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FALLING THROUGH THE CRACKS: HOW THE COMMUNITY-BASED APPROACH HAS FAILED CALGARY'S CHRONICALLY HOMELESS

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SUMMARY

The seeds of chronic homelessness, with the addictions and mental illness that often accompany it, are sown frequently in traumatic childhoods. A survey of 300 people experiencing chronic homelessness and those sleeping rough in Calgary reveals that these individuals have suffered childhood trauma at a rate five times higher than the general population. Those traumas include neglect, parents with addiction issues, domestic violence and abuse. Unfortunately for those seeking help, community-based services in Calgary have been unable to keep up since the prevailing philosophy became one of releasing these people from institutions into the community.

A 62 per cent reduction in psychiatric beds some 30 years ago was accompanied by levels of funding that simply weren't enough to provide all the resulting community services needed. People without families to turn to, and with no social supports, tended to end up homeless. It has become a vicious circle – while mental health issues can lead to homelessness, homelessness also puts people at greater risk for mental illness.

Because childhood trauma plays such a key role in chronic homelessness, it needs to be figured into the kinds of housing and support programs that are put in place for people who are homeless. Psychiatric supports should be among the programs that homeless shelters offer and should also be provided on a priority basis for people using the intervention program called Housing First.

There is no doubt about the link between adverse childhood experiences and future mental health problems. People who have experienced at least four types of childhood trauma are 12 times more likely to have attempted suicide, seven times more likely to be alcoholic, and 10 times more likely to have injected street drugs. They are also much more likely to be violent.

Interaction with the health-care and justice systems started early for the individuals surveyed in Calgary, aged between 18 and 80. Forty-two per cent of

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them had been foster children. Within the past year, 59 per cent had slept rough, 31 per cent had spent time in detox, 23 per cent had served jail time and 31 per cent had been in hospital. Eighty-two per cent regularly used alcohol, with 32 per cent using it daily and 70 per cent using drugs other than alcohol.

Yet, the help that is available for the chronically homeless population is at best scattershot. More than 50 per cent of those surveyed who had received help for mental health and addiction issues said they didn't get enough assistance. A quarter of those who didn't receive treatment said they'd asked for help and hadn't received it, while a third said long waitlists prevented them from accessing help. Many were in and out of a patchwork of programs with little to show for it.

Solutions are not out of reach. Funding should target housing and case management programs designed to address the psychiatric issues resulting from childhood trauma. And Calgary's network of community-based health care, housing and support programs should be expanded to help people suffering from multiple disorders. Currently, homeless shelters are serving as ad hoc institutions of mental health care for far too many people. With adequate funding and supports, long-term shelter users can be prioritized for psychiatric care, and shelters can return to their original mandate of being places where people who are temporarily homeless and in transition can get the help they need.

INTRODUCTION

De-institutionalization is defined as the release of previously excluded groups from large-scale mental hospitals into small-scale settings within the community (Dear and Wolch, 1987, 3). Prior to the Second World War, administrators in psychiatric institutions and hospitals struggled with overcrowding and inadequate budgets (Scull, 1977, 99). Following the war, increasing attention was paid to the poor treatment of patients in these facilities (Rose, 1979, 431). "By deinstitutionalizing patients, the government was able to save a substantial amount of money and present society with the belief that this was being done under the guise of humanitarian care" (Niles, 2013a, 68). Most institution and bed closures occurred in the 1970s and 1980s when there was a 62 per cent reduction in psychiatric beds (Sealy and Whitehead, 2004a, 251).

Once discharged, former patients did not receive improved quality or better access to services. "Although funding was provided in the community, it was provided at levels far below that needed to successfully support these individuals' needs" (Niles, 2013b, 75). Many lacked social and familial supports and ended up in homelessness.

"Deinstitutionalization was an incredible thing ... all you had to do was to load them with neuroleptic drugs and send them into the community … So we took tens of thousands of patients and threw them out of the hospital without any support system. We said there was going to be follow-up, but the fact of the matter is that nobody really understood, so the bureaucrats were delighted to get them out of hospitals ... and only ... later did we say, 'Hey, this is crazy, what about housing …?'" (Simmons, 1990, 160).

According to Calgary's point-in-time counts, the growth of homelessness for single adults has stabilized (Calgary Homeless Foundation, 2014, 4). However, the effects and implications of homelessness continue to be an issue, particularly for the chronically homeless. Researchers, including Hwang in 2001, have identified that people experiencing homelessness are at high risk for serious mental health issues and have worse than average health compared with stably housed people. Hwang (2001a, 231) also showed that mortality rates for people experiencing homelessness are 2.3 to 8.3 times higher than the general population of the same age. Further, people experiencing homelessness have higher than average rates of suicidal thoughts and suicide attempts, often related to un- or under-treated mental health issues (Hulchanski et al., 2009a, chap 2.3). The most commonly reported mental health issues are psychoactive substance use, depression, anxiety and post-traumatic stress disorder. People experiencing homelessness also have higher than average rates of schizophrenia, bi-polar disorder and delusional disorders. Mental health issues are cited as the most common reason people experiencing homelessness access emergency rooms, accounting for more than one-third of visits. Further, the longer someone is homeless, the more complex their mental health issues become (Hulchanski et al., 2004, chap 2.3). This means that the experience of homelessness itself worsens mental health.

Studies such as *At Home Chez Soi* (Goering et al., 2014a, 5) show that people with severe mental health issues can be successfully housed in the community if they have the proper supports. Those supports have been collected into a best-practice intervention called Housing First (HF), with the *At Home* study showing improved health outcomes, reduced costs and less strain on public systems overall. In Calgary, despite the fact that more than 8,000 people have been housed since the launch of Calgary's 10-Year Plan to End Homelessness, shelter statistics show that hundreds of people have been staying in emergency shelters for many years (Kneebone, Bell, Jackson and Jadidzadeh, 2015a, 12).

Despite the vast amount of empirical research arguing that homelessness is a public health issue, (Donovan and Shinseki, 2013, 180), people with very complex health needs continue to slip through the cracks of our public support systems. To try to address this gap, in 2014 the Calgary Recovery Services Task Force was formed and consisted of municipal and provincial government representatives, Alberta Health Services, the Calgary Police Service, emergency shelters, non-profit agencies and service providers. In turn, the task force commissioned research to identify and assess health issues, support needs and evaluate the strengths and weaknesses of existing public systems to create recommendations for improved and streamlined service delivery (Calgary Recovery Services Task Force, 2017, i). The findings presented here are part of this larger effort to understand and improve community-based care for those who, in another era, would likely have been institutionalized.

For this study, we conducted a survey of 300 individuals inside two emergency shelters and with a small group of rough sleepers. Survey questions focused on adverse childhood experiences, diagnosed mental health issues, depth and breadth of substance use, including non-beverage alcohol use, and experiences accessing health and social services.[1] The study received ethics approval from the University of Calgary Conjoint Health Ethics Review Board.[2] The question that guided our analysis for this report is whether experiences of childhood trauma can tell us something new about service and support needs and inform adaptations to housing programs to specifically address trauma.

Our intention is to provide local information on a serious issue in the hopes that we can shed some light on the relationship between childhood trauma and chronic homelessness. The findings presented here show the important role childhood trauma plays in those who experience chronic homelessness – an issue we think is important when considering housing and support programs. The policy options we discuss are: adding psychiatric supports to the emergency shelters which have become *de facto* mental health facilities, and to prioritize those who are chronically homeless for HF programs that include psychiatric supports for trauma.

BACKGROUND

Researchers have argued that the de-institutionalization movements that began in the 1950s, while well intentioned, were not well planned and resulted in a lack of appropriate community-based care for persons with mental illnesses (Morrow, Dagg and Manager, 2008, 2). The rationale supporting de-institutionalization was to improve choice and autonomy, reduce restrictions and improve human rights. It was believed that shifting from institutional care toward home and community-based care would result in reduced costs and improved health, wellbeing and societal acceptance (Lesage, 2000, 163). It was argued that institutions actually increased fear and stigma toward those considered different or deviant as they made "invisible" or removed people with mental illnesses from the public eye (Carey, Ben-Moshe and Chapman, 2014, 316). "What in fact occurred was rapid movement of mental health patients out of hospitals and into the community, accompanied by a slow growth of community mental health services. Deinstitutionalization appeared to be a policy of moving patients out of the institutions for legal and financial reasons, and the results were felt not just in the community but also on the street" (Sealy and Whitehead, 2004b, 250).

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1 For a copy of the survey questions, please contact katrina.milaney@ucalgary.ca

2 Ethics certification number: REB15-2194.

On any given day in Canada, 35,000 people will access an emergency shelter. Over the course of a year, emergency shelters will see more than 235,000 people (Gaetz, Gulliver and Richter, 2014, 5). Research on adult shelter utilization in Calgary shows that 86 per cent of people will access an emergency shelter only once; 12 per cent will access a shelter repeatedly over the course of several years. A smaller sub-group, considered chronically homeless, will stay in shelter for several years (Kneebone, Bell, Jackson and Jadidzadeh, 2015b, 8). This research substantiates results from other Canadian studies arguing that, for the majority of people, homelessness is a singular and temporary event likely related to poverty, changes in income or family situation (Trypuc and Robinson, 2004, 5). However, chronic shelter users utilize the majority of available resources in the homeless and health sectors. These chronic shelter users are, we argue, the long-tailed consequences of de-institutionalization without adequate attention to, and support for, community-based equivalents.

Research has shown that traumatic childhood experiences are predictors of chronic disease and mental health issues in adulthood. The Adverse Childhood Experiences survey (ACE) was developed in the 1990s to assess several types of abuse, family dysfunction and neglect (Centers for Disease Control and Prevention, 2016a). Findings have consistently shown that the higher the number of adverse childhood experiences, the greater the risk for issues later on. "Compared with people with zero ACEs, those with four categories of ACEs … were 12 times more likely to have attempted suicide, seven times more likely to be alcoholic, and 10 times more likely to have injected street drugs. People with high ACE scores are more likely to be violent … more broken bones, more drug prescriptions, more depression, more auto-immune diseases, and more work absences" (Stevens, 2012).

This discouraging cycle, in which adverse childhood experiences lead to mental health concerns and other issues requiring treatment that is unavailable in the community is, we posit, a significant factor in chronic homelessness. From an examination of the relationship between childhood trauma and chronic homelessness, this paper makes reform recommendations for existing community-based shelter and housing programs.

DATA AND ANALYSIS

Participants were recruited in a few ways. Posters were placed in two emergency shelters, shelter staff let potential participants know about the study and research assistants accompanied street outreach workers who approached rough sleepers and told them about the study. All participants volunteered and sat with a research assistant to go through the questions together. Data collection took place over the course of three months; participants were screened for length of time in homelessness (more than six months) and to ensure they were over the age of 16. Survey questions were adapted from a study in Edmonton that was trying to determine the need for harm reduction services. The Calgary Recovery Services Task Force reviewed all questions and led the development of the final survey. Questions included demographics, incidence of physical and mental health conditions and addictions, length of time in homelessness, and utilization and satisfaction levels accessing health and mainstream services. The survey consisted of 88 questions, 10 of which were taken from the ACE survey. While our total sample was 300, 299 people completed the ACE portion of the survey. Analysis was done using Excel and SPSS. The data presented here are in the form of descriptive statistics, correlations and regressions that highlight incidences of trauma, health and substance use issues.

DEMOGRAPHICS

The average age in our sample was 47, with respondents ranging between 18 and 80 years of age. Seventy-two per cent were men, 27 per cent were women and one per cent (two people) were transgender or two-spirited. Sixty-two per cent of respondents were Caucasian, 30 per cent Indigenous and eight per cent from other cultural backgrounds. Seventy-two per cent had been homeless for more than four years, with the largest cohort (29 per cent) having been homeless for longer than 11 years. Furthermore, 27 per cent of respondents reported being homeless for more than five years.

TABLE 1 NUMBER OF EPISODES OF HOMELESSNESS IN THEIR LIFETIMES

	Once	Twice	3 times	4 times	5 times	> 5 times
Number of respondents	79	47	43	28	21	82
Percentage of respondents (N=299)	26.42%	15.72%	14.38%	9.36%	7.02%	27.42%

TABLE 2 NUMBER OF YEARS EXPERIENCING HOMELESSNESS THROUGHOUT LIFETIME

	6-11 months	1 year	2-3 years	4-5 years	6-7 years	8-9 years	10-11 years	> 11 years
Number of respondents	10	16	54	49	24	18	42	86
Percentage of respondents (N=299)	3.34%	5.35%	18.06%	16.39%	8.03%	6.02%	14.05%	28.76%

SYSTEMS USE

Results show high systems interactions often starting in childhood as, for example, 42 per cent of respondents had been in foster care. In the previous 12 months, 59 per cent had been rough sleeping, 31 per cent had been in detox, 23 per cent in jail and 31 per cent in hospital.

ACE SURVEY

The ACE survey asks 10 yes-or-no questions related to experiences of childhood trauma. Respondents are asked whether or not they witnessed or experienced family violence, neglect or sexual assault. They are also asked if they lost a parent to divorce, death or to incarceration, if they ever went without food, clothing or adequate care and if a parent or family member had an addiction or mental health issue.[3] A score was then created based on how many yes answers a person checked. If a respondent said yes to four of the questions, they were assigned an ACE score of four.

Baseline surveys conducted in the 1990s using the ACE showed that one in eight people or 12.5 per cent had an ACE score of four or higher (Centers for Disease Control and Prevention, 2016b). In our study, 178 respondents (59.5 per cent) scored between four and 10 on the ACE survey. This is five times higher than the frequency of this score observed in the general population. Table 3 reports that the median ACE score among those in our survey was 4.2 for men and five for women. The mode, or most common score for both men and women, was five. This means that on average, respondents had experienced four to five types (not numbers) of traumatic events before the age of 18. Each type of traumatic event may have been experienced many times.

[3] See Appendix A for a copy of the ACE questions.

TABLE 3 ACE SCORES BY GENDER

	Average	Median	Mode
All genders* (N=299)	4.43	4	5
Women	5.02	5	5
Men	4.21	4	5

*Including one transgender and one two-spirited respondent

The most common adverse childhood experience was having a parent with an alcohol or drug addiction (70 per cent of women and 63 per cent of men). Fifty-three per cent of women and 46 per cent of men reported experiencing childhood abuse and 52 per cent of women and 22 per cent of men reported being a victim of childhood sexual assault. Fifty-five per cent lived in fear of physical violence and almost 40 per cent lived in a house where there was severe depression, mental illness and/or suicide.

The following regressions identify the relationships that ACE scores have with the variables *number of times homeless* and *number of years homeless*. Both number of years homeless and number of times homeless were self-reported by participants. Respondents were asked how long they had been homeless over the course of their entire lives and how many times they had been homeless in their lives. When reporting how long they had been homeless, respondents were provided with the following options: six to 11 months, one year, two to three years, four to five years, six to seven years, eight to nine years, 10 to 11 years, and more than 11 years. Further, respondents identified if they had been homeless once, twice, three times, four times, five times, or more than five times.

TABLE 4 LINEAR REGRESSIONS EXAMINING DEPENDENT VARIABLES NUMBER OF YEARS AND LENGTH OF TIME HOMELESS SCORES

Variables	Years Homeless Score Coefficients	Times Homeless Score Coefficients
ACE score	.128* (.050)	.098* (.044)
Age	.054* (.012)	-.025* (.011)
Male	.180 (.294)	.263 (.256)
Indigenous	.587 (.307)	.597* (.268)
Children	-.338 (.271)	-.163 (.236)
Children in respondent's care	-1.933* (.904)	-.747 (.789)
Number of physical health diagnoses	.005 (.046)	.090* (.040)
Social support	.105 (.271)	.140 (.236)

Standard errors in parentheses

* $p < .05$

Note: the variables diagnosed addiction in the last year and undiagnosed addiction in the last year were initially included in the regression; however, they had no noticeable influence on statistical significance or coefficient values. A full set of regression results is available upon request.

Table 4 identifies that when controlling for demographics, health and social support, a one unit increase in ACE score, on average, is associated with a statistically significant increase in the

number of years' homeless score. The second column of table 4 similarly shows that, when controlling for demographics, health and social support, a one unit increase in ACE score, on average, is associated with a statistically significant increase in the number of times homeless score. Age and whether children were in the respondents' care also emerged as significant when examining the number of years homeless. When examining the number of times homeless, age, identifying as Indigenous and the number of physical health diagnoses also emerged as significant. This suggests that these variables also impact the length of time and/or the number of times that individuals experience homelessness.

SUBSTANCE USE

Use of substances on a regular basis was high. Eighty-two per cent of people in our survey used alcohol regularly with 32 per cent doing so daily. Seventy per cent used drugs other than alcohol on a regular basis with 47 per cent using weekly or daily. Twenty-nine per cent have used more than one drug at a time and almost half have used drugs and alcohol at the same time. Fifteen per cent used non-beverage alcohol when regular alcohol was not available (for example, hand sanitizer), 22 per cent of whom used on a weekly or daily basis. Sixty per cent had been hurt or had hurt others because of alcohol use and 42 per cent had the same response for drug use.

Fifty-one per cent of people had a diagnosed addiction and 30 per cent felt they had an undiagnosed addiction. While 59 per cent reported using substances to cope with stress, 13 per cent reported using violence and 60 per cent reported avoiding contact with other people.

Table 5 reports how substance abuse differs by ACE score. A greater proportion of individuals with high ACE scores reported using each of the below substances in the past six months. Furthermore, a greater proportion of respondents with ACE scores of seven or higher reported having been diagnosed with the above mental illnesses. This further emphasizes the association that adverse childhood experiences have with long-term health outcomes.

TABLE 5 MOST COMMON SUBSTANCES USED IN PREVIOUS SIX MONTHS

	Respondents with ACE scores of 7+ (N=85)	Respondents with ACE scores of 0 to 3 (N=121)
Alcohol	71 (83.53%)	99 (81.82%)
Marijuana	58 (68.24%)	50 (41.32%)
Crack	36 (42.35%)	24 (19.83%)
Cocaine	33 (38.82%)	21 (17.36%)
Methamphetamine	29 (34.12%)	13 (10.74%)
Opioids • *OxyContin* • *Heroin* • *Fentanyl* • *Opium*	23 (27.06%) *17 (20.00%)* *14 (16.47%)* *10 (11.76%)* *6 (7.06%)*	8 (6.61%) *7 (5.79%)* *3 (2.48%)* *2 (1.65%)* *1 (0.83%)*
Amphetamine	17 (20.00%)	6 (4.96%)
Hashish	15 (17.65%)	11 (9.09%)
Non-beverage alcohol	10 (11.76%)	3 (2.48%)
MDMA*	8 (9.41%)	6 (4.96%)
Inhalants (solvents)	1 (1.18%)	0 (0.00%)
Other	8 (9.41%)	6 (4.96%)

* Note: Methylenedioxymethamphetamine (MDMA) is commonly known as ecstasy.

The vulnerability of people in our sample was troubling. Thirty per cent of people had considered suicide in the last year, 62 per cent had considered it in their lives, seven per cent had attempted suicide in the last year, and 39 per cent had attempted it in their lifetimes. Twenty-nine per cent of people had engaged in one or more forms of self-harm including cutting, hitting themselves and burning themselves. Twenty-two per cent of people had been in a psychiatric facility, 44 per cent of whom had been admitted multiple times. The times ranged from several days (44 per cent of those admitted), several weeks (33 per cent), several months (20 per cent) and several years (1.5 per cent). Seventeen per cent had been discharged to another facility or a jail and 26 per cent had been discharged to the street. Further, 64 respondents (21 per cent) had been diagnosed with a mental health condition, had an ACE score of four to 10, reported having been diagnosed with an addiction and experienced homelessness for one or more years.

TABLE 6 MENTAL HEALTH DIAGNOSES

	Respondents with ACE scores of 7+ (N=85)	Respondents with ACE scores of 0-3 (N=121)
Depression	28 (32.94%)	24 (19.83%)
Anxiety	25 (29.41%)	15 (12.40%)
PTSD	16 (18.82%)	9 (7.44%)
Personality disorder	8 (9.41%)	4 (3.31%)
Bi-polar	7 (8.24%)	5 (4.13%)
Schizophrenia	5 (5.88%)	0 (0.00%)
Psychotic Disorder	2 (2.35%)	0 (0.00%)
Other	8 (9.41%)	3 (2.48%)

Tables 5 and 6 indicate that high ACE scores are associated with high levels of substance use and mental health issues.

EXPERIENCES WITH SUPPORTS

Of those participating in the survey who indicated they received information about health and community services and treatment programs, about half said they received this information from staff in emergency shelters. The other half indicated that they did not know whom to ask, were afraid to ask, felt they could not afford it, or simply did not have a means of transport for receiving services or treatment. Furthermore, of those in the survey who received residential treatment for emotional or mental health issues or who received assistance with substance use, over half indicated they feel they did not receive enough help. Of those who did not receive treatment for these issues, one-quarter indicated they asked for, but did not receive help and another third indicated they did not receive help because waitlists were too long.

DISCUSSION

In many ways the results from our survey support previous researchers' arguments. For example, the prevalence of mental health issues and substance use is comparative to rates already reported (Hwang, 2001b, 231; Hulchanski et al., 2009b, chap. 2.3). In addition, we see high rates of adverse childhood incidents, substantiating previous arguments that people with early experiences of trauma are likely to experience economic, health and social issues in adulthood (Centers for Disease Control and Prevention, 2016c). A significant number of

participants had histories of cycling in and out of various systems and/or institutions (128 in foster care, 70 in jail and 92 in hospitals) and moving from shelter to rough sleeping appears to be a common experience. Results also showed that 82 per cent of participants used alcohol and 70 per cent used drugs on a regular basis, in some cases as a reaction to stress. The rates of self-harm, suicide attempts, violence, isolation and post-traumatic stress disorder are troubling.

Our results show a deep level of complexity and vulnerability for people who have faced early trauma. This trauma appears to manifest as very poor mental health. As such, it could be argued that the institutionalization of people with mental health issues continues. However, instead of being in one facility, people who are chronically homeless are cycling in and out of several institutions, each of which appears to reduce further their mental and physical health. This perverse effect is the direct opposite of what was intended by those arguing for de-institutionalization in the first instance. Long-term utilization of emergency shelters provides people with a roof over their heads but does not provide them with the health care generally, and mental health care specifically, that all Canadians are guaranteed access to according to the Canada Health Act.[4] The community-based health-care alternatives promised during de-institutionalization have not been developed and so emergency shelters have developed well intentioned, but less than ideal responses to fill the gaps. They have become, in their service to the chronically homeless, the present-day institutions of mental health care.

The best-practice intervention, based on the *At Home Chez Soi* program, for chronically homeless individuals with severe mental health issues, is the provision of housing with individualized case-managed supports to ensure stabilization and prevent a return to homelessness (Goering et al., 2014b, 5). Funding, including health funding, should be directed towards housing and case management programs that are specifically designed to address the complex psychiatric needs associated with childhood trauma. The appropriate response is to expand Calgary's network of community-based health care, housing and support programs and to target people with co-morbid and concurrent disorders. People experiencing chronic homelessness should be prioritized for housing and support programs that emphasize physical, psychological and emotional health and wellbeing and that help individuals build a sense of control and safety (Trauma Informed Care Project, n.d). Engaging the Ministry of Health in community-based health care, housing and case management programs would ensure that those with the most complex addictions and mental health issues can be prioritized. This could also reduce the likelihood that people being discharged from acute and psychiatric care are being discharged to emergency shelters and/or the streets. By prioritizing long-term shelter users for trauma-informed housing and case management, we can help return emergency shelters to their intended role: the support of those experiencing short-term, transitional homelessness. Through increasing accessibility to Housing First programs for those with high ACE scores, it is possible to provide wrap-around mental health and addictions services and trauma-informed care.

However, these are long-term solutions. Interventions must be added in the meantime while advocacy for expanded and flexible funding continues. Suggestions include mobile health care, enhanced psychiatric supports in shelters and potentially, an evaluation of the triage and referral process currently underway. A determination of who is being housed in HF programs could provide valuable information about how to ensure the most vulnerable (rather than the most likely to succeed) are being served first. This could also help to reduce the number of long-term shelter stayers if they are prioritized for housing and psychiatric care.

[4] Canada Health Act RSC 1985, c C-6.

CONCLUSION

Our interest in conducting this study was to assess the depth and breadth of complexity and vulnerability of people considered chronically homeless. We argue that very vulnerable Calgarians have become trapped in chronic homelessness and emergency shelters have become the one and only response. Our fear is that any approach not based on evidence could lead to a push for the re-institutionalization of people rather than an expansion of evidence-based best practices for supporting people in community with housing and health-care supports.

Policy and funding changes are required to address continued barriers for the most vulnerable. The central evidence of our study is that chronically homeless Calgarians have high rates of childhood trauma, mental health issues and addictions. Our analysis of that evidence suggests that people experiencing chronic homelessness would benefit in the long term from an enhanced HF model that recognizes and responds to childhood trauma. In the shorter term, reforms to the emergency shelter system that introduce the delivery of mental health care focused on trauma are, we argue, necessary to break the cycle of institutionalization.

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APPENDIX A: ADVERSE CHILDHOOD EXPERIENCES SURVEY

I am going to ask you some very personal questions about your early childhood. A lot of research now shows that adverse childhood experiences (ACE) contribute to problems later in life such as obesity, heart disease, mental health problems and different types of addiction. Your responses will help us understand how child maltreatment and family dysfunction are related to homelessness and health outcomes. While the questions often say "parent" and "household", we'd like to know if any of these experiences happened to you in any place you lived in while you were growing up. This could include a relative's home, foster home, group home, residential school or halfway house. We know that talking about adverse childhood experiences may be sensitive and potentially upsetting for some people. I just want to remind you that anything you say to us is confidential and you have the right to refuse to answer any questions.

Note: You may wish to do this section privately.

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often …
   Swear at you, insult you, put you down or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household often or very often …
   Push, grab, slap or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least five years older than you ever …
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal or vaginal intercourse with you?
   Yes No If yes enter 1 _____

4. Did you often or very often feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other or support each other?
   Yes No If yes enter 1 _____

5. Did you often or very often feel that …
   You didn't have enough to eat, had to wear dirty clothes and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Was a biological parent ever lost to you through divorce, abandonment or other reason?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

About the Authors

Dr. Katrina Milaney is an Assistant Professor in Community Rehabilitation and Disability Studies at the University of Calgary. She has an interdisciplinary academic background that includes sociological and gender-disability theory frames and has several years in community-based research. Her research track record was established in communities where she spent several years on projects related to public policy development. Katrina is a qualitative researcher and she uses critical theory frameworks to study social determinants of health including disability, homelessness, gender, culture, domestic violence and mental health. Part of her critically driven research revolves around her interest in political and economic ideology and their impact on public systems and service delivery. Katrina currently serves as an Executive Steering Committee member for the Canadian Observatory on Homelessness.

Nicole Williams is a community-based researcher focused on addressing issues regarding domestic violence, gender inequality, harm reduction, and homelessness. She is currently the Research and Evaluation Specialist for The Elizabeth Fry Society of Calgary and is involved in several community-based research and evaluation projects. As the data analyst for various research projects, she has provided evidence-based research to support service delivery changes and public policy recommendations.

Daniel J. Dutton is a Post-Doctoral Scholar at The School of Public Policy. His current research falls into three general categories: social and health economics, applied policy, and computational epidemiology. Most of his work is quantitative, utilizing large data sets and modeling strategies from economics and epidemiology. His primary interests are population-level exposures and their impact on poverty and health, how governments can address those exposures and the distributional impacts of addressing those exposures. He also has an interest in methodological practice, including how research is done in applied epidemiology and the questions researchers answer. Dan completed his PhD in Community Health Sciences with a specialization in Population and Public Health at the University of Calgary in 2014. Prior to his PhD Dan worked for a short time in the Ontario Ministry of Finance.

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