Older People 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

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Executive Summary

This research project was initiated in response to an identified lack of housing with appropriate supports available to Older People with Experiences of Homelessness (OPEH) who also experience mental health challenges and/or problematic substance use. This population often has complex psychosocial and physical health needs, requiring tailored mental health and addiction services that are accessible both financially and geographically. In Calgary's current housing, health, and social services landscape, this specific demographic continually 'falls through the cracks' and there are significant barriers that need addressing to enhance housing stability and quality of life.

This report details 3 key learnings, which shed light on what is distinct about the housing and service experiences of OPEH with mental health and/or substance-use related challenges, and the barriers to meeting their unique needs:

- **Key Learning 1:** the housing trajectories of OPEH with mental health and substance use-related challenges in Calgary are chaotic and rife with bans, evictions, prolonged hospital stays, premature discharges, and intermittent or prolonged stays in emergency shelters. In our current landscape, there are very few available options where these older adults can find secure and stable housing.
- **Key Learning 2:** Organizational policies aimed at avoiding risk and institutional liability are a major contributor to housing instability for this population. They may be used as justification for discrimination and exclusion. These policies may reflect stigmatizing beliefs about substance use and act on ageist assumptions about older peoples' capacity to make decisions about their care.
- **Key Learning 3:** There are currently several features of our health, housing, and social service landscape that hinder the multisectoral collaboration and information sharing needed to improve housing stability and health outcomes for OPEH. This is significant, as OPEH with mental health and/or substance use-related challenges often access services from a variety of agencies and organizations to meet their complex needs, and fragmented care is detrimental to their wellbeing.

The following recommendations were developed to address the barriers outlined in our key learnings.

- **Recommendation 1: Agencies should hire and train peer support workers who are OPEH and have lived expertise of mental health challenges and/or problematic substance use.** These peers can help work with OPEH to overcome distrust for health, housing, and social services that can result from many years of negative and stigmatizing encounters. They can build rapport and connect OPEH with services they may otherwise avoid or be excluded from.
- **Recommendation 2: Organizations/agencies across sectors should work to identify and address policies, practices, and aspects of their organizational cultures that**

perpetuate stigma toward OPEH and people with mental health/substance use-related challenges. There is a role for formal training in things like harm reduction and trauma-informed care; however, there must be sustained effort beyond these short-term educational opportunities. Organizations and agencies should create long-term goals with realistic timelines, and be intentional about the methods they choose to promote culture change.

- **Recommendation 3: Opportunities for in-person and real-time relationship building should be implemented by organizations providing housing and care to OPEH.** Participants suggested that face-to-face meetings can be one means of combatting stigma and exclusion, improving multisectoral collaboration, and improving information sharing. This includes opportunities for service providers (across sectors) to meet and work collaboratively, as well as for clients/patients to meet and connect with service providers and representatives from prospective housing sites.
- **Recommendation 4: More programs, services, and housing sites targeted toward older adults should adopt a harm reduction philosophy of care.** There is a need for more housing for OPEH that is resourced to support those who are actively using substances, including illicit drugs.
- **Recommendation 5: The housing landscape should reflect the diversity of OPEH.** There should be an array of services to meet the individualized needs and goals of OPEH with mental health and/or substance use-related challenges. Individuals may have goals of maintaining housing and quality of life while continuing to use substances, or alternatively, to reduce or abstain from substance use. They may wish to secure housing with increased on-site supports, or to transition to a more independent model of housing. The landscape should support them in exercising these choices.
- **Recommendation 6: Organizations and agencies should educate themselves about the legalities around inter-agency and cross-sectoral information sharing and improve the flow of information necessary in the care of OPEH.** Training and education in data ethics and patient privacy can help ensure that this occurs ethically and responsibly.

Key Terms

Harm Reduction – can refer to policies and practices intended to "[reduce] the negative effects of health behaviors without necessarily extinguishing the [. . .] health behaviors completely" (Hawk et al 2017, p. 1). One example would be providing clean syringes and disposal supplies to people who use injection drugs to reduce the spread of blood-born illness. Another would be dispensing alcohol to people with alcohol use disorders in controlled quantities to reduce the risks associated with binge drinking. Harm reduction is most commonly described in relation to use of alcohol or drugs; however, it can also be applied to other behaviours (for example, increasing ventilation to reduce the risk of air-born transmission of illness during group gatherings, or promoting the use of condoms to reduce the risk of sexually transmitted infections).

Continuing Care – "A range of services that support the health and well-being of individuals living in their own home, or a supportive living or long-term care setting. Continuing care clients are defined by their need for care, not by their age or diagnosis or the length of time they may require service." (Alberta Health Services 2022a)

Supportive Housing – "Combines rental or housing assistance with individualized, flexible and voluntary support services for people with high needs related to physical or mental health, developmental disabilities or substance use" (Homeless Hub 2021). The Calgary Homeless Foundation identifies that their supportive housing buildings can offer harm reduction or require abstinence, and can be offered in individual units across various buildings, with either visiting or community-based support services, or be more place-based with services all under one roof (2014, p. 7). Supportive housing accommodations are not necessarily designated supportive living facilities (where a certain level medical care is available 24/7 and managed by Alberta Health Services).

Designated Supportive Living, or **Assisted Living –** Accommodations with supports such as meal services for individuals with complex medical needs, where Alberta Health Services is responsible for admissions and service provision for at least a segment of available beds (Alberta Government 2014). 24-hour on-site medical support from health care aides is available, and access to these services occurs by referral from an Alberta Health Services Case Manager (Alberta Government 2014; Alberta Health Services 2022b).

Long Term Care – for individuals requiring a higher level of care than is available in Designated Supportive Living/Assisted Living. 24-hour on-site support from registered nurses is available, and access to these services occurs by referral from an Alberta Health Services Case Manager (Alberta Health Services 2022c).

Low-Barrier Housing – The Calgary Homeless Foundation defines low-barrier housing as housing models that "adopt harm reduction philosophies and practices" (2014, p. 15), and allow people to reside there that use licit and illicit substances. By working 'with' the client, they "address behaviours deemed to be disruptive or harmful" (2014, p.15), with emphasis on helping clients maintain their housing.

Context and Rationale

Older people with experiences of homelessness (OPEH) have distinct housing and service needs that have been historically neglected in policy (Grenier et al. 2016a; Grenier et al. 2016b) and systems of care (Canham et al. 2021; Milaney et al. 2020; Kaplan et al. 2019; Canham et al. 2018; Crane & Joly 2014; Serge & Gnaedinger 2003). Rates of older adult homelessness are rising in Canada and the United States, and expected to continue to rise – a trend that can be attributed to demographic aging and increasing numbers of people becoming homeless in mid- to late-life (Murphy & Eghaneyan 2018; Brown et al. 2015; Gonyea et al. 2010). Locally, from 2001 to 2016 the Calgary Drop-In and Rehab Centre (the largest emergency shelter in North America) reported that residents between the ages of 56-65 increased by 320%. In 2016, older adults (56 – 65) made up 40% of clients residing at this shelter (Rowland & Hamilton, 2016).

The social and environmental conditions that both lead to, and result from, unstable housing have been shown to contribute to a wide range of mental and physical health challenges (Khandor & Mason 2007; Hwang et al. 2009; Crane & Warnes 2000), and OPEH experience disproportionately high chronic disease burden and rates of physical and cognitive disability (Kellogg et al. 2012; Gelberg et al. 1990; Henwood et al. 2019; Canham et al. 2021). The conditions of homelessness contribute to accelerated aging, or the early onset of geriatric conditions, to the extent that OPEH may become functionally geriatric up to 20 years earlier than housed adults (Henwood et al. 2019; Brown et al. 2017; Cohen 1999). Because of these factors, in the literature OPEH tend to be considered "elderly" or "older" at age 50 (Kaplan et al. 2019; Grenier at al. 2016b; McDonald et al. 2004; Serge & Gnaedinger 2003; Cohen 1999). This is significant as Canada Pension Plan and other senior-oriented supports are often reserved for individuals 65 years of age and older, excluding these older adults (McDonald et al 2004).

Shelters are typically ill-equipped to support the physical and mental health needs of OPEH, with challenges around accessibility, safety, and a lack of necessary medical supports (Canham et al. 2019; Grenier et al. 2016b; Serge & Gnaedinger 2003; Power & Hunter 2001). Study of a large emergency shelters in Montreal suggested that the average length of stay is longer for individuals over 50, despite the incompatibility of this environment with older adults' needs (Rothwell et al. 2016). Among adults 50 and older accessing shelters and sleeping outdoors in Calgary, significant barriers to appropriate services include financial limitations, long wait lists, and not receiving requested assistance (Milaney et al. 2020).

In response to these realities, there is a growing body of research to identify 'promising practices' in housing for OPEH in Canadian urban centres, that will allow them to comfortably age in the 'right' place for their needs (Canham et al. 2020); however, few studies identify the needs and experiences of older adults who experiences homelessness **in combination** with mental health and/or substance use-related challenges. This study provides a detailed exploration of the health, housing, and social service landscape in Calgary, Alberta, specifically highlighting the distinct needs and experiences of OPEH with co-occurring mental health and substance use challenges.

Study Background

In a 2016-2018 case study of one permanent supportive housing building for formerly homeless older adults (Nixon & Burns, 2022), staff and relevant community stakeholders suggested that more

permanent housing for OPEH with mental health and/or substance use challenges is needed locally. This research project was developed based on these findings to further inquire:

1) What barriers do older adults with problematic substance use and mental health challenges face locally to accessing housing and relevant health and social services?
2) What opportunities exist locally to facilitate increased housing stability and appropriate health and social service access for OPEH with substance use-related and/or mental health challenges?

This study will inform local multisectoral initiatives (including models of housing with integrated services currently in place/under development) to improve care for this distinct and growing population of older adults.

This report represents the perspectives and experiences of service providers. It is only one component of a larger programme of research by the study team that includes participatory action research conducted in partnership with OPEH to co-design a model of care based on their distinct needs (for more information see www.hrhopeh.com).

Methods

This qualitative study involved i) in-depth interviews with executive, administrative, and frontline staff from housing, health, and social service settings in Calgary, Alberta (n=13); ii) one focus group with representatives from permanent supportive housing, emergency shelters, mental health outreach services, community health services, and larger agencies and government sectors responsible for service oversight (n=14). Study participants were asked to consider:

- Their observations about the distinct needs of older adult clients/patients with experiences of unstable housing, problematic substance use and mental health challenges.
- How their organizations have facilitated successful care for OPEH with substance use-related and/or mental health challenges, as well as barriers they've faced in meeting the needs of these older adults.
- What could be done to improve the experiences for their older adult clients with experiences of unstable housing, problematic substance use, and/or mental health challenges.

An inductive thematic analysis (Braun & Clark 2006) was conducted by 2 research assistants supported by the multidisciplinary study team. The study team met weekly to review analyses, add context or alternative interpretations, and discuss any discrepancies or "outlying" data to reach consensus. Through this process, a set of mutually agreed upon themes was developed that form the basis of this report.

Participant Profile

Interview participants in this study were purposively sampled based on their specific position within the health, social, or housing service landscape. 3 participants were recruited using snowball sampling.

Participants in the focus group were recruited from a local working group dedicated to co-developing strategies to enhance harm reduction supports in various housing and shelter settings.

It is important to note that during this study, there was a provincial election and subsequent change in government, and with this change came a shift in policies and funding relating to the provision of harm reduction services. Because this study directly concerns harm reduction services for OPEH and substance use-related and/or mental health challenges, the implications of this change were significant. One participant withdrew from the study, stating these circumstances as their rationale. To protect participants and their organizations from any unintended repercussions that could emerge from public recognition or discussion of their harm reduction services, we have refrained from directly identifying specific agencies or portfolios in this report, instead referring to the *type* of agency/organization and/or services offered. For further details about interview and focus group participants, see table 1 and 2 below.

Table 1: Interview Participants

Participant ID	Role	Type of Organization
2015	Manager	Addiction Outreach Services
2016	Clinical Director	Shelter/Homeless Services
2017	Director	Shelter/Homeless Services
2018	Director	Alberta Health Services
2019	Manager	Alberta Health Services
2020	Executive Leader	Alberta Health Services
2021	Peer Support Worker	Mental Health and Addiction Outreach Services
2022	Peer Support Specialist	Homeless/Housing services
2023	Executive Leadership	Permanent Supportive Housing
2024	Social Worker	Acute Care and Long-Term Care
2025	Frontline Support Worker	Shelter/Homeless Services
2026	Executive Leadership	Long-Term Care

Table 2: Focus Group Participants

Participant ID	Role	Type of Organization
2001	Medical Director	Health & Social Services
2002	Manager	Permanent Supportive Housing
2003	Director	Government
2004	Manager	Shelter/Homeless Services
2005	Case Manager	Shelter/Homeless Services
2006	Manager	Post-Secondary Institution
2007	Coordinator	Homeless/Housing Research
2008	Social Worker	Homeless/Housing Services
2009	Nurse Practitioner	Health & Social Services
2010	Manager	Shelter/Homeless Services
2011	Program Lead	Health & Housing Services
2012	Community Planner	Mental Health Services

2013	Senior Manager	Housing & Homelessness Consulting
2014	System Planner	Homeless/Housing Services

Learnings: Local Barriers to Housing and Services

There are 3 key learnings from this study. Each speak to systemic barriers to housing and care for OPEH with mental health/substance use-related challenges. Our first key finding concerns the housing trajectories for OPEH with mental health/substance use-related challenges, highlighting the system gaps that contribute to housing instability and can lead to a revolving door to hospitals or emergency shelters. For our second finding, we "zoom in" on facility-based continuing care and supportive housing landscape, describing how pervasive societal stigmas around aging and substances use manifest, often under the guise of minimizing or reducing "risk", contributing to housing instability for OPEH. Our final key learning concerns how effective housing and service delivery for this distinct population is heavily reliant on multisectoral partnerships. We describe current limitations to healthy partnerships and communication between stakeholders, as identified by participants.

"There's Nowhere for Them to Go": Housing Trajectories

Substance Use and/or Behavioural Concerns Leading to Eviction/Ban/Discharge

Participants identified a shortage of viable options when it came to housing older people with significant substance use related challenges and/or mental illness. They frequently described scenarios where aggressive behaviours, violations of guest management policies, indoor smoking, and/or substance use resulted in eviction from private dwellings, supportive housing, or continuing care environments. This is one pathway leading older adults with substance use-related and/or mental health challenges to reside in emergency shelters.

> *"We end up having to pick up the pieces of people that get kicked out of [permanent supportive housing], because they end up at our shelter or in the hospital or something like that."* [2015]

Such behaviours can also lead OPEH to be prematurely discharged from hospitals. Participants reported that such punitive measures can occur regardless of medical needs or lack of options for sheltering.

> *"One thing that we notice a lot is – people will come into hospital and they'll get booted out. There is still this idea that [substance dependence] is a choice, you know? And they're not given that time to really – given that chance to get better. They just sort of get – a lot of times just get thrown right back into that same environment [they came from] and there's no way that they could get themselves healthier"* [2024]

For individuals with a recorded history of evictions due to illicit substance use or behavioural concerns, finding housing placement from hospital or shelter is often a significant challenge. They may face bans or be denied housing based on their records.

> *"[I had a client with] complex health needs. Didn't necessarily have a primary mental health diagnosis, but mental health-like behaviours [. . .] Because of some of the structural damage that he did at one of*

the other sites, his name essentially somewhat got tarnished across the owner-operator groups in Calgary [. .] This resulted in a long hospital stay, like I think up to two years [. . .]" [2018]

Revolving Door: Shelter to Hospital

The complex mental and physical health conditions of OPEH often exceed what shelters are resourced to provide. Physical frailty, cognitive decline, or other challenges may place them at risk of predatory behaviour from other clients. Land use bylaws and staffing levels restrict the level of care that can be accommodated. Very limited on-site medical supports mean transfer to hospital is often deemed the only viable solution.

"So if you have a person that's declining rapidly due to chronic illness and age – like, for example they are soiling themselves [or] can't feed themselves [. . .] In those circumstances, if we have no housing for them and can't get them into housing, we will deem them as beyond our level of care [. . .] and we will send them to hospital" [2017]

However, if a hospital deems that an individual is not acutely ill enough to require admission, it is common for them to discharge these older adults back into the community, leading back to shelter repeatedly:

"[It's] not the right place for the person at the hospital either. So, [the hospital] is pushing on our system, and we push back on their system, and it's failing everybody" [2017]

Prolonged Hospital Stays

If an OPEH and complex mental health/substance use-related challenges is admitted to hospital, it is common for them to reside there for long durations of time awaiting placement in housing equipped to meet their needs. As described above, histories of bans or evictions may significantly reduce housing options, further extending hospital stays.

For individuals medically complex enough to require designated supportive living or long-term care, eviction from these settings can result in long-term hospitalization:

"…Usually most people who don't do well [in our long-term care facility] end up going to the hospital and back to the, unfortunately, the emergency room is the only other avenue where they can get back into the acute care system [. . .] Those are often very complex situations and require a lot of support for the team." [2026]

Exclusion from Seniors-Oriented Housing and Services

Significantly, most senior lodges and subsidized housing directed to seniors accept only those 65 years of age or older. One frontline worker from a local shelter expressed that although shelters have dedicated resources for finding and securing housing for clients, this made older adults with experiences of homelessness under 60 particularly challenging to house:

"Where the challenges lie, is finding appropriate housing for people with complex needs who are maybe 50 years old instead of 65. When they really needed…when most services started. So the gap in age between the 50 and 60 we found really difficult to manage." [2025]

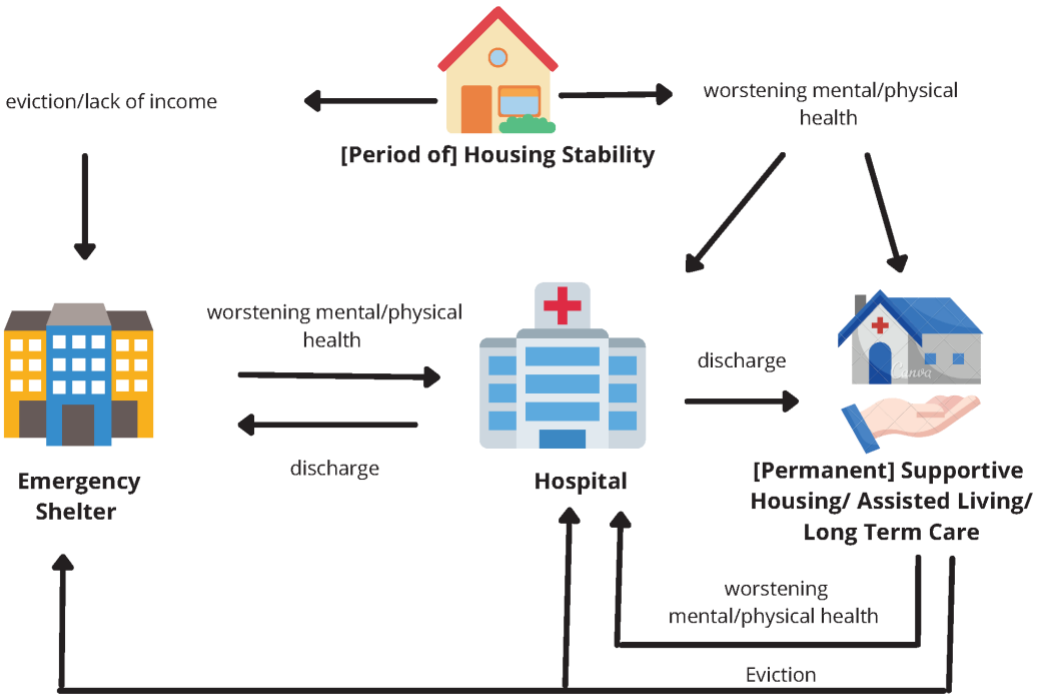
Focus group participants identified that in their experience, this challenge begins at an even earlier age. They recalled clients who they considered to be functionally geriatric at the age of 40, for whom they struggled to find housing that would accommodate their care needs. Two of the shelter staff who participated in interviews shared the sentiment that, for individuals who have experienced chronic homelessness and/or prolonged periods of heavy substance use, age may be an arbitrary admission criteria as premature aging is so common and pronounced.

Low-barrier, harm reduction housing models with embedded supports are in short supply locally, and those that exist have long wait lists. This is especially true of designated supportive living and long-term care facilities, which often have rigid policies around substance use that exclude individuals who are unable or unwilling to abstain from use altogether. Additionally, supportive living and long-term care facilities often have many rules and regulations for residents to abide by, which can become a source of tension for OPEH with mental health and/or substance use-related challenges. Participants provided several examples where OPEH residents opted to leave stable housing for precarious conditions because of dissatisfaction with these strict rules. In these ways, the culture of these facilities can feel hostile and exclusionary to this population of older adults.

Previous research by Sussman et al. (2021) speaks to the challenges faced by homeless older adults who require assisted living or long-term care. Unstably housed individuals are more likely to be transferred to these types of care environments, in large part because they are lacking the physical space to receive visiting supports such as home care that might enable aging in place (Sussman et al. 2020, p. 1150; Sussman et al. 2021). Since publicly funded supportive living beds are in short supply, older adults transitioning from acute care are often given little choice in their placement, which can be a significant source of distress (Sussman et al. 2021). Participants' anecdotes about clients being evicted from designated supportive living and long-term care environments illustrate the consequences of these conditions.

"[One of my clients was] young, 64 -- requiring a living environment that was structured. [He] failed at multiple other designated living option sites. So failed in Long-term Care, and by failed I mean either got evicted or wasn't successful [. .]

Diagram 1: Trajectories of Older People with Experiences of Homelessness and Co-Occurring Substance Use and/or Mental Health Challenges



Not "High Needs" Enough for Limited Housing with Integrated Supports

Because waitlists for low-barrier housing with integrated supports are so long, beds are typically triaged based on the complexity of clients' needs. However, the volume of OPEH with substance use/mental health related challenges who could benefit from such housing greatly exceeds available placements. Some participants expressed that his led to a situation where only the most complex of clients are housed in these units, while all others with comparable needs are left languishing in the system. Unless an individual is quite apparently declining and unable to perform their daily living activities, the perception was shared that intervention or supports are rarely offered. This was viewed as a missed opportunity to prevent individuals from reaching this stage of acuity in the first place.

"[Clients] would tell us that, you know, the biggest frustration is they're either too sick to receive help, or they're not sick enough to receive help, and what that came from was really criteria-based referrals. All our programs are trying to be black and white around who fits and who doesn't, and that creates gaps in the system, and we know people aren't binary." [2019]

"Risk Aversion", Substance-Use Related Stigma, and Ageism

"In terms of [seniors housing providers] – it's frustrating that, you know – the homeless sector is having to house all of these senior people […] when there's people in the business of [housing and caring for seniors], but they just don't want to deal with addiction issues. They're very risk averse in who they take" [2015]

Formal policies, including those shaping the housing and care of OPEH, are far from neutral documents – they are a reflection social norms and values. Structurally vulnerable populations, such as OPEH, have been made "vulnerable" by institutions, policies, economic systems, and systems of beliefs that support specific hierarchies of power within our society (Bourgois et al. 2017). Therefore, in order to remedy the health and housing inequities experienced by OPEH with mental health and substance use-related challenges, it is important to take a critical look at the policy decisions shaping their housing and care experiences.

Participants in this study demonstrated critical consideration of current policies posing barriers to OPEH. This was most commonly described in conversations about "risk aversion", or the tendency for seniors-oriented housing and services to have a low tolerance for perceived "risks". Participants identified that risk-reducing policies are often influenced by pervasive stigmas around substance use and mental health, as well as ageist assumptions, and can perpetuate discrimination against OPEH. This is outlined in more detail below.

"Risk Aversion": Institutional Liability

In the above section, we described that facility-based continuing care settings are often not accommodating to OPEH with complex mental health/substance-use related challenges, frequently resulting in exclusion, evictions, or individuals opting to leave these accommodations and live in precarious conditions. Participants repeatedly mentioned instances of OPEH with complex needs struggling to maintain housing with an appropriate level of support when they encountered "too many rules", leading them to leave or be evicted. This tension between rules and regulations versus inclusion and patient or client-centred services was observed by participants from subsidized housing contexts, assisted living and long-term care contexts, and even in low-barrier harm-reduction housing and services. Participants were critical of organizations which presented as overly 'risk averse', which they associated with rigid adherence to, and enforcement of, rules and regulations. Their critiques were consistent with recent literature exploring how regulations in Canadian residential care contexts reflect the logic of "neoliberal auditing", and "disempower residents while empowering paperwork" (Banerjee and Armstrong 2016: p. 7). Participants were critical that risk-reducing policies were interpreted and applied to protect organizations from institutional liability, rather than to protect patients/clients from harm. It was evident that participants felt this had negative implications for OPEH's access to housing, and for their quality of life once housed.

One example can be seen in the service standards for continuing care facilities, as determined by the provincial health authority. Facilities are regularly audited to ensure compliance:

"The Continuing Care Health Service Standards [. . .] They're pretty stringent which influences the kinds of risks sites are willing to take. So, even things like falls. If we measure sites' performance based on how many falls they have, then how willing are we to accept someone who's intoxicated? Because what are they going to do? They're more likely to fall, right?" [2020]

Another example can be seen in smoke-free policies, such as those detailed in Alberta Health Services' policy document 1134 ("Tobacco and Smoke Free Environments"). Tobacco use is prohibited on all Alberta Health Services' properties, including assisted living and long-term care facilities, unless special exemptions are in place. While these policies may be viewed as well-intentioned, participants in this study indicated that smoke free policies are a direct barrier to finding appropriate housing placement for older people with complex physical and mental health needs. This is evident in the following excerpt from a participant describing how assisted living facilities do not permit on-site smoking, leading to inappropriate placements:

"A sad thing in the system is that only long-term care centres right now, only a few of them offer smoking. So sometimes you have people, and they just don't want to change – they are always going to smoke. They really only need [assisted living], yet are being put into [long-term care] because they're smoking -- because there's no middle ground for them." [2020]

Stigma and Discrimination

Substance Use

A 2008 report by the Canadian Centre on Elder Law notes that while harm reduction is a recommended approach for older adults with substance use-related challenges, prohibitive policies around possession and distribution of alcohol and illicit substances are one of the most commonly shared policies in supportive housing and assisted living in Canada. In this local study, it was evident that a number of participants viewed such prohibitive policies with cynicism. As an example, one participant observed that individuals with histories of substance use are assumed to be a threat to the safety of other residents. Because OPEH who use substances may experience accelerated aging and require supportive living or long-term care at an earlier age, they can be perceived as posing a risk of physical violence against older residents, who are assumed to be more frail. As described above, this can be used as a justification for their exclusion from supportive living, long-term care, or other seniors-oriented accommodations.

Canadian Mental Health Association (CMHA) Ontario defines stigma as "a negative stereotype" associated with an aspect of an individual's identity (CMHA Ontario 2022). In this case, being a "substance user" is associated with the stereotype of being dangerous, volatile, or aggressive. Discrimination is "unfair treatment" or negative actions that result from stigma (CMHA Ontario 2022) – in this case, being refused housing with needed supports.

Participants' also noted that stigma impacts the healthcare that OPEH receive, including from healthcare providers and aides working in Supportive Living or Long-Term Care settings, and community settings (such as shelters), through Home Care:

"I think often when people think of themselves, like our healthcare aides or the RN's that are working in those areas [. . .] we sort of have this vision of the nice little lady, who's 80 years old, and she's probably going to make you some tea when you come. . . You know, there's going to be this very typical client, and I don't know that we are always the most open-minded when it comes to clients who may have different lifestyle choices" [2020]

"We have a number of co-managed clients with Home Care providing their end of things – it has never worked out very well. I think they're good with seniors, but they're not really good with our population [. . .] I think you need Home Care people that know [this is] the population they're going to be offering care to, and that are interested in and willing to do that." [2024]

One participant commented that, while they acknowledged workplace health and safety should always be prioritized, they feared that these safety concerns may in some instances be a "red herring", or an excuse for care providers to opt out of caring for patients they deem more complex or less desirable.

Ageism

Another theme that emerged in discussions of risk aversion was ageism. Existing literature suggests that seniors-oriented services can be prone to paternalism, grounded in ageist assumptions about the capacities of older people, and that this is harmful to the wellbeing of older adults in their care (Cook et al. 2021; Sanchez-Izquierdo et al. 2019; Theurur et al. 2015). Significantly, the philosophies of both harm reduction and patient-centred (or person-centred) care emphasize autonomy and the right for individuals to make decisions about their own care (Hawk et al. 2017; Sanchez-Izquierdo et al. 2019). Focus group participants observed that for service providers lacking training in these philosophies, more participatory approaches to service delivery may be 'counterintuitive', or even seen as harmful to patients/clients. However, study participants shared the sentiment that involving OPEH and mental health/substance use-related challenges in their own care decisions was important for their housing stability.

"It shows up in virtually all seniors work: ageism." [2023]

"I think, often, with older adults we get really caught up in whether they have capacity to make decisions, and then it becomes a really judgement piece. So, just because it's maybe not the decision I would make, doesn't mean you don't have the capacity to make it. You still have capacity to make that decisions – it's just not maybe a choice I would choose. And so, that [shouldn't] mean you can't choose it" [2020]

Barriers to Inter-Agency and Cross-Sectoral Partnership

"I think it's just openness – that other people are doing a great job and appreciating that they are here as partners and not competitors." [2016]

Both homeless populations and chronically ill older adults often rely on services from several agencies or providers to meet their care needs. In the case of these populations, 'fragmented' or unintegrated services have been identified as a barrier to wellbeing (Magwood et al. 2020; Boling 2009; Manderson et al. 2011). Interview and focus group participants expressed that improving communication between sectors and services should be prioritized to better meet the needs of OPEH with mental health and/or substance use-related challenges. There was wide consensus that organizations and agencies should be collaborating to find appropriate placements for OPEH. Participants frequently described or referred to a 'warm hand-off', where service providers communicate closely with each other, and with patients/clients, to facilitate a smooth transition to a new care setting. Ideally, these lines of communication remain intact after the transition in care, so that both the patient/client and the new care setting continue to be well supported. This was identified as particularly important in the case of older adults with complex mental and physical health conditions associated with homelessness and substance use.

Collaborative partnerships that enabled multiple programs and services to be delivered at a single point of access, such as within permanent supportive housing, at a shelter, or through a community health centre, were also identified as valuable. For OPEH and mental health/substance use-related challenges, who may struggle with mobility and system navigation, this model of program delivery was identified as promising in terms of reducing barriers to care. Despite this shared recognition, participants described the following barriers that interfere with the development and maintenance of these collaborative partnerships, to the detriment of OPEH.

Lack of Permanence: Reliance on Frontline Connections

Participants identified that inter-agency/cross-sectoral partnerships and communications can be fickle, due to the fact that they are often developed on a relatively makeshift, as-needed, emergent basis. These partnerships therefore often lack contracts or formal inter-agency agreements (such as memoranda of understanding). This can mean that frontline workers dedicate a significant proportion of their time advocating for and negotiating care from external service providers on behalf of their clients. In some cases, frontline workers develop strong interpersonal relationships across agencies, facilitating informal arrangements with other frontline staff for the benefit of clients/patients. In these cases, finding appropriate resources for clients can be a matter of "who you know":

"Sometimes, if you have a really good relationship with people, you can get your [clients] into their programs. I'm not saying that that's great, but that's where we've been most successful." [2020]

These arrangements are unfortunately often unsustainable, as this means service provision and access to care can also deteriorate when these interpersonal and individualized relationships falter, or when staff turnover inevitably occurs.

"We had a change in staff at one point and I had a doctor who told me she would no longer come to our [permanent supportive housing building] because she disagreed with a staff person leaving. And that

was a tough one for me to rationalize – because, are you helping the staff person or are you helping the residents?" [2023]

System Limitations: Competition and Funding Models

One participant noted that rather than cross-sectoral/inter-agency relationships resting on the shoulders of frontline workers, collaboration should be forged more strategically, "from a systems perspective". However, there are system-level tensions that hinder collaboration across sectors, as evidenced by one participant's observation about the provincial health authority and its relationship to the non-profit sector:

"In the non-profit sector, the lack of funding creates dynamics where they're always in competition – rarely do they have funding more than two years for a specific thing. And so no sustainable funding creates a lot of weird dynamics. Alberta Health Services does have sustainable funding – we're secure – so we become the bad guys." [2019]

This cross-sectoral tension was also noted in focus group meetings, where participants from the non-profit sector acknowledged that they often "expect the worst" from government workers and organizations. They acknowledged that the negative impacts on relationship could be detrimental to client/patient care. One interview participant noted that it can take years to repair or develop a healthy partnership across sectors and agencies, as it takes time to develop trust and a shared vision for patient/client care; however, these timelines are typically not feasible in a landscape where staff, structures, and models of decision-making are constantly in flux.

Barriers to Information Sharing

Another challenge to cross-sectoral collaboration mentioned in the focus group and by a number of interview participants were matters of patient/client privacy. Services operating under the auspices of the provincial health authority are able to exchange information with relatively few barriers. For these services, there is a centralized platform for charting information, which is typically accessible between providers. However, this exchange of information is complicated when it comes to sharing between Alberta Health Services' programs and services and external agencies (such as non-profits). Participant expressed that this has negative implications for OPEH's continuity of care.

"For us, because we're Alberta Health Services, there's not as much friction to co-ordinate between specialists [. . .] We're able to navigate the system much more effectively than maybe our community partners where there's communication barriers, privacy barriers" [2019]

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"I don't know where other agencies or foundations – where they document their information and how does that translate over to me? How do I get it? [. . .] Once the client is under our care, how do I better understand what other agencies, ministries, this client has been involved with? That part's not communicated very clearly or that information is not readily accessible" [2018]

Opportunities for Enhanced Housing and Services for OPEH with Mental Health and Substance Use-Related Needs: Recommendations

Peer Support

"[P]eer support is so desperately needed, especially seniors and people with mental health issues or addiction issues, because then there's that go-between. There's a person with lived experience [who's going to say] 'how can we make this work for you?'" [2021]

Participants acknowledged that many OPEH with mental health/substance use-related challenges have had repeated negative or even traumatizing encounters with the health and homeless-serving systems of care. These experiences can undermine their trust and willingness to accept support. Furthermore, the generational gap that may exist between OPEH and their care providers can in some circumstances be a barrier to building strong rapport. Peer support was one recommendation to address this.

"This [nonprofit sector] is dominated by young people. So the [shared age] thing is useful too, because of the shared experience of life before computers, life before the internet, stuff like that [. . .] I've met other peer support workers from a variety from other programs [. . .] and we have the ability to get a rapport with the client" [2022]

Peer support workers often have a wealth of not only lived expertise, but also relevant training, that gives them a close familiarity with the circumstances of their peer client, as well as the professional tools to assist them in creative ways. There is strong potential for long-term residents in supportive housing environments and harm reduction programs to receive training and supports to enter these roles, as they are already well established in their communities. One participant indicated that their agency had a 'peer mentor home', where individuals who 'graduated' from their program received affordable housing and were able to offer peer support to other clients of the agency with much success.

"Culture Change": Shifting Perspectives of Substance Use

As described in the above sections, participants provided examples of stigmatizing beliefs about substance use, and the ways these were expressed in their organizational cultures and contexts. They expressed that substance use continues to be commonly viewed as a personal choice, indicative of weak morals, rather than a response to complex social, emotional, and physical circumstances. When asked what could be done within their organization or across organizations to combat pervasive stigmas, some participants suggested that there was a role for formal training and education:

"[our organization] worked with [organization name], to really educate our staff on that harm reduction model ,and identify what some of the barriers were to those clients [. . .] from there we developed a bit of a memorandum of understanding [. . .] and I think that's been fairly successful, and something we'd probably like to see spread a bit more" [2020]

Another service provider suggested that training in trauma-informed care can be helpful in teaching staff how to have positive and compassionate, rather than stigmatizing, interactions with OPEH clients/patients:

"At [organization] every staff member is required to take trauma informed care training [. . .] It just helps to have them understand how we influence those who experience trauma—how what we do, what we say, and how we act may be triggering to them and [cause them] to become escalated, not because they want to but because of what we're doing." [2016]

Some participants were skeptical about the impacts of staff training for reducing substance use-related stigma within organizational cultures. One expressed that negative 'mental models of addiction' are deeply ingrained into our culture and that it will take significant investments on the part of organizations and institutions to change them. Participants advised that this type of meaningful change is a long-term goal, and can't simply be solved in the short-term through training sessions or educational initiatives:

"I think the temporal frame we put around things is completely magical thinking – like, the timing. If we're talking about addictions and people need to change their mental models – your timeframe needs to be, like, 4 years. And yet, our projects are one month to 3 months." [2019]

In the long-term, it was suggested that there is strong potential for arts-based communication, storytelling, and relationship-building with people who use substances as methods for building empathy and understanding within organizations with regard to substance use. A second participant, who worked for an agency providing permanent supportive housing with harm reduction supports, mentioned notable successes using arts-based initiatives to reduce stigma and foster community inclusion for residents in their buildings.

On-Site Visits and Face-to-Face Meetings: Relationship Building

Between OPEH and Housing/Service Providers

Participants who worked frontline roles frequently described instances where they facilitated face-to-face meetings between their clients and representatives from organizations or agencies where they hoped to broker access to housing or services. This was recommended as one means of challenging stigmas and addressing exclusionary policies. For example, participants in the focus group recommended that if designated representatives from AISH or Alberta Works made in-person visits with clients in shelters or supportive housing sites, rather than over the phone, they could build a more positive relationships with residents and staff and familiarize themselves with their distinct contexts. In doing so, accessibility would improve as communication barriers (such as lack of reliable access to a telephone or internet connection) could also be overcome.

Interview participants working in, or closely with, acute care settings also emphasized the importance of real-time conversations and in-person visits between patients and prospective housing providers in continuing care. It was suggested that these face-to-face meetings create human connections and can help patients who might be excluded or deemed 'too risky' based simply on their records:

"We're trying to bring the [housing] owner-operator groups closer to the client and into acute care, so that we can build those relationships and have successful transitions from acute care into a facility [. . .] Sometimes what's written on the patient's profile is so complex that they're not comfortable or they feel like they client's not a good fit. There is so much value in [facilitating a meeting with] the client and saying 'Hey, why don't you come meet him or her?'" [2018]

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"Recently, within [department], we have hired what we're calling intensive case managers, and they really will try to help facilitate that transfer [between the hospital and continuing care facilities]. Because sometimes what happens is, right now, that transfer into supportive living or long-term care is on a computer system, so you have, like a profile which, you know, says your name and your demographics, and I think as soon as some of those things come up, like substance use or, you know, those histories our provider sites are a little bit hesitant, because of the stigma associated with that.

So we're trying to really have more of those face-to-face conversations about these clients and say to the sites, like this is what it looks like on paper but, really, this person's care needs ... you know, this is really what they look like and yes, maybe this has been their history but right now that's not where they're at. Like, they're in a different place." [2020]

Between Agencies and Organizations, Across Sectors

Participants also suggested that regular opportunities for face-to-face communication between representatives from different agencies, organizations, and sectors could help overcome the barriers to multisectoral collaboration and information sharing. Two interview participants mentioned a local, cross-sectoral committee, meeting at regular intervals to collaboratively determine appropriate placement for clients or patients deemed to have complex needs. Participants reported that, once at the same table, these cross-sectoral stakeholders were able to (with permission) share important information about these patients/clients and therefore work together to negotiate their care in innovative ways:

"We usually meet once a month with certain people from different agencies and programs that – like [program name] and [provincial health authority]—and kind of brainstorm what to do with individuals who are accessing services quite a bit. We've come up with some creative sort of out-of-the-box ideas – and kind of target people that we can, you know, figure out maybe some more continuity around their healthcare to maybe looking at long term housing and stuff in the long term" [2015]

One suggested reason that these committees and cross-sectoral stakeholder meetings may be effective is that they help providers across the service landscape to develop a sense of "shared responsibility". In a service landscape where programs and services are regularly competing for funding, this shared agenda was described as particularly important. Again, it is important that executive leadership and organizations as a whole buy into this collaborative process, rather than relegating responsibility for these relationships to frontline staff, in order for them to remain sustainable.

Harm Reduction, or "Compassionate Care"

"For me 'harm reduction' is [a term] for a model of compassionate care. Let's get right down to that – you're helping people where they're at. And if you're doing that – you're helping people, you're building that relationship, you're building that trust – harm reduction is the result of that, right?" [2023]

Closely related to conversations about combatting stigma and promoting culture change were discussions about the potentials of harm reduction programming for OPEH with substance use-related challenges. Harm reduction can be defined as "interventions aimed at reducing the negative effects of health behaviours without necessarily extinguishing the problematic health behaviour completely" (Hawk et al. 2017, p.1). Harm reduction is most commonly described in relation to substance use (especially illicit drug use), but can be applied to many other health behaviours. Participants expressed that the stigma, contingent care, and frequent premature discharges and evictions experienced by OPEH who use substances could potentially be ameliorated if more organizations embraced a harm reduction philosophy of care. There was a wide range of definitions and perspective on harm reduction. The Canadian Mental Health Association of Ontario (2022) defines the key features of a harm reduction philosophy of care as:

- Pragmatism: recognizing that substance use is pervasive and inevitable but that steps can be taken to reduce the harms and enhance public health
- Humane Values: recognizing the dignity of people who use substances, suspending judgement, and respecting each individuals' decisions about their own health and care.
- Focus on harms: treating an individuals' substance use as secondary, while prioritizing the potential harms of use.

Features of harm reduction philosophy and programming identified by participants included:

- "compassionate care" and "trauma-informed care"
- acceptance for individuals at all stages of their journey, from daily substance use to complete abstinence
- Managed alcohol programs and/or managed tobacco programs, where alcohol/tobacco are distributed to individuals in controlled amounts.
- Indoor smoking spaces
- Flexibility, avoiding unnecessary or overly stringent "rules"
- A strong commitment to keeping people housed, even when behavioural challenges emerge
- Treating people with dignity and respecting their autonomy

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. One interview participant, from one of the few available long-term care facilities with harm reduction supports, reported that the waitlist to reside there was 3 years. He also noted that many individuals on the waitlist reside in hospital for this duration of time before they are able to move in. The demand for these services within continuing care is significantly higher than supply, and therefore more facilities equipped to provide care to OPEH who are actively using substances are needed.

Participants also noted that much of the available harm reduction housing and services for older people are designed to address alcohol use specifically, in turn excluding those who use illicit substances or are polysubstance users. Despite a common assumption that older adults "slow down" or "age out" of drug use, Kuerbis et al. (2014) note that the rates of older adults who use illicit and prescription drugs is rising

(p.629 – 630). Participants recommended that harm reduction housing and services for older adults be expanded to address these other substances:

"I think a big part is that it's difficult to find your 'typical' alcoholic these days – that there's drug use too, probably. I would say the managed alcohol [programming] is important, but then, how are you dealing with the seniors that are using drugs?" [2015]

A Diverse Spectrum of Housing-Based Supports

"Many people think of long-term care as being the last place you go before you die. We're trying to challenge that quite a lot here, and we actually had eight people discharged back to the community to places that have less supports [. . .] We've had great success with people being able to transition, who for the last 40 years have either been homeless, or in and out of the hospital, or living in condemned housing, like just terrible stories." [2026]

OPEH with substance use and mental health-related challenges come from tremendously diverse backgrounds and are equally as diverse in their own individualized needs and goals. As such, a spectrum of housing options, with varying levels of integrated on-site supports, should be available to them. This recommendation relates closely to our findings about ageism and the detrimental impacts of paternalistic approaches to care.

Participants expressed that because only a very small number of housing sites will accept or accommodate the needs of OPEH with mental health or substance use-related challenges, these have become a "catch-all"; as such, there were concerns about "institutionalization" and a tendency to approach all OPEH from a palliative approach. To be clear, participants appreciated the need for housing with comprehensive and integrated supports, as well as palliative care options. However, they also emphasized the need for resources to support OPEH who may have goals to move to a more independent model of housing, or to decrease or abstain from substance use. They expressed that a limitation of the current landscape is that there are only programs and services to support those with the most acute needs, and therefore there are few options for individuals in these programs who may have goals of "stepping down" their level of care:

"If programs that are like, 'no, no, we can't handle [substance use], send them somewhere else' -- like [the place they're sent] becomes a dumping ground in my opinion. Do you actually have the right people living there that actually need that level of support? Like do you need your meals provided, do you need your med management, do you need managed alcohol, or could you actually do well in a lower level of housing?"

Many functionally "older" adults with experiences of homelessness are not necessarily chronologically old. Many may have goals to maintain or return to a certain degree of independence over certain activities of daily living, such as cooking or housekeeping.

Low-barrier and harm reduction housing providers should reflect on their assumptions about their older residents. Namely, they should not assume that because they are older they will remain on a downward trajectory with their mental and physical health or continue using substances at their current level for the rest of their lives. All housing and care settings for OPEH should try and be responsive to the individualized goals of their residents. If these include gaining skills, maintaining or regaining certain

functions, or reducing or abstaining from substance use, there should be resources put in place to support this. Likewise, if an individuals' goals include simply maintaining their current quality of life or remaining stably housed, these are equally relevant and should also be supported.

Improved Information Sharing

While concerns around ethics and legality have created hesitance around information sharing, participants mentioned that with patient/client permission, information sharing can be accomplished legally and ethically in most circumstances. Therefore, it is likely that training and communication of the rules and legalities surrounding patient/client privacy, as well as ethical considerations in data and information sharing, could help address this barrier.

"I would say in health, for sure, [privacy] is a tough one, right? So we tend to be quite protective of our information [. . .] but, again, I don't think that's insurmountable. I think it's just figuring out what's urban myth and what is actual – the actual legality around privacy and things like that" [2020]

Where hesitance around information sharing stems from inter-agency competition or protectiveness over data and information, opportunities for relationship building and development of shared priorities (as described above) are essential.

Within the homeless serving system of care, many housing providers participate in the Calgary Homeless Foundation's Coordinated Access and Assessment (CAA). This is a centralized intake process by which standardized assessments are used to triage individuals into appropriate housing based on their specific needs. It is intended as a "single-point entry into the system of care" (Calgary Homeless Foundation n.d.), eliminating the need for clients to share their histories and complete assessments multiple times. This is one example of inter-agency collaboration and information sharing to improve client care.

Conclusion

This project analyzed local service providers' perspectives of the limitations in Calgary's housing, health, and social service landscape as it pertains to the needs and preferences of older people with experiences of homelessness and mental health/substance use-related challenges. It offers a critical perspective of policies and practices which are currently standard in housing and services available to these older adults. The interview and focus group data in many ways aligned with the literature on aging and homelessness, which points to the distinct experiences of older people with housing instability, while adding perspectives about how substance use and complex mental health challenges impact OPEH's housing and care trajectories. A systems-level perspective, which examined diverse services and housing models and their interaction (or lack thereof), highlighted opportunities for improved inter-agency and cross-sectoral collaboration.

At the heart of the barriers outlined in this report lie cultural assumptions about people who experience homelessness, mental health challenges, and substance use, as well as about the role of older people in decision-making regarding their housing and care. Participants provided several recommendations to address these challenges, but also acknowledged that remedying these matters will take long-term commitment on the part of organizations and agencies. Identifying and evaluating these approaches to

organizational culture change is potentially an important area of future research. This research pertains specifically to the Calgary landscape; however, we believe that these learnings may be valuable in other provincial, national, and some international contexts.

The learnings from this study have informed a larger programme of research, which includes participatory methods and close collaboration with OPEH and mental health/substance use-related challenges. For more information, please see www.hrhopeh.com.

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