DNSSAB Homelessness System Review and Feasibility Study

Homelessness Indicators and Hub Alternatives Report

April 24, 2024

VINK CONSULTING

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Executive Summary

On behalf of the District of Nipissing Social Service Administration Board (DNSSAB), Vink Consulting conducted an in-depth Homelessness System Review and Feasibility Study for a Homelessness Hub in North Bay. This analysis aimed to evaluate the current capacity and access pathways of homelessness support services and the feasibility of establishing a Homelessness Hub. Through diverse data collection methods, including community partner and service user interviews, the study sought to address key questions about service needs, need for a hub, feasibility, and potential business models.

Key Findings:

Needs: Homelessness count and system administrative data reveal significant homelessness within the district, and a particular need for services aimed at males, Indigenous peoples, and single adults, who are disproportionately affected by homelessness. Data also points to a need for solutions for individuals with the highest levels of need, often with concurrent mental health and substance use issues.

System Strengths and Challenges: The review identified strengths such as existing collaboration and progress towards establishing key system components such as the establishment of a low barrier shelter and options that provide housing with supports for individuals with high levels of need. However, challenges like insufficient shelter capacity, and a lack of affordable housing options and access to permanent supportive housing targeting those with the highest levels of need are notable.

Access and Cultural Equity: While strides have been made towards improving service access and cultural equity, barriers persist, particularly for Indigenous populations and those in rural areas.

Opportunities and Recommendations: Recommendations include refining emergency accommodation models, expanding outreach services, and focusing on improving access to affordable housing and housing with supports for individuals with the highest levels of need. Recommendations also include several areas where DNSSAB should continue working towards reliable and quality HIFIS data and ongoing monitoring and analysis, including shelter demand, returns to homelessness, outcomes for various population groups, and flows from transitional housing to other permanent housing solutions.

Homelessness Hub Need: The need for a Homelessness Hub was broadly supported. It was envisioned as a central point for coordinated, comprehensive services ranging from basic needs to intensive support services.

Homelessness Hub Best Practices: Best practices suggest a hub should be housing-focused and provide a mix of core and complementary services tailored to the community's needs. It should have a governance model that ensures collaboration and accountability.

Conclusion:

The homelessness system review underscored the need for system enhancements and the potential benefits of a Homelessness Hub in North Bay. By addressing the identified gaps and implementing the recommended strategies, there is an opportunity to improve outcomes for individuals experiencing or at risk of homelessness in the district.

1.0 Introduction

The District of Nipissing Social Service Administration Board (DNSSAB) retained Vink Consulting to conduct a Homelessness System Review and Feasibility Study of a Homelessness Hub in North Bay. This study aims to assess existing homelessness supports, service capacity, and access pathways across the district. Additionally, it evaluates the feasibility of developing a Homelessness Hub in North Bay.

Five key questions were developed to guide the review:

1. What are the current needs and gaps in homelessness services? Is a homelessness hub needed?
2. How should a 24/7 service continuum be designed?
3. Is a homelessness hub feasible?
4. What successful hub models can the district adopt?
5. What would be the hub's business model?

The study draws on multiple sources, including document reviews such as funding agreements, data analysis, and community partner interviews and focus groups. Participants included:

- DNSSAB staff (4 participants)
- Health and social service agencies (20 participants)
- Community Advisory Board (17 participants)
- DNSSAB Board members and local municipal mayors and CAOs (13 participants)
- Homelessness system users (31 participants)
- Business community and other community partner (5 participants).

This report is intended to review indicators and discuss opportunities and recommendations related to the homelessness service system. The report is structured as follows:

- Section 1 – Introduction (this section)
- Section 2 – Data Limitations
- Section 3 – Homelessness Need Indicators
- Section 4 – Homelessness Supply Indicators
- Section 5 – Strengths and Challenges of Existing Homelessness Services
- Section 6 – Access to Services
- Section 7 – Cultural Equity of the Homelessness System
- Section 8 – Opportunities and Recommendations
- Section 9 – Need and Service Models for a Homelessness Hub
- Appendix 1 – Detailed Supply Indicators
- Appendix 2 – Details on Homelessness Hub Service Models
- Appendix 3 – Glossary of Terms

Accompanying this report is a full assessment of a potential homelessness hub.

2.0 Data Limitations

The Homelessness Individuals and Families Information System (HIFIS) provides a rich information and data source for measuring the extent of homelessness in local communities and the impact of service interventions and the intended outcomes. During the study research period however, the DNSSAB HIFIS team and CAN agencies were still in the process of implementing HIFIS, which includes extensive data exploration, transformation, and cleaning in the HIFIS database. Thus some of the homelessness information and data – such as shelter and service utilization – was not available at the time of the study. Report recommendations include leveraging this data for deeper analysis of the emergency shelter system and homelessness when it becomes available.

3.0 Homelessness Need Indicators

Homelessness and Risk of Homelessness

We can look to Census data on households who are in core housing need[1] as an indicator of Nipissing District's population at increased risk of homelessness[2]. In 2021, Census data showed that 3,590 households in Nipissing District were in core housing need. These households are primarily located in North Bay, but there are households at risk of homelessness in each of Nipissing District's local municipalities.

Households in Core Housing Need

Municipality	Total Households in Core Need	Percent of Households in Core Need
South Algonquin	80	15.1%
Papineau-Cameron	60	14.5%
Mattawan	N/A	N/A
Mattawa	235	27.8%
Calvin	45	21.4%
Bonfield	50	5.8%
Chisholm	30	6.2%
East Ferris	85	4.6%

[1] Core housing need helps to identify households living in dwellings considered unsuitable, inadequate or unaffordable. It also considers if income levels are such that they could not afford alternative suitable and adequate housing in their community. A household is considered to be in core housing need if it meets two criteria: 1) A household is below one or more of the adequacy, suitability, and affordability standards. 2) The household would have to spend 30% or more of its before-tax household income to access local housing that meets all three standards.

[2] It should be noted that income data from the 2021 Census was based on total income for 2020, when the federal government was distributing the Canada Emergency Response Benefit (CERB) during the first phase of the Covid-19 pandemic. It is widely acknowledged that CERB increased incomes in the 2021 Census, particularly for the lowest-earning households, and temporarily decreased the number of households in core housing need.

Municipality	Total Households in Core Need	Percent of Households in Core Need
North Bay	2490	10.8%
West Nipissing	410	6.6%
Temagami	50	11.9%
Nipissing, Unorganized, South Part	N/A	N/A
Nipissing, Unorganized, North Part	40	5.5%

Source: Statistics Canada Census, 2021, Table: 98-10-0259-01

Based on the previous Point-in-Time (PiT) homeless count and survey conducted in 2021, it was estimated that about 300 people were experiencing homelessness in Nipissing District at that time[3]. More recently (September 2023) and based on HIFIS administrative data, there are 177 individuals who are on the Nipissing By-Name List (BNL) and experiencing homelessness. While the PiT and HIFIS homelessness counts are not directly comparable, together they provide the extent of the problem and a range of the number of people experiencing local homelessness.[4]

Over the course of a year, a minimum of 721 households experience homelessness based on emergency accommodation data provided by the NDSSAB[5]. However, this does not account for people sleeping rough or experiencing hidden homelessness.

The following table breaks down the demographics of people experiencing homelessness based on the individuals on the By-Name List.[6] It also compares the demographics to the overall population. Males, Indigenous people, and single adults are overrepresented among those experiencing homelessness in the District.

[3] District of Nipissing Social Services Administration Board, 2021, Nipissing Counts 2021: A Count and Survey of Individuals Experiencing Homelessness in the Nipissing District

[4] HIFIS is the Homelessness Individuals and Families Information System. The By-Name List (BNL) represents individuals who are in the HIFIS and experiencing homelessness, and are 16 years of age or older and consented to sharing their information for the BNL and the prioritization of services.

[5] District of Nipissing Social Services Administration Board, 2023, Analysis of Four Elms, Overflow, and Low Barrier Shelter Admissions, September 2022-September 2023

[6] Since the HIFIS data collection in September and the writing of this report, there has been further data transformation and cleaning in the HIFIS database. Thus, some of the BNL counts in these reports may have changed retrospectively.

Demographic Breakdown of BNL Prioritization List (based off of 177 Individuals)

Demographic Breakdown of BNL Prioritization List based off of 177 Individuals	Number of Individuals with data in BNL Prioritization List	Percentage of Individuals with data in BNL Prioritization List	Percentage of Nipissing District Population
Gender Identity			
Female	47	26.6%	51.2%[7]
Male	126	71.2%	48.8%[8]
Gender Diverse	2	1.1%	1.0%[9]
Unknown	2	1.1%	
Veteran Status			
Self Identify as a Veteran	10	5.6%	1.0%[10]
Indigenous Identity			
Indigenous	53	29.9%	14.5%
Family Status of Individuals			
Single Adult	145	81.9%	30.5%
Member of a Family	20	11.3%	78.9%
Single Youth	12	6.8%	3.2%[11]
Age			
Youth (16-24)	12	6.8%	9.6%
Adult (25-64)	161	91.0%	52.1%
Senior (65+)	4	2.3%	22.9%

Source: Coordinated Access Nipissing By-Name List as of September 29, 2023, provided by DNSSAB

Forms of Homelessness

Homelessness can take many forms. At the time of the homeless count in 2021, there were 91 people experiencing absolute homelessness, 159 provisionally accommodated, 10 transitionally housed, and 33 dependent children[12]. As of September 29, 2023, there were 32 individuals identified as currently living rough (on the street or in the bush) and receiving Outreach Support across the District, including Mattawa and Sturgeon Falls[13].

[7] 2021 Statistics Canada Census data is for Women+

[8] 2021 Statistics Canada Census data is for Men+

[9] Based on 2021 Statistics Canada Census data for households

[10] Based on Ontario numbers reported by the Government of Canada, at https://www.veterans.gc.ca/eng/about-vac/news-media/facts-figures/1-0

[11] This number refers to unattached youth, whereas the number below includes youth living in families and unattached youth

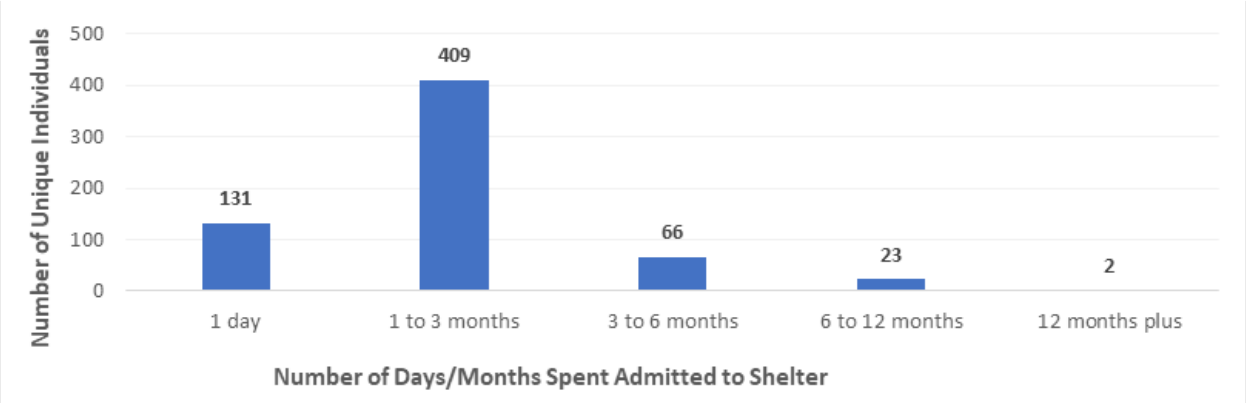
[12] District of Nipissing Social Services Administration Board, 2021, Nipissing Counts 2021: A Count and Survey of Individuals Experiencing Homelessness in the Nipissing District

[13] Based on correspondence from District of Nipissing Social Services Administration Board, October 6, 2023

Length of Homelessness

Most individuals experiencing homelessness are able to resolve their experience of homelessness quickly. Based on data from DNSSAB, over half (58.0%) of the individuals who accessed emergency accommodations did so for 30 days or less[14]. However, a relatively small proportion of service users experience longer term homelessness. Some 91 individuals accessed emergency accommodation for three months or more. Of the 104 individuals on the By-Name List with a Homeless Information Assessment (HIA) on file, 40 (38.5%) were experiencing chronic homelessness[15].

Number of Days Unique Individuals were Admitted to Shelter (Low Barrier Shelter, Four Elms, and Overflow) from September 15, 2022 to September 15, 2023



Source: District of Nipissing Social Services Administration Board, 2023, Analysis of Four Elms, Overflow, and Low Barrier Shelter Admissions, September 2022-September 2023

Level of Need

Individuals on the By-Name List (BNL) are being prioritized for action-based case conferencing based on their attained scores from a Priority Assessment of vulnerability factors developed by the Coordinated Access Nipissing Partnership. The Homelessness Information Assessment (HIA) considers whether the individual is: unsheltered/staying at the low barrier shelter/couch surfing, experiencing chronic homelessness, Indigenous, have mental health issues, have substance use issues, youth (16-24), have a developmental cognitive disability, have a physical disability, have an acute/chronic medical condition, have recently been discharged from an institution, are fleeing violence and/or victimization, are experiencing environmental displacement, and identify as LGBTQ2S+. Scores of 1-3 on the assessment tool are classified as 'low', 4-9 are classified as 'medium', and 10+ are classified as 'high' acuity (need) for the purposes of resource matching.

As of September 29, 2023, 46.2% of people on the BNL with a Homelessness Information Assessment on file were identified as having a low acuity of need and 53.8% were identified as having a medium acuity. At the time, none of the individuals who had completed a Homelessness Information Assessment had been identified as high acuity. It should be noted that the HIA Priority Matrix provides a score for prioritization for access to resources, but does not determine the level of supports needed. It should be

[14] District of Nipissing Social Services Administration Board, 2023, Analysis of Four Elms, Overflow, and Low Barrier Shelter Admissions, September 2022-September 2023

[15] Coordinated Access Nipissing By-Name List as of September 29, 2023, provided by DNSSAB

noted that there could be individuals that would be classified as 'high' acuity but the Homelessness Information Assessment had not yet been completed.

Housing Needs

The following is a breakdown of the housing needs of the 104 individuals who have a HIA on file. Individuals may have more than one need identified below.

Housing Need Analysis based on 104 Individuals with Homeless Information Assessment (HIA) on File	Number of Individuals	Percentage
Accessible Unit Needed:	10	9.6%
Would like congregate living	23	22.1%
Has a pet	13	12.5%
Needs Parking	10	9.6%
Mental Health as a Barrier	53	51.0%
Developmental Disability	16	15.4%
Physical Disability	18	17.3%
Medical Condition	4	3.8%
Substance Use	31	29.8%
Discharged from an Institution in the last three months	6	5.8%
Identifies as LGBTQ2S+	7	6.7%

*Based off the Coordinated Access Nipissing Homelessness Information Assessment Priority Matrix
Source: Coordinated Access Nipissing By-Name List as of September 29, 2023, provided by DNSSAB

Supports Required

Over half (55.8%), of individuals with a HIA require one or more supports. The majority of these require mental health supports (62%) and/or brain injury supports (56%). Close to 30% require substance use supports (29%) and physical health related supports (28%). One third (33%) require supports only on a time-limited basis.

Type of Support	Number of People	Percentage of Responses who Require Supports (n=58)
Transitional Supports	19	33%
Substance Use Supports	17	29%
Physical Accessibility Supports	11	19%
Mental Health Supports	36	62%
Medical/Health Related Supports	16	28%
Tenancy Related Supports (Rent Smart etc.)	4	7%
Employment Skills/Supports	3	5%
DSO Related Supports	4	7%
Budgeting/Financial	6	10%
Trusteeship	4	7%
Brain Injury Supports	9	16%

Shelter Demand

An average of 28 individuals per night were provided with a bed at the Low Barrier Shelter in 2022[16]. An additional six people accessed the Low Barrier Shelter for amenities only. In addition, an average of 11 single individuals and nine couples or families spent the night in overflow shelter beds.

Over the course of the year, 198 unique individuals stayed in overflow shelter beds in 2022/2023[17]. Almost two thirds (64%) of these were single individuals. Overflow shelter bed users stayed 37 days on average. Families stayed longer than singles, with an average of 46 days for households of two or more compared to 31 days for one person households.

[16] Based on personal correspondence with District of Nipissing Social Services Administration Board, Sept. 25, 2023 – 2022 Overflow Analysis

[17] District of Nipissing Social Services Administration Board, 2023, Analysis of Four Elms, Overflow, and Low Barrier Shelter Admissions, September 2022-September 2023

4.0 Homelessness Supply Indicators

The system of homelessness supports and services in Nipissing District includes several homelessness prevention services, 97 permanent emergency shelter beds (21 of which are funded by the DSSAB), plus overflow beds, outreach and re-housing support services, as well as over 100 transitional housing beds and 168 units of permanent supportive housing. It should be noted that the permanent supportive housing units include 34 units operated by PHARA, which at the time of writing this report do not currently target individuals experiencing homelessness. Further details on service providers/program, program mandates, program spaces and funding by program can be found in Appendix 1.

Program Type	**Program Spaces**	**DNSSAB Funding**
Homelessness Prevention	N/A	$683,000
Emergency Accommodation	97 permanent beds plus typically 17 motel rooms and 3 units for overflow and daytime warming services in winter[18]. DNSSAB funds a portion of the 19 bed family shelter (Four Elms) 21 of the permanent beds (for singles) plus overflow and warming services.	$1,796,371
Outreach	N/A A portion of the outreach services in the community are funded by DNSSAB.	$111,000[19]
Re-Housing Supports	125 households per year plus 2 FTE workers for overflow clients, funded by DNSSAB	$406,000
Transitional Housing	100 beds + 16-24 CMHA transitional beds. The DNSSAB funds 60 of these beds plus some extra staffing support at Futures Transitional Housing.	$2,566,517
Permanent Supportive Housing	168 units including 134 CMHA units and 34 PHARA units	Only PHARA units are DNSSAB funded (but not homelessness specific funding)

[18] Permanent beds based on District of Nipissing Social Services Administration Board, 2023, Nipissing Housing Inventory – July 2023. Motel rooms and townhouses based on agreement between DNSSAB and Crisis Centre and conversations with DNSSAB staff.

[19] Based on data provided by DNSSAB staff. This includes $55,000 in original funding plus the additional $56,000 approved in November for December 2023 – March 2024

5.0 Strengths and Challenges of Existing Homelessness Services

The following section provides a discussion of the strengths, gaps and challenges in each of the core areas of homelessness services and housing supply for people experiencing and at risk of homelessness.

5.1 Homelessness Prevention

Strengths

A range of homelessness prevention services are available, including financial assistance for rental arrears, security deposits, last month's rent, utility deposits and payments for arrears, moving costs, etc. Financial assistance has flexibility to address a range of needs. Homelessness prevention supports are also available to assist with eviction prevention and housing searches. Existing homelessness prevention services take an empowerment approach and aim to intervene early in a housing crisis, which reduces the cost of assistance and increases likelihood of success. Services also assess the likelihood of the household remaining housed if they receive assistance.

Gaps and Challenges

Some service providers reported that there are a growing number of youth that are precariously housed, but there is limited housing and services dedicated to youth. However, throughout the past year Crisis Centre's transitional housing for youth has rarely been full and their Community Mobile Housing and Support Youth Worker has had a caseload of between 10 and 20 people, which they reported to be quite manageable. That said, Crisis Centre staff believe that if they had two staff on each shift at their transitional housing for youth, they could serve youth with higher needs.

Service providers also reported limited coordination related to early prevention and education measures and a need for additional coordination in this area, including with secondary schools, child welfare services, and mental health services.

Service providers reported that some people are being missed by prevention services, particularly those in outlying municipalities. Individuals with lived experience of homelessness pointed to some opportunities for greater prevention supports, as they noted that some landlords take advantage of people who don't know their rights and people experience illegal evictions as a result.

A challenge with existing homelessness prevention programs is that they are not necessarily identifying persons who have the highest risk of becoming homeless. People who receive prevention assistance may not become homeless even without assistance. Consideration also needs to be given to early intervention and supports, as waiting could drive up the costs associated with eliminating the risk. There is a need to balance intervention timing with accuracy in identifying need for prevention assistance and cost.

5.2 Discharge Planning

Strengths

Community partners are providing some discharge planning services at North Bay jail, hospital, and treatment programs prior to discharge. For example, Crisis Centre staff will connect with the occupant's prime worker at the institution and share information to ease the transition into Northern Pines and will request case conferences with the occupants circle of care. Four Elms staff regularly attend discharge planning meetings at the hospital and at the jail. Presentations have been made to hospital discharge planners and social workers advising them of Crisis Centre's discharge planning services, and ability to work to find housing prior to discharge to prevent a shelter admission. Crisis Centre also provides its Identification Clinic services to the jail to start the process for those in need of identification. CMHA has a Release from Custody Service and True Self also provides discharge planning services at the North Bay jail.

Gaps and Challenges

While Crisis Centre North Bay, CMHA, and True Self provide some discharge planning to individuals in the North Bay jail, hospital and treatment programs, there are some opportunities for additional coordination around discharge planning. For example, coordinating between service providers that offer discharge planning, and identifying specific contacts the hospital can communicate with when discharging after an emergency department visit.

5.3 Emergency Accommodations

Strengths

There are a number of strengths of the existing emergency accommodations available in the district:

- A low barrier shelter was established in 2020 providing improved access to emergency accommodation for individuals who may not have previously been able to access services at the Four Elms Residence. The low barrier shelter has practices in place that reduce potential barriers to people being able to access service. For example, individuals are able to access the low barrier shelter when under the influence of substances and pets are allowed if they are safe.
- Hotels are used to flex the number of beds available for emergency accommodation and better serve rural residents in their own communities.
- Full diversion services are conducted at the Four Elms Residence to avoid unnecessary entry into emergency shelter. Re-housing assistance is available to existing shelter clients who request it to find housing as well as ongoing follow-up through Crisis Centre North Bay's Community Mobile Housing Support Program.

Gaps and Challenges

Four major gaps and challenges have been identified related to emergency accommodation:

- First, there is often insufficient shelter capacity to meet demands. The Crisis Centre reported that on average they turn away four to 10 individuals per day from the Low Barrier Shelter due

to capacity constraints. Hospital staff reported that this sometimes results in people accessing the emergency department because they don't have another place to go and are cold and hungry. Individuals with lived experience reported that it was difficult to get into low-barrier beds. Municipal representatives from communities outside of North Bay often reported limited motels or limited access to motels to meet emergency accommodation needs.

- Second, overflow shelter services in hotels/motels are costly in comparison to the level of service provided.
- Third, families tend to stay a long time in hotels/motels as they struggle to access market housing due to poor tenancy history, and larger families face challenges finding enough bedrooms.
- Fourth, the low barrier shelter could benefit from several enhancements to align more closely with established best practices[20]. These include:
    - Efforts to explore other safe and appropriate options before offering shelter (diversion) are limited because of the hours of service.
    - There may be some barriers preventing access to shelter. Although people may be admitted to the low barrier shelter if they are under the influence of alcohol, there is a perception by some that they will not be served. Individuals with lived experience reported that it is "impossible to find shelter when using". Some also reported that they choose not to go to shelter because of the rules, including the 10pm curfew. However, it should be noted that this is a misperception, as the Crisis Centre reported that there isn't a curfew at the Low Barrier Shelter. Some individuals with lived experience also reported a perception that Indigenous men are not allowed at the shelter because they have the opportunity to access Suswin (which is transitional housing).
    - The shelter is open from 8pm to 8am and shelter users are required to go to the shelter at a certain time to access services. The shelter currently uses a number system to access services. Individuals with lived experience reported that there can be bullying that occurs by individuals wanting to take someone's number if they have higher priority. Shelter users seek a variety of other services during the day, but none are focused on re-housing support and meals are only available at The Gathering Place (soup kitchen) during weekdays and non-holidays. There are, however, meals at the Baptist church on Saturdays and holidays and meals were provided by the Gathering Place on the weekends at the warming centre this winter. Individuals with lived experience reported challenges with access to food, including that Gathering Place doesn't provide food on weekends, churches can be restrictive, and food banks ask for an address, identification or rent receipts. Access to facilities to use the washroom and bath during the day remains a gap. Individuals with lived experience identified the need for 24/7 shelter. It is best practice for shelters to provide 24/7 access to services where shelter users can have their basic needs met, such as accessing food, hygiene, shelter, and storage.
    - Although the shelter has historically had some Indigenous staff, it does not currently

[20] Best Practices have been documented in the following resources: Orgcode Consulting Inc, 2022, An Introduction to Low-Barrier, Housing-Focused Shelter; National Alliance to End Homelessness, The Five Keys to Effective Emergency Shelter; United States Interagency Council on Homelessness, 2017, Key Considerations for Implementing Emergency Shelter Within an Effective Crisis Response System

have culturally specific staff/teams, in part due to increasing demands from many employers for Indigenous employees. Having staff that reflect the population of those seeking shelter is a best practice approach to support inclusion and cultural competence. The shelter, with support from the DNSSAB, should review demographics of shelter users and work towards having a staff the reflects service users.

- Harm reduction supplies are not available at the shelter, although it is best practice for shelters to provide direct access to harm reduction supplies (e.g., needle exchange, distribution and disposal) as well as education regarding how to avoid risky behaviours and engage in safer practices (e.g., overdose prevention).
- The built form at the shelter is limited in its ability to promote dignity for shelter users. For example, all shelter users sleep in one room, with half walls around each person's cot area. While the galley design does allow for sight lines to each person's cot area, ideally, sleeping accommodations should be provided through multiple rooms and there should be women-only sleeping accommodations that are securely separated from men's accommodation[21]. This helps recognize the value of the individuals and avoids the perception of warehousing. This approach does however require appropriate staffing, clear staff sightlines, and/or video monitoring of people with challenging behaviours, such as violence or risk of overdose, to support safety. Good sightlines in entrances, circulation areas, gathering spaces, and program areas are important. It is also considered best practice to provide opportunities for accommodating individuals with disruptive behaviours, e.g. through a proportion of single rooms and sitting areas outside of sleeping rooms.
- Although some re-housing supports are available to shelter clients through Crisis Centre North Bay's Community Mobile Housing Support Program, the shelter is not oriented around supporting shelter users to quickly access permanent housing. The shelter was designed as a temporary overnight solution and has limited operating hours that would support on-site resources or housing search assistance.
- There is work underway to support the community's ability to use HIFIS to analyze the performance of homelessness services. However, at this time, there are limitations in the availability of readily accessible data to analyze performance.

Although not an issue specific to emergency accommodation, the engagement identified some community concerns in North Bay about people experiencing visible homelessness and concurrent substance use and/or mental health issues. Concerns include feeling unsafe on the streets due to unpredictability of the behaviours or violence by some individuals and frustrations with loitering, garbage, and property damage.

[21] BC Housing, 2017, Shelter Design Guidelines

5.4 Outreach

Strengths

There are a variety of outreach services in North Bay, including services that take a culturally safe approach and are housing-focused. The community has also seen success with the mobile nurse practitioner pilot. The program has enabled primary care to vulnerable residents and connected clients that have other needs to other service providers. Another strength of the existing outreach services is that there are practices in place to support coordination of outreach across the district through regular meetings of outreach workers. These include regular meetings of outreach workers to discuss where they are seeing individuals and who they are supporting.

Gaps and Challenges

At the time of drafting this report, True Self was piloting evening outreach services which were originally scheduled until the end of September 2023. However, DNSSAB has since committed funding to extend to September 30th, 2024. Other outreach services were generally limited to daytime hours. Areas outside of North Bay were particularly underserviced by outreach and transportation in outlying areas was (and continues to be) a challenge. True Self's evening outreach services were subsequently extended to the end of January. DNSSAB approved enhancing the True Self contract until September 30th, 2024 to expand hours and outreach to outlying areas. Evening outreach services and outreach outside of North Bay allow service providers to see and support a broader range of individuals.

Some service providers reported that current street outreach services are more focused on providing supports and less about connecting individuals to services, as outreach workers feel there are limited resources they can connect individuals with.

Service providers also expressed concerns about instances where municipal staff remove individuals from encampments before a coordinated approach can be taken to support the individuals. As a result, service providers struggle to regain contact with the individuals and service is often interrupted.

5.5 Re-Housing Supports

Strengths

There are a number of re-housing supports available to people experiencing homelessness in the district:

- Crisis Centre North Bay's Community Mobile Housing Support Program provides rapid re-housing assistance to existing shelter clients to find housing as well as ongoing follow-up.
- The Crisis Centre North Bay provides re-housing supports for overflow clients.
- The Brain Injury Association of North Bay and Area has begun a relatively new Housing Support Program that provides individuals who identify as having a brain injury or cognitive impairment support finding, securing and retaining permanent housing.

Supports for veterans experiencing homelessness are also seen as a strength. Referrals are made to the Royal Canadian Legion Service Bureau, which connects individuals to veteran specific housing resources.

Gaps and Challenges

At the time of drafting this report, Crisis Centre North Bay reported that its one Community Mobile Housing Support Program staff that focuses on adults had a caseload of approximately 40 individuals (at-risk and experiencing homelessness), which is too high to allow them to provide effective services. In "Performance Management in a Housing First Context", Dr. Alina Turner states that an appropriate case manager to client ratio is 1:25 for lower acuity clients and 1:20 for moderate acuity clients[22]. Since drafting the report, DNSSAB has committed funding for this year towards a part-time staff to help deliver these services as an interim solution.

Some service providers also reported that they are "not really re-housing people" due to limited access to affordable housing. Service providers reported that they have to keep households on their case load longer once housed now that there is limited access to the Brief Intervention Services with mental health service providers. Some community partners reported that they would like to see more supports for people to maintain their housing once housed, including follow-ups, case management, or trusteeships. However, it should be noted that since the engagement with community partners, DNSSAB has increased funding provided to LIPI for trusteeships for households in shelter.

Individuals with lived experience reported that some of the challenges in retaining housing once they have been housed include no one to follow up with them and a lack of mental health supports; landlords taking advantage of people not knowing their rights; and facing evictions due to damage to the property caused by having friends coming to stay.

5.6 Transitional Housing

Strengths

The newly developed transitional housing at Northern Pines and Suswin and the beds/units currently under development at Northern Pines are a key source of new housing for people experiencing homelessness in the district who need supports. Rapid Access to Addictions Medicine (RAAM) and Assertive Community Treatment (ACT) teams are going to be available at Northern Pines and accessible to residents to get help with high-risk substance use and addictions and complex mental health issues.

The rental assistance provided to Northern Pines residents are anticipated to be portable, which will support transitions to housing in the community. However, the residents are not receiving portable rental assistance in the current phase (Phase 1).

The Crisis Centre's Futures transitional housing also plays an important role in meeting the housing needs of vulnerable youth experiencing homelessness. When a youth is being transitioned from the hospital to Futures, Crisis Centre works with hospital staff to develop a case plan prior to the transition. Futures also provides after-care, which helps support successful transitions into the community.

[22] Alina Turner (2015): Performance Management in a Housing First Context: A Guide for Community Entities. Toronto: The Homeless Hub Press.

Gaps and Challenges

Access to transitional housing at Northern Pines Phase 1 is being done through an interview and reference checks, as consideration needs to be given to the congregate nature of the living arrangements. Crisis Centre staff consider how the presenting factors will impact the program and other residents when determining admissions. This can create barriers to access for people with perceived barriers to housing such as drug use or mental health. It is considered best practice for a standardized approach to be used for prioritization and placement in housing. The current approach also may not result in targeting housing resources towards people that are most suited for the highest intensity housing with supports that could be possible by having the ACT team on-site. However, it should be noted that the admission process for Phase 3, which is intended to be low barrier, short term transitional housing is anticipated to be different.

The current transitional housing is all abstinence-based, which leaves a large gap for individuals who may be using substances and are often the most vulnerable. At Northern Pines Phase 1, for example, having paraphernalia or substances in the room but not in a safe would be grounds for discharge. This increases the barriers to residents in being able to maintain their housing at Northern Pines. Another gap exists because the current transitional housing does not allow for couples or pets. Northern Pines Phase 3 will not be abstinence-based and Phase 2 will allow pets.

While it is helpful that the three levels of support at Northern Pines are integrated, transitioning between these levels may present challenges. Firstly, individuals may not be ready to progress to the next phase after a predetermined time, therefore demand for each level of support is likely to fluctuate, often leading to a bottleneck in certain stages. Moreover, the transition to affordable housing in the community, which lacks the support offered at Northern Pines, can be particularly daunting, further complicating the flow between different support levels.

It is important that transitional housing be focused on permanent housing outcomes. Access to ongoing rental assistance and wrap-around supports/after care would likely be important for many people leaving Suswin and Northern Pines. Currently, no after care is available to help people sustain housing after leaving Northern Pines or Suswin. The Crisis Centre reported that a few residents are ready to move out of Northern Pines 1, but are waiting for Phase 2 because it provides an affordable option. They reported that they would likely have more residents that would look at the private market if rental assistance were available. It should be noted that rental assistance provided to residents of Northern Pines 2 will be portable, so it will allow them to maintain affordability after leaving Northern Pines. There has been no discussion yet about opportunities for Suswin residents to receive rental assistance when they transition.

Some service providers reported that if residents have not met expectations in transitional housing, they are discharged without a plan, in particular if they pose a major health and safety risk to others. However, it is best practice not to discharge to homelessness and develop a plan for alternative housing/supports prior to discharge. Crisis Centre reported that the only circumstance they would discharge a Northern Pines occupant without alternative housing is if they are a major health and safety risk to others. They would be told they are welcome to attend the Low Barrier Shelter in the evenings.

Some service providers are seeing needs beyond those that they can effectively serve. The North Bay Indigenous Friendship Centre reported that there is a need for greater access to mental health services for the residents at Suswin, as staff are noticing needs beyond their scope of work. The Crisis Centre

reported that they have one staff 24/7 for 10 youth, but would be able to support youth with higher needs if they had two staff in the evenings.

Individuals with lived experience reported that they would like to see more places like Suswin for non-Indigenous people. Northern Pines serves a similar population group.

5.7 Housing First/Intensive Case Management and Supportive Housing

Strengths

There are over 130 units of permanent supportive housing in the district focused on individuals with mental health issues. The units are operated by Canadian Mental Health Association Nipissing (CMHA) and intake is conducted through CMHA. Individuals must be receiving case management or eligible for mental health case management services from CMHA to access the units.

Gaps and Challenges

A key challenge for the district is that there are several individuals with higher levels of need than the system is currently designed to support. There is a particular gap for people with very high acuity, and co-occurring substance use and mental health needs. The future phase 3 of Northern Pines may help respond to this need, but it will depend on prioritization for those beds/units and a number of these individuals will likely need permanent intensive supportive housing rather than a transitional solution. The district also does not have any Housing First Intensive Case Management spaces that leverage private market housing in the community for individuals that may not want, or may not be eligible for, or effectively served, at Northern Pines or Suswin.

While all housing resources relevant to homelessness cannot be mandated to receive referrals and fill vacancies through Coordinated Access Nipissing if they do not receive homelessness program funding through DNSSAB, participation of service providers with other funders, such as CMHA, should be actively encouraged. CMHA should consider committing at least a portion of their units to placement through Coordinated Access Nipissing. Commitment to Coordinated Access supports an integrated approach where service providers across the community are working together to achieve common goals.

It has been a challenge for the district to increase the supply of supportive housing, as there has been lack of long-term operational funding available for additional supports and service providers are at capacity with their existing services.

Existing permanent supportive housing provided by CMHA does not have time limits and is often provided for life, which results in very limited turnover and access to housing for new people.

5.8 Access to Housing

Strengths

The DNSSAB has plans to increase rental subsidies over the next several years as part of its Service Level Standards Action Plan, and the DNSSAB has been targeting those towards people experiencing homelessness. The DNSSAB has a ‘Homeless’ priority that increases access to subsidized rental housing

for households experiencing homelessness. The DNSSAB has also prioritized households experiencing homelessness for the Canada-Ontario Housing Benefit.

Nipissing District Housing Corporation has approximately $13 million set aside for new housing development that it would like to use to leverage federal and provincial funding to maximize the number of new units that can be added in the District.

Gaps and Challenges

Community partners identified that limited access to affordable housing for people experiencing homelessness is a significant barrier to the community's efforts addressing homelessness. Housing costs have been increasing, but there have not been increases to Ontario Works and only a minor increase to ODSP. There are challenges in finding affordable housing for both singles and families. Increasing the supply of affordable housing has also been a challenge with limited funding and rising costs of construction.

Individuals with lived experience also reported limited incomes/high costs of rent/limited affordable housing as one of the main barriers to housing. They also reported that many landlords only want to rent to students or women. They would like to see more housing, including housing where rents are geared to incomes.

6.0 Access to Services

The following is an assessment of access to homelessness services in the district.

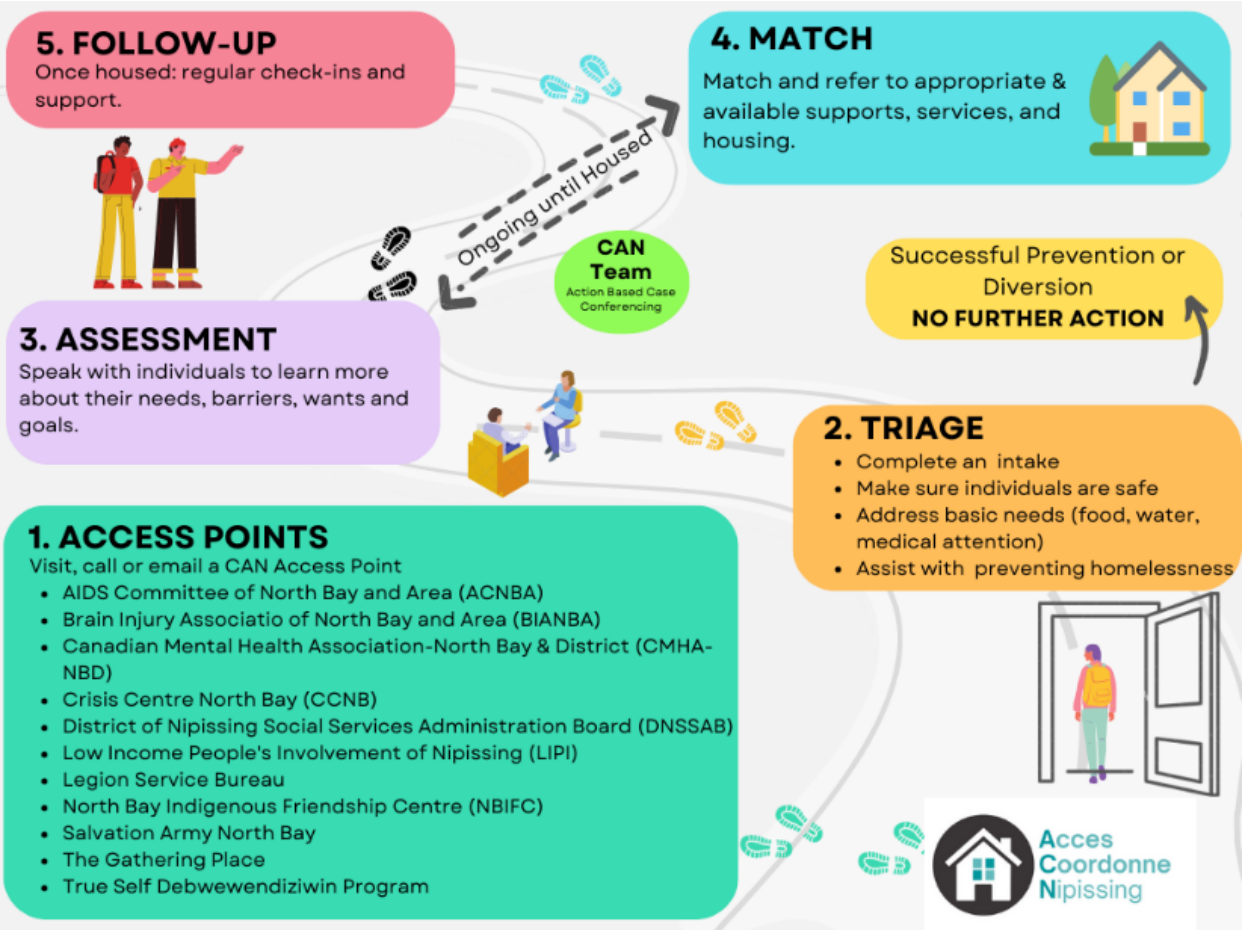
Strengths

The DNSSAB and its community partners have made significant efforts to provide more opportunities for access to service by modifying and expanding services over the past few years, including the additions of the low barrier shelter and Northern Pines.

Service providers are taking a team approach to addressing homelessness, and there are excellent partnerships on the front-lines.

Service providers across the district have used a 'no wrong door' approach to accessing services for many years, which has provided a strong base for the work of Coordinated Access Nipissing.

The community has established a Coordinated Access process. The following diagram provides a visual of the process.



The DNSSAB and community partners have taken significant steps in implementing Coordinated Access in the district. The community has:

- Developed a process by which people experiencing or at risk of homelessness access the homelessness serving system
- Identified access points across the district
- Developed a governance model that provides oversight for the Coordinated Access System
- Implemented a Homelessness Information Management System
- Developed and implemented a common assessment tool
- Developed prioritization criteria
- Developed processes, protocols, and tools for the system
- Developed a guide that outlines the Coordinated Access System and processes
- Implemented case conferencing meetings focused on matching prioritized individuals from the By-Name list to appropriate housing and supports.

Gaps and Challenges

Service providers don't believe they are reaching everyone in need of services. There are several barriers to access to services in the district:

- Availability of services – Key areas where individuals with lived experience and community partners both identified limited availability of services included: affordable housing; mental health services, including psychiatry, counselling and PTSD support; addictions services, including withdrawal management and residential treatment; other health services including primary care; and basic needs services such as shelter, food, bathrooms and showers. While community mental health services can be accessed without a doctor's referral, high levels of demand and wait lists for mental health and addictions services are acting as significant barriers to service. CMHA reported that their base of clients has increased by approximately 50% since COVID-19, but resources have not increased. Service providers reported that even brief intervention supports, which are intended to be immediately available, are often completely booked up. Service providers also reported that there isn't a central location for people experiencing homelessness to receive mail. Service hours are also presenting as a barrier to receiving outreach services (evenings), shelter/warmth (daytime warming centre operates November to March/April), and food (weekends and holidays).
- Location – Existing services are not located throughout the whole District. There is very little emphasis on prevention services to the outlying municipalities and rural communities have limited access to motels or rental housing. There are hotels in some communities outside of North Bay, but in some cases, access may be limited to off-season tourist rentals. There is limited access to transportation services outside of North Bay. Representatives from West Nipissing reported visible homelessness, but limited services, and a desire to support people right in their community. Representatives from South Algonquin reported that supports in North Bay are unattainable to their community members because of the significant distance of the community from North Bay and lack of public transportation options, and there are no supports operating locally. Other communities reported less visible homelessness, but a lack of rental housing.
- Physical access – It can be physically difficult for people to come to care. For example, someone may be required to walk to receive wound care, but the distance required to walk is not feasible.

- Administrative barriers – Complicated or exclusionary processes make it more difficult for people to access certain services. For example, Home and Community Care and remote care monitoring as well as some food security services require an address to access services. Service providers reported that the GAINs assessment can be a significant barrier to accessing addictions treatment. There is sometimes a six month wait, it can take multiple sessions to complete the GAINs assessment, and it expires after six months. As well, the assessment is felt to be culturally inappropriate. Service providers also reported that there are limited services that permit pets, and people do not want to leave their pets.
- Lack of cultural safety and response to diverse needs – The consultations identified several limitations in service providers' response to different cultures and groups. Community partners identified that service philosophies result in many of the most vulnerable people with mental health and addictions issues, who do not intend on quitting their substance use, being denied access to needed services. Community partners also reported that some groups, such as seniors and people in rural areas are not getting as many services because they are less visible to service providers. They also noted that there needs to be a defined approach to addressing the needs of couples. Some community partners reported that community members do not report comfort at specific agencies as a result of a lack of culturally appropriate services.
- Psychological barriers – Shame, embarrassment, discomfort, lack of trust, lack of motivation, or fear of failure keep many people from seeking services. Service providers reported that some of the most vulnerable individuals don't trust service providers, preventing them from accessing help. Some service providers also reported that some people find it difficult to enter an office building for service. Some service providers also noted that individuals more willing to access mental health services and stay in counselling are probably getting services, but individuals who need more prompting and assistance to stay in programming aren't getting service.
- Awareness – Some service providers reported that there is some lack of awareness in the community of services available to people experiencing homelessness. Individuals with lived experience also identified that more promotion of available services would make it easier to access services.

The community has made strides to implement a By-Name List to support coordinated access to housing, but still needs to work to ensure everyone experiencing homelessness across the district has an opportunity to be added to the list.

An effective Coordinated Access system is dependent on dedicated housing and support resources to serve people experiencing homelessness. However, the community has not yet determined housing resources that are available only to individuals who are on the By-Name List or where a percentage of spots are allocated to individuals on the By-Name List. Service providers are largely still conducting their own intake. This is resulting in limited referrals of prioritized individuals to available housing resources and does not allow the community to see the value of Coordinated Access. Some service providers reported that having different funders can challenge collaboration and, in some areas, still creates an effect of 'working in silos'.

7.0 Cultural Equity of the Homelessness System

An assessment of the cultural equity of the homelessness system has been provided below.

Strengths

There is Indigenous organization representation on both the Community Advisory Board and Coordinated Access Nipissing's Executive Committee. Indigenous agencies also participate in the Coordinated Access Nipissing Team, which carries out the implementation of the Coordinated Access System. Organizations participating in the Coordinated Access Nipissing Team designed a common assessment tool specific to the district, which as intended to be more culturally appropriate than some of the other existing standardized assessment tools. The assessment tool is used to assign a prioritization score to each client within the Coordinated Access system. Priorities include: unsheltered/low barrier shelter or couch surfing; chronicity, Indigenous identity, mental health, substance use; age 16-24; developmental cognitive disability; physical disability; acute/chronic medical condition; recent institutional discharge; fleeing violence and/or victimization; environmental displacement and LGBTQ2S+. This provides some prioritization of Indigenous peoples for action-based case conferencing and in the future for housing resources that are dedicated to Coordinated Access Nipissing.

Gaps and Challenges

Based on an analysis of homelessness funding provided through the Homelessness Prevention Program and Reaching Home, Indigenous organizations do not receive a proportioned share of funding resources, despite their overrepresentation among people experiencing homelessness. DNSSAB staff reported that it continues to work with Indigenous organizations to encourage them to submit additional program proposals when funding opportunities are available.

8.0 Opportunities and Recommendations

The following are recommendations to addressing challenges and gaps in providing a 24/7 District-wide continuum of homelessness services.

Recommendations Related to Emergency Accommodation

1. The homelessness system is in a state of transition with Northern Pines Phase 3 under construction and Suswin not yet fully operational. As such, it is recommended that the DNSSAB monitor demand for shelter once this housing is fully operational to inform necessary capacity. The HIFIS team is continuing to improve HIFIS data reliability and quality, and this information and data will assist with this analysis.

2. The information and data in HIFIS could also be analyzed to look at family shelter demand and assess whether a fixed site facility to provide emergency shelter for families would reduce operating costs.

3. The DNSSAB and its partners should refine operational models for emergency shelter for singles to align with best practices:

    - Transition from an overnight shelter model towards a 24/7 shelter model that provides three meals a day, access to washrooms and showers during the day, access to resources and support during the day, and where intake includes diversion screening that occurs once per stay rather than daily.
    - Implement a housing-focused orientation with practices to intentionally link people to permanent housing resources and re-house people as quickly as possible. All messaging to shelter users from the shelter should be focused on housing. All shelter users should be provided with opportunities to access on-site resources that support self-directed housing searches as well as housing supports to develop and implement individualized case plans and problem solving to address barriers to housing.
    - Review rules and policies that may create barriers to access or make people reluctant to access shelter, including curfews and service restriction policies
    - Strive to integrate Indigenous specific services/staff/teams within shelter
    - Take a harm reduction approach, including providing direct access to harm reduction supplies (e.g., needle exchange, distribution and disposal) as well as education regarding how to avoid risky behaviours and engage in safer practices (e.g., overdose prevention).

4. To improve the DNSSAB's ability to monitor performance in key areas of emergency accommodation, it should ensure collection of quality data and prepare reports on the following indicators: diversions, turnaways and reasons for turnaways, occupancy on a daily basis, length of stay, destinations at exit, and subsequent returns to homelessness. It should be noted that the DNSSAB has already begun working towards this recommendation.

Recommendations Related to Outreach Services

5. The DNSSAB should consider maintaining the expanded outreach services that have recently been funded both within North Bay during evening and weekend hours and outside of North Bay.

Recommendations Related to Prevention Services

6. It is recommended that in the short-term the DNSSAB continue to focus its efforts within the homelessness service system. However, in the future when the homelessness system has been refined toward improved housing outcomes, the DNSSAB should expand its homelessness prevention efforts for greater inclusion of other systems:
    - The DNSSAB and its partners should work with system partners such as the North Bay Jail, North Bay Regional Health Centre, and the Children's Aid Society to expand discharge and transition planning from jail, hospital, treatment, and child welfare and develop protocols to reduce homelessness from these institutions.
    - The DNSSAB and its partners may also wish to consider pursuing an upstream initiative related to homelessness prevention that involves a coordinated approach among various government entities, non-profit service providers and the community at large.

7. The DNSSAB and service providers should continue to monitor demands for homelessness prevention services for youth.

Recommendations Related to Re-housing Supports

9. The DNSSAB should continue to monitor returns to homelessness among households who have been housed following experiences of homelessness, but who are not provided with follow-up supports to help determine need for additional time-limited re-housing supports.

10. The DNSSAB should also monitor caseload and outcomes of the Community Mobile Housing Support Program to inform the need to increase similar homelessness prevention and re-housing supports.

Recommendations Related to Transitional Housing, Housing First and Permanent Supportive Housing

A lack of access to permanent supportive housing targeting individuals with the highest levels of need, often with concurrent mental health and substance use issues, is significantly hampering the ability to end chronic homelessness in the district. Improving access to housing for this group requires a multifaceted approach:

11. Strategies to increase access to existing housing with mental health supports – The DNSSAB should consider opportunities to explore the potential for CMHA to transition some of their clients who have improved their stability and now have lower support needs to rent subsidies provided by DNSSAB for scattered-site private market housing. This could allow CMHA to facilitate additional turnover and offer housing along with supports to additional individuals experiencing homelessness in need of mental health supports who are on the By-Name List.
12. Carefully planning access to Northern Pines 3 – Additional structure should be established for prioritization, referral and placement into Northern Pines 3, given that there are no other

housing resources in the community serving individuals with the highest level of needs. It is recommended that:

- The DNSSAB, the Crisis Centre, and the North Bay Regional Health Centre document project-specific eligibility criteria for each phase of Northern Pines.
- Coordinated Access Nipissing should determine prioritization criteria for different types/levels of housing with supports, including Northern Pines. Community-level outcomes should inform the criteria used to rank individuals on the Priority List[23]. It is recommended for spaces that offer the highest level of intensity of supports, e.g. Northern Pines 3, that acuity be used in (or at least be part of), the prioritization. This is particularly important given the current 'bottleneck' of individuals with the highest level of needs in gaining access to housing.
- Vacancies at Northern Pines 3 should be filled exclusively from the Coordinated Access Nipissing Priority List. It is not recommended that Crisis Centre have a secondary vetting process, such as an additional interview to determine "fit" or "readiness". Nevertheless, if Crisis Centre continues to interview clients to determine "fit", it should follow a transparent and consistent process. The Crisis Centre should base admissions around strong policy.

13. Ongoing monitoring and consideration of need for additional capacity building approaches for service providers serving individuals with high needs – Along with the implementation of Northern Pines 3, the DNSSAB should monitor the need for additional approaches to increase service providers willingness and ability to serve individuals with the highest needs, particularly those who may not be able to follow an abstinence-based approach. Such approaches may include additional training, professional supervision, organizational cultural shifts, and refining operational models, such as increased flexibilities in programming based on individual needs.
14. Collaborative networks for advocacy – The DNSSAB should continue to engage with the Nipissing Wellness Ontario Health Team, the North East Region of Ontario Health and local health partners such as the North Bay Regional Health Centre and Canadian Mental Health Association to continue to explore opportunities to collaborate to provide mental health and substance use services to individuals in housing resources targeting people experiencing homelessness and engage in joint advocacy for funding and resources for permanent supportive housing with high intensity supports.
15. Expanding the diversity of housing with supports as funding allows – As funding is available, the DNSSAB should pursue opportunities to fund a Housing First Intensive Case Management program using scattered site housing to provide an alternative for individuals who may not want, or be eligible for, or be effectively serviced at Northern Pines or Suswin. The housing may include both private sector and non-profit subsidized housing.

16. As more data from Coordinated Access Nipissing's Homelessness Information Assessment (HIA) becomes available, the DNSSAB should conduct an analysis of the reliability and validity of the HIA as a measure of level of support need. If not reliable and valid, it is recommended that Coordinated

[23] The Priority List is a subset of the By-Name List of all those experiencing homelessness. The Priority List includes everyone consenting to be on the list and share their contact information. These individuals and families are ranked in order of the priority determined by the community based on Coordinated Access Nipissing's Priority Matrix.

Access Nipissing consider adopting an additional tool to support assessment of level of need (acuity) in addition to the HIA that would be used for prioritization. Given that the community has already decided to make selective use of the Service Prioritization Decision Assistance Tool (SPDAT), this tool could be considered on an interim basis, until other tools are determined to be valid and reliable. It is further recommended that the DNSSAB use such a tool with individuals on the By-Name List experiencing homelessness to determine the number of people on the Priority List with varying levels of support need, in particular those with very high levels of need, in order to make the case to funders for additional resources and support.

17. The DNSSAB should conduct an analysis of the By-Name List on an annual basis to determine subpopulation groups who are experiencing poorer housing outcomes and work with community service providers to address disparities. This may include refining operational models for transitional housing so that they are not all abstinence-based or to allow pets or couples.

18. The DNSSAB should monitor flows from transitional housing to other permanent housing solutions and monitor the level of supports required when individuals transition from transitional housing. Transitional housing is important for certain subpopulation in need of temporary housing and services, but permanent supportive housing solutions may be required for some of the individuals currently being served through transitional housing. The DNSSAB may need to refine operational models for transitional housing in the future to enhance permanent housing outcomes.

19. The DNSSAB should establish policies and protocols that require service providers to establish a plan for alternative housing/supports with the individual prior to discharge from transitional housing.

Recommendations to Increase Access to Affordable Housing

20. Access to affordable housing for people experiencing homelessness is critically important and currently appears to be one of the biggest barriers to addressing homelessness in Nipissing District. The DNSSAB and its partners should continue to pursue all available opportunities to increase access to existing housing and expand the supply of affordable housing in the District that is available to people experiencing homelessness.

    The DNSSAB's plans to increase rental subsidies and target those towards people experiencing homelessness is an important strategy to address issues with access to affordable housing. The DNSSAB should continue to pursue resources to allow it to provide rental subsidies to households experiencing chronic homelessness. The DNSSAB should also pursue other creative approaches to increase access to existing private market housing for people experiencing homelessness, such as the DNSSAB or another service provider entering into headleases for private market units that can be used to provide shared housing or programs that reduce the financial risk for landlords such as damage banks or rent guarantee programs.

    Creating additional affordable housing for people experiencing homelessness is also critically important. The DNSSAB and Nipissing District Housing Corporation should continue to pursue opportunities to access senior government funding to leverage local funds set aside for new housing to directly develop additional affordable housing. The DNSSAB should also pursue other creative approaches, such as:

    - Innovative construction methods such as modular and prefabricated housing that can reduce the cost and time required to build affordable housing

- Repurposing existing underutilized public or private buildings into affordable housing units
- Involving the faith community in converting unused space.

Recommendations Related to Coordinated Access

21. The DNSSAB should continue efforts to implement an effective Coordinated Access System. Suggested next steps include:
    - As part of any efforts to expand outreach services, the DNSSAB should review and expand access points to service outside of North Bay.
    - The DNSSAB and Coordinated Access Nipissing (CAN) agencies should continue efforts to improve completeness and quality of the By-Name List so that all people experiencing homelessness who are consenting to have their name on the List are added to and updated on the List
    - The DNSSAB should continue working towards having all service providers using the same homelessness information management software.
    - The DNSSAB should work with community partners to ensure that prioritization, matching, and referral for housing resources funded through the DNSSAB is conducted though Coordinated Access Nipissing and service providers with housing resources funded through other sources are encouraged to commit to having some or all of their housing resources filled through Coordinated Access Nipissing.
    - The DNSSAB and its partners should engage in efforts to increase community awareness of access points to the Coordinated Access System/homelessness services.

Recommendations Related to Cultural Equity

22. The DNSSAB should set targets to increase the funding allocation for services delivered by Indigenous organizations and continue to encourage Indigenous organizations to submit proposals for needed services.

9.0 Need and Service Models for Homelessness Hubs

The following section begins with a discussion of community partner perspectives on the need and potential service models for a homelessness hub. This is followed by key takeaways from the review of best practice services models for hubs. Details on each of the hubs reviewed can be found in Appendix 2.

9.1 Community Partner Perspectives on the Need and Potential Service Models for a Hub

Community partners largely believe there is a need for a hub in some form. They most often pointed to the importance of having a safe place that provides access to warmth during the day, on weekends, and in the evenings during inclement weather. They also thought it would reduce the need to track people down to provide services. Community partners had different visions of how a hub should operate; some thought it should be similar to an enhanced soup kitchen, while others thought is should be more of a service/resource centre than a drop-in centre. Some community partners expressed concern that a hub would not address the ultimate need for housing.

Individuals with lived experience indicated having a physical location for people to drop into would make it easier to access services. They indicated that having a place where people could go 24/7 would be helpful. They would like to see access to all services in one spot, as it can get confusing going to a number of different places. Some mentioned that if there were a hub, they don't want it to have sign-in or other program requirements to be able to access it. In terms of services, they suggested that a range of services be available including:

- Washrooms and showers
- A place to have coffee, snacks and opportunity to cook food
- Phones and internet
- Identification services
- Housing supports
- Mental health supports, addictions services, and health services, including care for wounds
- Harm reduction services and training including supervised consumption and training on administering naloxone
- Counselling
- Legal assistance
- Financial counselling
- Beds
- Survival supplies and teachings
- Veterinary services
- Employment support and a job board.

They would like to see more people who have experience with homelessness providing services.

Community partners identified a range of services that they would like to see located in a hub. The most commonly identified services were services to meet basic needs, including food, showers, hygiene

supplies, a quite room for daytime and warm in the evening, clothes and laundry, a place for service user storage. Health services were also frequently identified including first aid, acute medical care, wound care and foot care, mental health services and addictions services. Some suggested that this include psychiatry services. Other services suggested by at least one individual include income supports, connection to Coordinated Access Nipissing and long term housing, navigation, crisis management and intervention, harm reduction, ID services, mail services, veterinary services, justice services, and cultural services. Some also suggested that services include activities for people to improve their wellbeing, such as art therapy, work on schooling, or CPR. It was also noted that services should be available in French and Indigenous languages and having outdoor space where people can spend time is particularly important.

Community partners generally thought a hub should serve anyone at risk of or experiencing homelessness, but many suggested a focus on people experiencing absolute homelessness.

Service providers thought that there may be some opportunity to use existing services to resource the hub, but they generally noted that they are at capacity with their existing resources. Concern was expressed about the outcomes that would be achieved without sufficient resources.

Individuals with lived experience and community partners generally thought the hub should be centrally located, within close proximity to existing services and 2-3 blocks of the downtown core and on a bus route. However, they also noted that it would be important to continue to provide outreach into the community. Some suggested having satellites in other communities, or even one worker that can connect to hub services. They would like to see someone able to provide same day services. One community partner would like to see a mobile hub, so that the requirement to attend an office building does not act as a barrier to care, and people could be transported to other locations if they need further services. However, others thought that a physical location would be important for people seeking inclement weather services.

Community partners also reported the need to continue outreach in North Bay and to expand outreach in areas outside of North Bay to ensure access to services. Some municipal representatives would like to see one number to access services, satellite services with scheduled drop-ins, combining homelessness services with existing health or employment centres or training to leverage more informal outreach service providers such as faith-based organizations and other community volunteers. Some also suggested starting with a hub in North Bay, with plans to support people where the are or closer to where they are over the longer term.

9.2 Best Practices Service Models for a Hub

Information gathered through the best practice research shows there is no one best practice hub model. Operations, services, and governance vary based on the context of the specific community. However, there are a number of consistent elements to an effective hub, discussed below. These have been determined based on the models reviewed and literature on community hubs.

Problems Being Solved:

- Most of the hubs reviewed are intended to provide immediate access to holistic or wrap-around services. Best practice hubs serving people experiencing homelessness have a specific focus on

ending chronic homelessness or decreasing the days a household experiences homelessness (based on hub models reviewed).

- Hubs can be an effective way to improve access to services, help address inequities, and integrate care (Canadian Research Network for Care in the Community, 2014).
- Service providers can achieve economies of scale through shared systems/"back office" duties (Canadian Research Network for Care in the Community, 2014).
- Some hubs are heavily focused around active service provision, while others provide more informal space intended to foster the development of supportive relationships and meet basic needs, such as warmth.

Client Segments:

- Most of the hubs reviewed focus on the most vulnerable individuals experiencing homelessness. One source suggested that greater outcomes can be achieved if the space also provides housing loss prevention assistance for people at risk of homelessness (City of Windsor, Homelessness and Health Hub).

Channels:

- Most of the hubs reviewed only provide the options for walk-in/drop-in services. However, best practices suggest that access points should be available in some form throughout the geographic area (Government of Canada, n.d.). Having an online resource with phone number(s) or virtual access opportunities (e.g. telemedicine) are examples of access that is provided throughout the geographic area (Association of Ontario Health Centres, 2015).

Key Activities/Services:

- Hubs generally have a core service or mandate, which all of the other services complement. (Strathcona County, N.D.). Some mandates are focused on basic needs, some on fostering a sense of belonging or developing supportive relationships, some have housing-focused models, and others have health-focused models.
- Hubs have various types of service:
    - Core services
        - A critical part of core services is ensuring the visitor has the ability to effectively navigate the services. Visitors should be offered a single access point to many services and provided with a customized experience that meets their specific needs. This is typically done through case workers or navigators.
    - Complementary services
    - Light touch services and opportunities for casual interactions (Strathcona County, N.D.)
        - Casual interactions give visitors an opportunity to spend time. This allows for organic interactions that reflect the intention that everyone is welcome, feels they belong and should feel safe and comfortable. (Strathcona County, N.D.)
- Providing services tied to immediate outcomes such as income supports, food and harm reduction is important for improved results (Strathcona County, N.D.). Based on the review of best practice models, core services include:
    - Basic needs
    - Housing assistance

- Coordinated access to services
- Health services (primary care, wound care, mental health, and addictions)
- Income supports/financial assistance
- Identification services

- Several of the best practice models include, or plan to include, both respite beds/rest areas and emergency shelter beds which are reserved beds dedicated to an individual.

- Other complementary services could include:
  - Spiritual and cultural supports
  - Justice services
  - Legal assistance
  - Counselling
  - Gender and sexuality services
  - Education services
  - Employment services

- Light touch services and opportunities for casual interactions should include:
  - Food
  - Rest/recharge area
  - Warmth
  - Hygiene supplies and facilities (washrooms, showers, laundry)
  - Clothing
  - Communication (phones, computers, internet, photocopies, mail)

Approach to Service Provision:

- Hubs should use a principle-based approach to service provision. Best practices include:
  - Anti-racism/anti-oppression framework
  - Transparent communication
  - Community engagement
  - Culturally safe
  - Empowerment model
  - Ensuring choice in care
  - Harm reduction approach
  - Housing First approach
  - Informed by social determinants of health
  - Input from people with lived and living experience
  - Low barrier
  - Trauma and violence informed
  - Shared accountability and engagement.

- There should be a single point of contact for the visitor (ie. to either provide service or to help the visitor navigate to an appropriate one).

- Case managers or navigators should be ready to listen and support the visitor in developing an action plan tailored for the individual's needs. This allows the hub to provide unique and focused service delivery for each individual.

Key Partners:

- Most hubs are run by non-profit organizations, but some are municipally run (Strathcona County, N.D.).
- Hub should have a minimum of 3-5 partners co-located to be considered a hub, but ideally should include a broad range of partners and have the ability to provide a full range of services including: housing assistance, health (physical health and mental health and addictions), income supports (based on hubs reviewed), (Association of Ontario Health Centres, 2015).
- Municipal government, DNSSAB, Province and Government of Canada could all be key partners in providing support and contribution (e.g. land and capital grants, forgivable loans, waived property taxes), facilitate the creation of efficient, coordinated hub application process, and support the emerging hub throughout the process (Association of Ontario Health Centres, 2015).
- Other partners may include United Way, Trillium, financial institutions (Association of Ontario Health Centres, 2015).

Collaboration:

- There needs to be a collective vision between partners and a Social Framework that outlines shared commitments between partners (Strathcona County, N.D.), including a shared commitment to transforming and delivering services in new ways (Association of Ontario Health Centres, 2015).
- Collaboration among partners is critical and must be intentional, not just about co-location (Association of Ontario Health Centres, 2015) (Strathcona County, N.D.), (Government of Ontario, 2012)
- Information sharing is key. Service partners need to be well versed in each other's roles, processes and pressures. (Strathcona County, N.D.)
- Service staff should be cross-trained for a more seamless service experience. (Strathcona County, N.D.)
- There should be shared systems/back office supports (e.g. reception, phone, database, individualized care plans) (Association of Ontario Health Centres, 2015)

Governance:

- Having a 'backbone structure' is essential to ensuring efforts maintain momentum and facilitates impact. The governance structure should be the backbone structure that helps maintain focus on outcomes as a hub develops, operates, and evolves.
- Governance structure can take many forms:
    - A single funder that does all the planning, financing and bringing partners together to support the hub. This can avoid the challenges of pulling together start-up funding because the funder provides it, but can affect long-term sustainability because it depends on a single funder.
    - An existing non-profit leads the hub. This can be effective if the organization has credibility in the community, has existing infrastructure in place, and is well supported. However, the non-profit will have competing priorities and other projects.
    - A new non-profit organization is created to run the hub. The new non-profit requires a dependable stream of funding support.

    - A steering committee that includes members of the community. A possible challenge is that having multiple parties can cause confusion around accountability.
    - Multiple organizations share ownership of the hub. Each party would have to put less resources into the hub and there is a broader pool of expertise to lead. However, accountability may be less clear and coordination a challenge.
    - A local or district government body manages the hub. A hub backed by government may have an easier time getting permits and approvals and may have more existing infrastructure to support a hub, but it would need to follow government processes (Strathcona County, N.D.).

- Regardless of the governance model, the following are key elements to support the success of the governance structure:
    - A unified structure which works for the hub and the whole range of services to be delivered
    - Representation by all relevant parties on a decision-making group and involvement of the community, including individuals with lived experience
    - Support and training for decision-makers
    - Unified policies agreed and applied to the whole hub
    - Shared organizational development, planning and evaluation (Certfordshire Children's Trust Partnership, N.D.), (Strathcona County, N.D.), and (Association of Ontario Health Centres, 2015).

Key Resources:

- Staffing levels depend on the services provided, and whether the hub also operates as an emergency shelter. With a lack of operating funds, at a minimum, hubs should identify and resource 3-4 staff to oversee the development and operations of a hub (e.g. Project Lead/Coordinator, Administrative Support (reception, website updates, appointment scheduling) and 1-2 Case Managers/Navigators), (based on models reviewed), (Association of Ontario Health Centres, 2015), and (Government of Ontario, 2012).
- Hubs typically rely heavily on existing services, not net new funding for services delivered (based on hub models reviewed) and (Government of Ontario, 2012).

Physical Space:

- Space should be designed for the community with the community (Association of Ontario Health Centres, 2015)
- Hubs generally have a minimum of 8,000 square feet, but can be as big as 330,000 square feet (based on hub models reviewed) and (Strathcona County, N.D.)
- Hubs should have a range of sizes of flexible meeting and gathering spaces, and should have both indoor and outdoor elements, temporary and permanent components, public and private areas, an intake area, and effectively facilitate informal interactions, eating, spending time/lounging and gathering, resting, hygiene, and receiving more formal services, including meeting and appointment spaces and exam/multi-purpose rooms (based on hub models reviewed), (Association of Ontario Health Centres, 2015), (Strathcona County, N.D.) and (Association of Ontario Health Centres, 2015).
- Hubs should provide temporary individual secure storage and allow pets (based on hub models reviewed).

- If hubs include emergency shelter or other housing, there should be separate entrances for each form of accommodation (based on hub models reviewed).
- Once developed, the hub architecture should continue to evolve and have flexibility to bring on other programs and services over time. This requires a flexible floor plan. Ideally, spaces should be designed for expansion (e.g. modular construction approach, unfinished shell for future development) (Association of Ontario Health Centres, 2015).
- The space should have a barrier-free design (Strathcona County, N.D.).

Geographic Location:

- The hubs reviewed are generally located in, or in close proximity to (less than 750m), the downtown core area and in close proximity to other social services.
- Hubs should be located on or near arterial roads where visitors can easily access services by using a variety of modes of transportation, including walking and public transportation (Strathcona County, N.D.)
- Hubs should not be located in close proximity to elementary schools, splash pads and wading pools, directly adjacent to licensed child care centres, directly park adjacent, or within residential neighbourhood interior (based on hub models reviewed).

Engaging Rural Residents:

- Providing access to rural residents is an essential element of a successful hub approach (Strathcona County, N.D.).
- Some emerging practices in providing service delivery to rural areas are outlined below and can be used in combination:
    - Intake and triage hotline and/or internet-based service
        - A phone intake and triage hotline and digital hub provides services through a single phone number and virtual portal that provides information and services in an online format. Limitations, however, can include poor internet services, and reduced ability to create synergy around services. (Strathcona County, N.D.).
    - Hub and spoke model, that includes:
        - Mobile outreach in rural areas and links to hub in urban area
            - Mobile van
            - Use peer navigators to facilitate mobile outreach
    - (or) Service sites in (population centres in) rural areas that host an outreach worker/case manager/navigator with links to hub in urban area
    - (or) Pop-up hub with travelling hub team (ie. multiple services) to rural areas
        - A pop-up hub would take advantage of facilities and locations residents already know and use in their communities and could include services on a regular basis in rural municipal buildings. A pop-up hub would function as a traveling team incorporating many of the services available in the central hub. The team would set up in the rural location for a short period of time, providing services to that community before moving on to the next location. The needs of rural population should be continuously assessed

to ensure a clear understanding of what combination of services are most needed, as it may not be possible to co-locate all services from the central hub at every pop-up hub. (Strathcona County, N.D.)

- Use a regionalized approach with regional community partner networks and regionally coordinated outreach.
- Partnerships with non-targeted systems and programs, faith-based organizations, and informal partners. This could include:
    - Having municipal staff, local businesses, local law enforcement partners, affordable housing operators, school staff, behavioural health or other medical service providers, EMS staff, hospital discharge planning staff, employment agencies, food banks, faith community, and/or postal workers act as referral sources to formal access points for the hub/Coordinated Access System.
    - Having formal service providers in rural areas, such as behavioural health or other medical service providers, act as access points for the hub services/Coordinated Access System.
    - Having community partners identify where to start looking for encampments, abandoned buildings, and other places where people experiencing homelessness might be living.
- Provide transportation assistance to the (hub in the) urban area.

Hours:

- Hubs should operate at hours that meet people's needs and should operate seven days a week. The hours of the hubs reviewed differ based on access to other services in the community. Communities without sufficient emergency shelter beds or warming spaces elsewhere generally operate their hubs on a 24/7 basis.

Outcomes Achieved:

- The hubs reviewed demonstrate the following benefits:
    - Improved housing, health, social and economic outcomes for individuals
    - Collective impact at the community level
    - Integrated service delivery at the individual level, resulting in improved experience:
        - Centralized intake and scheduling to support coordinated access to on-site services
        - Reduced risk of multiple or duplicate assessments
        - Improves hand-offs of clients across programs and providers
        - Improves access to multiple services in one location
        - Reduces the need for multiple visits to access services (review of best practice models) and (Government of Ontario, 2012).

Coordinated Planning and Identifying a Lead Organization:

- Coordination during a hub's development should occur between various planning bodies (e.g. CAB, Ontario Health Team, Ontario Health, lead agency) (Association of Ontario Health Centres, 2015).
- A request for proposals process should be used to identify a lead agency. The community should be involved in the selection process (Association of Ontario Health Centres, 2015).

- The hub should build on the resources a lead organization has to offer (e.g. availability of land, an existing building, or reserve funds to contribute) (Association of Ontario Health Centres, 2015).
- As part of the selection process for a lead organization, there should be an assessment of the organization's experience, readiness and capacity to lead a hub (Association of Ontario Health Centres, 2015).

Community Engagement:

- When establishing a new hub, community engagement should include:
  - Hand-delivered or mailed informational flyers
  - Website
  - Online meetings
  - Having a minimum of one day as an information session about the hub
  - Site tours of the facility as construction allows
  - Regularly engaging with individual points of feedback (email, phone, etc.).

Appendix 1 – Detailed Supply Indicators

The following section provides information on the supply of homelessness services, supports and housing targeted towards people experiencing homelessness.

9.3 Homelessness Prevention

Service Provider/ Program	Mandate	Program Spaces	Primary Funder	DNSSAB Funding
DNSSAB's Internal Homelessness Prevention Program	Financial assistance for homelessness prevention	N/A	DNSSAB (HPP)	$481,000 in Direct Client Benefits and Navigation supports
Low-Income People Involvement of Nipissing (Community Crisis Funding)	Community emergency housing response	N/A	DNSSAB (HPP)	$20,000
Low-Income People Involvement of Nipissing (Homelessness Prevention Services)	Services, including financial assistance, that prevent homelessness and reduce reliance on emergency services	N/A	DNSSAB (HPP)	Up to $425,000 including $27,500 for rent bank and $23,500 for housing resiliency fund
Low-Income People Involvement of Nipissing (Global Emergency Homelessness Fund)	Flexible financial assistance to prevent and address homelessness	N/A	DNSSAB (HPP)	$25,000
Low-Income People Involvement of Nipissing (Trusteeship Pilot)	Voluntary Financial trusteeship	Funded for 60 financial trusteeships through DNSSAB and 6-10 through MCCSS, but average 90	DNSSAB (HPP), MCCSS	$12,500 from DNSSAB plus an additional $70,000 in one-time funding provided as a pilot for targeted trusteeships for those in shelter, for

Service Provider/ Program	Mandate	Program Spaces	Primary Funder	DNSSAB Funding
				period of Nov 2023-March 2024.
Crisis Centre North Bay's (Community Mobile Housing Support Program)	Assistance to households at risk of homelessness to find and retain housing	Prevent loss of housing for 90 unique households at risk, facilitate access to affordable accommodations for 85 households experiencing homelessness One worker primarily dedicated to youth and one to adults	DNSSAB (HPP)	$172,336

Source: DNSSAB Funding Agreements with service providers and data provided by DNSSAB

9.4 Emergency Accommodation

Service Provider / Program	Mandate	Beds/ Rooms	Municipality	Primary Funder	DNSSAB Funding
Crisis Centre North Bay (Low Barrier Shelter)	Singles, low barrier shelter 8pm – 8am	21	North Bay	DNSSAB	$1,098,144
Hope Awaits Ministries	Homeless Men	7	North Bay	Philanthropic contributions and fundraising	N/A
Crisis Centre North Bay (Four Elms Residence)	Shelter diversion, 24-hour emergency accommodation for Homeless Families, Singles and Women and Children Fleeing	19	North Bay	DNSSAB, MCCSS (VAW)	$350,000

	Violence, re-housing support				
Nipissing Transition House	Women and Children Fleeing Violence	20	North Bay	MCCSS	N/A
Mattawa Women's Resource Centre	Women and Children Fleeing Violence	10	Mattawa	MCCSS	N/A
Ojibway Women's Lodge	Women and Children Fleeing Violence	10	Nipissing 10 Reservation	Indigenous Service Canada	N/A
Horizon's Women's Centre	Women and Children Fleeing Violence	10	West Nipissing	MCCSS	N/A
Warming Centre (operated by The Gathering Place North Bay	Daytime warming services	8am-8pm Nov. – Mar. (April, as required by weather)	North Bay	DNSSAB (Reaching Home and HPP)	$468,729
Crisis Centre North Bay (Emergency Overflow Services)	Emergency accommodations at a motel or hotel for any individual or family experiencing homelessness when either of the providers emergency shelters are at capacity	Currently up to 17 motel rooms and 3 units owned by the Local Housing Corporation and one detached home owned by Crisis Centre North Bay			$1,426,246 in 2022

Source: DNSSAB Funding Agreements with service providers; District of Nipissing Social Services Administration Board, 2023, Nipissing Housing Inventory – July 2023; and data provided by DNSSAB

9.5 Outreach

Service Provider/ Program	Mandate	Program Spaces	Primary Funder	DNSSAB Funding
True Self	Daily peer led street outreach in downtown, and 1-2 times per week to the	N/A	Provincial Office of Women's Issues and Health Canada (to end of September)	N/A

	encampments on the border for North Bay			
True Self	Evening and weekend peer led downtown street outreach (go out with security)	N/A	City of North Bay	N/A
True Self	Once a week outreach teams to Mattawa and Sturgeon falls	N/A	DNSSAB	Enhanced $56,000 in one-time funding from December 2023 to March 2024
True Self	Rural outreach	N/A	DNSSAB's Healthy Communities Fund	$55,000
Boots on the Ground	Informal street outreach	N/A	Volunteer based	N/A
No More Tears	Informal outreach in West Nipissing	N/A	Volunteer based	N/A

Note: Crisis Centre North Bay's Community Mobile Outreach as been listed below in re-housing supports.

Source: DNSSAB Funding Agreements with service providers and data provided by DNSSAB

9.6 Re-Housing Supports

Service Provider/ Program	**Mandate**	**Program Spaces**	**Primary Funder**	**DNSSAB Funding**
Brain Injury Association of North Bay and Area (Housing Support Program)	Support finding, securing and retaining permanent housing for individuals who identified as having a brain injury or cognitive impairment	Up to 40 households per year	Reaching Home	$110,449 for 2023/24
Crisis Centre North Bay (Community Mobile Housing Support Program)	Rapid re-housing assistance to existing shelter clients to find housing as well as ongoing follow-up	facilitate access to affordable accommodations for 85 households experiencing homelessness One worker primarily dedicated to youth and one to adults	DNSSAB (HPP)	Included in $172,336 above for CMHSP

Crisis Centre North Bay	Re-housing supports for overflow clients	2 FTE workers		DNSSAB (HPP) $124,092

Source: DNSSAB Funding Agreements with service providers

9.7 Transitional Housing

Service Provider/ Program	Mandate	Beds/ Rooms	Municipality	Primary Funder	DNSSAB Funding
Crisis Centre North Bay (Northern Pines I)	Transitional housing with agreement for up to a year with possible extension, individualized case management, goal to live without support at exit (or minimal support if transitioning to phase 2) 2 staff 24/7	16 units	North Bay	DNSSAB	Phase 1- $902,160
Crisis Centre North Bay (Northern Pines 2)	Transitional housing with four year occupancy agreement, which can be extended, Housing Navigator M-F, goal to live without support at exit	20 units	North Bay	DNSSAB	$494,736
Crisis Centre North Bay (Northern Pines 3) Target opening Spring 2024	Highest level of support, with objective of stabilization 3 staff 24/7	24 bedrooms	North Bay		$1,095,884
Crisis Centre North Bay (Futures)	DNSSAB funds Futures Transitional	10 beds	North Bay	DNSSAB (HPP),	$73,716 – HPP for Futures

	Housing Supports to provide enhanced staffing hours (1FTE) to youth experiencing anxiety to build confidence, life skills and self-sufficiency DNSSAB's Health Communities Fund funds food security Reaching Home funds 64 hours of staffing (8 hours M-F and 12 on weekends) to accompany youth to off-site activities and appointments	Target of 20 youth per year for Youth Housing Support Program		DNSSAB (Reaching Home) MCCSS	Transitional Housing Services $25,000 Healthy Communities for food security services Reaching Home for Youth Housing Support Program MCCSS funding allows for one staff per shift
North Bay Indigenous Friendship Centre (Suswin)	Transitional housing for males with one year occupancy agreement, but can stay up to four years	30 units	North Bay	Ontario Aboriginal Housing Services has committed operational funding for three years.	N/A
CMHA	Transitional housing and group home that is transitional	16-24 transitional beds		MOH	N/A

Source: DNSSAB Funding Agreements with service providers; District of Nipissing Social Services Administration Board, 2023, Nipissing Housing Inventory – July 2023; and data provided by DNSSAB

9.8 Housing First/Intensive Case Management and Supportive Housing

Service Provider/ Program	Mandate	Units	Municipality	Primary Funder	DNSSAB Funding
CMHA-Nipissing	Mental health permanent supportive housing	134	North Bay	MOH	N/A
CMHA-Nipissing - 416 Lakeshore	Mental health permanent supportive housing	20	North Bay	MOH	N/A
Physically Handicapped Adults' Rehabilitation Association (PHARA)	Supportive housing and congregate care for adults with disabilities	34 supportive housing and congregate care units (plus 109 subsidized and market rent units)	North Bay	DNSSAB	N/A

Source: District of Nipissing Social Services Administration Board, 2023, Nipissing Housing Inventory – July 2023; and data provided by DNSSAB

9.9 Other Services to People Experiencing or At Risk of Homelessness

Service Provider	Mandate	Primary Funder	DNSSAB Funding
The Gathering Place	Food Outreach	DNSSAB Healthy Communities Fund	$30,000
The Gathering Place	Souper Suppers Project	DNSSAB Healthy Communities Fund	$20,000
Salvation Army North Bay	Household Setup program	DNSSAB Healthy Communities Fund	$10,000
Crisis Centre North Bay	ID Clinic	DNSSAB Healthy Communities Fund	$30,000

Source: data provided by DNSSAB

Appendix 2 – Details on Homelessness Hub Service Models

The following section provides details on each of the hub best practice models reviewed.

9.10 Windsor Homelessness and Housing Help Hub

Windsor, Ontario

Description of the Service Model:

Brief Summary: H4 operates as an enriched service centre and inclusive daytime drop-in — connecting people experiencing homelessness to services, community support agencies, and basic medical care, all while helping provide for their basic needs such as food, restrooms, clothing and quiet/safe spaces for daytime rest.

Problems Being Solved: The purpose of H4 is to be a consistent anchor in the community that allows for persons who are not traditionally connected to supports or who are underserviced to access immediate holistic services, thereby decreasing the amount of days a household experiences homelessness.

Client Segments: The current capacity of the space requires H4 to focus on people experiencing homelessness. However, it is believed that the program would achieve greater outcomes if the physical space allowed expansion into housing loss prevention assistance that could work to reduce illegal evictions, and increase proactive searches for housing before individuals/families access emergency shelters. Org Code Consulting conducted an evaluation of H4 in 2021 and recommended that H4 continue to focus on people experiencing homelessness, and not a location were people come once housed to avoid diluting the mission of H4 and decreasing its impact.

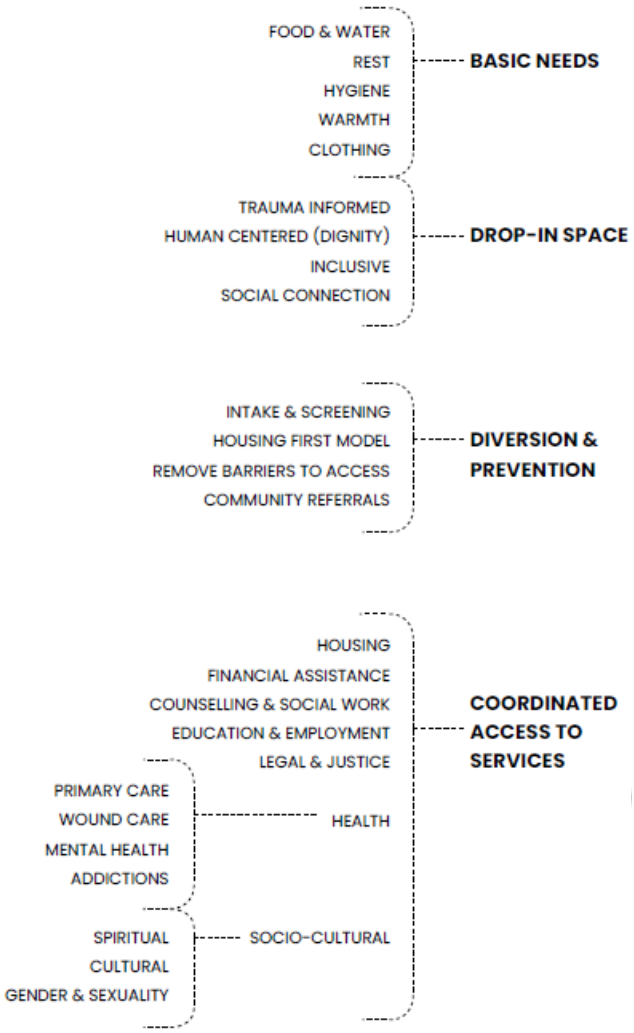
Channels: Drop-in service

Key Activities/Services: H4 currently provides low barrier service connection of people experiencing homelessness to necessary resources, including housing assistance, basic medical care, income assistance, justice services, addiction and mental health support, while helping provide for their basic needs such as food, restrooms, clothing and quiet/safe spaces for daytime rest.

Based on the recent comprehensive community consultation to explore the feasibility of re-homing and re-imagining the H4 facility as a permanent community asset, it was determined that the core-programming of the permanent H4 should include:

- Basic needs
- Housing with wrap around supports
- Drop-in service hub
- Diversion
- Prevention and coordinated access to services

The following is an expanded visual of various aspects of these categories.



The research recommended that the property be phased and expanded to accommodate onsite single occupancy permanent housing to meet individual's very high intensity housing and support needs that are not currently available in Windsor Essex and leverage wrap around multi-sector support services available on site. As a related service, the City of Windsor is proposing that emergency shelter space for single men be included as a core service.

Key Partners:

- Housing Information Services has Housing Intervention Workers which provide housing assistance, connect people to the By-Names Prioritized List and assist in completing applications to the Central Housing Registry
- Family Services Windsor-Essex has Homelessness Street Outreach staff that support people currently accessing shelter to ensure their housing and support needs are met
- Canadian Mental Health Association – Windsor Essex Branch provides mental health and addictions services

- Windsor Essex Community Health Centre (Nurse Practitioner onsite 2 half days per week, Addiction Support Workers onsite 1.5 days per week, HepC Mobile Outreach onsite one afternoon a week), and Identification clinic one afternoon a week
- Can Am Indian Friendship Centre offers their Kizhaay Anishinaabe Niin "I am a Kind Man" Program, Indigenous Drug & Alcohol Program, and Indigenous Housing Workers and hold sharing circles outside at H4
- John Howard Society has Probation and Parole staff onsite several hours a week to remove barriers to reporting appointments and facilitate further community integration for justice affected populations experiencing homelessness
- Ontario Works (two care workers are onsite five days per week)
- CommUnity Partnership, which is a partnership between the local housing corporation, another non-profit housing corporation and post-secondary institutions to provide placements and supervision for students in social work, music therapy, child and youth care, and nursing. Students are invited into high-needs social housing communities and other settings such as H4 to provide crisis intervention, eviction prevention, case management, forms clinics, referrals, vegetable distribution, food pantries, etc. with the aim of working to revitalize neighbourhoods, build resilience, and create a healthy, supportive community for all.

Key Resources: As of Feb. 2021, H4 had 9 full time staff Monday-Friday, and 7 part time staff Sat-Sun.

Space: The City of Windsor determined that the permanent hub should have an intentional design for flexible spaces that can change with the needs of the community, including civic emergencies, natural disasters, and peak demand of services in winter months. It should include onsite laundry, showers, lockers for storage, public phones, computer access with internet service, have a quiet space for daytime rest, and more active spaces for programming and recreation.

The City of Windsor determined that sites between 80,000-100,000 square feet are considered ideal. This would offer flexibility to integrate outdoor space or community bridging amenities.

Geographic Location: H4 is currently located in the downtown core, in close proximity to emergency shelters, health care providers, harm reduction pharmacies, and other core community agencies.

The City of Windsor recently retained an architectural firm to undertake comprehensive community consultation to explore the feasibility of re-homing and re-imagining the H4 facility as a permanent community asset. The consultation determined that the permanent H4 facility will also require close proximity (within a maximum distance of 2km) to emergency shelters, health care providers, harm reduction pharmacies, and other core community agencies.

Hours: 9am – 6pm 7 days per week

Costs: Costs were $79,997 per month to provide City and community agency staffing. When solely operated by community agency staff, monthly staffing costs are $55,249. The physical building has been operating in-kind from the City.

Currently, operating costs are approximately $2 million annually. This supports operating from 8:30am to 6pm daily including weekends and holidays.

Outcomes Achieved:

As of June 2022, H4 has welcomed over 2,200 unique clients, with 59,654 visits. The program averages attendance between 110-150 unique visitors per day on most days, and often reaches capacity shortly after opening the doors.

98% of service users felt that H4 was a necessary and safe place where they could get help. Guests felt that H4 has the capacity to provide housing assistance in a way that other programs and service providers do not, and that H4 staff were focused on their needs. Many service users feel they have no other safe place to go other than the H4.

H4 is assisting in meeting the objectives of Built for Zero Canada. People previously thought to be inactive have been reconnected to the housing list. People not on the housing list have been assessed and added to the list. By co-locating a number of agencies at the current H4, there has been a noted increase in the number of people who have moved into housing and a significant decrease in the length of time a participant experiences homelessness. The H4 has assisted 168 individuals in exiting homelessness through securing permanent housing.

An evaluation report found that the hub has achieved cost savings in the health sector and justice system, while improving health and justice outcomes for program participants.

Additional Discussion:

Consultation feedback regarding a permanent H4 emphasized that people must feel safe. Physical choices in space should be rooted in trauma-informed design to promote dignity and decrease conflict, while also considering cultural safety and Indigenous representation.

The evaluation of H4 identified the importance of ensuring participants are actively assisted with housing and supported to replace their identification.

9.11 Whitehorse Emergency Shelter

Whitehorse, Yukon

Description of the Service Model:

Brief Summary: WES provides a low-barrier, trauma informed, culturally-appropriate, and housing-focused shelter to homeless and street involved individuals, which includes meeting basic needs, case planning, and support to access available services. WES also includes 20 permanent Housing First units and a range of services including acute medical care, mental wellness and substance use services, housing assistance and services offered by the local First Nation's Outreach clinic.

Problems Being Solved: WES supports the elimination and prevention of homelessness through housing-focused interventions aimed at improving quality of life and housing outcomes for community members who are homeless or street involved.

Client Segments: There are three client segments, vulnerable individuals living in the community, individuals experiencing homelessness and staying in shelter at WES and residents of the Housing First units.

Channels: Primarily by drop-in, but WES can also be reached by phone

Key Activities/Services: WES provides 24 overnight emergency shelter beds and 30 overflow beds, with 24/7 intake as well as 20 units of permanent supportive housing (Housing First units). The following drop-in services and supports are also provided:

- Supports for communication (mail distribution, phone access, message board)
- Managing client property and assigning lockers for temporary storage
- Outreach services to link homeless and street involved adults to available services and supports
- Breakfast and lunch programs for drop-in clients, and dinner program for overnight clients
- Access to hygiene services including hygiene product distribution and showers
- Distributing clothing and footwear donations
- Assistance with activities of daily living (ADLs) and personal care needs provided by Health Care Aides
- First aid when needed
- "Meds Assist" program to support clients to independently manage their medications
- Harm reduction supplies and education
- Primary care through EMS paramedics
- Primary care for existing clients with complex mental health challenges and substance use disorders and Opioid Treatment Services for existing and new clients
- Foot care, referrals to other agencies, sexually transmitted infection testing, and adult immunizations to Kwanlin Dün First Nation members.

Key Partners:

- Connective, which is a community-based non-profit, established as a partnership between John Howard Society of BC and the Council of Yukon First Nations, took over operation of the shelter from the Government of Yukon in March 2023.

- EMS paramedics provide onsite primary care, daily for 16 hours/day and will increase to 24 hours/day once staffing is in place.
- Mental Wellness and Substance Use Services operates its Referred Care Clinic with a nurse and doctor two days per week. The Referred Care Clinic is a primary care clinic for vulnerable adults with complex mental health challenges and substance use disorders. It is for existing clients and by referral for new patients. It also provides an Opioid Treatment Services Clinic (no referral required) at WES, along with harm reduction education, drug checking services, naloxone kits and individual naloxone training.
- Community Outreach Services provides case management and outreach supports for housing to individuals who are homeless or have a history of homelessness and have complex mental, physical or cognitive health needs or addiction challenges and need ongoing support to maintain a successful tenancy and independence in the community.
- Safe at Home provides support for individuals who need help finding and maintaining housing and help individuals navigate and participate in the Coordinated Access System.
- Kwanlin Dün Downtown Outreach Clinic operates out of WES one day per week (11am-3pm) and offers a variety of services including foot care, referrals to other agencies, sexually transmitted infection testing, and adult immunizations.
- Blood Ties Four Directions Centre provides harm reduction resources

Key Resources: 1 manager, 4 supervisors, a facility supervisor, a kitchen supervisor, 4 team leads, an outreach worker, 26 regular frontline staff and 11 occasional frontline staff, and 2 cooks, in addition to external partners. On each shift one supervisor or team lead and 3 frontline staff.

Geographic Location: Downtown core, within a couple blocks of other services and supports

Hours: Shelter and permanent housing and supports are 24/7, drop in 7am - 4:30pm

Costs: In 2021/2022, the costs of operating the Shelter were $4,376,000.

Outcomes Achieved: An evaluation of the Whitehorse Emergency Shelter found that it achieved the following outcomes:

- Shelter guests have access to basic needs including meals, shelter, clothing, showers, and harm reduction supplies
- Shelter guests have increased feelings of safety
- The Shelter has had a positive impact on the immediate health and safety crises of guests – Half (50%) of the guests interviewed reported that the Shelter has had a positive impact on their immediate health and safety crises. Guests reported that the Shelter has allowed them to: access medical care and reduce acute health conditions/symptoms; avoid emergency department visits and hospital stays; avoid 911 calls; avoid overdoses; avoid death, from drug toxicity and from the elements.
- Shelter guests having increased knowledge and skills for reducing health and safety risks and increasing personal wellbeing

- Shelter guests have increased access to available supports and willingness to connect to supports
- Some guests reported that the Shelter has contributed to a reduction in their substance use

Housing First residents have experienced a range of positive outcomes, including: increased housing stability; increased skills for independence; employment; enrolment in school; and other improvements to quality of life.

9.12 Health and Homeless Hubs

London, Ontario

Note: The Hubs are still in the early phases of being implemented and the following is based on the plan for implementation.

Description of the Service Model:

Brief Summary: The proposed hubs will include multiple locations distributed throughout the community, built to serve the most marginalized community members with a range of care and service, from: 24/7 safe spaces and access to basic needs, to healthcare, harm reduction and addiction treatment services, and housing supports. Every interaction is an intentional effort to meet people where they're at, supporting an individual's next steps towards housing. While basic needs supports exist in a hub, hubs do not exist solely to provide basic needs.

Problems Being Solved: The impetus for the hubs is to save lives, to better deliver healthcare and housing for the most marginalized community members in London, and to address the whole of community impacts of the health and homelessness crisis. The hubs are intended to support the highest acuity Londoners to move safely inside, help them get stabilized, wrap around them with supports, connect them to the right housing and help them stay housed.

Client Segments: The hubs are intended to support the highest acuity individuals experiencing homelessness. Within this group the following are considered priority populations (in alphabetical order):

- Couples and Families
- Indigenous individuals
- Medically complex individuals[9]
- Women & Female-Identifying Individuals
- Youth (16-25)

Channels: Participants will drop in to the hubs. Services are intended to include the following modalities:

- On-site permanent (e.g. case management)
- On-site rotating scheduled and/or by appointment (e.g. medical care, income supports, PSW)
- On-call timely services that are more acute in nature or as needed (e.g. community paramedicine, crisis response services)
- Via referral based on individual need (e.g. developmental services, psychiatric services)

Key Activities/Services:

The hubs take a Housing First approach, while ensuring an individual's health and wellness needs are attended to. The hubs are intended to operate as an entry way into the housing system.

The hubs do not operate with traditional recreational drop-in program. The drop-in services are intended to mean that the hubs will be a staffed space open 24/7 where anyone can walk in, access immediate basic needs and stabilization support, and is a conduit to services.

Hubs have:

- Approximately 35 beds:

    - 25-30 transitional (a reserved stay with a bed dedicated to an individual). These beds are supported by a case worker and a plan to maintain stability, build trust interactions, and move individuals forward with their housing plans. These beds include 3 meals and snacks each day
    - 5-10 are respite beds (non-reserved, with flexible in and out and participant defined length). These beds offer flexibility for those who are not yet engaged in a support and housing plan. Individuals may move to a transitional bed after consistent stays. These participants are provided with services to meet immediate needs, for example: clothing, food, rest, water, wound care, hygiene, etc.
- Access to basic needs, including clothing, food, rest, water, showers, laundry service, washrooms, hygiene supplies, social interaction and rapport building
- Supports managed through case workers and provided via in-house, mobile/appointment-based, and on-call services.
- Housing focused supports including case workers engaging in frequent and consistent care planning, conversations around housing needs and plans, opportunities for intake, opportunities to support paper-readiness, all participants should be offered opportunity for application to Rent-Geared-to-Income Housing, support person-directed searches for private market housing, rapid connection to the appropriate housing stability resources, and working collaboratively with housing and housing stability services to ensure seamless transitions of support once participants are housed
- Supports individuals with income planning and access, including accessing income supports (Ontario Works - OW, Ontario Disability Support Program - ODSP, etc), transportation supports (bus passes, cab fare) and financial management (pensions, tax, debt and related legal support) in one coordinated way based with in-hub and external appointment-based services (including accompanied appointments as required). Linkages to financial education and employment supports or opportunities are provided through external partners if applicable (e.g. to low barrier employment programs).
- Integrated care planning provided by care facilitators that support participants for the duration of their stay and engagement with the hub including supporting participants with maintenance and facilitation of coordinated care plan; receiving referral recommendations from participant, internal team members and community partner; explore connection or reconnection with natural supports; providing referrals to appropriate internal and external services and coordination of involved resources; tracking participant progress toward participant goals in coordinated care plan; advocating with community partners when systemic and complex barriers to care/ services arise; acting as a primary point of contact for participant services to ensure appropriate tracking of internal and external connections
- Collaboration among established supports to help: navigate the justice system for those on charges, facilitate intake pre-release, facilitate follow-up with probation and bail, and plan for connection to resources upon discharge.
- Specialized hubs will also include medical stabilization beds for individuals have significant acute medical diagnoses, medical issues that require ongoing care for a defined time period and/or multiple medical comorbidities that pose a high risk of morbidity or mortality if not medically managed.

- Quick access and intentional connections to acute and primary care including wound care, foot care, managing medications (for those in transitional beds), nursing assessments, primary care, mental health care, which may include access to psychiatry (on-call) and access or referral to the harm reduction and substance use continuum of support and treatment.
- Transportation for warm transfers between referring organization, transportation to services within coordinated care plan.
- Continuum of care and support to those using substances with an evidence-based approach. Supports will be available for people who use any psychoactive substance including but not limited to: alcohol, opioids, amphetamines, cocaine, marijuana. Supports will be developed and implemented based on review of the existing and evolving scientific literature base.

Key Partners: The hubs are still being implemented and partners are currently being established.

The intention is to have interdisciplinary, cross sectoral and multiagency teams work collaboratively and alongside one another in Hubs. All partners in the Hubs System share the responsibility for proactively connecting participants to the functions, services and resources from which they can benefit; regardless of whether that service is provided by the Partner's organization or not; or whether it is provided at the Hub or elsewhere in the community.

Key Resources: 6 frontline staff day and evening shifts, 5 for overnight

Space: The implementation plan estimates that each hub will require 8,000 to 10,000 square feet of multi-use space. The exterior should have a side entry off of street (for privacy and line management), a fenced private space, green space, an awning/weather protection for outside engagement. The interior should include separate services paces for people in transitional beds and respite beds. Spaces for individuals in transitional beds should include: a commercial kitchen, single rooms, shared single-use washrooms, laundry facilities, meeting and appointment space, communal room/multi-purpose room, dining space, exam/multi-purpose rooms, individual storage, secure storage (for medication management), and pets allowed. Space for those accessing respite beds and basic needs should include separate crisis de-escalation space, lobby/front of building space that includes small gathering space, laundry facilities, single use washrooms and shower facilities, private room for intakes, individual storage, and pets allowed. The facility should also include reliable WiFi, printing capacity, cameras, case management office space, secure storage outside of participants rooms, participant overflow storage (e.g. for items traditionally stored in carts), and commercial hot water capacity.

Geographic Location: The implementation plan outlines that the hubs should be located near arterial roads and transit routes and should not be located in close proximity to elementary schools, splash pads and wading pools, directly adjacent to licensed child care centres, directly park adjacent, within residential neighbourhood interior. It also states that hubs should be located in existing buildings, should represent net new beds or an addition to capacity, not the repurposing of existing facilities and services that are already over capacity.

Hours: Staffed space accessible 24/7.

Costs: The anticipated annual operating costs are $2,700,000 per hub, which reflects 25-35 beds and a multidisciplinary team of supports.. This includes $1,810,000 in staffing costs, $47,000 in participant expenses (travel, support, supplies), $718,000 in office supply, cleaning, food, training, utilities, repairs,

IT, insurance, communications and lease, and $125,000 for admin. It is anticipated that contributions from partners could produce cost savings.

Outcomes Achieved: The hubs are newly being implemented and outcomes are not yet available.

Additional Discussion:

There will be a Hubs Integrated Leadership Table for Lead Agencies and partner agencies to ensure continuous improvement and quality assurance.

The hubs will have shared systems, including individualized care plans, data management and communication (with attention to consent, privacy and information sharing practices).

The Hubs model assumes contributions to Hub services via a range of existing partners and service providers, not net new teams, ensuring both expertise and efficiency in the delivery of Hub functions.

The hubs are required to take the following approaches to service:

- Anti-racism/anti-oppression framework
- Transparent communication
- Community engagement & relationships
- Culturally safe
- Empowerment model
- Ensuring choice in care
- Harm reduction approach
- Housing First approach
- Informed by social determinants of health
- Input from people with lived and living experience
- Low-barrier
- Trauma and violence informed
- Shared accountability and engagement

9.13 1001 Erbs Rd. Outdoor Shelter

Waterloo, Ontario

Description of the Service Model:

Brief Summary: Fifty individual cabins for people experiencing unsheltered homelessness along with a common building, meals, and services with a strong focus on connecting residents to permanent housing options.

Problems Being Solved: To offer accommodation to the unprecedented number of individuals living in encampments and services with a strong focus on connecting residents to permanent housing options.

Client Segments: The site was designed for individuals currently living in encampments, but it will also work to offer accommodation to those living unsheltered elsewhere in the region.

Channels: Residents were selected from individuals living in encampments.

Key Activities/Services:

Freshly cooked meals are served daily in the food server, within the common building. Individuals can also store and consume food brought in from outside.

Services include mental health and addictions supports, with a strong focus on connecting residents to permanent housing options.

Transportation is provided to and from the city so that residents can access and attend appointments in the surrounding area.

Key Partners: The shelter is managed by The Working Centre. Ontario Works staff goes onsite regularly. Also have health partners onsite regularly (approximately 15 hours per week).

Key Resources: There are currently 5 staff onsite at all times.

Space: The site has 50 cabins each measuring approximately 107 square feet and furnished and equipped with electricity, heating and cooling. A main common building provides running water, common space, washrooms, laundry services, heating, and electricity. Food preparation takes place off-site in a regulated commercial kitchen operated by The Working Centre. Couples are accommodated and pets are welcome onsite.

Geographic Location: The shelter is located on a regionally-owned site just outside of the urban area. The region uses adjacent property for paramedic services and landfill.

Hours: The site is accessible to residents and staffed 24/7.

Costs: Capital costs for the shelter were $2.4 million. The forecast annual cost was $940,000 (based on Community Services Committee report Aug. 9, 2022), however the estimate noted that there may be additional costs for staffing.
Operational costs not public at this time, however, staffing costs seems to be inline with other shelters.

Outcomes Achieved: The shelter just began operations at the end of April 2023. There is a 3-month evaluation underway which is looking at information collected from the Working Centre as well as from community partners and neighbours. Specific outcomes are not yet available.

Prior to COVID the Region had 253 adult shelter spaces, going into the winter 2023 there are over 500 spaces.

Additional Discussion:

Constructing the shelter on a Regionally-owned site allowed Waterloo Region to get the site up and running as quickly as possible.

The outdoor shelter is intended to be an interim solution.

In August 2022, staff went to council with a number of transitional housing options including the Outdoor Shelter. Other initiatives that were implemented include an Indigenous Housing Program, expansion of existing shelter space, and creating 100 scattered-site supportive housing units.

The decision for Erbs Rd. was not unanimous, initially there was a sense that what was needed was an investment in permanent housing. There was however an acknowledgement of an increase in unsheltered homelessness, chronic homelessness, and that current shelter spaces were not meeting needs and desires of people experiencing homelessness. The Erbs Rd. option provided accommodation

for a range of populations, including men, women, couples and could also accommodate pets and was not a congregate setting.

One key element considered for the shelter is that supports should follow people into housing, i.e., people should not need to be in shelter to access a certain service. They need to be able to access the service even when they leave shelter.

There is another hub in the Region, in Cambridge, the Multi-Agency Community Space (MACS). This is more of a wrap around service model hub, providing Regional housing services, family services, Ontario Works and has contracts with other community agencies. The site has been very helpful in providing warm hand-offs and the ability for people to access services right away without having to go somewhere else or make an appointment.

9.14 Boyle Street Community Services

Edmonton, Alberta

Note: this is a new model being implemented starting in October, so the description below is based on plans.

Description of the Service Model:

Brief Summary: Boyle Steet has an interdisciplinary model of care that includes interdisciplinary teams, den spaces, auxiliary supports, external supports, and light touch services. The model brings staff from multiple disciplines together into one space to form an interdisciplinary team that works collaboratively with the person seeking care to meet that person's goals. The team is supported by various other programs, including light touch services.

Problems Being Solved: The purpose of the interdisciplinary model of care is to provide access to care by allowing people to walk through the doors, explain their situation to one person, and be guided to the service or services that will best meet their needs. The intention is to reduce the work necessary to seek care and redirect that into meeting needs more promptly.

Client Segments: The services are targeted a people experiencing chronic homelessness.

Channels: Participants will drop in to a 'triage' space. The space will contain reception, intake workers, a substance use worker, a nurse, housing intake, and youth and young adult workers. People can receive 'light tough' services in the 'triage' space. Participation in the 'den' space will be based on membership, and becoming a member is based on a variety of factors, such as being chronically houseless, being ready and willing to begin working toward (self) set goals, and many others. Members of a den will be able to show up to one space - the den - and work toward their goals.

Key Activities/Services: Light touch services include:

- Harm reduction supplies
- Identification services
- Mail services
- Nurse/primary care
- Washrooms
- Coffee

Interdisciplinary team services include:

- Case management
- Housing assistance
- Substance use services
- Cultural supports

Key Partners: Boyles St. is a large non-profit and the interdisciplinary teams include staff from various programs.

Key Resources: Each team will have two adult support workers, one substance use worker, a cultural support worker, a nurse, and den members. The staff will work together out of the same physical space, which they call a den. Each team has its own den.

Space: A den will have a common area, individual offices, a computer/technology station, and a variety of seating options.

The den spaces will have triage spaces and den spaces. Triage capacity will be separate from den spaces. People looking to meet simple needs, like making a phone call, printing a document are part of the triage capacity, whereas a person seeing a counsellor will be part of a den's space capacity. The intention is to avoid having all of the capacity being used by people looking to meet more time-intensive needs and connecting people more quickly to the specific services they are looking for.

Geographic Location: The community centre is located downtown on a transit route. However, Boyle St. is also opening new, smaller warming locations across the city as a step toward the decentralization of social services in Edmonton.

Hours: May 1 – October 31: Monday – Friday 8am – 4:30pm, November 1 – April 30, Monday – Friday 8am – 4:30pm, with extended drop-in hours until 8pm, Monday - Sunday

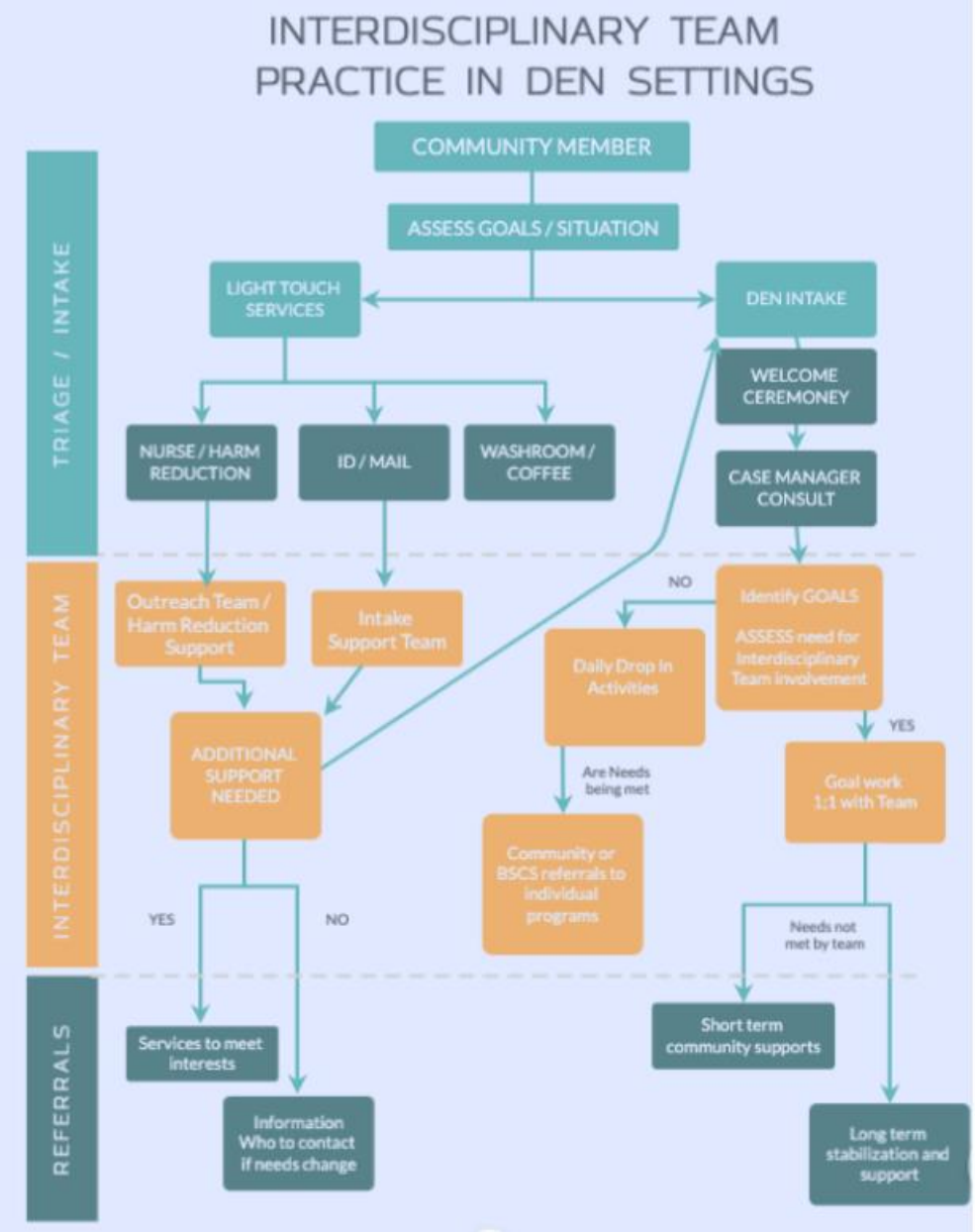
Costs: Not available.

Outcomes Achieved: This is a new model, outcomes are not yet available.

Additional Discussion:

The way Boyle St.'s programs have been delivered in the past often resulted in someone going to one office to see a housing worker, then another to see an adult support worker, then another to see a mental wellness worker, going to another to see a nurse, and in each case hoping the worker's office hours are open, or that they aren't so busy that they have to come again at another time, or that they are actually the right person for their needs, and so on.

Below is an overview of the interdisciplinary team approach.


INTERDISCIPLINARY TEAM PRACTICE IN DEN SETTINGS
TRIAGE / INTAKE
INTERDISCIPLINARY TEAM
REFERRALS
COMMUNITY MEMBER
ASSESS GOALS / SITUATION
LIGHT TOUCH SERVICES
DEN INTAKE
NURSE / HARM REDUCTION
ID / MAIL
WASHROOM / COFFEE
WELCOME CEREMONEY
CASE MANAGER CONSULT
Outreach Team / Harm Reduction Support
Intake Support Team
NO
Identify GOALS
ASSESS need for Interdisciplinary Team involvement
Daily Drop In Activities
YES
ADDITIONAL SUPPORT NEEDED
Are Needs being met
Goal work 1:1 with Team
Community or BSCS referrals to individual programs
YES
NO
Needs not met by team
Services to meet interests
Short term community supports
Information Who to contact if needs change
Long term stabilization and support

9.15 SORCe (Safe Communities Opportunity & Resource Centre)

Calgary, Alberta

Description of the Service Model:

Brief Summary: SORCe is a multi-agency collaborative that connects people experiencing or at risk of homelessness, to programs and services that can help to address the barriers to stable housing. By bringing together multiple agencies and programs in a single location, SORCe strives to connect each client to all necessary programs and services to address the individual and complex needs of each client that comes in the door. The Distress Centre is responsible for the overall management of SORCe.

Problems Being Solved: SORCe was created to connect people experiencing or at risk of homelessness, to programs and services that can help to address the barriers to stable housing. Implementing Coordinated Entry was the key driver in establishing SORCe.

Client Segments: People experiencing or at risk of homelessness

Channels: Walk-in services

Key Activities/Services: To access programs and services, people and families are required to complete an intake process. This intake process includes completing a client profile questionnaire. Clients must acknowledge that intake information shared with SORCe will be shared with all agencies that are participating in the collaborative.

Services provided at SORCe include:

- Alberta Health Services provides mental health support for vulnerable homeless and newly housed individuals who are not connected with other mental health services two mornings a week, including psychosocial assessment and support, mental health assessments, specialist and community referrals, short-term mental health skills building, and short term mental-health-focused case management. AHS also operates a Wellness Exchange group program one afternoon a week that teaches a series of skills that help individuals cope with stress and adversity while promoting positive mental health and well-being. AHS provides short-term outpatient non-medical treatment from an addiction counselor, including short-term outpatient counselling, referral support, education, skill building, and support group programs four days a week.
- Alberta Solicitor General, Government of Alberta provides access to a Probation Officer for individuals who have probation conditions and no fixed address.
- CUPS provides Rapid Care Counselling allowing a timely access to mental health services for people with lived experience of homelessness. The program is available for short or long term based on the participant's needs.
- Distress Centre provides 24-hour crisis support, counselling and referrals to programs and agencies for further assistance.
- Inn from the Cold provides housing information, referrals and assessments for families one day a week.

- Calgary Drop-In Centre provides victim outreach services to support victims of a crime, with a particular focus on persons who are homeless or without a fixed address. The Drop-In Centre also operates a Diversion program were the program partners with the Coordinated Access Diversion Housing Strategist to provide diversion services for people accessing the SORCe and presenting with housing needs where they may not triage into a supportive housing program through the Coordinated System, with a specific focus on reducing long-term shelter use when an individual has accessed shelter for the first time.
- The Alex Steet Team provides addiction outreach services to street-involved individuals engaged in substance use and/or facing mental health barriers, including peer support, addictions and mental health referrals and community resource navigation, and intakes for the Rapid Access Addictions Medicine (RAAM) clinic three days a week.
- Trellis Society works with youth 16-24 who are at risk or currently Homeless, to permanently end their experience of homelessness through outreach case management one and a half days a week.

Key Partners: SORCe was developed as a grassroots initiative that is supported by a variety of community based organizations operating:

- Alberta Health Services
- Alberta Justice and Solicitor General
- CUPS
- Distress Centre Calgary
- Inn from the Cold
- The Calgary Drop-In and Rehab Centre
- The Alex
- Trellis Society

Key Resources: There are 16-18 staff on site including 4 housing strategists, a dedicated ID staff, financial empowerment coach, 2 diversion staff, operations coordinator, and a director and manager on site. This does not include partner agency staff that are also on site. There is also a mobile clinic that comes to the Centre once a week.

Space: Centre has a check-in window when you first enter the building and then people are asked to go into the lobby/waiting room. Currently there are 4-5 booths where system navigators sit and call people for an initial conversation. Information is collected within HMIS. Depending on needs of the individual they may move on to speak with a housing strategist who will do an assessment. The Centre also has a number of desk spaces for staff, some offices for staff, an office for Victim Services, as well as a kitchen for staff. There are washrooms onsite and a basic needs room which holds supplies and donations for participants. There is also a food storage are and hampers are prepared for people who are in need.

Geographic Location: Located downtown at LRT platform.

Hours: Monday-Friday: 9:00 a.m. - 12:00 p.m. and 1:00 p.m. - 4:00 p.m.

Costs: SORCe operates primarily through funding from the Calgary Homeless Foundation, as well as additional funding from United Way, City of Calgary and in-kind contributions from the agencies participating in the collaborative, along with an annual operating grant for office supplies.

The City provides the building and maintenance. The largest component of funding from Calgary Homelessness Foundation is for staffing. OW funding is also used for staffing. (Although based on discussions with staff, it seems like this is a much smaller amount to what they receive from the Calgary Homelessness Foundation). The Source is the central location for Coordinated Access and so when they started most of their staffing was for Coordinated Access – which came from the Calgary Homelessness Foundation. Essentially – the Source funds about 20 FTE positions – at approx. $80,000 per staff (includes salary/benefits, CPP etc.), which would mean that staffing costs would be approximately $1.6 million/year.

Outcomes Achieved: Staff point to increased collaboration as the biggest outcome. The Centre brings in partners from a range of sectors including housing, justice, and health. Alberta Health Services plays a large role in the centre which is seen as key to the success of the program. The model has also helped create consistency in the system.

Another key outcome has been the creation of a 'communications hub' that has computers and telephones, with 3 staff on at all times. With this number of staff, one-to-one support is available for individuals looking to complete applications and other key tasks.

In 2022, 1,474 housing assessments or updates and 9,791 housing check-ins were completed. In addition, 260 community partners were supported with training to become Housing Strategists.

Additional Discussion:

A new family-sector hub is being established in the upstairs of the same location. The family-sector hub is intended to provide vulnerable families with a single stop to access services and explore alternatives before homelessness hits.

SORCe is currently doing a review of their assessment tool. Originally used the ViSPDAT, the NSQ, and now looking to Toronto and San Diego as a new approach.

9.16 Integrated Care Hub

Kingston, Ontario

Description of the Service Model:

Brief Summary: The ICH provides 24/7 low barrier and wrap-around services to vulnerable citizens with immediate needs such as safety, food and rest and longer-term needs such as addiction and mental health services.

Problems Being Solved: The purpose of the ICH is to specifically offer a low barrier, trauma informed space for clients to gather and provide these services and supports in a wrap around and holistic way. The goal of the ICH is to provide supports to individuals on site by various health, housing and social service agencies.

Channels: Individuals drop-in to the site

Key Activities/Services:

Currently at Artillery Park, there are 70 emergency shelter beds and another 30 people can access rest areas.

Services also include harm reduction and consumption and treatment services, including supervised consumption, overdose prevention, counselling and treatment

Key Partners:

The Integrated Care Hub at 661 Montreal St. will be operated by HIV/AIDS Regional Services (HARS).

Kingston Community Health Centres will provide harm reduction and Consumption and Treatment Services.

Geographic Location: The current site is located within a park four blocks of the downtown. A new home is being planned well outside of the downtown.

Site: The site has onsite security, a surveillance system, exterior lighting and partial fencing.

Hours: 24/7

Outcomes Achieved: Not available

Cost: Not available

Additional Discussion:

By co-locating consumption and treatment services with the ICH services, Kingston found that there has been a significant number of individuals who use substances accessing the consumption and treatment services that also have been able to take advantage of the services provided at the ICH. The co-location has also assisted in reversing overdoses for a number of individuals. The addition of consumption and treatment services adds life-saving services (overdose prevention, supervision, counseling, etc.) and removes a powerful barrier to seek treatment.

9.17 Charlottetown Outreach Centre

Charlottetown, PEI

Description of the Service Model:

Brief Summary: The Charlottetown hub is a space that brings together government and community services — such as employment, financial assistance counselling, food and housing — and makes them more accessible to Islanders struggling with issues including homelessness, poverty or mental health.

Problems Being Solved: The hub is intended to provide access to a range of services under one roof to help people to address more than one barrier at a time. The hope is that the hub will also partners to get a better understanding of what needs are being met and what needs may have been overlooked.

Client Segments: People experiencing homelessness or who are at risk of homelessness. The intention is to focus on the needs of the most vulnerable.

Channels: Participants generally go directly to the Outreach Centre. Most people staying at the Park Street Shelter will take one of two buses (provided by Park Street Shelter) to the Outreach Centre each morning.

Key Activities/Services:

Services include:

- Warming Centre
- Connections to services
- Laundry
- Showers
- Telephones
- Computers
- Lockers
- Light breakfast/snacks

Key Partners: The centre is managed by The Adventure Group. Other partners include P.E.I.'s Department of Social Development and Housing, Health PEI, the John Howard Society, Police Services, Community Legal Information, Mi'kmaq Confederacy of PEI, Native Council of PEI, PEERS Alliance, PEI Council of People with Disabilities, the Upper Room Food Bank, Blooming House women's shelter, and the Salvation Army. A working group of fourteen agencies currently meet on a monthly basis.

Key Resources: There are 2 security staff on every day, in addition to 8 staff on site. Of the 8 staff on-site approximately 5-6 are on the main floor at all times. Daily, there are 4 front-line staff in addition to a site supervisor and custodian. There is also an Activity and Event Coordinator.

The Centre is currently looking at hiring a nurse to be on-site 40 hours a week and hope to have doctors on-site for 24 hours each month. Staff are also looking to establish a partnership the University's Medical Centre.

Space: The Centre moved locations earlier in 2023 and is now within the former curling club which was purchased by the Province.

Geographic Location: The hub is located within 3 blocks (850m) of the downtown core.

Hours: 8 a.m. to 8 p.m., seven days a week

Costs: The province provides the building and utilities in addition to $1.5 million in operating funds. The Centre raised an additional $800,000 through various other funding streams including Reaching Home.

Outcomes Achieved: The Adventure Group has been managing the Outreach Centre for about 18 months, over that time have seen approximately 80 people a day and support approximately 300 individuals a month. One of the biggest outcomes has been the success of the life skills program.

Additional Discussion: The Outreach Centre is currently experiencing some resistance from the Community, there is a sense that people are coming from outside Charlottetown and outside the province to seek services.

The centre initially opened as a pilot January 15, 2020 at 211 Euston Street, moved to Birchwood School in March 2020 for several months due to Covid-19, then moved to Smith Lodge at 35 Weymouth Street before moving to the current location in 2022.

9.18 Best Practices in Service Provision in Rural Areas

Hub and Spoke Model

Montana is an entirely rural state, large parts of which are frontier areas. The Yellowstone City-County Health Department's HCH project in Billings and its sub-grantees in Helena, Butte, and Missoula use a hub-and-spoke service model. Besides serving people experiencing homelessness who migrate to these cities from outlying areas, the project uses a mobile van to reach out to unsheltered persons in remote areas without HCH services. All towns with homeless health care projects have specialists within their provider network. There is lots of community support for providing care to people experiencing homelessness in Montana, where the media play an important part in educating the public about client needs and often participate in solving problems associated with homelessness. Overlapping responsibilities among public health workers at community health centers, health departments and HCH, Indigenous, and migrant health services foster a high degree of collaboration and service integration not often seen in more urban areas.

Mobile Outreach

Blue Lake California has a Mobile Medical Office in Blue Lake, California, which serves people experiencing homelessness all over Humbolt County. The van is 39 feet long, includes two exam rooms, an office lab, a dispensary for medications, and medical records — just like a stationary clinic, but smaller. In addition to providing medical services, they have a needle exchange program. Clients see a doctor every time they come in to exchange needles. Physicians screen them for HCV, HIV, TB, STDs, and mental illness. The Mobile Medical Office maintains good electronic communications with other providers. They reported that they can do a lot to connect people up to services with a laptop computer and a phone from a mobile unit.

Creatively engaging non-targeted systems and programs, faith-based organizations, and informal partners to address resource gaps

Communities can strengthen their service provision in rural areas by recruiting people with influence and who represent a variety of sectors from various locations across the geographic area. Partners could include, but are not limited to, municipal staff, local businesses, civic leaders, local law enforcement partners, affordable housing operators, school staff, behavioural health or other medical service providers, hospital discharge planning staff, food banks, postal workers, EMS staff, employment agencies, and family resource or other community networks. Leaders of these non-targeted programs can help determine if there are opportunities to pool existing resources to achieve shared outcomes. School leaders, for example, can play a critical role in identifying and connecting families and youth who are living doubled up to coordinated entry processes. Because they are embedded in the community, these community partners tend to know where to start looking for encampments, abandoned buildings, and other places where people experiencing homelessness might be living.

In rural settings, informal partnerships, like those with faith-based partners, community members, and other allies, may be particularly valuable due to a scarcity of programs and services targeted to homelessness.

The rural communities convened by United States Interagency Council on Homelessness (USICH) have built partnerships with convenience stores, given that convenience stores often serve as a grocery store,

fueling station, and community hub in rural areas. People who work in convenience stores can be outreach sources who are regularly connecting to people experiencing homelessness.

Faith-based organizations can serve many instrumental roles in addressing rural youth homelessness: helping identify people experiencing or at risk of homelessness and referring them to points of access for coordinated entry processes, sponsoring events that create connections to housing and services for people experiencing homelessness, providing emergency shelter via congregation buildings or in the homes of congregation members, creating supportive and mentoring relationships between rural individuals experiencing homelessness and congregation members, or providing flexible funding to fill the gaps in assistance that the homelessness system cannot.

Regional Approach

To make service provision in large rural areas more manageable, some communities have divided their territory into sub-regions. Each region usually has its own governance structures, including roles for various staff, and defined approaches to coordination. There are several benefits to implementing regional approaches, including:

- Enhancing buy-in among community partners as they are invited to work locally to address homelessness
- Creating opportunities to better tailor responses based on geographic and population-specific needs
- Reducing the burden on current staff and more evenly distributing work
- Better ensuring coverage and coordination across the entire geography or rural area.

Appendix 3 – Glossary of Terms

Accessible: In reference to a type of housing unit, accessible refers to units that are designed to promote accessibility for individuals with disabilities. This sometimes includes physical elements such as low height cupboards or light switches, wide doorways, and adapted bathrooms

Acuity: An assessment of the level of complexity of a person's experience. Acuity is used to determine the appropriate level, intensity, duration, and frequency of case managed supports to sustainably end a person's or family's homelessness.

Adequate Housing: Dwellings not requiring any major repairs, as reported by residents

Affordable Housing: The term 'affordable housing' encompasses a broad range of housing, including social housing, private market rental units, and ownership housing. Based on the Provincial Policy Statement's (PPS) definition of affordable housing: affordable rental housing refers to units rented at or below the average market rent for a specified unit size

Assertive Community Treatment (ACT): An interdisciplinary team of professionals available around the clock to provide treatment, support, and other needed services. The ACT team will typically engage people immediately after they have secured permanent housing and will regularly offer a variety of services to choose from. Services may be delivered in people's homes or in community offices or clinics. ACT teams might include social workers, physicians, nurses, occupational therapists, psychologists, counsellors, addictions specialists, housing specialists, employment specialists, administrative assistants, and other professionals (Homeless Hub)

At Risk of Homelessness: Refers to people who are not homeless, but whose current economic and/or housing situation is precarious or does not meet public health and safety standards (Canadian Observatory on Homelessness)

Best Practices: Refers to practices and procedures rooted in evidence-based research

By-Names Prioritization List or By-Name List: Refers to a real-time list of people experiencing homelessness that includes a robust set of data points that support coordinated access and prioritization at a household level and an understanding of homeless inflow and outflow at a system level. The real-time actionable data supports triage to appropriate supports and services, system performance evaluation, and advocacy. (20K Homes Campaign)

Client: A person served by or utilizing the services of a social agency.

Community Advisory Board (CAB): The Community Advisory Board is a catalyst for developing and supporting a local homeless-serving delivery system. The CAB is responsible for being representative of the community; producing the Reaching Home Community Plan; and recommending projects for funding to the Community Entity (DNSSAB). (Homelessness Partnering Strategy)

Coordinated Access: A coordinated access system is the process by which individuals and families who are experiencing homelessness or at-risk of homelessness are directed to community-level access points where trained workers use a common assessment tool to evaluate the individual or family's depth of

need, prioritize them for housing support services and then help to match them to available housing focused interventions. (Reaching Home Directives)

Chronic Homelessness: Refers to individuals who are currently experiencing homelessness and who meet at least one of the following criteria:

- They have a total of at least six months of homelessness over the past year
- They have recurrent experiences of homelessness over the past three years, with a cumulative duration of at least 18 months. (Reaching Home Directives)

Core Housing Need: A household is in core housing need if its housing does not meet one or more of the adequacy, suitability or affordability standards and it would have to spend 30% or more of its before-tax income to access local housing that meets all three standards. (Canada Mortgage and Housing Corporation)

Diversion: A preventative strategy/initiative to divert individuals from becoming homeless before they access a shelter or immediately expedite their exit from the shelter system. This may include helping people identify immediate alternative housing arrangements and connecting them with services and financial assistance to help them maintain or return to permanent housing.

Evidence-based: The integration of best practice research evidence within clinical expertise and client values. In the context of social programs, services and supports, evidence-based refers to the use of high-quality evidence (e.g. randomized control trials) to develop, test, and modify programs and services so that they are achieving intended outcomes

Families: Households of two or more people and include two adults who are married/living together as well as head(s) of household with a child or children

High Acuity: In the District of Nipissing a person will be considered high acuity for the purposes of resource matching if they score 10+ on the Homelessness Information Assessment.

Homeless Count: provides a snapshot of the population experiencing homelessness at a point in time. Basic demographic information is collected from emergency shelters and short term housing facilities, and a survey is done with those enumerated through a street count. Public systems, including health and corrections, provide numbers of those without fixed address on the night of the count as well.

Homeless Hub: A homeless hub is a centralized facility designed specifically to provide a comprehensive range of services and resources aimed at supporting individuals and families experiencing homelessness. Hubs are designed to be easily accessible to individuals and families experiencing homelessness, removing barriers to service access and providing a safe, welcoming environment for those in need. While providing immediate needs like shelter and food, homeless hubs also focus on longer-term solutions aimed at transitioning individuals out of homelessness.

Homelessness: Describes the situation of an individual, family or community without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it (Canadian Observatory on Homelessness)

Homelessness Information Assessment (HIA): The Homelessness Information Assessment assesses the vulnerability factors of individuals in order to prioritize individuals for resources. The HIA considers

whether the individual is: unsheltered/staying at the low barrier shelter/couch surfing, experiencing chronic homelessness, Indigenous, have mental health issues, have substance use issues, youth (16-24), have a developmental cognitive disability, have a physical disability, have an acute/chronic medical condition, have recently been discharged from an institution, are fleeing violence and/or victimization, are experiencing environmental displacement, and identify as LGBTQ2S+ and assigns a score based on these vulnerability factors.

Housing First: Is a recovery-oriented approach to ending homelessness that centres on quickly moving people experiencing homelessness into independent and permanent housing and then providing additional supports and services as needed. There are five core principles of Housing First:

1. Immediate access to permanent housing with no housing readiness requirements
2. Consumer choice and self-determination
3. Recover orientation
4. Individuals and client-driven supports, and
5. Social and community integration

Indigenous: A collective name for the Indigenous Peoples of North America and their descendants. The Canadian Constitution recognizes three groups of Aboriginal people: Indians (commonly referred to as First Nations), Métis, and Inuit. (INAC)

Indigenous Homelessness: describes the situation of First Nations, Metis, and Inuit individuals, families or communities lacking stable, permanent, appropriate housing, or the immediate prospect, means or ability to acquire such housing. (Canadian Observatory on Homelessness)

Intensive Case Management (ICM): Intensive case management is a team-based approach to support individuals, the goal of which is to help clients maintain their housing and achieve an optimum quality of life through developing plans, enhancing life skills, addressing mental and physical health needs, engaging in meaningful activities and building social and community relations. It is designed for clients with lower acuity, but who are identified as needing intensive support for a shorter and time-delineated period.

Low Acuity: In the District of Nipissing a person will be considered high acuity for the purposes of resource matching if they score from 1 to 3 on the Homelessness Information Assessment.

LGBTQ2S+: Refers to Lesbian Gay, Bisexual, Transgender, Queer, Two-Spirit and other gender/sexual identities Low Acuity: a person will be considered low acuity if they have a VI-SPDAT score of 6 or less as a youth or a single adult, or 3 or less as a family.

Mid Acuity: In the District of Nipissing a person will be considered high acuity for the purposes of resource matching if they score from 4 to 9 on the Homelessness Information Assessment.

Prevention: refers to the activities, interventions and planning that prevents individuals and families from experiencing homelessness.

Rental Assistance: This is a term that generally applies to any form of financial assistance provided by government to lower the rent. This includes rent-geared-to-income assistance in social housing, rent supplements, housing allowances, and housing benefits.

Service Prioritization Decision Assessment Tool (SPDAT): An assessment tool to determine client placement based on the level of need. The SPDAT looks at the following: self care and daily living skills; meaningful daily activity; social relationships and networks; mental health and wellness; physical health and wellness; substance use; medication; personal administration and money management; personal responsibility and motivation; risk of personal harm or harm to others; interaction with emergency services; involvement with high risk and/or exploitative situations; legal; history of homelessness and housing; and managing tenancy.

Shelter: A shelter is a facility designed to provide temporary safe accommodation and basic necessities for individuals and families who are experiencing homelessness. In addition to providing a safe place to sleep, shelters typically offer essential services such as meals, showers, and access to laundry facilities. It is best practice for hub to be housing-focused and assist clients with transitioning out of homelessness. Many shelters also offer or connect individuals with a range of support services.

Sleeping rough: People who are unsheltered, lacking housing and not accessing emergency shelters or accommodation. In most cases, people sleeping rough are staying in places not designed for or fit for human habitation, including: people living in public or private spaces without consent or contract (public space such as sidewalks, squares, parks or forests; and private space and vacant buildings, including squatting), or in places not intended for permanent human habitation (including cars or other vehicles, garages, attics, closets or buildings not designed for habitation, or in makeshift shelters, shacks or tents).

Social Housing: Social housing is subsidized housing that generally was developed under federal and provincial programs during the 1950s – 1990s, where ongoing subsidies enable rents to be paid by residents on a 'rent-geared-to-income' (RGI) basis (i.e. 30% of gross household income). Social housing is also called subsidized, RGI, community, or public housing. Additional social housing units are generally no longer being developed due to changes in programs.

Subsidized housing: A type of housing for which government provides financial support or rent assistance

Support Services: Services directed at supporting individuals and families with daily living (e.g. referrals, individual case management, personal identification, transportation, legal/financial assistance, mental health and child care)

Supportive Housing: Refers to a combination of housing assistance and other supports that help people to live as independently as possible. This includes several forms of rent subsidies (e.g. rent-geared-to-income in social housing, rent supplements, housing allowances) and housing types (e.g. dedicated buildings, individual units). Supports also take a variety of forms and vary in intensity based on people's unique needs (e.g. Occupational Therapy, Physical Therapy, Nursing, social work, etc.)

Youth Homelessness: Describes the situations and experience of youth people between the ages of 16 and 24 who are living independently of parents and/or caregivers, but do not have the means or ability to acquire stable, safe or permanent residence. (Canadian Observatory on Homelessness)