Toronto: Canadian Homelessness Research Network Press.

Kania, J., and M. Kramer. 2011. "Collective Impact," *Stanford Social Innovation Review*. Available at: http://www.ssireview.org/articles/entry/collective_impact

Kertesz, S.G., M.A.O. Posner, J.J. Connell, S. Swain, A.N. Mullins, M. Shwartz, and A.S. Ash. 2009. "Post-Hospital Medical Respite Care and Hospital Readmission of Homeless Persons," *Journal of Prevention & Intervention in the Community* 37(2): 129-142.

Kodner, D.L., and C. Spreeuwenberg. 2002. "Integrated Care: Meaning, Logic, Applications, and Implications – A Discussion Paper," *International Journal of Integrated Care*, (2).

Konrad, E. 1996. "A Multidimensional Framework for Conceptualising Human Services Integration Initiatives," *New Directions for Evaluation* (69): 5-19.

KPMG. 2013. *The Integration Imperative: Reshaping the Delivery of Human and Social Services*. Available at https://assets.kpmg.com/content/dam/kpmg/nz/pdf/October/integration-imperative-kpmg-nz.pdf

Local Government Association. 2013. "Integrated Care Evidence Review." Available at: www.local.gov.uk

Ly, A., and E. Latimer. 2015. "Housing First Impact on Costs and Associated Cost Offsets: A Review of the Literature," *Canadian Journal of Psychiatry* 60(11): 475-487.

Lynn, J., and S. Stachowiak. 2017. "The Collective Impact Research Study: What is All This Really Going to Mean, Anyway?" Available at http://sparkpolicy.com/2019-2/

Mares, A., G. Greenberg, and R. Rosenheck. 2008. "Client-Level Measures of Services Integration among Chronically Homeless Adults," *Community Mental Health Journal*, (44) 367-376.

Mays, G.P., F.D. Scutchfield, M.W. Bhandari, and S.A. Smith. 2010. "Understanding the Organization of Public Health Delivery Systems: An Empirical Typology," *Milbank Quarterly* 88(1): 81-111.

Mental Health Commission. 2011. *Turning the Key: Assessing Housing and Related Supports for Persons Living with Mental Health Problems and Illness* (Ottawa: Mental Health Commission of Canada). Available at https://www.mentalhealthcommission.ca/sites/default/files/PrimaryCare_Turning_the_Key_Full_ENG_0_1.pdfsites/default/files/PrimaryCare_Turning_the_Key_Full_ENG_0_1.pdf

Morrissey, J.P., M.O. Calloway, N. Thakur, J. Cocozza, H.J. Steadman, D. Dennis, and ACCESS National Evaluation Team. 2002. "Integration of Service Systems for Homeless Persons with Serious Mental Illness through the ACCESS Program," *Psychiatric Services* 53(8): 949-957.

Morse, A. 2017. "Health and Social Care Integration." Report by the Comptroller and Auditor General Department of Health, Department for Communities and Local Government and NHS England. Available at https://www.nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf

Moss, J.E., C.L. Flower, L.M. Houghton, D.L. Moss, D.A. Nielsen, and D.M. Taylor. 2002. "A Multidisciplinary Care Coordination Team Improves Emergency Department Discharge Planning Practice," *The Medical Journal of Australia* 177(8): 435-439.

National Audit Office. 2017. "Health and Social Care Integration." Press release. https://www.nao.org.uk/report/health-and-social-care-integration/

Nelson, G., J. Sylvestre, T. Aubry et al. 2007. "Housing Choice and Control, Housing Quality, and Control over Professional Support as Contributors to the Subjective Quality of Life and Community Adaptation of People with Severe Mental Illness," *Administration and Policy in Mental Health* 34(2): 89-100.

Nuffield Trust. 2013. *Evaluating Integrated and Community-Based Care: How do We Know What Works?*

Ontario 211. Video. Available at https://www.youtube.com/watch?v=duY3c_rNbIg&feature=youtu.be

Ontario 211. 2018. "Video: 211: Make the Right Call with 911 Emergency Help (No 311 Municipal Hotline)." Available at https://211ontario.ca/

Preskill, H., M. Parkhurst, and J. Splansky Juster. 2014. "Learning and Evaluation in the Collective Impact Context." Guide to Evaluating Collective Impact. Available at: https://collectiveimpactforum.org/sites/default/files/Guide%20to%20Evaluating%20CI%2001.pdf

RAND Europe, and Ernst and Young LLP. 2012. *National Evaluation of the Department of Health's Integrated Care Pilots*. March.

Randolph, F. 1995. "Improving Service Systems Through Systems Integration: The ACCESS Program (Access to Community Care and Effective Services)," in *American Rehabilitation*, 21(1):36.

Richter, R.S.M. 2008. *Report on the Cost of Homelessness in the City of Calgary*. Calgary (AB): Calgary Homeless Foundation.

Rowe, M., M.A. Hoge, and D. Fisk. 1998. "Services for Mentally Ill Homeless Persons: Street-Level Integration," *American Joumal of Orthopsychiatry* 68(3): 490-496.

Smelson, D.A., H. Zaykowski, N. Guevermont, J. Siegfriedt, L. Sawh, D. Modzelewski, S. Tsemberis, and V. Kane. 2016. "Integrating Permanent Supportive Housing and Co-Occurring Disorders Treatment for Individuals who are Homeless," *Journal of Dual Diagnosis*, April-June 12(2):193-201.

Statistics Canada. 2007. "Satellite Account of Non-Profit Institutions and Volunteering, 2007." Available at https://www150.statcan.gc.ca/n1/pub/13-015-x/13-015-x2009000-eng.pdf

Sun, A.P. 2012. "Helping Homeless Individuals with Co-occurring Disorders: The Four Components," *Social Work* 57(1): 23-37.

Turner, A. 2014. "Beyond Housing First: Essential Elements of a System-Planning Approach to Ending Homelessness." The School of Public Policy, 7(30), 1-24.

Turner, A. 2016. Calgary Case Management Group Evaluation – Technical Report. Calgary Homeless Foundation.

Turner, A., T. Albanese, and K. Pakeman. 2017. "Discerning 'Functional and Absolute Zero': Defining and Measuring an End to Homelessness in Canada," *SPP Research Paper* 10(2). Available at: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2957845

Wright, O. 2016. "Ten Places where Collective Impact Gets it Wrong," *Collaboration for Impact*. Available at http://www.collaborationforimpact.com/ten-places-where-collective-impact-gets-it-wrong/

About the Authors

Dr. Alina Turner brings expertise is in developing and implementing solutions to complex urban social issues like poverty, homelessness, mental health, addictions, and violence. She leverages research, technology, community engagement, and systems thinking to accelerate large-scale social change.

She is recognized as a leading Canadian researcher and thinker on homelessness and her work on system planning is recognized as a leading practice and often called upon as a model internationally. She is a Fellow at The School of Public Policy, University of Calgary where she focuses academic research and publishing on systems integration to improve health and social outcomes.

Alina leads Turner Strategies, a consulting firm that builds capacity in non-profits, government and private sector partners to accelerate social impact by leveraging research, community engagement, and creative technologies. She also co-founded HelpSeeker as a social enterprise dedicated to connecting people with the help they need, fast. The back-end of HelpSeeker provides service providers and decision-makers with real-time analytics to inform strategy and decision-making. HelpSeeker is fast becoming a system mapping tool across Canadian communities, essential to mapping and analyzing over 100,000 social and health resources nationally.

Diana Krecsy (RN, BN, and M.Ed) joined the Calgary Homeless Foundation as President and CEO in 2014. Diana has more than 30 years of leadership experience, spanning health services, non-profits and academia. Diana's prior roles include having served as CEO of the Heart and Stroke Foundation of Alberta, NWT and Nunavut, CEO of the Calgary Drug Treatment Court Society and as a Tenured nurse educator at Mount Royal University (formerly MRC). Throughout her career she has been instrumental in making transformative and sustainable change that benefits vulnerable Calgarians. Her work has been at the frontline, program and systems level and has traversed formal structures including Post-Secondary Education, Justice, Social Services, and Health; and intersected with numerous Not For Profit community based organizations. Diana is a passionate and visionary leader with a proven capacity to inspire trust within complex collaborations and drive performance within collective impact initiatives. She has served on more than 40 Committees and/or Boards throughout her professional career.

CHF partnered in the RESOLVE Campaign and is a provincial leader in 7 Cities on Housing & Homelessness.

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