YELLOWKNIFE COMBINED DAY SHELTER AND SOBERING CENTRE:

EVALUATION REPORT

PUBLISHED: AUGUST 29, 2019.

SUBMITTED TO:

Northwest Territories Health and Social Services Authority, and
Department of Health and Social Services
Government of the Northwest Territories
P.O. Box 1320
Yellowknife, NT, X1A 2L9

SUBMITTED BY:

DPRA Canada
60 Adelaide Street East
Suite 501
Toronto, ON
M5C 3E4
www.dpra.ca
1-800-661-8437

This page has been intentionally left blank.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACRONYMS

AMS	Advanced Medical Solutions
ED	Emergency Department
GNWT	Government of the Northwest Territories
HSS	Department of Health and Social Services
MAP	Managed Alcohol Program
NTHSSA	Northwest Territories Health and Social Services Authority

EXECUTIVE SUMMARY

BACKGROUND

The Combined Day Shelter and Sobering Centre located in Yellowknife is intended to provide a safe environment for publicly intoxicated individuals to stay while the effects of drugs and/or alcohol wear off. The Day Shelter and Sobering Centre were combined into one newly renovated permanent location in September 2018 and funded by the NTHSSA. The combined facility is open 24 hours a day, seven days a week. The Combined Day Shelter and Sobering Centre is operated by the NWT Disabilities Council, with on-site triage medical services provided by Advanced Medical Solutions (AMS).

The main objectives of the Combined Centre, as identified in the Terms of Reference, are:

1. To provide homeless adult clients that are intoxicated access to a Sobering Centre; an environmentally safe place to sleep off the effects of drugs and/or alcohol.
2. To demonstrate the capacity to meet the needs of both adult men and women within the physical space or spaces, and in the case of the Sobering Centre, this includes separate sleeping areas for men and women.
3. To work with the principle of harm reduction for those in this population, as it may offer a less difficult transition from their current lifestyle.
4. To meet the needs of basic human dignity for all homeless and at-risk clients by offering access to bathroom facilities, laundry facilities, etc.

In April 2019, DPRA Canada was contracted by the NTHSSA to conduct an evaluation of the Combined Day Shelter and Sobering Centre. Additionally, DPRA was contracted to conduct an environmental scan in order to understand best practices in service integration and co-location in harm-reduction facilities. The current contract for the provision of services of the Combined Centre is ending in fall 2019. In order to inform an upcoming Request for Proposals for the provision of services, the NTHSSA requested an evaluation of the Combined Centre's implementation, level of integration, and current practices. This evaluation is also intended to inform the planning of any future Centre in Yellowknife.

KEY FINDINGS

Based on the environmental scan and consultations conducted by DPRA, as well as an analysis of program usage data provided by the NWT Disabilities Council, Advanced Medical Services, and the Stanton Territorial Hospital, the following key findings have emerged:

Ideal Mix of Services and Level of Service Integration

Most integrated services models that exist across Canada include a combination of services in the areas of housing, harm reduction, medical care, and counselling. These are often essential services required by vulnerable populations that generally have high-barrier access. Based on the findings of this evaluation, it was identified that housing and shelter services are needed by the target audiences, as well as a growing need for case management, expanded medical services and harm reduction and addiction treatment programs. By having these services fully integrated and co-located, it would reduce the barriers to access and could leverage existing positive relationships between staff and clients to encourage continuity of care for the most vulnerable populations.

The Day Shelter and Sobering Centre have two target audiences:
The Day Shelter audience can be described as non-violent individuals experiencing homelessness, precarious housing, food insecurity, and/or poverty regardless of their level of intoxication. The Sobering Centre audience can be described as non-violent intoxicated individuals that do not have access to a safe and warm place to sleep off the effects of substances. While some clients reported being unable to access the Sobering Centre due to lack of intoxication, the Combined Centre seems to be reaching its target audience.

The mandate, activities and target audience of the Combined Centre are unclear to some stakeholders:
Partner agency stakeholders are unclear about the mandate and the target audience of the Combined Centre, particularly the Day Shelter. Key stakeholders, including community members and partner agencies, were unclear if programming takes place in the Day Shelter and whether intoxicated individuals are allowed to access the Day Shelter.

The Combined Centre is perceived positively by most stakeholders. In particular, the Sobering Centre, is viewed as a needed service:
Clients have positive perceptions of all aspects of the Combined Centre, overall. The location of the Combined Centre is perceived positively and negatively across stakeholder groups, including clients, with respect to its proximity to the Liquor Store. The Sobering Centre is perceived as a positive service that is needed.

Most clients and staff feel safe at the Combined Centre. Some stakeholders have concerns about incidences of violence in and around the Centre:
Clients express feelings of safety most of the time in the Day Shelter and Sobering Centre. Some clients, partner agency representatives, and neighbours have expressed concerns related to incidences of lateral violence amongst clients.

Many aspects of the Combined Centre are facilitating success and providing a needed service in Yellowknife:
Clients report feeling respected and safe at the Centre and both clients and staff emphasized the importance of building rapport and trust between each other. Many clients, staff, and partner agency representatives state that the Centre is providing a needed service that clients cannot access otherwise. Based on data from the Stanton Territorial Hospital Emergency Department and reports from RCMP and AMS personnel, demand on emergency services representatives have decreased since the Combined Centre opened.

Some aspects of the Centre are creating barriers to success:
The lack of programming is perceived (by clients, community members, and partner agencies) to potentially be resulting in boredom and leading to incidences of aggression among clients. The lack of formal partnerships between the Combined Centre and other agencies has resulted in a lack of clarity as to what the scope of programming is for the Combined Centre. Additionally, the lack of a structured substance-based harm reduction programs, like a managed alcohol program, may be limiting for some clients experiencing issues related to addictions.

Integration through co-location of services benefits many clients but is perceived with mixed feelings by others:

When asked what benefits clients' perceived as a result of the Day Shelter and Sobering Centre becoming integrated, many clients reported the benefit of the ease of accessing both the Day Shelter and the Sobering Centre due to their co-location, as well as their ability to access services that they are unable to access elsewhere, including medical services. The community perceives the integration of services through their co-location as promoting intoxication and substance use and leading to increased violence and alcohol abuse amongst clients.

KEY CONSIDERATIONS

Based on the results of this evaluation, DPRA has identified the following key considerations that are informed by the evaluation findings and best practices referenced in this report:

Identified Issue: Lack of Programming at Day Shelter

- *Short-term Consideration*:
  - Develop programming activities in the Combined Centre
- *Long-term Considerations*:
  Develop and implement Structured Harm Reduction Programs
  Implement Expanded Medical and Social Services

Identified Issue: Gaps in Physical Infrastructure

- *Short-term Consideration*:
  - Increase surveillance outside of the Combined Centre
- *Long-term Consideration*:
  - Provide clients with outdoor space
  - Create dedicated spaces for sober clients

Identified Issue: Staffing Resources

- *Short-term Considerations*:
  - Introduce a formalized peer-support role
  - Formalize role of Elders in the Combined Centre
  - Increase existing capacity
  - Increase availability for staff training
- *Long-term Considerations*:
  - Establish a dedicated medical team
  - Create positions for Addictions and Family Counsellors

Identified Issue: Lack of collaboration and integration of services

- *Short term consideration*:
  - Formalize partnerships with community agencies
- *Long-term Consideration*:
  - Provide an integrated service model to promote continuity of care

Identified Issue: Lack of Community Outreach and Education

- *Short-term Consideration*:
  - Develop communication tools to promote the mandate and goals of the Combined centre
- *Long-term Consideration*:
  - Engage in public education

Identified Issue: Management of Client Data

- *Short-term considerations*:
  - Revise the existing intake form and process to improve quality
  - Develop and implement a data system
- *Long-term Consideration*:
  - Establish data sharing agreements with partner agencies

1.0 INTRODUCTION

This report presents the evaluation of the Combined Day Shelter and Sobering Centre for the Government of Northwest Territories (GNWT), Department of Health and Social Services (HSS) and Northwest Territories Health and Social Services Authority (NTHSSA). The report provides background information on the program and the evaluation project, outlines the evaluation approach and methodology, presents and summarizes findings and identifies key considerations for the development of the upcoming Request for Proposal for the Combined Centre's service provisions, as well as for planning for any future Centres.

1.1. OBJECTIVES OF THE EVALUATION

In April 2019, DPRA Canada was contracted by the NTHSSA to conduct an evaluation of the Combined Day Shelter and Sobering Centre. The current contract for the provision of services of the Combined Centre is ending in Fall 2019. To inform an upcoming Request for Proposal for the provision of services, the NTHSSA requested an evaluation of the Combined Centre's implementation, level of integration, and current practices. This evaluation is also intended to inform planning for any future Centre in Yellowknife.

The objectives of the evaluation were to:

1. Understand current practice in other jurisdictions for co-locating or integrating services for vulnerable persons similar to the services being considered for any future centre in Yellowknife, such as shelter services, sobering programs, managed alcohol programs, counselling services, and hard-to-house units;
2. Inform program development for the permanent facility, any future facilities that are established in downtown Yellowknife; identifying the preferred mix of programs and providing any recommendations to mitigate negative interaction between proposed programs;
3. Understand impacts related to the level of integration in the current program location in order to recommend the following for the permanent facility:
    a. The ideal level of integration for the Day Shelter and the Sobering Centre; and
    b. Mitigation approaches to improve safety, related to program management, resourcing, staff training, policy changes (e.g. changes to screening questions or intake), and infrastructure (e.g. physical boundaries, such as a fence, or surveillance cameras, etc.);
4. Assess the effectiveness of the level of integration between the two programs, the Day Shelter and the Sobering Program, in the current temporary location on achieving the programs' intended outcomes, namely in:
    a. Providing appropriate and quality service to meet the needs of clients and staff;
    b. Ensuring the safety of clients, staff, and the reducing the impact on other community members; and
    c. Managing and responding to incidents;
5. Measure staff, client, and key stakeholder perceptions of safety; and
6. Identify program strengths and challenges.

1.2. SCOPE OF THE EVALUATION

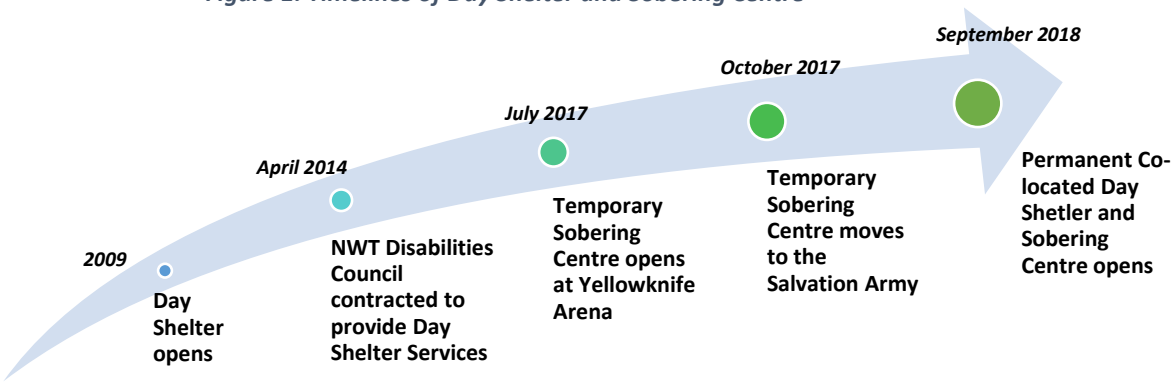
The scope of this project focused on evaluating the existing design and implementation of the Combined Day Shelter and Sobering Centre. While the two services previously existed as stand-alone services, the design and implementation of those service models were not included in the scope of this evaluation. For the purposes of this evaluation, the consultants assessed the Combined Centre based on the specific evaluation objectives (outlined in **Section 1.1).** Additionally, DPRA conducted an environmental scan to identify best practices in co-locating[1] and integrating[2] services to increase access for vulnerable persons. This evaluation did not seek to directly address the need for broader mental health and addiction treatment services within Yellowknife and the Northwest Territories, specifically. This provides a limitation in extracting findings and identifying key considerations to inform the broader mental health and addiction system within the Territory.

1.3. BACKGROUND

The Combined Day Shelter and Sobering Centre located in Yellowknife is intended to provide a safe environment for publicly intoxicated individuals to stay while the effects of drugs and/or alcohol wear off. Historically, the Day Shelter and the Sobering Centre existed separately; operating in different locations in Yellowknife by different community agencies. The Day Shelter originally opened in 2009 with services being provided by the John Howard Society. In April 2014, after completion of the first Day Shelter service contract, the NWT Disabilities Council was awarded the contract to provide services at the Day Shelter. In June 2017, a temporary Sobering Centre opened at the Yellowknife Arena before moving into another temporary space at the Salvation Army.

The Day Shelter and Sobering Centre were combined into one newly renovated permanent location in September 2018 and funded by the NTHSSA. The combined facility is open 24 hours a day, seven days a week, with the Day Shelter open from 7 am to 7 pm and the Sobering Centre open from 10 am to 8 am daily, only closing for two hours while the beds and rooms are being cleaned and serviced. The Combined Day Shelter and Sobering Centre is operated by the NWT Disabilities Council, with on-site triage medical services provided by Advanced Medical Solutions (AMS). The timelines of the Day Shelter and Sobering Centre can be seen in **Figure 1** below.

Figure 1: Timelines of Day Shelter and Sobering Centre



[1] Co-located services refer to services that are housed in the same facility

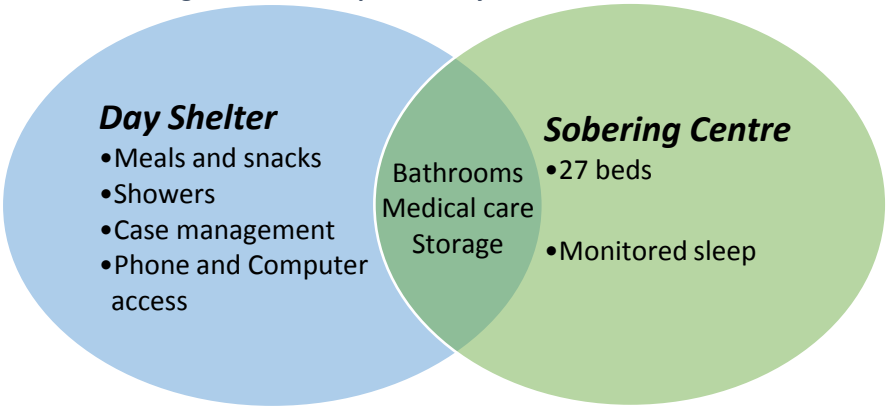
[2] For the purposes of this report, 'integrated services' refers to services and supports within a single agency or facility that are served by the same staff and have streamlined access to multiple services.

The four main objectives of the Combined Centre as identified in the evaluation Terms of Reference are:

1. To provide homeless adult clients that are intoxicated access to a Sobering Centre, an environmentally safe place to sleep off the effects of drugs and/or alcohol.
2. To demonstrate the capacity to meet the needs of both adult men and women within the physical space or spaces, and in the case of the Sobering Centre, this includes separate sleeping areas for men and women.
3. To work with the principle of harm reduction for those in this population, as it may offer a less difficult transition from their current lifestyle.
4. To meet the needs of basic human dignity for all homeless and at-risk clients by offering access to bathroom facilities, laundry facilities, etc.

The Combined Centre provides several different services for its clients. The current Combined Centre offers a co-located model with the Day Shelter and Sobering Centre located in the same facility, but with distinct areas where their services are provided. Staff within the Combined Centre serve clients accessing both the Day Shelter and the Sobering Centre integrating the services that are offered between the Day Shelter and Sobering Centre. These services include necessities such as food, access to bathrooms and showers, phone and computer access through the Day Shelter, as well as beds for intoxicated individuals to sleep off the effects of substances through the Sobering centre. The Combined Centre also provides access to other services for Yellowknife's vulnerable population, including access to a medically trained staff member from AMS, access to a Case Manager, and referrals to other services in the city. These services are identified in **Figure 2** below.

Figure 2: Services provided by Combined Centre



2.0 APPROACH AND METHODS

To capture both the breadth and depth of the available data, a combination of qualitative and quantitative methodologies was employed. **Table 1** provides a summary of the data collection methods used, according to each of the objectives of the evaluation.

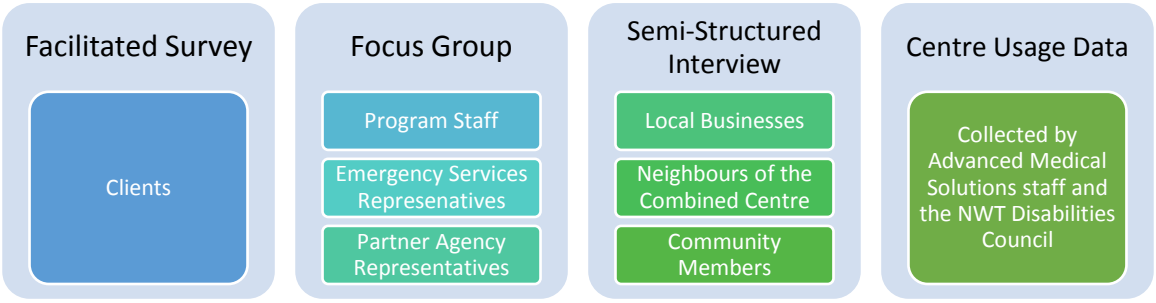
Table 1: Overview of data collection by evaluation objective

Objective	Sources of Data	Data Collection Methods
Understanding best practices integrating services for vulnerable populations	Academic and Grey literature Key Program Documents Program Staff	Environment Scan Focus Groups Interviews
Inform program development	Program Staff Service Users Program Demographic and Utilization data	Focus groups Interviews Document and/Data Review Facilitated Survey
Understand impacts of the level of service integration	Program Staff Service Users RCMP/Ambulatory/ Emergency Services Community Members	Focus Groups Interviews/Facilitated Survey
Assess the effectiveness of the level of integration	Program Staff Service Users NWT HSS staff RCMP/Ambulatory/Emergency Services Community Members Program Demographic and Utilization Data	Focus Groups Interviews/Document and Data Review Facilitated Survey
Measure perceptions of safety	Program Staff Service Users RCMP/Ambulatory/Emergency Services Community Members Program Demographic and Utilization Data	Focus Groups Interviews Facilitated Survey Document and Data review
Identify program strengths and challenges	Program Staff Key Program Documents Program Demographic and Utilization data	Focus Groups Interviews/ Document and Data Review

2.1 DATA COLLECTED AND DATA GATHERING TECHNIQUES

To effectively gather the information required for this evaluation from each stakeholder group, a range of data collection tools were developed. Additionally, a range of facilitation and data collection methods were employed ensure all participants were engaged in respectful and meaningful ways. **Figure 3** identifies the key stakeholder groups consulted and the specific methods employed to obtain information from them.

Figure 3: Data collection methods utilized



2.1.1 DOCUMENT AND DATA REVIEW

Data regarding the access and usage of the Combined Centre services was provided to DPRA through four key data sources:

- NWT Disabilities Council – Colocation Stats since Opening report (Sept 20, 2018 – December 18, 2018)
- NWT Disabilities Council – Co-Location – February 16, 2019 – May 15, 2019
- NWT Disabilities Council – Facts & Figures: Day Centre – no date
- NWT Disabilities Council – Day Centre Stats – June 2019
- NWT Disabilities Council – Sobering Centre Raw Stats – April to June 2019
- NWT Disabilities Council – Sobering Centre Raw Stats – March to May 2019
- NWT Disabilities Council – Summary of Stats Day Centre – Jan – May 2019
- Advanced Medical Solutions – Medical Support Services Weekly Report (July 17, 2017 – May 30, 2019)

Data related to the co-location statistics, client demographics, and medical support provided through AMS at the Sobering Centre was extracted from these reports.

Additionally, data related to the use of the Stanton Territorial Hospital Emergency Department was provided to DPRA through the following sources:

- Stanton Territorial Hospital Emergency Department: Utilization for Alcohol Abuse – Pre and Post Sobering Centre Opening: Year One Results (July 17, 2017 to July 16, 2018)
- Stanton Territorial Hospital Emergency Department: Utilization for Alcohol Use – Interim report for April 2014 – February 2019

The reports covered varying time periods and the data was reported at an aggregate level.

2.1.2 STAKEHOLDER ENGAGEMENT

The following sections describe the methods which were used to engage with each set of key stakeholders, as depicted above. The data collection tools used to conduct all engagement can be found in **Appendix B**.

In-Person Facilitated Survey

In order to gather data from Combined Centre clients in a respectful and meaningful manner, DPRA worked in consultation with program staff and program administrators to determine the best method of engaging this population. In-person facilitated surveys were conducted with clients in a private space at the Combined Centre facility. Posters were distributed to the Combined Centre and posted to advertise

about the facilitated survey. Clients were able to sign-up to participate in the evaluation, if they were interested, with the Combined Centre's Program Coordinator. Clients were offered grocery store gift cards as honoraria for participating in the evaluation. To ensure clients were respected and felt safe when completing the survey, staff discussed the nature of the evaluation ahead of time and facilitated interactions between the clients and the evaluation team. Surveys were conducted in a similar fashion to informal, short interviews, with clients offered a range of response options based on their level of comfort. Surveys were carried out with varying degrees of length and detail depending on the comfort level of the client and all clients were compensated for their participation.

Focus Groups

Focus groups were conducted with program staff, emergency services representatives and partner agency representatives as a time-efficient way of gathering multiple opinions and perspectives at once while also facilitating open discussion and communication between individuals with similar levels of experience with the Combined Centre. Detailed notes were taken throughout all focus groups, compiled, triangulated and analyzed in the evaluation project.

Semi-structured Interviews

In order to allow for as many individuals to provide input into the evaluation, DPRA conducted several one-on-one semi-structured interviews with individual stakeholders. While on-site in Yellowknife, the evaluation team conducted informal interviews with local business employees and owners and community members regarding their perceptions of the Combined Centre. Interview questions were developed for the interviews in order to initiate discussion and prompt the participants, if necessary. However, the evaluation team allowed participants to guide the discussion depending on their level of familiarity and their opinions regarding the Combined Centre.

In consultation with the NTHSSA, DPRA scheduled interviews with several neighbours of the Combined Centre in which participants were able to provide feedback and insight into as few or as many aspects of the Combined Centre as they wish. Once again, a semi-structured style was used to prompt participants while also allowing them to discuss any issues they wanted to raise. Detailed notes were taken throughout all interviews, compiled, triangulated and analyzed in the evaluation project.

2.1.3 ENVIRONMENTAL SCAN

In order to understand the broader context concerning the level of integration within centres across Canada that provide similar services to vulnerable populations, DPRA conducted an environmental scan prior to the start of this evaluation. The scan aimed to examine the different levels of integration of harm reduction, housing, and other services for vulnerable persons. The findings collected from this scan were presented in a separate report; however, as the scan supported lines of inquiry in this evaluation, the report has been included as an appendix to this report and can be found in Appendix A. Additionally, some major findings from the environmental scan report have been integrated into this report and used to support the key considerations.

The scan was conducted by performing a desktop scan of centres across Canada which offer temporary, short, and long-term shelter for vulnerable populations. Results were compiled and compared across jurisdictions according to levels of integration of services and the range of services offered. Sources reviewed in this scan included centre websites, academic articles and publications, and publications by non-profit and public health agencies.

2.2 RESPONSE RATES

The response rates for participation in the stakeholder engagement activities are located in **Table 2**.

Table 2: Response rates by stakeholder group

Stakeholder	Target	Response Rate	Date Collected
Program Clients	Between 15 and 30 clients of the Day Shelter and/or Sobering Centre	45 clients	April 25 and 26
Program Staff	One focus group of 10-15 staff members	One focus group with 13 staff members	April 24
Community Members	Up to 8 individuals	11 individuals	April 23-26
Partner Agency Representatives	One focus group involving representatives from partner agencies: • RCMP; • City Fire Department and Emergency Services; • Advanced Medical Solutions; • Stanton Emergency Department	Two focus groups: • Emergency Response Representatives • Shelter and Wellness Groups Four interviews	April 23 – 30

2.3 LIMITATIONS

Throughout this evaluation, a variety of methodological challenges were encountered that have the potential to limit the overall validity of the findings and the subsequent key considerations put forth. Each limitation is identified and described in **Table 3**. It is important to note that as a result of the data limitations identified below, specifically usage and intake, DPRA recommends that interpretations based on the data presented in the report be considered with caution.

Table 3: Limitations impacting evaluation

Limitation	Description
Availability of Stakeholders	• Data collection for this evaluation took place over a short period of time. While every effort was made to engage with identified representatives of specific stakeholder groups in person in Yellowknife or via telephone, some stakeholders were unavailable. The inability to connect with all identified stakeholders means that information relevant to the evaluation was only obtained from a small group and may not be indicative of the experiences and opinions of other stakeholders who were unable to take part in the engagement process. For example, no representatives from Stanton Emergency Department were engaged in the evaluation due to limited availability and while several Combined Centre staff members were engaged, it may not have been a representative sample of all program staff. • Engagement with clients of the Combined Centre was limited to a few days in which the DPRA team could conduct data collection onsite. The number and range of clients engaged was limited based on the willingness of clients to participate and their availability during the data collection time period. While DPRA had more client uptake than might have been anticipated given the

	timelines and the target population, information was only collected from a small number of clients and as such cannot be considered representative of the entire population accessing services at the Combined Centre.
Vulnerability of Clients	• Given the vulnerable population that uses the Day Shelter and Sobering Centre and the potential for high levels of intoxication with the target audience, special considerations regarding how data would be collected from the target audience were made to ensure respectful and ethical data collection. • In an attempt to engage clients when they were sober and could provide verbal consent to participate in the evaluation, data was collected early in the morning when the Day Shelter opened (7am – 10am) and before the liquor store opened which may have resulted in the DPRA team not having captured a representative sample of the service users (i.e., those that access the services at other times in the day). • As described above, to collect data from centre clients in a manner that was respectful and understanding of the context in which the evaluation was operating, time spent with each client was limited. As such, limited or partial data was collected from some clients.
Quantity of Usage and Intake Data	• Limited Combined Centre usage and intake data restricted the range of analysis DPRA was able to conduct. • A Microsoft Excel file of client demographics for 69 clients was provided to DPRA; however, based on the average monthly intake at the Sobering Centre, a sample size of over 248 is needed to be representative of the broader population.
Quality of Usage and Intake Data	• Lack of detailed, comprehensive usage and intake data for the Centre limited the depth of analysis DPRA was able to undertake for this evaluation. Specifically, daily data was presented at an aggregate level which limits DPRA's ability to report on the total number of unique individuals the Day Shelter is serving. • Variability in how data was being reported each month creates limitations in how analysis can be conducted. In April and May 2019, the Day Shelter individual and access data was reported as a daily total, whereas the data from November 2018 to March 2019 was broken down by AM and PM. For total accesses, the AM and PM could be added together. However, for 'individual clients', it is currently unknown if the individual clients in the AM are different than the 'individual clients' reported in the PM, so the total number of 'individual clients' accessing the Day Shelter is unknown. • Data inaccuracies were present in the Combined Centre's usage and intake data. For example, the total number of monthly intakes in September for the Sobering Centre was lower than the combined number of males and females accessing the Sobering Centre in the same time period.
Time Periods of Data Sets	• Because the AMS Medical Report provided aggregate level data from the period of July 2017 to May 2019, DPRA was not able to extract data specific to the period under review for the new Combined Centre.

3.0 FINDINGS

This section presents an overview of the key findings from all lines of evidence. The findings are presented according to the five (5) key objectives of the evaluation:

- Best Practices in Integrating Services for Vulnerable Populations
- Program Development:
    - Day Shelter and Sobering Centre Usage
    - Services Provided
    - Program Accessibility
    - Target Population Reach
    - Program Perceptions
- Impacts and Effectiveness of Service Integration
- Perceptions of Safety

3.1 BEST PRACTICES IN INTEGRATING SERVICES FOR VULNERABLE POPULATIONS

As part of this evaluation process, DPRA conducted a brief environmental scan of best practices in service integration amongst programs that serve vulnerable populations similar to those that the Combined Centre services. The objective of this scan was to understand current best practices in serving vulnerable populations and determine the ideal level of integration of services.

Findings from this brief environmental scan indicate that there are several different types of integrated service delivery models with a plethora of services that are offered to meet the needs of vulnerable populations, particularly those that experience substance dependencies. To understand the ideal level of integration, it is necessary to understand the various types of integrated delivery models that could be considered. Additionally, it is important to consider the benefits and hindrances to implementing various models of integrated service delivery to identify potential opportunities and mitigate potential barriers early in the planning process.

This section includes a summary of the major findings from DPRA's brief scan that identifies the types of integrated delivery models, the benefits and hindrances, as well as the types of services that are required by vulnerable populations and often included in integrated service models. The complete report can be found in *Appendix A*.

3.1.1. TYPES OF INTEGRATED DELIVERY MODELS

When considering levels of integration, there are various programs across Canada that incorporate multiple services and supports within a single agency or facility to decrease access barriers to necessary services for vulnerable populations. Depending on the agency, target audience, and other community resources available, service centres may offer different combinations of services and integration levels. From the results of the scan of existing integrated and co-located services, three main types of delivery models were revealed:

1. Partial Integration: Community Health and Harm Reduction Models: programs that offer some or all of a range of services including: basic health care, case management and counselling, and harm reduction programming.

2. Partial Integration: Housing and Harm Reduction Models: programs that offer a variety of housing supports with harm reduction services embedded into housing options.

3. Fully Integrated: models that provide harm reduction, housing and health and social services that wrap around an individual.

When considering types of integrated service delivery models, it is necessary to consider what services are currently available to the target population, what barriers exist in accessing the services, and how integrating and co-locating services could decrease barriers to access. Understanding the context of the current landscape of available services and service utilization is important when considering what and how service delivery could be integrated. In large urban centres like Toronto, Vancouver or Calgary, there are multiple agencies offering varying levels of service integration and co-location to meet the specific needs of vulnerable populations. Not all services are integrated because there may be more options and opportunity for partnerships and referrals within the service landscape in these cities. When considering the context of Yellowknife, it would be important to understand what gaps currently exist in service delivery and how they could increase access to necessary services through an integrated model to increase low-barrier access to services.

3.1.2. BENEFITS OF INTEGRATING SERVICES

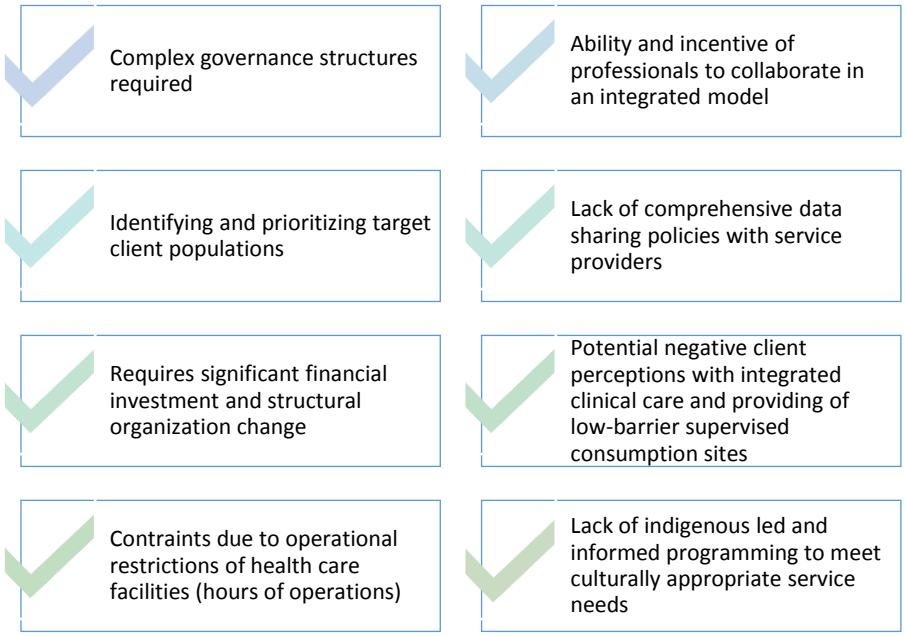
Based on the findings of DPRA's scan, there are several benefits to the integration of services for vulnerable populations, including:

- Potential to address multiple underlying issues simulatenously
- Reduce costs of delivering support and care
- Improves access to services for vulnerable populations that often experience barriers to services
- Facilitates a shared-care approach where care teams can share information and knowledge
- Increase cooperation and collaboration between provders and agencies
- Improvements in service quality, client satisfaction, and client outcomes

These benefits, as they relate to the Combined Centre, are referenced later on in this report.

3.1.3. FACTORS THAT HINDER INTEGRATION OF SERVICES

Despite the benefits of integration listed above, there are several factors that hinder the effective implementation of integrated models. Such factors need to be considered and mitigation efforts be put in place to promote the success of an integrated service delivery model. Some of the hinderances related to integrating services for vulnerable populations that may need to be considered include:



Improvements in the delivery of integrated services for vulnerable populations are also hindered by the lack of evaluations that report of the effectiveness, efficiency and outcomes of service delivery.[3] Some of these factors, as they relate to the Combined Centre, will be discussed below.

3.1.4. SERVICES OFFERED IN CO-LOCATED OR INTEGRATED MODELS

It is evident in the literature that individuals in vulnerable populations face a multitude of barriers in accessing services and supports and navigating the health and social system to seek appropriate and timely care when needed[1]. Co-located and/or integrated centres can offer a variety of services that are necessary for vulnerable populations but often are associated with high barriers to access. Through the scan of existing integrated service models across Canada, there were many programs that are designed to target specific programming areas including housing, health care, harm reduction and counselling.

As described previously, fully integrated service models include elements of all four of these programming areas to be able to provide the most vulnerable populations with low-barrier access to a full continuity of care. Different combinations of the services listed below can be provided depending upon the size, infrastructure, and resources available to each program:

[3] OECD (2015), Integrating Social Services for Vulnerable Groups: Bridging Sectors for Better Service Delivery, OECD Publishing, Paris, https://doi.org/10.1787/9789264233775-en.

Housing	Harm Reduction	Health Care	Counselling
•Emergency Shelters •Temporary Housing •Transitional Housing •Long--term housing	•Sobering/Detox Centres •Managed Alcohol Programs •Safe Injection Sites •Overdose Prevention Sites •Needle Exchange	•Primary Care •Triage services •Dental •Disease prevention •Public Health •Referrals	•Case management •Support Groups •Individual/ Group Therapy •CBT/DBT •Recovery Programs

Currently in the existing co-located model, the Combined Centre offers emergency shelter for intoxicated individuals through the Sobering Centre, as well as case management support, and basic primary medical assessments and triage. The Combined Centre also provides some basic needs services, such as food, clothing, showers, bathrooms, and access to telephones, all of which contributes to their own wellbeing.

3.2 PROGRAM DEVELOPMENT

This section provides an overview of the current state of the Combined Centre as it relates to program development. The information presented in this section of the report is intended to assess how often clients are accessing the centre, which services are being used the most by clients, and how accessible the centre is for those it is intended to serve and those that are seeking it out. The results of this analysis can inform future programming needs for the service delivery contract, as well as for any future centre.

3.2.1 DAY SHELTER AND SOBERING CENTRE USAGE

Since the opening of the Combined Centre, the NWT Disabilities Council has collected statistics regarding the number of clients entering and leaving the Day Shelter and the number of intakes conducted at the Sobering Centre as reported in the Co-Location Reports indicated in the methodology section. This information can provide insight into the level of client volume that a permanent Centre, like the Combined Day Shelter and Sobering Centre, may need to support.

3.2.1.1 Day Shelter

The number of individual clients[4] accessing the Day Shelter and total number of accesses[5] have been collected and reported by the NWT Disabilities Council on a daily basis[6]. To present an approximation of the number of daily accesses to the Day Shelter, **Figure 4** displays the average number of accesses in the morning and afternoon for each month from November 2018 to March 2019. **Figure 5** illustrates the average number of individuals accessing the shelter on a daily basis.

[4] 'Individual clients' refer to the number of discrete individuals who have accessed the shelter in a given time period.
[5] 'Total number of access' refers to the total number of individuals accessing a shelter in a time period, including individuals who access the shelter multiple times in a month.
[6] Data regarding unique individuals accessing the Day Shelter on a monthly basis is unavailable as unique individuals are not tracked day by day.

Figure 4: Number of Total Monthly Accesses for Day Shelter Between November 2018 to May 2019

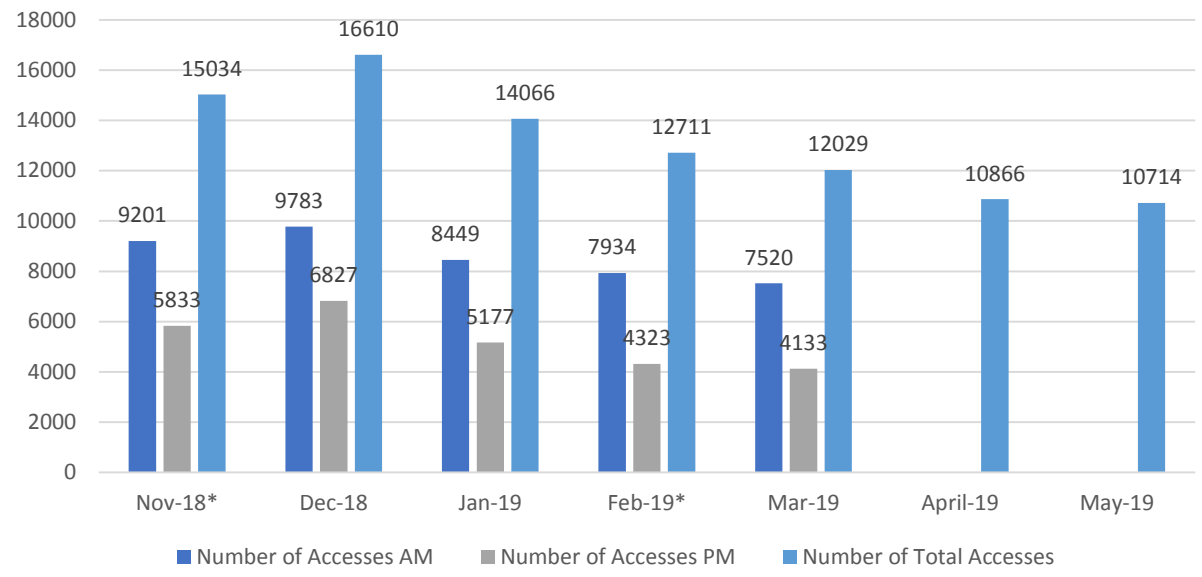
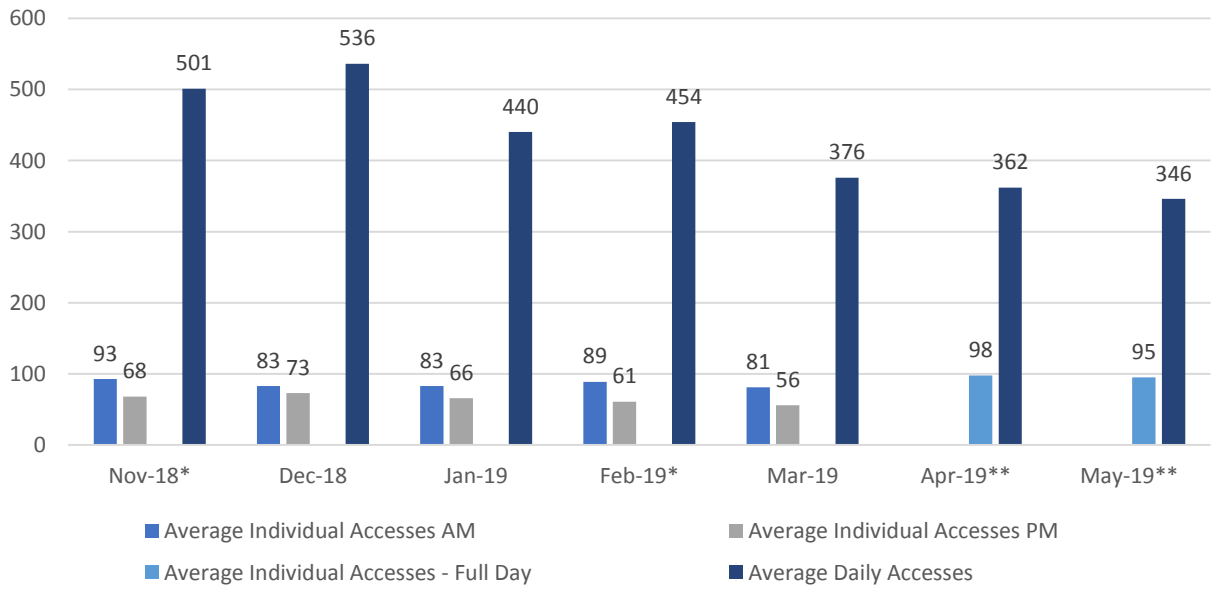


Figure 5: Daily Average Number of Individual Clients Accessing the Day Shelter and Average Number of Total Daily Accesses Between November 2018 to May 2019



*Indicates months in which there was no access data for one or more days.
** Indicates months in which the data that was not broken down by AM and PM

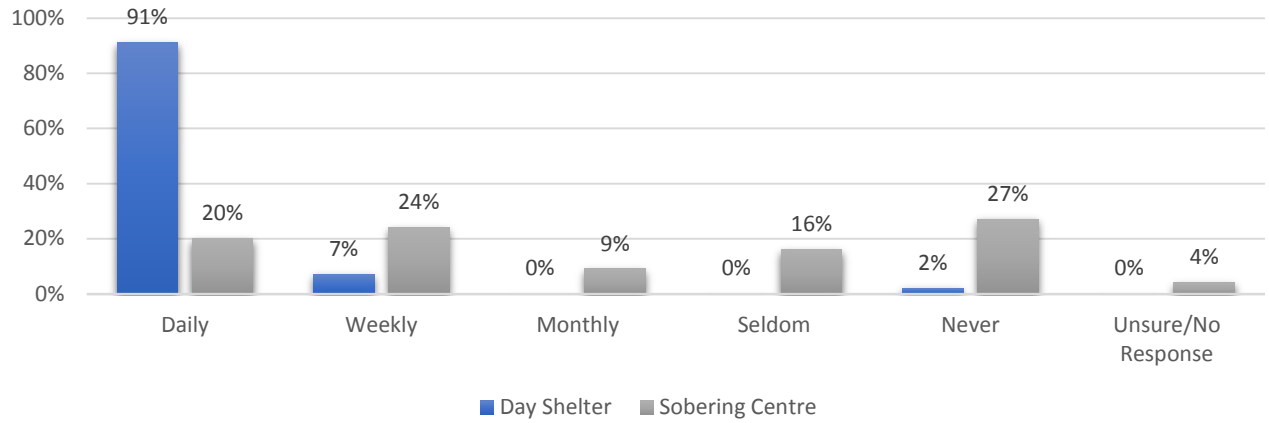
Between November 2018 and March 2019, on average, there were as many as 93 accesses to the Day Shelter during the morning and as many as 73 during the afternoon, per day[7]. The data does not indicate

[7] Data on individual clients accessing the Day Shelter was not captured by AM and PM, so is presented as total number of individual clients accessing

if those individuals accessing the Day Shelter in the AM are the same individuals accessing the Day Shelter in the PM, therefore, it is unclear how many 'individual clients' actually accessed the Day Shelter on a daily basis between November 2018 and March 2019.

As identified in the data provided by NWT Disabilities Council, between November 2018 and May 2019 there were as many as 16,610 total accesses in one month (December 2018) (refer to **Figure 5**). The large difference between the 'individual clients' and 'total number of accesses' reflects a high rate of clients returning to access the Day Shelter on the same day (i.e., a client may access the Day Shelter in the early morning, leave, and then access the Shelter again in the afternoon, or, they may come and go multiple times throughout the day, each time resulting in a new access record). This was supported by the findings from the facilitated survey (see **Figure 6**) with clients where almost all respondents (91%) stated that they access the Day Shelter on a daily basis. Due to the limitations of the data, it was not possible to identify the rate of clients that are return service users.

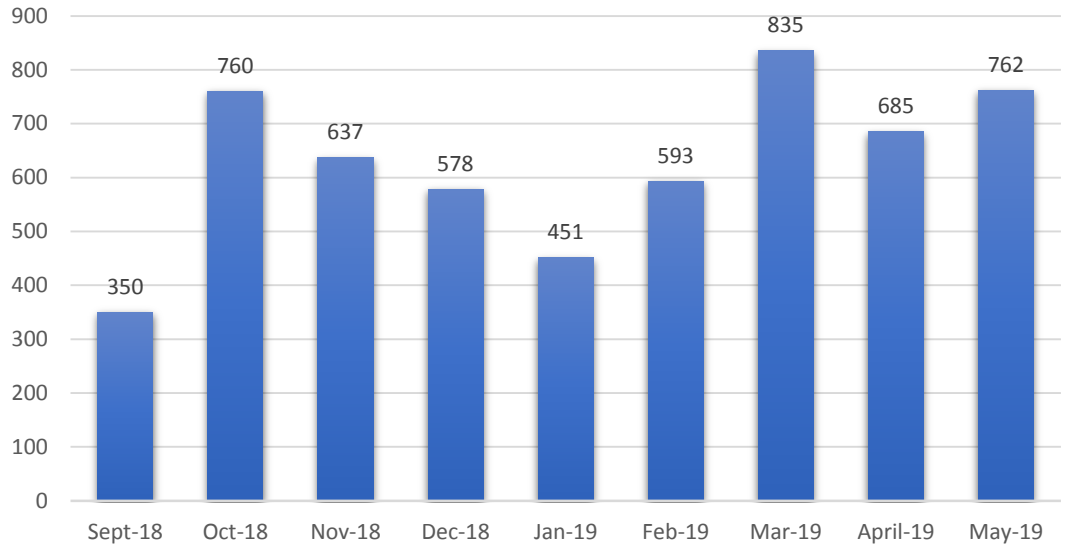
Figure 6: Surveyed clients self-reported frequency of accessing Day Shelter and Sobering Centre



3.2.1.2. Sobering Centre

Figure 7 below displays the number of intakes recorded by the Sobering Centre between September 2019 and May 2019. The Sobering Centre has 27 beds available, so if each bed is used once every night, there is the potential for 810-837 intakes per month, depending on the number of days in each month. Based on this range, the best utilization rates the Sobering Centre has had since opening in the Combined Centre was 99.76%, in March. However, the Sobering Centre beds may be used multiple times over the course of a 24-hour period by different clients depending on when the bed is being accessed. Some clients may access a Sobering Centre bed in the afternoon and again in the evening which may impact the overall utilization rates.

Figure 7: Number of intakes to Sobering Centre between September 2018 and May 2019



[8]

The clients surveyed at the Day Shelter stated that they access the Sobering Centre less often than the Day Shelter, with 44% stating they access the Sobering Centre weekly (24%) or daily (20%), and 43% stating they access it seldom (16%) or never (27%) as shown in **Figure 6** above. When clients were asked why they did not access the Sobering Centre, there were two themes that emerged: (1) the clients did not use intoxicating substances so could not access the service; and, (2) clients had other safe places to stay. These findings support the understanding that the Day Shelter and Sobering Centre have slightly different target audiences as discussed in **Section 3.2.4** below.

It was reported by the NWT Disabilities Council that 46% of clients' check-in to the Sobering Centre between 8:00pm and 12:00am. Not only does this time period represent the most consistently high volume each day but it is also the time period in which there is an increase in the volume of medical assessments conducted by AMS. The AMS data also indicated that since the opening of the Combined Centre there have been increased medical screenings between 10:00am and 2:00pm as well. These findings indicate that there is a continued need for medical services to be available at the Combined Centre. Additionally, based on these findings and the reports from clients through the facilitated survey, it appears that the AMS services provided at the Centre are perceived as being more accessible than a standard clinic setting due to the familiarity with the staff and the location within the Day Shelter and Sobering Centre.

3.2.2 SERVICES PROVIDED

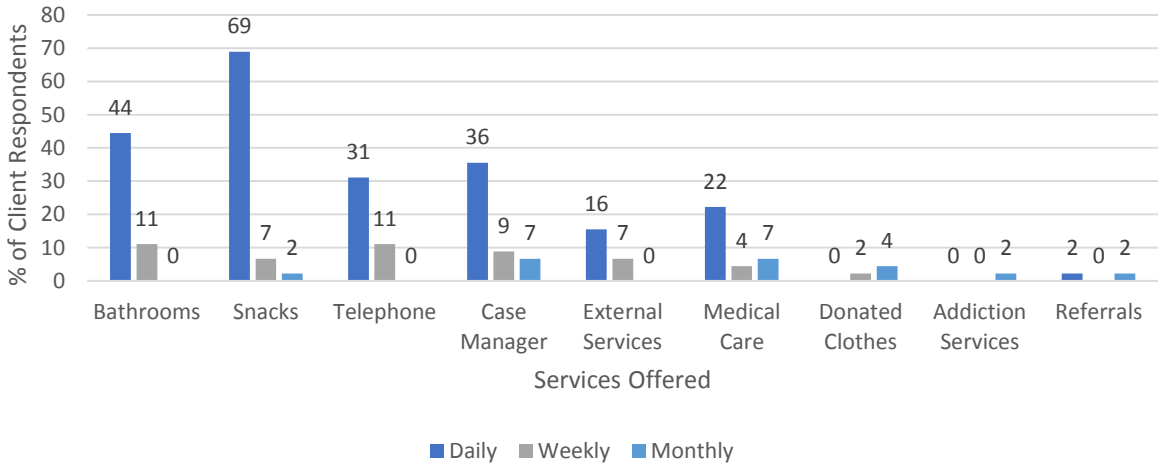
Because the services are provided by the NWT Disabilities Council, they recognize that addiction is not a choice but consider it a disability that requires special care and support to help those living with addiction to improve their quality of life and wellbeing.

[8] Please note that Sobering Centre intake data was compiled from multiple sources of data provided by NTHSSA. In some cases, total number of intakes was calculated by combining intake numbers via all modes of arrival in a month and subtracting the number of turnaways in that same month. Additionally, in some cases the total number of arrivals in a month was not the same as the total number of both males and females in that same month. This may reflect the fact that some clients refused to state their gender in the intake process.

3.2.2.1 Client Self-Reported Service Use

Respondents of the facilitated survey were asked to identify how often they use each of the services offered through the Combined Centre. The frequency of use for each of the services provided as identified by the clients is displayed in **Figure 8.**

Figure 8: Percentages of Clients Reporting Use of Combined Centre Services at least 'monthly'



The majority of clients reported that they use the basic services like bathrooms and meals/snacks at least once a week. The case management services were also reported to be used on a regular basis with over half of the respondents reporting using this service at least 'monthly' due to the helpfulness of the service and the staff. External services visiting the Combined Centre, like outside programs or public health, and medical care are the other services that are used at least 'monthly' by some clients of the Combined Centre. Many clients were unaware of the external services, or reported that they were offered infrequently, which led to their reported lower update in these services.

3.2.2.2 NWT Disabilities Council Reported Service Use

In addition to the clients' self-reported frequency of service use in the facilitated survey, the NWT Disabilities Council collects statistics regarding the frequency of use of several of the services provided by the Day Shelter. **Figures 9 and 10** display the frequency with which these services were accessed between October 2018 and May 2019.

Figure 9: Frequency of meal access October 2018 to May 2019

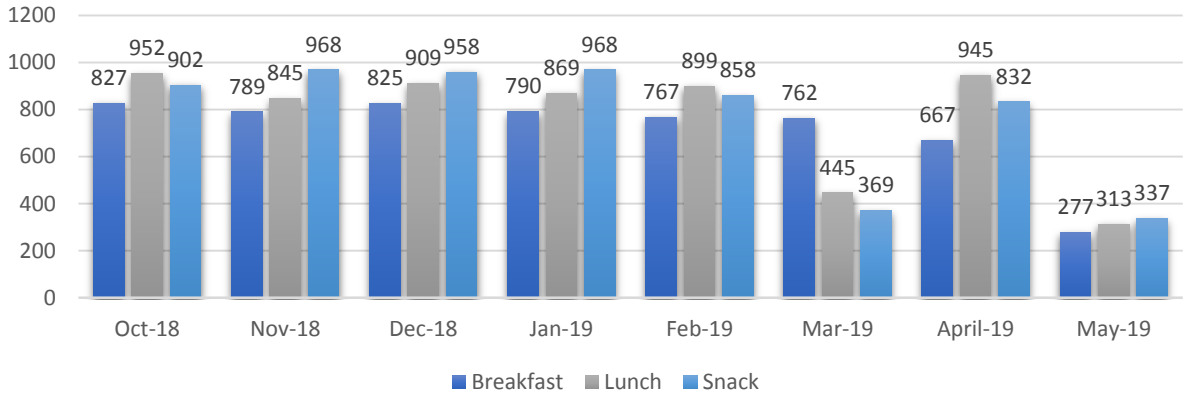
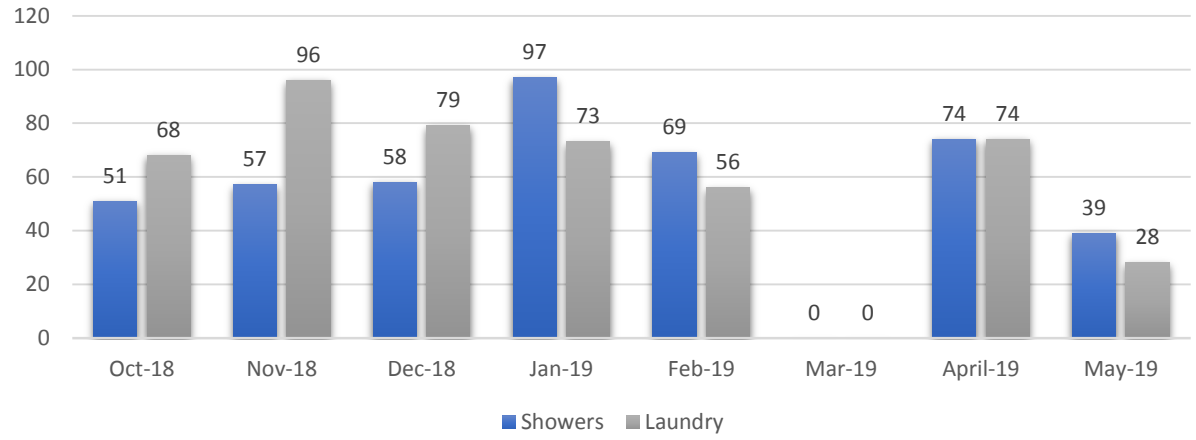


Figure 10: Frequency of service use October 2018 to May 2019



Considering the reported daily average numbers of the unique individuals accessing the Combined Centre which ranges from 81-93 clients in the mornings and 56-73 clients in the afternoons (refer to **Figure 5**), it seems like the shower and laundry services have fairly low uptake by many of the Combined Centre clients.

Food provided by the Combined Centre appears to have a much higher uptake than the other services tracked with more lunches being served than breakfast during most months. In the facilitated surveys, several clients reported that they use the Combined Centre, even though they may have adequate housing, because they cannot afford food. Several of those clients who reported having adequate housing also noted that they have access to their shower and laundry, so those services are not needed. This may provide insight into why the meals are being accessed at a much higher rate than the shower, laundry and donation services.

3.2.2.3. Case Management Services

Almost all clients and staff stated that the Case Manager is one of the most commonly used and valued resource. Almost all clients who have accessed the Case Manager described the experience as positive. According to surveyed clients and usage data collected by the NWT Disabilities Council, clients accessing the Case Manager receive support with the following:

- Obtaining birth certificates
- Guarantor declarations
- Applying to educational institutes
- Obtaining health and ID cards
- Developing resumes
- Seeking counselling
- Scheduling appointments
- Obtaining letters of support

Many clients and staff stated that the support provided by the Case Manager has allowed clients to advocate for their needs and improve their wellbeing. These services, in addition to the harm reduction services provided by the centre, allow clients to achieve some of the short- and long-term outcomes related to independence and wellness, as depicted in the program's logic model (see **Appendix C**). A commonality across many co-located and integrated service models across Canada is the inclusion of

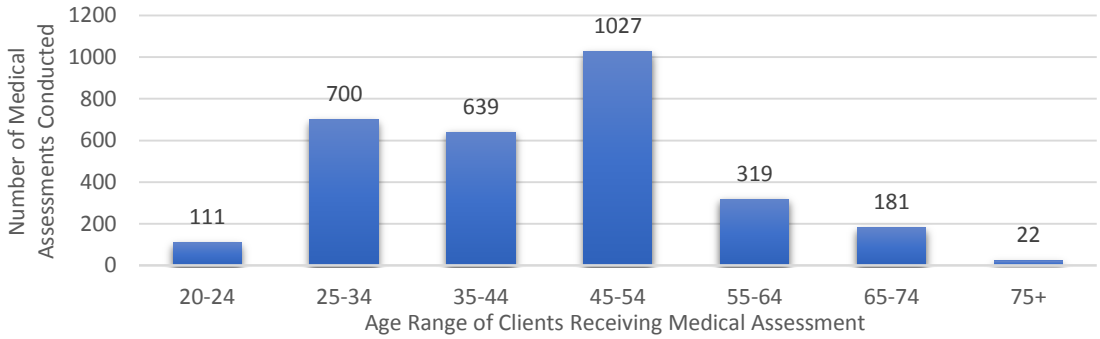
case management services.[9] Case management is a core aspect to providing ongoing support to individuals to help them navigate the health and social systems to access appropriate and timely services and supports.

3.2.2.4. AMS Medical Services

Since the opening of the Combined Centre, there have been on average 23 medical screenings completed per day of clients at the Sobering Centre as reported by AMS with a total of 2,999 screenings between October 1, 2018 and February 28, 2019. The 2019 AMS Report stated that since the opening of the Combined Centre, medical screenings related to wellness checks, medical consultations and wound management have increased. In considering programming for any future planning, access to a range of medical services should be embedded in the mix of programming provided.

Data provided by AMS shows the age breakdown of Sobering Centre clients that access medical assessments as seen in **Figure 11**.

Figure 11: Number of clients receiving medical assessments by age range



3.2.3 ACCESSIBILITY

In order to determine the accessibility of the Combined Centre for clients, the evaluation identified how clients access the Combined Centre, any barriers or challenges they may encounter when attempting to access the Combined Centre, as well as client perceptions of the current location of the Combined Centre.

3.2.3.1. Accessing the Combined Day Shelter and Sobering Centre

The majority of stakeholders indicated that the Combined Centre was accessible for clients who need it and when they need it. This finding is supported by the high volume of individual and total visits to the Combined Centre. Clients that participated in the survey were asked a series of questions about any barriers they may have encountered when entering the Combined Centre in order to provide greater context surrounding their perception of accessibility. Most clients indicated that they experienced little to no barriers accessing the Combined Centre. As shown in **Figures 12 and 13**, 82% of clients surveyed stated that they can access the Day Shelter when they need to and 66% stated neither they nor anyone they know have experienced a time when they couldn't access the shelter.

[9] Tunstall, L., & McIntyre, S. (2014). Effective practices on collaboration between affordable seniors' housing providers and mental health service providers. Retrieved from: https://caryacalgary.ca/wp-content/uploads/2014/12/OASPOC-Final-Report-Oct-2014.pdf

Figure 12: Client self-reported ability to access Day Shelter

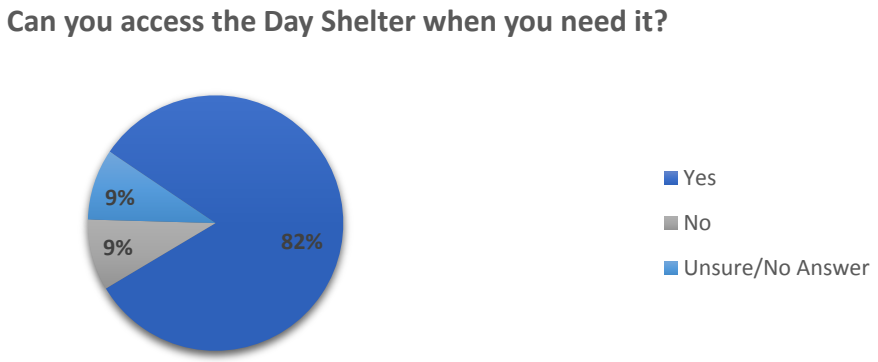
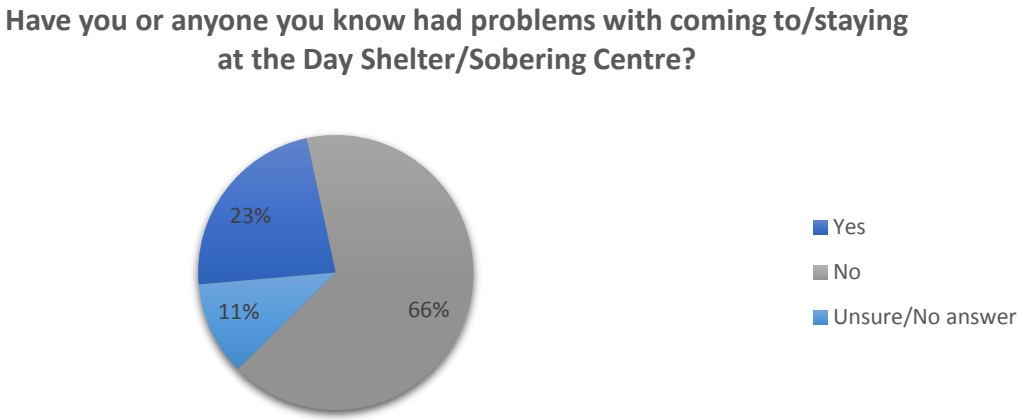


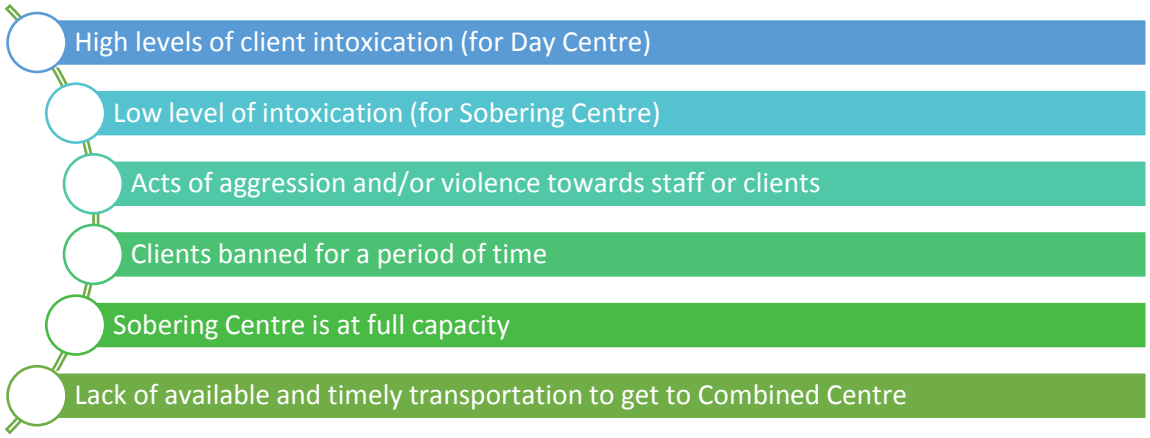
Figure 13: Client self-reported problems with coming to or staying at the Combined Centre



3.2.3.2. Barriers to Accessing the Combined Day Shelter and Sobering Centre

When problems with accessing the Combined Centre were identified, respondents (clients, staff and partner agency representatives) were asked to elaborate on the circumstances in which individuals are unable to access the Combined Centre. Across the various stakeholder groups, there were several key themes that emerged as seen in **Figure 13.**

Figure 13: Themes identified by stakeholders related to barriers accessing the Combined Centre



The most frequently identified issues by clients were related to high level of intoxication and aggression/ violence. This finding was supported by staff who reported asking clients to leave the Day Shelter if they were getting aggressive or violent. When asked to discuss the practice of banning clients, some staff noted that there are instances in which clients are banned temporarily from the Day Shelter due to previous incidences of violence or overly aggressive behaviour towards staff or other clients.

Alternatively, there were reports from clients and staff that clients were unable to access the Sobering Centre because they were not considered intoxicated (or intoxicated enough). These reports are supported by the turn-away data for the Sobering Centre provided by NWT Disabilities Council (refer to **Figure 15**). There were concerns regarding this particular practice as it was viewed as promoting intoxication in order to obtain safe shelter.

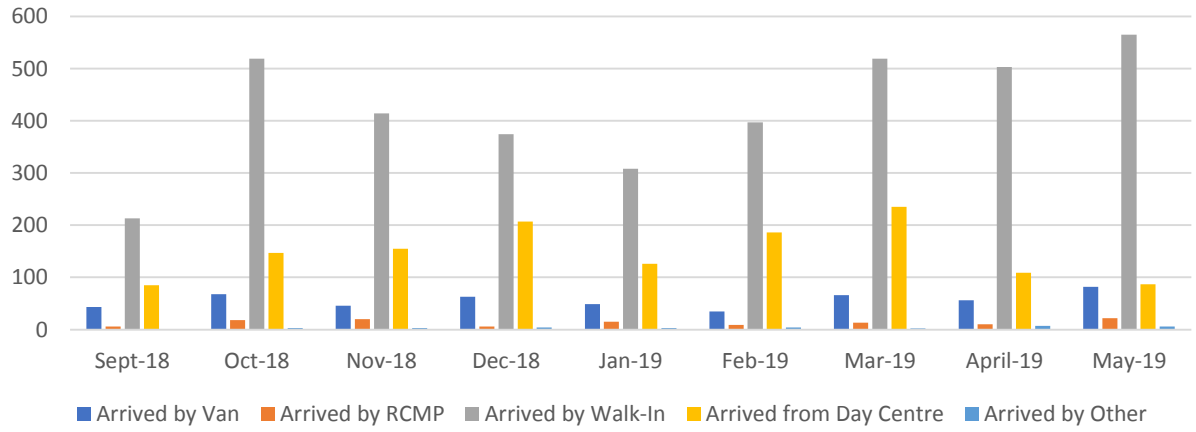
An additional challenge to accessing the Combined Centre is that clients may be too far away to walk and may need to rely on the availability of the Street Outreach van to take them to the Combined Centre. Staff suggested that this is a potential barrier that could be addressed through partnerships with other services (see **Section 3.2.5.1**. for further details).

3.2.3.3. Mode of Arrival to Access the Sobering Centre

The NWT Disabilities Council collects data on the mode of arrival for clients accessing the Sobering Centre **Figure 14** shows the results of the mode of arrival data collected from September 2018 to May 2019.

In the first four months following the opening of the Combined Centre, most clients accessing the Sobering Centre arrived by walking in. The number of clients arriving by other methods fluctuated over the months, with the number of clients arriving via walk-in representing the majority of clients in all months. The second largest proportion of clients are received in the Sobering Centre from the Day Shelter. Anecdotally, it was reported that often Day Shelter clients who are highly intoxicated will be brought over to the Sobering Centre by the staff, so that the client can sleep off the effects of intoxication in a safe place.

Figure 14: Client mode of arrival at Sobering Centre September 2018 – May 2019[10]



[10] Based on this data, DPRA has interpreted that the "van" mode of arrival refers to the Street Outreach Program, currently operated by the Yellowknife Women's Society.

3.2.3.4. Data Supporting Turn-aways from the Sobering Centre

The NWT Disabilities Council also collects data on the number of clients turned away from entering the Sobering Centre. A total of 543 turn-aways occurred between the opening of the current Sobering Centre and February 2019. This represents approximately 15% of those trying to access the Sobering Centre (n=3489) in the same time period. **Figure 15** presents the four most common reasons for turning away clients.[11]

The most common reason for clients to be turned away from the Sobering Centre during the months of September through to October 2018 was sobriety. Without further context regarding the reasons why sober clients were attempting to access the Sobering Centre, it may be safe to assume that many sober individuals in Yellowknife are attempting to secure safe overnight shelter at the Sobering Centre.

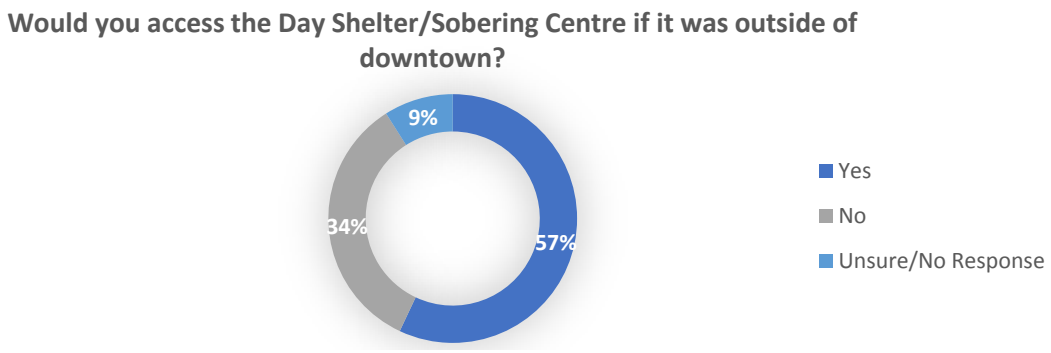
Figure 15: Reasons for, and Percentage of, client turn-aways by Gender, September to December 2018

Client was sober	•48% of male turnaways •24% of female turnaways
Client left on their own	•19% of male turnaways •34% of female turnaways
Client was aggressive	•6% of male turnaways •4% of female turnaways
Client was restricted from centre	•6% of male turnaways •5% of female turnaways

3.2.3.5. Location of Combined Centre

To assess the importance of the Combined Centre's location in downtown Yellowknife, stakeholders were asked to comment on the current location. While program staff and partner agency representatives indicated their belief that clients would not access the Combined Centre if it was outside of the downtown area, 57% of clients said that they would access the Centre (refer to **Figure 16**). Of those 57%, several clients stated that they would only access the Combined Centre outside of downtown if the Street Outreach Program van was able to provide transportation.

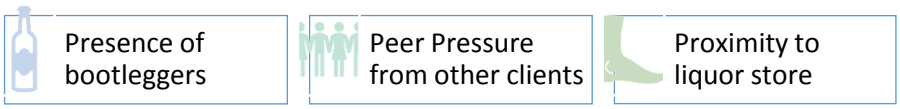
Figure 16: Client willingness to access Combined Centre outside of town



[11] Exact percentages

Of those 34% of clients who stated that they would not access the Combined Centre if it were located outside of the downtown area, most stated that the Combined Centre would be too far for them to access by walking, that they did not have any means of getting there, and that it would be too difficult for them to access in winter.

While clients perceive the Combined Centre to be a place for socializing and connecting with friends and family, it was also perceived by the clients, as well as community members and partner agency representatives, that the Combined Centre enables individuals to drink alcohol. When inquiring about reasons for how the Combined Centre enables drinking, several themes emerged as seen below.

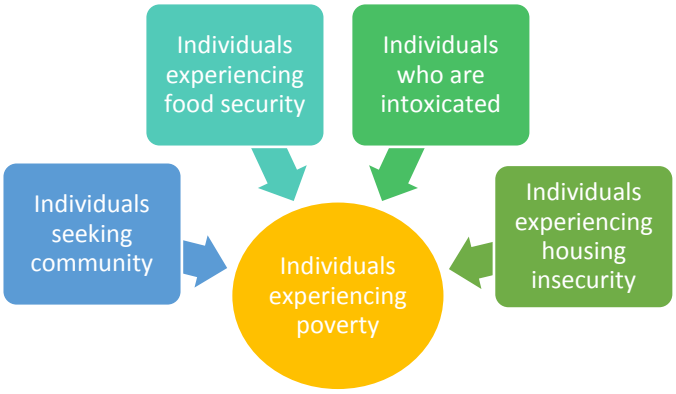


Some clients, community members and local businesses indicated their concern that proximity to the liquor store increased opportunity and access to alcohol, while others indicated that the location did not make a difference and those who desire alcohol will find means to access it regardless of the location. This belief that the location would not make a difference in clients' ability to access alcohol was echoed across multiple stakeholder groups including the program staff and partner agency representatives.

3.2.4 REACHING TARGET POPULATION

3.2.4.1. Intended Target Audiences

The Combined Centre staff, administration and key stakeholders were asked about the target population for the Combined Centre and to indicate how well they feel the Combined Centre is reaching this group. Combined Centre staff stated that the target population includes the following:



Program staff stated that while the original target audience for the Day Shelter was individuals who were severely homeless and did not have safe shelter to access during the day, it has morphed into a focus on individuals who are low-income, including individuals who have access to housing and/or employment, but still experience the impacts of poverty. Based on this understanding of the Day Shelter target audience, program staff believe that the Day Shelter is reaching their target audience. Additionally, in the interviews with clients, many clients shared that they access the Day Shelter because either 1) they were homeless and didn't have anywhere else to go, 2) they were unable to afford their own meals, and 3) they felt that the Centre provided them a sense of community, or all of the above. Given these findings, it appears that the Day Shelter is reaching the intended audience.

While many external stakeholders agreed that the Combined Centre provides valuable services to the city, many were uncertain about the actual target audience. More specifically, while the target

population for the Sobering Centre was clear to most stakeholders, the target audience for the Day Shelter was less clear. Partner agency representatives, as well as community members, are unsure if the Day Shelter is intended only for those experiencing homelessness and if intoxicated individuals are allowed in the Day Shelter.

Based on the findings from the various lines of inquiry for this evaluation regarding the intended target audience and existing barriers, it appears that the Sobering Centre and Day Shelter have slightly different target audiences. The major difference being that the Sobering Centre is strictly targeting individuals that are intoxicated and do not have a safe place to sleep while the Day Shelter is available for any individual regardless of their level of intoxication and housing status.

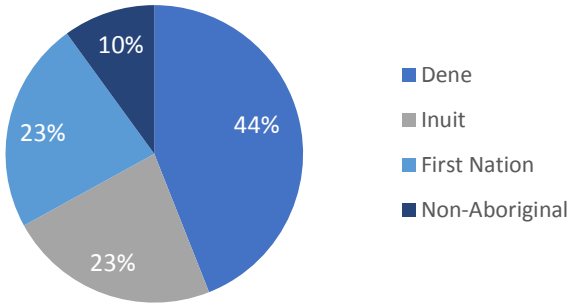
3.2.4.2. Client Demographics

The demographic data of clients accessing the Combine Centre available through the NWT Disabilities Council provides some insight into the type of clients who are accessing the services. This data can inform programming that may be prioritized in the Combined Centre to better serve the clientele. However, given some of the limitations on client demographics related to not having a representative sample of data, it should be interpreted with caution as there may be characteristics of the existing clients that have not been captured in the sample that this report is informed by. Additionally, the client data regarding food insecurity, employment status, and level of intoxication while accessing the Combined Centre is limited by the extent to which it can be reported how the centre is reaching its intended audience.

Ethnicity

Data provided by the NWT Disabilities Council also provides insight into the demographics of clients accessing the shelter. As displayed in **Figure 17**, of the 70 Day Shelter clients[12] who provided demographic information, the largest proportion of clients (44%) self-identified as Dene. Equal proportions of clients (23%) self-identified as Inuit and First Nation. The remaining 10% of clients identified as Non-Indigenous.

Figure 17: Ethnic Identity of clients accessing Day Shelter between January and May 2019



Gender

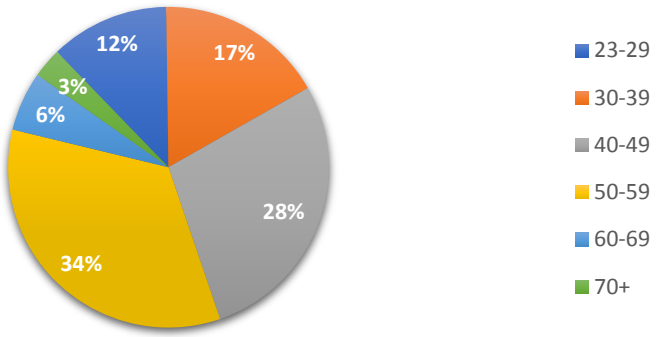
Based on the data from the NWT Disabilities Council, 72% of the clients were male and 28% were female. This breakdown was supported by reports from program staff that the majority of clients are male. However, program staff reported increases in female client in recent months and contributed the increase to building positive relationships with female clients. It was noted that the perceptions of the Combined Centre have shifted so now it is being considered a safe space for women to go to access services that may not be able to access at the Women's Shelter.

[12] This number may not be representative of all clients accessing the Day Shelter.

Age

The largest proportion of clients accessing the shelter at this time (34%) were between the ages of 50 and 59, followed by 28% who were between the ages of 40 and 49. The NWT Disabilities Council states that the proportion of individuals between the ages of 50 and 59 accessing the Centre will continue to increase due to limited housing options for seniors in Yellowknife. **Figure 18** below displays the complete range of ages of clients during this period.

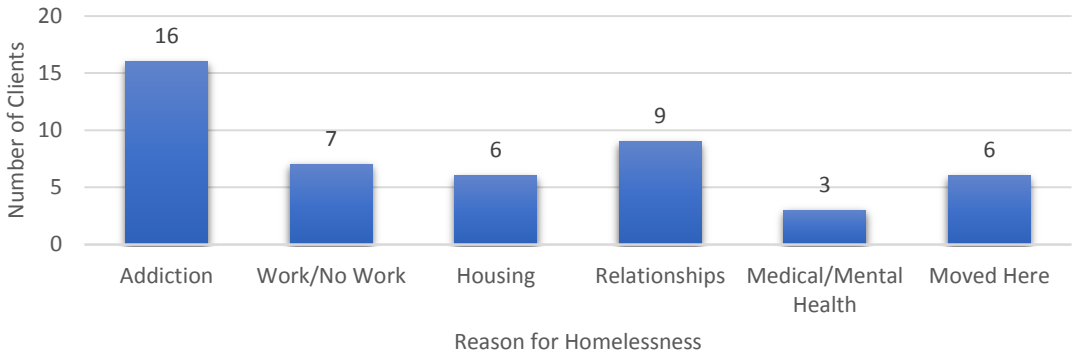
Figure 18: Proportion of clients accessing day shelter between January and May 2019 by age range



Reason for Homelessness

Of those same 70 clients, several reasons for homelessness were identified by 47 (67%) of them.[13] The most common reason for homelessness was addiction (34%), followed by relationships (19%)[14]. **Figure 19** below displays all the responses to this question.

Figure 19: Number of clients experiencing homelessness according to reason for homelessness



Additional Factors

In addition to the demographic information detailed above, the NWT Disabilities Council provided data regarding those same clients' length of time experiencing homelessness, addiction, and their time in Yellowknife.[15] As seen in **Figure 20**, the largest proportion of those clients who are experiencing homelessness (51% or 24 clients) have done so for 1-5 years. Conversely, the largest proportions of

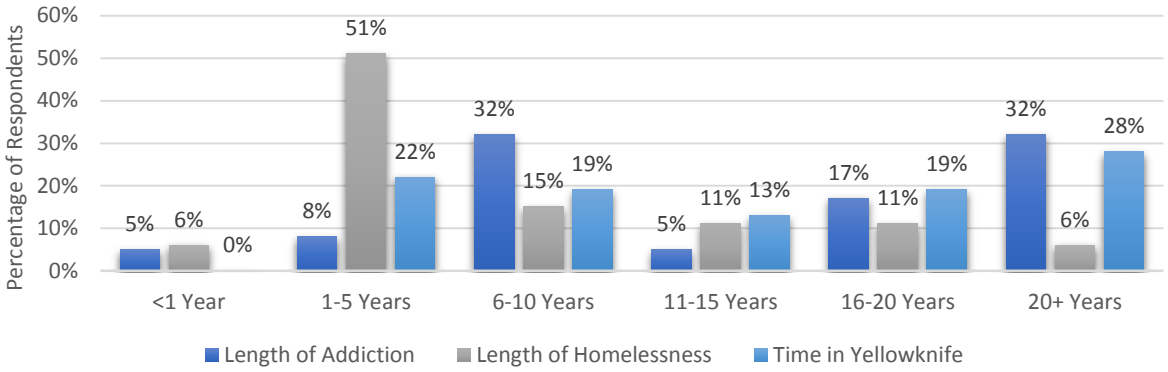
[13] Without further clarification, DPRA has assumed that the remaining 23 (33%) clients did not state that they were homeless.

[14] No further details were provided regarding what is meant by these reasons.

[15] Total respondents for each factor equal less than 70 clients. Total respondents for length of addiction were 56; 47 for length of homelessness; and 32 for length of time in Yellowknife.

those clients experiencing addictions have done so for 6-10 years or 20 or more years (32% or 19 clients each).

Figure 20: Length of time clients have spent experiencing different factors



Based on these results, just over half (51%) of clients accessing the Day Shelter have been experiencing homelessness for a few years, while most (86%) of these clients have been experiencing addiction for six years or more.[16]

The data reveals that the Combined Centre is serving their two target audience groups: 1) individuals experiencing housing insecurity and 2) individuals that are intoxicated. Beyond those specific groups, it is known that the majority of the clients are Indigenous, male, and between 40 and 59 years of age. Understanding these demographic details can help inform the development of appropriate programming and services.

3.2.5. STAKEHOLDER PERCEPTIONS OF THE COMBINED CENTRE

Across all the stakeholder groups, it was noted that the Sobering Centre services are needed in Yellowknife and that they have made a difference in the number of people who are passing out in unsafe places outdoors and are at risk of exposure-related harms.

Across the external stakeholder groups (partner agencies, emergency services, and community members), it was noted that the Combined Centre requires their staff to have more training in the area of trauma-informed care and de-escalation and management of aggressive behaviours. The increased training is considered necessary to allow staff to offer more trauma-informed services and to mitigate and respond to incidents occurring within and outside of the Centre more effectively. It was also noted by several external stakeholders that there is a greater need for security presence at the Combined Centre, particularly to monitor the activities outside of the Centre where many aggressive and violent incidents are said to occur.

Opportunity for Improvement

- Increase staffing resources and qualifications/training of Combined Centre staff to promote safety within and outside of the centre

As it relates specifically to the Day Shelter, representatives from the partner agencies and emergency services indicated that they were unclear about the Day Shelter mandate, target audience, and services

[16] As noted above, the total number of clients may not be representative of all clients who access the Day Shelter.

provided (other than providing warm shelter and meals and effectiveness. In part this lack of clarity arose due to individuals who are not homeless or street-involved are accessing Day Shelter services for what the public perceives to be intended only for the homeless population. Irrespective of the lack of clarity, it was noted that the Shelter does offer a common place to build community and access basic services, which is important.

Program staff, partner agency representatives and local community members expressed the need to improve public communication and messaging regarding the Combined Centre's mandate. Program staff emphasized that they feel there is a lot of miscommunication and misperception about the overall objective of the Combined Centre. They stated that the public is not aware of the range of services offered and that many believe the Combined Centre is an addictions treatment facility. Additionally, program staff stated that the public is not aware of the importance of building rapport and trust between clients and staff, adding that this is a long-term process which requires regular interactions over a long period of time.

Similarly, partner agency representatives expressed the need for clearer communication between the Combined Centre, partner agencies, and the general public regarding the target audience of the Combined Centre, the range of services provided, and the activities that take place within the Day Shelter.

Opportunity for Improvement	•Broad Communication and Promotion of the Day Shelter and Sobering Centre Mandates

3.2.5.1 Community Partnerships

Many internal and external stakeholders, including staff, partner agency representatives, and neighbours of the Combined Centre, emphasized the need for formal partnerships with several other community agencies in Yellowknife. While informal partnerships may currently exist between the Combined Centre and other agencies, many stakeholders stated that there is an opportunity to formalize these partnerships as several agencies have similar goals regarding harm reduction and providing a safe space for this target audience. Agencies and partnerships that were suggested by stakeholders are summarized in **Figure 21** below:

Figure 21: Potential partnerships with Combined Centre proposed by stakeholders

Street Outreach Program
•Streamline communication between agencies
•Increase communication to clients regarding transportation opportunities
•Transporting clients to outside programming
Arctic Indigenous Wellness Foundation
•Client participation in wellness programming or trips on the land
Tree of Peace Friendship Centre
•Client participation in recreation and programming
•Elder led cultural programs and activities thorugh the Day Shelter
Salvation Army and Yellowknife Women's Centre
•Streamline communication between agencies

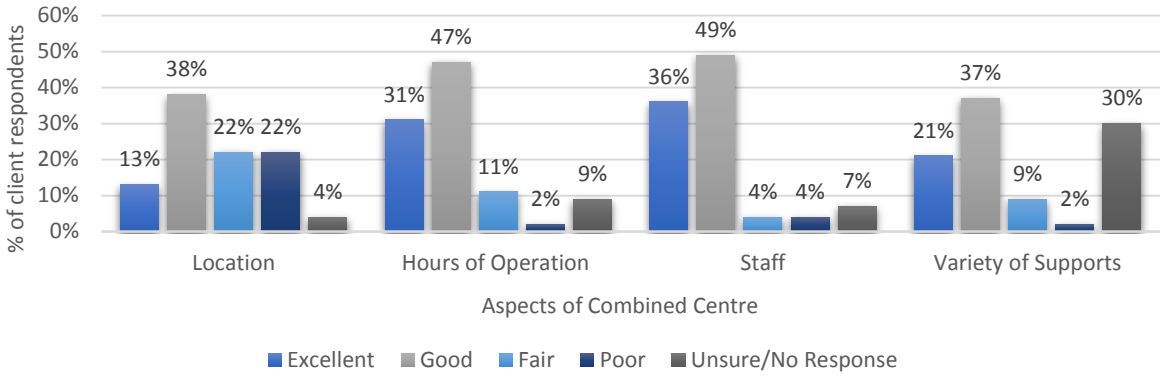
Opportunity for Improvement	•Establish more formal partnerships with community agencies

Some community members and local business owners stated that the Combined Centre is problematic for the community because it leads to the congregation of large numbers of individuals that experience substance dependencies, in part because of the proximity to the Liquor Store. Some feel that the existence of the Combined Centre and the harm reduction approach it takes promotes unhealthy and risky behaviours, including substance abuse. Business owners around the Combined Centre raised concerns about the negative effects on their business due to the decrease in perceived public safety in the area. However, businesses in other parts of Yellowknife have seen positive changes and have had fewer incidents with homeless or street-involved individuals because they congregate at the Day Shelter rather than in other pockets of the city.

3.2.5.2. Client Perceptions

Clients were asked to rate aspects of the Combined Day Shelter and Sobering Centre through the facilitated survey. Overall, clients identified most aspects of the Combined Centre to be 'good' or 'excellent'. As previously mentioned, the location of the Combined Centre was the aspect that had the most varied responses from the clients with only 13% of respondents rating the location as 'excellent'. Additionally, the variety of supports was another category that received mixed responses with 30% of respondents being unsure of the available variety of supports. The ratings of the clients can be seen in **Figure 22**.

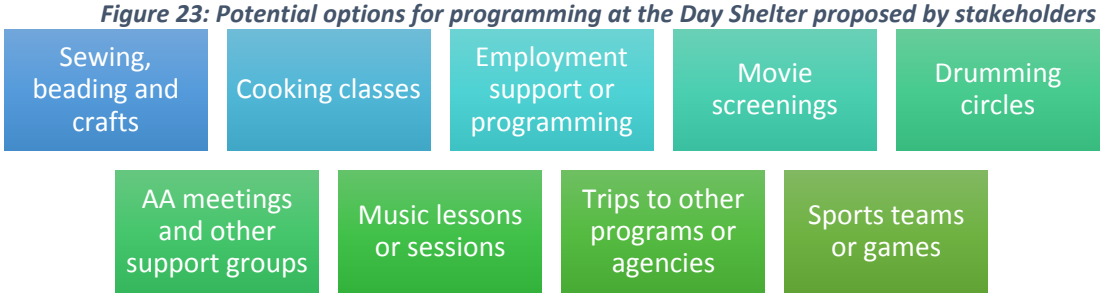
Figure 22: Client perceptions of aspects of the Combined Centre



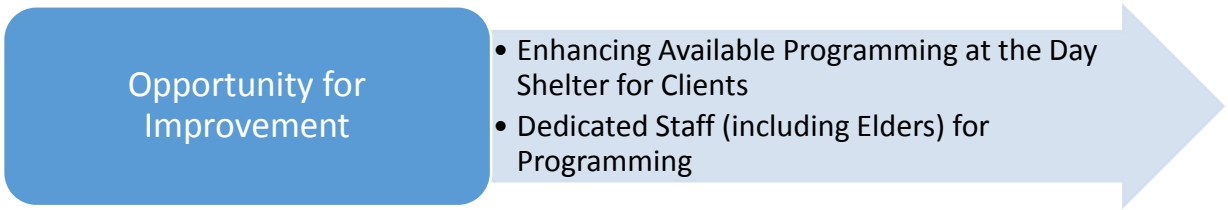
All stakeholders noted the lack of structured programming at the Day Shelter and expressed an immediate need to address this gap. Prior to the co-location with the Sobering Centre when the Day Shelter was located elsewhere, program staff and clients stated that there were some programs available to clients, including sewing and beading. However, the current Day Shelter does not offer any structured programming to clients due in part to the lack of available staff who can take the time to offer programming. Other than accessing services such as food, showers, and case management, clients can listen to the radio, watch television, play cards, or interact with other clients and staff. The lack of structured programming, according to many clients, staff and external stakeholders, results in boredom amongst clients and increases the potential for incidences of lateral violence and alcohol consumption.

Many staff and clients stated that they would like to see formal programs taking place within the shelter. Potential programming options suggested by participants are displayed in **Figure 23** below:

Figure 23: Potential options for programming at the Day Shelter proposed by stakeholders



While staff expressed an interest and a desire to implement formal programming, they added that they may not have the staff resources (including physical space indoors or outdoors) or time to develop and run such activities. Additionally, some programming would require formal partnerships with other agencies, as discussed above. Some external stakeholders stated that structured programming may be beyond the scope of the Combined Centre which, they state, should be focused solely on harm-reduction. Staff suggest having Elders on staff to be able to engage with clients' more effectively through cultural programming and activities at the Day Shelter.



In other jurisdictions, programming that targets an individual's bio-psychosocial or spiritual well-being in one form or another including programs like: Aboriginal ceremony, Alcoholics Anonymous/Narcotics Anonymous support, medical consultation, daily exercise, peer support groups, yoga therapy and staff presentations on various health and wellness topics.[17]

3.3 IMPACTS AND EFFECTIVENESS OF SERVICE INTEGRATION

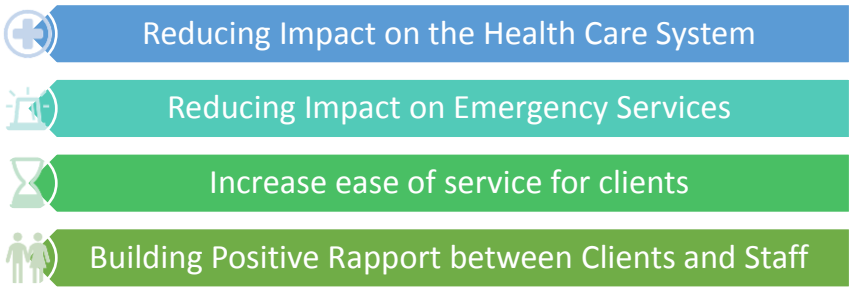
Due to the fact that the Day Shelter and Sobering Centre previously operated in separate locations, the evaluation aimed to look at the impact and effectiveness of having these two services co-located.

3.3.1. Effectiveness of Co-Located Services

The current model of the Combined Centre focuses on a co-located model where clients can access an emergency shelter, immediate medical assessments and triaging, case management support, and access basic health services through the Sobering Centre and the Day Shelter.

Through this evaluation, it was reported through qualitative sources that this co-located model has shown effectiveness in achieving the programs' intended outcomes in the following ways that will be explored below.

[17] See Appendix A for more details of programs in other jurisdictions offering programming through the findings of the Environment Scan.

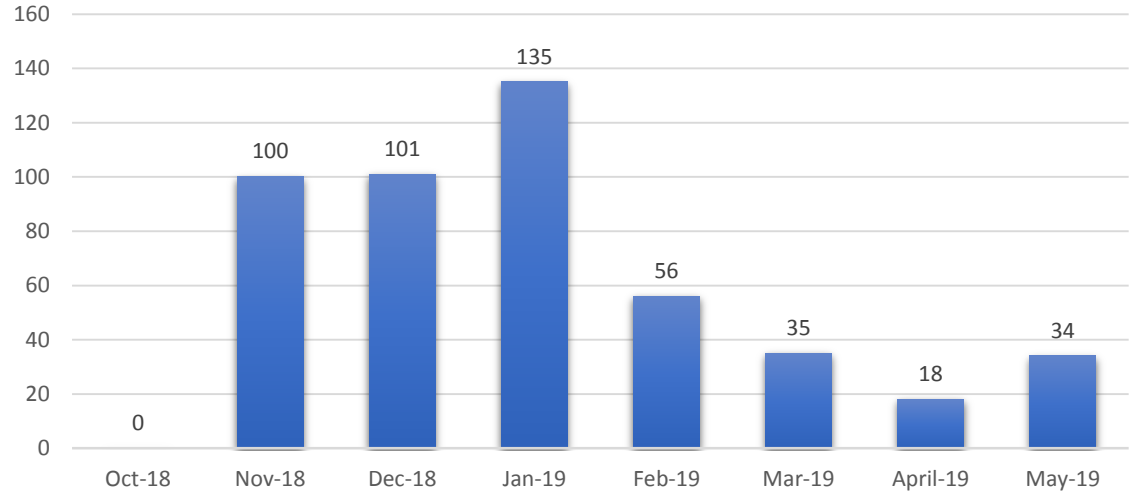


3.3.1.1. Reducing Impact on Health Care System

The NWT Disabilities Council collects data on the number of accesses to the on-site medical personnel at the Day Shelter. **Figure 24** below displays the total number of medic accesses by month from October 2018 to May 2019.

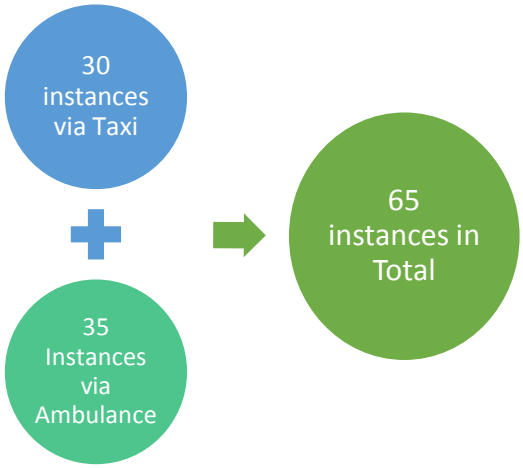
January 2019 saw the largest number of accesses with 135 over the entire month. November and December 2018 saw the second highest number of accesses at 100 and 101 respectively.[18] During these months, the average number of medic accesses per day were 4.35, 3.33 3.26 per day, respectively.

Figure 24: Number of Medic Accesses from Day Shelter Clients by Month from October 2018 to May 2019



In addition to the clients accessing the medic, there were 65 instances between November 2018 and May 2019 where clients who were seen by the medic were transferred to the hospital via taxi or ambulance depending on the acuity of their health needs. The breakdown of how clients accessed the hospital from the Day Shelter can be seen below.

[18] Data regarding unique client access of medical personnel was unavailable. It is important to note that the total number of accesses does not represent unique individuals and that one individual may be accessing the medic multiple times per month.



Clients, emergency partner representatives, and program staff stated that having professional medical personnel on-site, through AMS, is one of the most valuable resources for the Combined Centre. Having this service co-located with the Sobering Centre and Day Shelter allows clients to receive a more holistic range of care and increased their access to immediate medical services. It also reduces the need for clients to seek medical care in the emergency department, particularly for minor medical issues or injuries.

Additionally, staff and clients stated that having medical personnel on-site at the Combined Centre provides an entry point into the medical system for clients in a manner that may be safer and more positive for them overall. When clients are able to receive medical assessments in an environment in which they feel safe and respected, staff reported that clients feel more comfortable receiving care and returning for future care. Staff stated that medical personnel can provide clients with referrals to other services and can act as advocates for clients when they need to schedule appointments or speak with a medical professional. This is supported in the literature identified in the environment scan where many of the integrated service models across Canada, particularly those living with mental illness and addictions, include medical services as a core program function, recognizing the existing challenges these populations face in accessing timely and appropriate medical care[19]. Given that clients are accessing medical services through the Combined Centre, it may be worth considering how the Combined Centre can support clients in accessing a broader scope of medical services through their facility where clients already feel safe and free from judgement.

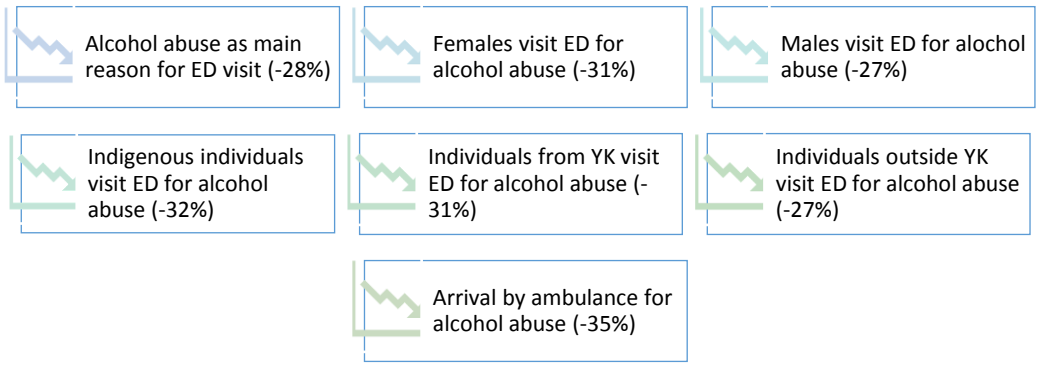
Opportunity for Improvement

- Increase clients' access to receiving medical care by expanding the scope of medical services provided within the Combined Centre.

Prior to Co-Location

Stanton Territorial Hospital collects and analyzes statistics on utilization of the emergency department (ED) and the reasons for utilization. In a report prepared by the hospital which compared utilization of the ED for three years (July 17, 2014 to July 16, 2017) prior to the opening of the temporary Sobering Centre in Yellowknife with utilization of the ED in the year since the temporary Sobering Centre was open (July 17, 2017 and July 16, 2018). The major findings from this comparison are noted below:

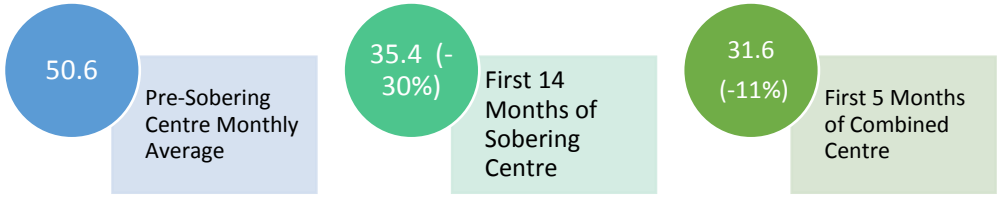
[19] See Appendix A for examples of integrated programs that incorporate medical services for vulnerable populations.



The report notes that there has been a clear decrease in the amount of alcohol abuse-related arrivals at the ED since the temporary Sobering Centre opened until July 16, 2018. While other rates of access have increased during this same time period (Non-Indigenous individuals accessing the ED for alcohol abuse and accesses for reasons other than alcohol abuse), the report states that it is likely that the opening of the temporary Sobering Centre impacted ED utilization. However, it is also reported that the correlation between the opening of the Sobering Centre and the decrease in ED utilization does not necessarily imply causation.

Following Co-Location

Stanton Territorial Hospital also collects statistics on the number of urgent visits to the ED prior to and following the opening of the Sobering Centre in 2017. Additionally, the hospital has continued to collect statistics on the number of urgent visits to the ED, in which alcohol was the most responsible diagnosis (MRDx), since the opening of the Combined Centre. The results of these statistics are displayed below:



As indicated by the statistics above, the average number of monthly urgent visits to the ED resulting in an alcohol diagnosis, over 40 months prior to the opening of the Sobering Centre was 50.6. This number decreased by 30% in the first 14 months that the Sobering Centre was open to an average of 35.4 urgent visits per month. In the first five months following the opening of the Combined Centre, the average decreased even further by 11% to 31.6 visits per month. This demonstrates that there has been a decrease in the number of ED visits due to alcohol since the opening of the Sobering Centre and again since the opening of the Combined Centre. However, this correlation does not necessarily imply a causal relationship.

3.3.1.2. Reducing Impact on Emergency Services

Representatives from emergency services agencies stated that since the opening of the Combined Centre their agencies have experienced a reduction in calls for service. Additionally, the Sobering Centre has reduced the number of individuals being held in detention cells overnight due to intoxication. Emergency Services representatives noted that the reduction in calls for service is due, in part, to the implementation of the Street Outreach Program, which now transports many clients who would otherwise have been transported by YK Fire or the RCMP and takes them to the Sobering Centre. The

Combined Centre has provided an alternative space for intoxicated individuals without access to shelter to be transported to in order to rest or sleep off the effects of intoxication. Since November 2018, there have 163 calls to the RCMP to come to the Combined Centre with on average, 23 calls a month to the RCMP.

Staff, emergency services representatives and other external stakeholders added that this change is important as the Combined Centre is a more appropriate space in which to provide shelter and support for this vulnerable population, as compared to emergency services agencies. Emergency service representatives noted that the staff at the Combined Centre were able to provide a more appropriate space for intoxicated individuals because they do not take a punitive approach, but rather use a more trauma-informed and supportive approach to providing care. The Combined Centre provides a harm-reduction-based space in which clients are treated with dignity, respect and can access a range of services and referrals.

Philosophical Approach to Service Delivery

The focus on delivering a harm-reduction approach, which focuses on the reduction of adverse health, social and economic consequences of substance use without requiring abstinence without requiring abstinence[20], is particularly important for this population. The Combined Centre maintains a non-punitive approach in which clients who are intoxicated or experiencing issues related to trauma, addictions, and homelessness are accepted. Program administrators stated that the model of service is not sobriety-focused but about addressing the client's current and most pressing needs. Staff complimented this statement by expressing that their approach focuses on, "meeting the client where they are", and working to develop trusting relationships over time.

Some program staff, administrators, clients, and external stakeholders stated that there are opportunities to expand beyond this harm reduction model by offering more opportunities for clients to achieve sobriety.

Emergency services representatives and some local community members suggested the need to incorporate a more recovery and treatment-based model within the Combined Centre to promote healthy behaviours rather than just prevent harm. After more than eight months of operation as a Combined Centre and having reduced the impact of public intoxication on emergency services, some stakeholders believe the Combined Centre should incorporate new services and mandates, including:

Opportunity for Improvement

- Expanding programming and services beyond harm reduction approaches

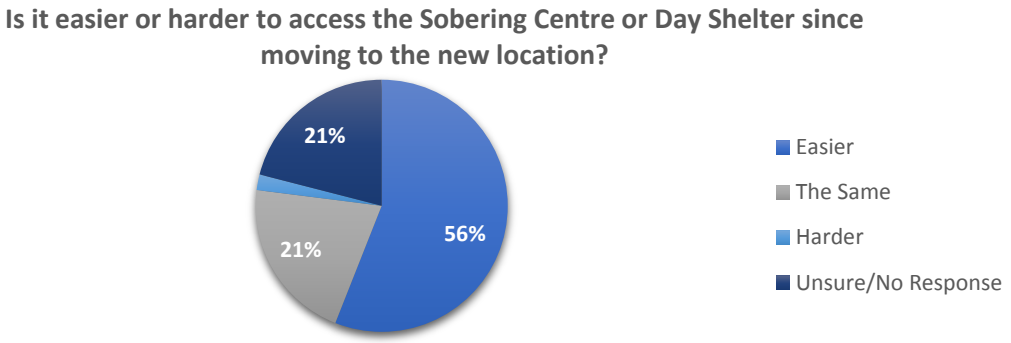
[20] Podymow, T., Turnbull, J., Coyle, D., Yetisir, E., & Wells, G. (2006). Shelter-based managed alcohol administration to chronically homeless people addicted to alcohol. 174(1), 45-49.

These type of programs and services are often included in the integrated service delivery models in other jurisdictions as identified in the environment scan (see ***Appendix A***). There are specific programs in Vancouver, Alberta, Ottawa, and Toronto that offer shelter-based managed alcohol programs, as well as counselling services, including addictions counselling, which help clients plan and manage their addiction, as well as obtain and maintain adequate housing that matches their level of independence and phase of recovery[21]. These types of programs are not without challenges and limitations, therefore would require further investigation within the context of Yellowknife to be considered appropriate and feasible.

3.3.2. Impacts of Integration on Ease of Access and Client Benefits

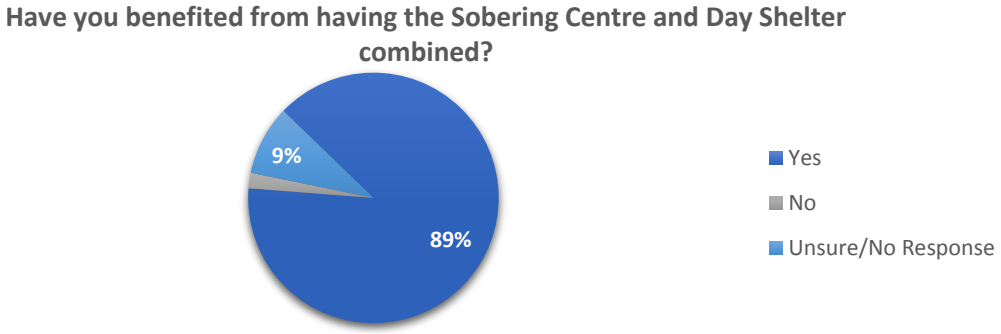
Clients who accessed the Day Shelter in its previous location were asked during the survey to compare the ease of accessing the new Combined Centre compared to the previous one. **Figure 25** shows that while most clients (56%) feel that it is easier to access the Combined Centre at the new location, 21% feel there is no difference, and 2% feel it is harder to access at the new location.

Figure 25: Client self-reported ease of accessing Combined Centre



Clients were also asked during the survey if they have benefited from having these services co-located. **Figure 26** shows that most clients (89%) stated that they have benefited from having the Sobering Centre and Day Shelter combined.

Figure 26: Percentage of clients self-reporting benefit from combined services



When asked to explain how they have benefited, most clients stated that having the two services co-located is easy, convenient, or saved them having to walk a significant distance. Some clients stated that

[21] See Appendix A for examples of integrated service delivery models that incorporate MAPs, addiction treatment programs, counselling services, and housing opportunities.

it is easy for them to transition between the services at different times of the day (e.g., Sobering Centre overnight to the Day Shelter in the morning).

Similarly, Combined Centre staff stated they have benefited from the co-location of these services because in addition to being able to serve clients who are transferring from one service to another with ease, the co-located space allows for the offering of a broader range of client supports. For example, clients are now able to access a safe space to sleep, medical care, meals, showers, bathrooms, and the support of staff within the same building.

3.3.3. Relationship building between clients and staff

Many clients, staff, and partner agency representatives noted that one of the most critical successes of the Combined Centre is the building of trust and rapport between clients and staff. Staff emphasized the importance of fostering an atmosphere in which street-involved, vulnerable individuals feel they can seek shelter, supports, and socialize while being treated with dignity and respect by staff members. Additionally, many clients stated that one of the main reasons they access the Combined Centre and feel safe there is that they feel respected by staff. Anecdotal findings indicated that some staff at the Combined Centre were former clients of the Day Shelter and are now able to help others who are in similar situations to what they have personally experiences. It was noted that the shared lived experience was valuable in being able to offer support and build trust with the clients.

Opportunity for Improvement

- Formalizing peer-support roles within the Day Shelter to empower people with lived experience to support current clients

Staff emphasized the importance of developing long-term relationships with clients, many of whom are experiencing issues related to addiction, trauma, and homelessness. Staff stated that regular, respectful interactions between themselves and clients results in trust and increases the likelihood that clients will seek out support from centre staff. It also increases the likelihood that clients will seek medical and mental health support from the centre and through referrals provided by the centre.

Program staff identified the importance of relationship building with this target audience and that having the co-located services provides more opportunities to build and leverage existing relationships with clients and to be able to provide them with the services they may need in a safe and respectful environment.

3.3.4. Impacts of Integration

Based on the perspectives of all stakeholders involved, the integration of the Sobering Centre and the Day Shelter is providing several benefits to clients, staff and the general public.

Safety

- Decreased risk of exposure related harms as clients who are intoxicated do not have to travel far between services
- Clients have access to medical services onsite and do not have to travel to the hospital or other service providers
- Decreased prevelance of public intoxication as clients do not have to travel far to access Sobering Centre

Access

- Clients who become intoxicated can transition from the Day Shelter to the Sobering Centre without going outside and with the support of staff
- Clients who have slept off the effects of intoxication can go to the Day Shelter to access food, case management services, and socialize with staff and clients
- Staff can offer a broader range of services to clients and can easily transport clients from one service to another due to the co-located nature of the services.

Continuity of Care

- Program staff are able to follow up with clients in either the Sobering Centre or Day Shelter to check in on their needs and wellbeing due to the co-located nature of the services
- Clients are able to access the same staff between the two services which allows for anincreased level of familiarity and opportunity to build trust.
- Rapport built between clients and staff in the co-located services increases clients' level of comfort in seeking additional services and supports

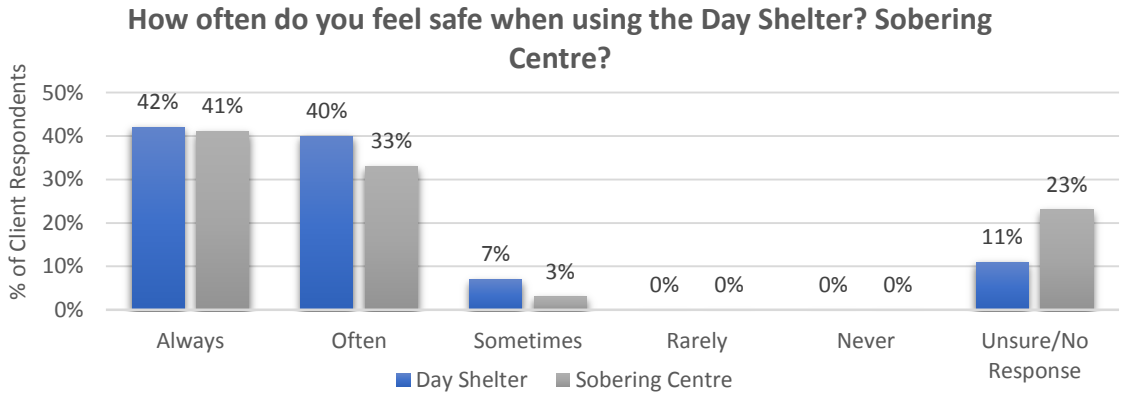
With these benefits in mind, however, there are also several measures which could be taken to optimize or further develop integration within the Centre. These are discussed in **Section 6.0.**

3.4 PERCEPTIONS OF SAFETY

3.4.1 CLIENTS AND STAFF

Staff and clients of the Combined Centre were asked to describe their feelings of safety when at the Centre. Most surveyed clients stated that they feel safe on a regular basis at the Day Shelter or Sobering Centre, with 82% of surveyed clients stating they feel safe always or often at the Day Shelter and 74% stating they feel safe always or often at the Sobering Centre (refer to **Figure 27**).

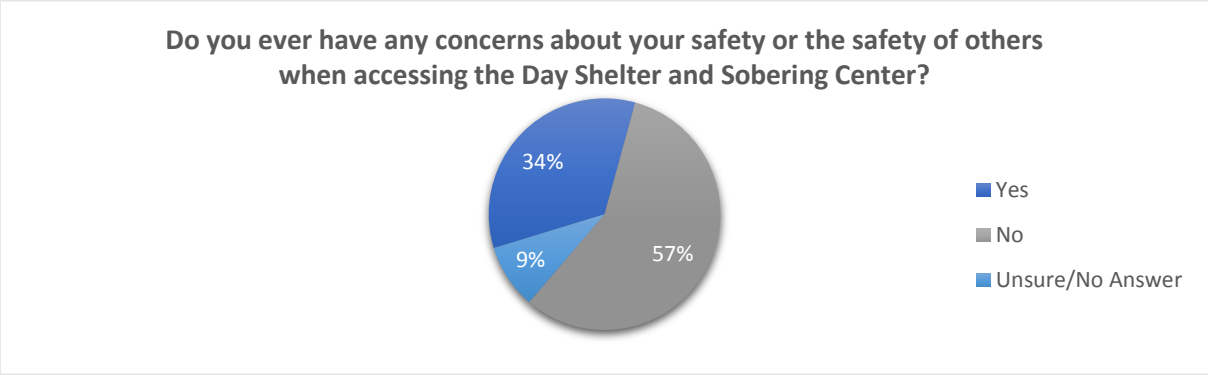
Figure 27: Client reported feelings of safety when using Day Shelter or Sobering Centre



These feelings of safety, combined with strong relationships between clients and staff, access to a range of services, and feelings of respect and dignity within the Combined Centre, increase the likelihood that clients will return to the Centre and will continue to seek supports in order to achieve wellness and independence. It was noted that this shared respect has a positive impact on clients' desire to spend time at the Combined Centre.

Clients were also asked if they have any concerns about their safety while at the Combined Centre. **Figure 28** shows that more than half (57%) of all surveyed clients stated that they do not have any concerns about their safety or the safety of others when accessing the Combined Centre.

Figure 28: Client reported concerns about safety at Combined Centre



Of those clients who indicated they did have concerns about their safety (34%), they noted the following:

- Recurrent episodes of lateral violence;
- Hostility and anger amongst other clients;
- Many intoxicated clients; and
- Unpredictability and/or chaos in the Centre.

When Combined Centre staff were asked to comment on client safety, while some noted that there have been a few incidences of violence at or near the centre, they also added that they believe the number of violent incidences has decreased since the opening of the Combined Centre and that the rate of violence would be higher among the clients if the Centre did not exist. Staff also added that Centre closing time and times when meals and snacks are served are the times in which violent incidences are more likely to occur.

When asked to comment on personal safety when in the Day Shelter, program staff reported they felt safe. They stated that most staff members have Crisis Prevention Training. It was noted by some staff that an increase of staffing levels would increase the perceptions of safety for staff, clients and the public. Additionally, program staff noted that the Combined Centre maintains a "hands-off" policy which reduces the number of staff-involved violent altercations. However, this policy was seen as ineffective in preventing and managing violent or aggressive incidents from external stakeholder perspectives.

Opportunity for Improvement

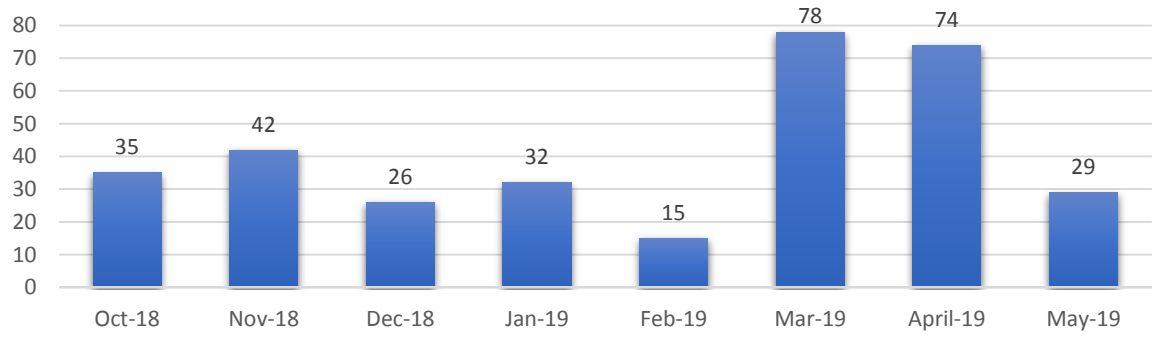
- Increase staffing levels to increase perceptions of safety for clients, staff and the public.

Client Restrictions

The NWT Disabilities Council collects the number of client restrictions per day. Clients may be restricted from accessing the Combined Centre due to violent behavior towards staff or other clients, or due to excessive intoxication, a policy implemented to ensure that the Combined Centre is a safe space for everyone. Anecdotal findings suggest that client restrictions can range from a several hours to a day in length. **Figure 29** below displays the number of client restrictions per month between October 2018 and May 2019.

The greatest number of client restrictions occurred in March (78) and April (74) 2019. As an average, these months experienced 2.52 and 2.47 restrictions per day. February saw the fewest number of client restrictions with only 15 over the entire month, at an average of 0.55 restrictions per day.[22]

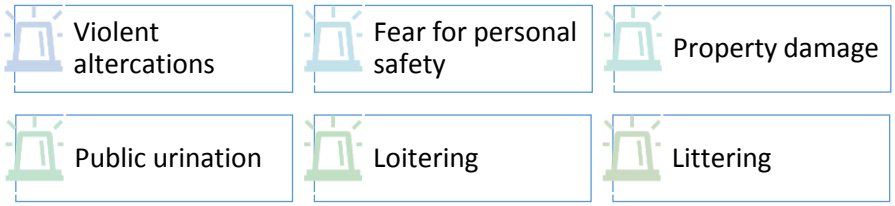
Figure 29: Number of Client Restrictions per Month October 2018 to May 2019



3.4.2 EXTERNAL STAKEHOLDERS

Partner agency representatives and community members described a range of perceived levels of safety with regards to the Combined Centre. Most individuals agreed that they feel the Sobering Centre is a safe environment for clients. However, the Day Shelter is often perceived as a location in which altercations or violent behavior can be seen. Emergency service representatives stated that they believe staff do not always feel safe in this environment.

Local community members and businesses located near the Combined Centre expressed many concerns regarding the safety of clients in and around the Day Shelter, as well as concerns regarding public safety in and around the Centre. They expressed frustration with the level of public intoxication around the shelter, particularly after the Liquor Store opens at 11am and expressed discomfort and feelings of lack of safety when walking around the area. Local businesses and community member regarding the safety issues with the Combined Centre include personal, public and environment concerns as seen below.



[22] Data regarding the number of unique individuals restricted per day or month was unavailable. As such, it cannot be determined how many of these restrictions are designated towards the same individual.

Emergency service representative identified that based on data from their agencies, there have not been increases in violent incidents since the opening of the Combined Centre. Emergency Service representatives and program staff indicated although there hasn't been an increase in violent incidence, the violent incidents that do occur may be more visible to the public around the Combined Centre now whereas historically, these incidents were occurring more privately in alleyways, parks, or other 'hidden' areas.

Local community members and business owners who are not located in the immediate vicinity of the Combined Centre felt that public safety in the downtown area has improved since the opening of the Combined Centre and that there were less incidents of property damage and issues related to public intoxication in areas where this was historically a problem.

Increasing Security Presence Outside the Centre

Some clients and local community members expressed the need for an increased security presence in and around the Combined Centre, adding that regular patrols by RCMP or the presence of a security guard stationed onsite would help to reduce rates of violence. However, some clients stated that they would not feel comfortable accessing the Combined Centre if this security presence was increased. Staff added that this security presence would hamper the fostering a safe atmosphere for clients, many of whom may have had negative experiences with law enforcement or uniformed officials.

In other jurisdictions, this common challenge of managing perceptions of public safety around the location of the Centre is addressed using internal staff. Designated staff work outside around the perimeter of the building and with their direct neighbours to provide the quickest response to community concerns and monitoring of client care. They also provide community rounds every hour around the several key city blocks giving them the opportunity to help clients into their Centre, move clients along off property and clean the areas as needed.[23]

Opportunity for Improvement

- Dedicate staff roles to do more community rounds and engage clients or potential clients outside of the Centre to increase perceptions of public safety

Good Neighbour Agreement

Despite these concerns regarding violence, almost all neighbours and external stakeholders agreed that the Combined Centre, particularly the Sobering Centre, provides valuable services to the community. For that reason, several participants stated that there is a need for a formal partnership or agreement between the Combined Centre and neighbours in order to establish regular times of communication, determine responsibility for matters such as security and cleanup, and to develop a positive working relationship between these groups.

Opportunity for Improvement

- Addressing Public Safety Conerns by:
  - Increasing security presence outside the Centre
  - Establishing Good Neighbour Agreements

[23] Tuner, A. (2015). Alternatives to criminalizing public intoxication: Case study of a sobering center in Calgary, AB. University of Alberta: The School of Public Policy SPP Research Papers, 8(27).

4.0 SUMMARY OF FINDINGS

Based on information obtained from all lines of evidence, the following section presents a summary of the findings organized by the guiding evaluation questions. Given some of the data limitations regarding the client usage and intake information as presented in earlier in this report, the findings based on these data points should be interpreted with caution.

4.1. WHAT IS THE IDEAL MIX OF SERVICES AND LEVEL OF INTEGRATION BETWEEN THE DAY SHELTER AND SOBERING CENTRE?

- As noted in the literature reviewed as part of the Environmental Scan (see Appendix A), there are typically four key program areas when considering the mix of services that are needed for the vulnerable populations: housing, health care, harm reduction, and counselling. These categories of programs can range in delivery but should be considered when planning and implemented an integrated service delivery model with the objective of decreasing barriers to access for vulnerable populations.
- Based on the results of the environmental scan (see Appendix A), there are three commonly seen models that combine different levels of integration and services provided: integrated community health and harm reduction models (including health care, case management, harm reduction programming/services, and counselling); integrated housing and harm reduction models (offering harm reduction services in supportive housing), and fully integrated models that incorporate housing, health and social services, counselling and harm reduction programming in a wrap-around care model.
- To fully assess the ideal mix of services that should be included in any future centre, an assessment of existing services and supports should be undertaken to understand the gaps in services, barriers to access, and opportunities for partnership and collaboration across various service providers and agencies.
- The literature on integrated service models suggests that integrated services should include the ability to share information and knowledge between professionals serving the same population through data sharing agreements and case conferences to optimize the services individuals can receive from one program.
- Given the demographics of the clients accessing the Combined Centre (See Section 3.2.4.2), Indigenous led and informed services and programming may need to be integrated into the services that are currently being offered to be more effective in providing appropriate and quality services that meet the needs of clients. The scan identified the importance of Indigenous-specific services and supports.
- Improvements in the delivery of integrated services for vulnerable populations are also hindered by the lack of evaluations that report of the effectiveness, efficiency and outcomes of service delivery.[24]

4.2. TO WHAT EXTENT IS THE PROGRAM REACHING THE INTENDED CLIENTS? WHO IS BEING EXCLUDED AND WHY?

- Based on findings from clients and program staff (see section 3.2.4), there appear to be two target audiences: one for the Sobering Centre and another for the Day Shelter.

[24] OECD (2015), Integrating Social Services for Vulnerable Groups: Bridging Sectors for Better Service Delivery, OECD Publishing, Paris, https://doi.org/10.1787/9789264233775-en.

    - *Day Shelter Audience*: Non-violent individuals experiencing homelessness, precarious housing, food insecurity, or poverty regardless of their level of intoxication
    - *Sobering Centre Audience*: Non-violent intoxicated individuals that do not have access to a safe and warm place to sleep off the effects of substances.
- Based on findings from a small subset of Combined Centre clients, most clients[25] accessing the Day Shelter reporting actively experiencing homelessness and self-report as having an addiction, indicating that the Day Shelter is reaching its intended target audience.
    - The majority of clients are Indigenous, between the ages of 30 and 60 with the largest proportion of clients accessing the Day Shelter are between the ages of 50 and 59 (see section 3.2.4.2).
    - The largest proportion of clients accessing the Day Shelter who are experiencing homelessness have done so for 1-5 years (see section 3.2.4.2).
- Findings from client and program staff identified that some individual clients are not able to access Sobering Centre services because they are sober and may be able to access safe shelter elsewhere.
- The number of daily accesses to the Day Shelter is much higher than the number of individuals accessing the Day Shelter on a daily basis as seen in the data presented in Section 3.2.1. This indicates that clients are accessing the Combined Centre multiple times a day and possibly, multiple days a month. As reported by the clients, returning users report the need for the services offered by the Day Shelter that they cannot access anywhere else, as well as having a sense of community that draws them to visit the Day Shelter regularly.

4.3. HOW IS THE PROGRAM PERCEIVED BY STAKEHOLDERS (STAFF, PARTNER AGENCIES, CLIENTS, BUSINESSES, AND COMMUNITY)?

- Clients reported having positive perceptions of all aspects (location, services, staff, hours of operation) of the Combined Centre program with nearly all respondents reporting 'good' or 'excellent' for staff and hours of operation (See Section 3.2.5.2).
- The location of the Combined Centre received mixed reviews from all stakeholder groups, including clients with respect to its proximity to the Liquor Store (See Section 3.2.5).
- The Sobering Centre is perceived as a positive service that is needed and effective in Yellowknife based on the findings through the stakeholder engagement with partner agencies, emergency services and program staff.
- Based on the findings through the stakeholder engagement, partner agencies, emergency services, local businesses and community members were unclear about the mandate of the Day Shelter (See section 3.2.5).

4.4. WHAT IS THE PERCEIVED LEVEL OF SAFETY ASSOCIATED WITH THE COMBINED SHELTER/SOBERING CENTRE FOR CLIENTS, STAFF, AND COMMUNITY MEMBERS?

- 34% of clients that participated in the evaluation reported having concerns for their safety or the safety of others at the Combined Centre. Most of the concerns were due to the physical altercations that occur in the Combined Centre vicinity.
- As seen in section 3.4, 82% and 74% of surveyed clients stated that they 'always' or 'often' feel staff at the Day Shelter and Sobering Centre, respectively.

[25] Based on a sample of clients that may not be representative of all clients accessing Day Shelter.

- Program staff identified that 'restrictions' are given to clients who may be exhibiting violent or aggressive behavior to ensure the Combined Centre is a safe place for everyone.
- Program staff report feeling safe while working at the Combined Centre because they have built positive relationships with the clients and use a 'hands-off' policy when dealing with escalating situations which protects them from immediate harm. However, it is suggested that an increase in staffing levels could increase perceptions of safety for staff, clients and the public (See Section 3.4.1).
- Based on the findings in the evaluation, local community members and business owners near the Combined Centre identified strong concern for the safety of the clients, safety for themselves, as well as public safety near the Combined Centre. Some feel that is negatively impacting local businesses in the area However, local community members and business owners in other areas of Yellowknife reported increased sense of safety in their neighbourhoods since the opening of the Combined Centre (see section 3.4.2).

4.5. WHAT ASPECTS OF THE PROGRAM ARE FACILITATING SUCCESS BY ACHIEVING INTENDED OUTCOMES AND THE REACHING TARGET AUDIENCE?

- The findings in the evaluation show that having professional medical personnel on site to provide assessments and triage clients facilitates success in reaching intended outcomes by (see Section 3.3.1):
    - Providing this service within the same facility as the Sobering Centre and Day Shelter allows clients to receive a more holistic range of care and increased their access to immediate medical services.
    - Clients have a reduced need to seek medical care in the ER, particularly for minor medical issues or injuries.
    - Staff and clients stated that this provides an entry point into the medical system for clients in a manner that may be safer and more positive for them overall.
    - There were 65 instances between November 2018 and May 2019 where medics made referrals to the hospital for clients who otherwise may not have sought or received appropriate care.
- As seen in findings in section 3.2.2.3, providing case management services to clients:
    - Clients and data provided by the NWT Disabilities Council state that the Case Manager is assisting clients with a range of services, including resume and employment help, obtaining ID cards, and scheduling appointments.
    - Many clients and staff stated that the support provided by the Case Manager has allowed clients to advocate for their needs and improve their wellbeing.
- As seen in the findings in section 3.3.3, relationship building between staff and clients:
    - Clients and staff stated that the co-located space allows for the development of trust and rapport between them.
    - These relationships ensure clients feel a sense of dignity and respect when accessing the Combined Centre.
    - Long-term, staff state that this relationship-building increases the likelihood that clients will seek medical and mental health support from the Combined Centre and through referrals provided by the Centre.
- As seen in the findings in section 3.3.4, philosophical approach to service delivery:
    - The NWT Disabilities Council recognize that addiction is not a choice but rather they consider it a disability that requires special care and support to help those living with addiction to improve their quality of life and wellbeing.

    - The Combined Centre maintains a non-punitive approach in which clients who are intoxicated or experiencing issues related to trauma, addictions, and homelessness are accepted.
- As seen in section 3.4.1, providing a Safe Space for Vulnerable Populations:
    - Many clients indicated that if the Day Shelter did not exist, they would not have anywhere to go during the day and would be on the street.
    - These feelings of safety, combined with strong relationships between clients and staff, access to a range of services, and feelings of respect and dignity within the centre, increase the likelihood that clients will return to the centre and will continue to seek supports.

4.6. WHAT AREAS OF THE PROGRAM ARE CREATING BARRIERS TO SUCCESS?

- Lack of public clarity about the Day Shelter mandate (see Section 3.2.5):
    - Partner agency representatives and community members indicated a lack of clarity regarding the target audience and staff roles and responsibilities in the Day Shelter.
    - Uncertainty was expressed related to availability of existing programming at the Day Shelter.
- Lack of available programming at the Day Shelter (see Section 3.2.5.2):
    - Many stakeholders expressed a significant gap with the lack of organized programming offered at the Day Shelter, stating it results in boredom among clients which can lead to aggressive behavior and violent incidents.
    - Several stakeholder groups, including clients, considered the lack of programming as an encouragement to continue alcohol consumption.
    - Stakeholders suggested that more staffing resources would increase the ability to implement programming in the Combined Centre.
- Approaches to de-escalation and managing violence (see Section 3.4):
    - Clients, partner agency representatives and neighbours expressed dissatisfaction with the hands-off approach taken by staff during incidences of violence at the Day Shelter.
- Informal community partnerships (see Section 3.2.5.1):
    - Partner agencies representatives expressed a lack of formal partnerships between their agencies and the Combined Centre.
    - Findings from the program staff and partner agency representatives suggest that the lack of formalized partnerships has led to miscommunication (such as around the banned clients list) and has not allowed for the opportunity to provide an integrated continuum of care (i.e. transportation of clients by the Street Outreach Program from the Combined Centre to other services, such as the Arctic Indigenous Wellness Foundation, to allow clients to participate in activities).
- Lack of health promotion, recovery-orientated programs and services (See sections 3.2.5 and 3.3.1.2):
    - Neighbours, some clients and community members stated that the proximity of the liquor store to the Combined Centre promotes increases in alcohol consumption in public near the Combined Centre where clients can go sleep off the effects.
      Some clients, neighbours and partner agency representatives stated that there is a need for additional programming within the Combine Centre that supports individuals in changing their behaviours in a positive way through more structured harm reduction programs like a monitored substance consumption programs for clients who are

experiencing addiction, or offering detox programs for those who wish to seek treatment.

4.7. WHAT CHANGES ARE NECESSARY TO THE PROGRAM TO MITIGATE IDENTIFIED PROBLEMS, BARRIERS OR SHORTCOMINGS AND REDUCE ANY POTENTIAL IMPACT RELATED TO BOTH THE CURRENT LOCATION OF THE FACILITY AND THE LOCATION FOR THE PERMANENT FACILITY?

- Stakeholders engaged in the evaluation suggested that the Combined Centre should provide culturally appropriate programming activities at the Day Shelter for interested clients to promote more positive engagement within the Combined Centre.
- Based on the findings in the environmental scan (see Appendix A) and through data gathered for this evaluation, it was suggested that the Combine Centre provide more health promotion and treatment services like addictions and counselling services to support individuals who are contemplating behavior change, rather than focusing only on harm reduction approaches.
    - Many integrated service delivery models across Canada offer a variety of programs that cover a spectrum of health and wellbeing, including detox programs, managed alcohol programs, supportive housing, and withdrawal management programs to be able to meet their client where they are at and provide necessary services based on their level of readiness for behaviour change. [26][27]
- Clients, program staff, and emergency service representatives suggested providing outdoor space connected to the Combined Centre where clients can congregate without disrupting community members and businesses or trespassing on public property.
- The current location and its proximity to the Liquor Store was identified as a problem that would need to be mitigated in any future location facility that serves vulnerable populations, including those experience substance misuse and abuse (see section 3.2.3.5).
- Increasing staffing capacity, including having Elders, to implement programming and increase the perceptions of safety both in and outside of the facility.

4.8. WHAT ARE THE IMPACTS OF THE CURRENT LEVEL OF INTEGRATION BETWEEN THE DAY SHELTER AND THE SOBERING PROGRAM ON ACHIEVING THE INTENDED OUTCOMES, NAMELY MEETING NEEDS AND ENSURING SAFETY?

- 89% of clients indicate have benefited from having the Sobering Centre and Day Shelter co-located as reported in the client facilitated survey.
- The types of benefits reported by clients in this evaluation include:
    - The convenience of having both services co-located;
    - The ease of access from one service to the other; and
    - Continuity of service provision and providers across the two services.
- Through the facilitated survey, 52% of client respondents reported accessing medical care through the Combined Centre at least monthly.
- Anecdotally, it was reported that there were fewer exposure-related deaths in Yellowknife since the Combined Centre opened.[28]

[26] Portland Hotel Society (PHS) Portland Hotel (Vancouver). Retrieved at: https://www.phs.ca/project/portland-hotel/
[27] Podymow, T., Turnbull, J., Coyle, D., Yetisir, E., & Wells, G. (2006). Shelter-based managed alcohol administration to chronically homeless people addicted to alcohol. CMAJ, 174(1), 45-49.
[28] This has not been confirmed as the 2018 coroner's report is not yet available.

- Utilization rates of the Sobering Centre reached 91% based on the utilization data presented in Section 3.2.1.2).
- The community perception based on those engaged in the evaluation is that integration of sobering services (wherein clients are intoxicated) with shelter services promotes intoxication and substance use and leads to increased violence and alcohol abuse amongst clients.
- Emergency services representatives feel that co-location of services helps get individuals off the streets. However, there is also a feeling that the harm reduction model has done as much as it can and there needs to be health promotion and that more recovery-focused programming should be implemented within the program to expand the range of services that can be provided (see Section 3.3.1.2).

4.9. WHAT HAVE THE IMPACTS OF THE PROGRAM BEEN ON ANCILLARY AND SUPPORT SERVICES?

- Emergency services providers reported there has been a decrease in calls to respond to individuals intoxicated on the street because there is a safe place for intoxicated individuals to go rather than the hospital or RCMP cells (see Section 3.3.1.2).
- It was reported by RCMP representatives that there has been a drop on cell visits for those who are intoxicated and unable to access shelter.
- Emergency services representatives reported a decrease in visits to ED for alcohol abuse which is supported by the Stanton Territorial Hospital ED data on utilization for alcohol-related issues.

5.0 KEY CONSIDERATIONS

Based on the results of this evaluation presented in this report, DPRA identifies the following 20 key considerations for the Combined Day Shelter and Sobering Centre. These considerations are organized based on the main issues identified in this report. For each main issue presented, DPRA is proposing both short and long-term considerations in order to address the given issue. The short-term considerations may be applicable to address in the upcoming RFP, while the long-term considerations may be more appropriate for the planning and development of any future centres. A high-level summary of the considerations is illustrated below.

Identified Issue: Lack of Programming at Day Shelter

- *Short-term Consideration*:
  - Develop programming activities in the Combined Centre
- *Long-term Considerations*:
  - Develop and implement a Structure Harm Reduction Program
  - Implement Expanded Medical and Social Services

Identified Issue: Gaps in Physical Infrastructure

- *Short-term Consideration*:
  - Increase surveillance outside of the Combined Centre
- *Long-term Consideration*:
  - Provide clients with outdoor space
  - Create dedicated spaces for sober clients

Identified Issue: Staffing Resources

- *Short-term Considerations*:
  - Introduce a formalized peer-support role
  - Formalize role of Elders in the Combined Centre
  - Increase staff capacity
  - Increase availability for staff training
- *Long-term Considerations*:
  - Establish a dedicated medical team
  - Create positions for Addictions and Family Counsellors

Identified Issue: Lack of collaboration and integration of services

- *Short-term Consideration*:
  - Formalize partnerships with community agencies
- *Long-term Consideration*:
  - Provide an integrated service model to promote continuity of care

Identified Issue: Lack of community outreach and education

- *Short-term Consideration*:
  - Develop communication tools to promote the mandate and goals of the Combined Centre
- *Long-term Consieration*:
  - Engage in public education

Identified Issue: Management of Client Data

- *Short-term Considerations*:
  - Revise the existing intake form and process to improve quality
  - Develop and implement a data system
- *Long-term Considerations*:
  - Establish data-sharing agreements with partner agencies

These key considerations are expanded upon in the brief descriptions below.

5.1 PROGRAMMING

Issue identified in the findings:

There are limited programming activities that currently exist in the Combined Shelter and there is a need to expand the service model to include more structured addiction supports and medical care (see Section 3.2.5.2) .

5.1.1. Short Term Considerations

Develop programming activities in the Combined Centre

It was identified in the findings by several of the stakeholder groups including clients and program staff that there are limited programming options provided in the Combined Centre. Stakeholders suggested that implementing culturally appropriate programming could provide clients of the Combined Centre with more opportunities to engage in positive activities. Suggestions for programming provided by the clients and programs staff included:

- Drumming activities
- Sewing or beading
- Life skills workshops
- Wellness programs

- Aboriginal ceremony, Alcoholics Anonymous/Narcotics Anonymous support, medical consultation, daily exercise, peer support groups, yoga therapy and staff presentations[29].
- On-the-land programs

Based on the findings of the evaluation, programming considerations should include the following:

- Specifically targeting programming activities to male populations given that they make up approximately 80% of the clients
- Scheduling programming during the peak morning times before the liquor store opens to optimize accessibility and uptake
- Ensuring consistency in the programming and the individuals implementing the programming to optimize the opportunities for relationship-building between the programming staff and clients

5.1.2. Long-Term Considerations

Develop and implement structured harm reduction programs

Structured harm reduction programs, like managed alcohol programs or safe consumption sites, have shown benefits in reducing the negative impacts of harmful substance use and improving the health of substance users[30]. Given the findings of the evaluation (though the client facilitated survey, and program staff and community member engagement) that indicate high use alcohol and other substances by Combined Centre clients, considerations around the development and implementation of programming that reduces harm, rather than promoting abstinence may lead to increased individual and community benefits.

Managed Alcohol Programs were specifically by several stakeholder groups in this evaluation as a potential program model that could be embedded in the Combined Centre (see Section 3.3.1.2). A Managed Alcohol Program (MAP) is a harm reduction approach to reduce the negative health and social impacts of individuals experiencing severe alcohol dependency by providing regulated doses of alcohol to individuals in a drop-in, supportive housing or shelter environment[30]. MAPs require individuals to consume dosages of alcohol daily under medical supervision with the intent to be able to stabilize alcohol intake over time[31].

Given the target audiences of the current Combined Centre, developing and implementing a MAP within any future centres for vulnerable populations may have a positive effect on the intended long-term outcomes related to improved health outcomes of street-involved populations.

MAPs can have a number of positive impacts on participants, including [31,32,32,33]:

---

[29] Tuner, A. (2015). Alternatives to criminalizing public intoxication: Case study of a sobering center in Calgary, AB. University of Alberta: The School of Public Policy SPP Research Papers, 8(27).

[30] Stockwell, T., Pauly, B., Chow, C., Vallance, K., Perkin, K. (2013). Evaluation of a managed alcohol program in Vancouver, BC: Early findings and reflections on alcohol harm reduction. CARBC Bulletin #9, Victoria, British Columbia: University of Victoria.

[31] Podymow, T., Turnbull, J., Coyle, D., Yetisir, E., & Wells, G. (2006). Shelter-based managed alcohol administration to chronically homeless people addicted to alcohol. 174(1), 45-49.

[32] Evans, J., Semogas, D., Smalley, J. G., & Lohfeld, L. (2015). "This place has given me a reason to care": Understanding 'managed alcohol programs' as enabling places in Canada. Health & Place, 33, 118-124. https://doi-org/10.1016/j.healthplace.2015.02.011

[33] Pauly, B., Vallance, K., Wettlaufer, A., Chow, C., Brown, R., Evans, J., Stockwell, T. (2018). Community managed alcohol programs in Canada: Overview of key dimensions and implementation. Drug and Alcohol Review, 37, S132-S139. doi: 10.1111/dar.12681

- Providing a safe space for alcohol consumption;
- Initiating a process of recovery and treating participants with respect and dignity;
- Improving health outcomes among participants; and
- Reducing non-beverage alcohol use

However, if a MAP is implemented, considerations should also be made regarding minimizing risk for clients involved in a MAP. Clients participating in a MAP may be at higher risk of alcohol-related organ problems, particularly if clients are also drinking outside of the program.[34] Participants of MAPs have reported consuming excessive amounts of alcohol due to high levels of consumption outside of the program.[35] Researchers in this area have suggested that the implementation of policies which deter outside drinking is a potential solution to this issue.[36] Additionally, other researchers have discussed the importance of recognizing and incorporating traditional Indigenous cultural viewpoints in the treatment process in order to ensure engagement in the program.[37,38]

Implement Expanded Medical and Social Services

As seen in the findings of this evaluation, the medical services provided on site were seen as a factor in the success of the services and stakeholders indicated an increasing need to provide more medical services on site (see Section 3.3.1.1). Providing access to expanded medical services including a physician or nurse practitioner who is onsite will increase the access to medical care for vulnerable populations that often face barriers to accessing such care in a timely manner. Additionally, providing access to counselling and integrated case management services in the same space where vulnerable individuals may already be accessing basic needs like food, shelter, and hygiene and have established positive relationships with service staff may increase individuals' accessibility to these services that can lead to individuals achieving an enhanced ability to achieve independence and wellness, an intended impact of the Combined Centre[39].

[34] Nielsen, E., Novotna, G., Olson, N. (2018). Harm reduction interventions for chronic and severe alcohol use among populations experiencing homelessness. A literature review. University of Regina. https://www.uregina.ca/arts/community-research/Research/FINAL%20Managed%20Alcohol%20Programs_Report%20September%202018_.pdf

[35] Chow, C., Wettlaufer, A., Zhao, J., Stockwell, T., Pauly, B., & Vallance, K. Counting the cold ones: A comparison of methods measuring total alcohol consumption of managed alcohol program participants. Drug and Alcohol Review, 37(Suppl. 1), S167–S173. doi:10.1111/dar.12648 https://www.ncbi.nlm.nih.gov/pubmed/29266461

[36] Nielsen, E., Novotna, G., Olson, N. (2018). Harm reduction interventions for chronic and severe alcohol use among populations experiencing homelessness. A literature review. University of Regina. https://www.uregina.ca/arts/community-research/Research/FINAL%20Managed%20Alcohol%20Programs_Report%20September%202018_.pdf

[37] Ibid

[38] Ramsperger, E. & Ramage, K. (2017, January). A selective literature review on managed alcohol programs and Indigenous healing methodologies. Retrieved from https://www.uvic.ca/research/centres/cisur/assets/docs/MAPLiterature%20Review_January%202017-Final.pdf

[39] Scheim, A. PhD & Werb, D. PhD. Integrating supervised consumption into a continuum of care for people who use drugs. CMAJ 2018 August 7;190:E921-2. doi: 10.1503/cmaj.180824.

5.2 INFRASTRUCTURE

Issue identified in the findings:

There are safety concerns as a result of the existing physical infrastructure due to blind spots outside of the centre where incidents occur most frequently.

There are structural barriers to offering indoor and outdoor programming.

(See Sections 3.2.5.2. and 3.4)

5.2.1. Short-term Considerations

Increase surveillance outside of the Combined Centre

Based on the safety concerns raised by stakeholders in the evaluation, including clients, staff, and community members, adding additional surveillance cameras outside of the Combined Centre may help to mitigate potential safety concerns outside of the Combined Centre building by removing existing blind spots where clients may loiter. In absence of surveillance cameras and to increase monitoring of the Combined Centre grounds, consider applying a staffing approach similar to that of the Alpha House in Calgary where they have a dedicated outside staff work around the perimeter of the building and with their direct neighbours to provide the quickest response to community concerns and monitoring of client care.[40]

5.2.2. Long-term Considerations

Provide clients with protected outdoor space

To address concerns from community members regarding the issues of trespassing and loitering around the vicinity of the Combined Centre, it is suggested that there is protected or contained (fenced) outdoor space, that is monitored by program staff, for clients to access through the Day Shelter. It may be more appealing to clients to use this protected space if they are able to consume substances in this space (cigarettes, alcohol) which may prevent them from consuming substances on other private property resulting in trespassing. By having the space shielded from the public with fencing and having it only accessible through the Day Shelter, it may result in improved perceptions of public safety and give program staff greater control of who is accessing the space.

Create dedicated spaces for programming

Based on the findings from the evaluation that there are limited programming opportunities and physical spaces to run programs, it is suggested to create dedicated spaces for programming to allow for more structured activities to be implemented. This will also allow for a separate space from the communal areas, so that those clients that are interested in participating in the programming are able to do so without distraction from non-participants. It was reported that in the previous location of the Day Shelter, there was dedicated space that could be used for programming that both clients and program staff perceived positively. This type of space will be required in order to implement organized activities at the Day Shelter for those interested.

Create dedicated spaces for sober clients

To address some of the safety concerns identified through the evaluation from clients regarding the level of intoxication of other clients, it is suggested that a dedicated space specifically for sober clients be created. This will ensure that all clients feel safe to access the services and programs within the

[40] Tuner, A. (2015). Alternatives to criminalizing public intoxication: Case study of a sobering center in Calgary, AB. University of Alberta: The School of Public Policy SPP Research Papers, 8(27).

Centre. Having a separate designated area for those who are sober and do not wish to interact with individuals who are intoxicated may increase their likelihood of accessing services that they otherwise would not access if they did not feel safe in the space.

5.3 STAFFING

Issue identified in the findings:

Staff would benefit from increased staff levels to enhance perceptions of safety of clients and staff, as well as be able to dedicate more time to programming.

Some staff require additional training to feel more confident in providing appropriate and quality services to the clients.

(See Sections 3.2.5 and 3.4)

5.3.1. Short-term Considerations

Introduce a formalized peer-support role

There are models of harm reduction programs specifically related to substance-users that incorporate peer-support workers into the delivery of the services[41]. Based on the findings in the evaluation regarding the interest in more health promotion and harm reduction programming, peer-support workers may be a great resource to clients through roles of advocates, educators, or navigators[42]. While some existing staff at the Combined Centre self-identified as previous clients to the Sobering Centre, they did not identify as peer supports. Providing opportunities to for these existing staff to engage in a more formalized peer support role, if they are interested, could benefit both the staff and the clients of the Combined Centre. Addictions and Mental Health Ontario released a report in 2014 that outlines best practices in Peer Support[43] which could be a starting place in developing and implementing a peer support role at the Combined Centre.

Formalize role of Elders in the Combined Centre

Given the high representation of indigenous individuals accessing the Combined Centre, there may be great benefit to engaging Elders in the delivery of services and programming. By formalizing the role within the Combined Centre, Elders can become a consistent support build rapport with clients. Additionally, Elders can lead culturally programming based on their understanding of needs within the client population and broader community.

Increase existing Capacity

To be able to provide more programming activities and one-on-one support the clients as the evaluation findings suggest, existing capacity within the Combined Centre may need to increase. Increasing capacity to be able to maintain existing service levels and allow for the potential addition of structured programming will be necessary. Increasing staff capacity can also potentially mitigate issues related to safety because staff may be able to better response to clients' needs and may be more responsive to escalating situations. Adding an additional Case Manager, with training in social work and/or counselling and some experience working with vulnerable populations, may be beneficial to provide to increase the

[41] Scheim, A. PhD & Werb, D. PhD. Integrating supervised consumption into a continuum of care for people who use drugs. CMAJ 2018 August 7;190:E921-2. doi: 10.1503/cmaj.180824.

[42] Mings, E. & Cramp, J. (2014). Best Practices in Peer Support. Addictions and Mental Health Ontario. Retrieved from: http://eenet.ca/sites/default/files/wp-content/uploads/2014/08/Best-Practices-PeerSupport-Final-Report-2014.pdf

[43] Mings, E. & Cramp, J. (2014). Best Practices in Peer Support. Addictions and Mental Health Ontario. Retrieved from: http://eenet.ca/sites/default/files/wp-content/uploads/2014/08/Best-Practices-PeerSupport-Final-Report-2014.pdf

accessibility of that services within the Combined Centre as the existing resource appears to be in high demand and limited in the number of clients that can be seen in a day. Although staffing requirement information as limited in the jurisdiction scan, the Alpha House in Calgary hires Addictions Support Workers with education in the Social Work field and training and experience with Withdrawal management, as well as trauma, crisis assessment, and intervention.[44,45]

Increase availability for staff training

Findings from the evaluation support the ongoing need to ensure that all staff are equipped to work with vulnerable populations that access the Combined Centre, increased availability for training may be necessary. Training is suggested for all staff in the following areas to promote improved safety for both clients and staff:

- Mental health first aid;
- De-escalation; and
- Trauma-informed approaches to care.

5.3.2. Long-term Considerations

Establish a dedicated medical team

Because it has been identified through these evaluation findings that relationship building and trust is an important factors in clients' deciding to access the services provided, it will be important to establish a dedicated medical team that can provide regular and consistent care in a non-judgmental and respectful manner to vulnerable persons that may not be able or willing to access medical care elsewhere. Several of the integrated service models in other jurisdictions have medical teams available to provide ongoing care to clients in their programs.[46]

Create positions for Addictions and Family Counsellors

Because of the existing barriers for accessing addiction services in Yellowknife as noted by program staff and partner agency representatives, Addictions Counsellors were identified as a necessary resource to help the existing target audience of the Combined Centre. In addition, Family Counsellors were identified as a priority resource because of the prevalence of inter-generational trauma in the target population for the Combined Centre and of how many of the existing clients are in Yellowknife because of family issues in their home community.

5.4 COLLABORATION AND INTEGRATION OF SERVICES

Issue identified in the findings:

Lack of existing formal partnerships to coordinate available services and programs offered through other community agencies.

(see Section 3.2.5.1)

5.4.1. Short-term Considerations

Formalize partnerships with community agencies

[44] Tuner, A. (2015). Alternatives to criminalizing public intoxication: Case study of a sobering center in Calgary, AB. University of Alberta: The School of Public Policy SPP Research Papers, 8(27).
[45] http://alphahousecalgary.com/
[46] Shepherds of Good Hope. (2019). Programs and Services. https://www.sghottawa.com/programs-services/

As indicated by the evaluation findings from partner agency representatives and program staff, by formalizing partnerships with community agencies such as the Street Outreach Program, Arctic Indigenous Wellness Foundation, Tree of Peace, and other community and indigenous groups, services and supports that are provided by each of the agencies can be optimized to ensure the clients' needs are being met. For example, if formalized partnerships are arranged between the Street Outreach Program, the Arctic Indigenous Wellness Foundation, and the Combined Centre, it could be arranged that clients of the Combined Centre are picked up by the Street Outreach Van on a voluntary basis at a set time and taken to the Arctic Indigenous Wellness Camp to spend the day on the land and participating in culturally-appropriate wellness programming. Additionally, if data-sharing and communication agreements between the Street Outreach Program and the Combined Centre are optimized, clients of both services can receive a more effective continuum of care. This would reduce inefficiencies and delays in service delivery (i.e. clients who are banned from the Combined Centre being transported by the Street Outreach van to the Centre). The Peter Coyle Place in Calgary has an innovative partnership with Alex Health Care Centre to provide medical services and supports that include access to in-home physicians and nurse practitioners.[47]

5.4.2. Long-term Considerations

Provide an integrated service model to promote continuity of care

Evidence has shown that integrated health and social services offer clients a multitude of services and supports that they may need in settings where they have established trusting relationships which positively influences their likelihood of attending follow-up appointments and following treatment plans[48]. By developing an integrated service model, with existing local services or establishing new services within a Combined Centre environment, it can promote continuity of care for clients who may have limited knowledge and ability to navigate the health and social system. Based on the evaluation findings suggesting that clients are accessing medical care primarily through the Combined Centre, there is opportunity to reach these clients with additional medical and social services where they are have rapport and trust with the service deliverers.

5.5 COMMUNITY OUTREACH AND EDUCATION

Issue identified in the findings:

Lack of public awareness regarding the current mandate and target audience for the Day Shelter and Sobering Centre.

Lack of public education and understanding on the topic of addictions, harm reduction, and trauma leading to stigmatizing behaviours towards Combined Centre clients.

(see Sections 3.2.5 and 3.4.2)

5.5.1. Short-term Considerations

Develop Communication tools to promote the mandate and goals of the Combined Centre

As indicated in the evaluation findings, there is a lack of understanding and acceptance of the Combined Centre, particularly from community members. To increase the public understanding and acceptance of the mandate and goals of the Combined Centre, it is suggested that communication tools be developed to share publicly with the community. Developing a public service announcement on the Combined

[47] https://caryacalgary.ca/wp-content/uploads/2014/12/OASPOC-Final-Report-Oct-2014.pdf

[48] Sylla L, Bruce RD, Kamarulzaman A, et al. Integration and co-location of HIV/AIDS, tuberculosis and drug treatment services. Int J Drug Policy 2007;18:306-12.

Centre to educate potential clients and the general public on what services and supports Combined Centre offers and who the services are targeting.

5.5.2. Long-term Considerations

Engage in public education

To address issues of stigma experienced by the Combined Centres target audiences as reported in the clients' facilitated survey, efforts to increase public education regarding mental health and addictions, harm reduction approaches, and trauma-informed practices should be made. Particularly by increasing public education and awareness of harm reduction models, there may be increases in public acceptance of programs like the Day Shelter and Sobering Centre. A literature review of best practices in health education and addressing stigma could provide insight into appropriate approaches to addressing stigma in the NWT regarding street-involved individuals, addiction and harm reduction models for service delivery to improve public perceptions of the Combined Centre.

5.6 DATA MANAGEMENT

Issue identified in the findings:

Inconsistant data collection and reporting leading to limitations in understanding who and how often individuals are using the services provided through the Combined Centre and partner agencies.

(See Section 2.3)

5.6.1. Short-term Considerations

Revise the existing intake form and process to improve data quality

The existing intake form is extensive in the number and type of questions which may be difficult for a client to properly complete when they are intoxicated. An intake form should collect data based on what information is required from each individual that will inform the type of services they require, the programming that Combined Centre needs to be offering, and tracks who is accessing what services to be able to inform continuous program improvement. To understand what data should be collected in an intake form, key stakeholders including program staff, program administration, and funders should collaborate to identify necessary information for the purposes of informing programming and reporting purposes.

Develop and implement a data system

To ensure that high quality and reliable data is being collected consistently, a data system should be developed and implemented. Having a data system in place that collects high quality data necessary for planning and decision-making will be crucial in the development of any future centre. To develop a data system, stakeholders should collaborate to identify what data is necessary, how often it should be collected, how it will be collected and who will collect it. Once a database is established and data collection tools are prepared, stakeholders responsible for collecting data should be trained on how to properly collect and enter data.

5.6.2 Long-term Considerations

Establish data-sharing agreements with partner agencies

Because there are several agencies services the same population, it may beneficial to establish data sharing agreements that protect the confidentiality of the service-users but allow partner agencies gain a better understanding of the client populations' service needs and optimizing service capacity as

suggested by program staff and partner agency representatives. For example, if the Combined Centre has a data sharing agreement with the Street Outreach Program, the list of clients' that are banned temporarily from the Combined Centre could be shared with the Van staff to ensure that those clients are not being dropped off at a location that they are unable to access.

REFERENCES

Ayden Scheim PhD, Dan Werb PhD. Integrating supervised consumption into a continuum of care for people who use drugs. CMAJ 2018 August 7;190:E921-2. doi: 10.1503/cmaj.180824

Bryans, M. (n.d.). Managed Alcohol Programs in Manitoba: Feasibility Report. https://sunshinehousewpg.files.wordpress.com/2018/06/2018-managed-alcohol-programs-in-manitoba-feasibility-report.pdf

Chow, C., Wettlaufer, A., Zhao, J., Stockwell, T., Pauly, B., & Vallance, K. Counting the cold ones: A comparison of methods measuring total alcohol consumption of managed alcohol program participants. Drug and Alcohol Review, 37(Suppl. 1), S167–S173. doi:10.1111/dar.12648 https://www.ncbi.nlm.nih.gov/pubmed/29266461

Evans, J., Semogas, D., Smalley, J. G., & Lohfeld, L. (2015). "This place has given me a reason to care": Understanding 'managed alcohol programs' as enabling places in Canada. Health & Place, 33, 118-124. https://doi-org/10.1016/j.healthplace.2015.02.011

Mings, E. & Cramp, J. (2014). Best Practices in Peer Support. Addictions and Mental Health Ontario. Retrieved from: http://eenet.ca/sites/default/files/wp-content/uploads/2014/08/Best-Practices-PeerSupport-Final-Report-2014.pdf

Nielsen, E., Novotna, G., Olson, N. (2018). Harm reduction interventions for chronic and severe alcohol use among populations experiencing homelessness. A literature review. University of Regina. https://www.uregina.ca/arts/community-research/Research/FINAL%20Managed%20Alcohol%20Programs_Report%20September%202018_.pdf

OECD (2015), Integrating Social Services for Vulnerable Groups: Bridging Sectors for Better Service Delivery, OECD Publishing, Paris, https://doi.org/10.1787/9789264233775-en.

Pauly, B., Vallance, K., Wettlaufer, A., Chow, C., Brown, R., Evans, J.,…Stockwell, T. (2018). Community managed alcohol programs in Canada: Overview of key dimensions and implementation. Drug and Alcohol Review, 37, S132-S139. doi: 10.1111/dar.12681

Podymow, T., Turnbull, J., Coyle, D., Yetisir, E., & Wells, G. (2006). Shelter-based managed alcohol administration to chronically homeless people addicted to alcohol. 174(1), 45-49.

Ramsperger, E. & Ramage, K. (2017, January). A selective literature review on managed alcohol programs and Indigenous healing methodologies. Retrieved from https://www.uvic.ca/research/centres/cisur/assets/docs/MAPLiterature%20Review_January%202017-Final.pdf

Scheim, A. PhD & Werb, D. PhD. Integrating supervised consumption into a continuum of care for people who use drugs. CMAJ 2018 August 7;190:E921-2. doi: 10.1503/cmaj.180824.

Stockwell, T., Pauly, B., Chow, C., Erickson, R. A., Krysowaty, B., Roemer, A., . . . Zhao, J. (2018). Does managing the consumption of people with severe alcohol dependence reduce harm? A comparison of

participants in six Canadian managed alcohol programs with locally recruited controls. Drug and Alcohol Review, 37(Suppl.1), S159-S166. doi: 10.1111/dar.12618

Stockwell, T., Pauly, B., Chow, C., Vallance, K., Perkin, K. (2013). Evaluation of a managed alcohol program in Vancouver, BC: Early findings and reflections on alcohol harm reduction. CARBC Bulletin #9, Victoria, British Columbia: University of Victoria.

Sylla L, Bruce RD, Kamarulzaman A, et al. Integration and co-location of HIV/AIDS, tuberculosis and drug treatment services. Int J Drug Policy 2007;18:306-12.

APPENDICES

APPENDIX A: ENVIRONMENTAL SCAN REPORT

ENVIRONMENTAL SCAN:

INTEGRATING AND CO-LOCATING HOUSING, HEALTH AND SOCIAL SERVICES FOR VULNERABLE POPULATIONS

SUBMITTED ON:
APRIL 23, 2019

RE-SUBMITTED ON:
JUNE 14, 2019

SUBMITTED TO:
GNWT HEALTH AND SOCIAL SERVICES

SUBMITTED BY:
DPRA Canada
60 Adelaide Street East
Suite 501
Toronto, ON
M5C 3E4
info@dpra.ca
1-800-661-8437
www.dpra.ca

This page has been intentionally left blank.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

1.0 INTRODUCTION

In planning how to effectively provide supports and services to populations that experience homelessness and/or mental health and addictions problems, the Government of Northwest Territories (GNWT), Department of Health and Social Services (HSS), engaged the services of a Consultant to conduct a limited environmental scan[49] of existing integrated or co-located approaches to service provision for vulnerable populations including shelter services, sobering programs, managed alcohol programs, counselling services, and hard-to house units in other Canadian jurisdictions.

1.1 PURPOSE

The purpose of this report is to present information on best practices and innovative approaches to integrating programming for vulnerable populations that may be considered for adoption by the Combined Day Shelter and Sobering Centre Program in order to better address the complex needs of vulnerable populations in Yellowknife.

2.0 METHODS

The methodological approach employed for this scan is illustrated in Figure 1. A limited desktop search of other Canadian programs was conducted. For each program, a search was undertaken for information on the target populations (age, gender, ethnicity, mental health status), services provided, level of integration, staffing (composition, education and qualifications, training), challenges or limitations to program implementation[50], and reported effectiveness of services and supports provided. The programs reviewed for this scan include:

Community Health and Harm Reduction Models

- Portland Hotel Society (PHS) Street Entrenched Managed Alcohol Program (SEMAP) (Vancouver)
- Annex Harm Reduction Program (Toronto)
- The Works (Toronto)

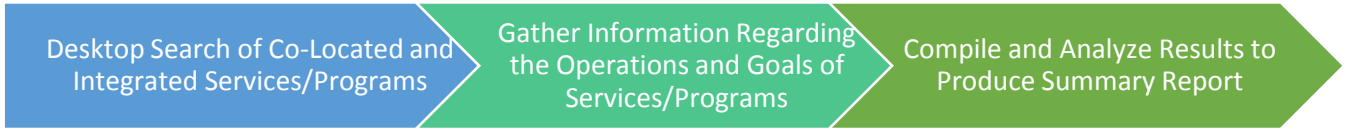
Housing and Harm Reduction Models

- Test Sobering and Assessment Centre (Victoria)
- Portland Hotel Society (PHS) Street Entrenched Managed Alcohol Program (SEMAP) (Vancouver)
- Peter Coyle Place (Calgary)

Fully Integrated Models

- Alpha House (Calgary)
- Portland Hotel Society (PHS) Street Entrenched Managed Alcohol Program (SEMAP) (Vancouver)
- Kwae Kii Win Managed Alcohol Centre (Thunder Bay)
- The Oaks - Shepherds of Good Hope (Ottawa)

Figure 1: Methodological Approach



[49] It is important to note that this document does not represent a comprehensive review of integrated programming for vulnerable populations in Canada.

[50] Information on specific program challenges was not found in the literature.

3.0 OVERVIEW OF INTEGRATED SERVICES

The following section provides general information on the integration of services and supports for vulnerable populations.

3.1 BENEFITS OF INTEGRATING SERVICES FOR VULNERABLE POPULATIONS

The literature suggests that service integration for vulnerable populations can be beneficial for both service users and providers, especially for populations with multiple disadvantages. Some of the benefits include: [51]

- Integrating services for vulnerable populations has the potential to address the multiple underlying issues simultaneously (e.g., mental and physical health needs).
- Integrated services have the potential to reduce the costs of delivering support and care, as multiple visits, duplication of services, and costly interventions are reduced.
- Integration improves access to services.
- Integrated services help facilitate information and knowledge sharing between professionals.
- More integrated models of service delivery increase cooperation and collaboration between providers and agencies, lead to improvements in service quality, and produce better outcomes and satisfaction with service delivery among service users and providers.

3.2 FACTORS THAT HINDER INTEGRATION OF SERVICES FOR VULNERABLE POPULATIONS

Irrespective of the potential benefits, the literature also identifies a number of factors that hamper the implementation of integrated models of service delivery for vulnerable populations. These factors include: [52,53,54,55]

- Complex governance structures challenge integration.
- Differences in frontline provider skills and employment conditions can hinder effective integration and delivery both in terms of the ability and the incentive of professionals to collaborate.
- Identifying who should receive integrated services, and the priority for receiving those services, create implementation challenges for jurisdictions/organizations without comprehensive client/patient data sharing policies.
- Implementing an integrated service system requires significant financial investment and the undertaking of organizational and structural changes in financing, management and practice in the short-term.
- Tension between integration with clinical care and provision of low-barrier supervised-consumption services may client limit use. For some individuals who use substances, the regulations imposed by government-sanctioned models (e.g., time limits and inability to share drugs) may be unacceptable, and

[51] OECD (2015), Integrating Social Services for Vulnerable Groups: Bridging Sectors for Better Service Delivery, OECD Publishing, Paris, https://doi.org/10.1787/9789264233775-en.
[52] OECD (2015), Integrating Social Services for Vulnerable Groups: Bridging Sectors for Better Service Delivery, OECD Publishing, Paris, https://doi.org/10.1787/9789264233775-en.
[53] Ayden Scheim PhD, Dan Werb PhD. Integrating supervised consumption into a continuum of care for people who use drugs. CMAJ 2018 August 7;190:E921-2. doi: 10.1503/cmaj.180824
[54] Neilsen, E., Novotna, G., Berenyi, R. and Olson, N. (2018). Harm Reduction Interventions for Chronic and Severe Alcohol Use among Populations Experiencing Homelessness – A Literature Review. University of Regina: Carmichael Outreach Inc.
[55] Bryans, M. (n.d.). Managed Alcohol Programs in Manitoba: Feasibility Report. https://sunshinehousewpg.files.wordpress.com/2018/06/2018-managed-alcohol-programs-in-manitoba-feasibility-report.pdf

others may prefer to access supervised-consumption services separately from other health services to maintain their anonymity.

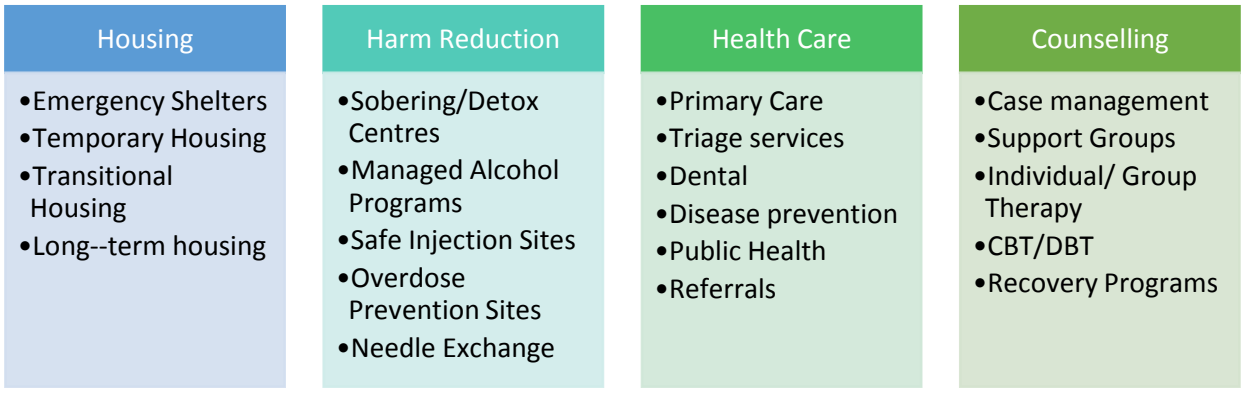
- Constraints due to operational restrictions of health care facilities, such as limited hours of operation.
- Client/patient stigma at integrated service sites may lead to less than optimal service uptake.
- Lack of Indigenous led and informed programming may lead to decreased service uptake by Indigenous clients.

Improvements in the delivery of integrated services for vulnerable populations are also hindered by the lack of evaluations that report of the effectiveness, efficiency and outcomes of service delivery.[56]

3.3 TYPES OF SERVICES

Vulnerable people experiencing poverty, homelessness or inadequate housing, mental health and addictions, abuse or violence require specific services to address daily challenges of life. These specific services required can be grouped into housing, harm reduction, health care, and counselling as identified in Figure 2.

Figure 2: Services Offered in Co-Located or Integrated Models



The literature also suggests that since Indigenous peoples are part of the vulnerable population seeking services and supports through integrated models, that care be culturally grounded and trauma informed[57], and that Indigenous peoples (e.g., Elders, Knowledge Keepers, peers) help implement the healing practices (healing circles, smudging) and ceremonies (sweat lodges, feasts) and provide counselling.[58,59]

[56] OECD (2015), Integrating Social Services for Vulnerable Groups: Bridging Sectors for Better Service Delivery, OECD Publishing, Paris, https://doi.org/10.1787/9789264233775-en.

[57] Trauma informed care contains four main components: (1) trauma awareness, (2) emphasis on safety and trustworthiness, (3) opportunities for choice, collaboration and connection, and (4) strength based and skill-building. [Reference #9]

[58] Bryans, M. (n.d.). Managed Alcohol Programs in Manitoba: Feasibility Report. https://sunshinehousewpg.files.wordpress.com/2018/06/2018-managed-alcohol-programs-in-manitoba-feasibility-report.pdf

[59] Neilsen, E., Novotna, G., Berenyi, R. and Olson, N. (2018). Harm Reduction Interventions for Chronic and Severe Alcohol Use among Populations Experiencing Homelessness – A Literature Review. University of Regina: Carmichael Outreach Inc.

3.4 TYPES OF SHELTERS

The scan revealed that several types of shelters are used by organizations that offer co-located or integrated services (refer to Figure 3).

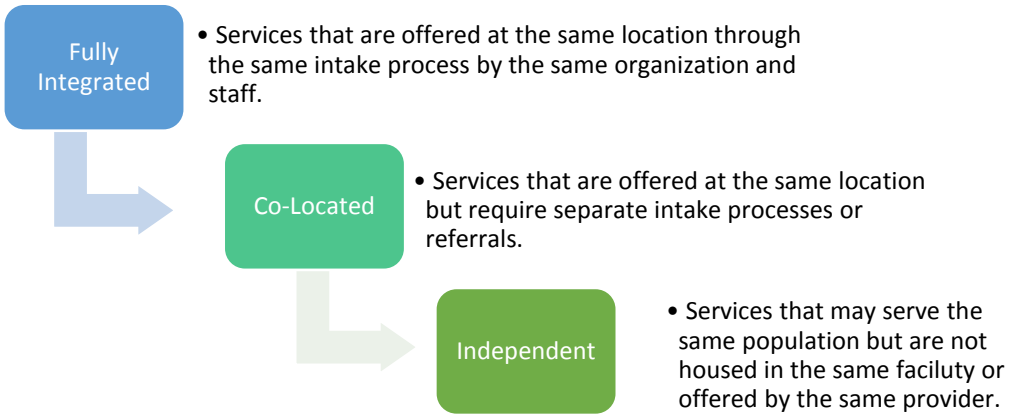
Figure 3: Shelter Types

Emergency Shelter	• Facilities that are designed to meet the immediate needs of people who are experiencing homelessness. May target specific sub-populations (such as women, youth or Indigenous persons) and usually have minimal eligibility criteria.
Temporary Shelter	• Short-term facility similar to emergency shelter which may allow people to stay on an ongoing basis. May offer services such as food, clothing and other amenities beyond a sleeping facility.
Transitional Housing	• Supportive – yet temporary – type of accommodation that is meant to bridge the gap from homelessness to permanent housing by offering structure, supervision, support (for addictions and mental health, for instance), life skills, and in some cases, education and training.
Permanent 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.

3.5 COMMON SERVICE PROVISION MODELS

Most vulnerable populations have complicated and ongoing physical, medical, psychological and social needs that requires a full continuum of care that is accessible through simultaneous or sequential services and supports[60]. There are several models for providing services to these populations that have varying levels of integration. The three most common models are presented in Figure 4 – fully integrated, co-located (e.g., partial) and independent.

Figure 4: Common Models



[60] Ayden Scheim PhD, Dan Werb PhD. Integrating supervised consumption into a continuum of care for people who use drugs. CMAJ 2018 August 7;190:E921-2. doi: 10.1503/cmaj.180824

The foundation of integrated care is the bringing together or merging of elements or components of health care systems and health institutions that were previously separated. By integrating multiple services, a continuum of care can be provided, offering co-coordinated care that is more patient centered.

When considering types of integrated service delivery models, it is necessary to consider what services are currently available to the target population, what barriers exist in accessing the services, and how integrating and co-locating services could decrease barriers to access. Understanding the context of the current landscape of available services and service utilization is important when considering what and how service delivery could be integrated. In large urban centres like Toronto, Vancouver or Calgary, there are multiple agencies offering varying levels of service integration and co-location to meet the specific needs of vulnerable populations. Not all services are integrated because there may be more options and opportunity for partnerships and referrals within the service landscape. When considering the context of Yellowknife, it would be important to understand what gaps currently exist in service delivery and how they could increase access to necessary services through an integrated model to increase low-barrier access to services.

4.0 JURISDICTIONAL SERVICE DELIVERY MODEL EXAMPLES

This section provides examples of service delivery models offered by other jurisdictions in Canada that provide co-located/partial and fully integrated services. As requested by the Client, program information is provided (when available)[61] on the following:

- Service model description
- Target population
- Services and supports offered
- Level of integration
- Staffing
- Implementation challenges
- Reported effectiveness and outcomes

4.1 PARTIAL INTEGRATION: COMMUNITY HEALTH AND HARM REDUCTION MODELS

Description of Model

In partial integration – community health and harm reduction models of delivery, various community health programs and services are offered in addition to harm reduction services. As a whole, programs that fit under this model may deliver any of the following services:

[61] Since the information for this environmental scan was obtained from a review of publicly accessible websites, it was not always possible to find information on each of the program area descriptions.

With these models, clients may access any or all of these services in consultation with staff or through referrals from healthcare workers or support staff. As such, different combinations of services may be co-located within one facility, may be spread out across several separate facilities, or may be provided through separate agencies within the same community service system.

Approach

Under partial integration – community health and harm reduction models, programs and services are intended to prevent immediate drug and substance-related harms. This approach provides low-barrier access to services for clients who are experiencing issues with substance use and any related health issues.

These models can be structured in a variety of ways, including:[62]

[62] Ayden Scheim PhD, Dan Werb PhD. Integrating supervised consumption into a continuum of care for people who use drugs. CMAJ 2018 August 7;190:E921-2. doi: 10.1503/cmaj.180824.

- Peer-run “overdose prevention sites”
- Street Outreach Units
- Mobile vans
- In-hospital services
- Women-only sites
- Community health centres

Operationalization of these models as part of a community health centre or within a hospital may result in populations that are not experiencing problems with substance use and addiction also being serviced. While some researchers have questioned the potential efficacy of such a range of models there is insufficient literature to determine whether or not these models can be considered “effective”.[63]

Examples of Community Health and Harm Reduction Models

Table 1 identifies examples of Canadian organizations that implement the Community Health and Harm Reduction Model.

[63] Ayden Scheim PhD, Dan Werb PhD. Integrating supervised consumption into a continuum of care for people who use drugs. CMAJ 2018 August 7;190:E921-2. doi: 10.1503/cmaj.180824.

Table 4: Examples of Community Health and Harm Reduction Models

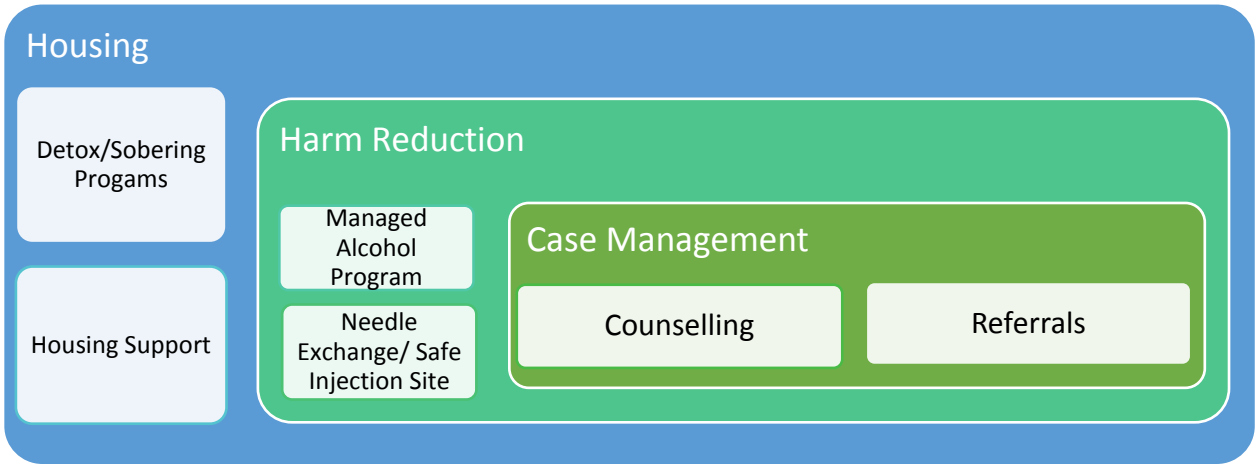
Program Name	Service Model Description	Target Population	Services and Supports Offered	Level of Integration	Staffing	Implementation Challenges	Reported Effectiveness and Outcomes
British Columbia							
Portland Hotel Society (PHS) Street Entrenched Managed Alcohol Program (SEMAP) (Vancouver)	SEMAP is a brew co-op where those suffering chronic addictions can brew their own beer or wine. The aim of the program is to create community, support each other, and decrease illicit alcohol consumption and have a bit more stability in people's lives. The program focuses on outreach to street entrenched members of the community. PHS encourages their members to be accepting and supportive to one another by adhering to the following principles: • Enabling– Striving to enable each person to function at the level determined by that person. • Self-determination– Allowing each person to determine for themselves the time, place, course and method of therapeutic treatment, if any. • Therapeutic Family – Fostering an environment within our housing and services which accepts, has faith in, forgives, and looks to the good in each member. The PHS endeavours to find an alternative to eviction in every situation.	Homeless or street-entrenched individuals who have severe alcohol use disorder, live in abject poverty, and sometimes drink non-beverage alcohol such as mouthwash or rubbing alcohol. [Consuming non-beverage alcohol as a result of severe addiction can destabilize the person's life, increasing homelessness, stigmatization, violence, visits to the hospital, and even mortality.]	SEMAP programs and services include: • Options for exchanging illicit beverages for low cost beer and wine • Peer employment opportunities "brewing" low-cost beer and wine from kits and bottled for participant use • Weekly meetings and seminars to engage drinkers in opportunities to learn about the health and social risks of non-beverage alcohol consumption and alternatives available • Outreach to people in the community to check on their well-being and provide hydration for those who are homeless. • Linkage to housing and health services, psychosocial and cultural supports	**Partial Integration:** SEMAP offers managed alcohol programs with health and social education, as well as outreach for wellness checks. **Referrals and Linkages:** Clients/Members who participate in the programs or services at SEMAP can be connected to other housing and health services.	Participants receive a high standard of addiction medicine overseen by PHS Medical Director and tied to PHS Primary Care Services. PHS managed alcohol programs also have a longstanding, close relationship with research through CARBC. This research is funded by CIHR and operates under approval from the research ethics board at the University of Victoria.	Not available	Not available
Ontario							
Annex Harm Reduction Program (Toronto)	The Annex Harm Reduction Program is a satellite of Seaton House which provides care and treatment for chronic alcoholics who are homeless and who do not wish to stop drinking. Referral primarily through Seaton House, or through other City of Toronto shelters and outreach programs	Men 18 years and older who are ineligible for service in other programs due to chronic alcohol use, or who are vulnerable in other programs due to their behaviours related to alcohol use and/or mental illness. Capacity for 100	Overnight wet shelter Managed Alcohol Program Client centred case management services Consultation with physicians/health care workers Alcohol is dispensed hourly by staff between 7:30 am and 11pm, tailored to the client. Standard is 11 drinks/day, varies based on client's request to reduce or increase the standard amount. Dispensing occurs in consultation with a physician based on level of addiction and relative harms associated with the addiction.	**Partial Integration:** The Annex Program is a satellite of Seaton House Shelter which provides care and treatment for homeless individuals with addictions issues. Referrals to the Annex Harm Reduction program comes through Seaton House Shelter or other local shelters.	Not available	Not available	Not available

The Works (Toronto)	The Works opened its doors on August 9, 1989. It plays an integral role in reducing drug use related harm in Toronto by taking leadership in the area of harm reduction. The Works provides programs and services to reduce drug-related harm for people who use drugs, including preventing the spread of communicable diseases.	People who use drugs	The Works provides: • Supervised Injection Services • Harm reduction supplies (safer injection equipment, safer smoking equipment and safer sex products) • Counselling • Testing (e.g., HIV, hepatitis, syphilis) • Free vaccinations (e.g., Hepatitis A and B, tetanus, influenza) • General nursing services (e.g., wound care, pregnancy testing, referrals) • Opioid Substitution Clinic • Mobile and Street Outreach	**Partial Integration:** Through the Works program, individuals can access counselling, harm reduction services, and primary health care. **Referrals and Linkages:** Clients/Members who attend the Works can be referred to other Toronto Public Health (TPH) services by staff and medical professionals.	Not available	Not available	Not available

4.2 PARTIAL INTEGRATION: HOUSING AND HARM REDUCTION MODELS

Description of Models

The partial integration – housing and harm reduction models of service focus on the provision of housing supports ranging from emergency to permanent supportive housing and, embedding harm reduction supports within the housing options. These models often involve the co-location of harm reduction programming within a housing complex and shelter to increase access with low-barrier services. Case management is often included in these models to support individuals in connecting to other services outside of the housing and harm reduction supports. Typical referrals would include primary health care and addiction and mental health services.



Approach

The partial integration – housing and harm reduction models often to use a 'housing first approach', recognizing the impact that homelessness and precarious housing has on an individual's ability to access and engage with health and social services. Within these types of integrated service provision, harm reduction services can be accessed by individuals through emergency shelters, temporary shelters or permanent supportive housing. The intake process to enter the harm reduction aspects of these programs may be low barrier, there are often options for clients/patients to transfer to short and longer-term housing, detox and/or sobering programs. Housing and harm reduction models offer patients/clients a safe place to live for a period of time while providing them access to harm reduction services.

Examples of Housing and Harm Reduction Models

Table 2 identifies examples of Canadian organizations that implement the Housing and Harm Reduction Model.

Table 5: Examples of Housing and Harm Reduction Models

Program Name	Service Model Description	Target Population	Co-located Services and Supports Offered	Level of Integration	Type of Shelter	Staffing	Implementation Challenges	Reported Effectiveness and Outcomes
British Columbia								
Test Sobering and Assessment Centre (Victoria)	The Test Sobering and Assessment Centre (TSAC) is an important part of the continuum of care for clients dealing with addictions within the Vancouver Island Health Authority (VIHA). It is one of the entry points for these clients into the system if they choose to exercise that option. Access to this service is through any of the following methods: police referral, hospital referral, client walk-in.	Inebriated clients	A 20-bed facility, offering shelter and assessment of inebriated clients for less than 24 hours. The TSAC is the only community resource that provides shelter for clients who are under the influence of drugs or alcohol. TSAC staff see their clientele over a length of time and build relationships with them. Clients are assessed during this time, and are monitored for changes in their physical, mental and emotional health. TSAC staff then work with individuals to help them make appropriate choices - something staff are able to do because of the trusting relationship that has been built with clients. Services available at the TSAC (services are connected to Island Health in Victoria) include: • Access - Referrals to Mental Health and Substance Use Services • Access - Referrals to Youth & Family Substance Use Services • Anscomb Outpatient Services • Assertive Community Treatment (ACT) • Central Island Child & Adolescent Psychiatry Program • Collaborative Psychiatric Outreach Program • Crisis & Emergency Services • Developmental Disability Mental Health Team • Discovery Youth & Family Substance Use Services • Early Psychosis Intervention • Hoarding Services (HEAT) • Housing, Vocational & Independent Living • In Hospital Care • Integrated Mobile Crisis Response Team (IMCRT) • Mental Health & Substance Use Teams in Your Community • Opioid Agonist Therapy • Outpatient Treatment for Mental Health • Outpatient Treatment for Substance Use • Overdose Prevention Services • Prevent Alcohol & Risk Related Trauma in Youth (P.A.R.T.Y.) • Psychosocial Rehabilitation • Referrals to Child Youth & Family Mental Health • Tertiary Care • Withdrawal & Detox Services	**Partial Integration/Co-Location:** TSAC is unique because of its ability to act quickly once a client has made the decision to enter recovery. The Victoria Detox is physically attached to the TSAC facility. Also located in the building is Pembroke Place, a longer-stay stabilization unit. Alcohol and Drug Services, which offers outpatient counselling and group work for recovery, is within a 10-minute walk away. This concentration of resources has proven to be invaluable for helping clients move through the stages of recovery when they are ready. If clients choose to continue their current lifestyle, they can do so, knowing they will receive non-judgemental care of TSAC.	Temporary Transitional	TSAC staff are trained to educate clients about community resources that are available, but to do so only at a client's request. The staff know that it is a client's choice to enter recovery; when clients are ready, staff are prepared to assist them with information and guidance.	Not Available	Not Available

Program Name	Service Model Description	Target Population	Co-located Services and Supports Offered	Level of Integration	Type of Shelter	Staffing	Implementation Challenges	Reported Effectiveness and Outcomes
Portland Hotel Society (PHS) Station Street (Vancouver)	The PHS is for everyone in need of our services. PHS encourages their members to be accepting and supportive to one another by adhering to the following principles: • Enabling– Striving to enable each person to function at the level determined by that person. • Self determination– Allowing each person to determine for themselves the time, place, course and method of therapeutic treatment, if any. • Therapeutic Family – Fostering an environment within our housing and services which accepts, has faith in, forgives, and looks to the good in each member. The PHS endeavours to find an alternative to eviction in every situation.	Housing is for individuals who are poorly served elsewhere in the community due to their physical health, mental health, behavioural issues, substance dependencies, forensic history, and for those who are homeless. Provides supportive transitional housing to new families and youth, 10 of which are fully wheelchair accessible.	In addition to its 80-unit supportive housing, Station Street offers: PHS mental health workers, clinically supervised Managed Alcohol Program, on-site LPN, case manager, Aboriginal outreach, home support, art group, meditation group. The living model at Station Street is both supportive and independent: residents have private bathrooms and kitchens, as well as access to 24-hour free laundry, a daily home-cooked meal, numerous wellness programs, and extensive clinical support.	**Partial Integration**: Station Street is connected a larger service provider – PHS. PHS offers a wide variety of housing, harm reduction and community service programs, however, primary health care services are not directly offered in this location.	Permanent Supportive	Staffing complement includes - mental health workers, clinically supervised Managed Alcohol Program, on-site LPN, case manager	Not available	Evaluation findings based on only 7 participants: • Doctor- and self-rated mental health improvements • Reduced quantity and frequency of Non-Beverage Alcohol (for most) • Reductions in some alcohol-related harms (especially social, financial, withdrawal seizures) • Self-rated physical health worsened for most • Liver function deteriorated for most by 6 months • Alcohol consumption up for some by 6 months
Alberta								
Peter Coyle Place (Calgary)	Trinity Place Foundation of Alberta is responsible for operating this facility which was opened in the spring of 2005 and is the first of its kind in Calgary. The program focuses on harm reduction philosophy model.	Men and women 55 years of age or older who are unable to access traditional seniors housing for reasons typically related to income and mental health challenges, including addiction.	• 70-suite facility • Onsite dispensing of alcohol • Support services • On-site medical services • 24-hour qualified and caring non-medical personnel • Full meal service (3 daily) in a comfortable dining room, all snacks and beverages provided • Recreation/leisure opportunities • 24/7 emergency response system	**Partial Integration**: Trinity Place Foundation operates this facility and offers a wide variety of housing, harm reduction and community service programs, but does not provide medical services directly. An innovative partnership with the Alex Health Care Centre enables Peter Coyle Place to provide medical services and supports that include access to in-home physicians and nurse practitioners.	Permanent Supportive Housing	Not available	Not available	Not available

4.3 FULLY INTEGRATED MODELS

Description of Model

Fully integrated models provide harm reduction, housing and health and social services that wrap around an individual (refer to Figure 5).

Figure 5: Wrap Around Services

Approach

Fully integrated models are intended to provide a holistic and patient-centered approach to care. As such, it is understood that treatment for substance abuse requires a wide range of services. While an individual may enter the program or service through a harm reduction point of entry or intake, they may also access primary health services, transitional and long-term housing, counselling, detox, and a range of other health and social service programs.

While the "one-stop-shop" approach of the previous models presented in this report are known to be effective models for treating drug-related harms, more inclusive models have the ability to provide more comprehensive care for patients/clients.

Examples of Fully Integrated Models

Table 3 identifies examples of Canadian organizations that implement the fully integrated model.

Table 6: Examples of Fully Integrated Models

Program Name	Service Model Description	Target Population	Services and Supports Offered	Level of Integration	Staffing	Implementation Challenges	Reported Effectiveness and Outcomes
British Columbia							
Portland Hotel Society (PHS) Portland Hotel (Vancouver)	The Portland Hotel has contributed towards bringing stability into the lives of many individuals who were at one time considered to be "at risk" and homeless. The PHS is for everyone in need of our services. PHS encourages their members to be accepting and supportive to one another by adhering to the following principles: • Enabling – Striving to enable each person to function at the level determined by that person. • Self determination – Allowing each person to determine for themselves the time, place, course and method of therapeutic treatment, if any. • Therapeutic Family – Fostering an environment within our housing and services which accepts, has faith in, forgives, and looks to the good in each member. The PHS endeavours to find an alternative to eviction in every situation.	City's most challenging and historically hard-to-house individuals They will not discriminate against: • Persons with a mental health diagnosis • Persons with physical disabilities and/or ailments including positive HIV & AIDS status • Persons with a history of criminal activity and/or involvement in the criminal justice system • Persons who engage in active alcohol, drug, and/or IV drug use • Persons with any combination of the above, or persons in need of housing	Services and supports provided include: • 88 units of Supportive housing • PHS mental health workers • food program • harm reduction services and supplies • home support • medication and methadone dispensation • HIV outreach • Advocacy • Embedded primary care clinic • Creative workshops • Acupuncture and massage therapy • Barber shop	**Fully integrated and Co-located**: Providing shelter, harm reduction services, health care services, and health care.	Not available	Not available	Not available
Alberta							
Alpha House (Calgary)	The Alpha House Shelter opened on January 18, 1982 in Victoria Park as a safe haven for clients and an alternative to city cells for those affected. It delivers services from a Harm Reduction and Social Model that respects the client's right to self-determination as it addresses the impact of homelessness and addiction in their lives. Alpha House's values and beliefs include: respecting the clients' right to self-determination as they address the impact of alcoholism and addiction in their lives. The organization strives to develop relationships of trust with clients, working on client-identified objectives from withdrawal management and mental health	Men and women struggling with addictions, as well as mental and physical health issues. **<u>Housing program:</u>** referral based -must have a housing assessment (VI-SPDAT) by their "Encampment Team" Operates 5 place-based buildings: 1 specifically for seniors and 1	Alpha House currently runs four programs: **Outreach/DOAP** • Downtown Outreach Addictions Partnership (DOAP) Team. The DOAP Team is often the first point of contact with vulnerable individuals in the community, and this is a critical first step in connecting these people with the support that they need. • The Encampment Team reaches out to people who are sleeping rough and offers to provide them with assistance into housing, including conducting intake and SPDAT assessments for Housing First Programs.	**Fully Integrated and Co-located:** Alpha House contains both a shelter and a detox in the same building. Clients who are intoxicated are admitted to the Shelter and directed to Social Detox. Alpha House combines both a	• Staff trained in withdrawal management • Individuals are encouraged to apply as Addiction Support Workers (casual staff/position). Require the following qualifications: ○ Bachelor or Diploma in Social Work or related field	Not Available	○ More than 6,000 men and women access support through their programs in shelter, detox, outreach and housing each year. • The majority of unique sobering centre clients were male (2,793, or 80.3 per cent); there were 681 females (19.6 per cent). The average age across all shelter users at first intake was 39; most clients were either in the 25–35 or 36–50 age range, at 29.5 per cent and 37.6 per cent respectively. Aboriginal people were over-represented at 42.3 per cent (1,473) of the total unique clients. • Throughout Alpha House's history, occupancy rates have remained steady from 85% to 120% for the Shelter and Detox programs. • A total of 69,617 entries from 3,480 unique

Program Name	Service Model Description	Target Population	Services and Supports Offered	Level of Integration	Staffing	Implementation Challenges	Reported Effectiveness and Outcomes
	concerns, treatment, housing needs and more. The Alpha House offers four main programs: • Outreach/DOAP ○ The DOAP team seeks to remove barriers for individuals with multiple risk factors, such as street issues, by coordinating access to a range of medical, shelter, housing, and addiction programs. ○ Needle Debris Program ○ Connect 2 Program • Shelter • Detox • Housing	specifically for women **Detox program:** has capacity for 38 clients For clients withdrawing from an addictive substance Take on referrals from community stakeholders (Alberta Health Services and Calgary Police Services) **Short-term Transitional Bed Program**: - has capacity for 4 clients - clients can move into this program after detox. Welcomes clients who are otherwise not eligible for shelter in other "high barrier" or "dry" facilities. Veterans Housing is dedicated to serving individuals who served in the Canadian Armed Forces and are experiencing homelessness and addiction.	• Alpha House runs a Needle Debris Program (Gov. of Alberta funding) in a more efficient and cost-effective response to growing concerns about needle debris. The program provides a response line where Calgarians can call to report found needles on private or public property, as well as pro-active sweeps in the community looking for needle debris and providing training on how to discard of needles safely. • Connect 2 is a partnership between Alpha House and CUPS Health and Education Centres where staff connect with hospitalized homeless patients and help support them with social and health care needs, both during their hospital stay and once upon discharged into the community to reduce inappropriate use of the health care system while assisting with better health outcomes for this population. **Shelter (Type: Temporary and Transitional)** • 24/7 access to immediate and emergency shelter is available to individuals affected by substance dependencies through outreach, assessment, referrals and community partnership and is open to actively intoxicated individuals. • Provide clients with meals and hygiene services (showers, laundry). • A medical clinic, in partnership with CUPS, is provided for five days a week with two alternating nurses and a doctor who come three half days a week. • Safeworks (Alberta Health Services) staff meet with clients once a week to provide testing, results and naloxone training. **Detox:** • The Alpha House's Detoxification Program provides a stable setting where programming and meals are provided for people withdrawing from an addictive substance and offers addiction	shelter and a detox centre in the same building, sometimes referred to as a Social Shelter/Detox, or a Community-Based Intox/Detox. Clients who are intoxicated are admitted to the Shelter and directed to the Social Detox area where they are monitored by staff who are trained in withdrawal management.	○ A working understanding of addictions and harm reduction ○ A working understanding and skill level in trauma, crisis assessment, and intervention. • Successful applicants receive training and are encouraged to apply for part- or full-time positions.		clients used service from Feb. 1, 2013 to Feb. 1, 2014. Note: due to the 2013 floods in Alberta, the facility's data collection was hampered, bringing overall figures down — likely by at least 5,000 interactions • The majority of people who access the shelter use it for a short period of time. In 2013-14, 63% of individuals who stayed in our shelter accessed it for only seven days or less. Under 31 days, this amount increases to 83%. ○ During a twelve-month assessment period there was: ○ 50.1% annualized decrease in the average number of days that clients were hospitalized, compared to the 12-month average prior to their intake into facility programs. ○ 62.6 % decrease in the number of times clients were hospitalized, ○ 50 % decrease in the use of emergency medical services, and ○ 42.4 % decrease in the number of times using an emergency room. ○ 92.7 % decrease in the average number of days clients spent in jail compared to the year prior. ○ 70.8 % decrease in the number of interactions with police. ○ The number of times clients went to jail actually increased by 26.6 %, but that may have to do with Alpha House's staff encouraging clients to address outstanding warrants and charges during their program participation.

Program Name	Service Model Description	Target Population	Services and Supports Offered	Level of Integration	Staffing	Implementation Challenges	Reported Effectiveness and Outcomes

			support workers to develop care plans to assist with clients' detoxing successfully.
			• Programming available through Detox promotes one's bio-psychosocial or spiritual well-being in one form or another including:
			  ○ Aboriginal ceremony,
			  ○ Alcoholics Anonymous/Narcotics Anonymous support,
			  ○ medical consultation,
			  ○ daily exercise,
			  ○ peer support groups,
			  ○ yoga therapy; and
			  ○ staff presentations.
			• Clients can move into our *Short-Term Supportive Housing Program (STSH Program)* where they can continue to be supported by program staff after they have detoxed
			• STSH clients have access to detox programming, as well as access services and support outside of our facility since they are no longer detoxing.
			
			Housing
			• The accredited housing program focuses on housing women and men who are experiencing addiction, chronic homelessness, and frequent interactions with emergency services like police, EMS, and/or hospitalizations.
			  ○ *Scattered-Site-Community*: The goal of this program is to stabilize an individual in their housing and then move them to graduation which allows for new clients to enter program.
			  ○ *Permanent Supportive Housing (PSH)*: Individuals are housed throughout the community in their own units and sign their own leases, but receive intensive case management with frequent case manager visits for 1-2 years.
			  ○ *Place-Based Models*: On-site staff allows for intensive case management services to be available to clients 24/7. Staff help in areas like budgeting, unit				

Program Name	Service Model Description	Target Population	Services and Supports Offered	Level of Integration	Staffing	Implementation Challenges	Reported Effectiveness and Outcomes
			cleanliness, personal hygiene, follow-up and follow-through on medical/legal appointments, and transportation to appointments. **Other:** • Addiction counselling, • Basic medical needs, • Treatment referrals, • Fast tracking for prescriptions, • Medical and housing needs. • Provide ID clinics • Outside staff work around the perimeter of the building and with their direct neighbours to provide the quickest response to community concerns and monitoring of client care. They also provide community rounds every hour around the blocks of 15th and 17th Avenues giving them the opportunity to help clients into Alpha House, move clients along off property and clean the areas as best as we can.				
Ontario							
Kwae Kii Win Managed Alcohol Centre (Thunder Bay)	In March 2012, Shelter House opened the doors to the Kwae Kii Win Managed Alcohol Program. The managed alcohol program provides stable, supportive housing to 15 tenants who have lived with chronic alcoholism and homelessness for years.	15 beds - mixed gender Criteria for admission to the program include severe alcohol dependence, chronic homelessness, and a high rate of police contacts.	The program generally uses 12 % alcohol/volume white wine, and clients may receive up to one 6 oz, i.e., 20.46 mL or 16.14 g of ethanol hourly between the hours of 8 am and 11 pm. To receive a dose, participants must not be overly intoxicated and must have been present at the facility for at least 60 min prior. Drinking outside the program is discouraged, and participants are not allowed to store their alcohol on-site for later consumption. Residents receive meals, help managing money, access to primary health care, life skills training and counseling, and help accessing legal and income supports. An Elder visits the program weekly and activities such as a drumming circle are offered as part of the shelter program next door. Housing is provided with separate sleeping areas and a number of communal living spaces in the house where the clients can cook, watch television, or do other activities. Residential tenure in the house is	**Fully integrated**: Residents must participate in the Managed Alcohol Program in order to maintain residence in the centre. All residents have access to the available supports and programming. Shelter type: Transitional	Not available	Not available	**<u>Evaluation report findings:</u>** **Overall:** All the MAP participants expressed that participation in the MAP program was beneficial to them and had positive impacts on their lives. In particular, they highlighted that the program gave them access to housing, home, health and hope. **Housing**: Overall, participants clearly expressed that housing was a highly valued aspect of the program. The availability of housing and presence of program staff increased feelings of safety and contributed to the harm reduction goals of the programs including reducing the harms of street life. The majority of MAP participants (14/17) retained their housing in the program during the study period, whereas controls remained homeless. Participants' ratings of their satisfaction with their housing were significantly higher than controls on length of stay, safety, spaciousness, privacy, and overall quality. MAP participants did express some concerns around the requirement to be in the building 90 minutes before alcohol administration and the occasional room searches for alcohol but they also appreciated that these were a necessary part of the program and highly valued the safety and security of the program compared to the dangers of the street. Thus, the MAP facilitates housing retention and increased safety

Program Name	Service Model Description	Target Population	Services and Supports Offered	Level of Integration	Staffing	Implementation Challenges	Reported Effectiveness and Outcomes
			contingent on their participation in the MAP. The program is funded in part by contributions from the residents through their social assistance amounts and through a grant to conduct a pilot program. The program is staffed 24 h per day, with at least two staff on at any given time.				for MAP participants. **Mental Health and Well-Being:** Residents and staff reported an improved quality of life for MAP participants, as evidenced by improvements in mental and physical health including enhancing feelings of self-esteem and self-worth, reconnection with family, and improved life skills. Improved skills included learning communication skills, self-care, relationship skills, and money management skills. Participants in the MAP rated their psychological wellbeing, the quality of the environment they lived in and their social relationships higher on a standard scale (WHO-BREF) than controls. **Physical Health:** MAP participants commented on how they had better access to food and were eating much better in the program. Their ratings of physical health at baseline on the WHO BREF scale for both participants and controls indicated compromised health and functioning. In the sub sample followed up over 6 months, these ratings indicated further declines in health for both participants and controls. Out of the 13 MAP participants for whom complete liver function tests were available at some point during the study, 10 had results that indicated alcoholic liver damage. However, examination of individual test results for program participants over time showed that in the great majority of cases test results for liver function were improving. **Reduction in Alcohol Related Harms:** Fewer MAP participants than controls reported harms due to alcohol in the past month in the domains of home life, legal, housing, and withdrawal seizures. Because most MAP participants had been resident in the MAP several months before this interview this is suggestive of long-term program benefits. During the monthly follow-up assessments, only rates of passing out and seizures were assessed. **Access to Health Care Services:** Both residents and staff reported that MAP participants gained increased access to health care services as part of being in the program. This was facilitated by no longer being in survival mode, as well as by a nurse practitioner at the program site and support in getting to and keeping medical appointments. Participants reported being able to attend to previously unaddressed health issues. **Changes in Contact and Police and Health Services:** MAP participants felt they had better relationships with the police than when they lived on the street. Our analysis of health and police data indicated substantial reductions for MAP participants in rates of police contacts, hospital admissions and detoxification admissions mostly in the region of

Program Name	Service Model Description	Target Population	Services and Supports Offered	Level of Integration	Staffing	Implementation Challenges	Reported Effectiveness and Outcomes
							between 40% and 80%, both in comparison with rates when the same participants were not on the MAP and in comparison, with controls. Despite individual variability and relatively small sample sizes, these comparisons were statistically significant for both hospital and detoxification admissions. There was also a significant reduction in police contacts resulting in being taken into custody when they were on the MAP. MAP participants also presented less often at hospital emergency rooms compared with controls, but this difference was not statistically significant. **Non-Beverage Alcohol Use:** The three most common types of non-beverage alcohol (NBA) consumed by both participants and controls were mouthwash, hand sanitizer and hairspray. All participants and 16/19 controls reported some NBA use in the previous month though MAP participants reported significantly smaller quantities than the controls. This change in NBA use by MAP participants was confirmed variously by the qualitative interviews with staff and residents and also quantitative survey data collected at baseline and follow-up interviews. Consumption of NBA did continue for some participants, but at a lower level. In the qualitative responses the participants made a strong distinction between the wine provided on the program and the "garbage" and "bad stuff" they had consumed outside. **Overall Alcohol Consumption:** Participants consumed on average 9 to 11 standard drinks per day, based on the records kept by MAP staff regarding drinks administered on the program and participants' self reports of drinks consumed outside the program. This was a stable pattern during the 7-month course of the study. However, among the smaller subsamples of participants (n=5) and controls (n=6) followed up for 6 months, drinking frequency in the past 30 days was markedly higher for MAP participants (28 days) than for controls (16 days), representing a slight increase for participants and a marked reduction for the controls. This would of course reflect compliance with the MAP for participants on the one hand and the less secure supply of alcohol and/or higher rate of incarceration among controls.
The Oaks - Shepherds of Good Hope (Ottawa)	The MAP is one of the truest expressions of the organization's mission to provide harm-reduction services to its clients and residents. It is operated in partnership with Ottawa Inner City Health Inc. The MAP is designed to stabilize participants' alcoholism through a medically regulated administration of alcohol. MAP participants require support in managing their addiction and maintaining their physical and	Single individuals 18 years and older who are homeless or at risk of homelessness Catering primarily to individuals with a mental illness or concurrent disorder	The Oaks is a 55-unit facility, located across two buildings in the west end of Ottawa. It houses the Managed Alcohol Program, an aging-at-home program, and provides a limited number of residential units to the Canadian Mental Health Association. 24-beds are reserved for the MAP. Participants receive a medically prescribed dosage of wine, every hour, for fifteen	**Fully-integrated/ Co-Located:** Shepherds of Good Hope also operates a Men's Shelter, Women's Shelter, Women's Special Care Unit and Rapid Housing and Employment	Not available	Not available	**2017-18 Annual Report** • 2888 total shelter clients • Average length of stay = 40 days • Seventeen adults with an average age of 51 years and a mean duration of alcoholism of 35 years were enrolled in MAP for an average of 16 months. Their monthly mean group total of ED visits decreased from 13.5 to 8; police encounters, from 18.1 to 8.8 • For all participants, the absolute amount of alcohol consumed was found to decrease, from an average of 46

Program Name	Service Model Description	Target Population	Services and Supports Offered	Level of Integration	Staffing	Implementation Challenges	Reported Effectiveness and Outcomes
	mental health, but through this structured and supportive program, staff are able to help them stabilize, gain a sense of community, and live life with dignity. The housing-based MAP at The Oaks is the second step for individuals in this innovative harm-reduction program. Once participants are stable, and feel ready, they graduate from the shelter-based MAP to this permanent, supportive housing facility.		hours a day. These structured servings significantly reduce the amount of alcohol consumed at any one time, enabling the participant to remain stable and address their addiction. As a result, many residents also drastically reduce their overall consumption of alcohol, or refrain from consuming alcohol completely. On-site staff provide comprehensive support to participants, including ongoing medical and mental health services and tailored case management. Participants also have access to assistance with personal needs, regular activities, daily meals and life-skills training.	Program			drinks per day to 8 • A cost analysis was performed. Mean monthly direct cost of the program was $771 per client, with estimated per-client reductions in the costs of ED services of $96; hospital care, $150; and police services, $201

5.0 CONCLUSIONS

There are several partial and fully integrated models available for providing harm reduction and associated services to vulnerable populations affected by drug or alcohol-related addictions and precarious housing. As all models have some merit, the literature suggests that municipalities may benefit from having a range of service models available to meet the complex and variable needs of residents. Providing access to multiple models optimizes access for all people who use drugs and allows service providers to address a diversity of social contexts, patient needs, and health service capabilities.[64]

Partial and fully-integrated models of services for vulnerable populations provide low-barrier access to services that may otherwise not be accessing, enhancing the opportunities for individuals to access necessary services. While these integrated models provide the opportunity to increase access to shelter and can improve health outcomes for individuals who are at immediate risk[65], they are not without their limitations and challenges as it related to implementation and effectiveness. Further exploration should be conducted to understand the benefits and limitations to the various service models to reach and impact the most vulnerable populations.

[64] Ayden Scheim PhD, Dan Werb PhD. Integrating supervised consumption into a continuum of care for people who use drugs. CMAJ 2018 August 7;190:E921-2. doi: 10.1503/cmaj.180824.
[65] Ayden Scheim PhD, Dan Werb PhD. Integrating supervised consumption into a continuum of care for people who use drugs. CMAJ 2018 August 7;190:E921-2. doi: 10.1503/cmaj.180824.

6.0 PROGRAM REFERENCES

British Columbia

Portland Hotel Society (PHS) Street Entrenched Managed Alcohol Program (SEMAP) (Vancouver)

http://beatroute.ca/2014/09/04/brew-co-op-in-vancouvers-downtown-eastside-aims-to-decrease-illicit-drinking/

https://www.phs.ca/project/community-managed-alcohol-program/

Portland Hotel Society (PHS) Portland Hotel (Vancouver)

https://www.phs.ca/project/portland-hotel/

Test Sobering and Assessment Centre (Victoria)

https://www.islandhealth.ca/our-locations/mental-health-substance-use-locations/test-sobering-assessment-centre

http://www.heretohelp.bc.ca/visions-alcohol-vol2/sobering-and-assessment-centre

Portland Hotel Society (PHS) Station Street (Vancouver)

Portland Hotel Society. (2019). Station Street. https://www.phs.ca/project/station-street/

Stockwell, T., Pauly, B., Chow, C., Vallance, K., Perkin, K. (2013). Evaluation of a Managed Alcohol Program in Vancouver. Early Findings and Reflections. CARBC Bulletin 9, University of Victoria.

http://homelesshub.ca/sites/default/files/bulletin9-evaluation-managed-alcohol-program.pdf

Ontario

Annex Harm Reduction Program (Toronto)

https://www.centraleasthealthline.ca/displayservice.aspx?id=133555

https://www.toronto.ca/community-people/community-partners/emergency-shelter-operators/about-torontos-shelter-system/see-our-shelters/

https://www.toronto.ca/311/knowledgebase/kb/docs/articles/shelter,-support-and-housing-administration/homelessness-initiatives-and-prevention-services/annex-harm-reduction-program.html

The Works (Toronto)

https://www.toronto.ca/community-people/health-wellness-care/health-programs-advice/services-provided-by-the-works/

https://hiv411.ca/organization/the-works-toronto-public-health-needle-exchange-program/

Kwae Kii Win Managed Alcohol Centre (Thunder Bay)

http://www.shelterhouse.on.ca/article/kwae-kii-win-managed-alcohol-centre-497.asp

https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-016-0102-5

Pauly, B., Stockwell, T., Chow, C. et al. (2013). Towards Alcohol Harm Reduction: Preliminary Results from an Evaluation of a Canadian Managed Alcohol Program. http://www.shelterhouse.on.ca/upload/documents/miscellaneous-/research-report-map.pdf

http://www.shelterhouse.on.ca/upload/documents/annual-report-final.pdf

Vallance, K., Stockwell, T., Pauly, B., Chow, C., Gray, E., Krysowaty, B., Perkin, K., & Zhao, J. (2016). Do managed alcohol programs change patterns of alcohol consumption and reduce related harm? A pilot study. Harm Reduction Journal, 13, 13.

The Oaks - Shepherds of Good Hope (Ottawa)

Shepherds of Good Hope. (2019). Programs and Services. https://www.sghottawa.com/programs-services/

https://www.champlainhealthline.ca/displayservice.aspx?id=20528

Podymow, T., Turnbull, J., Coyle, D., Yetisir, E., & Wells, G. (2006). Shelter-based managed alcohol administration to chronically homeless people addicted to alcohol. CMAJ, 174(1), 45-49.

Alberta

Peter Coyle Place (Calgary)

http://tpfa.ca/peter-coyle-place-2/

https://www.cbc.ca/news/canada/calgary/calgary-managed-alcohol-program-peter-coyle-place-1.3925821

https://obrieniph.ucalgary.ca/system/files/2018-09-21-lara-nixon-poster.pdf

https://caryacalgary.ca/wp-content/uploads/2014/12/OASPOC-Final-Report-Oct-2014.pdf

Alpha House (Calgary)

http://alphahousecalgary.com/

Tuner, A. (2015). Alternatives to criminalizing public intoxication: Case study of a sobering center in Calgary, AB. University of Alberta: *The School of Public Policy SPP Research Papers*, *8*(27).

APPENDIX B: COMBINED CENTRE EVALUATION TOOLS BY STAKEHOLDER GROUP

COMBINED CENTRE STAFF – FOCUS GROUP GUIDE

Construct	Question
Program Development	1. Can you start by describing how the Day Shelter and Sobering Centre are currently integrated? a. Prompt: Level of Integration, Location, services, etc. ? 2. To what extent is the program reaching the intended audience? a. Prompt: Any groups being excluded? If so, why?
Program Strengths and Challenges	3. What aspects of the program are facilitating success? 4. What aspects of the program are creating barriers to success?
Effectiveness of Level of Integration	5. How would you describe the effectiveness of the Combined Centre in achieving its objectives? a. Prompt: Providing basic human needs, medical services, and a safe environment for client, staff, and community? 6. How does the current level of integration contribute to the achievement of the objectives?
Impacts of the Service Integration	7. How has the existing integrated model of the Day Shelter and the Sobering Centre impacted the provision of services? a. Prompt: Program management? Safety improvements? Resourcing? Staff training? 8. Consider the existing model of the Combined Day Shelter and Sobering Centre, what changes would you like to see made that would enhance the positive impact on clients and the community?
Perceptions of Safety	9. What is your perceived level of safety associated with the combined shelter/Sobering Centre for clients? a. Prompt: for self, for clients, for public?
Wrap-up	10. Based on our conversation today, what would you like to see prioritized moving forward with the Combined Day Shelter and Sobering Centre?

STREET OUTREACH PROGRAM STAFF – FOCUS GROUP GUIDE

Construct	**Question**
Program Development	1. Overall, how do you perceive the Combined Day Shelter and Sobering Centre? a. Prompt: Integration, Location, services, etc. ? 2. Consider the existing model of the Combined Day Shelter and Sobering Centre, what changes would you like to see made that would enhance the positive impact on clients and the community?
Impacts of the Service Integration	**3.** How effective do you feel the Combined Centre is in achieving the objectives of providing basic human needs, medical services, and a safe environment?
Perceptions of Safety	**4.** What is your perceived level of safety associated with the combined shelter/Sobering Centre for clients? **a.** Prompt: for self, for clients, for public?

EMERGENCY SERVICES REPRESENTATIVES – FOCUS GROUP GUIDE

Construct	**Question**
Program Development	1. Overall, what are your perceptions of the Combined Day Shelter and Sobering Centre? a. Ie. Level of integration, Location, services offered, etc. ? 2. How have your perceptions changed since the integration of these two services in their new location? 3. Consider the existing model of the Combined Day Shelter and Sobering Centre, what changes would you like to see made that would enhance the positive impact on clients and the community? 4. To what extent do you feel the program is serving their target client population?
Impacts of the Service Integration	**5.** How effective do you feel the Combined Centre is in achieving the objectives of providing basic human needs, medical services, and a safe environment? **6.** What impacts has the Combined Centre had on the services you provide in the community?
Perceptions of Safety	**7.** What is your perceived level of safety associated with the combined shelter/Sobering Centre for clients? **a.** For self, for clients, for public?

COMMUNITY PARTNER AGENCIES – FOCUS GROUP AND INTERVIEW GUIDE

Construct	**Question**
Program Development	1. Overall, what are your perceptions of the Combined Day Shelter and Sobering Centre? a. Ie. Level of integration, Location, services offered, etc. ? 2. How have your perceptions changed since the integration of these two services in their new location? 3. Consider what you know about the existing model of the Combined Day Shelter and Sobering Centre, what changes would you like to see made that would enhance the positive impact on clients and the community? 4. To what extent do you feel the program is serving their target client population? a. Who is being excluded?
Impacts of the Service Integration	**5.** How effective do you feel the Combined Centre is in achieving the objectives of providing basic human needs, medical services, and a safe environment? **6.** How has the Combined Centre impacted the services you provide in the community?
Perceptions of Safety	**7.** What is your perceived level of safety associated with the combined shelter/Sobering Centre for clients? **a.** For self, for clients, for public?

SERVICE USERS – FACILITATED SURVEY

Construct	**Question**
Program Development	1. How often do you use the following services? *Service* Daily Weekly Monthly Seldom Never Day Shelter Sobering Centre 2. Is the Day Shelter accessible to you when you need it? ☐ Yes ☐ No 3. Have you, or anyone you know, experienced any barriers with coming to or staying at the Day Shelter or Sobering Centre? ☐ Yes ☐ No If yes, please explain: 4. Would you access the Sobering Centre/Day Shelter if it was outside of

downtown?

☐ Yes
☐ No. If no, why not?

How would you rate the follow aspects of the Day Shelter and Sobering Centre?

Aspect	Poor	Fair	Good	Excellent
Location				
Hours of operation				
Staff				
Variety of supports offered				

How often do you access the following services at the Day Shelter and Sobering Centre?

Service	Daily	Weekly	Monthly	Seldom	Never
Bathrooms/Showers					
Snacks/Food					
Bed for Sleeping					
Telephone					
Computer Access					
Public Health					
Counseling					
NWTDC Information					
Coordinator					
External services					
Donated clothes					
Addiction Groups					
Referrals to other services					

Program Strengths and Challenges

5. What do you like best about the Combined Day Shelter and Sobering Centre?
6. Is there something you wish the Day Shelter or Sobering Centre did that would make it better for you?

Effectiveness of Level of Integration

7. Is it easier or harder to access the Sobering Centre or Day Shelter changed since moving to this location?
   ☐ Easier
   ☐ Harder
   ☐ The same

Impacts of the Service Integration

8. Have you benefited from having the Sobering Centre and Day Shelter being located together?
   ☐ Yes
   ☐ No
   If yes, how? If no, why not?

Perceptions of Safety	9. How often do you feel safe when using the following services? Service Never Rarely Sometimes Often Always Day Shelter Sobering Centre 10. Do you ever have concerns about your safety or the safety of others when accessing the Day Shelter and Sobering Centre? ☐Yes ☐No If yes, please explain:
Wrap-up	11. Based on our conversation today, what would you like to see prioritized moving forward with the Combined Day Shelter and Sobering Centre?

NEIGHBOURS – IN-PERSON INTERVIEWS

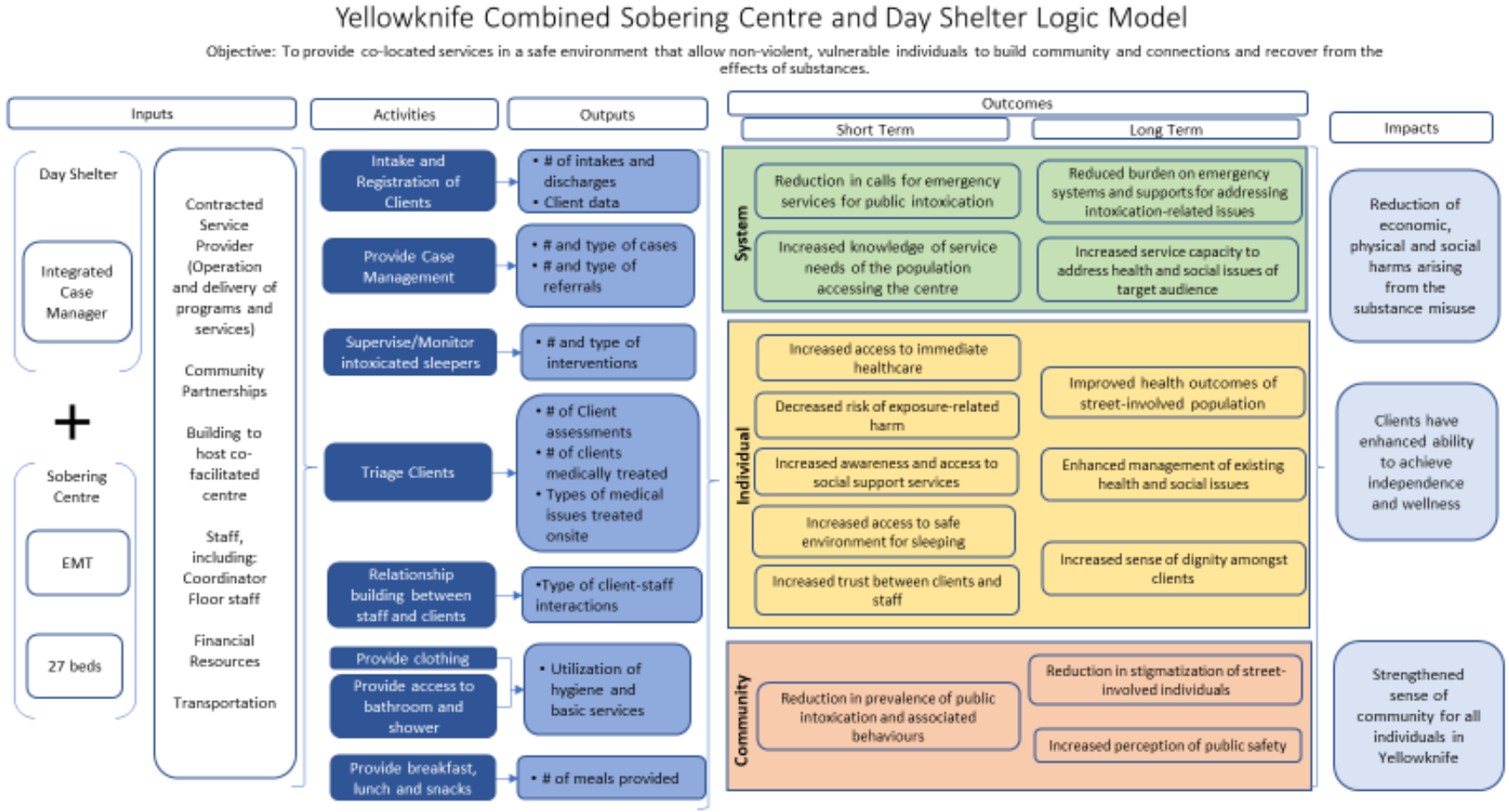
Construct	Question
Program Activities	• What do you know about the Combined Day Shelter and Sobering Centre in Yellowknife? • Have you ever interactions with the Day Shelter/Sobering Centre? • If yes: *Was it a positive or negative experience? What do you recall from the experience?*

Acceptability	• Do you experience any issues, as a neighbour with homelessness or intoxicated individuals in the area?
	  • *Prompt for anyone who has experienced issues*: What could be done to help alleviate the stress caused by these issues?
	• Overall, what is your perception of the Day Shelter/Sobering Centre?
	  • *Prompt: Positive, negative or neutral?*

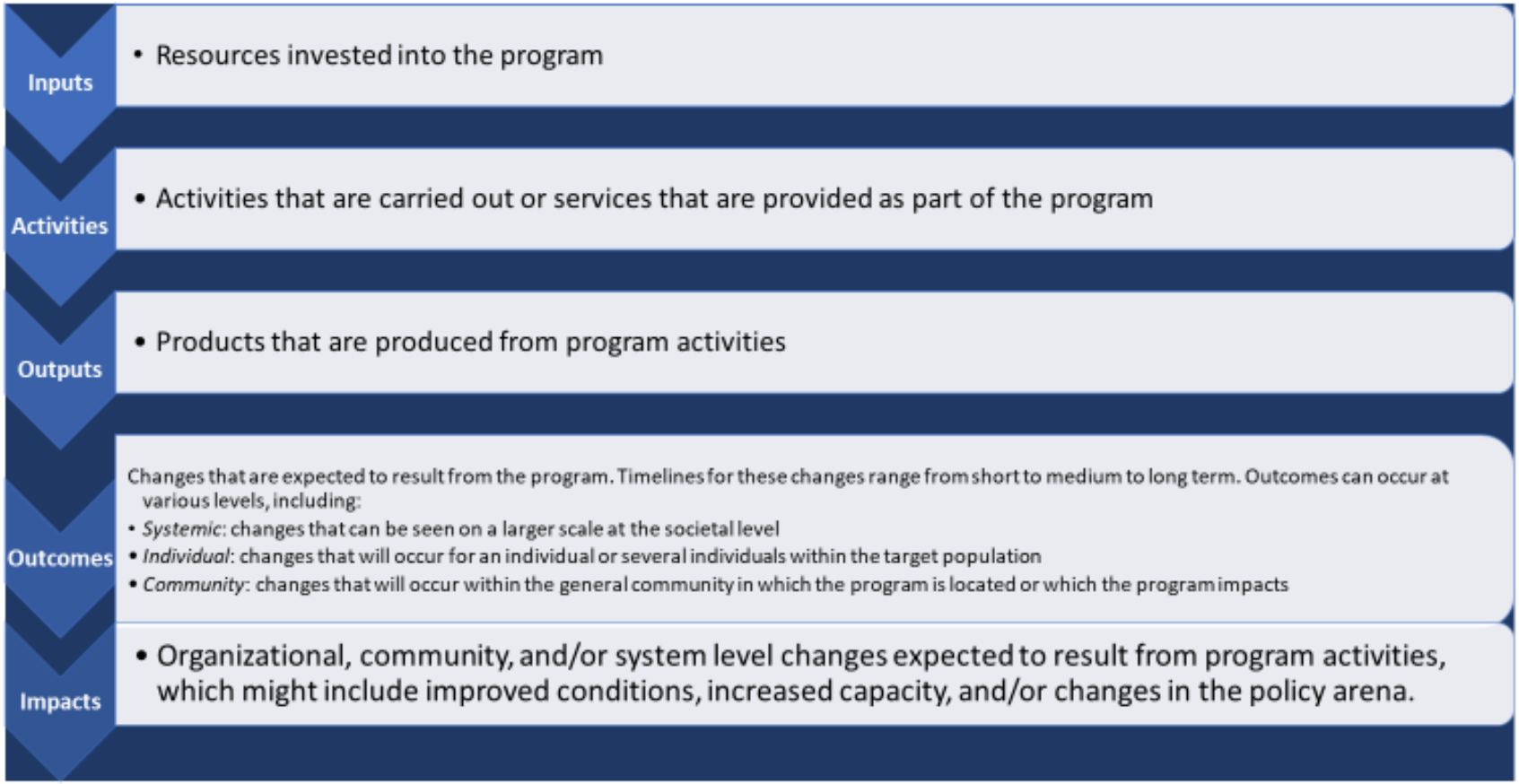
Outcomes	• How has the Day Shelter/Sobering Centre impacted your daily life? • How do you think the Day Shelter/Sobering Centre is impacting the downtown area? • Prompt: Intoxication levels? Public urination? Disputes or altercations? • What do you think the Day Shelter/Sobering Centre is doing well? • Do you have any suggestions for how the Day Shelter/Sobering Centre could improve?

APPENDIX C: REVISED LOGIC MODEL AND EVALUATION FRAMEWORK

After completing the evaluation detailed in this report, DPRA revised the Combined Sobering Centre and Day Shelter's logic model and evaluation framework in order to ensure these documents reflect the current objective of the program and the activities undertaken at the centre.



Definitions



Sources:
Public Health Ontario (2016). Focus On: Log model - A planning and evaluation tool. Retrieved from: https://www.publichealthontario.ca/-/media/documents/focus-on-logic-model.pdf?la=en
W.K. Kellogg Foundation (2004). Logic Model Development Guide. Retrieved from: https://www.bttop.org/sites/default/files/public/W.K.%20Kellogg%20LogicModel.pdf

Combined Sobering Centre and Day Shelter Evaluation Framework

Project Goal

To provide co-located services in a safe environment that allows non-violent, vulnerable individuals to build community and connections, and recover from the effects of substances.

Rationale	Key Stakeholders	Activities and Outcomes

Overview:
The purpose of the project is to:
• Provide non-violent intoxicated individuals access to a safe environment to sleep off the effects of substances
• Provide a harm reduction approach to support vulnerable populations in transitioning their current lifestyles
• Provide needs of basic human dignity (food, water, shelter, bathrooms) for homeless or precariously housed individuals regardless of their level of sobriety.
• Establish partnerships with other local agencies to facilitate the provision and access to health, social, and wellness services for vulnerable individuals
 	
Current State:
• Currently, there are several agencies in Yellowknife that provide emergency shelters for men and women; however, most of these shelters have zero to low tolerance for intoxication which limits the availability of safe shelter for substance users.
• Historically, there have been limited centres where street-involved individuals can congregate to receive basic needs like food, water, bathrooms, and warm shelter leading to congregation in public spaces that may be inadequate to meet basic needs.
• Incidence of exposure-related mortality in the winter months where the homeless or precariously housed population are most severely at-risk.
Guiding Principles:
• Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans
• Canadian Evaluation Society Program Evaluation Standards
	Target Population:
	
	• *Sobering Centre*
	  • Intoxicated individuals (all genders) who do not have a safe space to sleep
	
	• *Day Shelter*
	  • Non-violent, vulnerable individuals who are or at-risk of becoming homeless or precariously houses
		Major Activities:
		• Intake and registration of clients
		• Provide case management
		• Supervise/monitor intoxicated sleepers
		• Triage clients
		• Relationship building
		• Providing basic human needs
		• Providing access to bathrooms and showers
		Outcomes:
		• Reduction in calls for emergency services for public intoxication
		• Increased knowledge of service needs of the population
		• Increased access to immediate healthcare
		• Decreased risk of exposure-related harms
		• Increased awareness and access to social support services
		• Increased access to a safe environment for sleeping
		• Reduction in prevalence of public intoxication and associated behaviours
		• Reduced burden on emergency systems and supports for addressing intoxication-related issues
		• Increased service capacity to address health and social issues of target audience
		• Improved health outcomes of street-involved populations
		• Enhanced management of existing health and social issues
		• Increased sense of dignity amongst clients
		• Reduction in stigmatization of street-involved individuals
		• Increased perception of public safety
		• Reduction of economic, physical and social harms arising from the substance misuse
		• Clients have enhanced ability to achieve independence and wellness
		• Strengthened sense of community in Yellowknife

Evaluation Framework

Informing Program Development					
Evaluation Question	**Indicator** (What will show that the objective is achieved?)	**Data Source** (What data will reflect the indicator?)	**Completion** (Who will complete the measure?)	**Collection** (Who will collect the information?)	**Timing** (At what time will data be collected?)
What is the ideal mix of services to be housed in a future centre?	• Best practices in academic literature on service models for vulnerable populations, including those living with addictions and at-risk for homelessness	Academic literature	• Evaluators	• Evaluators	Per evaluation period/ during planning of a future centre
	• Perceived need for services and programs for clients in the target population	Focus groups	• Program staff • Partner agencies	Evaluators	
What is the ideal level of integration between the day shelter and sobering program for the permanent facility?	• Best practices in academic literature on models of integrated services for vulnerable populations, including those living with addictions and at-risk for homelessness	Academic literature	• Evaluators	• Evaluators	Per evaluation period/ during planning of a future centre
	• Perceptions of current level of integration between the day shelter and sobering centre	Focus groups	• Program staff • Partner agencies	• Evaluators	
To what extent is the program reaching the intended clients? Who is being excluded and why?	• # and demographics of clients turned away • Demographics of clients • % of return service users	Client intake/ discharge form	• Program staff	• Program staff	Ongoing
	• Client demographic data	Client intake/ discharge form	• Program staff	• Program staff	Ongoing
	• Perceptions of who is and is not accessing the services	Focus groups interviews	• Program staff • Partner Agency representatives • Emergency services representatives	• Evaluators	Per evaluation period
	• % of service users that self-report using the day shelter monthly or more • % of service users that self-report using the sobering centre monthly or more • % of service users that report the Day shelter is accessible • % of service users reporting barriers to accessing the Day shelter or Sobering Centre	Facilitated survey	• Service users	• Evaluators	Per evaluation period

How is the program perceived by stakeholders (staff, partner agencies, clients, businesses, and community?)	• Stakeholder perceptions of the combined sobering centre and day shelter services and function	Focus groups Interviews	• Program staff • Partner Agency representatives • Emergency services representatives • Service Users	Evaluators	Per evaluation period
	• % of service users reporting a 'good' or 'excellent' rating of aspects of the Day Shelter and Sobering Centre	Facilitated survey	• Service users	Evaluators	Per evaluation period
What changes are necessary to the program to mitigate identified problems, barriers or shortcomings and reduce any potential impact related to both the current location of the facility and the location for the permanent facility?	• Perceptions of necessary changes to the facility location • Perceptions of the impact of the current location of the facility	Focus groups interviews	• Program staff • Service users	• Evaluators	Per evaluation period
	• % of service users reporting easier access to the Day Shelter and Sobering centre in the new location	Facilitated survey	• Service users	• Evaluators	Per evaluation period

Identify program Strengths and Challenges

Evaluation Question	Indicator (What will show that the objective is achieved?)	Measure (What measure will reflect the indicator?)	Completion (Who will complete the measure?)	Collection (Who will collect the information?)	Timing (At what time will data be collected?)
What aspects of the program are facilitating success?	• Perceptions of facilitators leading to program delivery and outcome success	Focus groups Interviews	• Program staff • Partner agency representatives • Emergency Services	• Evaluators	Per evaluation period
What areas of the program are creating barriers to success?	• Perceptions of barriers to success within the program and service delivery	Focus groups Interviews	• Program staff • Partner agency representatives • Emergency Services	• Evaluators	Per evaluation period

Understand Impacts and Assess Effectiveness of the Level of Service Integration					
Evaluation Question	**Indicator** (What will show that the objective is achieved?)	**Measure** (What measure will reflect the indicator?)	**Completion** (Who will complete the measure?)	**Collection** (Who will collect the information?)	**Timing** (At what time will data be collected?)
What are the impacts of the current level of integration between the day shelter and the sobering program on achieving the intended outcomes, namely meeting needs and ensuring safety?	• % of service users who report personally benefiting from the combined Sobering Centre and Day shelter • Types of benefits service users report from the combined Sobering Centre and Day shelter • % of service users accessing medical care primarily through the Sobering Centre medics	Facilitated Survey	Service users	• Evaluators	Per evaluation period
	• Incidence of exposure-related deaths and injuries in Yellowknife	NWT Coroner's Report	Department of Justice	• Evaluators	Annually
	• # of referrals made to health and social services for service users	Client intake/discharge files	Program Staff	• Program staff	Ongoing
	• Utilization rates of sobering centre beds	Client intake/discharge files	Program staff	• Program staff	Ongoing
	• Perceptions of impact of service integration on program objectives • Perceptions of impact of service integration on partner agencies	Focus group	Program staff Emergency services representatives Partner agency representatives	• Evaluators	Per evaluation period
What has the impacts of the program been on ancillary and support services?	• Trend of emergency department visits for substance-related disorders • # of emergency department utilization for alcohol-abuse before and after the opening of the Combined Sobering Centre and Day Shelter • Rate of ambulance use for alcohol-related calls before and after the opening of the Combined Sobering Centre and Day Shelter	Stanton Territorial Hospital Department Emergency Department Utilization for Alcohol Abuse report	Stanton Territorial Hospital	• GNWT CPRE staff	Ongoing
	• Perceptions of impact of the program on emergency services	Focus group	Emergency service representatives	• Evaluators	Per evaluation period

Measure Perceptions of Safety					
Evaluation Question	**Indicator** (What will show that the objective is achieved?)	**Measure** (What measure will reflect the indicator?)	**Completion** (Who will complete the measure?)	**Collection** (Who will collect the information?)	**Timing** (At what time will data be collected?)
What is the perceived level of safety associated with the combined shelter/sobering centre for clients, staff, and community members?	• % of service users that reported safety concerns when accessing the Day Shelter or Sobering Centre • Service user perceptions of type safety concerns	Facilitated survey	Service users	• Evaluators	Per evaluation period
	• Staff's perceptions of the level of safety with working in the combine sobering centre and day shelter	Focus group	Program staff	• Evaluators	Per evaluation period
	• Perceptions of the level of safety associated with the combined sobering centre and day shelter	Focus groups Interviews	Partner agencies Emergency service representations Local businesses Community members	• Evaluators	Per evaluation period