Older People Experiencing Homelessness with Complex Needs in Alberta: A Systems Perspective and Policy Analysis

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Executive Summary

This report examined the policies that shape the health and social outcomes of older people with experiences of homelessness (OPEH) in Alberta. OPEH often have complex and unique social and healthcare needs. Provincial strategies that seek to prevent the institutionalization of seniors by focusing on the ability of older people to 'age in place' are often centred upon the provision of homecare, which is unrealistic for those experiencing homelessness. Furthermore, long term care homes and supportive living centres across Canada do not (yet) have robust systems to support those who struggle with poverty, addiction, and complex mental health needs as well as experiences with homelessness and housing precarity.

The question of how to respond to and support OPEH is quickly becoming one of national urgency. Canadians and Indigenous peoples who were born between 1946 – 1964 represent a very large portion of the population structure. It is therefore very likely that the already stressed continuing care and homeless serving systems in Canada will be increasingly hard-pressed to provide services and care to OPEH.

This arguable crisis yields the province of Alberta the unique opportunity to repeat past policy successes as a national leader in impactful, evidence-based, and fiscally sound approaches to housing, homelessness, and social supports for the most marginalized members of our society. To do so, it is necessary for scholars and policy makers to critically examine these problems closely and to catalogue the successes and failures of previous strategies. For that reason, our research team worked with government reports and grey literature, a select list of expert interviews, and a broad survey of academic publications to report upon the different factors that shape the outcomes of OPEH with complex needs in Alberta. The goal of this report was to synthesize this information and report upon it in plain language.

In this report, we identified and expanded upon four pillars of policy formation:

Pillar 1: The Housing and Homelessness Sector
We report upon the federal government's handing off of social housing to provinces in the 1990s as well as Alberta's response to this policy development, which involves the province's early implementation of 'Housing First' policies in 2008.

Pillar 2: Continuing Care in Alberta
We survey the landscape of continuing care and supportive living in Alberta and explain recent policy developments associated with *The Continuing Care Act* and fiscal strategies towards funding facility-based forms of care.

Pillar 3: Federal and Provincial Approaches to Harm Reduction
We introduce federal drug policies and approaches to harm reduction, as well as the way in which Alberta has responded to this emergent policy framework. Though we are critical of past provincial approaches to harm reduction and the opioid crisis, we conclude by underscoring the United Conservative Party's

recent decision to invest $8 million in funding for harm reduction services over a two-year period, which suggests that this historically controversial but evidence-based policy approach is becoming an increasingly bipartisan issue.

Pillar 4: The Operation of Canadian federal Indian policy and the Production of Indigenous Homelessness

We discuss the operation of federal Indian policies that often encouraged First Nations people to move to Albertan cities, as well as the ways in which the specific dimensions of Indigenous homelessness contribute to the overrepresentation of Indigenous peoples amongst OPEH in Alberta.

In all four realms of policy discussion, the interplay between Alberta and Ottawa is a complicating but foundational factor that is key to understanding the structures and policies that impact the health and social outcomes of OPEH. Also, the timing of this study also made it necessary to report often on the impacts of the COVID-19 pandemic, which had severe implications for several homeless serving sectors and continuing care systems across Canada. Of course, the long-term impact of the pandemic as well as the economic recession that it precipitated will take several years to emerge in full, but this should not prevent forward-looking and preventative policies from taking shape in the meantime.

Recommendations

1. Commit to engaging with OPEH with complex needs as policy directors, stakeholders, and as architects of the service provision schemas that impact them.
2. Develop Standardized Assessments to Enumerate OPEH in Alberta Using Age 50 as the Threshold of Inclusion
3. Review 65 as the Age of Inclusion in Alberta's Senior Living Settings so that OPEH with complex needs between the ages of 50 and 65 who need this kind of care can access it with fewer impediments following a needs-based assessment.
4. Commit to Defending the Age of 65 as the Threshold of Eligibility for Old Age Security Payments.
5. Integrate Harm Reduction Services within Facility-Based Continuing Care Systems in Alberta.
6. Acknowledge the Risks of Investing in and Relying upon Home-Based Continuing Care as a Fiscal Strategy to Produce Savings and Limit Expenditures in Alberta
7. Ground Emergent Strategic Frameworks to Address OPEH with complex needs within a Consideration of Federal Indian Policy and the Unique Causes and Contours of Indigenous Homelessness

Introduction

How a society treats its most vulnerable…is always the measure of its humanity. Even more so during instability and conflict. When a society begins to disregard the vulnerable and their rights, instability and conflict will only grow.

- Matthew Rycroft

This report offers a survey of the policies that impact the health and social outcomes of older people experiencing homelessness (OPEH) in the province of Alberta. Our critical attention is directed in what follows towards folks who do not fit easily (or at all) into these extant models of continuing and home care. OPEH often have complex needs and are some of the most vulnerable people in Alberta. As the epigraph above suggests, the humanity and the political stability of the province of Alberta is inextricably bound up within the social and health outcomes of these severely marginalized members of our society.

This topic is by its very nature a politically charged subject. The provision of care and services to OPEH with complex needs brings up several complex as well as contentious questions with respect to the governance and administration of healthcare and other services in Alberta. It was for this reason that our team tried as far as possible to approach this work in good faith and to adopt an analytic outlook that favoured a diagnostic rather than polemic approach and form of communication. Our outlook is a bipartisan one and our intent was to generate more light than heat. Of course, because Conservative governments have been uniquely successful in Alberta's electoral political history, most of the critical content in what follows will be directed towards policies that were created and implemented by Conservative politicians at the provincial as well as the federal level. Nonetheless, we strongly affirm that impactful, evidence-based, and fiscally sound social and health policy for aged care is a common goal on which Canadians can find common ground. We also wish to underscore at the outset that Alberta has much to be proud of when it comes to histories of Canadian social policy. In 2008, for example, Alberta became an early provincial adopter of 'Housing First' policies, whereas ten-year plans to end homelessness were declared in several of Alberta's major cities before they appeared anywhere else in Canada.[1] Other Canadian provinces soon followed suit and thousands of Canadians and Indigenous peoples received integrated forms of care for addiction and mental illness as well as stable housing under 'Housing First' frameworks. We are hopeful that Alberta can retrace these past policy successes when it comes to aged care policies and assist OPEH with complex needs in receiving the support they need towards improving their health and social outcomes.

[1] As Collins and Stout noted, by late 2017, more than 15,000 Albertans received housing and other supports due to the implementation of the Housing First policy framework. See Damian Collins and Madelaine Stout, "Does Housing First Policy Seek to Fulfil the Right to Housing? The Case of Alberta, Canada." *Housing Studies* vol. 36, no. 3 (2021): 336.

How to Read this Report

In the remainder of this introduction, we will do some definitional work as well as discuss the demographic data associated with homelessness in Canada in general and OPEH in Alberta more specifically. We also make efforts to avoid pathologizing the Baby Boomer generation and challenge terms such as "Gray Wave" or "Silver Tsunami" while underscoring that robust continuing care systems for Albertans is a policy objective that has benefits for everyone. We then carry through what we term the four policy pillars that produce and shape the health and social outcomes of OPEH in Alberta: first, The Housing and Homeless Sector; second, Continuing Care in Alberta; third, Federal and Provincial Approaches to Harm Reduction; and fourth and finally, to The Operation of Federal Indian Policy and the Production of Indigenous Homelessness. All of these policy realms overlap with one another and we stress that they ought to be understood holistically rather than additively; however, we did write each policy pillar so that it might 'stand on its own', so to speak, which means that readers need not necessarily read this report in a back-to-front fashion should their interest be limited to one specific policy pillar. Though the report contains a progressive and argumentative logic that develops throughout each section and supports our recommendations, each pillar can also be read as a 'chapter' that has (we hope) conveniently curated together a wide array of studies and policy frameworks in a way that is accessible.

We also sought to offer readers no shortage of quantitative data and empirical evidence when describing demographic trends, financial or funding arrangements, or other population-based outcomes associated with the topic at hand. Our citational choice and formatting of footnotes also offers readers easier access to the various studies we cite throughout the report. Though the journal articles we cite will require institutional affiliation or individual subscriptions for those seeking access, we made efforts to include the URLs of government reports and the other grey literature we cited. For those reading this report electronically, these sources are merely a click away and we strongly encourage our readers to familiarize themselves with the documents and policies themselves. And while we will offer recommendations in the closing pages of this report, we also acknowledge that ours is not the only nor the final analysis. For that reason, we sincerely welcome feedback from anyone who was kind enough to invest their time in the reading of this report. Though these issues are complex and involve of a wide array of federal and provincial policy frameworks, we hope that readers engage with this report with the same good faith and sense of urgency with which it was written.

Defining and Enumerating 'Homelessness' in Canada

The Canadian Observatory on Homelessness defines homelessness as "the situation of an individual, family or community without stable, safe, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it."[2] This includes four different groups of people:

[2] Stephen Gaetz, Carolann Barr, Anita Friesen, Bradley Harris, Charlie Hill, Kathy Kovacs-Burns, Bernie Pauly, Bruce Pearce, Alina Turner, Allyson Marsolais, *Canadian Definition of Homelessness* (Toronto: Canadian

1. **Unsheltered people** who are "absolutely homeless and living on the streets or in places not intended for human habitation."
2. **Emergency sheltered peoples**, who are staying in overnight shelters or shelters that offer spaces for those dealing with situations of familial or domestic violence.
3. **The provisionally accommodated**, which refers to individuals who can find temporary shelter (e.g., transitional homes and second stage housing programs) as well as those who are considered amongst the 'hidden homeless', which refers to "people who are temporarily staying with friends, relatives, or others because they have nowhere else to live and no immediate prospect of permanent housing."[3]
4. **At risk of homelessness**, which refers to those who currently have access to housing yet risk losing it due to poverty, precarity, or unsafe housing conditions that fail to satisfy public health and safety standards.[4]

More recently, **Indigenous homelessness** has been identified as a unique social problem that policy makers, service providers, and scholars ought to understand as causatively and conceptually different from homelessness amongst the broader Canadian public.[5]

Observatory on Homelessness Press, 2012), 1; available online at https://www.homelesshub.ca/sites/default/files/COHhomelessdefinition.pdf [accessed October 17, 2022].

[3] Stephen Gaetz, Jesse Donaldson, Tim Richter, & Tanya Gulliver, *The State of Homelessness in Canada* (Toronto: Canadian Homelessness Research Network Press, 2013), 6; available online at https://www.homelesshub.ca/sites/default/files/SOHC2103.pdf [accessed October 17, 2022].

[4] Stephen Gaetz, Carolann Barr, Anita Friesen, Bradley Harris, Charlie Hill, Kathy Kovacs-Burns, Bernie Pauly, Bruce Pearce, Alina Turner, Allyson Marsolais, *Canadian Definition of Homelessness* (Toronto: Canadian Observatory on Homelessness Press, 2012), 1; available online at https://www.homelesshub.ca/sites/default/files/COHhomelessdefinition.pdf [accessed October 17, 2022].

[5] Jesse Thistle, *Definition of Indigenous Homelessness in Canada* (Toronto: Canadian Observatory on Homelessness, 2017); available online at https://www.homelesshub.ca/IndigenousHomelessness [accessed October 17, 2022]. Also, see Julia Christensen, *No Home in a Homeland : Indigenous Peoples and Homelessness in the Canadian North* (Vancouver: UBC Press, 2017).

Figure 1

In the 2016 *State of Homelessness in Canada* report, it was estimated that 235,000 people will experience homelessness in the country each year.[6] This same report also suggested that at least 35,000 people will be homeless on any given night in Canada.[7] These facts and figures are derived from numerical counts of emergency homeless shelters, transitional and second-stage housing units, violence against women shelters, other temporary institutional accommodations, and counts of those who are unsheltered or 'sleeping rough.' 'Hidden homelessness' is often missed in these counts. How to best study and quantify hidden homelessness is a question that often confounds researchers, though one study that was federal in scope suggested that as many as 50,000 people are grappling with hidden homelessness on any given night in Canada.[8] More recently, Statistics Canada released a report suggesting that 3% of people who make housing decisions for their household have experienced unsheltered or absolute homelessness, whereas roughly 15% have experienced hidden homelessness.[9]

[6] Stephen Gaetz, Erin Dej, Tim Richter, and Melanie Redman, *The State of Homelessness in Canada 2016*. Toronto: Canadian Observatory on Homelessness Press, 2016), 5; available online at https://homelesshub.ca/sites/default/files/SOHC16_final_20Oct2016.pdf [accessed October 17, 2022].
[7] Stephen Gaetz, Erin Dej, Tim Richter, and Melanie Redman, *The State of Homelessness in Canada 2016*. Toronto: Canadian Observatory on Homelessness Press, 2016), 5; available online at https://homelesshub.ca/sites/default/files/SOHC16_final_20Oct2016.pdf [accessed October 17, 2022].
[8] Stephen Gaetz, Jesse Donaldson, Tim Richter, & Tanya Gulliver, *The State of Homelessness in Canada* (Toronto: Canadian Homelessness Research Network Press, 2013), 6; available online at https://www.homelesshub.ca/sites/default/files/SOHC2103.pdf [accessed October 17, 2022].
[9] Statistics Canada, *Homelessness in Canada*, March 14, 2022, https://www150.statcan.gc.ca/n1/pub/11-627-m/11-627-m2022017-eng.htm.

A 2018 shelter capacity report found that Canada had 392 emergency shelters and 15,859 permanent beds.[10] In 2019, the Government of Canada implemented "Reaching Home: Canada's Homelessness Strategy", wherein the federal government outlined its larger approach to accomplishing the goals of the first National Housing Strategy, which it described as "an ambitious $40-billion plan to help ensure that Canadians have access to housing that meets their needs and that they can afford."[11] A study in this same year by Alina Turner and Diane Krecsy found that the Government of Canada spent approximately "$33.5 billion…each year on an array of 167,000 fragmented services provided by both government and non-profit organizations across the country."[12] When the World Health Organization declared the COVID-19 pandemic a global emergency in March of 2020, data collection and academic research on homelessness was significantly impeded. Nonetheless, a government release in April of 2020 estimated that Canada had, at that time, "15,400 emergency shelter beds distributed in more than 400 emergency shelters" across the country.[13] When we recall the commonly cited figure that 35,000 people will experience homelessness in Canada on any given night, it is easy to imagine the degree to which the homeless serving sector began to face extreme difficulties with staffing, providing sufficient space for social distancing, and shouldering the costs from the increased need for personal protective equipment and sanitizer at emergency shelters.

The federal government supported the homeless sector through the COVID-19 Economic Response Plan. In April of 2020, one-time transfer payments were issued to Reaching Home ($157.5 million), Women and Gender Equality Canada ($40 million), and Indigenous Services Canada ($10 million), all of which went towards supporting emergency shelters on- and off-reserve, sexual assault centres, and other supportive programs.[14] In September of 2020, the Government of Canada announced its plans to provide Reaching Home with an addition $236.7 million, which further assisted the homeless serving sector in Canada with operational funding

[10] Employment and Social Development Canada, *Homelessness Partnering Strategy: 2018 Shelter Capacity Report,* 2018; available online at https://www.homelesshub.ca/sites/default/files/attachments/Shelter_Capacity_Report_2018-EN%20%281%29.pdf [accessed October 17, 2022].

[11] Government of Canada, *A Place to Call Home: Canada's National Housing Strategy,* 2019; available online at https://www.placetocallhome.ca/-/media/sf/project/placetocallhome/pdfs/canada-national-housing-strategy.pdf [accessed October 17, 2022].

[12] Alina Turner and Diane Krecsy, "Bringing it All Together: Integrating Services to Address Homelessness", *The School of Public Policy Publications* Vol. 12 (2019): 1.

[13] Employment and Social Development Canada, "Canada announces support to those experiencing homelessness and women fleeing gender-based violence during the coronavirus disease (COVID-19) pandemic,", April 4th, 2020, https://www.canada.ca/en/employment-social-development/news/2020/04/canada-announces-support-to-those-experiencing-homelessness-and-women-fleeing-gender-based-violence-during-the-coronavirus-disease-covid-19-pandemic.html

[14] Of this $157.5 million in funding for Reaching Home, Calgary received $13,517,143 and Edmonton received $7,572,510. As a point of comparison, Vancouver received $13,522,453 and Toronto received $22,169573. See Employment and Social Development Canada, "Canada announces support to those experiencing homelessness and women fleeing gender-based violence during the coronavirus disease (COVID-19) pandemic,", April 4th, 2020, https://www.canada.ca/en/employment-social-development/news/2020/04/canada-announces-support-to-those-experiencing-homelessness-and-women-fleeing-gender-based-violence-during-the-coronavirus-disease-covid-19-pandemic.html

and other supports.[15] As policy expert Nick Falvo explains, the federal government also announced in September of 2020 that more than $1 billion in funding was being mobilized for "modular housing, the acquisition of land, and the conversion of existing buildings into affordable housing."[16] Readers seeking a clearer picture of how this funding was deployed in Alberta can find this discussion in Policy Pillar No. 1 under the heading of *COVID-19 and Homelessness in Alberta*; however, it is necessary at this juncture to locate OPEH more precisely within this larger national picture.

Defining and Enumerating OPEH

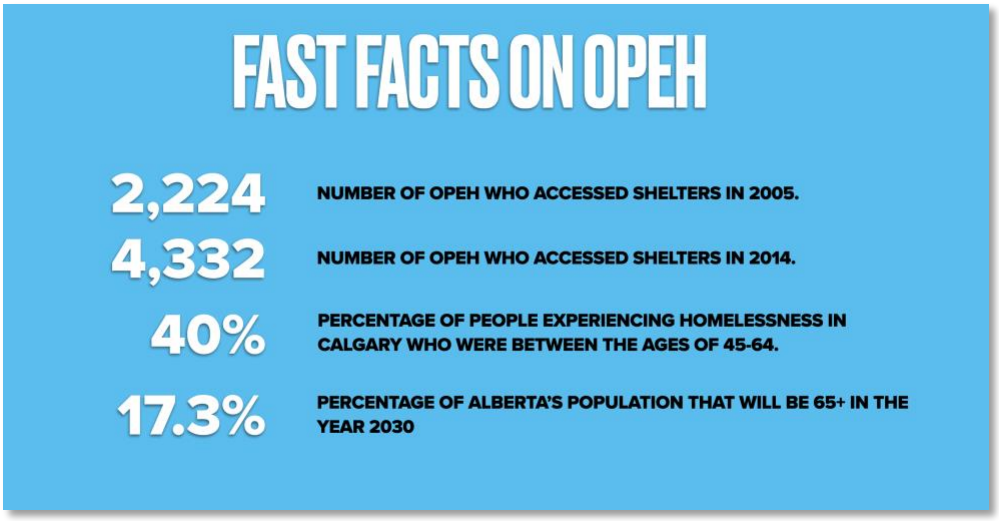

Figure 2

Older people in Canada tend to experience homelessness in two ways. Many OPEH have struggled with housing and shelter for much of their adult lives and can be described as chronically or episodically homeless; conversely, others will experience homelessness for the first time later in life, which is often related to a different set of causative circumstances when compared to those who experienced homelessness earlier in life.[17] Retirement, the loss of loved ones, and declining mental health and mobility can combine to create very difficult circumstances, particularly for those who are economically precarious. Dr. Lara Nixon describes this diversity within OPEH in an Albertan context: "We have people who are coming into homelessness for the first time in their seventies, in their sixties, in their fifties, and then we have a whole mass who have experienced unstable housing for years and years and years."[18] In any

[15] Nick Falvo, *The long-term impact of the COVID-19 Recession on homelessness in Canada: What to expect, what to track, what to do*, December 2020, 6, https://nickfalvo.ca/wp-content/uploads/2020/11/Falvo-Final-report-for-ESDC-FINAL-28nov2020.pdf
[16] Falvo, *The Long-Term Impact of the COVID-19 Recession*, 6.
[17] Amanda Grenier, Rachel Barken, Tamara Sussman, David Rothwell, Valérie Bourgeois-Guérin, and Jean Pierre Lavoie, "Homelessness and aging in Canada: Defining the parameters of a policy and practice-relevant research agenda" in *Canadian Journal on Aging*, vol. 35 no. 1 (2016): 1-14.
[18] Interview with Dr. Lara Nixon, July 25th, 2022.

case, most data collected on OPEH does not seek to quantify or distinguish between these two sub-groups. What is more, experts and researchers who focus on OPEH tend to include in their scope of analysis those aged 50 and above as opposed to 65 and above (the normative retirement age in Canada). One oft-cited literature review from 2016 argued that the age marker of 65+ was "deficient where homelessness is concerned" because "older people who are homeless tend to exhibit mental and physical health characteristics that are more consistent with non-homeless people who are approximately 10 years older than they are."[19] A more recent study of OPEH in Calgary also affirmed that "chronic health conditions associated with aging emerge decades earlier amongst people experiencing homelessness."[20] Thus, for the purposes of this report, we follow other scholars and experts and frame the issue of OPEH as an issue impacting those 50 and above. This is important to underscore given that older adults aged 50-64 make up the largest sub-group of OPEH who access shelters in Canada.[21]

Using these metrics and definitions, a 2021 study suggested OPEH constitute about 24% of shelter users in Canada.[22] Sadly, this is the only demographic that has demonstrated a significant and measurable increase in emergency shelter access over the past two decades. For example, in 2005, 2,224 seniors stayed in emergency shelters whereas nine years later, in 2014, this number had swelled to 4,332.[23] To a limited extent, this growth in older adult and senior homelessness is associated with the graying of the population; however, "the rate of shelter use among seniors has increased even taking into consideration the aging population."[24] What is more, this population is very likely undercounted given that OPEH who are too medically complex (read: beyond the 'level of care') of shelters or low-income housing can often end up residing in hospital for long durations of time awaiting appropriate placement, which will exclude them from counts that focus on shelters and other conventional metrics of counting homelessness.

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[19] Amanda Grenier, Rachel Barken, Tamara Sussman, David Rothwell, Valérie Bourgeois-Guérin, and Jean Pierre Lavoie, "A Literature Review of Homelessness and Aging: Suggestions for a Policy and Practice-Relevant Research Agenda" in *Canadian Journal of Aging* vol. 35, no. 1 (2016): 28-41.

[20] Katrina Milaney et al. "A Portrait of Late Life Homelessness in Calgary, Alberta." *Canadian Journal on Aging*, vol. 39, no. 1, *Cambridge University Press*, 2020, pp. 42–51. Also, see Rebecca Brown, Ryan Kimes, David Guzman, and Margot Kushel, "Health Care Access and Utilization in Older Versus Younger Homeless Adults." *Journal of Health Care for the Poor and Underserved* vol. 21, no. 3 (2010): 1060–70.

[21] Annie Duschesne, Jacqueline Rivier, Patrick Hunter, Ian Cooper, *Highlights of the National Shelter Study 2005-2016 – Emergency Shelter Use in Canada*, 2019, https://www.infrastructure.gc.ca/alt-format/pdf/homelessness-sans-abri/reports-rapports/000920-RH-NSS-Highlights-Report-EN-Draft05Aug2019.pdf. Also, see Christine A. Walsh, Jennifer Hewson, Karen Paul, Cari Gulbrandsen, and Dorothy Dooley, "Falling Through the Cracks: Exploring the Subsidized Housing Needs of Low-Income Preseniors From the Perspectives of Housing Providers" *SAGE Open* 5, no. 3 (2015): 1-9.

[22] Joe Humphries and Sarah L. Canham, "Conceptualizing the Shelter and Housing Needs and Solutions of Homeless Older Adults" in *Housing Studies* vol. 36, no. 2 (2021): 157.

[23] Stephen Gaetz, Erin Dej, Tim Richter, and Melanie Redman, *The State of Homelessness in Canada 2016*. Toronto: Canadian Observatory on Homelessness Press, 2016), 32; available online at https://homelesshub.ca/sites/default/files/SOHC16_final_20Oct2016.pdf [accessed October 17, 2022].

[24] Stephen Gaetz, Erin Dej, Tim Richter, and Melanie Redman, *The State of Homelessness in Canada 2016*. Toronto: Canadian Observatory on Homelessness Press, 2016), 32; available online at https://homelesshub.ca/sites/default/files/SOHC16_final_20Oct2016.pdf [accessed October 17, 2022].

Complicating this empirical picture even further is the fact that different cities use different ages as benchmarks in their studies on OPEH. For example, a City of Toronto report noted in 2013 that 29 per cent of people experiencing homelessness were 51 and older; in the same report, it was explained that the "share of respondents who indicated they were aged 61 and older increased from 5% to 10% between 2009 and 2014."[25] In a 2017 study, OPEH in Vancouver were counted as those over the age of 54 and constituted 21% of the total population experiencing homelessness, which was part of a larger municipal trend in increased rates of OPEH that began in 2008.[26] In 2018, a Point-in-Time (PiT) Count in the city of Calgary reported that 40% of those experiencing homelessness were between the ages of 45-64.[27] As Walsh et. al noted as far back as 2015, "the definition of older adults in the literature is inconsistent and may refer to adults aged 50, 55, 60, or 65, presenting policy and practice challenges for examining the risk factors and needs of this population."[28]

Two things seem clear from these numbers: first, that practices of enumerating OPEH need to be standardized across Canadian cities and provinces (see our Recommendation No. 1); second, the data suggests that it can be reliably expected that Canadians and Indigenous peoples over the age of 50 represent roughly one-fifth to one-quarter of those experiencing homeless in major Canadian cities. This is probably a conservative estimate; for example, a more recent study (2020) of 300 individuals sleeping rough and using shelters in the city of Calgary found that 47% of those surveyed were over the age of 50.[29] In any case, it seems very likely that rates of OPEH will continue to increase in Alberta as well as across Canada more broadly due to the population structure of the country.

Demographic Dynamics and the So-Called 'Gray Wave'

Terms such as 'gray wave' or 'silver tsunami' have been widely used to refer to the aging of the Baby Boomer Generation (1946-1964), who are now entering their senior and advanced stages of life.[30] Such terminology is often deployed in an alarmist way to discuss the financial impacts that this demographic trend might have on the Canadian or Albertan economic sector

[25] City of Toronto, *Street Needs Assessment Results*, 2013, 4, https://www.toronto.ca/legdocs/mmis/2013/cd/bgrd/backgroundfile-61365.pdf.
[26] BC Non-Profit Housing Association and M. Thomson Consulting, *2017 Homeless Count in Metro Vancouver Final Report*, September 2017, 7, https://www.vancitycommunityfoundation.ca/sites/default/files/uploads/2017HomelessCountInMetroVancouver.pdf
[27] Calgary Homeless Foundation, *Calgary Point in Time Count Report Spring 2018*, 24, http://www.calgaryhomeless.com/wp-content/uploads/2019/11/Calgary_PiT_Report_2018.pdf
[28] Christine A. Walsh, Jennifer Hewson, Karen Paul, Cari Gulbrandsen, and Dorothy Dooley, "Falling Through the Cracks: Exploring the Subsidized Housing Needs of Low-Income Preseniors From the Perspectives of Housing Providers" *SAGE Open* 5, no. 3 (2015): 2.
[29] Katrina Milaney, Hasham Kamran, and Nicole Williams, "A Portrait of Late Life Homelessness in Calgary, Alberta." *Canadian Journal on Aging*, vol. 39, no. 1 (2020): 45.
[30] Stephen J Bartels and John A Naslund, "The Underside of the Silver Tsunami — Older Adults and Mental Health Care." *The New England Journal of Medicine* vol. 368, no. 6 (2013): 493–96. https://doi.org/10.1056/NEJMp1211456.

and healthcare system. For example, the *Calgary Herald* ran an article in March of 2021 whose headline suggested that "the coming gray wave of boomers will overwhelm society if we don't act now."[31] Citing Statistics Canada data that predicted the +85 population would swell from 844,000 in 2019 to 2.63 million in 2049, the article discussed a coming crisis of care for seniors whose sheer numbers threaten to overwhelm an already stressed system of long-term, supportive living, and continuing care in the province. This alarmism is hardly new; for example, in 2011, *The Calgary Herald* ran a similar headline which read "Aging Boomers Will Stretch Health-Care System."[32]

On a more national level, the discourse around the issue is much the same in that the sustainability of care for seniors is frequently called into question due to the aging of Baby Boomers. For example, The National Institute on Ageing released a report in October of 2019 underscoring that "the number of Canadians over age 85 is expected to more than triple [over the next thirty years]…If current health and social care policies and practices continue, these factors point to a future in which there will be significant increases in the amount of support needed from family caregivers and substantially larger costs to the public purse."[33] There are, to be sure, several good reasons to deploy this kind of language and alarmist rhetoric when discussing public health policies and health system coordination, as the need to create a culture of urgency around this question will be felt by all who study it in a serious way, and doubly so in Alberta. As the Alberta Association of Gerontology noted in 2015, "Alberta's population is aging. Eleven percent of the Alberta population is now over 65 years. It will grow to 17.3% by the year 2030. This means one in five Albertans will be over 65 years in 2030."[34] This demographic trend will pose significant challenges for policy makers and has to be responded to in an even-handed and evidence-based fashion to ensure high standards of care that will assist those in Alberta to age with dignity, in the place of their choosing, alongside loved ones, and with access to an array of well-funded medical services that will provide comfort, convenience, and relief.

Nonetheless, we want to underscore the problematic associations with constructing a specific generation as an undue strain on social supports, the economy, and/or healthcare system. First and foremost, ageing is an issue that impacts everyone. To construct this issue as one that uniquely centres around the Baby Boomer generation is to frame the matter reductively. As Gabrielle Betts rightly points out, "we are *all* aging, but only one year at a time, a pace more

[31] Licia Corbella, "The Coming Grey Wave of Boomers Will Overwhelm Society If We Don't Act Now", *Calgary Herald*, March 3, 2021; available online at https://calgaryherald.com/news/postpandemic/corbella-11 [accessed June 3, 2022].
[32] E. Ferguson, "Aging Boomers Will Stretch Health-care System." *The Calgary Herald*, January 4th, 2011, A1.
[33] National Institute on Ageing, *The Future Cost of Long Term Care in Canada*, October 2019; available online at https://bc.healthyagingcore.ca/sites/default/files/2020-05/The%2BFuture%2BCost%2Bof%2BLong-Term%2BCare%2Bin%2BCanada.pdf [accessed June 3, 2022].
[34] Carl Amrhein, *Alberta Health, Deputy Minister of Health Policy Panel Discussion: Transforming Seniors' Policies and Programs to Meet the Needs of the New Aging Population*. Alberta Association of Gerontology Policy Panel Presentation, Edmonton, AB, 2015; available online at https://iccer.ca/pdf/events/AAG_3Oct16_paneldiscussion.pdf [accessed June 3, 2022].

consistent with a 'silver glacier' than a tsunami."[35] Secondly, terms like 'gray wave' or 'silver tsunami' unduly pathologize and homogenize those who will require a variety of services and complex forms of care in the decades to come. This is arguably true of the term "Baby Boomer" more generally, which has been widely critiqued as a category of social scorn through which ageism and ableism have operated.[36] Third, in the same way that a spotlight on a theatrical stage performs the double function of revealing what it illuminates and concealing what it does not, the spotlight being shone on the so-called 'gray wave' also conceals this issue's intersection with other demographic trends that also go towards shaping the fiscal landscape of continuing care in Canada. Of primary relevance here is the way in which an inverted pyramid population structure (that is, with many more seniors than adolescents) has significantly reduced public spending needs on primary and secondary education relative to earlier historical periods, which mediates the fiscal impact of increased healthcare costs. For that reason, we wish to echo Robert G. Evans who wrote in 2010 that "panic-mongering about a 'gray tsunami' is yet another distraction from the real health care problems and solutions that should be concerning us."[37] Thus, while the urgency of the matter at hand is undeniable, it is important to frame it in a level-headed way that resists alarmism and fosters intergenerational solidarities. As Katrina Milaney noted, Canadians should care deeply about Baby Boomers "because many of them were war veterans, because they were economically productive throughout their lives. They contribute: they had children; they had jobs; they paid taxes…there is possibility to leverage that sort of 'gray movement' to say that these are people who are valued members of society and have proven that over the course of their lives, and are now in a position where they need some support."[38] Of course, in addition to stressing a culture of support towards older people in in Canada, it is important to understand what systems of support currently exist for OPEH with complex needs in Alberta, how these structures emerged and developed, and where the legislative and fiduciary dynamics of provincial-federal relations come into play. It is in pursuit of this kind of structural coherence that we procced to the first policy pillar.

Policy Pillar No. 1:
Housing Policies and the Homelessness Sector

[35] Gabrielle Betts, *Graying States: Elder Care Policy in Alberta, Canada and Sweden* (Dissertation: Carleton University, 2014), p. 15;.
[36] See Jennie Bristow. "The Making of 'Boomergeddon': The Construction of the Baby Boomer Generation as a Social Problem in Britain." *The British Journal of Sociology* vol. 67, no. 4 (2016): 575–91. Also, see Cody Cox, Friederike K. Young, Adrian B. Guardia, and Amy K. Bohmann, "The Baby Boomer Bias: The Negative Impact of Generational Labels on Older Workers" in *Journal of Applied Social Psychology* vol. 48, no. 2 (2018): pp. 71–79. Finally, see Brad A. Mesiner "Are You OK, Boomer? Intensification of Ageism and Intergenerational Tensions on Social Media Amid COVID-19" in *Leisure Sciences* vol. 43, no. 1-2 (2021): pp. 56–61.
[37] Robert G. Evans, "The Unsustainability Myth: Don't Believe Claims Medicare is Becoming Unaffordable", *Canadian Centre for Policy Alternatives*, July 1, 2010; available online at https://policyalternatives.ca/publications/monitor/unsustainability-myth [accessed 29 June 2022].
[38] Interview with Katrina Milaney, June 15th, 2022.

In this section, we review the approach of both federal and provincial governments to addressing and preventing homelessness amongst older adults and seniors. Because the issue of OPEH is implicitly related to poverty amongst older adults and seniors, we begin by examining income support policy for seniors. Thereafter, we review a brief policy history that covers the emergence of modern homelessness in Canada in the 1980s and the impacts of policy responses from the federal government in the 1990s. We then carry through with an analysis of the emergence of 'Housing First' frameworks in Alberta as well as the emergence of municipal ten-year-plans-to-end-homelessness in the same period of the late 2000s and early 2010s. As noted elsewhere in this report, we view the success of 'Housing First' in Alberta as an example of the province's capacity for evidence-based, fiscally sound, and impactful policy leadership in the Canadian context of housing and homelessness. Finally, we assess the provincial response to COVID-19 and discuss the impact that the pandemic had on the homeless sector in Alberta.

Income Supports for Seniors in Canada

At the age of 60, Canadians become eligible for the Canadian Pension Plan (CPP) retirement pension payment. This monthly taxable benefit is a payment that is determined by three things: first, one's average earnings throughout their working life; second, one's contributions to the CPP; and third, the age at which one applies to start receiving CPP payments.[39] If one opts to delay receiving their CPP payments, their monthly payments will increase, whereas if one applies to receive them at age 60, the amount will be reduced (thereby creating an economic incentive to delay one's CPP payments as far as possible up until and including the age of 70). As the federal government explains:

> The standard age to start the pension is 65. However, you can start receiving it as early as age 60 or as late as age 70. If you start receiving your pension earlier, the monthly amount you'll receive will be smaller. If you decide to start later, you'll receive a larger monthly amount. There's no benefit to wait after age 70 to start receiving the pension. The maximum monthly amount you can receive is reached when you turn 70.[40]

There are several reasons why CPP payments are not effective at or even necessarily designed to support seniors with low-income or those who might experience homelessness. First and foremost, there are other senior income support programs that are meant to perform this function (see paragraphs below). Second, those who experience homelessness or poverty have less disposable income to invest in retirement plans such as the CPP or other pension programs. Third, the CPP payment plan must be applied for and opted into at age 60, which causes a difficulty for those who might lack the structural knowledge and administrative capacity required to successfully initiate, navigate, and complete the application. The question of homelessness also begs the question of where an individual might receive a monthly cheque given the lack of a

[39] Government of Canada, *Canadian Pension Plan – Overview*, last modified August 8th, 2022, https://www.canada.ca/en/services/benefits/publicpensions/cpp.html.
[40] Government of Canada, *Canadian Pension Plan – Overview*, last modified August 8th, 2022, https://www.canada.ca/en/services/benefits/publicpensions/cpp.html.

home address. Though direct deposit schemas have to some degree increased the accessibility of CPP payments, the government form of application for direct deposit of CPP payments still asks applicants for a fixed address.[41] In any case, policy recommendations directed at CPP policies, standards, and procedures are unlikely to have an impact on OPEH given that this monthly retirement payment plan is to a considerable degree geared to one's income. Similarly, OPEH tend to generate very little income from RRSP withdrawals, capital gains (e.g., from the sale of property that is not a principal residence), or investments; low-income seniors rely overwhelmingly on Old Age Security and Guaranteed Income Supplement payments.[42]

Canadian citizens become eligible for Old Age Security (OAS) payments the month after they turn 65. If they are low-income seniors, they are also eligible for Guaranteed Income Supplement (GIS) programs as long as they fall below a certain threshold of income. In 2022, a low-income senior must have an annual income below $20,784 to be eligible for GIS payments.[43] This rate is adjusted for household income levels and also shifts if one's spouse or common-law partner also receives OAS. For OPEH, then, turning 65 can be a major turning point in one's life given the sudden eligibility for senior's income support payments. The rate of poverty (defined here as any individual or household making less than fifty per cent of the median annual income) drops off significantly when Canadians turn 65. For example, single women in Canada who are 64 years of age experience poverty at a rate of 37 per cent; by age 65, however, this rate drops to a 21 per cent.[44] 22 per cent of single men in Canada who are 64 years of age will experience poverty, yet this figure falls to 15 per cent once these individuals turn 65.[45] Thus, OAS and GIS payment structures are a foundational and extremely relevant piece of the policy puzzle when discussing strategies to prevent and address OPEH both in Alberta as well as across Canada.

Employee sponsored Registered Pension Plans (RPPs), Registered Retirement Savings Plans (RRSPs), and other investment-based strategies for building economic resiliency in retirement years (such as tax free savings accounts [TFSA] or guaranteed investment certificates [GIC] are less effective strategies when discussing OPEH from a policy perspective. By definition, such approaches involve the investment of disposable income, which is a luxury most people experiencing homelessness cannot afford. Further, one's capacity to generate investment-based or 'passive income' also requires forms of economic literacy and financial acumen that

[41] This form, SC-ISP-1011, was last updated or modified in January of 2018. See https://hfg.ca/files/DirectDepositCPPOAS_99.pdf
[42] As a point of reference, GIS benefit recipients made up roughly 6% of those who held TFSAs in Canada in 2011; see Minister of Finance, *Part 2—Tax Evaluations and Research Reports, Tax-Free Savings Accounts: A Profile of Account Holders*, last modifed May 17th, 2018, http://www.fin.gc.ca/taxexp-depfisc/2012/taxexp1202eng.asp#ftn13
[43] Government of Canada, *Guaranteed Income Supplement Amounts – October to December 2022*, last modified May 5th, 2022, https://www.canada.ca/en/services/benefits/publicpensions/cpp/old-age-security/guaranteed-income-supplement/benefit-amount.html
[44] Allan Moscovitch, Nick Falvo, and David Macdonald, "The Federal Government and Old Age Security", *How Ottawa Spends: 2015-2016* eds. Christopher Stoney and Bruce Doern, (Ottawa: School of Public Policy and Administration, 2016), 148, https://carleton.ca/sppa/wp-content/uploads/HOW-OTTAWA-SPENDS-2015-2016.pdf
[45] Allan Moscovitch, Nick Falvo, and David Macdonald, "The Federal Government and Old Age Security", *How Ottawa Spends: 2015-2016* eds. Christopher Stoney and Bruce Doern, (Ottawa: School of Public Policy and Administration, 2016), 148, https://carleton.ca/sppa/wp-content/uploads/HOW-OTTAWA-SPENDS-2015-2016.pdf

policy makers cannot reasonably or reliably expect OPEH to have. For example, if one generates income from a tax-free savings account (TFSA), this income is not counted towards one's individual or household income when calculating one's OAS benefits and by extension GIS eligibility. However, like delaying CPP payments, contributing to a RPP, or making RRSP investments, this kind of economic maneuvering requires considerable disposable income as well as financial literacy for one to take advantage, which mediates its impact on OPEH considerably.

Poverty amongst seniors and older adults in Canada is also significantly stratified across race and gender.[46] For example, White Canadians enjoy an average income of $42,800, which is 25% higher than Indigenous seniors, whose average income is $32,200, and 32% higher than the average income of racialized Canadians, whose average income is $29,200.[47] There is also some significant variation within this category of 'racialized Canadian.' For example, Chinese seniors have the lowest average income ($28,200), followed by South Asian seniors ($29,000), and Black seniors ($32,400).[48] Within all of these groups, women generate less income than men, which means that racialized and Indigenous women are precariously positioned in the Canadian economic landscape.[49] This dynamic has led to what others have termed "the unequal uptake of government pensions in Canada" and matters for any policy makers who are seeking to meaningfully address or proactively prevent older people and seniors from experiencing homelessness in Canada.[50]

What is more, recent immigrants who are low-income older adults and seniors are also broadly identified in the literature as individuals who are uniquely vulnerable to experiences of

[46] See Valerie Preston, Natalie Weiser, Katharine King, Nancy Mandell, Ann H. Kim, and Meg Luxton, "Worked to death: diverse experiences of economic security among older immigrants" in *Immigrant Integration: Research Implications For Future Policy*, ed. Kenise M. Kilbride (Toronto: Canadian Scholars Press, 2014), 67-81. Also, see Naomi Lightman and Hamid Akbary, "Working More and Making Less: Post-Retirement Aged Immigrant Women Care Workers in Canada" in *Journal of Aging & Social Policy* 35, no. 2 (2023): 261–86.

[47] Sheila Block, Grace-Edward Galabuzi, Hayden King, *Colour-Coded Retirement: An Intersectional Analysis of Retirement Income and Savings in Canada* (Canadian Centre for Policy Alternatives, June 2021), 5, https://policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2021/06/Colour%20coded%20retirement.pdf

[48] Sheila Block, Grace-Edward Galabuzi, Hayden King, *Colour-Coded Retirement: An Intersectional Analysis of Retirement Income and Savings in Canada* (Canadian Centre for Policy Alternatives, June 2021), 5, https://policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2021/06/Colour%20coded%20retirement.pdf

[49] See Valerie Preston, Natalie Weiser, Katharine King, Nancy Mandell, Ann H. Kim, and Meg Luxton, "Worked to death: diverse experiences of economic security among older immigrants" in *Immigrant Integration: Research Implications For Future Policy*, ed. Kenise M. Kilbride (Toronto: Canadian Scholars Press, 2014), 67-81. Also, see Naomi Lightman and Hamid Akbary, "Working More and Making Less: Post-Retirement Aged Immigrant Women Care Workers in Canada" in *Journal of Aging & Social Policy* 35, no. 2 (2023): 261–86.

[50] Josh Curtis, Weizhen Dong, Naomi Lightman, and Matthew Parbst, "Race, Language, or Length of Residency? Explaining the Unequal Uptake of Government Pensions in Canada" in *Journal of Aging & Social Policy* 29, no. 4 (2017): 332–51.

homelessness.[51] In 2016, Statistics Canada reported that 24% of all senior immigrants who had landed in Canada since 2006 were in a low income bracket, compared to 14% of the non-immigrant population.[52] The same report underscored that "senior immigrants represented 31% of the total senior population over the age of 65."[53] Further, one study underscores that "immigrants in Canada overall earn less than Canada's native-born throughout their working years and disproportionately face barriers in accessing 'good' jobs with strong employer pensions."[54] Therefore, any policy response related to poverty or homelessness amongst seniors and older adults must take into account the fact that the landscape of poverty in Canada is both racialized and gendered. A failure to acknowledge this will prevent Canadians from understanding the impacts and outcomes of particular policy shifts, which will risk reproducing the economic inequities and inequalities that already exist in Canada to the extent that they fail to take into account the intersecting impacts of race and gender on income levels for seniors.

A key example in this regard is the history of attempted delays to the age of OAS eligibility. In 2012, the Harper government announced its intentions to change the age of OAS eligibility from 65 to 67 by the year 2023. Using the Social Policy Simulation Database, a team of researchers underscored that this decision would "almost certainly increase poverty among seniors who are under the age of 67" as well as "result in considerably more persons aged 65 and 66 relying on social assistance, which will represent a substantial transfer of spending from the federal government to provincial and territorial governments."[55] Naming the policy directive as "a clear decision to increase senior poverty", the research team was no doubt influential in raising public awareness on the matter and can be credited with informing the decision of the Trudeau federal government to undo this planned postponement of age eligibility from OAS. Policy expert Nick Falvo focused on a 2016 story from Calgary as a way to drive home the importance of freezing the OAS age benchmark at 65 as a means of preventing older folks from experiencing homelessness. One individual who had been staying at the Calgary Drop-In Centre found that, at age 65, he was eligible to receive a kind of 'pay-raise', so to speak, as he had crested the threshold of age eligibility. For five years, this individual had been relying on the emergency shelter, as his social assistance benefits were insufficient to fund his transition into an

[51] For a Canadian study on this subject, see Boris Palameta, "Low income among immigrants and visible minorities" in *Perspectives on Labour and Income* 5, no. 4 (April, 2005): 1-10, https://www150.statcan.gc.ca/n1/en/pub/75-001-x/10404/6843-eng.pdf?st=cHjpggcD. Also, see Edward Ng, Daniel W.L. Lai, Aliza T. Rudner, and Heather Orpana, *What do we know about immigrant seniors aging in Canada? A demographic, socio-economic and health profile*, CERIS Working Paper Series, February 2012, http://eapon.ca/wp-content/uploads/2014/03/What-do-we-know-about-immigrant-seniors-aging-in-Canada.pdf

[52] Wendy Kei, Marc-David L. Seidel, Dennis Ma and Marjan Houshmand, *Results from the 2016 Census: Examining the effect of public pension benefits on the low income of senior immigrants*, Statistics Canada, 2019, 1, https://www150.statcan.gc.ca/n1/pub/75-006-x/2019001/article/00017-eng.htm

[53] Wendy Kei, Marc-David L. Seidel, Dennis Ma and Marjan Houshmand, *Results from the 2016 Census: Examining the effect of public pension benefits on the low income of senior immigrants*, Statistics Canada, 2019, 1, https://www150.statcan.gc.ca/n1/pub/75-006-x/2019001/article/00017-eng.htm

[54] Josh Curtis and Naomi Lightman, "Golden Years or Retirement Fears?: Private Pension Inequality Among Canada's Immigrants" in *Canadian Journal on Aging* 36, no. 2 (2017): 179.

[55] Allan Moscovitch, Nick Falvo, and David Macdonald, "The Federal Government and Old Age Security", *How Ottawa Spends: 2015-2016* eds. Christopher Stoney and Bruce Doern, (Ottawa: School of Public Policy and Administration, 2016), 168, https://carleton.ca/sppa/wp-content/uploads/HOW-OTTAWA-SPENDS-2015-2016.pdf

affordable apartment program. However, upon turning 65, he became immediately "eligible for Old Age Security and Guaranteed Income Supplement… that helped him secure a spot in the Calgary Drop-In's affordable apartments."[56] In an overview of social assistance trends in Canada, Kneebone and White used Sarlo's measurement of basic needs—which adjusts for costs of living by year and location— to present how consistently provincial social assistance payments fall short of what is considered the minimum amount income required to meet one's basic needs in Alberta. Interestingly, they also plotted the amount of income that those unable to collect CPP due to insufficient work histories could receive from OAS and GIS, illustrating that what is considered by the Federal government as the minimum amount of income required to meet one's needs greatly exceeds what is provided by the Provincial governments social assistance programs.[57] Further, Falvo explained (using the fiscal year of 2015/2016 as a reference point):

> For example, a single senior with no other income currently has access to just over $17,000 annually from OAS and GIS; but as a social assistance recipient, the same person would receive between $7,000 and $11,000 per year (depending on the province)—or $6,000 and $16,000 in the territories. What's more, social assistance is funded by provincial governments, meaning that the proposed changed would offload spending from the federal government onto provincial governments.[58]

As one can see, the decision to increase the age eligibility of OAS from 65 to 67 would not only result in a predictable increase to rates of OPEH in Canada, but it would also substantially impact public funding schemas in Alberta to the extent that the province would have to fund social assistance benefits for low-income seniors aged 65 and 66. Though it is true that Alberta is much better positioned than other provinces to absorb and adapt to increased social assistance expenditures, this report nonetheless recommends that it is in the best interest of Albertans to prevent the federal government from any further attempts to increase the age eligibility for OAS. This would have devastating impacts for Indigenous peoples, racialized Albertans, and immigrants, who already experience disproportionate amounts of poverty, especially amongst senior populations.

The Invention of Homelessness in Canada

Like many other western countries, Canada saw a sharp rise as well as a diversification of those experiencing homelessness in the 1980s. Prior to this decade, the face of homelessness in

[56] "Calgary Man Lands Apartment After Five Years Staying at Drop In Centre", August, 3rd, 2022, https://www.metronews.ca/news/calgary/2016/08/03/calgary-man-lands-apartment-after-five-years-staying-drop-in.html.
[57] Ronald Kneebone and Katherine White, *Welfare Reform in Canada : Provincial Social Assistance in Comparative Perspective*, eds. Béland, Daniel, and Daigneault, Pierre-Marc, (Toronto: University of Toronto Press, 2015), 88.
[58] Nick Falvo, "Federal Income Support for Seniors Can Help End Homelessness", *Calgary Homeless Foundation*, Sepetember 1, 2016, https://www.calgaryhomeless.com/federal-income-support-for-seniors-can-help-end-homelessness/

the country was often that of single men who were more likely to be referred to as 'transient' than 'homeless.' As David Hulchanski noted in a keynote address on homelessness delivered in Calgary in 2009, those labelled as 'transients' often had housing, although for many, that housing was in poor condition—an indicator of core housing need.[59] Likewise, there were also transient single men in many cities who were assisted by organizations like the Salvation Army. These men were referred to at times as homeless, though they generally lived in poor-quality 'skid-row' rooming houses and flophouses."[60] The post-war period and following decades (read: the 1960s and 1970s) witnessed a surge in government supports, the consolidation of the social welfare state, and a general investment from the federal government in the creation of housing programs that assisted in affordability and access. Nonetheless, cutbacks to social housing and programs in the 1980s coalesced with a larger economic shift towards free market ideologies, laissez-faire policy outlooks, deinstitutionalization, and a rolling back of full-time employment opportunities that offered pensions and sufficiently stable incomes.[61] Gentrification and urban restructuring also reduced low-cost housing options in many locales and exacerbated the existing impacts of economic recessions on struggling families and communities who resided in larger Canadian cities.[62] Hulchanski refers to this time period as "the invention of homelessness" for two reasons: first, to illustrate that emergent economic trends had unhoused thousands of people in developed countries in new and unprecedented ways; and second, to show that our contemporary understanding and use of the term 'homelessness' was foundationally formed during this decade. To illustrate this point, Hulchanski and a research team conducted a review of a historical database of *New York Times* articles published between 1851 and 2005. They found that 87 per cent of the references to 'homelessness' were made in articles published between 1985 and 2005.[63] In a manner of speaking, then, 'homelessness' is a problem that has emerged recently within the last four decades rather than a long-standing socio-economic trend.

The Canadian federal government policies to address homelessness in the early to mid-1990s did little to address burgeoning rates of homelessness in Canada. In 1990, for example, the federal government created a cap on funding for the Canadian Assistance Program and discontinued its practice of offering the provinces of Ontario and Alberta a 50/50 cost-sharing

[59] *Core housing need* is defined by the Canadian government using three metrics: affordability, adequacy, and suitability. See Dictionary, Census of Population, 2016: Core housing need; available online at https://www12.statcan.gc.ca/census-recensement/2016/ref/dict/households-menage037-eng.cfm [accessed January 13, 2023]

[60] David J. Hulchanski quoted in Emma Mooley, "Why Wasn't Homelessness a Social Problem until the 1980s?", *Canadian Observatory on Homelessness*, 2015; available online at https://www.homelesshub.ca/blog/why-wasnt-homelessness-social-problem-until-1980s [accessed October 17, 2022].

[61] Joe Humphries and Sarah L. Canham, "Conceptualizing the Shelter and Housing Needs and Solutions of Homeless Older Adults" in *Housing Studies* vol. 36, no. 2 (2021): 157.

[62] Cheryl Zlotnick, Suzanne Zerger, and Phyllis B. Wolfe, "Health Care for the Homeless: What We Have Learned in the Past 30 Years and What's Next" in *The American Journal of Public Health*, Vol. 103, No. 2 (2013): S199-S205.

[63] David Hulchanski, "The invention of homelessness" in *The Star*, September 18th, 2010; available online at https://www.thestar.com/opinion/editorialopinion/2010/09/18/the_invention_of_homelessness.html.

approach to the funding of social assistance and social services.[64] In 1993, the federal government ceased all funding dedicated towards the construction of new social housing across the country. Three years later, in 1996, the Government of Canada fully transferred fiduciary responsibilities for low-income social housing to provincial authorities. Housing expert Nick Falvo refers to this period of retrenchment as "the dark years of housing policy in Canada" given that government divestment from social housing and increased rates of visible homelessness in Canadian cities followed predictably from these dramatic policy shifts.[65] Erin Dej succinctly explains this larger policy history and its impact on Canadians' capacity to house ourselves:

> From the '50s straight on through up until the '80s, we had a huge investment in social housing [in Canada]… For example, in 1973, 20,000 units of social housing were built in just that one year. And that investment in 20,000 housing units a year happened every year for a decade…And then in the 1980s, [the federal government] started to slow down that investment in social housing until 1993, when the federal government said 'we're out of the housing game, we're taking a step back. We're not going to support social housing anymore.' And they put it onto the provinces… In 1995, it was 1,000 housing units built in that year, so a huge drop in the number of units we were building. At the same time, those social housing units that were being built in the '50s and '60s and '70s, they started to get older and so they needed repairs. And so that investment was no longer there in maintaining…the social housing that did exist. So not only were we not building, we were starting to lose the social housing that had been built previously because it was falling into disrepair.[66]

Broadly speaking, the federal government's abdication of social housing responsibilities failed to address what had emerged in the previous decade as a significant social problem. As homelessness waxed as a social problem in Canada, federal funding, responsibility, and leadership waned. As John Sewell noted, this divestment from social housing policies was matched with a significant reduction in funding for all social services: "in the fiscal year 1992/93, the federal government's contribution to provinces for social spending was $17.9 billion; by 1995 it was $16.6 billion, and by 1996/97 it was $14.9 billion."[67] These larger fiduciary relations between the provinces and the federal government are a significant turning point in any policy history that reports upon the health and social outcomes of OPEH with complex needs in Alberta or, indeed, in any province. Of course, federal factors continued to

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[64] In May of 1995, the Canadian Assistance Plan was replaced entirely by the Canadian Health and Social Transfer Program. See John Sewell, "Housing: Who Is Responsible?" in *Literary Review of Canada* vol. 13, no. 4 (2005): 9–10.

[65] Dr. Nick Falvo, "What housing policy existed in the past?", *Understanding Homelessness in Canada*, February 16th, 2022; available online at https://youtu.be/zS_ihwnoGIM?list=PLesOiZ7KqWPZ37Wnlgwtw_MSbiNqRo3xi [accessed October 17, 2022].

[66] Erin Dej, "What Housing Policy Existed in the Past?", *Understanding Homelessness in Canada*, February 16, 2022; available online at https://youtu.be/_nrE_ulZWt8?list=PLesOiZ7KqWPZ37Wnlgwtw_MSbiNqRo3xi [accessed October 17, 2022].

[67] John Sewell, "Housing: Who Is Responsible?" in *Literary Review of Canada* vol. 13, no. 4 (2005): 9–10.

shape these outcomes, particularly in the realm of federal drug strategies as well as government pension and income assistance programs. However, by the end of the 1990s, provincial policies and approaches to housing and homelessness became much more influential by virtue of federal divestments from these sectors. It is also probably worth noting here that the lion's share of these federal policy developments during the 'dark years of housing policy in Canada' came from the leadership of the Liberal party and Prime Minister Jean Chrétien, whose austerity can hardly be diagnosed as a function of Conservative political ideologies.

Alberta Responds to Federal Divestments: The Klein Era

Alberta's immediate response to the federal divestment from social housing and supportive services was to create and consolidate provincialist frameworks for their governance and administration. At the same time, cities across the province began to engage with homeless as a pressing social problem that required significant attention. For example, in 1992, the City of Calgary conducted its first census of the homeless. In 1994, the Alberta Housing and Mortgage Corporation became the Alberta Social Housing Corporation (ASHC), which operated under the terms of the new Alberta Housing Act.[68] In the same year, a Provincial Mental Health Board was created, which "was responsible to the Ministry of Health for the delivery and oversight of institutional and community-based mental health services."[69] In 1995, the Alberta government carved out 0.36% of its total GDP and earmarked it as housing funding (though this number would steadily decrease in the years to come).[70] In 1998, the Calgary Homeless Foundation was created when the philanthropist Art R. Smith brought together agencies, corporations, and governmental bodies to create an organization whose express purpose was to serve and support the quickly growing homeless population in Calgary.[71] In 2003, the Calgary Homeless Foundation founded the Calgary Community Land Trust, which functioned as a real estate developer, rental housing owner, and property manager that helped to increase housing stock in Calgary for those who require affordable or specialized supportive housing units.[72]

In the broad sense, developments such as these attest to the way in which Albertans mobilized significant structural resources in the mid to late 1990s as a way to respond to homelessness as well as the shifting terrain of federal funding frameworks for housing and social services. The coordination of service delivery and larger management of public housing stock

[68] The provincial housing corporation was created in 1967 as the Alberta Housing and Urban Renewal Corporation. When the Alberta Housing Act of 1970 was passed, the name changed to the Alberta Housing Corporation. Later, in 1984, this body became the Alberta Housing and Mortgage Corporation.
[69] John Church and Neale Smith, *Alberta: A Health System Profile* (Toronto: University of Toronto Press, 2022), 28.
[70] Alina Turner, Victoria Ballance, Joel Sinclair, *Calgary's Ten Year Plan to End Homelessness: Collective Impact Report*, November 2018; available online at http://www.calgaryhomeless.com/wp-content/uploads/2021/02/Our-Living-Legacy-2018-Report.pdf [accessed October 17, 2022].
[71] Calgary Homeless Foundation, "History: Our Beginning"; available online at https://www.calgaryhomeless.com/meet-us/history/our-beginning/ [accessed October 17, 2022].
[72] The Calgary Community Land Trust later became the HomeSpace Society. See Land and Asset Strategy Committee, "Transfer of Affordable Housing Conditional Grant Agreement from Calgary Homeless Foundation to HomeSpace Society", November 17, 2016; available online at https://pub-calgary.escribemeetings.com/filestream.ashx?DocumentId=16058 [accessed October 17, 2022].

accomplished by provincial powers and municipal bodies in this period was in many ways commendable and in some ways novel. Nonetheless, the picture we are painting of provincial responses to federal policy shifts would be incomplete without a larger discussion of the impacts of neoliberal approaches to Albertan governance and the deployment of new public management techniques.

The period we are discussing in the above took place during the years of Ralph Klein's premiership of Alberta (1992 to 2006). Klein, who had also served as mayor of the city of Calgary from 1980 to 1989, came to provincial power at a time of perceived financial crisis. As Sonpal-Valias, Sigurdson, and Elson explain, "in mid-1992, when Ralph Klein ran for the leadership of the PC Party, the Alberta government had been running a budget deficit for the previous six years, had accumulated a net debt of $2.5 billion, and its cumulative debt had increased to more than $15 billion from zero in fiscal year 1985/86."[73] The provincial government under Klein began aggressive cuts across the board as a way to respond to this perceived financial crisis. Turner, Ballance, and Sinclair explain:

> In 1993, the Alberta government introduced strict reforms to social assistance, and provincial officials made it much more difficult for Albertans to qualify for social assistance, and the annual value of benefit levels for those who did qualify for social assistance dropped quite suddenly (and purchasing power eroded over time as benefits did not keep pace with inflation). This resulted in a very sharp loss in annual income for very low-income individuals.[74]

This period – which coincided with what Falvo called 'the dark years of housing policy in Canada' – also had significant impacts on the non-profit sector as well as the healthcare system. As Church and Smith recall, "during Klein's first term in office, bed numbers were almost halved, shrinking from 4.5 beds per 1,000 population to 2.4 – or from about 13,000 to around 6,500 beds."[75] Funding cuts also had devastating impacts on the non-profit sector. In 2001, Meinhard and Foster conducted a study on the legacy of Klein's reforms in this area and found that non-profit and voluntary organizations in Alberta were subject to more intensive forms of monitoring and scrutiny, were more likely to have smaller workforces due to reduced funding, and were forced to engage in much more diverse funding models in order to sustain operational capacities both during and after the tenure of Ralph Klein's premiership.[76] Shockingly, in the ten

[73] Nilima Sonpal-Valias, Lori, Sigurdson, and Peter Elson, "Alberta's Social Policy: The Neoliberal Legacy of the Klein Reforms" in *Funding Policies and the Nonprofit Sector in Western Canada*, ed. Peter Elson (Toronto: University of Toronto Press, 2016), 75.
[74] Alina Turner, Victoria Ballance, Joel Sinclair, *Calgary's Ten Year Plan to End Homelessness: Collective Impact Report*, November 2018, 7; available online at http://www.calgaryhomeless.com/wp-content/uploads/2021/02/Our-Living-Legacy-2018-Report.pdf [accessed October 17, 2022].
[75] John Church and Neale Smith, *Alberta: A Health System Profile* (Toronto: University of Toronto Press, 2022), 59.
[76] Agnes Meinhard and Mary Foster, *Responses of Canada's Voluntary Organizations to Shifts in Social Policy: A Provincial Perspective* (Toronto: Ryerson University, Centre for Voluntary Sector Studies, 2001), 21.

year period between 1992 and 2002, homelessness in the city of Calgary surged by 338%.[77] Thus, while Klein and his supporters could boast that the budget deficit had been defeated by 1996, the rates of homelessness in Alberta, the reduction of service capacity in the non-profit sector, and the cuts to the healthcare system established a lower standard of care for Alberta's most marginalized and vulnerable community members. What happened in this period was the combination of federal austerity from the Liberal party with the impacts of provincial strategies of new public management from Alberta's conservative leadership. And while it is probably fair to periodize this policy history and note that provincial responses to homelessness and mental health markedly improved in the post-Klein era, there is still a need to complicate this depiction as slightly simplistic and lacking in nuance. For example, in the fiscal year of 2003/2004, Alberta had public mental health expenditures at a rate of $207 per capita, whereas the national average was $172 per capita.[78] Of course, oil market dynamics and the considerable economic growth of Alberta between 2001 and 2007 can to some extent be credited with these higher-than-average rates of mental health expenditures. Nonetheless, Alberta opted to invest in its own mental health at a higher rate than most Canadians provinces in Klein's final years.

Housing First in Alberta

In January of 2008, the provincial government under the leadership of Premier Ed Stelmach gave the Alberta Secretariat for Action on Homelessness a directive to develop a ten-year plan to end homelessness in the province. In this same month, the City of Calgary distinguished itself as the first Canadian city to design and implement its own ten year plan to end homelessness. [79] In January of 2009, Edmonton followed suit with *A Place to Call Home: Edmonton's 10-Year Plan to End Homelessness*.[80] Later that year, Grand Prairie, Lethbridge, and Medicine Hat each implemented their own 10-year-plans.[81] Within this time frame, the province's 12-member task force met closely with municipalities and non-profits across Alberta to determine best practices and key strategic directives.[82] When the plan was published and endorsed by the provincial government in March of 2009, it officially instituted a 'Housing First'

[77] Susan Scott, *The Beginning of the End: The Story of the Calgary Homeless Foundation and One Community's Drive to End Homelessness* (Calgary: The Calgary Homeless Foundation, 2012), 10; available online at http://www.calgaryhomeless.com/wp-content/uploads/2021/02/The-Beginning-of-the-End [accessed October 17 2022].
[78] Philip Jacobs, Rita Yim, Arto Ohinmaa, Ken Eng, Carolyn S. Dewa, Roger Bland, Ray Block, and Mel Slomp, "Expenditures on Mental Health and Addictions for Canadian Provinces in 2003 and 2004" in *Canadian Journal of Psychiatry* vol. 53, no. 5 (2008): 306–13.
[79] Alina Turner, Victoria Ballance, Joel Sinclair, *Calgary's Ten Year Plan to End Homelessness: Collective Impact Report* (November 2018), 8; available online at http://www.calgaryhomeless.com/wp-content/uploads/2021/02/Our-Living-Legacy-2018-Report.pdf [accessed October 17, 2022].
[80] Edmonton Homelessness Commission, *A Place to Call Home: Edmonton's 10-Year Plan to End Homelessness, 2009*; available online at https://www.edmonton.ca/public-files/assets/document?path=PDF/A_Place_to_Call_Home.pdf [accessed October 17, 2022].
[81] Fort McMurray's 10-year plan to end homelessness – *Heading Home: The Right Thing to Do* – was enacted in 2010.
[82] Government of Alberta, "Alberta Endorses 1o-year provincial plan to end homelessness", March 16th, 2009; available online at https://www.alberta.ca/release.cfm?xID=254840FE01E9C-E8FA-4F80-EDD32B06E4E3A81E [accessed October 17, 2022].

approach to ending homelessness across Alberta. Housing First is a recovery-oriented and rights-based approach to chronic homelessness that is housing-led, as opposed to previous approaches that were "housing-ready" and "required homeless people to progress through a series of residential settings towards independent living, dependent on compliance with medical treatment, psychiatric stability and abstinence from drugs and alcohol."[83] Housing First is often cited as having been pioneered by the Pathways to Housing program in New York in the 1990s, though it is also fair to say that some Canadian organizations (such as Houselink in Toronto) were approaching housing as a right as far back as the late 1970s.[84] Central to the Housing First approach is an acknowledgement that one's recovery from addiction or mental illness is made immensely more difficult when one has no stable home. As one report on Homelessness in Calgary explains: "lack of affordable, supported spaces contributes to a high rate of relapse among the addicted; that is, they begin treatment, reach the end of available programs, and return to environments that encouraged the addiction in the first place."[85] Thus, by leading with housing first and treatment later, the approach seeks to provide a stable basis for supportive services rather than try and administer these supports in the midst of a client's experience of homelessness.

The Housing First approach sponsored by the province of Alberta in 2008 not only dovetailed neatly with existing and emergent municipal strategies, but it also set the stage for federal investments in Albertan agencies and homeless serving organizations. Importantly, in 2008, the federal government invested $110 million in the Mental Health Commission of Canada to help fund a massive, nation-wide study on the impact of Housing First programming. The study, which became known as the *At Home/Chez Soi* project, did not include any sites in Alberta but focused instead on the cities of Vancouver, Winnipeg, Toronto, Montréal, and Moncton. The study produced longitudinal data sets between October of 2009 and June of 2013 and studied the outcomes of two groups of people: those who received Housing First interventions and those who did not.[86] The total sample size was in excess of 2,000 individuals of whom 1,158 received supports within a Housing First framework (with 990 people receiving what was termed "treatment as usual").[87] Participants in the study were also separated further

[83] Damian Collins and Madelaine Stout, "Does Housing First Policy Seek to Fulfil the Right to Housing? The Case of Alberta, Canada." *Housing Studies* vol. 36, no. 3 (2021): 336-337.
[84] Jeanette Waegemakers Schiff, *Comparison of Four Housing First Programs* (August, 2014), 21; available online at https://houselink.on.ca/wp-content/uploads/2011/01/Comparison-of-Four-Housing-First-Programs-Final-Aug-1-v2.pdf [accessed October 17, 2022].
[85] Calgary Homeless Foundation, *Housing Our Homeless*, June 2004, 7; available online at http://www.calgaryhomeless.com/wp-content/uploads/2021/01/Housing-Our-Homeless-2004.pdf [accessed October 17, 2022].
[86] Paula Goering, Scott Veldhuizen, Aimee Watson, Carol Adair, Brianna Kopp, Eric Latimer, Geoff Nelson, Eric MacNaughton, David Streiner & Tim Aubry, *National At Home/Chez Soi Final Report* (Calgary, AB: Mental Health Commission of Canada, 2014), 6; available online at https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/mhcc_at_home_report_national_cross-site_eng_2_0.pdf [accessed October 17, 2022].
[87] Paula Goering, Scott Veldhuizen, Aimee Watson, Carol Adair, Brianna Kopp, Eric Latimer, Geoff Nelson, Eric MacNaughton, David Streiner & Tim Aubry, *National At Home/Chez Soi Final Report* (Calgary, AB: Mental Health Commission of Canada, 2014), 14; available online at https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/mhcc_at_home_report_national_cross-site_eng_2_0.pdf [accessed October 17, 2022].

into categories of those with high needs and those with moderate needs. The results of the study were indeed impressive and have understandably been oft-cited both within and beyond the Canadian context. In addition to significantly improving the health and housing outcomes of participants, the *At Home*/*Chez Soi* study found that every $10 invested in housing first services yielded an average savings of $21.72. As the report explained, "the main cost offsets were psychiatric hospital stays, general hospital stays (medical units), home and office visits with community-based providers, jail/prison incarcerations, police contacts, emergency room visits, and stays in crisis housing settings and in single room accommodations with support services."[88] In other words, the five-year study showed that housing first programming helped to prevent stresses on other realms of supportive services and healthcare provision, while at the same time reducing strain on the criminal justice system.

Future studies that included data sets from Alberta bore out in the provincial setting what was suggested on the national scale by the *At Home/Chez Soi* report. A study on the impact of Housing First approaches in Alberta released in January of 2013 found that more than 5,926 people had received both housing and supports and that 80% of Housing First clients were able to successfully remain housed for at least 12 months.[89] Further, 1,455 people had 'graduated' from Housing First programming and made a full transition to housing stability.[90] Also, rather incredibly, "interactions with Emergency Medical Services by Housing First clients were reduced by 72 per cent, emergency room visits by 69 per cent, and days in hospital by 72 per cent. In addition, interactions with police were reduced by 66 per cent, days in jail by 88 per cent, and court appearances by 69 per cent."[91] The data from both federal and provincial government's attested to the significant and immediate impact of Housing First as an evidence-based, fiscally responsible, and overwhelmingly effective approach to addressing homelessness in Canada. On that basis, the Harper government announced in 2014 that it planned to provide the Calgary Homeless Foundation with $31 million in funding to continue Housing First

[88] Paula Goering, Scott Veldhuizen, Aimee Watson, Carol Adair, Brianna Kopp, Eric Latimer, Geoff Nelson, Eric MacNaughton, David Streiner & Tim Aubry, *National At Home/Chez Soi Final Report* (Calgary, AB: Mental Health Commission of Canada, 2014), 24; available online at https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/mhcc_at_home_report_national_cross-site_eng_2_0.pdf [accessed October 17, 2022].
[89] Government of Alberta, *A Plan for Alberta: Ending Homelessness in 10 Years, 3 Year Progress Report*. (Edmonton: Alberta Secretariat for Action on Homelessness, January, 2013), 3; available online at http://open.alberta.ca/dataset/ee893386-514b-4c72-81dd-f9b6f19e4802/resource/7a80b775-9459-49fe-bdab-a7f0a7d46df9/download/6214137-2013-plan-for-alberta-ending-homelessness-in-10-years.pdf [accessed October 17, 2022].
[90] Government of Alberta, *A Plan for Alberta: Ending Homelessness in 10 Years, 3 Year Progress Report*. (Edmonton: Alberta Secretariat for Action on Homelessness, January, 2013), 3; available online at http://open.alberta.ca/dataset/ee893386-514b-4c72-81dd-f9b6f19e4802/resource/7a80b775-9459-49fe-bdab-a7f0a7d46df9/download/6214137-2013-plan-for-alberta-ending-homelessness-in-10-years.pdf [accessed October 17, 2022].
[91] Nilima Sonpal-Valias, Lori, Sigurdson, and Peter Elson, "Alberta's Social Policy: The Neoliberal Legacy of the Klein Reforms" in *Funding Policies and the Nonprofit Sector in Western Canada*, ed. Peter Elson (Toronto: University of Toronto Press, 2016), 93.

programming.[92] In that same year, the federal government also followed Alberta's lead and made Housing First a central tenet of its renewed Homelessness Partnering Strategy.

Housing First is a significant example of social policy that positively impacts the outcomes of OPEH. In the most direct sense, housing first allowed seniors and elderly individuals who lacked housing access to a range of integrated supportive services far above and beyond what was previously accessible through emergency shelter systems. In the longer term, Housing First has a significant preventative effect with respect to OPEH, given that it provided thousands of OPEH in Alberta a pathway from chronic homelessness to stable housing prior to reaching their senior years. As Alina Turner and Diana Krecsy explain, "in 2016/2017, the Calgary Homeless Foundation reported 8,482 people had been housed over eight years. 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."[93] Similarly, the Edmonton Homelessness Commission reported in 2017 that eight years of "Housing First programs have housed and supported more than 6,000 people… [and] point-in-time homeless counts have fallen considerably since 2009."[94] The most celebrated or at least most widely covered example, however, certainly came from Medicine Hat.

In 2014, Mayor Ted Clugston made headlines when he told *CBC News* that housing first programming in Medicine Hat had been so successful that the city was on the verge of ending homelessness.[95] Interestingly, Clugston admitted that he was initially an opponent of Housing First programs. "When I first got elected on council I was a bit of a cowboy, and I was actually speaking against a lot of these projects. I was one of their biggest detractors," explained Clugston in the CBC interview, "and now I've become their advocate and have to admit it's the right thing to do, it's the moral thing to do. And it makes sense financially…If you can get somebody off the street, it saves the emergency room visits, it saves the police, it saves the justice system — and so when you add up all those extra costs … you can buy a lot of housing for that amount of money."[96] Later that year, *The Globe and Mail* shone a spotlight on Clugston and referred to him as "the mayor who ended homelessness."[97] Commenting upon Medicine Hat's policy success

[92] Employment and Social Development Canada: Media Relations Office, "Harper Government Invests in Evidence-Based Housing First Initiatives to Reduce Homelessness in Calgary", July 9th, 2014.
[93] Alina Turner and Diana Krecsy, "Bringing It All Together: Integrating Services to Address Homelessness" in *The School of Public Policy Publications*, vol. 12, no. 1 (2019): 12; available online at http://www.calgaryhomeless.com/wp-content/uploads/2021/01/Bringing-It-All-Together-Integrating-Services-to-Address-Homelessness.pdf [accessed October 17, 2022].
[94] Edmonton Homelessness Commission, *A Place to Call Home: Edmonton's Updated Plan to Prevent and End Homelessness* (Edmonton: Edmonton Homelessness Commission, 2017), 6.
[95] "Medicine Hat on brink of ending homelessness, mayor says", *CBC News*, May 15th, 2014; available online at https://www.cbc.ca/news/canada/calgary/medicine-hat-on-brink-of-ending-homelessness-mayor-says-1.2644074 [accessed October 17, 2022].
[96] "Medicine Hat on brink of ending homelessness, mayor says", *CBC News*, May 15th, 2014; available online at https://www.cbc.ca/news/canada/calgary/medicine-hat-on-brink-of-ending-homelessness-mayor-says-1.2644074 [accessed October 17, 2022].
[97] Allan Maki, "Medicine Hat's Ted Clugston, 'the mayor who ended homelessness', *The Globe and Mail*, December 11th, 2014; available online at http://www.theglobeandmail.com/news/alberta/medicine-hats-tedclugston-the-mayor-who-ended-homelessness/article22058811/ [accessed October 17, 2022].

was Minister of Families, Children, and Social Development Ahmed Huseen, who cited the city as "a wonderful example of what can be achieved when we all come together with a common goal to end chronic homelessness."[98] To be precise, Medicine Hat's success was to achieve functional zero homelessness, which is different than absolute zero homelessness. Whereas absolute zero homelessness refers to a situation in which no one experiences any lack of housing in a given municipality, functional zero homelessness signifies that a city has expanded its capacity to the "point where there are enough services, housing and shelter beds for everyone who needs them, and anyone who experiences homelessness does so only briefly, is rehoused successfully, and is unlikely to return to homelessness again."[99] In any case, Medicine Hat became a national leader in the provision of Housing First programming.

Housing First is certainly not without its limitations or its critics. Though it is broadly impactful in terms of reducing homelessness across Canada, it is not universally or unexceptionally successful. For example, Colin Philips demonstrated in a 2017 study that homelessness in the City of Toronto increased following the implementation of a specific Housing First program called 'Streets to Home.' Philips found that Housing First programming was not capable of counterbalancing the impacts of larger policy frameworks, such as an insufficient investment in the low-income housing sector as well as caps and cuts to social assistance benefits that left Housing First clients trapped in perpetual cycles of poverty.[100] Others have also noted that Housing First programming in Alberta is sometimes vaguely defined or applied in a fashion that is inconsistent with its central tenets or foundational rights-based principles.[101] Alina Turner has shared similar perspectives and stressed that integration and effective coordination of social services is a key piece of the Housing First approach, which is often understood in a limited sense as merely the provision of housing to the homeless, thereby missing the important pieces of the puzzle that go towards constituting the Housing First approach as a best practice that is replicable.[102] Other scholars have critiqued the notion of 'graduation' as it operates within Housing First programming in Alberta, arguing that it reproduces the same kind of linear logics of progression through a series of rehabilitative stages

[98] Canadian Alliance to End Homelessness, "Medicine Hat achieves functional zero chronic homelessness", June 21st, 2021; available online at https://caeh.ca/medicine-hat-functional-zero/ [accessed October 17, 2022].
[99] Alina Turner, Tom Albanese, and Kyle Pakeman, "Discerning 'Functional and Absolute Zero': Defining and Measuring an End to Homelessness in Canada" in *The School of Public Policy Publications* vol. 10, no. 2 (2017), 1.
[100] Colin Phillips, *Housing First and Its Impediments: The Role of Public Policy in Both Creating and Ending Homelessness* (Calgary: Calgary Homeless Foundation, 2017), 3-5; available online at http://www.calgaryhomeless.com/wp-content/uploads/2021/01/Housing-First-and-its-Impediments.pdf [accessed October 17, 2022].
[101] See Damian Collins and Madelaine Stout, "Does Housing First Policy Seek to Fulfil the Right to Housing? The Case of Alberta, Canada." *Housing Studies* vol. 36, no. 3 (2021): 336-337. Also, see Sophie L. Stadler and Damian Collins, "Assessing Housing First Programs from a Right to Housing Perspective" in *Housing Studies*, ahead-of-print (2021): 1–21.
[102] Alina Turner, "Beyond Housing First: Essential Elements of a System-Planning Approach to Ending Homelessness" in *The School of Public Policy Publications* vol. 7, no. 30 (2014). Also, see Alina Turner and Jaime Rogers, *The "First City to End Homelessness": A Case Study of Medicine Hat's Approach to System Planning in a Housing First Context*, (Medicine Hat: Canadian Observatory on Homelessness, 2016); available online at https://www.homelesshub.ca/resource/46-%E2%80%9Cfirst-city-end-homelessness%E2%80%9D-case-study-medicine-hat%E2%80%99s-approach-system-planning-housing [accessed October 17, 2022].

that were central to older approaches to homelessness.[103] Some critics go so far as to label Housing First as well as 10-year-plans to end homelessness as neoliberal tools that function to economize and manage homelessness, situate it improperly within depoliticized notions of public expenditures, and thus avoid tackling other more systemic drivers of both homelessness and poverty.[104] Further to the point, some have expressed that the Housing First approach when used alone falls short of meeting the distinct housing needs of Indigenous peoples, who contend with the lack of culturally-informed and adequate housing options.[105] Though such limitations or problems with Housing First ought to be seriously considered and not lightly dismissed, the fact remains that this approach to housing was supremely impactful and largely spear-headed by Albertan cities and levels of government who acted as leaders in the national struggle to meaningfully respond to crises of homelessness.

COVID-19 and Homelessness in Alberta

To state the case lightly, pandemics bring about incredible difficulties for the homeless sector. This is why scholars have paid special attention to the issue of 'pandemic preparedness' since well before the onset of COVID-19.[106] Though it is not the purpose of this report to assess the pandemic preparedness of Alberta's homeless sector, extant literature on the subject points in the broad sense to an already-stressed system of emergency shelters becoming overwhelmed with 1) an overall increase in the number of individuals accessing shelters and 2) the difficult demands that were unique to the nature of the pandemic, such as increased costs for sanitizing procedures, staffing shortages following employee infections, and other operational complications.[107]A recent study that appeared in *The Canadian Journal of Psychiatry* surveyed more than 700 individuals who worked in homeless service, supportive housing, or harm reduction organizations and networks, 79.5% of whom reported a decline in their mental health

[103] Jalene T. Anderson-Baron and Damian Collins. "Not a 'forever Model': The Curious Case of Graduation in Housing First" in *Urban Geography* vol. 39, no. 4 (2018): 587–605.
[104] See Evans, Joshua Evans and Jeffrey R Masuda, "Mobilizing a Fast Policy Fix: Exploring the Translation of 10-Year Plans to End Homelessness in Alberta, Canada" in *Environment and Planning C: Politics and Space* vol. 38, no. 3 (2020): 503–521. Also, see Brian Hennigan "House broken: homelessness, housing first, and neoliberal poverty governance" in *Urban Geography* vol. 38, no. 9 (2017): 1418–1440.
[105] Jino Distasio, Sarah Zell, and Marcie Snyder, *At Home in Winnipeg: Localizing Housing First as a Culturally Responsive Approach to Understanding and Addressing Urban Indigenous Homelessness* (Winnipeg: Institute of Urban Studies, August 2018), https://winnspace.uwinnipeg.ca/bitstream/handle/10680/1607/2018_Localizing-Housing-First_A-Culturally-Responsive-Approach.pdf?sequence=1&isAllowed=y
[106] See Kristy Buccieri and Rebecca Schiff, *Pandemic Preparedness & Homelessness : Lessons from H1N1 in Canada* (Toronto, ON: Canadian Observatory on Homelessness, 2016).
[107] See Ali Jadidzadeh and Ron Kneebone. "Homeless Shelter Flows in Calgary and the Potential Impact of COVID-19" in *Canadian Public Policy* vol. 46, no. S2 (2020): S160–S165. Also see, Ron Kneebone and Margarita Wilkins, "Social Policy Trends: Responding to the COVID-19 Pandemic in Alberta's Homeless Serving Sectors" *The School of Public Policy Publications* vol. 15, no. 1 (2022). Finally, see Kieran J.D. Steer, David C. Klassen, Claire M. O'Gorman, Marisa Webster, Mhairi Mitchell, Liubov Krichevsky, Kathy Christiansen, Jamie L. Benham, and Richelle S. Schindler, "Cups for COVID: Rapid Implementation of a Harm Reduction Initiative to Support Populations Experiencing Homelessness During the COVID-19 Pandemic" *in Canadian Journal of Public Health* vol. 112, no. 1 (2021): 29–35.

over the course of the COVID-19 pandemic.[108] This data helps point to the very real difficulties that front-line service providers were faced with when trying to administer services and provide emergency shelters to people experiencing homelessness. There is also good reason to believe that service providers struggled to provide OPEH with an adequate standard of care during the height of the pandemic. For example, one survey of direct service providers in a Canadian context explained that the study's "participants identified sources of staff stress that were uniquely related to occupational demands. Staff continued to work directly with vulnerable populations who have complex needs; at the same time, many community services were significantly reduced."[109] Just in the context of service administration and provision, then, the COVID-19 pandemic placed great amounts of stress on the homeless serving sector.

The restricted access to public facilities that offer restrooms and access to water was also quite devastating for those without homes during COVID-19.[110] Public health calls to self-isolate or practice social distancing were much more difficult and sometimes impossible for folks experiencing homelessness. As others have noted, individuals with severe and chronic mental illness also had their conditions exacerbated by the need to isolate amid the pandemic.[111]

Across Canada, shelters struggled to provide sufficient space for social distancing; however, Alberta's major cities of Calgary and Edmonton were especially challenged by province-wide mandates.[112] Both cities were granted exemptions on the mandate to provide 2 metres of space per individual within emergency shelters.[113] Both cities also repurposed massive local buildings (the TELUS Convention Centre in Calgary and the Edmonton Expo Centre) as provisional overflow sites for those seeking shelter.[114] It is worth noting here that when the TELUS Convention Centre in Calgary closed as an overflow site in June of 2020, those seeking shelter were housed in a hotel. Significantly, a needs assessment was carried out for those housed in the hotel, which revealed that 25% of the residents were "medically complex" and required nursing staff to support them during their stay in the hotel.[115] This points to the need to increase plans to support individuals experiencing homelessness with complex needs in Alberta in order

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[108] Nick Kerman, John Ecker, Stephen Gaetz, Emmy Tiderington, Sean Kidd, "Mental Health and Wellness of Service Providers Working with People Experiencing Homelessness in Canada: A National Survey from the Second Wave of the COVID-19 Pandemic" in *The Canadian Journal of Psychiatry,* vol. 67, no. 5 (2022): 371-379.
[109] Stephanie Campbell, Chelsea Noël, Ashley Wilkinson, Rebecca Schiff, and Jeannette Waegemakers Schiff, "'We Actually Came to a Point Where we Had no Staff": Perspectives of Senior Leadership in Canadian Homelessness Service Providers During COVID-19" in *The International Journal on Homelessness*, vol. 2, no. 3 (2022): 1-16.
[110] Jeanette Waegemakers Schiff, Bernie Pauly, and Rebecca Schiff, "Pandemic Preparedness in the Homeless Sector: Reports from Homeless People" in *Prehospital and Disaster Medicine* vol. 32, no. S1 (2017): S182–S182.
[111] Anees Bahji, Paxton Bach, Marlon Danilewitz, Nady el-Guebaly, Benjamin Doty, Laura Thompson, Diana E. Clarke, Sumantra Monty Ghosh, and David Crockford. "Strategies to Aid Self-isolation and Quarantine for Individuals with Severe and Persistent Mental Illness During the COVID-19 Pandemic: A Systematic Review" in *Psychiatric Research and Clinical Practice* vol. 3, no. 4 (2021): 184–90.
[112] Nick Falvo, *Isolation, Physical Distancing, and Next Steps Regarding Homelessness* (Calgary: Calgary Homeless Foundation, 2020), 10.
[113] Nick Falvo, *Isolation, Physical Distancing, and Next Steps Regarding Homelessness* (Calgary: Calgary Homeless Foundation, 2020), 10.
[114] Nick Falvo, *Isolation, Physical Distancing, and Next Steps Regarding Homelessness* (Calgary: Calgary Homeless Foundation, 2020), 10-11.
[115] Nick Falvo, *Isolation, Physical Distancing, and Next Steps Regarding Homelessness* (Calgary: Calgary Homeless Foundation, 2020), 10.

to boost the province's pandemic preparedness, though we will attend more fully to these conversations in our recommendations.

Policy Pillar No. 2:
Continuing Care in Alberta

The province of Alberta offers continuing care in three separate streams: **home care**, which allows seniors to receive supportive care and services in their own residence; **supportive living sites**, or congregate living facilities that offer residents housing as well as other "accommodations, meals, housekeeping, and social activities in addition to professional and personal support services"[116]; and **long-term care homes**, wherein residents who require the highest level of assistance with daily living have access to a 24-hour nursing and personal care to accommodate their complex needs. The continuing care system in Alberta has undergone some

[116] Julia Brassolotto, Carly-Ann Haney, Lars Hallstrom, and David Scott, "Continuing Care in Rural Alberta: A Scoping Review" in *The Canadian Geographer* vol. 63, no. 1 (2019): 159–70.

notable changes in the past three decades, which we review in what follows. As readers will note, these policy developments intersect powerfully with the policy realm just discussed, given that the question of how to house and care for seniors and older adults with an array of complex needs overlaps to a considerable degree with the issues of housing and homelessness.. However, in this section we focus more closely on continuing care systems in Alberta, their approach to funding and administering integrative care models, as well as the more recent debates in policy and legislation that surrounded Bill-11, which became Alberta's Continuing Care Act in May of 2021. As explained in the below, the primary trend we identify in what follows is a provincial tendency to reduce public expenditures on facility-based forms of care by investing in and relying upon homecare. Homecare is often not an option for OPEH; therefore, we suggest that this approach to funding places OPEH at risk, and this may be exacerbated in decades to come.

Centralization and The Broda Report

The provincial framework of integration for continuing care in the larger network of Alberta's healthcare system began in 1990 with the creation of a Single Point Entry System, but has since developed to include a more diverse range of service provision frameworks that has become increasingly centralized in its administration and governance structure.[117] In 1994, for example, 200 local hospital and public health boards were replaced with 17 regional health authorities.[118] While this larger strategy of regionalization went hand-in-hand with the principles of New Public Management and a desire to cut costs in healthcare, it also qualified Alberta as an early adopter of a regional framework for healthcare governance that was later taken up more broadly across Canada.[119] As Church and Smith explain, regional health authorities (RHAs) in Alberta "were expected to save money through greater integration and coordination of service delivery, improve responsiveness to local communities, realize economies of scale, rationalize service delivery, and shift the focus of the system away from hospitals towards less costly services provided in the community."[120] In this same year (1994), the Provincial Mental Health Board was created and became responsible for the delivery and governance of mental health services both in homecare as well as facility-based settings. This arrangement meant that RHAs did not have any meaningful control over the provision or funding of mental health services, which prevented their seamless integration within continuing care facilities. Within five years of its creation, the Alberta Mental Health Board handed operational and budgetary control of mental health services to the RHAs as further centralization and shifts to governance structure

[117] MNP LLP, *Improving Quality of Life for Residents in Facility-Based Continuing Care: Alberta Facility-Based Continuing Care Review Recommendations Final Report,* April 30, 2021, 26.
[118] John Church and Neale Smith, *Alberta: A Health System Profile* (Toronto: University of Toronto Press, 2022), 45.
[119] Jeremiah Hurley, "Regionalization and the Allocation of Healthcare Resources to Meet Population Health Need" in *Healthcare Papers*, Vol. 5 No. 1 (2004): 34-39. Also, see Paul Barker and John Church. "Revisiting Health Regionalization in Canada: More Bark Than Bite?" in *International Journal of Health Services* 47, no. 2 (2017): 333–351.
[120] John Church and Neale Smith, *Alberta: A Health System Profile* (Toronto: University of Toronto Press, 2022), 187.

began to take place. Such difficulties in the administration of care services reflect growing pains, so to speak, in the path to more integrated systems of care in Alberta.

In 1997, Alberta Health Minister Halvar Johnson initiated an intensive two-year review of long term care in the province. In 1999, the long term care advisory committee tasked with the review issued a report titled *Healthy Aging: New Directions for Care.* This report, often referred to as the Broda Report (after its chair, David Broda) was influential in shifting the larger provincial strategy for the coordination and planning of continuing care. As a larger policy piece, the Broda Report underscored Alberta's aging population and acknowledged the need "to increase the number of spaces in continuing care centres"[121] as a short term strategy; however, the long term policy points advocated in the report had to do with increasing homecare options and making it possible for Albertans to 'age in place.' To that end, the committee warned against the financial cost of investing in LTC homes: "we urge caution in 'over-building' long term care facilities if people's needs can better be met in other, more appropriate, and less costly alternatives. For that reason, the Committee suggests that the first priority should be to expand home care services."[122] Though understandable from a systems perspective, the focus on homecare did little for OPEH for whom homecare is not an option. In the same vein, the more robust funding of seniors home adaption and repair programs (sometimes called SHARP programs) allowed many housed Albertans to remain at home and avoid institutionalization in a LTC home or DSL site, though this was also not applicable to OPEH. Thus, while the Broda Report instructed regional health authorities to "look at all possibilities for using existing space and beds in the region, including re-opening closed beds", it nonetheless situated facility-based continuing care as an expensive last resort, only to be accessed "when a person's needs can't be met at home."[123] Interestingly, the Broda Report also noted that "drug utilization is a major concern" within many of the facilities then operating, but did not make any specific recommendations related to treating addictions or coordinating harm reduction services within and alongside other forms of continuing care.[124] Instead, one point of action suggested in the report was for the province to "develop a plan to address the mental health needs of older adults."[125] And while it focused on expanding homecare as the primary thrust of its policy recommendations, it should be made clear that the Broda Report did not aggressively advance the case for an expanded private sector of service provision as a policy directive, nor did it advocate for a significant divestment from facility-based forms of continuing care offered by the non-profit sector.

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[121] *Long Term Care Policy Advisory Committee Final Report: Healthy Aging, New Directions for Care,* November 1999, 25.
[122] *Long Term Care Policy Advisory Committee Final Report: Healthy Aging, New Directions for Care,* November 1999, 23.
[123] *Long Term Care Policy Advisory Committee Final Report: Healthy Aging, New Directions for Care,* November 1999, 17.
[124] *Long Term Care Policy Advisory Committee Final Report: Healthy Aging, New Directions for Care,* November 1999, 10.
[125] Alberta Health and Wellness, *Strategic Directions and Future Actions: Healthy Aging and Continuing Care in Alberta,* May, 2001; available online at /https://open.alberta.ca/dataset/3e59439e-66f4-4915-b612-1c30e7bdfa9d/resource/a40a4093-71f9-4625-806b-c93dd0d73450/download/strategic-healthy-aging-may-2000.pdf [accessed October 1, 2022].

In 2000, Alberta's Single Point of Entry system was replaced with a Coordinated Access System, which pursued the Broda Report policy directive by increasing the rate of service integration as well as the scope of the entry system into the existing range of continuing care options offered in the home, in LTC facilities, or DSL sites in Alberta. This also represents an instance in which Alberta acted as a provincial leader in its coordination and administration of a range of supportive services, effectively inching the province and by extension all of Canada closer to an 'every door is the right door' approach to care options. Also, as integration improved, centralization intensified. In 2004, the 17 RHAs of the province of Alberta were reduced to 9 (again, further centralizing the governance of healthcare in the province). In 2008, all RHAs were collapsed together into one single massive bureaucratic body – Alberta Health Services (AHS). Also brought into this larger bureaucratic fold were the Alberta Alcohol and Drug Abuse Commission and the Alberta Mental Health Board. Though the Mental Health Board had since passed budgetary and operational control of mental health services to the RHAs in 1999, this 2008 creation of AHS was a major shift in the governance of healthcare in Alberta; nonetheless, it was the end result of a longer process of centralization that had begun in the regionalization era of the 1990s.

Aging in the Right Place

In December of 2008, AHS released a new Continuing Care Strategy that was subtitled *Aging in the Right Place*. This document spelled out the provincial government's "approach to accelerate the growth and modernization of health and personal care services" and described itself as "intended to provide new ways of delivering services, offering more choice to Albertans in their homes and communities."[126] Five policy directives were named:

1. Investing in community supports;
2. Building infrastructure to support the "aging in the right place" vision;
3. Changing the way long-term care accommodations are paid for;
4. Options to fund individuals based on needs and/or funding providers; and
5. Providing equitable drug coverage for people, wherever they live.[127]

This 2008 document was much more of blueprint for privatization than its predecessor the Broda Report. In many ways, the report was a reproduction or re-emergence of New Public Management Principles as a guiding principle for healthcare provision in Alberta. Deploying the language of "choice" and "clients" regularly, the Continuing Care Strategy situated the private sector as an important player in the provision of continuing care services. These changes were also specifically directed at the LTC home sector:

> A small proportion of Alberta seniors and persons with disabilities require the services of a 24-hour long-term care facility. Today, however, because of current

[126] Alberta Health and Wellness, *Continuing Care Strategy: Aging in the Right Place*, 2008, 2.
[127] Alberta Health and Wellness, *Continuing Care Strategy: Aging in the Right Place*, 2008, 2.

> capacity issues and how waiting lists are managed, residents in need of placement have limited choice in where they will reside. Alberta's current approach of regulating residents' accommodation fees is believed to discourage the development of new beds which minimizes the variety of accommodation options available. Adjusting the framework for setting fees is expected to encourage more investment by the non- profit or private sector and increase the number of beds. As a result, individuals will have more choice to select a facility that meets location wishes, health service needs and personal preferences. This will allow operators to provide residents with the option to purchase increased services. Albertans have said they want more choice. And, that they want the ability to choose additional services and amenities. Future continuing care clients are expected to be less reliant on government sources of income, to have more disposable income, and have increased expectations for choice in their living accommodations.[128]

The passage points to the ways in which seniors requiring continuing care were often envisioned in the 2008 strategy as clients seeking to purchase an array of high quality services but being limited in their options by existing regulations. Again, this is not necessarily a poor approach to the larger provision of continuing care to Alberta; however, like increasing the robustness of homecare options and services, it does little to assist OPEH in securing a dignified and supportive living arrangement. What is more, the passage demonstrates the larger strategy of relying on private sector "services and amenities" as a means of coordinating, integrating, and expanding the spectrum of continuing care services.[129] Like the earlier strategy of expanding homecare advanced by the Broda Report (1999), the Continuing Care Strategy of 2008 did not meaningfully plan for older Albertans experiencing intersections of poverty, homelessness, and unmet mental health and mobility assistance needs. Unlike the Broda Report, however, the issue of drug use in LTC homes and DSL sites was not mentioned. Thus, in Alberta as elsewhere, "the older substance misuser is poorly represented in the range of policy initiatives, though this may be very gradually changing."[130]

Designated Supportive Living Frameworks in Alberta

Designation	Title	Description	Exclusion Criteria
DSL3	Assisted Living	"Provides 24-hour on-site scheduled and unscheduled personal care and support provided by Health Care Aides."	• "unpredictable behaviours placing self and others at risk" • "[requires] 24-hour on-site RN professional services" • "[requires] intensive and/or extensive rehabilitation services that cannot be easily accessed."

[128] Alberta Health and Wellness, *Continuing Care Strategy: Aging in the Right Place*, 2008, 14.
[129] Alberta Health and Wellness, *Continuing Care Strategy: Aging in the Right Place*, 2008, 14.
[130] Royal College of Psychiatrists, *Our Invisible Addicts: College Report CR211*, March 2018, https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr211.pdf?sfv

DSL4	Enhanced Assisted Living	"Provides a higher level of personal care supports and health care services onsite for scheduled and unscheduled care needs according to the plan of care"	• "social behaviour of resident does not induce fear and anxiety in other residents in this supportive living setting." • "unpredictable behaviours placing self and others at risk"
DSL-4D	Assisted Living with Dementia	"[Provides] a purposeful home-like design with small groupings of private bedrooms and associated spaces in a secured therapeutic environment. This environment provides 24-hour on site scheduled and unscheduled professional and personal care and support provided by Licensed Practical Nurses and Health Care Aides."	• "unpredictable behaviours placing self and others at risk" • "[requires] 24-hour on-site RN professional services" "[requires] intensive and/or extensive rehabilitation services that cannot be easily accessed."

Figure 3

In April of 2010, Alberta Health Services published its updated admission guidelines for publicly funded continuing care options, which included a detailed schematic of the spectrum of DSL sites available in the province.[131] To repeat, by 2010, successive policy guidelines and modifications to funding arrangements were such that homecare and community care (that is, continuing care *not* offered in a DSL or LTC) remained primary objectives of the province of Alberta, with facility based forms of care being configured as a last resort or final option. The first level of supportive living is DSL Level 3 or DSL3, which is defined as 'assisted living.' According to the guidelines, "assisted living is an environment that provides 24-hour on-site scheduled and unscheduled personal care and support provided by Health Care Aides."[132] Like other levels of DSL care, DSL3 has exclusion criteria that help case managers determine whether a given patient would be appropriate placed in DSL3. These exclusion criteria considerations include "unpredictable behaviours placing self and others at risk", the requirement on part of the patient for "24-hour on-site RN professional services", or "intensive and/or extensive

[131] Alberta Health Services, *Admission Guidelines for Publicly Funded Continuing Care Options*, April 15th, 2010, 1.
[132] Alberta Health Services, *Admission Guidelines for Publicly Funded Continuing Care Options*, April 15th, 2010, 1.

rehabilitation services that cannot be easily accessed."[133] It should be noted here that, in the context of the exclusion criterium, 'rehabilitation' is conceived of strictly in the physical sense of restoring the capacity for un- or lightly-assisted mobility (often in the wake of a traumatic brain injury or broken hip due to a fall, for example). Rehabilitation from an addiction to illicit or controlled substances (including alcohol) is not conceptually part of the 'rehabilitation' services offered in a DSL3 site.

The next level of designated living (DSL4) is known as 'enhanced assisted living.' DSL4 sites are different from DSL3 in that their occupants need more meal assistance, extra help with elimination or incontinence, mechanical lifts or multiple nurses/health care aides for assistance with mobility and daily activities, and some assistance in managing and administering their medications.[134] At the same time, both DSL3 and DSL4 sites were given the following inclusion criteria: "social behaviour of resident does not induce fear and anxiety in other residents in this supportive living setting."[135] Thus, though who consume illegal drugs or alcohol to excess are excluded from DSL3 and DSL4 sites to the extent that their social behaviours may cause fear and anxiety in other patients and occupants. DSL4 sites were also given a further exclusion criteria that identified "unpredictable behaviour placing self and others at risk" as something that would prevent an individual from gaining access to an 'enhanced assisted living' facility.[136]

The next level of designated living is known as 'supportive living with dementia.' These facilities are meant to provide housing, healthcare, and entry points into other social services for individuals who have deleterious brain conditions or injuries that can cause them to be confused, withdrawn, non-communicative, and in the broad sense unpredictable and prone to elopement. The guidelines describe DSL4 – Dementia as providing "a purposeful home-like design with small groupings of private bedrooms and associated spaces in a secured therapeutic environment. This environment provides 24-hour on site scheduled and unscheduled professional and personal care and support provided by Licensed Practical Nurses and Health Care Aides."[137] DSL4-Dementia sites also have the following as exclusion criteria: "unpredictable behaviour placing self and others at risk," "requires 24-hour on site RN professional services", and requires "intensive and/or extensive rehabilitation services that cannot be easily accessed."[138]

As one can see from the above, there are not specifically designated supportive living sites in Alberta that are earmarked as places where seniors and older adults with substance use

[133] Alberta Health Services, *Admission Guidelines for Publicly Funded Continuing Care Options*, April 15th, 2010, 3.
[134] Alberta Health Services, *Admission Guidelines for Publicly Funded Continuing Care Options*, April 15th, 2010, 2.
[135] Alberta Health Services, *Admission Guidelines for Publicly Funded Continuing Care Options*, April 15th, 2010, 1-2.
[136] Alberta Health Services, *Admission Guidelines for Publicly Funded Continuing Care Options*, April 15th, 2010, 4.
[137] Alberta Health Services, *Admission Guidelines for Publicly Funded Continuing Care Options*, April 15th, 2010, 4.
[138] Alberta Health Services, *Admission Guidelines for Publicly Funded Continuing Care Options*, April 15th, 2010, 2.

disorders can receive the care they need. Though coordination of services and integration of care models are arguably stronger in Alberta than in other provinces due to the centralization of healthcare governance and administration, there is an arguable 'blind spot' in the schematic of DSL designations that leaves OPEH with complex needs largely undiscussed and therefore underserved.[139] Though one can be excluded from a DSL site for using drugs, controlled substances, or even smoking, there is no designation or dedicated framework for service provision to OPEH who have complex and unmet health needs related to substance use. To be clear, there are models of care being developed and put into practice in some places in Alberta that provide harm reduction housing for OPEH with complex needs.[140] However, this is not the same thing as specifically designating supportive living sites to provide beds or dedicated programing for older adults and seniors who use substances.

As Nixon and Burns (2022) explain, "exclusionary care policy [also] contributes to the growing number of older adults experiencing homelessness and complex health challenges including substance misuse."[141] Probably the most relevant example in this regard is the way in which 'zero tolerance' policies can cause the eviction seniors and older adults who use tobacco or other substances in aged care settings. This is a common experience and worry for anyone who struggles to find supportive living arrangements for parents who are smokers. More broadly, however, the issue of smoking in aged care settings is a contentious and litigious friction within the provision of continuing care in Canada. One report from the Canadian Centre for Elder Law offers the following anecdote by means of an example:

> Jim had always smoked every day. He had been smoking for 60 years and had never been able to quit. He usually tried to smoke outside when he could, but the winter weather was turning very cold. Temperatures were hitting -30 degrees and it was becoming increasingly slippery and dangerous outside…Jim started smoking more in his suite. He was served with a notice that as a workplace, smoking was not allowed. Jim was confused – he thought that this was his own home and that he could do what he liked in it. Besides, he could not just stop smoking – he'd tried to quit before, but at his age, he joked, he had few pleasures left. He admits he is 'hooked' on the nicotine.[142]

Admittedly, the matter of smoking in aged care settings is a complex one, specifically in the legal context since it involves the intersection of personal liberty and the rights of workers not to

[139] "Seniors Health Strategic Clinical Network: Age Proofing Alberta through Innovation." *Canadian Medical Association Journal,* 192, no. 1 (2020): E18–E18.
[140] Lara Nixon and Victoria Burns, "Exploring Harm Reduction in Supportive Housing for Formerly Homeless Older Adults," *Canadian Geriatrics Journal* CGJ 25, no. 3 (2022): 285–94.
[141] Lara Nixon and Victoria Burns, "Exploring Harm Reduction in Supportive Housing for Formerly Homeless Older Adults," *Canadian Geriatrics Journal* CGJ 25, no. 3 (2022): 285–94.

[142] Canadian Centre for Elder Law, *Discussion Paper on Assisted Living: Past, Present, and Future Legal Trends in Canada*, October 2008, 14, https://www.bcli.org/wp-content/uploads/2008/12/3.-Discussion-Paper-on-Assisted-Living-Past-Present-and-Future-Legal-Trends-in-Canada.pdf.

experience workplaces that expose them to second-hand smoke. However, the case remains that a failure to specifically designate, fund, and support DSL sites and LTC homes in Alberta that make smoking possible has three impacts worth noting: first, it reliably produces further housing precarity for older adults and seniors who smoke, thus contributing to higher rates of OPEH; second, it prevents healthcare providers from having the opportunity to provide treatment to assist older adults and seniors in quitting smoking (or at least smoking less with managed tobacco programming); third, and as members of this team have observed in a separate study, it can sometimes lead individuals to take up residence in LTC homes that accept or provide more support for smokers when they otherwise would not require this level of facility-based care, which puts more stress on and reduces the capacity of continuing care systems in Alberta. Of course, the lack of dedicated designations is not the only structural matter that impacts the health and social outcomes of OPEH with complex needs, which brings us to the emergent legislative landscape.

The Continuing Care Act (2021)

Bill-11, now The Continuing Care Act, was a bill proposed by UCP Minister of Health Jason Copping that received Royal Assent May 31, 2021. According to the Government of Alberta's website, the impetus of the Continuing Care Act was to "begin a significant transformation of the continuing care system," that was "informed by feedback received during comprehensive reviews of Alberta's continuing care system to ensure Albertans have access to high-quality care and support."[143] In Copping's framing, Bill-11 was a way to simplify and streamline provincial legislation and policy frameworks related to the funding, governance, and oversight of continuing care in the province. As Copping stated:

> Alberta's current legislation falls under multiple acts and regulations, some dating back to 1985. The delivery of continuing care has evolved, and existing legislative requirements do not reflect present-day practices, services, or settings, and the COVID-19 pandemic revealed further gaps and inconsistencies. As a result, the government is introducing new, streamlined legislation under one act. It will strengthen government accountability and transparency and enable better co-ordination and alignment of care.[144]

Bill-11 was part of a broader UCP strategy to reform continuing care in Alberta as a response to the COVID-19 pandemic, which had revealed certain weaknesses and vulnerabilities, especially in facility-based streams of continuing care such as long-term care homes and designated supportive living centres. A study of facility-based continuing care was commissioned by the provincial government and delivered by MNP LLP (a major business consulting firm) in April of

[143] Government of Alberta, "Transforming Continuing Care", accessed July 30, 2022, https://www.alberta.ca/transforming-continuing-care.aspx#:~:text=The%20COVID%2D19%20pandemic%20also,high%2Dquality%20care%20and%20support.
[144] See Province of Alberta, 30th Legislature, 3rd Session, Monday, March 28th, 2022, 432. https://docs.assembly.ab.ca/LADDAR_files/docs/hansards/han/legislature_30/session_3/20220328_1330_01_han.pdf

2021. The report offered 11 policy directions and 42 recommendations.[145] A major recommendation from MNP LLP that was named by Copping as a stated goal of the UCP was to shift the distribution of facility-based continuing care in Alberta from its current rate of 39% to 30%; accordingly, this was a plan to increase homecare in Alberta from 61% to 70% of continuing care delivery in the province.[146] As readers will likely note, this continued a broader provincial trend of investing increasingly in homecare streams as a fiscal strategy to reduce public expenditures on continuing care in Alberta. As underscored in Recommendation 6, this is a risky strategy given the demographic composition of Albertans and the upper-bound limits of this approach may have already been reached; however, the situation is admittedly a complex one that requires further elaboration here.

MNP LLP's continuing care review suggested that this dramatic shift towards homecare would yield "a reduction in annual operating costs of $452 million" as well as a "cumulative capital cost savings of $1.7 billion."[147] Though this claim of 'streamlining' legislation and creating savings through policy changes was to receive considerable criticism from the opposition during debates and readings of Bill-11, the report itself suggested that this potential annual savings of $452 million could actually be an important source of funding for improvements to facility-based care centres. The $452 million, the report noted, was "slightly lower than the added costs of $498 million that result from increasing direct hours of care to an average of 4.5 hours per resident day for LTC, 4.0 hours per resident day for DSL4D, and 3.5 hours per resident."[148] Thus, the MNP LLP recommendation to increase rates of home-based continuing care was not necessarily a blueprint for divestment from facility-based forms of continuing care in Alberta. Nonetheless, Bill-11, which was rather short and non-descript as a document, was generative of significant debate and oppositional criticism given that it failed to include any clear standards or oversight mechanisms for things like monitoring direct hours of care.

Several political narratives were invoked throughout the rather heated debates associated with the tabling of Bill-11, signifying acute political polarization on the matter. On the UCP side, Copping and his supporters argued that:

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[145] MNP LPP, *Improving Quality of Life for Residents in Facility-Based Continuing Care*, April 30th, 2021, https://open.alberta.ca/dataset/f680d1a6-bee5-4862-8ea4-e78d98b7965d/resource/22092c9c-99bb-4fee-9929-7ce06e71bbd1/download/health-improving-quality-life-residents-facility-based-continuing-care-2021-04-30.pdf. It is also important to note that this report calls for the further integration of health and supportive services, which dovetails with Recommendation 5 in this report.

[146] MNP LPP, *Improving Quality of Life for Residents in Facility-Based Continuing Care*, April 30th, 2021, iv https://open.alberta.ca/dataset/f680d1a6-bee5-4862-8ea4-e78d98b7965d/resource/22092c9c-99bb-4fee-9929-7ce06e71bbd1/download/health-improving-quality-life-residents-facility-based-continuing-care-2021-04-30.pdf.

[147] MNP LPP, *Improving Quality of Life for Residents in Facility-Based Continuing Care*, April 30th, 2021, v, https://open.alberta.ca/dataset/f680d1a6-bee5-4862-8ea4-e78d98b7965d/resource/22092c9c-99bb-4fee-9929-7ce06e71bbd1/download/health-improving-quality-life-residents-facility-based-continuing-care-2021-04-30.pdf.

[148] MNP LPP, *Improving Quality of Life for Residents in Facility-Based Continuing Care*, April 30th, 2021, v, https://open.alberta.ca/dataset/f680d1a6-bee5-4862-8ea4-e78d98b7965d/resource/22092c9c-99bb-4fee-9929-7ce06e71bbd1/download/health-improving-quality-life-residents-facility-based-continuing-care-2021-04-30.pdf.

1. Bill 11 would be transformational and create much needed legislative scaffolding for future updates to continuing care in Alberta.
2. Bill 11 would produce transparency with increased fines and reviews
3. Bill 11 was client-focused because it is informed by the MNP LLP review, which consulted with stakeholders and members of the public.

In direct opposition, NDP critics argued:

1. Bill 11 is best understood as a housekeeping bill that is too vague and lacks any substantive changes in terms of improving cultures and systems of continuing care
2. That Albertans should not trust the UCP with continuing care policy directives given their (mis)handling of COVID-19 with respect to long-term care homes.
3. That Bill 11's most likely impact will be to facilitate the increased privatization of continuing care.

Also complicating the matter was the fact that Jason Copping had been recently shuffled into his position as Minister of Health following his replacement of Tyler Shandro in September of 2021. Previously the Minister of Labour and Immigration, Copping took over Shandro's position amidst heavy criticism of the latter due in part to his handling of the COVID-19 pandemic.[149] The fact that roughly 1,600 residents of long term care homes had died from COVID-19 was also cited by NDP critics when debating Bill-11.[150] In short, the bill that became the Continuing Care Act was quite controversial and generated several discussions and multiple readings that can fairly be characterized as more politically charged than usual. Though its impact has yet to be fully understood given its recent assent, it also must be judged in concert with the larger framework for the oversight of facility-based continuing care in Alberta that the UCP argued was better administered in an extra-legislative matter rather than written into Bill-11 itself.

For our purposes, we must underscore that the continued strategy of investing in home-care poses specific problems for creating a robust, coordinated, and well-integrated set of supports for OPEH. Though it is not necessarily a zero-sum game (e.g., savings generated by increasing rates of homecare can conceivably fund facility-based continuing care expansions, as per the MNP LLP report), clear and coherent policy frameworks ought to ensure that the continuing care sector is prepared to provide care for OPEH with complex needs for whom

[149] Ashley Joannou, "Shandro Shuffled Out as Health Minister, Takes on Labour Portfolio in Swap with Copping", *Edmonton Journal*, September 21, 2021, https://edmontonjournal.com/news/politics/kenney-to-shuffle-his-cabinet. Also, see Sammy Hudes, "Kenney Rejects NDP's Calls to Fire Health Minister Over Confrontation with Doctor", *Calgary Herald*, March 28th, 2020, https://calgaryherald.com/news/politics/bizarre-reckless-and-frankly-intimidating-ndp-calls-on-premier-to-fire-shandro-from-health-portfolio?_gl=1*gfzqnz*_ga*MTEwMzMxMzA5Ni4xNjY4ODgzNjQy*_ga_9H6VPHFHKG*MTY2ODg4MzY0Mi4xLjAuMTY2ODg4MzY0Mi42MC4wLjA.&_ga=2.18636730.2033246228.1668883642-1103313096.1668883642.

[150] See Province of Alberta, 30th Legislature, 3rd Session, Wednesday, March 30th, 2022, 554, https://docs.assembly.ab.ca/LADDAR_files/docs/hansards/han/legislature_30/session_3/20220330_1330_01_han.pdf.

homecare is not possible. What is more, OPEH who suffer from addictions and unmet mental health needs will require an array of rehabilitative and supportive services, which brings us to the matter of provincial approaches to harm reduction, which we identify as our third policy pillar when discussing the health and social outcomes of OPEH in Alberta.

Policy Pillar No. 3:
Federal and Provincial Approaches to Harm Reduction

Put plainly, aging can be painful. Free from the physical complications and pains experienced by older adults and seniors, the social experience of aging can bring about loneliness, isolation, depression, and financial strain following retirement, the loss of friends, and the death of spouses.[151] What is more, pain management can be difficult for older adults and seniors who deal with chronic pain from a long list of age-related medical conditions (e.g., arthritis) as well as accidents and bone-breaks (which are made all the more likely when an individual suffers from osteoporosis). Further, intense periods of pain that follow from medical procedures (e.g., hip or knee arthroplasties) can also substantially increase the risk of post-operation physical dependencies and addictions in older populations.[152] Dr. David Lussier, Director of the Geriatric Pain Clinic at McGill University's Health Centre in Montréal states the case quite clearly: "because pain is more common in older people, they take more opioids, more

[151] Michelle Cleary, Jan Sayers, Marguerite Bramble, Debra Jackson, Violeta Lopez, "Overuse of Substance Use and Mental Health among the 'Baby Boomers' Generation", *Issues in Mental Health Nursing*, 38, no. 1 (2017): 61-65
[152] See "The Opioid Epidemic and Seniors: Addiction, Misuse, and Dependency Are on the Rise." *Healthy Years* 13, no. 5 (2016): 1–13.

frequently."[153] The Canadian Coalition for Senior's Mental Health echoes this view, noting that Baby Boomers "have had more permissive attitudes toward drug use, easier access to opioid medications, and a greater exposure to illicit drug use than any previous generation."[154] And while the goal for many who enter into treatment programs is recovery and sobriety, the picture is more complicated for older adults and seniors who experience chronic pain as abstinence is a much less tenable or desirable goal, given that pain management rather than recreational use is often the pathway into dependency and addiction.[155] Further, as Lauren Vogel notes, seniors are also overrepresented in Canada when it comes to hospital visits for opioid poisoning: though they accounted for roughly 16% of the Canadian population, individuals aged 65 and above accounted for nearly 25% of hospitalizations in 2017.[156] A 2018 report from the Canadian Centre on Substance Use and Addiction also found that "43.9% of adults > 55 years of age have used a prescription opioid and 1.1% of that group have done so daily (or almost daily) in the last year."[157] In Alberta, surveillance data reveals that the highest number of fatalities from unintentional, non-fentanyl related opioid poisonings occurring in the first half of 2020 were in individuals 55 – 59 years old.[158] Individuals 50 and over also made up a significant proportion of fentanyl-related fatalities.[159]

It is also seems clear from general population studies that those born during the Baby Boom (1946-1964) "have a higher prevalence of substance use than those born in previous decades."[160] The Royal College of Psychiatrists in the United Kingdom, noting a similar pattern, referred to seniors with substance use disorders as "invisible addicts", whereas a more recent

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[153] Quoted in Lauren Vogel, "Seniors and Self-Harm Factor in the Opioid Crisis," *Canadian Medical Association Journal* 189, no. 1 (2017): E42.
[154] Canadian Coalition for Senior's Mental Health, *Canadian Guidelines for Opioid Use Disorder Among Older Adults, 2019*, 11, https://ccsmh.ca/wp-content/uploads/2019/11/Canadian_Guidelines_Opioid_Use_Disorder_ENG.pdf
[155] For an Ontario study to this effect, see Ana Johnson, Brian Milne, Matthew Pasquali, Narges Jamali, Steve Mann, Ian Gilron, Kieran Moore, Erin Graves, and Joel Parlow. "Long-Term Opioid Use in Seniors Following Hip and Knee Arthroplasty in Ontario: a Historical Cohort Study." *Canadian Journal of Anesthesia* 69, no. 8 (2022): 934–44.
[156] Lauren Vogel, "Seniors and Self-Harm Factor in the Opioid Crisis," *Canadian Medical Association Journal* 189, no. 1 (2017): E42–43.
[157] Canadian Coalition for Seniors Mental Health, Opioid Use Disorder Among Older Adults, https://ccsmh.ca/substance-use-addiction/opioids/#:~:text=According%20to%20the%20World%20Health,2012%3B%20UNODC%2C%202018 (accessed November 1, 2022).
[158] Alberta Health, *COVID-19 Opioid Response Surveillance Report*, September 2020, 17, https://open.alberta.ca/dataset/f4b74c38-88cb-41ed-aa6f-32db93c7c391/resource/e8c44bab-900a-4af4-905a-8b3ef84ebe5f/download/health-alberta-covid-19-opioid-response-surveillance-report-2020-q2.pdf .
[159] Alberta Health, *COVID-19 Opioid Response Surveillance Report*, September 2020, 17, https://open.alberta.ca/dataset/f4b74c38-88cb-41ed-aa6f-32db93c7c391/resource/e8c44bab-900a-4af4-905a-8b3ef84ebe5f/download/health-alberta-covid-19-opioid-response-surveillance-report-2020-q2.pdf .
[160] Matthew A. Spinelli, Claudia Ponath, Lina Tieu, Emily E. Hurstak, David Guzman, and Margot Kushel. "Factors Associated with Substance Use in Older Homeless Adults: Results from the HOPE HOME Study." *Substance Abuse* 38, no. 1 (2017): 88; Daniel Rosen, Daniel, Rafael J. Engel, Corinne Beaugard, Nia Davis, and Gerald Cochran. "Baby Boomer's Substance Abuse and Researcher Indifference," *Journal of Gerontological Social Work* 62, no. 1 (2019): 16–28.

2019 study lamented that a "paucity of published or funded work exists in this area despite growing misuse and treatment seeking among older adults with substance use disorders."[161] And while the evidence suggests that older adults and seniors in Canada smoke cigarettes and drink alcohol at a lower frequency than younger populations, this does not necessarily mean that policy makers can afford to shelve the issue. For example, though older Canadians (55+) smoke with less frequency than those in the 14-55 age range (10.5% to 14.3%, respectively), those that do tend to smoke more cigarettes than younger smokers and are more dependent on nicotine.[162] Similar trends exist with respect to alcohol consumption: though 55+ individuals are more like to not drink at all, those that do are more likely to be daily drinkers. The Canadian Centre on Substance Use and Addiction reported in 2018 that "the frequency of daily or almost daily alcohol use peaks in the 65–74 age group."[163] In this frame, the comparative statistics can be slightly misleading from a policy perspective, given that the impacts of smoking and drinking are much more pronounced on those at an advanced age. As a 2017 study in *The British Medical Journal* noted, "alcohol misuse in the older population may increase further as baby boomers get older because of their more liberal views towards, and higher use of, alcohol", which will likely result in an increased "need for treatment, longer duration of treatment, heavier use of ambulance services, and higher rates of hospital admission."[164] From a health system perspective, it is important to recall here that Albertans have "higher than average rates of obesity …higher smoking rates (16.2 per cent, Alberta vs. 15.5 per cent, Canada, 12 years and older)…[and] when it comes to lifetime alcohol use, Alberta is second only to Quebec."[165] Put plainly, the higher rate of alcohol consumption and cigarette smoking amongst all Albertans, including older adults, will result for many in higher utilization of healthcare.

We do not wish to pathologize smoking, drinking, and substance dependencies in any population; however, we believe it is easier for many to understand how chronic pain, isolation, loneliness, and mental health challenges may exacerbate substance use, increasing the likelihood of complex medical conditions and emergent events. Problematic substance use can also contribute to poverty and homelessness among older adults under 65. This is because addiction is correlated with premature physical and cognitive symptoms of aging.[166] Nonetheless, 'younger' older adults who experience this remain ineligible for seniors income supports, instead relying on less substantial social assistance measures. It is for these reasons that we identified harm

[161] Royal College of Psychiatrists, *Our Invisible Addicts: College Report CR211*, March 2018, https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr211.pdf?sfv
[162] Canadian Centre on Substance Use and Addiction, *Improving Quality of Life: Substance Use and Aging*, 2018, 27, https://www.ccsa.ca/sites/default/files/2022-04/CCSA-Substance-Use-and-Aging-Report-2018-en%20%28ID%2023186%29.pdf
[163] Canadian Centre on Substance Use and Addiction, *Improving Quality of Life: Substance Use and Aging*, 2018, 29, https://www.ccsa.ca/sites/default/files/2022-04/CCSA-Substance-Use-and-Aging-Report-2018-en%20%28ID%2023186%29.pdf
[164] Rahul Rao and Ann Roche. "Substance Misuse in Older People." *BMJ*, 358 (2017): j3885–j3885.
[165] John Church and Neale Smith, *Alberta: A Health System Profile* (Toronto: University of Toronto Press, 2022), 15.
[166] Keren Bachi, Salvador Sierra, Nora D Volkow, Rita Z Goldstein, and Nelly Alia-Klein, "Is Biological Aging Accelerated in Drug Addiction?" in *Current Opinion in Behavioral Sciences* 13 (2017): 34–39.

reduction as a key pillar of policy development. While this approach can be controversial and politically charged, we hope readers agree that there are obvious societal benefits to be gained in making harm reduction programs and services accessible to seniors in general and OPEH in Alberta more specifically.

Defining Harm Reduction

Harm reduction is an evidence-based approach to public health policy that supports "programmes and practices that aim to minimize negative health, social, and legal impacts associated with [substance] use, drug policies, and drug laws."[167] Examples of harm reduction in action include safe consumption service (SCS) sites, managed alcohol programs (MAPs), and the public distribution and availability of naloxone kits. Central to the philosophy of harm reduction is the acknowledgement that abstinence-only frameworks do not work well for most people who use drugs; thus, harm reduction is a strategy that seeks to mitigate both the risk and harm of using drugs as a means of improving both individual and public health outcomes. It is perhaps for this reason that the Canadian Centre for Mental Health and Addiction (CAHM) defines harm reduction as "any program or policy designed to reduce drug-related harm without requiring the cessation of drug use."[168] In the words of Allan Clear, Executive Director of the Harm Reduction Coalition: "harm reduction accepts that drug use exists" and does not embark upon the 'Just Say No' approach to assisting people who become addicted.[169] Thus, rather than positioning sobriety and abstinence as the end goal cohering service provision and supportive programming for those grappling with addiction, harm reduction seeks to mitigate the harms, risks, and negative impacts that using drugs can have on an individual or the community in which they reside. Harm reduction is also often seen as opposing carceral drug policies that criminalize and jail those who use substances that are illegal: indeed, if one believes they may face criminal charges or jail time for seeking assistance with addiction to a banned or controlled substance, their likelihood of accessing services or supports for substance abuse is significantly reduced. Furthermore, the social and economic costs of law enforcement and incarceration for drug use are considerable, resulting not only in harms to people who use illicit substances but also their families, communities, and societies at large.[170] Within the context of continuing care in Alberta, this carceral approach is mirrored in exclusionary and punitive operational policies within DLS sites and LTC homes wherein unregulated or unsanctioned substance can become immediate grounds

[167] Harm Reduction International, "What is Harm Reduction?", 2022; available online at https://www.hri.global/what-is-harm-reduction [accessed September 11, 2022].
[168] Canadian Centre for Mental Health and Addiction, "CAMH and Harm Reduction: A Background Paper on Its Meaning and Application for Substance Use Issues", May, 2002; available online at: http://prevent-cancer.ca/wp-content/uploads/2015/07/CAMH-and-Harm-Reduction_-A-Background-Paper.pdf [accessed September 11, 2022].
[169] Clear quoted in Dylan Foley, "Defining Harm Reduction: Three Experts Speak", *The Body: HIV/AIDS Resource*, March 31, 1997; available online at: https://www.thebody.com/article/defining-harm-reduction-three-experts-speak [accessed September 11, 2022].
[170] Dave Bewley-Taylor, Chris Hallam, and Rob Allen, *The incarceration of drug offenders: an overview*, International Centre for Prison Studies, March 2009, https://www.beckleyfoundation.org/wp-content/uploads/2016/04/BF_Report_16.pdf. Also, see Mohammad Hajizadeh, "Legalizing and Regulating Marijuana in Canada: Review of Potential Economic, Social, and Health Impacts" in *International Journal of Health Policy Management* 5, no. 8 (August 2016): 453–456.

for eviction. For this reason, OPEH who use substances rarely qualify as candidates for care with extant frameworks of service provision in Alberta.[171] For these reasons, harm reduction seeks to meet people who use drugs 'where they are at', so to speak, regardless of whether they are actively seeking to abstain from substance use or not. Again, within the context of continuing care in Alberta, this refers to funding models of care that work with seniors and adults to reduce the harm associated with their use of substances, which is a meaningful alternative to disqualifying them from care on the basis of their substance use.[172]

Some experts, however, prefer to articulate harm reduction more broadly – that is, beyond the realm of drug policy or service provision and as a rationalistic approach to good governance in the broad sense. Dr. Krishna Balachandra, a physician at Edmonton's first injectable Opioid Agonist Treatment Centre, uses driving as an example of an activity with implicit harms and dangers that government seek to reduce or mitigate: "If you think about driving, that's an inherently dangerous activity, because you can die from motor vehicle accidents, speeding, things like that. So, we have whole host of harm reduction features that we use for driving like seatbelts and speed limits, airbags, and 'Don't Drink and Drive Legislation.'"[173] Important here is the way in which a harm reduction approach does not rely solely on policing the behaviour of individuals, which will always be varied and ultimately impossible to fully control. Staying within the driving metaphor, a harm reduction approach acknowledges that many people will choose to engage in the dangerous behaviour of speeding or driving under the influence, but the physical environment (e.g. divided highways and safety railings), policy environments (e.g. vehicle inspection and registration systems), social environments (e.g. 'arrive alive' and 'keys please' campaigns), as well as economic environments (e.g., directing tax dollars towards these measures to benefit all people). Though, for our purposes in this report, harm reduction refers to public health services that work with people who use drugs to improve individual and public outcomes, it is useful to underscore this broader principle of harm reduction before proceeding, given that it frames the issue in an accessible way by focusing on a 'risk environment' framework. As Rhodes (2009) explains, "a 'risk environment' framework envisages drug harms as a product of the social situations and environments in which individuals participate. It shifts the responsibility for drug harm, and the focus of harm reducing actions, from individuals alone to include the social and political institutions which have a role in harm production."[174] In other words, harm reduction is not an approach that focuses negatively on the individual engaging in

[171] For a broader discussion of healthcare 'candidacy' (or the ways in which one must qualify for healthcare by embodying certain standards and norms), see Mary Dixon-Woods, Debbie Cavers, Shona Agarwal, Ellen Annandale, Antony Arthur, Janet Harvey, and Ron Hsu, "Conducting a Critical Interpretive Synthesis of the Literature on Access to Healthcare by Vulnerable Groups," in *BMC Medical Research Methodology* 6, no. 1 (2006): 35–48.
[172] For a description of one such care provision model, see Lara Nixon and Victoria Burns, "Exploring Harm Reduction in Supportive Housing for Formerly Homeless Older Adults," *Canadian Geriatrics Journal* CGJ 25, no. 3 (2022): 285–94.
[173] Interview with Dr. Balachandra, July 19th, 2022. It should be noted here that Dr. Balachandra credited Dr. Cam Wild of the University of Alberta's Public Health Department as having taught him the driving metaphor described in the passage above.
[174] Tim Rhodes, "Risk Environments and Drug Harms: A Social Science for Harm Reduction Approach" *in The International Journal of Drug Policy* 20, no. 3 (2009): 194.

the risk-associated behaviour; rather, it focuses positively on creating an environment in which any harm from said behaviour is mitigated as far as possible.

Harm Reduction is Evidence-Based

Harm reduction approaches have been impressively implemented in the context of health and healthcare provision. Thus, while it remains a politicized issue, harm reduction has a proven track record of working. For example, one study on the implementation of a syringe exchange program in Vancouver, British Columbia found "substantial declines in rates of syringe borrowing (from 20.1% in 1998 to 9.2% in 2003) and syringe lending (from 19.1% in 1998 to 6.8% in 2003)" after the implementation of harm reduction programming.[175] In the city of Edmonton, a study on the Streetworks needle exchange program found that "the cost per HIV case averted for one year was $9,537" and, on that basis, "the Streetworks needle-exchange program results in net savings and fewer AIDS cases, and is therefore a dominant strategy."[176] This is also true in the context of needle and syringe programs as preventative measures that contain the harms other communicable diseases. For example, a longitudinal study in the UK found that needle exchange programs and harm reduction syringe services were "a highly effective low-cost intervention to reduce hepatitis C virus transmission" that was often (though not always) cost-saving.[177] This seems to hold true across the Canadian context. For example, a study of needle exchange programs in Hamilton, Ontario determined that "in the first year of operation the program would be expected to provide total cost savings of $333,589. Over 5 years this amount would be $1,292,444. This translates into a ratio of cost savings to costs of 4:1; that is, for each dollar of resources spent in providing the program over 5 years, 4 dollars would be saved in costs."[178]

Another study on the performance of managed alcohol programs (MAPs) across Canada determined that "people enrolled in a diverse collection of Canadian MAPs (i) reduced their alcohol use over time, (ii) consumed their alcohol in a more, even, less sporadic pattern than controls and (iii) did not experience deterioration in liver function or of alcohol-related harms in general."[179] The same study noted further that some "MAP residents showed significantly fewer

[175] Thomas Kerr, Will Small, Chris Buchner, Ruth Zhang, Kathy Li, Julio Montaner, and Evan Wood, "Syringe sharing and HIV incidence among injection drug users and increased access to sterile syringes" in *American Journal of Public Health* 100, no. 8 (2010):1449.
[176] Philip Jacbos, Peter Calder, Marliss Taylor, Stanley Houston, L. Duncan Saunders, and Terry Albert, "Cost Effectiveness of Streetworks' Needle Exchange Program of Edmonton" in *Canadian Journal of Public Health* 90, no. 3 (1999): 168–71.
[177] Lucy Platt, Sedona Sweeney, Zoe Ward, Lorna Guinness, Matthew Hickman, Vivian Hope, Sharon Hutchinson, et. al., "Assessing the Impact and Cost-Effectiveness of Needle and Syringe Provision and Opioid Substitution Therapy on Hepatitis C Transmission Among People Who Inject Drugs in the UK: An Analysis of Pooled Data Sets and Economic Modelling" in *Public Health Research* 5, no. 5 (2017): 1.
[178] M.aa. Gold, A. Gafni, P. Nelligan, and P. Millson, "Needle Exchange Programs: An Economic Evaluation of a Local Experience" in *Canadian Medical Association Journal* 157, no. 3 (1997): 255–62.
[179] T. Stockwell, J. Zhao, B. Pauly, C. Chow, K. Vallance, A. Wettlaufer, J. B. Saunders, and J. Chick "Trajectories of Alcohol Use and Related Harms for Managed Alcohol Program Participants over 12 Months Compared with Local Controls: A Quasi-Experimental Study" in *Alcohol and Alcoholism* 56, no. 6 (2021): 651–59.

hospital admissions and police contacts", which underscores not only the efficacy but the cost-saving measures associated with the implementation of harm reduction programming as a larger public health framework.[180] Additionally, a study of harm reduction approaches and housing first programs found that program participants who had dual diagnoses "obtained housing earlier, remained stably housed, and reported higher perceived choice" while also having an increased uptake of substance abuse treatment.[181] In other words, harm reduction programs and services have proved their worth both in the fiscal sense as well as in terms of improving the health and social outcomes of people who use substances.

The Grassroots Emergence of Harm Reduction

Although The Commission of Inquiry in the Non-Medical Use of Drugs (The Le Dain Commission), concluded in 1972 that drug prohibition was both costly and inefficient, it would take decades for drug policy reform to materialize[182]. Prior to its widespread adoption as an impactful and effective public health policy strategy, harm reduction existed as a social movement organized by people who use drugs, as well as their advocates and allies. Underground needle exchanges and information-sharing networks that grew in response to the AIDS crisis of the mid-1980s are generally located as the origins of the harm reduction movement. Harm reduction movements in a European context are often linked to a 1985 protest in Amsterdam by drug users and advocates who were seeking a safe supply of needles against pharmacists who were at that time refusing to sell them.[183] Edith Springer, who later became the Clinical Director of the acclaimed New York Peer AIDS Education Centre, cited these protests as formative in her own organizing for harm reduction during the AIDS crisis.[184] The AIDS Coalition to Unleash Power (ACT UP) movement became widely celebrated for its role in advancing harm reduction as a way of preventing deaths and the spread of infections during this time.[185] Thus, while harm reduction has become largely institutionalized within the structures, laws, and the service provision schemas of various health authorities, it has its roots in community action, social cohesion, and the broader response to the Gay Men's Health Crisis of

[180] T. Stockwell, J. Zhao, B. Pauly, C. Chow, K. Vallance, A. Wettlaufer, J. B. Saunders, and J. Chick "Trajectories of Alcohol Use and Related Harms for Managed Alcohol Program Participants over 12 Months Compared with Local Controls: A Quasi-Experimental Study" in *Alcohol and Alcoholism* 56, no. 6 (2021): 651–59.
[181] Sam Tsemberis, Leyla Gulcur, and Maria Nakae, "Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis" in *American Journal of Public Health* 94, no. 4 (2004): 651–656.
[182] Walter Cavalieri and Diane Riley, "Harm Reduction in Canada: The Many Faces of Regression" in *Harm Reduction in Substance Use and High-Risk Behaviour: International Policy and Practice*, eds. Richard Pates and Diane Riley (London: Wiley-Blackwell Publishing, 2012), 392-394.
[183] Dylan Foley, "Defining Harm Reduction: Three Experts Speak", *The Body: HIV/AIDS Resource*, March 31, 1997; available online at: https://www.thebody.com/article/defining-harm-reduction-three-experts-speak [accessed September 11, 2022].
[184] Clear quoted in Dylan Foley, "Defining Harm Reduction: Three Experts Speak", *The Body: HIV/AIDS Resource*, March 31, 1997; available online at: https://www.thebody.com/article/defining-harm-reduction-three-experts-speak [accessed September 11, 2022].
[185] Nancy D. Campbell, "Who Needs Naloxone?" in *Critical Approaches to Harm Reduction : Conflict, Institutionalization, (de-)politicization, and Direct Action*, edited by Christopher Smith and Zach Marshall, (New York: Nova Science Publishers, Inc., 2016): 6-8.

the 1980s.[186] As Smith and Marshall contend, "the undeniable truth…is that almost without exception, interventions that fall under the guise of harm reduction were not dreamed up by the white-collar bureaucrats who dictate public health policy, but by the 'unsanctioned,' underground, and explicitly direct action-based tactics of people who use drugs and their allies."[187] Within a Canadian context, the community organization or movement most readily associated with the advancement of harm reduction has been the Vancouver Area Network of Drug Users (VANDU).

In September of 1997, a collection of grassroots activists in the Downtown East Side of Vancouver came together to create VANDU. VANDU was a response to high rates of HIV infection and overdose among community members who use injectable drugs. As a drug-user organization, VANDU has since become a widely studied and often-praised example of harm reduction given its significant impact in Vancouver.[188] It has also inspired and informed other similar organizations, such as the Western Aboriginal Harm Reduction Society (WAHRS) or the British Columbia Association of People on Opiate Maintenance (BCAPOM).[189] VANDU was pivotal in establishing street outreach programming and services to assist those who use injectable drugs in learning safest practices with needle usage, the dangers of using alone, and the administration of naloxone and CPR to those experiencing an overdose. Controversially, VANDU has undertaken harm reduction initiatives that were unsanctioned by local health authorities and drew the attention of law enforcement. For example, in September of 2001, VANDU began operating a safe needle exchange program from a tent in an area of the city known to be a hot-spot for public drug use. As one study noted, "on average, 1200 syringes were exchanged every evening, 7 days a week from 8:00 p.m. to 4:00 a.m., for 9 months without incident" until the Vancouver Police Department shut down the site in May of 2002 and citing VANDU's lack of a permit.[190] VANDU was ultimately victorious (or at least vindicated) in its harm reduction approach in 2003 when InSite – North America's first legal supervised safe injection site – was opened in downtown Vancouver. By 2020, this safe injection site had recorded more than 3.6 million visits with only 6,440 overdoses; quite incredibly, there has never been a recorded death at InSite, which is perhaps the strongest evidentiary basis supporting harm

[186] See Philip M. Kayal, *Bearing Witness: The Gay Men's Health Crisis and the Politics of AIDS* (London: Routledge Publishing, 1993).
[187] Christopher Smith and Zach Marshall (eds.), "Introduction" in *Critical Approaches to Harm Reduction : Conflict, Institutionalization, (de-)politicization, and Direct Action* (New York: Nova Science Publishers, Inc., 2016), xi.
[188] Thomas Kerr, Will Small, Wallace Peace, David Douglas, Adam Pierre, and Evan Wood, "Harm Reduction by a 'user-Run' Organization: A Case Study of the Vancouver Area Network of Drug Users (VANDU)" in *The International Journal of Drug Policy* vol. 17, no. 2 (2006): 61–69.
[189] Russ Maynard and Ehsan Jozaghi. "The Drug War Must End: The Right to Life, Liberty and Security of the Person During the COVID-19 Pandemic for People Who Use Drugs" in *Harm Reduction Journal* vol. 18, no. 1 (2021): 21–22.
[190] Thomas Kerr, Will Small, Wallace Peace, David Douglas, Adam Pierre, and Evan Wood, "Harm Reduction by a 'user-Run' Organization: A Case Study of the Vancouver Area Network of Drug Users (VANDU)" in *The International Journal of Drug Policy* vol. 17, no. 2 (2006): 61–69.

reduction strategies in a Canadian context.[191] In 2010, VANDU released a manifesto, which contained the following passage:

> This is a challenge to academics, policy experts and service providers: we do not want to be used as cheap labour, we do not want to be studied while we die, or be turned into clients while resources are given to 'service' agencies. We will not tolerate actions that exploit the labour, activist work, or experiences of people who use drugs. Finally, we expect responsible researchers, experts, and academics to support us.[192]

More recently, VANDU (with the support of the Drug Users Liberation Front [DULF]), has responded to the increased overdose deaths during the COVID-19 pandemic by setting up a safe supply site that sells cocaine, heroin, and methamphetamine. It is interesting to note here that those running the safe supply site applied for an exemption under Section 56 of the *Controlled Drug and Substances Act*, though were denied by Health Canada on July 29th, 2022.[193] As this example demonstrates, harm reduction and federal drug policy are enmeshed within one another to the extent that one cannot be fully or meaningfully understood without the other.

Federal Drug Policies from 1986-2016

Canadian federal drug policy has waxed and waned in terms of its support for harm reduction programming. In 1986, Prime Minister Brian Mulroney declared that drug abuse and addiction had become a national epidemic that required a concerted response from the federal government. Thus, when the Canadian Drug Strategy was first released in 1987, it was tempered by the broader public health crisis of HIV/AIDS and, largely for that purpose, included harm reduction as a pillar of the strategy. When the Canadian Centre on Substance Abuse was founded in 1990, its research supported harm reduction principles and practices.[194] Its research and policy unit received public criticism for anti-prohibitionist leanings, and it was eventually dissolved in 1996.[195] Despite some setbacks encountered in the mid-90s, in the late 90s and early 2000s anti-prohibitionists pushed forward modest drug policy reforms including the legalization of medical marijuana, and prompted a Senate review of drug policy calling for the legalization of non-medical marijuana use. However, when Conservative Prime Minister Stephen Harper took office

[191] Vancouver Coastal Health, "InSite User Statistics", 2020; available online at http://www.vch.ca/public-health/harm-reduction/supervised-consumption-sites/insite-user-statistics [accessed September 17th, 2022].
[192] VANDU Manifesto quoted in *Critical Approaches to Harm Reduction : Conflict, Institutionalization, (de-)politicization, and Direct Action*, edited by Christopher Smith and Zach Marshall, (New York: Nova Science Publishers, Inc., 2016): xii-xiii.
[193] Claire Wilson, "Drug User Compassion Groups in BC see success in safe supply distribution", *Vancouver is Awesome*, August 31st, 2022; available online at https://www.vancouverisawesome.com/highlights/drug-user-compassion-groups-in-bc-see-success-in-safe-supply-distribution-5763733 [accessed September 17th, 2022].
[194] Diane Riley, *Drugs and Drug Policy in Canada: A Brief Review and Commentary* (Ottawa: Canadian Centre on Substance Abuse, 1993), https://sencanada.ca/content/sen/committee/371/ille/library/riley-e.pdf.
[195] Walter Cavalieri and Diane Riley, "Harm Reduction in Canada: The Many Faces of Regression" in *Harm Reduction in Substance Use and High-Risk Behaviour: International Policy and Practice*, eds. Richard Pates and Diane Riley (London: Wiley-Blackwell Publishing, 2012), 392-394.

in 2006, federal drug policy took a drastic turn towards prohibitionist approaches that stressed criminalization and defunded harm reduction. As Smith and Marshall explain, "within six months of taking office in 2006…Prime Minister Stephen Harper attempted to effect a complete erasure of harm reduction by replacing Canada's Drug Strategy with the National Anti-Drug Strategy (2007), a document that consciously omitted harm reduction from Canada's national drug policy landscape."[196] Arguably, the federal government under Harper's direction sought to attack and undermine harm reduction through the cutting of programs and funding that might make it possible. We observed a similar tendency in the provincial government under Jason Kenny (see sections below on the *Impact* report); however, we will stay here within the analytic context of federal policy for purposes of continuity,

For example, in 2007, Stockwell Day – a Conservative politician from Alberta then serving as Canada's Public Safety Minister – cut funding for a $600,000 safe tattooing initiative in Canada's prisons. Day cited the program as a waste of tax dollars, which drew the criticism of Canada's Chief Public Health Officer David Butler-Jones who saw the program's capacity to prevent HIV and Hepatitis C infections as in the public interest as well as fiscally responsible.[197] As Wayne Kondro explained in the *Canadian Medical Association Journal*, "Corrections Canada pegs the annual cost of providing HIV treatment for an inmate at $29,000, and for hepatitis C treatment at $26,000. Those costs of roughly $90 million absorb the bulk of a burgeoning $100-million or so annual Corrections Canada health care budget."[198] In light of Corrections Canada's costs associated with increased infection rates, the safe tattoo initiative's price tag of $600,000 was justifiable; however, because it ran counter to the Harper's government views on harm reduction, the program was scuttled. In the same year (2007), the federal government also scrapped a Prison Needle Exchange Program (PNEP), with Stockwell Day claiming that "We prefer to educate inmates about the dangers of using drugs in prison. Tolerance zero."[199] For many observers, the scrapping of the PNEP in combination with the cutting of safe tattoo programs was alarming given the increased risk it posed to prisoners, correctional officers, and the general public.[200] It was also an example of anti-harm reduction being non-evidentiary social policy, given the extent to which PNEPs are widely studied across the world as impactful and successful.[201] Incredibly, in 2011, Harper's government also denied the renewal of a section 56

[196] Marshall and Smith (eds), "Introduction" in *Critical Approaches to Harm Reduction : Conflict, Institutionalization, (de-)politicization, and Direct Action* (New York: Nova Science Publishers, Inc., 2016): xii.
[197] Wayne Kondro, "Conservative Government Scuttles Needle Exchange" in *Canadian Medical Association Journal (CMAJ)* vol. 176, no. 3 (2007): 308–308.
[198] Wayne Kondro, "Conservative Government Scuttles Needle Exchange" in *Canadian Medical Association Journal (CMAJ)* vol. 176, no. 3 (2007): 308–308.
[199] Day quoted in Wayne Kondro, "Conservative Government Scuttles Needle Exchange" in *Canadian Medical Association Journal (CMAJ)* vol. 176, no. 3 (2007): 308–308.
[200] Richard Elliott, "Deadly Disregard: Government Refusal to Implement Evidence-Based Measures to Prevent HIV and Hepatitis C Virus Infections in Prisons" in *Canadian Medical Association Journal (CMAJ)* vol. 177, no. 3 (2007): 262–64.
[201] R. Lines, R. Jürgens, G. Betteridge et al. *Prison needle exchange: lessons from a comprehensive review of international evidence and experience.* 2nd ed. Toronto: Canadian HIV/AIDS Legal Network; 2006. Available: www.aidslaw.ca/publications/publicationsdocEN.php?ref=184 (accessed 2007 June 26).

exemption for the InSite safe injection site in Vancouver and cut funding for its operation.[202] As Shelley Marshall reflected in a 2015 article:

> the anti-harm reduction sentiment in Harper's drug policy has been demonstrated by the removal of harm reduction from the National Anti-Drug Strategy of 2007; federal funding cuts to harm reduction programs; the denial of a renewed exemption to section 56 of the Controlled Drugs and Substances Act for Vancouver's safe injection site, InSite, in 2011, leading to a Supreme Court ruling that deemed the denied exemption unconstitutional; and the passing of Bill C-2: Respect for Communities Act (2013), which sets out extensive criteria required by an applicant requesting a Criminal Code exemption for the purpose of establishing a supervised drug consumption facility.[203]

To a significant degree, then, the federal government's attack on harm reduction in Canada was carried out by Conservative politicians who were (more often than not) from Alberta. What is more, the method of attack was a broader defunding strategy, often couched in the language of saving tax dollars and fiscal responsibility, though deeply embedded in a criminalization/prohibitionist framework that was increasingly contradicted by the evidence and scholarly research. As noted above, it is well established that needle exchange programs and supervised (drug) consumption interventions demonstrate cost effectiveness and even cost savings when their impacts on public spending relating to healthcare, the criminal justice system, and social services are considered. This evidence is also not particularly new: early analyses of needle exchange and sterile supply programs in Canadian cities have been demonstrating their cost effectiveness since the late 1990s.[204] This era of federal governance had devastating impacts on the provision of harm reduction supports and services across Canada. Cathy McIsaac, executive director of a methadone clinic in Halifax, lamented at the onset of Harper's anti-harm reduction: "Ottawa's new approach is to criminalize what should still be seen as a health issue…You can't even use the term harm reduction anymore when applying for federal funding. The taps have been turned off."[205]

Trudeau's Approach to Harm Reduction and Alberta's Response

When Justin Trudeau and the Liberal party came to power in October of 2015, they pursued a policy program that was, in the broad sense, supportive of harm reduction as a pillar of

[202] Paul Christopher Webster, "The Redlining of Harm Reduction Programs" in *Canadian Medical Association Journal (CMAJ)* vol. 184, no. 1 (2012): E22.
[203] Shelley G. Marshall, "Canadian Drug Policy and the Reproduction ofIndigenous Inequities" in *The International Indigenous Policy Journal*, Volume 6, No. 1 [January 2015]: 1-19.
[204] See Martin A. Andresen and Neil Boyd, "A Cost-Benefit and Cost-Effectiveness Analysis of Vancouver's Supervised Injection Facility" in *The International Journal of Drug Policy* 21, no. 1 (2010): 70–76. https://doi.org/10.1016/j.drugpo.2009.03.004.
[205] McIsaac quoted in Paul Christopher Webster, "The Redlining of Harm Reduction Programs" in *Canadian Medical Association Journal (CMAJ)* vol. 184, no. 1 (2012): E21–E22.

federal drug policy. Perhaps most relevant here was the assent of Bill C-37 in May of 2017, which amended the Controlled Drugs and Substances Act to, in the words of Health Canada, "better equip both health and law enforcement officials to reduce the harms associated with drug and substance use in Canada."[206] In addition to streamlining the application process for communities seeking an exemption to the Controlled Drugs and Substances Act for the purposes of establishing supervised consumption sites, Bill C-37 also made it more difficult for Canadians to purchase "designated devices that may be used in the illicit manufacture of controlled substances, such as pill presses and encapsulators" and did away with statutes that prevented "border officers from opening mail weighing 30 grams or less, in order to stop drugs, like fentanyl, from entering Canada illicitly through the mail system."[207] Bill C-37 also garnered the attention of academics and scholars given that it allowed Health Canada to "grant exemptions for activities with controlled substances that have been illicitly obtained for the purposes of scientific research or other activities that the Minister determines are in the public interest, such as drug testing programs."[208] When discussing the reasoning behind the bill, Trudeau's Minister of Health Jane Philpott referenced the ongoing opioid crisis and the impact of safe injection sites, commenting that "in communities where they have been well-established and maintained, including of course Insite in Vancouver, . . . it has been shown to, of course, save lives and reduce infections but it has shown to have no negative impacts on crime rates in the community."[209] It is important to pause here on this claim that safe injection sites have no negative impacts on the communities in which they reside, as this was a claim with which Jason Kenney and the Alberta United Conservative Party took issue (see below). In any case, despite these developments in federal drug policy and harm reduction infrastructure, the opioid crisis in Canada continued apace. For example, from January of 2016 to March of 2022, more than 30,000 people died opioid-related deaths. In this same time frame, more than 32,000 opioid-related hospitalizations occurred across Canada.[210]

Provincial Harm Reduction Policies

Like other provinces, Alberta adopted some limited harm reduction policies in response to the HIV/AIDS epidemic. Most notably, the Non-Prescription Needle Use Initiative, which began in 1995 (under Ralph Klein), brought together needle exchange programs from Edmonton, Calgary, Red Deer, and Grande Prairie to exchange information and resources and reduce the harms of injection drug use. However, in 2012, Cavalieri and Riley noted an overall failure of the Alberta government to meaningfully fund or otherwise support harm reduction services, noting that the limited successes of grassroots harm reduction programs (such as Safework) were realized

[206] Health Canada, *Royal Assent of Bill C-37 – An Act to Amend the Controlled Drug and Substances Act and to Make Related Amendments to Other Acts*, May 18th, 2017, https://www.canada.ca/en/health-canada/news/2017/05/royal_assent_of_billc-37anacttoamendthecontrolleddrugsandsubstan.html
[207] Health Canada, *Royal Assent of Bill C-37,* 2018.
[208] Health Canada, *Royal Assent of Bill C-37,* 2018.
[209] Quoted in Kristy Kirkup, "Bill to make it easier to create supervised drug-consumption sites becomes law", *CBC News*, May 18th, 2017, https://www.cbc.ca/news/politics/injection-consumption-site-passed-1.4122528
[210] Government of Canada, Opioid- and Stimulant-related Harms in Canada, September 2022, https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/.

in spite of the provincial government, not because of them. They described "a political atmosphere that is hyper-responsive to public opinion, especially [. . .] driven by conservative family and social values [where] it is difficult for policymakers to support harm reduction publicly."[211]

Despite a policy environment that has been largely resistant to harm reduction programming, the province began to demonstrate a more pragmatic approach to substance use beginning in 2015 with the election of a majority NDP government led by Premier Rachel Notley. This was largely in response to the astounding number of drug poisonings the province was encountering driven by synthetic and highly potent opioids such as fentanyl. This public endorsement of harm reduction was a big departure from previous governments' approach to drug policy. The introduction of a harm reduction program manager to the Alberta Health Services board in 2015 was one way that the provincial government demonstrated their support for such programming.[212]

With a Liberal federal government and NDP provincial government, challenges associated with federalism were lessened, as these two governments' ideologies regarding harm reduction and drug policy were in many ways aligned. In response to the worsening opioid crisis, the province awarded $750,000 to harm reduction programs and activist groups in 2016 to assess the feasibility of Supervised Consumption Services in the province.[213] In 2017, they were able to take advantage of the changes introduced through Bill C-37 to establish and fund two Supervised Consumption Sites. By 2019 the number of SCS's in operation would increase to six provincially. The Province could be considered an early adopter of SCSs, as by 2020, despite a significant reduction in federal legislative barriers, only five of Canada's ten Provinces and Territories had implemented SCSs.[214]

In 2019, the transition from an NDP-led to UCP-led provincial government came with a wavering in support for harm reduction services. This is explored below in our discussion of former Premier Jason Kenny's Impact Report.

Introducing the Impact Report

[211] Walter Cavalieri and Diane Riley, "Harm Reduction in Canada: The Many Faces of Regression" in *Harm Reduction in Substance Use and High-Risk Behaviour: International Policy and Practice*, eds. Richard Pates and Diane Riley (London: Wiley-Blackwell Publishing, 2012), 10, https://www.eelgroundhealthcentre.com/wp-content/uploads/2012/10/Harm-Reduction-in-Canada.pdf.
[212] Jalene Anderson-Baron, Kamagaju Karekez, Jakob Koziel, and Ashley McCurdy, *Alberta Policy Analysis Case Report: Canadian Harm Reduction Policy Project* (Ottawa: CHARPP, 2017), https://crismprairies.ca/wp-content/uploads/2018/06/Alberta.pdf.
[213] Alexandra Zabjek, "Alberta Explores 'safe consumption sites' in face of fentanyl crisis", *CBC News*, October 27th, 2016, https://www.cbc.ca/news/canada/edmonton/alberta-explores-safe-consumption-sites-in-face-of-fentanyl-crisis-1.3824685
[214] Chaviva Manson-Singer and Sara Allin, "Understanding the Policy Context and Conditions Necessary for the Establishment of Supervised Consumption Sites in Canada: A Comparative Analysis of Alberta and Manitoba," In *Health Reform Observer* 8, no. 2 (2020): 1-20.

While on the campaign trail for the United Conservative Party's leadership, Jason Kenney promised that, if elected, he would review SCSs and their impact on the communities in which they reside. Kenney was quoted broadly and controversially making statements many considered to be anti-harm reduction in outlook. The specific and oft-quoted line from Kenney in this regard was his suggestion that "helping addicts inject poison into their bodies is not a solution to the problem of addiction."[215] In 2019, holding true to his promise, Kenney's UCP government paused funding for SCS sites pending a review of their "socio-economic impacts of existing and proposed SCS sites on their host communities."[216] The eventual report, titled *Impact: A socio-economic review of supervised consumption sites in Alberta*, was published in March 2020 and received immediate criticism from both academics and stakeholders.

Two open letters were published in March 2020 in response to *Impact*. The first was signed by 42 academics across Canada demanding the retraction of the report. This open letter – what we term 'the academic letter' - cited the *Impact* report as having poor methodological quality, as lacking transparency, and having offered a very biased presentation of results.[217] Though several methodological concerns were raised by the academic letter, the fact that the *Impact* report generated much of its data on the basis of what it called "town hall meetings, surveys, and other online submissions" was especially alarming for many, particularly in light of a lack of peer-reviewed citations in the report as well as a long-identified tendency towards NIMBYism as a dominant structure of community feelings towards service provision for peoples experiencing homelessness.[218] The academic letter also stated in no uncertain terms:

> We declare, clearly and unequivocally, that the findings contained in Alberta's SCS report were produced using unsound research method and deficient analytic procedures. Alberta's SCS review does not satisfy the minimal standards for a credible evaluation or a quality study. The report lacks validity and reliability and, therefore, should not be used to inform public policy.[219]

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[215] Jeremy Appel, "'Just Say No to Drugs,'" *Alberta Views - The Magazine for Engaged Citizens*, June 1, 2022, https://albertaviews.ca/just-say-no-drugs/.
[216] Alberta Health, Government of Alberta, "Impact: A socio-economic review of supervised consumption sites in Alberta," March 2020, 1, https://open.alberta.ca/dataset/dfd35cf7-9955-4d6b-a9c6-60d353ea87c3/resource/11815009-5243-4fe4-8884-11ffa1123631/download/health-socio-economic-review-supervised-consumption-sites.pdf
[217] Canadian Drug Policy Coalition, "Open Letter: Calling on the Alberta Government to Retract Supervised Consumption Site Report," Canadian Drug Policy Coalition, March 18, 2020, https://www.drugpolicy.ca/open-letter-calling-on-the-alberta-government-to-retract-supervised-consumption-site-study/.
[218] Alberta Health, Government of Alberta, "Impact: A socio-economic review of supervised consumption sites in Alberta," March 2020, 13, https://open.alberta.ca/dataset/dfd35cf7-9955-4d6b-a9c6-60d353ea87c3/resource/11815009-5243-4fe4-8884-11ffa1123631/download/health-socio-economic-review-supervised-consumption-sites.pdf. Also, see Myra Piat, "The NIMBY Phenomenon: Community Residents' Concerns About Housing for Deinstitutionalized People," *Health & Social Work* 25, no. 2 (2000): 127–38.
[219] Canadian Drug Policy Coalition, "Open Letter: Calling on the Alberta Government to Retract Supervised Consumption Site Report," Canadian Drug Policy Coalition, March 18, 2020, https://www.drugpolicy.ca/open-letter-calling-on-the-alberta-government-to-retract-supervised-consumption-site-study/.

The second letter was published by the HIV legal network and was endorsed by 30 stakeholders. For that reason, we refer to it as 'the stakeholder letter.' This stakeholder letter critiqued *Impact* for its limited scope, its fundamental lack of understanding of the opioid crisis, an ignorance towards the best practices associated with harm reduction, as well as for its recommendation to require identification with the primary goal of streamlining site users into treatment.[220] The report was scrutinized by multiple advocates for relying on "cherry-picked" responses from respondents and minimizing comments from site supporters.[221] The research team involved with the report was accused of using inflammatory comments to produce a misrepresentative narrative of SCS sites as spaces of disorder that not only enable drug use (as opposed to providing harm reduction) but also increased criminal activity (an impact that no peer reviewed research on SCS sites has found).[222] In the remainder of this pillar, we dedicate some considerable page space to unpacking what have been the most common critiques of the *Impact* report: first, the limited scope of the report itself; second, the UCP's deployment of a recovery-harm reduction dichotomy (as if these two things cannot co-exist); and finally, the report's politically motivated methodology and ideologue approach to provincial drug policy and harm reduction. We felt it important to provide a comprehensive response to this report given its popularity, its controversy, as well as its potential policy implications with respect to providing services for OPEH with complex needs in Alberta.

The Impact Report's Limited Scope

Ostensibly, *Impact's* committee included experts in harm reduction and recovery; however, the report was critiqued for not including in its scope the public health benefits of harm reduction.[223] It is relevant to note here that Health Canada lists SCS sites as having seven benefits, only one of which is improving access to treatment. The other six are: reduce overdoses, increase access to social services, reduce public drug use and discarded equipment (termed 'debris' in the *Impact* report), reduce the spread of disease, reduce the strain on emergency medical services, and to connect drug users with peers and staff to help them moderate their use.[224] Significantly, the *Impact* report neglected to comment on most of the

[220] "Letter: Reject the Socio-Economic 'Review' of Supervised Consumption Sites in Alberta," HIV Legal Network, October 4, 2022, https://www.hivlegalnetwork.ca/site/letter-reject-the-socio-economic-review-of-supervised-consumption-sites-in-alberta/?lang=en.
[221] Kalisha Mendonsa, "Harm Reduction Advocate Calls the SCS Review Report 'Deeply Flawed,'" LacombeOnline, accessed December 29, 2022, https://www.lacombeonline.com/articles/harm-reduction-advocate-calls-the-scs-review-report-deeply-flawed. Also, see Jordan Omstead, "Alberta's Safe Consumption Review Biased and Flawed, Researcher Says" *CBC News,* January 29th, 2021, https://www.cbc.ca/news/canada/edmonton/alberta-s-safe-consumption-review-biased-and-flawed-researcher-says-1.5867053.
[222] Johnathan P. Caulkins, Bryce Pardo, and Beau Kilmer. "Supervised Consumption Sites: a Nuanced Assessment of the Causal Evidence," in *Addiction* 114, no. 12 (2019): 2110.
[223] Jeremy Appel, "'Just Say No to Drugs,'" *Alberta Views - The Magazine for Engaged Citizens*, June 1, 2022, https://albertaviews.ca/just-say-no-drugs/.
[224] Health Canada, "Supervised Consumption Explained: Types of Sites and Services," Government of Canada, September 29, 2022, https://www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/explained.html.

widely documented benefits of SCS sites and focused instead on their perceived impacts as shared by citizens, community members, and residents of Albertan cities.

In line with building a narrative of SCS sites as drug-enablers as opposed to harm reducers, the committee for the *Impact* report expressed concern that SCS sites insidiously inflated their overdose reversal numbers to justify their existence. The committee stated that "the term 'reversal' is used even when the response is a simple administration of oxygen."[225] The Stakeholder letter responded to *Impact* by identifying that "oxygen is the first line of response in case of an overdose."[226] The UCP later clarified that the government "does not dispute whether the use of oxygen is effective as a medical intervention" and that the committee was "observing a lack of regulation around data collecting and reporting."[227] The *Impact* report portrayed the lack of regulation as an intentional attempt by SCS sites to mislead the public "with an inference that without these sites thousands of people would fatally overdose or no longer be alive."[228] The Stakeholder letter made it clear that "Alberta Health sets the standards for reporting adverse events of overdose and SCS providers are applying these standards."[229] In any case, the central point of contention here was that SCS sites and harm reduction supporters seek to inflate statistics in order to more positively represent their positive outcomes; however, the longitudinal and controlled data sets associated with the impact of harm reduction practices in Canada as well as abroad are quite impressive; what is more, even if harm reduction programs such as SCS sites had inflated their own impacts, this does not mean they are negative or neutral in their impact, and the onus remains on those who view harm reduction as poor policy direction to explain and defend this viewpoint.

The committee for the *Impact* report also recommended that needle distribution programs be replaced with needle exchange programs to reduce the debris in the surrounding areas. Debris (with reference to needles and paraphernalia) is mentioned 35 times in *Impact* and is presented as a major social cost of SCS sites. On the basis of cited social danger of needle debris, the report

[225] Alberta Health, Government of Alberta, "Impact: A socio-economic review of supervised consumption sites in Alberta," March 2020, iii, https://open.alberta.ca/dataset/dfd35cf7-9955-4d6b-a9c6-60d353ea87c3/resource/11815009-5243-4fe4-8884-11ffa1123631/download/health-socio-economic-review-supervised-consumption-sites.pdf

[226] "Letter: Reject the Socio-Economic 'Review' of Supervised Consumption Sites in Alberta," HIV Legal Network, October 4, 2022, https://www.hivlegalnetwork.ca/site/letter-reject-the-socio-economic-review-of-supervised-consumption-sites-in-alberta/?lang=en.

[227] Alanna Smith, "Doctors Dispute Claims of Alberta's Supervised Consumption Panel ...", *Calgary Herald*, January 1, 2023, https://calgaryherald.com/news/local-news/doctors-dispute-claims-of-albertas-supervised-consumption-panel-member/

[228] Alberta Health, Government of Alberta, "Impact: A socio-economic review of supervised consumption sites in Alberta," March 2020, iii, https://open.alberta.ca/dataset/dfd35cf7-9955-4d6b-a9c6-60d353ea87c3/resource/11815009-5243-4fe4-8884-11ffa1123631/download/health-socio-economic-review-supervised-consumption-sites.pdf

[229] Alberta Health, Government of Alberta, "Impact: A socio-economic review of supervised consumption sites in Alberta," March 2020, iii, https://open.alberta.ca/dataset/dfd35cf7-9955-4d6b-a9c6-60d353ea87c3/resource/11815009-5243-4fe4-8884-11ffa1123631/download/health-socio-economic-review-supervised-consumption-sites.pdf

recommended that Alberta "should immediately enact a policy for needle exchange."[230] In response to this policy recommendation, the Stakeholder's letter referenced reports from the World Health Organization that cited needle exchange programs as ineffective at stopping the spread of communicable diseases.[231] However, because the scope of the *Impact* report was limited to the social and economic impacts of SCS sites, the picture painted was one in which the negative consequences of harm reduction programming were spotlighted without any accompanying reason for the services in the first place. As noted earlier in this report, the prevention of disease transmission (particularly HIV and Hepatitis C) has immense saving in healthcare costs.[232] Thus, the *Impact* report's capacity to provide a balanced or fulsome financial analysis of the issue at hand seemed quite limited due its scope and methodology.

The *Impact* report also recommended that methamphetamine should not be accommodated at SCS sites, which became another contentious policy directive. The Stakeholder's letter pointed out that all street drugs are at risk of cross-contamination and 'cutting' with fentanyl, which makes such specific exclusionary criteria a public health risk.[233] Interestingly, the *Impact* report acknowledges "that many 'street drugs' include substances, such as fentanyl, not known to the drug user."[234] However, elsewhere in the report, the committee expresses its lack of support for "inhalation booths" wherein methamphetamine is smoked under supervised conditions. [235] The *Impact* report argued that "since most methamphetamine is not injected…unsafe needle practices and overdose risk of death are not the primary issues."[236] First and foremost, as several critics pointed out, polysubstance use is commonplace, which makes any drug-specific exclusion a policy directive that risks reducing the overall usage and appeal of

[230] Alberta Health, Government of Alberta, "Impact: A socio-economic review of supervised consumption sites in Alberta," March 2020, 8, https://open.alberta.ca/dataset/dfd35cf7-9955-4d6b-a9c6-60d353ea87c3/resource/11815009-5243-4fe4-8884-11ffa1123631/download/health-socio-economic-review-supervised-consumption-sites.pdf

[231] "Guide to Starting and Managing Needle and Syringe Programmes" (World Health Organization), accessed December 4, 2022, https://www.unodc.org/documents/hiv-aids/NSP-GUIDE-WHO-UNODC.pdf, 19.

[232] See Richard Elliott, "Deadly Disregard: Government Refusal to Implement Evidence-Based Measures to Prevent HIV and Hepatitis C Virus Infections in Prisons" in *Canadian Medical Association Journal (CMAJ)* vol. 177, no. 3 (2007): 262–64. Also, see Lucy Platt, Sedona Sweeney, Zoe Ward, Lorna Guinness, Matthew Hickman, Vivian Hope, Sharon Hutchinson, et. al., "Assessing the Impact and Cost-Effectiveness of Needle and Syringe Provision and Opioid Substitution Therapy on Hepatitis C Transmission Among People Who Inject Drugs in the UK: An Analysis of Pooled Data Sets and Economic Modelling" in *Public Health Research* 5, no. 5 (2017): 1.

[233] "Letter: Reject the Socio-Economic 'Review' of Supervised Consumption Sites in Alberta," HIV Legal Network, October 4, 2022, https://www.hivlegalnetwork.ca/site/letter-reject-the-socio-economic-review-of-supervised-consumption-sites-in-alberta/?lang=e.

[234] Alberta Health, Government of Alberta, "Impact: A socio-economic review of supervised consumption sites in Alberta," March 2020, 6, https://open.alberta.ca/dataset/dfd35cf7-9955-4d6b-a9c6-60d353ea87c3/resource/11815009-5243-4fe4-8884-11ffa1123631/download/health-socio-economic-review-supervised-consumption-sites.pdf.

[235] Alberta Health, Government of Alberta, "Impact: A socio-economic review of supervised consumption sites in Alberta," March 2020, 14.

[236] Alberta Health, Government of Alberta, "Impact: A socio-economic review of supervised consumption sites in Alberta," March 2020, 14.

harm reduction sites, which can have negative impacts on public health.[237] For example, the sharing of pipes can act as a vector for bloodborne diseases and contribute to the public's risk of exposure to harmful viruses (particularly emergency and correctional service workers). In short, there are several reasons why an 'inhalation booth' would be a useful and desirable inclusion to a SCS site. If a counter-argument is to be made that methamphetamine inclusion at SCS sites has more costs than benefits, this position ought to be advanced on the basis of research, data, and a scope of analysis that includes public health and medical impacts. Rather than citing this kind of supporting evidence and making a dispassionate case for best practices in public policy, the *Impact* report engaged in alarmist and ideological rhetoric, referring to SCS sites as "government-supported crack houses."[238]

The Recovery/Harm Reduction Dichotomy

Throughout the report, the committee acknowledges that the goal of SCS sites is to reduce the harms associated with drug use, including diseases and death. The committee also states that in their view, SCS sites should function as a "gateway to treatment and recovery in addition to consumption facilities."[239] The committee then paraphrases respondents who agree with their position: "many people suggested that the model was failing because SCS were not serving as gateways to detoxification, treatment and recovery programs, which were ultimately seen as solutions to the drug crisis."[240] Recovery is mentioned 24 times in the report and is the focus in seven of the ten 'quality control and outcome management' recommendations. With regard to the relationship between harm reduction and recovery, the committee states that "harm reduction has taken precedence over the other three pillars" of the Canadian Drug and Substances Strategy (which are prevention, enforcement, and treatment).[241]Dr. Rebecca Haines-Saah from the University of Calgary describes the UCP as creating a false binary between treatment and harm reduction - as if the two are in competition with harm reduction proponents being staunchly opposed or otherwise resistant to treatment.[242] Haines-Saah critiques the UCP's perception of harm reduction as "palliative care for people who use drugs."[243]

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[237] For a study of polysubstance use in a Canadian context, see Stephanie Parent et al., "Examining Prevalence and Correlates of Smoking Opioids in British Columbia: Opioids Are More Often Smoked than Injected," *Substance Abuse Treatment, Prevention, and Policy* 16, no. 1 (2021): p. 1-79, https://doi.org/10.1186/s13011-021-00414-6, 3.
[238] Alberta Health, Government of Alberta, "Impact: A socio-economic review of supervised consumption sites in Alberta," March 2020, 34.
[239] Alberta Health, Government of Alberta, "Impact: A socio-economic review of supervised consumption sites in Alberta," March 2020, 20-21.
[240] Alberta Health, Government of Alberta, "Impact: A socio-economic review of supervised consumption sites in Alberta," March 2020, 5.
[241] Alberta Health, Government of Alberta, "Impact: A socio-economic review of supervised consumption sites in Alberta," March 2020, 34.
[242] Jeremy Appel, "'Just Say No to Drugs,'" *Alberta Views - The Magazine for Engaged Citizens*, June 1, 2022, https://albertaviews.ca/just-say-no-drugs/.
[243] Jeremy Appel, "'Just Say No to Drugs,'" *Alberta Views - The Magazine for Engaged Citizens*, June 1, 2022, https://albertaviews.ca/just-say-no-drugs/.

Impact also includes comments from respondents who felt that sites were responsible for increasing crime and that in fact SCS site staff enabled it. The committee reported that respondents in Edmonton reported that they "felt intimidated and were prevented from expressing their true sentiments and opinions about these sites out of fear of retribution from site supporters."[244] Site supporters are also described as inappropriately believing that there are no-enforcement zones around SCS sites and have been reported to not cooperate and even actively interfere with police in the discharging of their duties.[245] One first responder described the SCS sites as a "lawless wasteland."[246] In an article critical of the report's methodology published in the *Harm Reduction Journal*, Dr. Andrew Livingston challenged the validity of including these statements in the report without attempting to confirm with police services whether or not no-enforcement zones existed.[247] We draw on Dr. Livingston work's here in order to unpack more precisely why the *Impact* report is not an ideal tool in terms of shaping public policy in Alberta.

Politically Motivated Methodology

As noted above, *Impact*'s primary methodology was qualitative data collection through town halls, written submissions, and online surveys. Livingston notes that the report uses evocative comments, primarily negative of SCS sites, to draw criminological conclusions.[248] None of these claims are verified from outside sources (such as police services) nor was the method for analyzing this data included in the report. According to Livingston, the committee's survey data is vulnerable to bias because the committee asked participants to recall a time up to two years prior to taking the survey to describe their pre- and post- SCS site experiences. Best practices in criminology are often to restrict surveys to 6 months to avoid cognitive errors such as telescoping.[249] The committee's other quantitative evidence was the change in police service calls. Livingston critiques this measure not only for the committee misrepresenting it as crime rate and not acknowledging the weakness in police service calls data, but also because the committee obscured the data with poor methodology. Police service calls were not defined, so each service included different types of calls. Further, the types of calls were collapsed, the calls were aggregated annually, and the time frame of the sample size was very short (2 years). These factors combined to make it unclear what was actually being measured, how extraneous variables affected the change or may have obscured long-term crime trends that could be responsible for the change.[250] On the basis of these critiques, Livingston explains:

[244] Alberta Health, Government of Alberta, "Impact: A socio-economic review of supervised consumption sites in Alberta," March 2020. P. iii
[245] Alberta Health, Government of Alberta, "Impact: A socio-economic review of supervised consumption sites in Alberta," March 2020. P. 25, 31
[246] Alberta Health, Government of Alberta, "Impact: A socio-economic review of supervised consumption sites in Alberta," March 2020. P. 25
[247] James D. Livingston, "Supervised Consumption Sites and Crime: Scrutinizing the Methodological Weaknesses and Aberrant Results of a Government Report in Alberta, Canada" in *Harm Reduction Journal* 18, no. 1 (2021), 2.
[248] Livingston, "Supervised Consumption Sites and Crime", 2.
[249] Livingston, "Supervised Consumption Sites and Crime", 2.
[250] Livingston, "Supervised Consumption Sites and Crime", 2.

> To date, peer-reviewed research has found no evidence linking supervised consumptions sites (SCSs) to increased crime. Yet, in March 2020, a government Report released in the province of Alberta, Canada, presented the results of a review that reached a different conclusion. This commentary highlights the Report's major methodological limitations with respect to its criminological components, including that crime was poorly operationalized and measured, change in crime was inadequately assessed, and the effect of SCSs on crime was not ascertained. It is argued that the magnitude of methodological flaws in the Report undermine the validity of its criminological claims and raise significant issues with the soundness of its conclusions.[251]

In the broad sense, it seems likely that the *Impact* report was produced in order to justify the closure or defunding of SCS sites with little regard for actually producing sound research to inform public policy. This is relevant to service equity for OPEH with complex needs given that peer-reviewed, evidence-based, and fiscally sound social policies are at risk of disruption in the province due to popular and non-expert discourses on harm reduction. To be clear, the lived experience of homeowners and testimonies of community residents matter, not least because they help identify tensions as well as the negative impacts associated with SCS sites and other harm reduction programming in Alberta; however, such sentiments are not sufficient to steer social policy on matters as important and critical as the opioid crisis or how we provide care, dignity, and stability for older adults and seniors in Canada. Candidly, we worry that the political controversy associated with the *Impact* report and SCS sites will in fact have a negative effect on how Albertans view other harm reduction initiatives by polarizing the discourse and generating more heat than light. It is for this reason that we concluded this pillar on harm reduction by underscoring it as a larger policy directive advocated for by service users themselves.

Conclusion: Listening to OPEH

We conclude this pillar by underscoring that the expansion of harm reduction housing and services within Alberta' continuing care system is an urgent issue that demands collective attention. In a recent Calgary based study, for example, a research team interviewed OPEH with complex needs and asked about available programs and services. As this report noted, "despite the fact that a growing number of harm reduction housing sites and healthcare interventions had recently emerged in Calgary at the time of this study, participants noted that harm reduction programs or services in continuing care were scant."[252] Significantly, and in contrast to the *Impact* report, participants in the study underscored that while managed alcohol and tobacco programs were welcome program initiatives, more consideration to and capacity for illicit substance users ought to be realized. "I think a big part is that it's difficult to find your 'typical'

[251] Livingston, "Supervised Consumption Sites and Crime", 1.
[252] Megan Beth Sampson, Mariam Keshavjee, Piper Matus, Martina Ann Kelly, and Lara Nixon, *Older Adults with Experiences of Homelessness, Substance Use, and Mental Health Challenges in Calgary, Alberta: A Qualitative Exploration of Opportunities for Enhanced Service Delivery*, Report Prepared for Alberta Health Services' Addiction and Mental Health Strategic Clinical Network, the University of Calgary's O'Brien Institute for Public Health, and the Brenda Strafford Centre on Aging, 22.

alcoholic these days – that there's drug use too, probably," said one participant, "I would say the managed alcohol [programming] is important, but then, how are you dealing with the seniors that are using drugs?"[253] This question is an incredibly important one and, given the population demographics and dynamics of Alberta, it will be an increasingly pressing one for policy makers and community stakeholders. Above all, we recommend that the voices of OPEH with complex needs be part of this conversation, given that recent political controversies associated with harm reduction have sidelined these voices and privileged respondents who for the most part have never had to grapple with homelessness, much less at an advanced stage of life.

Policy Pillar No. 4:
Federal Indian Policy and Indigenous Homelessness

When discussing OPEH with complex needs in the province of Alberta from a policy perspective, it is necessary to review the reasons why Indigenous peoples are over-represented amongst this population. By 'Indigenous', we are referring collective to First Nations, Métis, and Inuit communities, who have each experienced federal Indian policy in different ways.[254] Looking backward in historical time, the operation of Canadian federal Indian policy (specifically, from 1951-1985) has been a major contributor to homelessness in the province of Alberta. Moving forward, approaches to supporting OPEH with complex needs will need to remain cognizant of the specific dynamics associated with Indigenous homelessness, lest policy makers fail to attend to the unique factors that produce it. In this section we will begin by reviewing some empirical evidence and quantitative data to establish the reality of the overrepresentation of Indigenous peoples as homeless in Alberta. We will then review some specific policy histories and structural dynamics that have contributed to the mass urbanization

[253] Sampson et. al, *Older Adults with Experiences of Homelessness, Substance Use, and Mental Health Challenges in Calgary, Alberta*, 23.

[254] For example, whereas First Nations were considered 'Indian' pursuant to the Indian Act of 1876 as well as earlier forms of Crown legislation, Inuit communities were not enfolded into Canadian colonial governance until the 1939 *Re: Eskimos* Supreme Court Decision of 1939. Similarly, Métis communities in Canada were not considered 'Indian' in terms of federal recognition until the *Daniels Decision* of 2016, but have a complex history associated with the province of Alberta that is described well in Catherine Bell, *Alberta Métis Settlement Legislation: An Overview of Ownership and Management of Settlement Lands* (Regina: Canadian Plains Research Centre, University of Regina, 1994). For a larger discussion of Métis-specific histories of homelessness, see Maria Campbell,
Stories of the Road Allowance People (Penticton, B.C: Theytus Books Ltd., 1994).

of Indigenous peoples in Canada, including the federal government's (mis)management of Indian Status, the Indian Residential Schooling (IRS) system, and the Sixties Scoop. Our conclusion will stress that approaches to ending homelessness and supporting OPEH with complex needs in Alberta need to reflect an understanding of the issues described below.

Looking at the Data

The data on Indigenous homelessness in urban locales reveals a considerable pattern of overrepresentation across the country. Indigenous peoples constitute approximately 5% of the total population but typically represent 20-50% of the homeless population in major Canadian cities.[255] For example, a 2018 study demonstrated that, on average, one in fifteen urban Indigenous peoples experiences homelessness, whereas only one in 128 non-Indigenous people do.[256] Though places like Thunder Bay, Regina, Saskatoon, Edmonton, and Winnipeg tend to have higher rates of Indigenous overrepresentation compared to more major metropolitan centres such as Toronto, Montréal, or Vancouver, Indigenous homelessness in urban locales has been described as a 'crisis' or 'epidemic' from Halifax to Yellowknife.[257] Broadly speaking, Indigenous peoples in Canada are eight times more likely to experience homelessness than their non-Indigenous urban counterparts.[258] The academic and grey literature that analyzes these trends uses terms such as 'migration', 'mobility', or 'churn' to refer to the movement of Indigenous peoples from the reserve to the city.[259]

[255] Canadian Observatory on Homelessness, "Indigenous peoples", last accessed November 1, 2022, https://www.homelesshub.ca/about-homelessness/population-specific/indigenous-peoples.
[256] Jino Distasio, Sarah Zell, and Marcie Snyder, *At Home in Winnipeg: Localizing Housing First as a Culturally Responsive Approach to Understanding and Addressing Urban Indigenous Homelessness* (Winnipeg: Institute of Urban Studies, August 2018).
[257] "Aboriginal Homelessness an 'Epidemic', York researcher says", *CBC News*, March 28, 2014, https://www.cbc.ca/news/canada/thunder-bay/aboriginal-homelessness-an-epidemic-york-researcher-says-1.2589861
[258] Carol Patrick, *Aboriginal Homelessness in Canada: A Lliterature Review* (Toronto: Canadian Observatory on Homelessness Press, 2014), 22, https://www.homelesshub.ca/sites/default/files/AboriginalLiteratureReview.pdf
[259] See Trevor Denton, "Migration from a Canadian Indian Reserve." *Journal of Canadian Studies* 7, no. 2 (1972): 54–62; Martin Cooke and Danielle Belanger, "Migration Theories and First Nations Mobility: Towards a Systems Perspective," *The Canadian Review of Sociology and Anthropology* 43, no. 2 (May 1, 2006): 141–164; Yale Belanger and Gabrielle Weasel Head, *Urban Aboriginal Homelessness and Migration in Southern Alberta* (Edmonton: Alberta Homelessness Research Consortium, April 2013), Jaylene Taylor Anderson and Damian Collins, "Prevalence and Causes of Urban Homelessness Among Indigenous Peoples: A Three-Country Scoping Review," *Housing Studies* 29, no. 7 (June, 2014): 959–976; Martin Cooke and Erin O'Sullivan, "The Impact of Migration on the First Nations Community Well-Being Index," *Social Indicators Research* 122, no. 2 (2015): 371–89; Marilyn Amorevieta-Gentil, Robert Bourbeau, and Norbert Robitaille, "Migration Among the First Nations: Reflections of Inequalities," *Population Change and Lifecourse Strategic Knowledge Cluster Discussion Paper Series*, 3, No. 1 (2015). https://www.homelesshub.ca/sites/default/files/attachments/Belanger_WeaselHead_AHRC.pdf; also, see Cathryn Rodrigues, Rita Henderson, Katelyn Lucas Sean Bristowe, Kaylee Ramage, Katrina Milaney, *Understanding Homelessness for Urban Indigenous Families: How Can We Envision Gendered and Culturally Safe Responses* (Toronto: Canadian Observatory on Homelessness, Press, 2020).

National trends related to Indigenous homelessness are borne out in Alberta. For example, a 2018 study that surveyed point-in-time counts across the province demonstrated that Indigenous peoples were consistently over-represented amongst those experiencing homelessness in the seven major cities of Alberta. In Calgary, Indigenous peoples made up 20% of the population experiencing homelessness but just 3% of the total population; in Edmonton, 32% of those experiencing homelessness were Indigenous, though Indigenous peoples only made up 6% of the total population. Similar patterns emerged in Fort McMurray (40% of the homeless population were Indigenous vs. 11% of the total population), Grand Prairie (40% vs 10%), Medicine Hat (28% vs 5%), and Red Deer (44% vs 5%).[260] Lethbridge had the greatest rate of overrepresentation of Indigenous peoples experiencing homelessness in 2018: though Indigenous peoples only represented 5% of the total population, they represented 63% of those experiencing homelessness.[261]

Statistics that parse out the specific age-based contours of Indigenous homelessness are not as widely available, though the picture painted by the extant data suggests that overrepresentation also exists amongst OPEH in Alberta. For example, a recent 2020 survey of 300 individuals who were using emergency shelters or 'sleeping rough' in the city of Calgary determined that 47 per cent of respondents were over the age of 50; within this sub-group of OPEH in Calgary, 17 per cent identified as Indigenous.[262] Significantly, this study found that "of the older adults who identified as Indigenous, 71 per cent had family members who attended Residential School and 33 per cent had attended Residential School themselves."[263] In March of 2011, moreover, the Truth and Reconciliation Commission (TRC) travelled to the city of Calgary to hear from survivors after the team was invited by SkyBlue Morin of Métis Calgary Family Services. Morin explained to the TRC that of her 120 homeless clients, fifty were direct survivors of residential school while 62 had parents that had attended the institutions.[264] However, understanding *that* Indigenous peoples are overrepresented in populations experiencing homeless is different than understanding *why*. To that end, we briefly review in the below how the administration and governance of Indian Status by the federal government encouraged high rates of migration from the reserve to Albertan cities between 1951 and 1985. Thereafter, we touch upon the impacts of the IRS and Sixties Scoop as formative factors in the creation of urban homeless amongst Indigenous peoples in Alberta.

Indian Status, Enfranchisement, and Urbanization

[260] Alina Turner, *2018 Point-in-Time Homeless Count: Technical Report, 7 Cities on Housing and Homelessness*, June 2018, 23, https://docs.wixstatic.com/ugd/ff2744_5d899dceff12471c835fddf4e5d119fc.pdf
[261] Alina Turner, *2018 Point-in-Time Homeless Count: Technical Report, 7 Cities on Housing and Homelessness*, June 2018, 23, https://docs.wixstatic.com/ugd/ff2744_5d899dceff12471c835fddf4e5d119fc.pdf
[262] Katrina Milaney, Hasham Kamran, and Nicole Williams. "A Portrait of Late Life Homelessness in Calgary, Alberta," *Canadian Journal on Aging* 39, no. 1 (2020): 42–51.
[263] Katrina Milaney, Hasham Kamran, and Nicole Williams. "A Portrait of Late Life Homelessness in Calgary, Alberta," *Canadian Journal on Aging* 39, no. 1 (2020): 45.
[264] Shari Narine, "Statement Gathering Targets Homeless Residential School Survivors," *Alberta Sweetgrass* 18, No. 4 (2011): 5.

In Canada, the Indian Act defines who is and who is not officially considered and counted as a Status Indian by the federal government. Though the Indian Act first came into legislative force in 1876, it has undergone a series of revisions, adhesions, and other changes that are relevant to review when discussing policy factors shaping homelessness in Alberta. Of specific interest here is the concept of enfranchisement, which refers to the process whereby someone with Indian Status is absorbed into the Canadian body politic, loses their status, and becomes a Canadian citizen in the legal sense. Though 'enfranchisement' is generally understood to be a good thing in the context of one's political rights, the forced enfranchisement of Status Indians via federal Indian policy has contributed to Indigenous homelessness in general and doubly so in the context of Indigenous peoples born in the Baby Boomer era (1946-1964). As we shall see, these policies were not only racist but also sexist in that they often operated on a discriminative and deeply gendered logic. Their impact was to facilitate the creation of an urban Indigenous population that were at an increased risk of homelessness.

The Indian Act of 1876 defined an 'Indian' as "any male person of Indian blood reputed to belong to a particular band, any child of such person, [or] any woman who is or was lawfully married to such person."[265] Consistent with the worldview of those who created this legislation, Indian Status flowed through men and trickled down to women to the extent that they were related to a Status Indian through marriage or familial relation. Within this framing, Indigenous women who married non-Indian men became enfranchised, lost Indian Status, and therefore the right to live on-reserve. Further, Indigenous women who lost their connection to their husbands through divorce or death also became enfranchised, which often forced them to move to urban locales.[266] Those who tried to stay on reserve had to contend with an increasingly aggressive federal policy picture that targeted such women as 'squatters' and attacked their legal capacity to remain in their communities. In the early 1920s, further legislation was created by the federal government to allow Indian Agents to evict individuals or families of Indigenous peoples who were seen as 'squatters' on reserve land (as well as on lands adjacent to reserves). As Bonita Lawrence explains,

> The 1920s legislation that evicted or jailed Native "squatters" on band lands had severe implications for women who lost their status and were increasingly rendered homeless, especially if their husbands were not white but were, rather, nonstatus Indians or Métis, or if their marriages to white men failed, or they were widowed.[267]

For widows and divorcees especially, the enforced enfranchisement mandated by the Indian Act was devastating in that it often caused them to relocate from the reserve to urban locales in the aftermath of a death or divorce. Sadly, further revisions to the Indian Act in the 1950s did little to

[265] Government of Canada, *Background on Indian Legislation*, last modified November, 2018, https://www.rcaanc-cirnac.gc.ca/eng/1540405608208/1568898474141
[266] Kathleen Jamieson, *Indian Women and the Law in Canada" Citizens Minus* (Ottawa: Advisory Council on the Status of Women, 1980).
[267] Lawrence, *Real Indians and Others*, 53.

address the situation. To the contrary, gender discrimination in the Indian Act was thereafter exacerbated.

Revisions to the Indian Act in 1951 sought to intensify the rate of enfranchisement. The 'marrying out clause', or section 12(1)(b), reified previous provisions of the act that removed Indian Status from any Indigenous women who married a non-Indian man. These post-war revisions also introduced what became known as the 'double mother clause.' Officially spelled out under section 12 (1)(a)(iv) of the 1951 Indian Act, 'the double mother' clause enfranchised anyone whose mother and paternal grandmother gained status through marriage. Indigenous women fought this gender discrimination in the Indian Act and figures such as Mary Two-Axe Earley, Jeanette Corbiere-Lavell, Yvonne Bedard, Sandra Lovelace, and Sharon McIvor are celebrated by many Canadians and Indigenous peoples for helping to pressure the federal government into passing Bill C-31 in 1985. This bill tried to undo the damage of previous legislation by creating frameworks to un-enfranchise those who had lost Indian Status due to gender discrimination, thereby reinstating the status of thousands of Indigenous peoples across Canada; however, this failed to address root causes of displacement and homelessness for two reasons. First and foremost, the process to regain one's lost status was (and remains) quite laborious and demands significant investments of time as well as forms of structural understanding that, due to the complex nature of Indian policy, is difficult to acquire. Second, Bill C-31 also created the category of band membership, which is different than Indian Status and determined by individuals bands. Thus, many who were able to regain their status did not receive band membership and therefore lacked the ability to return to their home communities. In her own analysis, Jaime Mishibinijima used "stuck at the border of the reserve" as a fitting expression to symbolize the experience of many Indigenous women who found themselves impacted by Bill C-31.[268] One study suggested that, between 1867 and 1985, roughly 25,000 Indigenous women were forced to leave their communities.[269]

More recently, continued frictions between Indigenous peoples and the federal government have resulted in further Indian Act revisions via Bill C-3 (2011) and Bill S-3 (2017), both of which attempted to undo gender discrimination in the Indian Act with some more legislative tinkering that made more wrongfully enfranchised peoples eligible for status reinstatement; nonetheless, Canadian federal Indian policies from 1951-1985 remain particularly relevant from a policy perspective when discussing OPEH in Alberta. This is because many Indigenous peoples who were born in the Baby Boomer generation (1946-1964) were subject to these policies in what was arguably peak periods. Enfranchisement encouraged the creation of a marginalized urban population of Indigenous peoples who often had difficulties accessing services even once arriving in major cities.

[268] Jaime Mishibinijima, "Stuck at the Border of the Reserve: Bill C-31 and its Impact on First Nations Women" in *Aboriginal History: A Reader*, eds. Kristin Burnett and Geoff Read (Toronto: Oxford Press, 2012).
[269] Carrie Bourassa, Kim McKay-McNabb, and Mary Hampton, "Racism, Sexism, and Colonialism: The Impact on the Health of Aboriginal Women in Canada," *Canadian Woman Studies*, 24(1), (2004): 23-29.

Within this context, it is key to understand that the migration from the reserve to the city is not merely a literal and geographical transition but a jurisdictional migration as well: programming and services for Status Indians on-reserve are the fiduciary and legislative responsibility of the federal government, whereas these same services are a matter of provincial governance and administration for the rest of Canada. As Belanger and Weasel Head noted: "The black and white world of federal Indian policy made it literally impossible for one person to be a reserve resident and able to access programming, and band councils were forced to make difficult decisions, thus restricting who precisely could access local programs. This increasingly limited urban Aboriginal peoples' access, which has in recent years been growing even more restricted."[270] Thus, the disrupting impacts of the federal government's policies related to Indian Status have created barriers for urban Indigenous peoples when accessing services in Alberta. Further, the federal government's assimilatory framework of enfranchisement also had the effect of reducing the amount of Status Indians in general and the amount who were eligible to live on-reserve more specifically. Even if the socioeconomic conditions on-reserve in this period were equitable, the federal government's approach to Indian Status helped create a legislative infrastructure that facilitated the movement of Indigenous peoples from the reserve to the city. For example, between 1961 and 2006, "national Aboriginal urbanization increased from 12.9 per cent to 53.2 per cent."[271]

Residential Schools, the Alberta Eugenics Board, and the Sixties Scoop

The federal government funded Indian Residential Schools from the 1880s to the 1990s. As many as five generations of Indigenous children were subjected to the violence of the schools, in which torture, physical abuse, sexual assault, and hunger were common.[272] The federal government estimates that at least 150,000 First Nations, Métis, and Inuit children were sent to residential schools.[273] Rates of death from tuberculosis in residential schools were atrocious, particularly in the first few decades of the 20th century.[274] When Indigenous children became sick

[270] Yale Belanger and Gabrielle Weasel Head, *Urban Aboriginal Homelessness and Migration in Southern Alberta* (Edmonton: Alberta Homelessness Research Consortium, April 2013), 22 https://www.homelesshub.ca/sites/default/files/attachments/Belanger_WeaselHead_AHRC.pdf;
[271] Yale Belanger and Gabrielle Weasel Head, *Urban Aboriginal Homelessness and Migration in Southern Alberta* (Edmonton: Alberta Homelessness Research Consortium, April 2013), 7, https://www.homelesshub.ca/sites/default/files/attachments/Belanger_WeaselHead_AHRC.pdf
[272] Tamara Starblanket, *Suffer the Little Children: Genocide, Indigenous Nations, and the Canadian State* (Atlanta: Clarity Press, 2018); John S. Milloy, *A National Crime: The Canadian Government and the Residential School System* (Winnipeg: University of Manitoba Press, 1999); Ian Mosby, "'The Abiding Condition Was Hunger': Assessing the Long-Term Biological and Health Effects of Malnutrition and Hunger in Canada's Residential Schools," *British Journal of Canadian Studies* 30, no. 2 (2017): 147–162; *Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada*, Truth and Reconciliation Commission of Canada, 2015, https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Executive_Summary_English_Web.pdf.
[273] *Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada*, Truth and Reconciliation Commission of Canada, 2015, 3, https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Executive_Summary_English_Web.pdf.
[274] Travis Hay, Cindy Blackstock, and Michael Kirlew. "Dr. Peter Bryce (1853-1932): Whistleblower on Residential Schools," *Canadian Medical Association Journal* 192, no. 9 (2020): E223–E224.

in residential schools in Alberta, they were often sent to the Charles Camsell Indian Hospital in Edmonton, which has also been identified by historians as a place where poor treatment, abuse, and traumatic experiences were common.[275]

Several survivors testified to the TRC that they had developed addictions as a coping mechanism to try and grapple with the pain and trauma they experienced in the schools.[276] Further, as Jaylene Taylor Anderson and Damian Collins explain, "in numerous studies in Canadian cities, a family history of residential school attendance is identified as a major reason for contemporary homelessness."[277] Notably, one 2008 study that spoke with nine Indigenous women in Alberta who were grappling with homelessness underscored that every single participant in the study (*n*=9) had a family member who had attended residential schools.[278] And while we think it is important to stress here the devastating impact of the schools in terms of producing Indigenous homelessness across Canada, it is also worth mentioning that Indigenous women who were accessing shelters in the city of Calgary told a team of researchers that they had grown frustrated with the frequency with which they had to disclose details of traumatic life events in order to be considered for a range of services. This research team referred to this dynamic as "the requirement of repeated trauma disclosure or victimhood to gain services" and critiqued a service provision system that asks Indigenous women "to capitalize on their pain to gain needed supports."[279] Of course, Indigenous peoples who experience homeless ought to have robust access to services regardless of whether they are residential school survivors or not. In any case, it is important to report dutifully upon the larger history of policy violence against Indigenous peoples in Alberta to inform policy discussions as well as broader public discourses about reconciliation. It is for this reason that we now turn to the role of the Alberta Eugenics Board.

In 1928, the Alberta Eugenics Board was founded. In this same year, the province passed The Sexual Sterilization Act, which made legal the carrying out of medical procedures that prevented Albertans as well as Indigenous peoples from having children. This dark chapter in our provincial history was a prolonged, multi-decade affair that lasted until 1972. What were termed 'Mental Hygiene Clinics' were established in Calgary and Edmonton in 1929, in

[275] Maureen Lux, *Separate Beds : a History of Indian Hospitals in Canada, 1920s-1980s* (Toronto: University of Toronto Press, 2016). Also, see Laurie Meijer Drees, "The Nanaimo and Charles Camsell Indian Hospitals: First Nations' Narratives of Health Care, 1945 to 1965." *Histoire Sociale* 43, no. 85 (2010): 165–91.
[276] *Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada*, Truth and Reconciliation Commission of Canada, 2015, 136, https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Executive_Summary_English_Web.pdf.
[277] Jaylene Taylor Anderson and Damian Collins, "Prevalence and Causes of Urban Homelessness Among Indigenous Peoples: A Three-Country Scoping Review," *Housing Studies* 29, no. 7 (June, 2014): 970.
[278] Lia Ruttan, Patti LaBoucane-Benson, and Brenda Munro, "'A Story I Never Heard Before': Aboriginal Young Women, Homelessness, and Restorying Connections," *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health* 6, no. 3 (2008): 31-54.
[279] Cathryn Rodrigues, Rita Henderson, Katelyn Lucas Sean Bristowe, Kaylee Ramage, Katrina Milaney, *Understanding Homelessness for Urban Indigenous Families: How Can We Envision Gendered and Culturally Safe Responses* (Toronto: Canadian Observatory on Homelessness, Press, 2020), 17.

Lethbridge in 1930, and in Medicine Hat in 1933.[280] In 1937, an amendment was made to the act to make it less restrictive; significantly, this amendment revoked the need to obtain consent from those deemed 'medically defective', thus facilitating the growth of sterilization procedures across the province. Though this legislation was overtly ableist in that it targeted those with developmental or physical disabilities, it was also racist in practice and contributed to the larger network of policy violence arrayed against First Nations people in Alberta. As Karen Stote has shown in her own research, Indigenous women were thereafter grossly overrepresented as victims of sterilization procedures wherein consent was not obtained. As the author explains:

> this 1937 amendment made a distinction between psychotic persons and those considered mentally defective, and excised the consent requirement for the latter.27 The proportion of Aboriginal peoples sterilized by the Act rose steadily from 1939 onward, tripling from 1949 to 1959. Even when opposition to the Act gained momentum and its repeal became more likely, the rate at which Aboriginal peoples were sterilized underwent a terrific increase, representing more than 25 percent of those sterilized.[281]

The Sixties Scoop continued this kind of familial violence against Indigenous peoples in Alberta.

The term 'Sixties Scoop' refers to a policy period in Canada wherein a considerable number of Indigenous children were removed from their families and communities by child welfare workers.[282] This process began when federal and provincial governments began to adopt new approaches to the provision and funding of services for Status Indians in Canada. Empirical evidence suggests that at least 11, 132 children with Indian Status were scooped from their families between 1960 and 1990; however, the figure is likely much larger (as high as 20,000) given that non-status First Nations, Métis, and Inuit children were also caught up in the Sixties Scoop .[283] The mass removal of Indigenous children was coupled with their placement in non-Indigenous families, which created what Métis scholar Chelsea Vowel referred to as "cultural amputees", or Indigenous peoples whose connection to their land, identity, language, and cultural was severed.[284]

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[280] Malcolm Bow and F.T. Cook, "The History of the Department of Public Health of Alberta", *Canadian Public Health Journal*, Vol. 26, No. 8 (1935): p. 393.
[281] Karen Stote, "The Coercive Sterilization of Aboriginal Women in Canada" in *American Indian Culture and Research Journal*, vol. 36, no. 3 (2012): 117.
[282] The term Sixties Scoop was first coined by Patrick Johnston in a 1983 report; see Patrick Johnston, *Native Children and the Child Welfare System* (Ottawa: Canadian Council on Social Development, 1983).
[283] Chelsea Vowel, *Indigenous Writes: A Guide to First Nations, Métis, and Inuit Issues in Canada* (Winnipeg: Highwater Press, 2016), 182.
[284] Chelsea Vowel, *Indigenous Writes: A Guide to First Nations, Métis, and Inuit Issues in Canada* (Winnipeg: Highwater Press, 2016), 183.

In a study published in *The Canadian Review of Social Policy,* Indigenous scholar and therapist Peter Menzies offered the following description of the victims of the Sixties Scoop: "forced to assume the values of another culture that derided their own belief system, Aboriginal children were left in a cultural vacuum, relating neither to mainstream culture nor to their own community."[285] Thus, like the Indian Residential Schooling system, the Sixties Scoop caused Indigenous children to be taken from their families and placed in acculturating settings that attempted to assimilate them and absorb them into the Canadian politic. Though one cannot paint all victims of the Sixties Scoop with the same brush, numerous studies have revealed that Indigenous children were often subject to forms of physical and mental abuse when placed with host families that held anti-Indigenous and racist views about First Nations, Métis, and Inuit peoples.[286] For these reasons, some critics have argued that the Sixties Scoop embodied and amplified the core policy objectives of the residential schooling system.[287] In 2018, Alberta Premier Rachel Notley offered an official policy from the provincial government for its role in orchestrating the mass removal of Indigenous children from their families and communities.[288] It is important to note here, however, that the term 'millennial scoop' has also been used to refer to the continuation of this practice in recent years, particularly in light of a major 2019 Canadian Human Rights Tribunal decision, which found that 40,000 to 80,000 Indigenous children had been wrongfully removed from their families and deprived of services between 2006 and 2017.[289]

Several studies in a Canadian context have linked intergenerational trauma from Residential Schooling and the Sixties Scoop to the experience of homelessness.[290] In a study looking at the experience of homeless Indigenous men, Menzies argued that understanding the link between intergenerational trauma and homelessness was essential from a policy perspective,

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[285] Peter Menzies, "Intergenerational Trauma and Homeless Aboriginal Men," *Canadian Review of Social Policy*, no. 58 (2006): 1–24.
[286] Suzanne Fournier and Ernie Crey, *Stolen From Our Embrace: The Abduction of First Nations Children and the Restoration of Aboriginal Communities* (Vancouver: Douglas and McIntyre, 1997). Also, see Cindy Blackstock, Nico Trocmé, and Marlyn Bennett, "Child maltreatment investigations among Aboriginal and non-Aboriginal families in Canada: A Comparative Analysis", *Violence against women*, 10 (2004): 901–916.
[287] Cindy Blackstock, "Residential schools: Did they really close or just morph into child welfare?" *Indigenous Law Journal*, 6 (2007): 71–78.
[288] Government of Alberta, "Alberta Apologizes to Sixties Scoop Survivors, May 28th, 2018, https://www.alberta.ca/release.cfm?xID=5602290F38FE0-B9A4-A910-A0FA25640F0A9EDB
[289] Travis Hay, Cindy Blackstock, and Michael Kirlew. "Dr. Peter Bryce (1853-1932): Whistleblower on Residential Schools," *Canadian Medical Association Journal* 192, no. 9 (2020): E223–E224.
[290] See Peter Menzies, "Understanding Aboriginal Intergenerational Trauma from a Social Work Perspective," *Canadian Journal of Native Studies* 27, no. 2 (2007): 367–392; Lori Haskell and Melanie Randall, "Disrupted Attachments: A Social Context Complex Trauma Framework and the Lives of Aboriginal Peoples in Canada," *Journal of Aboriginal Health*, 5, no. 3(2009): 48-99;
Wilfreda E. Thurston, Katrina Milaney, David Turner, Stephanie Coupal, *Final Report: No moving back: A study of the intersection of rural and urban homelessness for Aboriginal people in Calgary, Alberta* (Calgary: Calgary Homeless Foundation, 2013), https://www.calgaryhomeless.com/wp-content/uploads/2016/10/No-Moving-Back-Final-Report-2013-07-09.pdf; finally, see Jennifer Lavalley, Shelda Kastor, Malcolm Tourangeau, Ashley Goodman, and Thomas Kerr, "You Just Have to Have Other Models, Our DNA Is Different: The Experiences of Indigenous People Who Use Illicit Drugs And/or Alcohol Accessing Substance Use Treatment," *Harm Reduction Journal* 17, no. 1 (2020): 19.

particularly in terms of a root causes analysis: "solutions to homelessness that focus only on helping people meet their personal needs are not likely to effectively address the underlying causes of homelessness as experienced by the participants in this study…For Aboriginal peoples, the solution to homelessness is not necessarily the construction of housing; rather, the response also requires a holistic approach that reconstructs the links between the individual, family, community, and Aboriginal nation."[291] It is also worth mentioning here that Blackfoot scholar and policy expert Gabrielle Lindstrom echoes this approach, but centres the land in the conversation as a therapeutic agent for Indigenous peoples who might be grappling with concurrent experiences of addiction, unmet mental heal needs, and homelessness: "So, there's got to be something else there. They've got to have access to the land, they've got to. And when I say the land, I mean, in very healing ways. Not just taking a field trip out to the mountains or something, but actually out there with healers and being able to connect. That's how we're going to heal. And that's not just for Indigenous people, that's for everyone."[292] It is in this context that we will move onto addressing what has been identified as the 12 dimensions of Indigenous homelessness.

Dimensions of Indigenous Homelessness

Because Indigenous homelessness has unique and specific causative elements, it has been necessary for Indigenous scholars, policy makers, and advocates to draw attention to the particular dynamics that shape and produce homelessness amongst First Nations, Métis, and Inuit peoples. Though the sections above spell out in deeper detail how the administration of Indian Status, the operation of the residential school system, and the far-reaching impacts of the Sixties Scoops have contributed to Indigenous homelessness, it is important to underscore, name, and briefly unpack the 12 dimensions of Indigenous homelessness as offered by Métis scholar Jesse Thistle.[293]

1) *Historic displacement homelessness* refers to the myriad of ways in which First Nations, Métis, and Inuit communities have endured forced and coerced relocations that has separated them from their traditional territories (which is inclusive to both lands and waterways).

2) *Contemporary geographic separation homelessness* seeks to name and categorize more recent separations of Indigenous peoples from their lands, which can include those who are unable to return to their home communities and tribal lands due to a lack of housing, band membership, or funds for travel.

[291] Peter Menzies, "Intergenerational Trauma and Homeless Aboriginal Men," *Canadian Review of Social Policy*, no. 58 (2006): 1–24.
[292] Interview with Gabrielle Lindstrom, June 9th, 2022.
[293] Jesse Thistle, *Definition of Indigenous Homelessness in Canada* (Toronto: Canadian Observatory on Homelessness, 2017), https://homelesshub.ca/sites/default/ files/COHIndigenousHomelessnessDefinition.pdf

3) *Spiritual disconnection homelessness* takes place when individuals are separated from their cultures, which has also been exacerbated by historical policies that criminalized Indigenous ceremonies such as the potlatch or Sundance.

4) *Mental disruption and imbalance homelessness* refers to the intersection of unmet mental health needs and a lack of housing, which is a common concurrent set of conditions for Indigenous peoples who lack access to safe and reliable shelter.

5) *Cultural disintegration and loss homelessness* names the impacts of acculturation and assimilation on Indigenous peoples whose experience of homelessness is shaped by a lack of connection to stories, teachings, languages, kinship networks, or rites of passage that help cohere one's identity as an Indigenous person.

6) *Overcrowding homelessness* refers to the high occupancy rate of Indigenous households both on-reserve and in more urban settings, which also increases one's risk of exposure to unsafe housing conditions, eviction, as well as general levels of stress.

7/8*) Relocation and mobility homelessness* refers to the precarity in housing experienced by those who are forced to travel often between the reserve and the city – a movement often mandated by a lack of healthcare infrastructure or educational and employment opportunities on reserve. This dimension of Indigenous homelessness dovetails with what is termed "Going home homelessness", which occurs when an individual who returns to their home community lacks safe or stable housing due to both formal and informal barriers.

9) *Nowhere to go homelessness* refers to situations in which Indigenous individuals "have a complete lack of access to stable shelter but also have nowhere to go because of a lack of kin supports, a lack of knowledge about housing support services, lack of funds to secure travel or housing, or community banishment."[294]

10) *Escaping or evading harm homelessness* takes place when an Indigenous person has to flee their home or household for purposes of personal safety.

11/12) Finally, *emergency crisis homelessness* and *climatic refugee homeless* refers to situations in which Indigenous peoples find themselves displaced from home or deprived of safe shelter due to political and environmental crises that can cause disruption and displacement.

Jurisdictional Complications

[294] Jesse Thistle, *Definition of Indigenous Homelessness in Canada* (Toronto: Canadian Observatory on Homelessness, 2017), 12, https://homelesshub.ca/sites/default/ files/COHIndigenousHomelessnessDefinition.pdf

Another factor that needs to be discussed before proceeding is the complicating nature of jurisdictional disputes related to the provision of healthcare for First Nations people. For example, healthcare is normatively under provincial jurisdiction; however, because First Nations signed treaties with the federal government, band members with recognized Indian Status are typically not part of provincial healthcare systems and funding structures. Rather, these individuals have healthcare provision within the larger framework of what are termed 'non-insured health benefits' (NIHBs).[295] This history of jurisdictional disputes between provinces and the federal government has delayed the development of on-reserve healthcare capacity as well as the treatment options available to Indigenous peoples across the country.[296] As Constance MacIntosh explains:

> In the face of jurisdictional disagreements, the fluid nature of Indigenous communities, and glaring health disparities, some provinces, including Alberta, Saskatchewan, Ontario and New Brunswick, have enacted legislation which authorizes their health ministries to enter agreements with Canada and First Nation communities regarding the delivery of health services for First Nations.[297]

This process has not been uniform nor complete in the province of Alberta, which has left some First Nations communities with more severe gaps in service than others. One key example here is the Kainai Continuing Care Centre (KCCC), which operates on the basis of a partnership between Alberta Health Services and the Blood Tribe Department of Health. In the Indian Hospital era, the federal Department of Health and Welfare was responsible for the administration of the Blood Indian Hospital and the five other on-reserve Indian hospitals in Alberta.[298] The KCCC began as a larger project to secure a hospital on-reserve, but due to jurisdictional and fiduciary disputes with the federal and provincial government, funding for the project was compromised and tribal leadership was forced to shift their strategy to secure a long term care facility instead, which opened in 1999. As one report explains:

> By 2007, the BTDH was struggling with the costs of continuing care. They were without provincial continuing care funding and what was coming in from Health Canada was insufficient. They were eventually forced to offset

[295] Kristen Jacklin and Wayne Warry, "The Indian Health Transfer Policy in Canada: Toward Self-Determination or Cost Containment?" in *Unhealthy Health Policy: A Critical Anthropological Examination,* ed. Arachu Castro and Merrill Singer (Landham: Altamira Press, 2004): pp. 215-34. NIHB (non-insured health benefit) is also not to be confused with the First Nations and Inuit Health Branch (FNIHB).
[296] Lori Chambers and Kristin Burnett, "Jordan's Principle: The Struggle to Access On-Reserve Healthcare for High Needs Indigenous Children in Canada" in *The American Indian Quarterly*, Vol. 41, No. 2 [Spring 2017]: pp. 101-124.
[297] Constance MacIntosh, "The Intersection of Indigenous Public Health with Law and Policy in Canada" *Public Health Law and Policy in Canada, 4th ed,* eds. *Tracey M. Bailey, C. Tess Sheldon & Jacob J. Shelley* (Toronto: LexisNexis Canada, 2019), 503.
[298] Alberta Health Services, *Continuing Care in Indigenous Communities: Guidebook*, September 23rd, 2022, 2, https://www.albertahealthservices.ca/assets/info/seniors/if-sen-ccic-guidebook.pdf

> the cost of continuing care with a contribution from the elders' personal income."[299]

In many ways, the KCCC is a success story; however the journey from the Indian Hospital era to provincial partnerships was an extremely difficult one that was accomplished in spite of, and not because of, the extant systems and structures that go towards shaping service provision on-reserve in Alberta. It is for this reason that we will recommend that any provincial strategy related to OPEH with complex needs in Alberta be approached in the spirit of good treaty relations and reconciliation. Meaningful consultation with First Nations communities, Métis organizations, and other Indigenous stakeholders in the province will not challenge their historical exclusion and marginalization from Canadian systems of healthcare, it will also capitalize on considerable expertise, as First Nations and Métis leadership are in the best position to understand the jurisdictional complexities associated with the provision of continuing care to community members both on- and off-reserve.

Conclusion

Appreciating the unique causes and dimensions of Indigenous homelessness is essential to developing impactful policies to curb homelessness in Alberta. More specifically, the overrepresentation of Indigenous peoples amongst populations of OPEH is rendered much more explicable when one understands the history of federal Indian policies in general and the more particular impacts of the administration of Indian Status, the operation of residential schools, and the onset of the Sixties Scoop. Though many Indigenous peoples were able to undo the impacts of enfranchisement, survive residential schools, and/or safely navigate their way through the cultural fog of post-apprehension family placements without losing house, home, and shelter, many were not. Thus, as we review in the recommendation section of this report, attending to policy development for OPEH in Alberta must be done in the spirit of reconciliation as well as in acknowledgement of structural violence, intergenerational trauma, and the specific contours of Indigenous homelessness. However, we also wish to avoid reproducing a trauma and deficit-centred approach and wish to underscore that First Nations and Métis political leadership have an expertise and a considerable policy history dealing with the complicated jurisdictional and fiduciary structures at both the federal and provincial levels.

[299] Alberta Health Services, *Continuing Care in Indigenous Communities: Guidebook*, September 23rd, 2022, 2, https://www.albertahealthservices.ca/assets/info/seniors/if-sen-ccic-guidebook.pdf

Recommendations

Recommendation 1:

Commit to engaging with OPEH with complex needs as policy directors, stakeholders, and as architects of the service provision schemas that impact them.

Seldom are OPEH with complex needs consulted meaningfully in the creation of public policies impacting them. This is undemocratic in the broad sense; more pragmatically, however, this also prevents lived experience of system navigation from being incorporated into future changes to service provision. Though we have several recommendations in what follows, none of our expert knowledge should be privileged over or valued above what OPEH say they need. These needs are also incredibly diverse amongst OPEH, which means that qualitative data is needed in order to secure proper and productive policy changes. In short, OPEH with complex needs should not merely be enumerated and counted but brought into the policy-making arena in Alberta. This will also help to address specific programs and identify desirable policies that will be needed to support OPEH with complex needs who are Indigenous, racialized, or who have immigrated to Alberta from elsewhere.

Recommendation 2:

Develop Standardized Assessments to Enumerate OPEH in Alberta Using Age 50 as the Threshold of Inclusion

In order to properly understand the best policy response to OPEH in Alberta, reliable data must be generated in order to ensure evidence-based policy pursuits; however, the relatively recent emergence of OPEH as a social phenomenon has also made it harder for academics and census-takers to develop best practices for enumeration. As explained more robustly in Pillar 1 under section subtitled *Demographic Dynamics and the So-Called 'Gray Wave',* various ages are being deployed as the threshold of inclusion both between and sometimes within Point-in-Time Count reports both in Alberta as well as across Canada. Though homelessness emergences differently in different places, it is not unreasonable to assume that OPEH (that is, those aged 50 and above) constitute anywhere between 25% and 50% of those experiencing homelessness in major Canadian cities. Of course, policy makers will need reliable quantitative data in order to construct actionable policy objectives as well to create metrics of success or failure in the pursuit of those objectives. Therefore, a coordinated effort ought to be made to use age 50 as the threshold of inclusion for the category of OPEH when surveying shelters, rough sleepers, and service providers across Alberta. Data collection should also take note that OPEH with complex needs are often forced to reside in hospitals for long periods of time awaiting assessment or placement. It is imperative that enumeration of homelessness take into account this kind of 'hidden homelessness' of OPEH with complex needs in Alberta's hospital beds.

Recommendation 3:

Review 65 as the Age of Inclusion in Alberta's Senior Living Settings so that OPEH between the ages of 50 and 64 who need this kind of care can access it with fewer impediments following a needs-based assessment.

OPEH who are aged 50 and above experience signs of advanced aging much earlier than their housed counterparts; however, because they are not seen as 'seniors' in the full sense, they are often ineligible for forms of care, supportive living settings, subsidized service provision, and other programming that is often reserved for those 65 and above. Dovetailing neatly with Recommendation 1, this recommendation seeks to remove barriers to care for OPEH with complex needs who are aged 50 to 64 on the basis that many in this demographic will require forms of support that are regularly or normatively reserved for seniors.

Recommendation 4:

Commit to Defending the Age of 65 as the Threshold of Eligibility for Old Age Security Payments.

There is a clear pattern in the Canadian history of social services of the federal government increasingly offloading its fiscal and legislative responsibilities for housing and social welfare onto provinces. Though this brings with it certain benefits in terms of healthcare autonomy and the coordination of social services under a centralized provincial framework, it is also a fiscal risk for Alberta when major shifts in federal policy can impact the public expenditures associated with supporting OPEH. As other policy experts have noted previously (and as we explain more thoroughly in the Pillar 1 of this report in the section subtitled *Income Supports for Seniors*) previous attempts by the federal government to delay the age of eligibility for OAS payments from 65 to 67 would have predictably increased rates of homelessness and poverty amongst seniors and older adults in Alberta. Further, this would ensure that provincial funding networks would be made to absorb the costs of assisting low-income seniors aged 65 and 66 who were at risk of losing their eligibility for OAS. Any future attempts to advance the OAS age of eligibility should be strongly critiqued and resisted by Alberta's political leadership to the extent that they care about preventing older people from experiencing homelessness.

Recommendation 5:

Integrate Harm Reduction Services within Facility-Based Continuing Care Systems in Alberta

Due perhaps to its reputation for political controversy, harm reduction has rarely been mentioned in the lion's share of grey literature discussing continuing care, homelessness, and reconciliation in Alberta. Similarly, few reports stress the importance or the reality of Alberta's struggle to provide services to OPEH with complex needs. We call upon the provincial government to commit to clearly worded policies that integrate harm reduction services within the spectrum of rehabilitative services available to residents of long-term care and designated supportive living facilities. We also suggest that such funding for harm reduction services not be subject to one-off project-based schemas but instead incorporated and integrated within the existing funding eligibility frameworks for designated living facilities (e.g., DSL3, DSL4, and DSL4-D). Though the NDP was successful in initiating some meaningful policy directives supportive of harm reduction in Alberta while it was in power, insufficient legislative and policy-based infrastructure was created to sufficiently address the issue of OPEH with complex needs. Currently, these services are often wrongfully conflated with those who require levels of care consistent with those who experience

dementia or declining cognitive abilities. For example, Alberta Health Services might create a new designation for supportive living called "DSL5", which can explicitly seek to serve OPEH with complex needs including addiction, unmet mental health needs, and other conditions that currently disqualify them from extant models of facility-based continuing care in Alberta. To be clear, our recommendation that harm reduction be integrated into continuing care in Alberta is one we state strongly, whereas our suggestion of creating a new DSL designation is offered as a representative example of the kinds of structural reform we advise to address the blind spot for OPEH with complex needs in current policy. Of course, such blind spots can also be addressed by implementing this in concert with Recommendation 1.

Recommendation 6:

Acknowledge the Risks of Investing in and Relying upon Home-Based Continuing Care as a Fiscal Strategy to Produce Savings and Limit Expenditures in Alberta

As we explain in deeper detail in Pillar 2 of this report in the sections subtitled *Centralization and the Broda Report*, *'Aging in the Right Place'*, and *Bill-11 The Continuing Care Act*, Alberta has for a very long time invested in homecare as a primary strategy in coordinating continuing care as well as in reducing public expenditures given the expenses associated with facility-based continuing care, which asks the provincial government not only to fund and coordinate services, but to acquire and manage property as well. Thus, the larger policy history wherein Alberta invests evermore in homecare has been completely understandable; however, given the population structure of Alberta and the increasing number of Baby Boomers who are entering their advanced years of age, this investment in homecare has several risks. Put simply, homecare is not possible for those who are experiencing homeless. If it remains a central pillar of aged care policy in Alberta, it should also be broadened to include and reflect the needs of OPEH. For example, AHS might seek to deploy specialists whose mandate it is to provide homecare for OPEH where they reside (e.g., in shelters, treatment centres, or even hospitals). This would also assist in Recommendation 1, bolster needs assessment practices in Alberta, and contribute to the generation of good will between AHS and OPEH with complex needs.

Recommendation 7:

Ground Emergent Strategic Frameworks to Address OPEH within a Consideration of Federal Indian Policy and the Unique Causes and Contours of Indigenous Homelessness

As we describe in deeper detail in policy pillar four of this report, Indigenous peoples are significantly overrepresented as individuals who experience homelessness in Alberta. Though residential schools and the Sixties Scoop are often cited as causative elements in this demographic make-up of homelessness in Canada, we stressed in this report the operation of federal Indian policy, enfranchisement, and urbanization between 1951 and 1985, given that this period of policy history impacted Indigenous peoples born between 1946 and 1964. Echoing a long list of Indigenous scholars, advocates, and political leaders, we recommend that any strategic frameworks that seek to address OPEH in Alberta remain grounded in engagement with Indigenous stakeholders as well as within a coherent policy context that acknowledges the structural causes of Indigenous homelessness. We also table the notion here that harm reduction integration into continuing care in Alberta will also assist those who have developed mental illness and addictions following their survival of residential school or experiences of the Sixties Scoop; however, we need to underscore that this suggestion does not reflect broad engagement with Indigenous stakeholders. The Indigenous expert we interviewed (Dr. Gabrielle Lindstrom) was complimentary of harm reduction service development but underscored that it is ultimately insufficient to the extent that it does not also involve culturally appropriate and land-based forms of care and healing.

Conclusion

The Province of Alberta has historically acted as a trailblazer in the implementation of fiscally-sound and evidence-based social policies related to housing and homelessness. The demographic dynamics in Alberta and the rest of Canada suggest that increasing continuing care capacity for OPEH with complex needs is an increasingly urgent public policy directive. More specifically, incorporating harm reduction services within the spectrum of continuing care options available in Alberta will assist OPEH with complex needs in accessing the specific forms of support they require and currently lack.

Of course, echoing Recommendation 1, nothing in this report ought to be valued and privileged over what OPEH with complex needs in Alberta say they need, as these individuals have the knowledge and lived experience of service access that is eminently important in the formation of impactful and needs-based policies. At the same time, there is much Alberta as a province and as a community can do in order to understand and respond to this issue in a more fulsome way. Though we council resisting the alarmist discourse of 'gray waves' that pathologize the Baby Boomer generation as an undue strain on the provincial or national economy, we also believe a dispassionate and objective analysis of the population structure points to the need for urgency in the way we approach and think about this issue. At the time of writing, it already remains extremely difficult to find stable and supportive housing options for older adults and seniors who use tobacco, alcohol, and other substances. Those who rest at the intersections of addiction and unmet mental health needs are even further marginalized within the current system. Of course, we acknowledge that harm reduction has been controversial in Alberta (particularly in the context of SCS sites and the *Impact Report* [see Pillar 3]); however, we affirm that providing older adults and seniors the option to age with dignity, in the place of their choosing, and with access to an array of well-funded medical services that will provide comfort, freedom, convenience, and relief in their later years is a bipartisan issue on which

Albertans can (and must) find common ground. We are all aging, after all, and making the supportive living and long term care system in Alberta the most responsive to and comfortable for older people and seniors is a policy directive that will benefit everyone.

Appendix A: Sources, Methods, and Interviewees

Our team was a multi-disciplinary team composed of individuals with training in social work, sociology, and history. Dr. Lara Nixon works as a family physician and holds a full-time academic appointment with the University of Calgary's Cumming School of Medicine. Further, she has extensive experience with the integration of harm reduction services into supportive living settings that provide service and shelter to OPEH with complex needs in Alberta. Dr. Travis Hay is an Assistant Professor of Humanities at Mount Royal University and a scholar who specializes in the Canadian history of medicine, federal Indian policy, and homelessness. Dr. Mandi Gray is a sociologist and a Canadian Institute of Health Research System Impact Post-Doctoral Fellow. Dr. Gray has published broadly in policy analysis, socio-legal studies, critical criminal justice studies, as well as in sociological forums. Megan Beth Sampson was the Project Coordinator for the larger Health Canada-funded research project within which this report was situated and made possible. Sampson has considerable experience leading engagement activities and conducts Community-Based Participatory Action Research project with older adults who were accessing services for those experiencing homelessness at an advanced age. Kaye Leatherdale holds a Master's of Social Justice Studies from Lakehead University and works in Thunder Bay, Ontario within the homeless serving sector. Jes Annan is a community-based researcher and grassroots activist whose policy analysis and community work seeks to broadly address the material conditions and realize the rights of Black communities.

This report drew upon three primary bodies of knowledge. First, we began with an extended policy analysis and a review of the grey literature relevant to the health and social outcomes of OPEH with complex needs in Alberta. This included not only aged care policies, but funding eligibility guidelines for public institutions, mental health strategies, Health Canada publications on addictions, minutes and debates from the Provincial Legislative Assembly of Alberta, as well as several reports from the Calgary Homeless Foundation. Next, we conducted a

review of the scholarly literature with a specific focus on peer-reviewed journal articles that contained empirical data or system-level analyses related to OPEH across Canada. Though our primary area of concern was the health and social outcomes of OPEH with complex needs in Alberta, we looked broadly across Canada to identify trends, patterns, and policy examples in the academic literature using "older adult", "senior", "elder", "Baby Boomer", "old age", "advanced age" and "late life" as primary search terms when identifying articles on "homelessness." We also used secondary search terms such as "addiction", "mental health", "concurrent", "co-occurring", "dual diagnosis", and "trimorbid" to identify articles and studies of relevance. Finally, on the basis of our review of grey literature and scholarly publications, we reached out to a short list of experts who generously provided us with in-depth interviews in their area of expertise. These semi-structured interviews helped us locate important studies and policy frameworks as well as inform our recommendations. To be clear, however, these recommendations do not necessarily reflect the views of the experts we interviewed.

For an expert perspective on Alberta Health Services and the development of health policy formation in Alberta, we spoke with Dr. John Church – a professor in the Political Science at the University of Alberta and an author of *Alberta: A Health System Profile.*[300] We also interviewed Dr. Krishna Balachandra, who is an Edmonton-based physician that has been broadly recognized as an expert in the administering of harm reduction strategies to individuals grappling with addictions (such as methadone clinics, buprenorphine maintenance treatments, and injectable opioid agonist therapy). Dr. Balachandra is also a clinical professor for the Psychiatry Department with the University of Alberta's Faculty of Medicine and Dentistry.
To look closely at the contours of OPEH in Alberta, we spoke with Dr. Katrina Milaney, who is a professor of Community Health Sciences at the University of Calgary as well as an Associate Scientific Director of Population Health with O'Brien Institute for Public Health.[301] Dr. Erin Dej, professor of Criminology at Wilfrid Laurier University and author of *A Complex Exile: Homelessness and Social Exclusion in Canada,* was also interviewed on the basis of their expertise in federal housing strategies and the political and social policy dynamics associated with providing care and support to peoples experiencing homelessness with co-occurring, concurrent, or dual diagnoses of addiction and mental illness.[302] Gabrielle Lindstrom is a prolific Blackfoot scholar who provided our team with expert advice and testimony on questions of reconciliation, the overrepresentation of Indigenous peoples experiencing homelessness in Alberta, harm reduction, and how to conduct research in the spirit of being a good treaty partner to Treaty No. 7 and other Indigenous communities.[303] Dr. Peter Choate is a professor of Social Work at Mount Royal University and expert in addictions and mental Health. Dr. Choate's

[300] John Church and Neale Smith, *Alberta: A Health System Profile* (Toronto: University of Toronto Press, 2022).
[301] See Katrina Milaney et al. "A Portrait of Late Life Homelessness in Calgary, Alberta." *Canadian Journal on Aging*, vol. 39, no. 1 (2020): 42–51.
[302] Erin Dej, *A Complex Exile : Homelessness and Social Exclusion in Canada* (Vancouver: UBC Press, 2020).
[303] Gabrielle Lindstrom, Steve Pomeroy, Nick Falvo, and Jodi Bruhn, Understanding the Flow of Urban Indigenous Homelessness: Examining the Movement Between Treaty 7 First Nations and Calgary's Homeless-Serving System of Care, Calgary Homeless Foundation, May, 2020, http://www.calgaryhomeless.com/wp-content/uploads/2021/08/Understanding-Flow_Final_print_2020_07_21.pdf

interview allowed our team to benefit from his considerable experience and knowledge of Alberta's non-profit sector and co-ordination of social services.

Finally, while our policy analysis method did not include the collection of interviews with OPEH who are service users, our team included several scholars and professionals who have considerable lived relations working with this community in Calgary, Alberta as well as Thunder Bay, Ontario. Though our report does not seek to embody or represent the voice of OPEH, our approach and urgency in addressing this subject was powerfully informed and enriched by interactions with OPEH.