Mental Health and Addiction Strategy

Phase 1 Full Report: What we Heard

May 28, 2019

Project overview

City Administrative staff were directed to create a community-wide mental health, addiction and related crime prevention strategy through City Council's Notice of Motion C2018-0956. The City of Calgary is conducting a two-phase Community Listening Project in 2019 to inform the strategy.

Engagement overview

In Phase 1 we heard from over 90 people including individuals from over 40 organizations and five City business units. We heard from front-line workers, strategic or management staff, first responders, people with lived experience, peer-support workers and City staff. We held eight in-person sessions or one-on-one interviews. These meetings happened from April 1 to April 18, 2019.

We heard more than 3,200 ideas. This report considers all ideas across all questions for a strategic-level summary. This phase does not include the verbatim (exact feedback as written or noted by participants) comments as The City of Calgary committed to stakeholder privacy as the topic includes disclosure of personal and/or confidential information. To balance this, the report uses more direct examples of participant comments within each theme description.

What we asked

We asked all participants to describe the "mental health and addiction system" and what that phrase means. We wanted to know about the local challenges and solutions/successes in Calgary or elsewhere. We also asked them to identify any other resources and anything else The City should know when creating a mental health and addiction strategy.

What we heard

From all the ideas in Phase 1 there were 23 different themes that could be put into four broad categories about Mental Health and/or Addiction in the community. These categories are:

- **System collaboration** (4 themes) - page 3;
- **Service access** by those who need support (9 themes) - page 4;
- **Supports outside** the formal "system" (4 themes) - page 7; and
- **Stigma and awareness** (6 themes) - page 9.

There were also a few other topics with independent themes, including different **population groups** (12 themes) and **strategic approaches** (21 themes) – page 15.

- For a detailed summary of the input that was provided, please see the Summary of Input section.
- For a verbatim listing of all the input that was provided, please see the Verbatim Responses section.

Next steps

- City staff have reviewed this information as part of their report to City Council in July 2019 by way of the Standing Policy Committee on Community & Protective Services in June 2019. A summary of this report was attached and the full version is available to Council members.
- The full report will be shared with Phase 1 participants and those who were invited to participate.
- There will be a Phase 2 engagement on the next stage of the strategy in 2019.

Summary of Input

DETAILED THEMES – considering challenges, success and solutions

System-level collaboration - organizations, funders and staff – 4 themes	
THEME	**DESCRIPTION and EXAMPLES**
Organizational/ System ***collaboration and data sharing***	Authentic and client-outcome-based collaboration in service delivery, at multi-organizational tables/collectives, for grant/funding applications. Data sharing between orgs about results of programs, about clients to help avoid re-traumatizing and improve personalized service and for public safety. "[clients are challenged] repeating their story over and over at each step." Concerns about privacy of data. And examples of these current collaborations. "Networks and collaborations among organizations are well-intentioned but not well resourced. People are doing this work off the side of their desks." and "The Calgary Council for Addiction and Mental Health has a good strategic plan…Calgary Chamber of Volunteer Organizations has a good model…" and "More partnerships needed between organizations." and "need to put all their resources on paper and map it out." and "Need good data and measures." and "Information sharing between agencies and organizations could be better…We need to simplify some of that." and "dictated collaborations don't work as well for clients – even if the push for collaboration is good."
System Cohesion	Cohesion of the system itself: organizations, levels of government and agencies to work in unison for clients as opposed to be in siloes. Provide services with seamless transition, open up services for individuals who need access to multiple supports but which aren't available or are fragmented (cannot be accessed concurrently – related to eligibility but also to lack of services). "Not an integrated approach between mental health care and addictions" and "There is a continuum of care and funding but we need to streamline it and make it work better." and "shifting from service to service is a challenge for clients" and "Design a system for the person with Lived experience or future experience in mind." and "The different programming is disjointed" and "Look at how the system interacts" *Relates strongly to and with better* system cohesion *would impact other themes:* system navigation, transitions, eligibility, collaboration, funding structures.
Funding structures as barriers for organizations/service providers	Challenges: competition for funding; funders' requirements are an administrative burden that takes resources away from service provision. Significant concerns expressed about short term and "pilot" funding as unsustainable and high effort (wrong to emphasize innovation & trends over sustaining services with evidence of success and best practice). Better funding models could promote meaningful collaboration and meaningful data. "…ongoing funding support…for non-profit organizations which are nimble" and "We don't want to see 'death by pilot' as it's a lot of effort to create and launch a pilot…especially not knowing if it will be sustained… Let's support the good things we've got." and "Please do not provide onetime funding or only for new things." and "no funding for debriefing and for counselling staff" and "Getting funding by age, family structure, LGBTQ2A+ is too restrictive" and "Improve the funding cycles. When they are 1, 2, 3 year cycles it makes it difficult to plan and is stressful on staff" and "Funding structure impacts

	organizations and clients because it limits what staff can do and it drains staff time away from client care to navigate the funding system" and "Could funders ask different questions that would reflect the systems perspective? Rather than having to show a need for funding, have to show how the work fits into the system…" "the applicant has to prove why a program is needed, why people can't find it elsewhere and have other organizations genuinely sign off on their application" and a "collaborative funding model…for community to give back to own community and the agencies who offer psychosocial first aid in the wake of a natural disaster" and "Realign funding so that prevention can be a strong focus and for partnering with unlikely parties to foster innovation"
Relationships between organizations	Relationships between organizations and funders and between individuals within organizations. For *system cohesion* and benefits to staff, clients, community and programs. Related to *natural supports* with clients and as a kind of peer support as service provider to service provider. "Need trust between the services" and "how can we as non-profit service providers be helped to collaborate…please no more cross-sectional committees, we need other ideas" and "constant effort to rebuild the professional contact networks…" "there is a significant loss of relationship and history through high turnover…" and "capacity, education and bringing people together" and "communication and relationships with the funders is key" and "…a connection between the community and hospitals that is working well as a model"
Service access – 9 themes	
THEME	**DESCRIPTION and EXAMPLES**
System Navigation	Multiple access points and inability to know where to go or where to find information or how to move from one service to another. Information is difficult to understand. Relates to individuals who need services, for people's families trying to provide support. Also challenges for agency staff and service providers who do not have system information or knowledge of the services that exist for themselves or their clients. Case management, client follow up, outreach, ethics review/ombudsman as useful. Challenge: "to know where to go, I have learned from my own experience and Google… depending how resourceful you are is how much help you will get." and "…[need] navigators to support clients through the system…" and "…very challenging especially when a solo individual need to navigate the system while detoxing… needs to have a case manager…" and "many will work around the system" and "hard to navigate a broken system" and for staff "the ongoing navigation of the system and telling people 'no' is hard." and "open service, no referral needed and… other wraparound services with warm hand-offs…" and "tell people what to ask for, not just referring people to a resource."
Waitlists/ lack of resources or specific programs	Need more beds/programs/service providers/staff or it takes too long to get services due to a lack of resources. The additional challenges that some people face because of wait times and having to re-experience trauma or needing to get services to people when they were ready for them (i.e. treatment). Need for 24/7 services and more widespread geographically located services. "there's a need for more safe consumption sites" and "When interrelated systems break down this can have a huge impact on general mental health and specifically for people/families with pre-existing mental health and addictions (no water to homes); "huge waitlists for family programs" and "lack of shelter space and resources" and "the complexity

	of the client is increasing while the resources are declining" and "DOAP Team – need more of them, wait times are too long…" and "can we expand programs to 24/7?" "access to them across all 4 quadrants of the city" and "Coming forward to ask for help is so hard. Every person who asks for help should be able to access help immediately." "Need to be able to access support in the moment that someone is ready…" "The system is too long. The difficulties lie in the interim." And "if they are ready at that moment but they can't come in now and have to wait 8 hours… they have to wait and experience all that trauma and will be using again."
Families and care-givers accessing supports for themselves or the people they are caring for	Meaning care-givers and families need supports, consider their secondary trauma and self-care but also help with system navigation. There aren't enough services and information sharing with supportive families of people *in the system*. "Need more informed and client-/family-driven services." and "Need different structure at emergency. Someone can be turned away but the family member, who may not be allowed to speak, could be the one to provide the information or decode/decipher the need…" and "Families find it hard to navigate mental health system." and "We are used to, when dealing with adults, seeing them as a contained little bit. Almost none of us are. We are connected to family." and "Families are petrified to find out that their 17 year old who they could help…becomes 18 and they no longer have access, information or ability to support…" and "create safe communities for kids and parents" and "We did not understand the system or where to go or what resources there were…" and "Families drop someone off and then pick them up – that's what I feels like. There's nothing else and it isn't good. Need wrap around supports for those families just like everybody else."
General "barrier to access" comment	When only general comments were made about access or barriers to access. "Barriers to access" and "Accessibility" and "how you access services…" and "too many hoops for attaining care."
Appropriate Services – ***culturally relevant***	"Cultural competency" and "acknowledge value in non-traditional methods" and "language barriers and reduced availability of translators or translated material" and "need to consider the values, in some cultures, the necessity of separating support groups for men and women" and "the Indigenous Gathering Place is great" and "Communities need to be given access to take care of their own group members" and "Lack of cultural-based options" and "Healing practices with cultural diversity considerations."

Eligibility	The complications and barriers that come from eligibility requirements or *factors* to get services or supports. A very strong connection was made to how people may not qualify or meet certain standards (i.e. age, sobriety, duration of living in X, etc.), and if this happens as they attempt to gain service, but are thus delayed, they can feel defeated or trapped, and miss the opportunity (i.e. window of the sense of safety to get the support they needed. "There are many different resources with different eligibility." and "For youth, if they are not housed and have no job and no school they will not meet the criteria for intake… then they will not get any service or support." and "Too many rules and exclusion criteria for family and individuals" and "Entrance criteria required to be able to access services" and "admission requirements – clients are lost in this system if they are rejected by several agencies due to 'failing' the criteria."
Diagnosis/ ***Assessment***	The important need for diagnosis and for good, accessible diagnostic services – but also the complexity of diagnosis for different populations (i.e. youth, poly-substance users, etc.) and how it is critical to have accurate diagnoses to get appropriate services. "The system offers diagnosis but no follow-up." and "often the addiction is the least of the concerns – the substance use may be a coping strategy for… underlying mental health conditions" and "Not able to properly diagnose mental health issues until a person is off drugs." and "Diagnosis can be difficult – many waitlists… [mean] people go back to using drugs while waiting" and a very high percentage of clients "at intake report they were exposed to childhood trauma or physical or mental abuse or intergenerational trauma… though this could increase after some amount of treatment and support and more is revealed/reported. Need to have professionals appropriately assessing." and "Clients may self-diagnose and look for services" and "Being assessed after using meth for 10+ years makes it nearly impossible" and "medical practitioners won't serve/admit when it's 'addictions related' like a drug-induced psychosis."
Appropriate Services – personally relevant and client ***choice***	"Large focus on the Calgary downtown core, but chronic and acute issues also exist externally, vulnerability is city wide" and "[with more than one peer-support worker you could] realize you won't connect with everyone [who comes in] but there is someone else who they can try and connect with [and] this isn't possible if there's only one peer-support worker" and "use technology and have online counselling [as an option]" "having self-serving options – virtual, in-person, text, etc." and "Lack of choice is a challenge" and "a model that allows for structured, collaborative planning processes that include all stakeholders and especially the client and client's family/social supports…" and "Service user choice is important. It's available in other areas or to some populations but not often for mental health and addictions… if you have a bad experience with one organization or person or it's not a fit, then that's it."

Cost	Cost as a barrier to clients or families accessing services was mostly used in the context of "middle class" or middle income households where people may be able to pay to access services, or to access better quality services, but then run out of money and won't get what they need, nor qualify for services beyond what they paid for. Sometimes in relation to a certain quality of services that aren't accessible to anyone unless they have the means to pay for it. A few times related to the costs that prevent certain services from being more available. "Alberta Works only allows for a limited amount of funding (for treatment)" and "a certified interpreter can be $40/hr" and "if service was free that would be ideal… or structure so they need to pay on the third visit. Why are people made to pay when they are still in distress?" and "Costly to have services or materials in French" and "Fee access systems – bus, recreation – large barriers" and "For middle income clients [facing] long waitlists, they can go to private services until they can't afford them…" and "Staff are often taking pretty serious pay cuts to move into this sector…. Less turnover with more compensation for the work."
Supports outside the formal Mental Health and/or Addiction **system(s)** – 4 themes	
THEME	**DESCRIPTION and EXAMPLES**
Natural and community supports	Relates both specifically to the individuals who are supportive in someone's network and how to build that and why it's valuable and also that the support of a general community is similarly important. "Natural supports and connections to the community can be 'the' system" and "What are we doing to build communities?" and "Cities can design spaces that help provide natural supports…social determinants of health and how they're related to urban design…" and "Abundant communities program…building a community structure in the suburbs" and "Create connection" and "Social connections are key in mental health, we need to leverage these more." and "Kindness is what's remembered by everyone… We can all integrate into our everyday actions: kindness. This makes people feel seen, feel real and it's the human experience. It's vital." and "Natural supports – having people in your life who are safe and stable, [and] balance that with services"
Basic needs being met first	Housing, food, transportation, skills, basic income, child care and meaningful activity too. "Mental Health and addiction is not just medical but as much about social determinants of health." and "Integrate support into basic needs support" and "Addictions treatment where families can remain intact and not need to have a place for the kids" and "…if they don't have housing they don't have a place to stay in between stages of their journey… if they are motivated to change that can be lost.. need a focus on these supports and resources as well as activities they can get involved in" and "in the city the 'formal medical piece' is not bad – the therapists, psychiatrists – but that formal piece is only 5% of someone's life – there's housing, food security, income, meaningful activity and all the other psychosocial time and space in someone's life that needs to be considered" and "it's hard to engage with clients if basic needs like having a safe place to sleep isn't met" "with the downturn in the economy, there is cutting off of power to people who can't afford to pay… we are making it (mental health/addictions) worse" and "social prescribing" and "treatment centres would be required to teach you life skills, transferable skills…" and "How many people are doing it [substance use] for

	survival? If you can stay awake for 24 hrs you're less likely to have your things stolen." And "if they don't have housing they don't have a place to stay between stages in their journey. Getting between detox and treatment is hard because they have nowhere safe to stay and also struggle transporting themselves."
Risk factors need to be considered – Trauma & Isolation	How risk factors compound the challenges of mental health, mental illness, substance use and addiction - most frequently: Trauma and "Isolation". Trauma either as intergenerational trauma, from escaping as a refugee or being a front-line worker with secondary trauma. Isolation for certain populations (seniors, language barriers) but also as a risk factor for anyone to develop or exacerbate mental health, mental illness, substance use or addiction. "need to address addition issues by recognizing the effects of trauma and social disconnection" and "compounded trauma" and "someone with PTSD (post-traumatic stress disorder) and addictions may have different challenges" and "other people are isolated like newcomers to Canada and that can mean their mental health or addiction needs are more likely to impact their families who are here…" and "if someone is experiencing one of these [risk factors] and still provides care to someone, that is an additional challenge" and "poverty itself is highly traumatic" and "racism and intergenerational trauma contributes to Indigenous people as over-represented in the homeless population" and other risk factors: "fatigue" , "feel overwhelmed", "psychological safety", "family history", "pain", "economic downturn… no job, money, power is cut off…", "recent refugees, survivors of ISIS", "nutrition", "skills"
Transitions	Follow-up and after-care, transitions between systems – hospital to community, jail to community, youth to adult, adult to senior, secondary to post-secondary school, on- to off-campus, immigrant families intergenerational transitions or individuals from permanent resident to citizen, detox to treatment - and how services change, support lacks, mental health and addiction can become more pronounced/active during transitions. "The current system does good before 18 for mental health and for addictions, but after 18 the continuity of care is lost… access becomes harder" and "Step Down Bed program at the D.I. provides out-patient care after hospitalization." and "[A challenge is] Transition points …it's a large black hole." and "Transition points are challenges and if we can improve those places we can make a significant impact for people. Youth to adult, inmates to community, hospital to community (or hospital to community organization)" and "Lack of lifelong sectors approach" and "More follow-up services would be beneficial…Reach out – *I'm thinking of you. Do you need anything*?" and "Better follow ups and more follow up services. By only responding to crisis we are teaching everyone that this is the only thing that matters and deserves attention." and "Very, very limited bridging and mainly a focus on immediate "safety" – as in 'safe enough'…"

Stigma and Awareness – 6 themes	
THEME	**DESCRIPTION and EXAMPLES**
Education, awareness and understanding	Trauma-informed care or other training for front line/agency workers is better for client outcomes and helps combat stigma. Raising awareness through campaigns to educate and normalize services for MHA – for general public, care givers. Not the education or information for clients or people who need services but the rest of the communities. "More education and understanding in general population and for people working in or needing the system" and "This awareness would help for prevention and promotion and could prevent a lot of cost" and "Chronic issues that can't be 'solved' and provide the education to the first responders and support staff in how to manage that. Change the end goal… reframe and re-educate" and "Training on 'what to expect' for staff as it relates to mental health and addiction. The community outreach piece is essential." and "There is a lot of misinformation in the system about the system…" and "Innovative learning opportunities (Brain Story)" and "community services guide" and "The best awareness campaigns are to demonstrate by example" and "a lot of focus in campaigns to de-stigmatize mental health issues…this is helpful to develop empathy/understanding" and "(A success is that) more sensitivity training has been happening" and "Large education project to enhance knowledge of trauma and effective ways of working with traumatised people" and "Courses/workshops for public and/or business in high issue frequency areas so they know how to respond to crisis" and "mental health first aid" and "Professional development training to align system on a common knowledge base… to allow the system to work better together." and "need to build understanding about why mental health and addictions problems exist. Need education or campaigns that explain 'not by choice, not my choice.'"
Stigma, shame from others and societal discrimination	Stigma is powerful and hard to change but needs to be changed. Lack of knowledge or pre-existing bias about what addictions/substance use or mental health/illness looks like. May have more stigma in different cultural communities to acknowledge mental health or addictions challenges or need for services. Shame as connected to isolation (see *risk factor* theme). "Stigma" and "not talked about until a crisis" and "Emphasize the stigma piece. This is a natural and universal healthcare issue." and "(success) DOAP and Transit - …they are shifting the culture of the relationship of someone wearing a uniform to the public…" and "Need to change the conversation… "ACE Score" focuses on the whole City…helps speak to where there are strengths and what areas need attention…but with less negative stigma" and "…zoning and bylaws…why is there a huge rigmarole for a 25 unit apartment for mental health and addiction but not the same rigmarole for a 25 unit apartment not for mental health and addiction but many people with mental health and addiction challenges could move in there? …There are fractured relationships (with the community) before anyone walks in the door." And "Self advocacy and system navigation – stigma has an impact on this and a person's experience" and "Think about framing the challenge in a way that removes stigma…" and "Harm Reduction, that helps people promote health if and when they are ready with non-stigma, non-judgemental approach." and "Reducing stigma through relationships, national research around this, is better than education"

Peer-to-peer (related to all four main categories)	Successes with peer support, importance/value of peer support as someone being understood is key to support. Need more (and paid) peer positions in all aspects of the system. "Peer support is important and there should be more of it available…in the courthouse, for addiction, for mental illness, and in other settings" and "AaWARE mentor – having community mentors that can help organize the communities they are in…" and "Peer-led spaces that are inviting, not so clinical or sterile- a think tank or hub for people with lived experience" and "Employ more people with lived experience and in higher positions" and "Peer support model is based on international research" and "everyone wants peer support" and "A compassionate system where peers help each other negotiate the system and create community" and "Peer navigation" and "Strong peer networks provide a voice to those with lived experience positioning them best to advocate, influence, collaborate with those that deliver or redesign systems of support." and "Peer-to-peer as preventative. We hire [peers to speak to those newly diagnosed] as this is when we find people are most confused and don't know what to do" "Family peer-support" and "Youth find peer support even more effective…" and "Courts, children's hospital… it means the same thing no matter where you are – you are not alone, people have survived this before and you can survive this. [Peer support] works in conjunction and is collaborative, complementary and interdisciplinary." and "Peer support is underutilized in community and medical system – lots of opportunity. Even could be useful at the private sector – what if you could go to someone instead of Human Resources for MH, Behavioural Health (eating disorder, self-harm, substance use) it is effecting your work."
Intersectional stigma/ discrimination	Stigma of other types of discrimination (class, education, cleanliness, racism, etc.) that are more of a barrier to receiving services or more of a barrier to good health than the mental health, mental illness, addiction, substance use stigma might be. For example: Recreational drug use by people of higher economic class or of political or social power is considered "glamorous" as opposed to shameful. "The stigma is more often about the person drinking (or using) than it it's about the addiction (or addiction in general)" and "additional challenges people face when their gender or sexual identity has related stigma…which can create or be the risk factors, amplify the mental health/addiction challenge, create barriers to service" and "systemic reproductions of racism and intergenerational trauma contributes to Indigenous Peoples as over-represented in the homeless population… or not wanting to deal with the system or be treated by the system…" and "Lack of intersectional approach"
Stigma as a barrier to access	When stigma or shame of the mental health, mental illness, substance use or addiction was mentioned as a barrier to accessing services in a general sense. "Stigma is a huge barrier" and "Stigma – reaching out for help can be difficult."
Self-stigma	Conditions, symptoms and causes of mental health, mental illness, addiction that someone blames themselves for and that this is a significant challenge for recovery, even more so for certain populations/individuals. "I blamed myself that I didn't do something right but now learning, realizing and accepting that there's only so much I can do to control that… the shame… come up from that… self-stigma" and "…if you go through the system and 'fail' you internalized that…" and "self-stigma is harder to beat than others. Some say: "I cannot tell myself that!" Often harder or impossible with the older generation. It's always present; worst enemy."

Populations – 12 themes	
THEME	**DESCRIPTION and EXAMPLES**
First responders	Most often relating to formal first responders such as law enforcement, emergency responders (Fire, EMS), but may have also been used to describe doctors/nurses in hospitals and other professionals or service providers in crisis or immediate response capacities (i.e. social workers in hospital, front line staff working with clients if they experience an overdose, etc.) **Key related themes:** need for trauma-informed and compassionate training/practices; needs for services themselves; collaboration with other responders/staff/agencies; shift in thinking about first responders by clients.
Agency staff	The paid employees or volunteers of the organizations/service providers. Mostly mentioned generally or not in the context of dealing with immediate crises such as overdoses or psychosis, however the point was often made that this line is blurred as many front-line agency staff are dealing with acute needs and crises so would be first responders in those instances. **Key related themes:** challenges for staff (growing need, more complexity, compassion fatigue); need for trauma-informed and compassionate service delivery; having their own or needing to respond to others' risk factors like trauma and isolation; system cohesion and navigation challenges for staff
Organizations	Organizations in the community. Mostly not-for-profit, but some private that provide services in the community. Sometimes also the government agencies that provide services for mental health/illness, addiction/substance use. **Key related themes:** collaboration and data sharing to enhance outcomes, better use resources and improve system cohesion; education and training for or by organizations is important; need to build relationships between organizations (another kind of peer-to-peer relationships); funder impacts on organizations' abilities to provide responsive, coordinated and efficient services
People with ***low income*** or living homeless	Mostly about individuals who are homeless or are living in poverty but sometimes also about those who are low income and at risk of losing housing. Also connected to those who need to access a variety of supports downtown that cater to those with low income or experiencing homelessness. **Key related themes:** basic needs (housing, safety, physical health) must be met first or along with mental health and addictions needs; huge challenge with waitlists and waiting for service when having to do so without a home; system cohesion and navigation challenges generally and for choice and eligibility reasons
People with ***middle income***	Mostly speaking about individuals or families with middle income that don't qualify for low income programs/services. Sometimes also in relation to living outside of the downtown core. **Key related themes**: stigma and shame is a huge barrier; some other kinds of discrimination may also exist as a barrier to make mental health/addiction hidden and some things are more 'socially acceptable'; cost is a challenge as some may not have enough money for sustained service or qualify for other low-cost programs
High acuity individuals	People who experience multiple complicating factors as part of their experience with the system of support - including physical health, mental health, mental

	illness and/or addiction, substance use and/or other risk factors (i.e. trauma). Or relating to poly-substance use and how that makes service provision more complex as well. **Key related themes:** Consider risk factors (trauma, isolation etc.); waitlists are huge challenges; basic needs (physical health) must also be met; diagnosis and assessment is important but additionally challenging; system cohesion related to eligibility for programs when part of the complexity of the care needs negate them from some services/programs.
Sex/Gender	Comments made specifically about women or men or LGBTQ2+ in terms of available services or needs. **Key related themes:** generally – consider how sex/gender relates to mental health and addiction, services and related risk factors. **As relating to *women*:** as employees for service agencies; intersectional – for Indigenous women, young women, pregnant women- more gaps; generally need for more addictions and housing services; some good examples of programs **relating to *men*:** higher rates/risks of certain challenges (suicide, homelessness); less services in some areas (sexual exploitation housing and related supports) **relating to *LGBTQ2+*:** need more focus on and services for these individuals; examples of better practices and of how eligibility is a challenge.
Age – Youth	This includes a few comments about children under 12, but mostly 12+. Also comments about the definition of youth (sometimes up to 18 years, sometimes up to 24 or 29 years). **Key related themes**: transition challenges into adult system; lacking services; examples of good services/models; prevention/diversion needed; families who struggle to support youth once they turn 18
Age – Seniors	Often to mean 65 years+ though not often specified. **Key related themes:** transitions of adults to seniors means changes in services/eligibility; intersectional- seniors who are recent immigrants and also have a language barrier may have additional risk factors; isolation as a significant risk factor; seniors as caregivers; intergenerational programs are successful and meaningful
Multicultural and/or multilingual populations	Individuals who have recently moved to Canada and do not speak English or those who speak only French. Anyone who needs language translation/ interpretation or different services based on cultural or healing practices beyond the typical English-speaking system/services. **Key related themes:** primarily about needing services/programs and approaches that incorporate and reflective of different cultural traditions and healing to be more supportive of individuals from that culture; natural supports from within the cultural group are important; there may be additional risk factors (isolation) or different/more stigma in certain cultural communities

Indigenous Peoples and cultures	The diverse needs and differences that Indigenous Peoples (either living on First Nations reserves or in urban areas) have and bring as world views, both as a population who needs more culturally relevant supports, and as groups/individuals who need to be part of the process to hear and understand their concerns and solutions. **Key related themes:** primarily about having Indigenous worldviews, cultures and Peoples a part of this process and in service delivery design; to indicate some challenges are disproportionately felt by Indigenous Peoples and are related to intergenerational trauma or colonial-based systems/structures; needing to build stronger relationships
Lived experience	People who have direct personal experience with mental health, mental illness, addiction, substance use. Sometimes referring also to people who have immediate relationships with people who have lived experience when relating to having experience with the "system" as a support for someone. **Key related themes:** important this perspective in this conversation; to consider the family and caregivers who also have lived experience; peer-to-peer is an important and growing movement
General "population-based" approach	This was when a "population approach" was recommended – which often included an example of one or more other populations. To have a strategy or services that are designed from the actual needs of a specific populations. **Key related themes:** important to consider how risk factors impact different populations; needing to have choice in services/supports related to populations or individuals; different populations will have different struggles and experiences with system navigation, access and supports

MUNICIPAL STRATEGY – Suggestions for The City's approach to this strategy

(in alphabetical order by theme name)

THEME	DESCRIPTION and EXAMPLES
Basic needs first	"it works, its good." "Quality of life is very important." "Restorative economic approach." "Community safety, psychological safety, resiliency" "Mental health is tied to housing issues." "Financial stability – hourly wage of employees."
City's role - suggestions	local leadership; City programs, policies and operations; essential service systems; advocacy to levels of government or other sectors; funding organization's programs; emergency response; data collection/evaluation; education and training; information and evaluation
Consider the ***built environment***	"What our system looks like from a built environment tells us a lot about what it looks like functionally." "How do green spaces support mental health – how do we pinpoint our successes for what we provide?"
Client service as customer service	"When clients approach service, now is the time, not two days or two hours later." "Kindness... It's vital." "Time is of the essence." "Outreach based model." "Access Open Minds model" "Drop-in and phone services are great." "Provide the education to the first responders…" "Critical time interventions…"
Community-based	"Create vibrant, inclusive communities… 'the opposite of addiction is connection.'" "We need more social connection…" Help build and reinforce the natural supports for people and mentorships. "Create inclusive societies and keep people safe, but this is hard." "This is a social issue and needs to be solved collaboratively." "Developmental relationship model." "all change happens within a relationship" "support natural supports…infrastructure that supports healthy living and well being…" "Abundant Communities Initiative" "Youth Refresh model" "Icelandic Model"
Collaborative and data sharing	Leadership and advocacy in bringing organizations together and looking for shared opportunities for funding, training, data collection/program evaluation, strategic planning at a "community-wide" level. "…a good model of working together and supporting the work of partner/network organizations through paid staff (in contrast to networks where people to collaborative work in addition to their regular job)." "if someone comes in to get support only once and they don't come back, how can we measure or know if it was a success?" "Leverage 'uncommon tables' and bring together people who aren't normally brought together."
Flexible services to fit individuals – identity and empowerment	Including setting goals and understanding outcomes based on the individual (i.e. wellness is not the same for everyone) "Wellbeing is a goal. Mental health looks different for everyone." "Health is subjective 'good health outcomes' are dependent on the individual…" "…need to change every 6 months to stay relevant… need to listen and reinvent. Be adaptable." "Any services that can be offered in the person's first language is a huge benefit." "The majority of the population are capable and we need to empower them with the correct information for the next steps in their journey…" "Shift the focus of the conversation 'what's going on for you?' and feeling validated and heard and empowered." "Human rights approach."

Foster hope **-** Stigma-reduction through compassion and education	For community, staff, first responders, for individuals coping/experiencing mental health and/or addiction challenges. Related to having candid conversations about related topics, to better understand evidence-based solutions especially related to harm-reduction. Training for service providers and front-line workers. "The stigma is more often about the person drinking than it is about the addiction…" "Decriminalizing drugs means destigmatizing." "Make it a public value." "Outcome indicators – Hope as an outcome." "Brain Story language." "ACE score model."
Involve other stakeholders/sectors	Indigenous Peoples, communities and service providers, school boards, business and developer sectors, post-secondary institutions, work places, other levels of government, specific not-for-profits, faith institutions, justice/enforcement sector, parents, doctors, first responders, all front-line workers, peers and people with lived experience.
Legal and judicial reform	Municipal advocacy for changes. Primarily around substance legalization and access to information to support caregivers (esp. for youth). "Portugal model."
Lived Experience & Peer support	Population, when lived experience should be consulted and the importance of leveraging that experience in finding solutions/changes. "Everyone wants peer support." "Peer to peer is preventative."
Like the ***physical health model***	Including Emergency Mental Health services, Mental Health First Aid – parallel structures and supports. "Mental Health First Aid is working well." "The model of physical health system needs to be considered more." "Health economics."
Problem-solving orientation	"Problem identification is also a problem and we can have lots of solutions but may not know the real problems. What are the drivers?" "need to define Harm Reduction and Treatment." "Need to discuss the level of prevention – primary? Secondary? Tertiary?" "Look at the role family violence plays."
Use ***policy levers*** to promote action	There are many policies that could be changed to better promote mental wellness in the community. These include City policies or others – the latter, The City could support changes to through advocacy. "The City could require that City [contractors] and vendors need to have wellness policies as part of RFPs." "Funders need to ask what are your partners…"
Population-based approach	Population specific services/supports – as related to the population category. "Start with target populations and their needs over philosophy. There's been too much starting with philosophy and we miss opportunities." "population-based needs are over looked – ex. Pregnant women struggling with addictions should have priority as it reduced FASD related risks."
Positive, proactive & informative	Not as a deficit, preventative. Sharing information that is easy and accessible. "The City strategy should be upstream (prevention/promotion) and long term." "…lift people up and encourage positive and healthy behaviours…" "Kindness. That's what is remembered by everyone. It's vital."
Public Health and Community Safety focus	"Challenges with MHA are different in different neighbourhoods." "Poor mental health happens in all areas of the city..." Prevention, Harm Reduction and Treatment.

Realistic	Setting goals and expectations realistically. "We need to be realistic, we need to acknowledge that some suicides or mental illness will happen…"
Strategic, sustainable	Looking at the long term, strategic aspects. This takes time and patience. Need to use evidence-based actions. Action-based, concrete (not trend or platitude driven, avoid aspirational statements). "One solution in isolation of the larger system or set of interacting systems can cause new problems…" "Design the system for the next 100 years" "Quit asking for innovative and new things, best practices are that for a reason." "Ongoing climate change and severe weather will strain existing systems and structures." "Knowledge of Theory of Change – long term goals and map backward to identify necessary preconditions." "Prioritization of spending – we try to address sustainable funding."
Social determinants of health	Including strengthening community and social prescribing to counteract risk factors like loneliness and isolation "mental health treatment is not just about pills. Opportunities for free activities should be provided through family doctors…" "Relationship building focus…" "…as related to urban design." "Socioeconomic factors and other intersectional issues – racism or lacking natural supports…MHA is not just medical, it's as much about social determinants of health."
Trauma-informed	"challenges in how people experience the system…can discourage future use of the system." "…need training to provide care in the right way." Instead of "what's wrong with you? Ask What's happened to you?" "Many non-profits have engaged actively in the professional development on early brain development which is the underlying science behind trauma-informed practice."

Verbatim Comments

Due to the nature of comments and for personal privacy reasons, the promise was made to all participants that the verbatim comments would not been included in public reporting. However, the next two sections do include some verbatim comments as written or spoken by participants. If facts or numbers were suggested, they have not been fact-checked and recorded as they were mentioned.

These comments are reproduced in the same way they were shared with us written or verbally by participants. If the comment had personally identifying contact information, that information was removed and this phrase was added [contact info removed]. This symbol (?) means we weren't sure about something shared, or couldn't read the handwriting correctly, but tried our best to interpret it. We added [*illegible*] if we couldn't read something.

Summary of Suggested Possible Actions

(200+ in total, but duplicates removed here)

Some action examples may fall into multiple categories but are only listed once. The "Approach" section below is closely related to the previous section. Sometimes when a comment was mentioned by two people they have been put into the same row in this table.

LEADERSHIP ACTIONS - REGULATION, ADVOCACY, COORDINATION
Regulate treatment centres - evidence based programming and more responsible for clients treatment outcomes. If agencies are regulated (under City umbrella), digitally were people can log in to a system
The City could require that City providers and vendors need to have wellness policies as part of RFPs.
Municipal roles could include community/land use planning for MAP (managed alcohol programs) and SCS (supervised consumption services)
Analyze what mental health and addiction services are under-utilized and find out why (e.g. barriers to client access? Not meeting client needs? Etc.)
HIV Community Link is good and is looking to start a new service but hasn't found a location yet could be ideal at/near the D.I. but may not be possible
The City's role could include helping to message/sell the priorities of the (eventual) strategy through advocacy by members of Council
The City of Calgary has policy levers that it can pull re: community planning, affordable housing, community building/development. This could be packaged as a "Calgary model" to addiction and mental health issues
massive system of policies and need for comprehensive change a Social Sustainability Framework
This Council motion and action is good. Needs ongoing support and sustainment too.
Education and the way MH & A is talked about by some public figures perpetuates the stigma or barriers. We are all in this together – accountable and responsible for all citizens. There is a tendency towards 'othering'. Social issue, community issue, pushing collaborative approach to problem solving. No 'not in my backyard'. MHA effects EVERYONE not just downtown and maybe it's not as visible everywhere but it's there. Just because you don't see it, especially poly-substance use – it does lead to deaths in people's homes and in the suburbs

More projects for agencies to work together on, to build relationships (for example: through development of emergency preparedness). It is uncommon to get funding for this, or may not even need funds but need the mandate/leadership.
Get the systems talking together openly and honestly. More projects for agencies to work together on, to build relationships (for example: through development of emergency preparedness). It is uncommon to get funding for this, or may not even need funds but need the mandate/leadership. Having open and honest conversations with all agencies and all levels of government.
present from the groups that were funded by The City in 2018 to CCAM and look for other ongoing projects, lessons learned, gaps.
Help funders understand and be more flexible for organizations. Need to understand and communicate the unintended consequences of funding requirements – if funding isn't going to cover the staff training or travel to maintain certain programs or the required licensing fees for related software or programs then that program won't be possible, even if it's successful, even with proof of outcomes. We are artists of pulling together funding from different sources but that takes time and resources too. Another example is being asked to do something new to get funding – sometimes the current or ongoing work is successful and to come up with a pilot or something new is an inefficient use of resources, especially for short term funding (i.e. a one year pilot).
Need good data/measures. The 30 day re-admission rate is the only measure that can be found as an indicator. Need to share data between groups. Also need the strategies to work together – how do all the FCSS, Crime Prevention, etc, ect, work together. If someone comes in to get support only once and they don't come back how can we measure or know if it was a success. Hard to get measurements and data on that. There are a lot of things we can't measure, but maybe we could measure hope. [some additional agreement on this and on how it is important, useful, relatable as a concept/indicator.]
Someone will always say "we're already doing that" and we need to leverage communication and improve communication and give the context to organizations so that they can improve. It's about building relationships between people between organizations.
Create and leverage "uncommon tables" bringing people together who aren't normally brought together. CCAM is good and allows for a conversation to happen. A table that is for the organizations without the funders.
Data sharing. Better to communicate the 'ah ha!' moments before the crisis occurs.
Public Health approach and customer service -> as systems and data person, need to have good outcome indicators. Hope is an outcome and while not asked for by funders is something that can be used to inform funders. To access programs.
What can City do? → get everyone to respond together, easy as collective to go to government – to say 'we need this'. City can bring powerful voice to province to advocate
Council of municipalities → bring to, should agree we are all having the same issue
pockets of committees with great collaboration. Need to streamline to be on fewer tables. Would prefer to invest well in collaboration and be on 3 or 4 and give 90% then to be on 8 or 9 and only be able to give 30% (effort).
Emergency preparedness sessions are a good example of organizations connecting and connecting with the community (doing community development).
Ongoing advocacy for all 4 pillars including HR.
There are great opportunities to be including each other on the local level, and on the federal side. There was a June learning event with other Parent Link centers which was great, but don't often do a municipal-level or functional-level networking (those organizations who offer similar functions of service) with the City.

One Windows project to centralize housing supports. More effective and continue with permanent funding (beyond the common 1 or 3 years).
There are francophone people here and they are isolated from the broader community and need support and need to make those connections for these families. Canada is bilingual and many francophones who arrive here feel displaced in a bilingual country – Alberta/Calgary are a shock as people are being sold as being bilingual (both from Quebec or from other countries or from other countries via Quebec). There are 30,000 native French speakers in Calgary.
Encourage partnerships – existing and new ones. It is also a United Way priority. Collaboration between agencies and referrals and more outreach – that's what is needed.
2017 Disaster Social Services- had a conference for local agencies and staff about psychosocial supports in community and wellness. This was amazing for capacity building and sharing training and to facilitate networks and relationships. Need to sustain these events and the funding/support to them.
Need more psychiatrists and different or more funding models and billing – sometimes it takes a creative doctor to help someone. And need them to train in community – they don't spend a day or month in there training, it's no one's fault but people go where they are familiar or comfortable or have experience. Training for professionals – attach to a site or a city, but not connect with community - for psychiatrists. The government could make connections with the community at large (the City could help advocate on this). the system in place now doesn't offer the on-site in-community training (like social workers might do or that public/community health nurses might do). The training isn't really connected to The City but all it might take is a visit from someone higher up or political with a department chair to figure out how it might be possible and to have The City lead some of that political engagement. There are only 150-180 psychiatrists and how many feel part of their community, like in their work how many are connected to the community at large?
Prison-integration program and working with inmates even before they transition back to the community (or if they don't). Need more agencies to help support this.
Edmonton's city suicide-prevention strategy is a good one. The rates of suicide are high especially for men 25-50 and for Indigenous Peoples.
Just HAVING supervised consumption sites is HUGE. Not only does it save lives but it also normalizes Harm Reduction as a good practice. It has created momentum and dialogue and that is important to increase understanding.
Need to have a minimum wage that is a living wage.
The Icelandic Model is something we NEED to look into. It's a WHOLE community solution we need to ask: how can that take place here?
Appreciate The City trying to do something. It sends a bold message to other levels of government.
Community court in the works (needs support and advocacy)
There needs to be alignment and an agreed to shared strategy otherwise we end up working at cross purposes.
CBE is actually cutting their "cluster program" that provided extra support for children with Autism and usually the children in the classroom who benefited from this support (which happened outside the classroom itself) were mostly dealing with increased anxiety (and so such supports may have also been a model of support for other children with anxiety – but that's not possible if they are reducing the support/funding to what they already had).
Centralized point of contact, standardized and accreditation for staffing and agencies. People build agencies on their passion – a 'global' standard.
Advocate for federal funding.

SERVICE/PROGRAM ACTIONS
City could provide a space for agencies to set up – for information (like a resource fair, not for client intakes) 1) Like a trade show 2) Organizations shouldn't be expected to pay 3) Community comes with the intention to get information 4)City can leverage City space and its ability to reach people 5) Could help build compassion in the whole community 6) Could build on conversations that are already happening 7) City presenting a resource fair is more impactful than the agencies doing it on their own
City of Calgary should model Employment of person with disabilities & MH challenges. The best awareness campaign is to demonstrate by example.
City cells won't allow you medication (in jails they need to prescribe methadone and nioxon).
Dropping people off in the middle of the night is not setting people up for success, how do we look across, jail/health/housing systems ad determine how we are supporting people
An oversight committee for the Police would be good, for problem solving orientation
If people could access transit for free they can get to appointments
Lockers for homeless people
Messaging systems for clients that they could use for referrals
Ability to access websites – one window to access services and see wait times. App Helpseeker is ok, too minimal
In homes need more to support for conversations between parents and children about substance use and mental health
Community-based approaches are needed to identify and who in the community is the mentor and teach people how to foster and have the conversations with family and community.
Volunteers with lived experience as individuals connect with a family who needs services but doesn't know where to go (adult child with autism is stuck after high school) and all of a sudden they have contact with so many other things and resources and being able to see their life change –it's wonderful to see people thrive but would be nice to know that was happening without it being a random stranger (from the individual volunteer).
Helping doctors/G.P.s to have conversations about substance use with patients. Doctors don't have answers or training and so then they have a shorter conversations. If it's not at home, at doctor's or at school – then where are these conversations happening?
The City could support mental health in the community and identify where to get help through: transit advertising, community spaces and facilities, parks.
Opportunities for free activities that support good mental health should be provided through family doctors. For example, she knew that yoga would be good for her, but classes are very expensive. Would like to have been referred to free classes through doctor, if that were possible *(social prescribing)*
Brain Story training through the Palix Foundation is offered for free. More staff at more organizations should take it.
For people with complex mental health and addiction issues, affordable housing is the most important intervention that would make the most difference. Affordable housing needs to be located close to support systems and services that people will continue to access once housed.
Creating vibrant, inclusive communities is also very important. Quoting British journalist Johann Hari, "The opposite of addiction is not sobriety. The opposite of addiction is connection."

We need spaces for social connection in the community. More population density leads to less driving alone and more opportunities to meet each other
Once affordable housing and inclusive communities are addressed, the next most important is mental health and addiction services: treatment options, supervised consumption services (SCS), co-location of services that are used by a similar population of clients, navigators to support clients through the system, etc.
All post-secondary institutions have some sort of mental health strategy. How to best link up/leverage the work that has been done at each institution?
Chumir services is a positive way forward and need to keep working on how to better co-exist with community.
Integrating psychological health with physical health (in workplaces, in education etc.) – this is happening somewhat but previously psychological health was stand-alone and now it is more infused into all places – where we talk about physical and psychological safety. Reduce isolation and increase communications to improve understanding, response and safety.
Increase the first- (and ongoing-) responder supports in health and safety to limit time on (working) and encourage taking time off and to understand one's health.
Effective programs exist and we need more of them or things like them. Example: Canadian Mental Health Association has "the Art of Friendship" targeted to people with Mental Health challenges learning and building skills to improve relationship building. Have heard good things about this from participants and there have been many client/program participant referrals from faith organizations and schools and interest in running the program themselves – there isn't enough capacity/resources to run more [meet demand/need].
A (public/accessible) ombudsman or advocate for ER/hospital system is needed especially for marginalized people as they don't have a hope of getting the services they need or advocating themselves if they don't get what they need. Maybe ethics reviews need to be accessible to others/everyone.
Drop the stigma –help find specialists AND other ways to support MH role modelling. "It's okay to reach out"
The Blood tribe has a very high rate of overdoses and death and more needs to be done specifically for and with them to help. Need to work with Indigenous people differently (culturally appropriately) and in the Indigenous communities on and off reserve.
Need to expand services beyond the downtown – both to have better geographic reach and to be able to reach the number of people who need the services. It would be good to have the Safeworks group expanded geographically. We see problems downtown but the over doses often happen in the home, they happen everywhere. Supports and services need to be everywhere.
Compassion fatigue and trauma-informed care as support for staff.
Include justice effectively and collaboratively in these discussions and actions – this will help people like police officers and probation officers behave differently (more positively).
What is the role of the private sector? There are MHA-and-related-crime impacts and those are often damaging to the business and people's livelihoods and so this causes businesses to view negatively and with the nuisance-perspective. Is there a different role? In Vancouver, the Downtown Business Association (DVBIA) recently came out in support of the safe consumption sites – working for multiple months on the press release. That kind of support was huge – seeing it as "collective support for a community problem". Bring the business people into these conversations and get them the research and information for supervised consumption services and may have value to study the impacts to businesses in Vancouver and

share those results to get buy-in. It's important to understand What are the economic impacts to businesses? What are the impacts to the neighbourhood?
When interrelated systems breakdown this can have a huge impact on general MH and specifically for people/families with pre-existing MHA – (story: when there was no water to homes for 3 weeks, for some it was 5 weeks, this kind of break-down is hard for everyone. We have 3 adults in our home and only got enough water to flush the toilet 4 times a day, in total, not per person or per toilet. All I could think of is "I'm so glad my husband isn't here as this would have been so hard" (both on him and on the family). There wasn't enough support or communication or even just someone coming to ask "how are you doing?" They tried to provide services, the came and brought us water, and I get it, but no one asks. [how MH isn't well supported in crisis situations even if the system isn't directly related to MHA] One system like water impacts another.
CPS and mobile response team – share data as a pilot project and no one knows results (when called to crisis can get AHS to get personal information when going to the scene/incident that can not only help them respond because they have more information and can understand better and possibly provide better service or even referrals after, but also because they can be safer as first responders).
Within the City of Calgary's Resiliency work -really needs to acknowledge Mental health. I did not see any mention of it.
If we are going to disrupt the system, we need the people the "rogue group" to be able to work differently. There are many people out there doing this kind of thing and we need to support them.
Access to the zoo or other places so people aren't on the street all day.
I met someone who had an Air B&B near the Foothills and it's always full… that made me think how many families have a room or space they could provide short-term to someone who needs respite or leaves the hospital and needs 24 hour observation. You could certify the family and use Uber to get them there… When you ask people "What did you need 2 days before you went to Emergency?" most people say they needed respite.
Like in domestic violence situations, people come to me when there is domestic violence and they need services – but they also need their child to be safe. I just want to be able to say "give me your son for a year, I'm stable and it will save your kid. You work yourselves out." (This is the kind of community support we need.) The ability to help a neighbour with the least amount of resources. The support in one square block.
Places of social connections. A place to gather – not to have info shoved down your throat. Preventative, with a place to belong. Long term strengthening our communities could alleviate a lot of issue. Anything to combat loneliness.
Make languages accessible
Deepen Community Associations.
"Make it a public value." Community awareness and community psyche is raised. There still is a lack of understanding of society. Emotional distress.
Intergenerational programs and relationships.
Mentoring and knitting groups as opposed to or along with counselling.
There are so many spaces we don't have access to – the CA and community hall should be the home of the community.

Calgary Housing problems with organization and program (rents, availability, non-collaborative with homeless foundation)
Biggest thing City can do is support affordable housing. Affordable housing and rehousing works. City can help there.
Increase in aboriginal service has helped (more clients serviced)
Underemployed upstream → need to focus on youth (vulnerability)
Look at the role that family violence plays in youth
Kindness. That's what is remembered by everyone. May be a nurse or during check-in… Turn tragedy into a message of kindness. And we can all integrate into our everyday actions: kindness. This makes people feel seen, feel real and it's the human experience. It's vital. We also want to work with the people who are kind. When we need help or are part of the system we said "Let's ask for that nice person at The City" or call back to get them and that's relatable for people. We are all human. We can all be kind.
for staff: pay more attention to the vicarious trauma for those who are working in the sector. Keep systems and people well. And we must dig deeper to understand why staff are struggling in their jobs. This is more about role design or organizational structure. There is design work needed to make jobs/roles work and avoid getting to a place of trauma.
Inclusivity and building community, youth is a good focus
Campaign → visionary and can align all. Create momentum and socialize the idea. Initiatives might be too broad.
Affordable housing access – it takes too long to go into Calgary Housing and the Social Worker just uses kijiji. The cost of living in Calgary is so much higher here.
Language and cultural barriers and concerns about what is appropriate parenting skills and the barriers to understanding the system are huge concerns. Families are afraid any time Childrens' Services are involved "will my kids be taken?" we need more language and culturally-appropriate supports.
More and broader occupational health and safety support. While reporting is up (and reporting is a good thing) need more support and clear criteria about what is a psychological incident, what is included, how to investigate, how to support it and what is there beyond EFAP.
Calgary Land-use bylaws: to get support/programs/housing we need zoning as a treatment facility and the related stipulations if we have a managed alcohol program – those are municipal barriers in place that prevent this service. A role the City plays, that is explicitly the municipal jurisdiction, the zoning and bylaws. This is very important where there are currently only 2 or 3 transitional housing homes and it is SUCH a challenge to get permits and to be in neighbourhoods. Now getting the permit signed off for 5 years is such a big benefit. This tends to force to have these services into a wedge and makes it centralized but not in a strategic way. Why is there a huge rigmarole for a 25 unit apartment for MHA but not the same rigmarole for a 25 unit apartment not for MHA but many people would move in there and could have MHA? Same with a supervised consumption clinic versus kids' cancer care. People don't want one and have no problem with the other – but both are clinics helping people. There are fractured relationships (with the community) before anyone walks in the door. It's easier for AHS if it's on land they already own – if it's zoned for a clinic then it's easier to make it an opioid access clinic.
Now that cannabis is "legalized" people living in Affordable Housing are being denied access to their suites because they are legally using cannabis. And people can't use it in public so it's penalizing those with low-income.

Non-medically trained are experts -> how can we leverage or use these people's knowledge/experience to train others to work with challenging populations.
Research and approach for HR with poly-substance use is important as it's currently a gap and growing in popularity of use. Need to understand better the long term health impacts.
Life skills for youth in transition to the adult system.
Need to define clearly what is a psychological incident? and get supports in place and reduce the stigma of reporting.
Calgary has 3 associations that have a focus on serving immigrants and families that look different and once someone becomes a citizen instead of a permanent resident the services they receive look very different and many ask why and are not prepared for this.
The DOAP teams and the Transit Peace Officer ride transit together are a great approach for public safety and for outreach support for clients. The data trends of incidents are going down, but not able to say this is a causality. The two teams are expanding into downtown and beltline which is great and great results!
Recreation and meeting spaces are things that are available with The City. But if there could be a more intentional effort made to make these available and make them more accessible/affordable/helpful that would be good both for organizations and for clients. City resources – recreation, spaces, - can be intentionally used in a low cost way, more fair entry. CUPS clients using the Public Library services and that works really well. Often to be able to access computers and internet but also that it is a welcoming place to be. An example of this happening outside of Calgary – in Medicine Hat, the Library is a key stakeholder and acts as a defacto day program.
Need to be able to access support in the moment that someone is ready to access services – need support all days and all hours.
Peer support is beneficial and there are more positions being created. AHS posted for a peer support worker and got 200 people applying. We need to find a way to leverage the 199 that didn't get the job.
Some successful programs include: services for youth involved in sexual exploitation – services gather and share info and help high risk youth
Community Food Centre – connections, food and relationships, youth fusion food courses
The 5 year permits with The City is very useful for running transitional housing. We are also glad to be getting another transition housing site finally.
Food Bank! "I have no idea where we would be without them."
What are we measuring? The City should create long term measurement
How to make Glenbow more accessible as Art space or for art therapy, we know that art can play an important role and need to bolster that role. In the process for getting funding for an Alzheimer's program. Other options would be on-site art therapists.
Need better data on short-term programs, cares, services (individuals who only have short term intervention/services) and on the short-term options and changes that can be made to improve the system.
What support do first-responders have at the city/ staff wellness? (Either to ensure this support exists and to share the models/processes/services with other organizations for their staff.)
Support individuals and agencies who are providing meaningful activity (work, volunteerism, etc.) for those who need it to help them feel like part of the community and reduce risk factors like isolation and stigma.

System navigation is a huge challenge for clients and for service providers. People need follow-up, information and support but don't know where to go for it. There used to be a Community Services Guide, the Street Guide and while there is 211 and Inform AB and those are good, sometimes we need something to hand someone, something physical. Even if this was something like the CMHA Edmonton's Tough Times handbook that's a printable pdf. The City used to print these and they were bound and I can understand if that's too expensive so even if it's something else or online that agencies can print as needed, those were extremely helpful. Bring back the community service guides (youth guide, street survival guide, Aboriginal guide, etc.)
Bolstering natural supports is important but not happening for all people/services. Need to learn more about the ways to provide peer-to-peer supports.
Coordinated systems and collaboratively mapping the system.
Solutions - Wrap around service supports; Financial sustainability; Transports; Mental Health authority; First responder fatigue
We must get the police to police the way we want them to and not the fall back they use. Break a cycle.
Youth find peer support more effective with youth but that's so much more difficult –being 'youth' can allow them to view their situation differently and once they are doing better they may not think to do peer support.
Peer support is underutilized in community and medical system – lots of opportunity. Even could be useful at the private sector – what if you could go to someone instead of Human Resources for MH, Behavioral Health (eating disorder, self-harm, substance use) it is effecting your work. Someone every few floors to support the staff – as whole or part of their job.
Huge dependency in private sector - need a phone line or mentor or something before Human Resources or EFAP - Gave a presentation to West Jet last year. Large companies do have CMHA present sometimes – better than long term disability.
Access Open Minds and the East Side clinic – drop in and via phone – are great. Access Open Minds is a MH program with the ___ Beck Foundation with rapid access in crisis and getting triaged and support in 72 hrs and then providing follow-up. Maybe this is a good model or would translate for other services.
Peer-to-peer as preventative. We hire parents who have kids with autism to speak to parents with children newly diagnosed as this is when we find people are the most confused and don't know what to do and are even afraid.
Need to remember that the 12 step groups are also a form of peer-support. Strengthening this movement, with AHS hiring paid peer workers is great. But other groups like Moms Stop the Harm and Grateful or Dead are also good resources and ways of using the peer support model.
Need to consider the value and in some cultures the necessity of separating support groups for men and for women.
Any services that can be offered in someone's first language is a huge benefit. The translation is good, but the direct service provision is best.
Inform AB website to be more built up more and more user friendly – a good centralized place for information.
Calgary Homelessness Foundation training is wonderful and needs to be expanded. AHS has quite a bit of online, specialized training and its great and available for free – like one module about secondary trauma – but more awareness, people need to know about it.
Community Association newsletters for outreach – the 211 flyer or notice in all of them. I know not everyone looks at their but it does get distributed to so many people and they are often looking for content.

City survey – collect data on how many people need services and who is aware of services. Then we can have some data and understand what peoples' awareness levels are.
AHS has a professional resource fair
Reactive, (fire) need to better interact in an empathetic way and resources for others (bystanders as those left and first responders), responding to overdoses in suburban homes where family says, 'now what?'
Long range planning and timely to think about MHA. The actual system related to planning – prevention side: shelter, community, environment and building strong, healthy communities/neighbourhoods and the social equity (as part of the review). Based on smart growth and healthy community principles – how to support MH overall –walkable, housing types, inclusive, overall vibrancy and services for a complete community (and easy to access) and support to the institutions that provide those services. Those are embedded into the plans – also from the regulation side with land-use bylaw pieces. But planning: social equity, housing. Work around housing-demand (research) to look at the future 10, 20 years to understand future demographic and family structure (more living alone, elderly) and that really ties into MH. Changing dynamic. Community engagement phases – talking about trade-offs and why these things are important and some good tie-ins from that perspectives.
O'Brien Institute – federal funding, data sharing (what does open source look like, York University), where tying it to physical form pieces (like a transit station/TOD), information gathering through Canadian data source, all agencies need to agree on what the system is, how to define the data and how to collect it so it can be compared (AHS and others).
Sustainable funding and evaluation and what is working in communities, supports for non-profits, clientele can only be responsive and reactive to what is happening in front of them (supporting non-profit sector to be engaged in that work)
Sustainable funding and evaluations and sharing what works well but also funding for strategic support for NFPs and their front line staff (those people are paid min wage and don't' have capacity for foresight planning and can only be reactive). They are experts and likely can help with problem definition. Supporting NFPs.
EDP funding had many agencies together and had material to connect people but difficult to track, individuals and how to follow to help… need a stronger governance structure. Kathy Taylor was driving it but no longer in that role.) Resource the people in the strategy so it doesn't die.
Fire success – front line worker fatigue, mental health program launched (psychologists) – ask to share this information
How do green spaces support mental health (how do we pinpoint our successes for what we provide).
Training on 'what to expect' for staff, as relates to MH&A, community outreach piece is essential
Vulnerable persons training.
Share MH strategies amongst the BUs. Collaborate more (via One Calgary).
From a policy side it's hard to tie to the successes with MH. Are looking at and collecting data, we know we are moving in the right direction for housing choice. Greening and environment and data "access to nature, green space, tree canopy" but hard to tie back specifically to MH. Community outreach side – do see in community that there is more awareness and acceptance of MHA.
AHS hired the position but connected with our program first person "on ward". AHS is starting peer-support workers that have come through or were from CMHA. There was a trial of 4 in 2016.

APPROACH ACTIONS
With a restorative economic and education approach - there could be a centre that helped people achieve stability (meet basic needs and find meaningful activities/work)
We see problems downtown but the over doses often happen in the home, they happen everywhere. Supports and services need to be everywhere.
Mental health system is reactive. If someone reaches out for help when they first notice a problem (but are still functioning well), they are offered limited services (such as very short-term counselling) and wait lists. By the time the services are available, the problem has become much worse and has affected the person's employment, financial situation, family, and other relationships.
There is too much focus on individual responsibility to promote wellness and prevent mental ill-health. Systems and policies should make it easy for people to make good choices to promote and maintain good mental health without thinking about it.
The focus of a City of Calgary/municipal strategy should be upstream (prevention/promotion) and long-term. Made a comparison to environmental issues: The City needs to make it easy for individuals and communities to do the short-term behaviours (e.g. recycling waste for the environment; or creating vibrant communities to walk, meet people, etc. that promotes good mental health) through long-term strategies and policies.
The strategy needs to integrate Indigenous perspectives – not just for Indigenous people and their mental health/addiction issues, but including the whole community (reconciliation)
Peer support is important and there should be more of it available: in the courthouse, for addiction, for mental illness, and other settings
Substance use/addiction is much lower when people have supportive social environments, a sense of purpose and meaning, meaningful employment, education – these are all prevention factors
As a community, we need to address addiction issues by recognizing the effects of trauma and social disconnection.
Our society/system places too much emphasis on individual responsibility for mental health and addiction issues rather than recognizing the impact of community design, structural injustice, etc.
When developing services that are meant to be responsive to the needs of people who use drugs (e.g. a warming centre that does not require people to be sober, and is separate from the supervised consumption service site), it should be done in consultation with people who use drugs (e.g. through Alpha House, Grateful or Dead group, etc.)
U of C was the first post-secondary in AB and one of the first in Canada to develop a mental health strategy (2015). U of C has received funds to train other post-secondary institutions and has achieved Silver Level from Excellence Canada standard.
the role for a City of Calgary strategy should be to focus on prevention (upstream), reducing stigma, reducing barriers to people getting the help they need, and promoting/enabling innovation through private sector involvement
ParticipACTION was a positive campaign for physical health – where is that for mental health.
Have a strong link with school boards and daycares to offer Parenting Training (PPP) and other services to parents/families. A lot of engagement and communications happen with school boards to improve participation and ensure access for working parents. Work with the 7 schools in the area. Provide child care. Host events in the evening not just during office hours. In the next year, school boards have MH resources/education PPP but with that need to coordinate to ensure good participation rates.

ELEMENTS (self-help) has a mandate more focused on mental health than addiction, but their model and programs help people feel connected and supported and creates community.
The FrameWorks institute is one of the only places doing the re-framing around this kind of (MH & A or other social issues) work. Look into their resources and organization.
Need to be patient and educate others on the need for patience. This is a process and it's not right to expect a "fix" to it. Often times faith organizations/centres are possibly the only places that will make time and have the patience to work through the process [of healing, of support, of compassion, etc.]
Reach out to those without a voice or whose voice isn't listened to – people living homeless may have very different things to say than the people who work at organizations that have people living homeless as clients/service providers. The individuals themselves will have different perspectives and they need to be targeted [effort is needed to reach them well and properly] When doing engagement on this strategy need to consider location – talk to people in spaces that are away from where they work or get services to allow them to think and speak freely (for people with lived experience and service providers).
Health is subjective and "good health outcomes" are also subjective (dependent upon the individual(s)) For someone who is sleeping rough to go to sleeping inside is a big step and the health outcomes for that individual are very different than from the health outcomes that I would have for myself. The achievement of these health outcomes (any or for specific populations) takes time.
supporting individuals in their needs/where they are at rather than having highly de-personalized services.
There is a divide between HR and treatment. Target populations' needs is the best place to start, not with a philosophy. Evidence and hypothesis is needed.
The Social Work and Psychology departments at The University of Calgary would be good contacts to reach out to
When considering and talking to lived-experience, need to also speak to families who have been impacted – by Overdose, by OD death as they have a lot of wisdom but are very, very overlooked and do not have a lot of support.
Developmental relationship model – helps understand underlying issues. Integrated models to provide people with appropriate supports and look at the relationships not just the medical. MHA are fueled by pain, loneliness and isolation. The brain interprets pain the same if it's mental or physical so we need to consider the way in which mental pain is impacting people. Opioid use coming from a place of pain – mental or physical. Building up social supports can help but also the integrated approach to care. Coordinated, integrated approaches with relational focus vs. punitive is better. Loneliness and disconnection are significant challenges.
We also need to be realistic, we need to acknowledge that some suicides or MH will happen, we as a community need to know and not feel hopeless about it. (story: if my husband tried to commit suicide three times I have to be realistic with myself and with my kids to help prepare them or others for what might realistically happen.)
There isn't enough older-adult research and treatment – need more communication of it or understanding of it if it does exist. Then we can develop better practices as this is a growing population.
"Pathways" – follows the client experience and that tells the tale of the system and gaps.
Scaling like in the design world. Need to trust and include the "uncommon partners" -include others in problem solving. How we think about the problems needs to change.
Celebrate what works and have compassion (and self-compassion) for what doesn't and learn (from the latter).

Use a hub approach. Let the hub review all the challenges.
One recommendation: do not pathologize and not only focus on the clinical for MHA. Needs to be beyond AHS and focus on valuing the public's values and acknowledging what the public doesn't know. Think about framing the challenge in ways that remove stigma – which are often also ways that are more accessible or resonate better with the general public. Like don't talk about where to go for mental health support but instead "what would be a good experience if you felt like you were in distress?"
Issues are different by zone/community. Cultures, norms, community connections. United Way' campaign brilliant. Food is a huge aspect, culture versus Canadian culture
Lived Experience is important: CHF working groups with the adult client action group meeting once every two weeks and the youth action group meeting once a month. An offer to connect us with them for this process and to incorporate their ideas and input.
Socioeconomic factors and other intersectional issues – racism, having or lacking natural supports (personal relationships and networks that are positive and supportive) this is crucial! MHA is not just medical but as much about social determinants of health. We need to think broader and more intersecting.
Youth and adults are struggling from childhood trauma. Need to change the conversation. The @ Collaborative Nashville focuses on the "Ace Score" and the whole City focuses on this and it helps to speak to where there are strengths and what areas need attention but with less negative stigma. Also use this in the State of Washington. ACES "scores are dropping" and that changes the conversation.
Building resilience and well-being. MHA is a deficit phrase. Consider for social media: "not my choice" and prevention and diversion for next generation.
Transition points are challenges and if we can improve those places we can make a significant impact for people. Youth to adult, inmates to community, hospital to community (or hospital to organization in community).
Supervised consumption services – normalize harm reduction as a method of practice.
City needs to involve the school boards, AHS and the U of C and needs to have them supporting in a big way.
Psychiatrists and in the city in particular [as opposed to rural] the "Formal medical piece" is not a bad job. The therapists etc. But that formal piece is only 5% of someone's life. There's the housing, food security, income, meaningful activity (work or not, or sometimes more often now people say this is video games or TV) and all the other psychosocial time and space in someone's life that need to be considered.
Global Standard Certification for frontline workers – Brain Story (see also Alberta Family Wellness Initiative) – Specific focus
Harvard study of the biology of fear and threat / multi-generation
There are general delays, system delays. As an example of a challenge: DBT super long waitlist but if there was a network of trained MH drop-in clinics (i.e. the former ADAAC model but for MH drop-in in a clinic).
Population based needs are very much over looked in many cases – for example pregnant women who are struggling with Addictions should have priority access to treatment and support as this prevents or lowers the FASD related risks.
Family doctors have very little MH training and even less for specific populations (e.g. people with autism)
There is professional and individual struggle but need to keep the client/patient in mind. How can we make it accessible for them.

MH&A as together or separate? Together. We have so many people and many peer support workers that suffer from anxiety and depression and alcohol (mentally healthy people don't drink like that). People who use alcohol as HR or coping. We don't see what the Mission part of Calgary see – in back alleys/stairwells (it's rare but do sometimes see someone who was sleeping rough and/or actively using). CMHA will not just leave you alone – we are right there engaging with them and need to see you taking steps. This is a tool to work on your recovery which can be a deterrent for some.
Critical time interventions – to explore this. Collaborative team in UK and Toronto – daily contacts from someone from a wrap-around team and an immediate response. Lots of great research and evaluation on that model.
Overall awareness. The Bell Let's Talk campaign is good but it's once a year, one day. A big splash then it goes away. This awareness would help for prevention and promotion and could prevent a lot of cost savings.
The former AADAC model was great: drop-in, no cost, had evening hours, had family program.
National Survey showed highest rates of anxiety in Alberta and how that relates to parenting.
Community Outreach Team positive impact (DOAP), shifting culture of relationship of 'law enforcement' officials, non-uniform is paying off well
Bylaw's Joint Encampment Team as collaboration and how to re-home people in encampments and understanding this was someone's home. Have housed 40 people with that. Changes in mentality "can't stay here" to "move along" to "helping you find the safe place" to go or reason why you're here… public safety impacts are better this way too. Opportunity to increase 'people-centric' work (like Joint Encampment Team philosophy)
MH act authority – takes us off the system but isn't well known, could be a win but a double-edge sword.
Need to remember Calgary Housing as a first responder.
Realizing that you aren't able to connect with everyone – due to age, demographics, experience but there is someone else here you can introduce them too. Which is less likely if there is only one peer support worker in the area.
Self-stigma is harder to beat than many other aspects. I cannot tell myself that- often with older generation. Always present and worst enemy.
Relationship connection piece is invaluable – young woman who wanted referrals and said "I appreciate that you are talking to me and listening to me and I don't feel pressured." I don't have an agenda for them – not directing them to go somewhere specific. If you only get the places to go next and then I feel like I'm being pushed out the door and to shift the focus of the conversation and what's going on for you and feeling heard, validated and empowered: "I don't need to hold your hand I have faith you can do it."
A lot of people report the school years were detrimental especially if they don't have supports from parents. Biggest indicator of success is that people have the supports. "Do you have a support system?" It breaks my heart when someone can't even name one person.
FUNDING ACTIONS
Applying funds to evaluate models/systems that appear to be working, but do not have empirical evidence/evaluation research yet
Youth programs are needed. There is 10 year evidence to follow, test or build off of those and would like to do more but often can't get funding for this and need to support via private fundraising.
If DOAP team can respond more that helps everybody. Extension of DOAP team great, good investment.

LGBTQ services are improving and we can learn from Vancouver and Toronto. It's coming along but need to have some focus there as Calgary is way behind here. Lots of good work done with the Shelter Guidelines and AURA by Boys and Girls club.
Ongoing support for Alpha House and DOAP and the needle response teams these save city resources (i.e. Fire Services) and also have impacts of ongoing service predictability so it can prevent people having to re-learn who to call, and that can make for more unsafe situation.
Success with a navigation. Program funding attached to 10 year plan to end homelessness.
Need increased investment in ongoing and sustained investment for those who provide direct-services. We don't want to see "death by pilot" as it's a lot of effort to create and launch a pilot and then especially not knowing if it will be sustained. The DOAP plus Transit project needs funding, it's been extended but for how long? Let's support the good things we've got.
Funding support for not for profits that The City doesn't fund in emergency situations but are enlisted/activated to provide service but need to be supported financially to recover costs or it can impact core services. This agreement was a 'hand-shake' agreement and it's understandable why, but some way of supporting agencies is needed and this is being looked into. Need to consider the impact that disasters have on the systems in the long term. We don't do a lot about that now. And there will be additional strain with the impacts of climate change and other staffing/resource impacts. There is the Alberta Government's Disaster Recovery Fund and The City could advocate for or help agencies access that but there is no guarantee. An agreement that's underway to support funding to agencies so they are more supported in, during and after emergencies (especially those activated to provide psychosocial supports). This is a positive collaboration but may need more support.
Funding and RFPs are a challenge when organizations are vying for limited dollars, and when someone gets funding then others cannot provide that same service - need a "do what you can do" approach and more freedom from those funders who seem to need more involvement. CHF does the more "figure it out" model that leverages the experts, the NFPs, to do what they know how to do.
Collaborative funding model with CN and CEMA.
In an emergency it would be great (and it's being investigated) how community members who are donating funds could do so directly back into the same community and how those funds could be used to off-set the recovery and support to agencies providing recovery services. (This would be instead of donations to the Red Cross which is an international organization and cannot direct funding/donations that locally.) This is under investigation somewhere, but need to keep supporting it.
CN funding/grants are successes in communities. The City's neighbourhood grants for BBQs and block parties etc. is a great way to build community and include people.
Collaboration versus Funding: this economic challenge adds another level of strain on front line workers and service providers. We need to break down the walls with our partners and community. This would make things better for clients and front line staff. Even though we can talk about the importance of partnerships we are still competitors for limited funding. We have to "chase the shiny" and systematically this and even collaborative proposals take a lot of administrative time.
McMan, Hull and Enviros have a collaboration based on a model called the High Fidelity Wrap Around and it has only 1 funder (Children's Services) so it may not have as much awareness in the community. Has been going on for 12 years and lots of good results. Model allows for structured, collaborative planning processes that include all stakeholders and especially the client and client's families/networks. This really leverages culture as a strength in service provision and a lot of people being involved means there are a lot of ideas but also provides actual control and choice for the individuals or families needing support. [in this case families refers to families in the child welfare system]. If we could so something like this, an adult-type

model relating to addictions I think it would be a good way forward. The Journeys program as a collaboration with Aventa (for women) is also a good model. It is currently funded by The City and was just started.
SORCe and Community Court – support this!
Funders demand or have requirements for what data needs to be collected and what needs to be tracked and this takes away from actually providing service and supporting clients.

Other Considerations – Resources and Stakeholders

We asked all participants to write down any other resources, research, stakeholders or networks they felt we should be aware of as we built this strategy. This question was optional. There may be other resources or stakeholders mentioned in the report if they were shared verbally or as part of other comments.

In Falconridge, there is a group of students at Bishop McNally High School who are focused on mental health - specifically focusing on a healthy relationships and may partner with the with Sheldon Kennedy Fund
Punjabi Health Services, Mental Health Addictions. Family and Wellness Programs - pchscalgary.com
Robert McClure United Church (Pineridge 'hub' food, insecurity, homelessness, and mental health)
Legal Guidance (Gabriel Chen)
Poverty Talks - Community Group Advocates for people living in poverty
Alternative Medicine
Nutrition
Getting into Nature - Participation
More CMHA Recovery College
Elements Calgary Mental Health Centre - hub of services/place to connect, feel welcome
Alts CONEX Team (Children & Families Mental Health) - case coordination & system navigation for children & youth
YYV Be the Change - Peer work/Outreach. IN direct contact with many people on the street with mental health & addiction. Volunteers have lived experience.
In terms of mental health/wellness, newcomers (services for newcomers) should be engaged. Depression, isolation, feedback, self-perpetuating.
Grateful or Dead
Icarus Mental Health support group (?)
AAWEAR (Alberta Advocates who Educate and Advocate Responsibly)
Safeworks
HIV Community Link
(scs) - proposed for East Calgary and East Village
Community Standards - Partner Agency Liaison (Jody St. Pierre and Melanie Thomas)
DOAP & Needle Response Team
East Village. Seniors Community Collaborative Outreach Team (talk to Kim Savard-carya and Loretta Dobbelsteyn - the Alex about lessons learned) - lost funding in 2017
Client Action Committee

Grateful or Dead
The Calgary Face of Addiction
Kelnna (?) Milaney - homelessness study 2018
Alpha House
SCS users
Addictions - IOAT
PCN Social Works
Calgary Council on Addiction & Mental Health
Skipping Stone Foundation
Stakeholder - Aboriginal Standing Committee on Housing and Homelessness (ASCHH) (health and housing sub group developing in a MAP pilot project
Calgary Coalition on Supervised Consumption
Psychosocial Disaster Network (emergency management related, psycho social wellness during response and recovery) Emergency Wellness Response Team - provides psychological first aid during response and recovery
Project Appartenance [contact info removed]
Recovery Services Task Force Report (7 recommendations) Task Force was renamed to Collaborative for Housing & Health
Managerial Alcohol Program (MAP) - The Alex
Psychedelics - LSD, MDMA, psilocybine - Multi disciplinary Association for Psychedelic Studies
Education - public / separate
Education - university
Workplace health and Safety Sector
Perhaps the vicarious trauma of staff in NGP's supporting homelessness (etc..) We see so much of this in the sector
We have great hope in the Planet Youth idea [*illegible*] United Way et al (Iceland) [*illegible*] Peer leaders
System [*illegible*] identity. Transport. Privacy. " [*illegible*] of resilience"
Need to include peer supports & drug user groups
Housing (lack thereof) fundamental to this issue
Research: police in Manitoba piloting use of anti-psychotic in handling psychosis. Interesting to apply to SCS but what are the ethics of this?
Harm reduction housing with worker peer staff to assist with the prevention of overdose/staffed. Perhaps not the solution but proven to save money in long run. i.e. stats in Calgary Homeless Foundation Housing First Programs.
Aboriginal Friendship Centre of Calgary (AFCC) is developing a "Indigenous Working Group on Opioids" First meeting in May (2019).
AHS - Provincial Opioid Use Disorder Treatment Policy Working Group
Collaborative on Home and Health
Calgary Coalition on Supervised Consumption
Collaborative on Addiction and Mental Health

Canadian Mental Health Association
RESOURCE RESEARCH - High Fidelity Wraparound model (Collaborative in Calgary (Hull, McMan, Enviros) and or Miiwrap Model - both models from USA but practised here in Calgary. Www.wraparound.ca (Calgary) www.vroon.vdb.com (USA) National Wraparound Index (USA) Supporting new work! These models connect people to help clients with MH addictions by using a team planning process with national supports, community and professionals.
CUPS has a mental health program and opioid replacement program - psychologist, singles counsellors, family counsellor, addictions counsellor, psychiatrist. CUPS is also upstream focused with its child development centre for children aged 3-5 of families struggling with poverty, homelessness and childhood trauma issues (OT/PT/SLP/PSYCH/ART THERAPY) Both programs heavily made use of AFWI's Brain Story Work.
CUPS also has a family development centre that offers parenting support for families with similar struggles. The collaborative to health and home (CHH) is focussed on integrating health supports throughout the homeless serving sector (managed alcohol protocols, mobile supervised consumptions services).
CUPS is also developing programming for adults with a late in life diagnosis of neurodiversity (ADHD, Autism Spectrum)
CUPS has developed a holistic assessment tool (the only one for a vulnerable population) (reliable and validated) that assess an individual on several domains: economic, social emotional, health, developmental (all social determinants of health)
Critical time intervention Funders Table's Collaborative initiatives – encourage them through RFP process Support capacity development in non-profit Auditor General 2012 report on MH and Addictions Strategic Foresight Planning to identify future issues.
Interacting daily with individuals with MHA Traditional are enforcement Law enforcement lacks training in MH How do we maintain safety or fix disorder in our area? Reactive role, need to address from a problem solving perspective. What is the underlying problem? Officers don't have a proper "real time" (in the field) option for MHA Transit peace officers face overdoes issues daily, lost for options (people report (using drugs in public so they can be saved) – what support systems are in place for first responders. 28 overdoses in 1st quarter.
A) Developers (BILD) B) Industry partners (UCI, AAUA, AAA, AACIP) C) Business owners in different environments – merchant survey, downtown, at CTrain stations D) Schools and education. E) Internal: Parks ops.
Valuing Mental Health (all integration committees)
Mental Health and Housing Committee (older adults)
Access Open Minds (University of Alberta)
U of C Homelessness Survey

Calgary Council on Addiction &MH
Calgary Homeless Foundation Committees
Edmonton CMHA 211 Resource List and Tough Times Handbook
Calgary Fetal Alcohol Network (CFAN)
CRISM
“Here to Help” BC website
AHS Calgary Addiction and MH Fair
Calgary Foundation is planning to commission a systems map – would love opportunity to partner or learning if this is already happening.
CMHA Recovery College
U of C offers 6 free counselling sessions to students
Red Woman Rising à paper from DTES Woman Centre (this (?) http://dewc.ca/resources/redwomenrising)
Recovery task force research
Client Action Committee & Poverty Talks
Lived experience advocacy groups with Calgary Homeless Foundation & UCC
A holistic approach to Wellness
Considerate of various demographics.
Provincial Community health Work (funded by Health following VMH review)
Low Arousal Approach
Training to families and front line workers to manage aggression. Dealing with unspoken family violence.
the Collaborative for Health and Home can be a resource to better understand the needs of people who experience homelessness in Calgary, and the particular gaps in service that affect them (E.g. PACT team does not provide services for people who are homeless
Programs like The Art of Friendship (CMHA) have been successful and helpful supports in the community
CCIS - trauma counselling for refugees and immigrants
Shift – Alpha House Community Outreach.
Steven J. Hoffman – CIHR – globalstrategylab.org