P.O. Box 1749
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Item No. 3i
Committee of the Whole
February 28, 2019

TO: Mayor Savage and Members of Halifax Regional Council

SUBMITTED BY: Original Signed by
Jacques Dubé, Chief Administrative Officer

DATE: February 19, 2019

SUBJECT: Navigator Suburban/Rural Pilot

ORIGIN

Halifax Regional Council November 27, 2018 motion put and passed that Halifax Regional Council:

1. Direct staff to explore options with respect to establishing an expanded pilot project with current program providers of the Street Outreach Navigator Program, Mobile Outreach Street Housing First, or any others that might exist; and

2. Return with a staff report and recommendation to Committee of the Whole as part of the 2019/2020, 2020/2021 budget deliberations.

LEGISLATIVE AUTHORITY

The Halifax Regional Municipality Charter[1], 2008, c. 39, s. 79 (1) "Th Council may expend money required by the Municipality for… av) a grant or contribution to … (v) any charitable, nursing, medical, athletic, educational, environmental, cultural, community, fraternal, recreational, religious, sporting or social organization within the Province."

Regional Municipal Planning Strategy[2], Policy S-31: "Where Provincial strategies are made in support of affordable housing, HRM may consider means to further or complement such strategies or programs through its programs, policies or regulations."

Regional Municipal Planning Strategy, Policy S-32: "HRM may consider partnerships or financial support for housing organizations."

Regional Municipal Planning Strategy, Policy S-33: "HRM shall monitor housing and demographic trends to assist in determining future housing needs."

[1] See Halifax Regional Municipality Charter.
[2] See Regional Municipal Planning Strategy.

Recommendation on next page

RECOMMENDATION

It is recommended that Halifax Regional Council

1. Direct the CAO to negotiate a Grant or Contribution Agreement with a party (or parties) identified by the Housing and Homelessness Partnership's (HHP) Homelessness Working Group, and that the agreement include the key terms and conditions identified in Attachment 1 to this report; and

2. Authorize the Mayor and Municipal Clerk to execute the agreement subject to review and approval as to form and authority by Legal Services.

BACKGROUND

Since 2011, the municipality has supported the outreach component of Halifax's homeless-serving system by funding the Navigator Street Outreach Program (NSOP).[3] The program is a proactive, positive lifeline for individuals who struggle with securing and maintaining housing and employment due to addictions, mental health issues and homelessness.[4] NSOP works on the street, as opposed to within the shelter system. NSOP supports unsheltered street involved and homeless individuals who are unwilling or unable to access provincially-funded support persons that work out of Halifax's emergency shelters and transitional/supportive housing units.

HRM has also funded the Halifax's homeless-serving system through grants to not-for-profit organizations and charities that provide emergency shelters, transitional housing and supportive housing.[5] The Community Grants Program provides project grants ($5k maximum) and capital grants ($25K maximum), but does not fund recurring operating expenses or any operating expenses assigned to a project.[6] HRM has provided funding outside of the Community Grants Program in the form of a multi-year grant supporting evaluation of Mobile Outreach Street Health (HOSH) Housing First.[7]

The Housing and Homelessness Partnership (HHP) is a collaborative of nine partners from the three levels of government, the private sector and non-profit organizations in Halifax.[8] In October 2013, Regional Council endorsed HRM's formal participation with HHP. HHP's Charter was formally signed in 2014, with the mandate to "end homelessness and housing poverty in Halifax" by addressing policy and systemic issues.

HHP operates through two working groups – the Affordable Housing Working Group (AHWG) and the Homelessness Working Group (HWG). The mandate of the AHWG is to put an end to housing poverty by leveraging the influence and capacity of each partner and the community to upgrade, preserve and expand the existing stock in both market and non-market housing. The mandate of the HWG is to put an

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[3] See Item 14.1.4 Halifax Regional Council October 17, 2017 and Item No.14.1.10 Halifax Regional Council July 31, 2018 for current and historical funding particulars for the NSOP.
[4] A significant number of NSOP's clientele have multiple addictions and/or physical or mental health concerns, putting them at higher risk of cyclical homelessness and unemployment. Often behaviours associated with mental health and/or addictions create barriers that are difficult to overcome without assistance
[5] The Community Grants Program provides homeless-serving-system-related funding annually under both the housing and emergency assistance categories. See for example Item No. 14.4.1 Halifax Regional Council May 10,2016; Item No. 1 Grants Committee May 15, 2017; and Item No. 14.4.1 Halifax Regional Council June 19, 2018
[6] See the Community Grants Program Guidebook for details on grant categories and eligibility requirements.
[7] In 2013, HRM committed $25,000 per fiscal year for a maximum of 4 fiscal years (2.6% of the estimated $968,544 annual budget) to fund a Housing First evaluation. See Item No. 9.1.2 Audit and Finance Committee July 15, 2015.
[8] The parties include: Affordable Housing Association of Nova Scotia, Canada Mortgage & Housing Corporation, Halifax Regional Municipality, Housing Nova Scotia, Investment Property Owners Association of NS, IWK, Nova Scotia Health Authority, United Way

end to homelessness by ensuring that people have access to the appropriate supports and services, and a healthy and safe place to live.

Following community consultation, the AHWG[9] and the HWG[10] set affordable housing targets and developed a 5-Year Strategic Plan (2014-2019). In response to Regional Council's endorsement of the HHP's affordable housing targets[11], staff developed an Affordable Housing Work Plan (AHWP) that outlines the purpose, progress to date, and direction of municipal affordable housing initiatives.[12] Implementation of the AHWP is ongoing.

DISCUSSION

Defining Homelessness

Homelessness is a dynamic, person-specific problem that changes from night to night and from person to person. In 2012, the Canadian Observatory on Homelessness (COH) established a working group to develop, refine and test a homeless definition.[13] The COH definition is based on a typology describing a range of housing situations along a homelessness continuum. There are four main categories of homeless on the continuum: (1) unsheltered; (2) emergency sheltered; (3) provisionally accommodated; and (4) at risk of homelessness (see Attachment 2).

The COH definition of homelessness acknowledges that many factors contribute to the experience of housing instability and homelessness. These contributing factors include a lack of affordable housing, insufficient supply of housing, inadequate income and/or employment opportunities, challenges or changes to an individual's physical or mental health, addictions, and family breakdown. Often, it is a series of crises that lead an individual or family to experience homelessness.[14]

Homeless-Serving System of Care

A Homeless-Serving System of Care is a local or regional system for helping people who are homeless or at imminent risk of homelessness. As a method of organizing and delivering services, housing and homelessness programs, it aims to coordinate resources to ensure community level results meet client needs. The term "system of care" includes the broader mainstream systems, community partners, all levels of government, philanthropists, faith communities and not-for-profit organizations – essentially all touch points serving people who are experiencing homelessness.[15]

Figure 1 (Attachment 3) presents common components of homeless-serving systems. The way these components evolve and interact depends on local needs, resources and priorities. Halifax's current homeless-serving system is characterized by the delivery of three (3) general types of services and

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[9] The AHWG's strategic goals are as follows: (1) Increase the supply of affordable housing options that meet people's need; (2) reduce the number of residents living in core housing need and (3) foster a strong housing sector.
[10] The HWG's strategic goals are as follows: (1) sustain community assets in shelter, transitional, and permanent supportive housing; (2) minimize new intakes into shelter system; (3) optimize lengths of stays in shelters to prevent harms associated with long shelter stays; and (4) minimize returns to shelter once housed.
[11] See Item No. 9.2.1 Halifax Regional Council December 13, 2016 for details concerning the Halifax Housing Needs Assessment and the affordable housing targets.
[12] In July of 2018 Regional Council endorsed the Affordable Housing Work Plan. See Item No. 14.2.3 Halifax Regional Council July 31, 2018.
[13] See Canadian Observatory on Homelessness. (2012.) Canadian Definition of Homelessness. Toronto: Canadian Observatory on Homelessness Press.
[14] In 2014, 8% of Canadians aged 15 and over reported that they, at some point in their lives, had to temporarily live with family, friends, in their car, or anywhere else because they had nowhere else to live—a situation referred to as 'hidden' homelessness. See Insights on Canadian Society: Hidden homelessness in Canada.
[15] See Calgary's System Planning Framework

supports for clients experiencing homelessness or at-risk of becoming homeless: (1) emergency shelters and crisis services; (2) homelessness prevention services; and (3) housing stability services and social housing. Individual service providers have unique service delivery models, target populations, prioritization criterion and performance indicators.[16]

Homelessness Data Collection

Historically, communities have attempted to use emergency shelter figures as a proxy for the entire homeless population. Methods such as counting the total number of unique individuals visiting shelters during a certain period can be inaccurate because they do not account for individuals who may be checked in at more than one shelter during the specified period (resulting in duplication).[17] Another problem is that this approach does not account for people who did not access a shelter when the count was being conducted.[18] The shortcomings of relying on shelter statistics alone has led to the development of alternative methods for measuring the scope of homelessness (most notably Point in Time (PiT) Counts and By-Name Lists) and prompted efforts to use real-time data to coordinate homeless-serving systems. See Attachment 3 for an overview of PiT Counts and By-Name Lists.

Coordinated Access System (CAS)

As the Canadian Alliance to End Homelessness notes, Coordinated Access Systems (CAS), sometimes called a Coordinated Entry Systems have been in place in the United States for several years and are being implemented in a growing number of Canadian communities. Coordinated access systems are designed to streamline the process for people experiencing homelessness to access the housing and support services needed to permanently end their homelessness.[19] See Figure 3 (Attachment 5) for a visual representation of how the elements of a coordinated access system interrelate.

By standardizing the intake and assessment process, sharing information in real-time, adopting uniform prioritization policies and coordinating referral processes, a CAS can connect homeless people to the right housing and supports as efficiently as possible (based on preferences and level of need). This ensures communities get the most out of limited resources and can more rapidly and effectively prevent and end homelessness for those in greatest need. A strong CAS uses a By-Name List and a Housing First Approach along with a standardized and coordinated process for access, assessment, prioritization and referral for housing and other services across all the agencies and organizations in a local area.

There are three (3) key steps to developing a Coordinated Access System:[20]

Access to the System	There should be an established and agreed upon process and structure for intake. It is imperative that outreach and access points provide full coverage of the community both geographically and by ensuring access to supports for all levels of housing and support needs including diversion, prevention, and safety needs such as for those fleeing domestic violence.

[16] See Item No. 14.4.2 Halifax Regional Council September 20, 2016 (Attachment 2; pp.46-53)) for an inventory of entities that make up Halifax's homeless-serving system of care.
[17] See National Shelter Study: Emergency Shelter Use in Canada.
[18] Shelter statistics can provide valuable insights into the scope of homelessness and demographic profile of the segment of the homeless population that access emergency shelters. See Attachment 6 for an overview of Halifax's shelter usage.
[19] See Canadian Alliance to End Homelessness' Coordinated Access Systems (CAS) overview.
[20] IBID.

Common Assessment and Prioritization	A healthy CAS is not based on "first come first served". Instead, it should include a standardized intake process that includes an assessment tool that provides understanding and insight regarding the strengths and vulnerability of each person. This aids in the system being able to accommodate those with the highest level of need first.
Referral Process	To make effective referrals it is important to complete a thorough mapping of services that could be considered touch points for those experiencing any level of homelessness along with documented and approved policies help to match individuals to available and appropriate housing and supports. Vacancies are then filled based on the community's established prioritization guidelines.

Current State of Coordinated Access in Halifax

Halifax service providers, have been building a Coordinated Access System since late last summer with support from current Homelessness Partnering Strategy (HPS) funding and 20K Homes Campaign. The work in Halifax has been informed by learnings from communities in the United States and Canada that have implemented a CAS. Halifax's current By-Name List includes ±118 individuals and largely includes chronically or episodically homeless individuals interacted with on the peninsula.[21] Roughly twenty (20) individuals are added to the By-Name List monthly.

Halifax has a community Case Conferencing Table that meets every two (2) weeks to review referrals, determine which agency is supporting which client and determine the allocation of available housing (including allocation of rent supplement subsidies).[22] At present, prioritization is determined (by all currently participating agencies) using a common client assessment tool – Service Prioritization Decision Assistance Tool (SPDAT).[23]

Work on developing a CAS Governance Table is ongoing. The Governance Table will lead the planning, implementation and management of CAS in Halifax. Among other things, the Governance Table will be responsible for adopting written policies and procedures for intake, assessment, prioritization, referral, referral rejection and protocols relating data sharing and privacy of information.

Rural and Suburban Homelessness

Homelessness is commonly thought to be an urban issue, a perception that is reinforced by the presence of homeless people on the streets in the urban core and by the characterization of homelessness in the media.[24] While homelessness in urban areas tends to be more visible, areas outside of urban centers are also affected by homelessness.[25] The same structural issues that cause homelessness in cities, including

[21] See Attachment 8 for definitions of chronic and episodic homelessness.
[22] Case conferencing can be used to both support people on a By-Name List towards housing and services and to further coordinate supports and services once someone is housed. See 200K Homes/Built for Zero Case Conferencing Overview.
[23] SPDAT was developed as an assessment tool for frontline workers at agencies that work with homeless clients to prioritize which of those clients should receive assistance first. It is an in-depth assessment that relies on the assessor's ability to interpret responses and corroborate those with evidence. As a result, this tool may only be employed by trained users. See Service Prioritization Decision Assistance Tool (SPDAT).
[24] Until recently, there was little acknowledgement that homelessness existed in rural areas in Canada. With a few exceptions, most research and intervention has concentrated on individuals and families living in urban areas. See Rural Homelessness in Canada: Directions for Planning and Research.
[25] A recent study examined rural homelessness dynamics in 22 communities spanning Canada's provinces and territories. The aim was to develop a preliminary understanding of rural homelessness from a comparative lens. See Housing First in Rural Canada: Rural Homelessness and Housing

lack of affordable housing and low incomes, exist in suburban and rural areas and contribute to the number of people who are homeless in those areas.[26]

In urban settings, most of those who are homeless seek support services, ranging from food at a soup kitchen or food bank to overnight shelter and social assistance for financial help.[27] Urban homelessness estimates have, therefore, commonly relied on counts of persons accessing the homeless-serving system. By this measure, homeless persons in rural areas are likely substantially undercounted due to the lack of service sites, the difficulty of identifying and counting persons who do not use homeless services and the limited number of researchers working on homelessness in rural and suburban communities.[28]

Due to a lack of homelessness services, many people who are homeless in rural communities rely more on informal networks – family, friends and neighbours – for help.[29] A recent study of homelessness in rural Nova Scotia found that those who are homeless rely on informal networks to couch surf or double up, they sleep rough in unsafe dwellings, seasonal "cottages" and recreational trailers during all seasons.[30] In cases of domestic violence that disproportionately affect women and children, emergency shelters are often inaccessible to those needing to flee unsafe situations, forcing individuals, living in rural settings, to return to sheltering with an abusive partner. [31].

Overall, suburban and urban homelessness are mostly alike, but the degree of hardship appears even more intense outside of the city core. Suburbs tend to lack homeless-serving resources. Moreover, adequate, affordable public transportation is less available in the suburbs than in the urban core. Suburban homelessness is also much more effectively hidden. Social stigma and safety concerns encourage the suburban homeless to stay invisible by hiding in ravines and woods and blending in with their surroundings as much as possible. This makes it easy for passers-by to overlook whatever signs of suburban homelessness are around them.[32]

Funding Recommendation

Staff affirm that the NSOP plays a critical outreach role in the urban core. Navigators represent the only sustained, homeless-serving, on-street, presence in Halifax's downtown. NSOP staff bridge the gap between services and homeless and street involved individuals. The NSOP is, and should remain, supported in the urban context. Homelessness solutions for the suburban and rural areas of HRM, however, must take account of the unique nature of homelessness outside of the urban environment. In staff's view, the NSOP model is ill-fitted to addressing homelessness in suburban and rural areas. An on-street presence is not appropriate outside the urban core and alternative approaches are needed.

Staff maintain that the ongoing efforts to refine coordinated access in HRM are central to addressing homelessness.[33] Real-time, person specific data allows a community to know every person experiencing homelessness by name, document their needs, prioritize them for housing, and refer them to the housing

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[26] See Geography of Homelessness
[27] See Rural Homelessness Study (County of Wellington)
[28] IBID.
[29] While on the one hand some informal networks 'absorb' local need, they also have an underside. Small towns are known for their lack of privacy. Word gets around about 'problem' individuals. Those so identified often have an even greater challenge in finding accommodation and a landlord who will rent to them. See Rural Alberta Homelessness.
[30] The homelessness research was conducted across Shelburne, Digby, Yarmouth, Annapolis, Kings and West Hants Counties in Nova Scotia. See Precarious Housing and Homelessness Across Our Rural Communities.
[31] See How is Rural Homelessness Different from Urban Homelessness? and Housing First in Rural Canada.
[32] See Homelessness in the Suburbs: Engulfment in the Grotto of Poverty.
[33] Halifax Public Libraries and Nova Scotia 211 have expressed their willingness to play an enhanced role in Halifax's Coordinated Access System. United Way Halifax have, likewise, expressed willingness to explore what role community hubs could play in extending the scope of CAS in vulnerable HRM communities.

and supports that best suit their preferences and needs. Community-wide data will allow HRM to monitor our homeless system performance, notice fluctuations, identify problems and respond in real time.[34] Staff, therefore, support funding that will allow the Homelessness Working Group to expand coordinated access's geographic scope to include suburban and rural HMR.[35]

Staff likewise recognize the need to build suburban and rural-community-capacity to prevent and address homelessness.[36] Municipal funding can help facilitate community-driven, locally-tailored efforts to meet the needs of suburban and rural residents who are unsheltered, emergency sheltered, transitionally sheltered or at risk of homelessness.[37] Innovative approaches to rural and suburban homelessness are being piloted in other jurisdictions and municipal funds can facilitate the piloting of similar innovations here in HRM.[38] Staff, therefore, support funding that will allow the Homelessness Working Group to develop and implement community-specific, homelessness-focused initiatives in suburban and rural HRM.[39]

Staff propose that HRM provide funding through a Grant or Contribution Agreement with a party (or parties) identified by the Housing and Homelessness Partnership (HHP) Homelessness Working Group in accordance with the key terms and conditions set out in Attachment 1 to this report.

FINANCIAL IMPLICATIONS

If approved by Regional Council, and upon signing of the Contribution or Grant Agreement with a party (or parties) identified by the Housing and Homelessness Partnership's (HHP) Homelessness Working Group, the municipality's contribution for the 2019/2020 fiscal year will be an amount not to exceed $90,000. If renewed by HRM, the municipality's contribution for the 2020/2021 fiscal year will not exceed $60,000. The funding has been referred to the Budget Committee to review along with other Budget adjustments. The expected impact in 2019/20 to the average residential tax bill is $0.32 with a possible adjustment of $0.0001 on the tax rate per $100.

RISK CONSIDERATION

Recommendation: Provide up to two-year contribution toward the work of the Housing and Homelessness Partnership's Homelessness Working Group

Risk	Likelihood	Impact	Risk Level	Mitigation

[34] Staff acknowledge that the Government of Canada's next phase of Homeless Partnering Strategy (HPS) funding is expected to support coordinated access and better local data. As of the writing of this report, it is unclear what funding parameters will apply to the Federal support of CAS in Halifax. See Reaching Home news release.
[35] PiT Count data from 2018 substantiates the need to address homelessness in suburban and rural communities. Forty-one percent (41%) of the homeless individuals surveyed indicated that they had come to downtown Halifax from rural Nova Scotia and thirty-two percent (32%) moved to Halifax within the prior year See Everyone Counts: Report on the 2018 Halifax Point in Time Count.
[36] The Canadian Observatory on Homelessness's prevention typology includes: structural prevention, institutional transition support, early intervention strategies, eviction prevention and housing stabilization See Attachment 2 for details on the COH's homelessness prevention typology.
[37] See Attachments 9 for HWG's Strategic Plan to End Homelessness and Housing Poverty in HRM and see Attachment 10 for a list of Halifax-based, homelessness-related projects funded by the Federal government.
[38] Many communities look to each other for solutions that work better in rural and remote contexts. For example, the NightStop program connects Canadian youth in crisis with a verified volunteer who provides safe shelter on a night-to-night basis.
[39] PiT Count data from 2018 substantiates the need to address homelessness in suburban and rural communities. Forty-one percent (41%) of the homeless individuals surveyed indicated that they had come to downtown Halifax from rural Nova Scotia and thirty-two percent (32%) moved to Halifax within the prior year See Everyone Counts: Report on the 2018 Halifax Point in Time Count.

	(1-5)	(1-5)	(I/L/M/H/VH)	
Financial	–	–	–	N/A
Environmental	–	–	–	N/A
Service Delivery	2	2	L	N/A
People	–	–	–	N/A
Reputation	1	1	L	
Legal and Compliance	2	2	L	N/A

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Alternative 1: Decline to provide financial support toward the work of the Housing and Homelessness Partnership's Homelessness Working Group.

Risk	Likelihood (1-5)	Impact (1-5)	Risk Level (I/L/M/H/VH)	Mitigation
Financial	–	–	–	N/A
Environmental	–	–	–	N/A
Service Delivery	–	–	–	N/A
People	–	–	–	N/A
Reputation	1	1	L	
Legal and Compliance	–	–	–	N/A

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Alternative 2: Provide a one-year contribution toward the work of the Housing and Homelessness Partnership's Homelessness Working Group without a renewal option.

Risk	Likelihood (1-5)	Impact (1-5)	Risk Level (I/L/M/H/VH)	Mitigation
Financial	–	–	–	N/A
Environmental	–	–	–	N/A
Service Delivery	–	–	–	N/A
People	–	–	–	N/A
Reputation	1	1	L	
Legal and Compliance	–	–	–	N/A

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Alternative 3: Defer a funding decision pending the receipt of a formal funding request

Risk	Likelihood (1-5)	Impact (1-5)	Risk Level (I/L/M/H/VH)	Mitigation
Financial	–	–	–	N/A
Environmental	–	–	–	N/A
Service Delivery	–	–	–	N/A
People	–	–	–	N/A
Reputation	1	1	L	
Legal and Compliance	–	–	–	N/A

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Alternative 4: Fund another activity or group

Risk	Likelihood (1-5)	Impact (1-5)	Risk Level (I/L/M/H/VH)	Mitigation
Financial	–	–	–	N/A
Environmental	–	–	–	N/A
Service Delivery	–	–	–	N/A
People	–	–	–	N/A
Reputation	1	1	L	
Legal and Compliance	–	–	–	N/A

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COMMUNITY ENGAGEMENT

In preparing this report, staff consulted with representatives from the following organizations and bodies: Affordable Housing Nova Scotia (AHNS), Halifax Public Libraries, Housing Nova Scotia, Mobile Outreach Street Health (MOSH), Nova Scotia 211 and United Way Halifax. Reports and strategies relied on in this report were developed following extensive consultation with homeless-serving organizations and people with lived experience of homelessness.

ENVIRONMENTAL IMPLICATIONS

There are no environmental implications.

ALTERNATIVES

1. Regional Council could choose to not to provide financial support toward the work of the Housing and Homelessness Partnership's Homelessness Working Group (HWG).

2. Regional Council could provide a one-year contribution toward the work of the Housing and Homelessness Partnership's Homelessness Working Group (HWG) without a renewal option, or could direct staff to negotiate terms for a grant or contribution agreement other than those provided in Table 1 of this report.

3. Regional Council could defer a funding decision pending the receipt of a formal funding request, made on behalf of the Housing and Homelessness Partnership's Homelessness Working Group (HWG).

4. Regional Council could provide a grant or contribution to fund another group or activity.

ATTACHMENTS

Attachment 1 Proposed Grant/Contribution Agreement – Key Terms & Conditions
Attachment 2 Typology of Homelessness (Table 1)
Attachment 3 Homeless Serving System of Care (Figure 1)
Attachment 4 Overview of PiT Counts and By-Name Lists (Table 2 | Figure 2)
Attachment 5 Coordinated Access List and Priority List Access (Figure 3)
Attachment 6 Shelter Use in Halifax (Table 3)
Attachment 7 Overview of Acuity and Chronicity in Homelessness (Figure 4)
Attachment 8 Key Homelessness Terms (Table 4)
Attachment 9 Strategic Plan to End Homelessness and Housing Poverty in HRM
Attachment 10 Homelessness Partnering Strategy Funding (Table 5)

A copy of this report can be obtained online at halifax.ca or by contacting the Office of the Municipal Clerk at 902.490.4210.

Report Prepared by: Scott Sheffield, Government Relations and External Affairs 902.490.3941

ATTACHMENT 1

Proposed Grant/Contribution Agreement
Key Terms & Conditions

a) The term of the Agreement shall be for one (1) fiscal year starting in 2019/2020 and that the amount of the annual grant or contribution shall not exceed $90,000.

b) The Agreement shall provide, at the Municipality's option, the ability to renew the Agreement up to a total of one (1) additional fiscal year, providing the grant or contribution for such renewal term shall not exceed $60,000 and the combined sum of the grants and contributions for the two (2) fiscal years shall not exceed $150,000.

c) The Agreement shall not be renewed beyond the 2020/2021 fiscal year without Council approval.

d) The annual grant or contribution shall be subject to Council approving, in the budget, the funds for the grant or contribution for the applicable fiscal year.

e) The grant or contribution shall be used in support of an integrated homeless-serving system of care, including developing and implementing:

   i. a community-wide (urban, suburban and rural) real-time, By-Name List;

   ii. coordinated outreach and access points for suburban and rural residents who are unsheltered, emergency sheltered, transitionally sheltered or at risk of homelessness; and

   iii. community-specific approaches to addressing the needs of suburban and rural residents who are unsheltered, emergency sheltered, transitionally sheltered or at risk of homelessness.

f) The Agreement shall require annual reporting which accounts for the expenditure of any grant or contribution received from the Municipality.

ATTACHMENT 2

Typology of Homelessness

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Table 1: Typology of Homelessness[40]

OPERATIONAL CATEGORY		LIVING SITUATION		GENERIC DEFINITION
1. UNSHELTERED	This includes people who lack housing and are not accessing emergency shelters or accommodation, except during extreme weather conditions. In most cases, people are staying in places that are not designed for or fit for human habitation.	1.1	People living in public or private spaces without consent or contract.	• Public space, such as sidewalks, squares, parks, forests, etc. • Private space and vacant buildings (squatting).
		1.2	People living in places not intended for permanent human habitation.	• Living in cars or other vehicles. • Living in garages, attics, closets or buildings not designed for habitation. • People in makeshift shelters, shacks or tents.
2. EMERGENCY SHELTERED	This refers to people who, because they cannot secure permanent housing, are accessing emergency shelter and system supports, generally provided at no cost or minimal cost to the user. Such accommodation represents an institutional response to homelessness provided by government, non-profit, faith based organizations and/or volunteers.	2.1	Emergency overnight shelters for people who are homeless.	These facilities are designed to meet the immediate needs of people who are homeless. Such short-term emergency shelters may target specific sub-populations, including women, families, youth or Aboriginal persons, for instance. These shelters typically have minimal eligibility criteria, offer shared sleeping facilities and amenities, and often expect clients to leave in the morning. They may or may not offer food, clothing or other services. Some emergency shelters allow people to stay on an ongoing basis while others are short term and are set up to respond to circumstances, such as extreme weather.
		2.2	Shelters for individuals/ families impacted by family violence.	
		2.3	Emergency shelter for people fleeing a natural disaster or destruction of accommodation due to fires, floods, etc.	
3. PROVISIONALLY ACCOMMODATED	This describes situations in which people, who are technically homeless and without permanent shelter, access accommodation that offers no prospect of permanence. Those who are provisionally accommodated may be accessing temporary housing provided by government or the non-profit sector, or may have independently planned for short-term accommodation	3.1	Interim housing for people who are homeless.	Interim housing is a systems-supported form of housing that is meant to bridge the gap between unsheltered homelessness or emergency accommodation and permanent housing.
		3.2	People living temporarily with others, but without guarantee of continued residency or immediate prospects for accessing permanent housing.	Often referred to as 'couch surfers' or the 'hidden homeless', this describes people who stay with friends, family, or even strangers.
		3.3	People accessing short term, temporary rental accommodations without security of tenure.	In some cases, people who are homeless make temporary rental arrangements, such as staying in motels, hostels, rooming houses, etc.

[40] See Canadian Observatory on Homelessness. (2012) Typology of Homelessness. Toronto: Canadian Observatory on Homelessness Press.

		3.4	People in institutional care who lack permanent housing arrangements.	People who may transition into homelessness upon release from: Penal institutions; Medical/mental health institutions; Residential treatment programs or withdrawal management centers; Children's institutions/group homes.
		3.5	Accommodation/ reception centers for recently arrived immigrants and refugees.	Prior to securing their own housing, recently arrived immigrants and refugees may be temporarily housed while receiving settlement support and orientation to life in Canada.
4. AT RISK OF HOMELESSNESS	Although not technically homeless, this includes individuals or families whose current housing situations are dangerously lacking security or stability, and so are at-risk of homelessness. They are living in housing that is intended for permanent human habitation, and could potentially be permanent (as opposed to those who are provisionally accommodated). However, because of external hardship, poverty, personal crisis, discrimination, a lack of other available and affordable housing, and / or the inappropriateness of their current housing (which may be overcrowded or does not meet public health and safety standards) residents may be "at risk" of homelessness.	**4.1**	People at imminent risk of homelessness	• Those whose employment is precarious • Those experiencing sudden unemployment • Households facing eviction • Housing with transitional supports about to be discontinued • People with severe and persistent mental illness, active addictions, substance use, and/or behavioural issues • Breakdown in family relations • People facing, or living in direct fear of violence/abuse
		4.2	Individuals and families who are precariously housed	Those who face challenges that may or may not leave them homeless in the immediate or near future. CMHC defines a household as being in core housing need if its housing falls below at least one of the adequacy, affordability or suitability standards and would have to spend 30% or more of its total before-tax income to pay the median rent of alternative local housing that is acceptable (meets all three housing standards).

Source: Canadian Observatory on Homelessness (COH)

ATTACHMENT 3

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Figure 1: Homeless-serving system of care

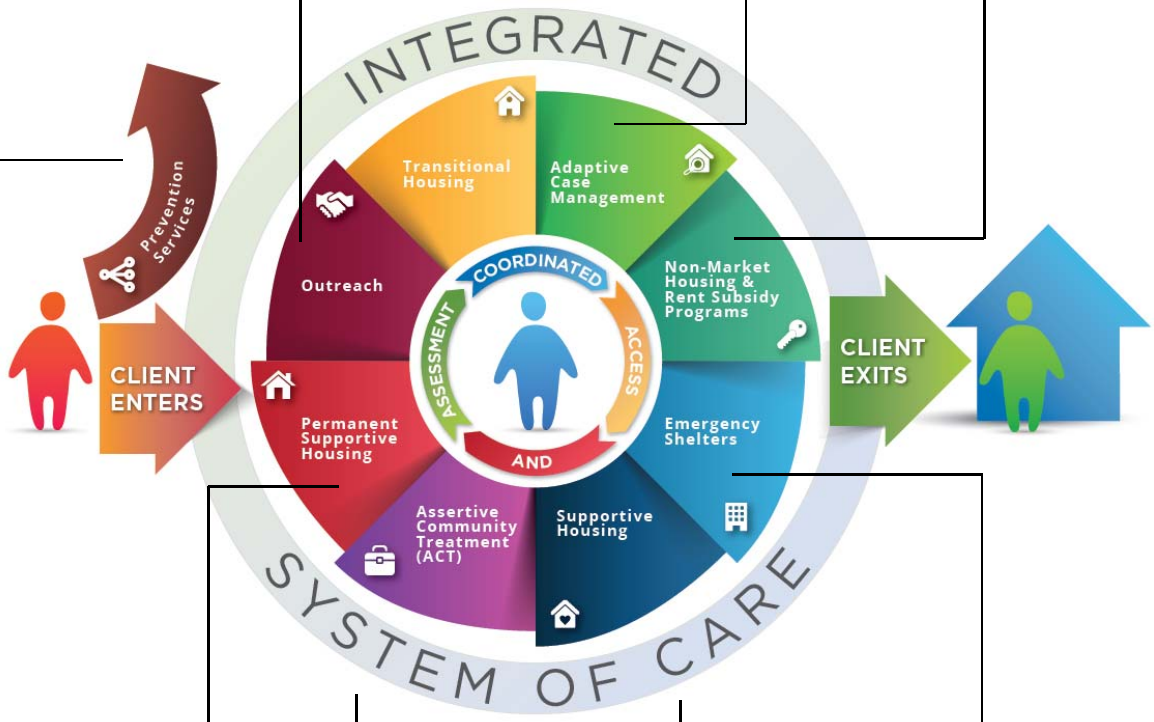
Prevention Services
Offer short term financial assistance and limited case management to prevent housing loss due to a housing crisis.

Outreach
Moving outside the walls of the agencies to engage people experiencing homelessness.

Transitional housing
A supportive temporary accommodation that is meant to bridge the gap from homelessness to permanent housing.

Adaptive Case Management
Client directed, flexible supports with time limited services and financial assistance to secure and sustain housing.

Non-market housing
Subsidized, social or affordable housing units.



Co-ordinated Access and Assessment
A centralized triage process for people experiencing homelessness to access housing and support services.

Permanent Supportive Housing
A long-term supportive housing model that targets individuals who experience chronic homelessness and are high acuity.

Assertive Community Treatment
An integrated team- based approach designed to provide comprehensive community based supports to help people remain stably housed.

Supportive Housing
Provide case management and housing supports to individuals and families who are considered moderate to high acuity.

Emergency Shelters
Any facility with the primary purpose of providing temporary accommodations and essential services for individuals experiencing homelessness.

Source: Calgary's System Planning Framework | March 2017

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ATTACHMENT 4

Overview of PiT Counts and By-Name Lists

Point-in-Time Counts

Point-In-Time (PIT) Counts, also referred to as "Street Counts", "Homeless Counts" or "Street Needs Assessments", measure the number of homeless people on a specific day (hence the point in time reference). A PiT Count estimates how many people are experiencing homelessness in emergency shelters, in transitional housing and in unsheltered locations on the day of the count. It may also include people who are in health or corrections facilities like hospitals, detox centres, detention centres or jails; these people often have no place to go when they are released from these facilities.[41]

A PiT Count is not just a count; it includes survey questions aimed at getting information to better understand the homeless population. This information can help determine what interventions are needed to help move people experiencing homelessness into a stable housing situation. PiT Counts can be repeated over subsequent years to evaluate progress in reducing homelessness, track demographic changes and monitor evolving service needs to better allocate resources.[42]

Everyone Counts 2018, the second Federally-funded, HPS-coordinated PiT Count, was held between March 1 and April 30, 2018.[43] The 2018 Halifax PiT Count counted 220 homeless individuals, over a 24-hour period, in the urban core of the Halifax peninsula. [44] Halifax's PiT Count included engagement on the street, at seven shelters, two non-shelter service providers and the central library on Spring Garden Road. [45] The Report on the 2018 Halifax Point in Time Count summarizes survey results from the enumerated visibly homeless population (see Table 2 below).

A PiT count cannot reach all the people who are homeless in the community over a period. People often cycle in and out of homelessness, so some people will not be homeless during the count but may have been the day before, or may become homeless the day after. Moreover, it cannot reach all people regarded as "hidden" homeless—those who are temporarily staying with friends or family because they have no place of their own.[46] For these reasons, PiT counts need to be complemented by other information gathering approaches to track who enter and exit homelessness within a community.

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[41] Across Canada, PiT Counts are coordinated through the Government of Canada's Homelessness Partnering Strategy (HPS).
[42] See Highlights – 2016 Coordinated Point-in-Time Count of Homelessness in Canadian Communities. for additional detail.
[43] Over 70 communities across the country participated in Canada's second national Point in Time (PiT) count
[44] Of the 220 visibly homeless individuals counted on the night of Halifax's PiT count, 145 people agreed to be surveyed at 11 locations.
[45] In Halifax, Affordable Housing Association of Nova Scotia (AHANS) coordinates the PiT Count.
[46] A growing body of experience from Canada and the US shows that a community cannot gather the necessary information to house its homeless solely by counting them anonymously once a year or every two years, See for example the Getting to Proof Points report by Community Solutions.

Table 2: Halifax PiT Count (2018) highlights

Single Night	Systems Contact	Housing Barriers	Loss of Housing	Moved into Halifax	Racial Group
18 Unsheltered homeless	35% Had been in foster care	70% Housing affordability	25% Eviction	32% Moved to Halifax in past year	71% Self-identify as white
5 Incarcerated homeless	30% Were in prison or in jail	35% Health related issues	17% Addiction or substance use	41% Came to Halifax from Rural NS	11% Self-identify as black
197 Emergency or transitionally sheltered homeless	71% Visited a hospital ER	17% Discrimination	18% Illness or medical condition	30% Migrant homeless youths	10% Self-identify as indigenous
	53% Had interactions with police	13% Home conflict	17% Family conflict (spouse or partner)	3% Immigrant or refugee (last 5 years)	4% Self-identify as bi-racial or mixed

Registry Week

Headed by the Canadian Alliance to End Homelessness (CAEH), the 20,000 Homes Campaign is a national movement of communities with a common goal of housing 20,000 of Canada's most vulnerable homeless. Since June 2015, 25 communities participating in the campaign have conducted Registry Weeks. A Registry Week is a coordinated outreach and triage assessment process (held over several days) to gather actionable, person-specific data on people experiencing homelessness (within a defined geographic area). At a minimum, this information includes people's names, chronicity and acuity (see Attachment 7 for an overview of acuity and chronicity). During the 2018 National PiT Count, 16 communities, including Halifax, conducted combined Registry Weeks and PiT Counts.[47] Data collected during a Registry Week facilitates the creation of a By-Name List.

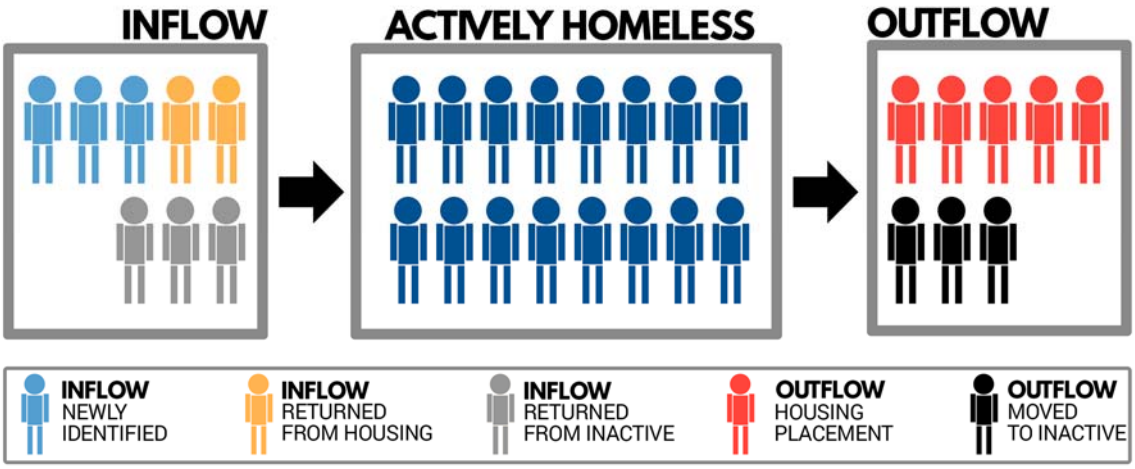
Source: Everyone Counts: Report on the 2018 Halifax Point in Time Count

By-Name List

A By-Name List is a real-time list of all people experiencing homelessness in the community. It 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. This real-time actionable data supports triage to services, system performance evaluation and advocacy (for the policies and resources necessary to end homelessness).[48]

[47] In Halifax, Affordable Housing Association of Nova Scotia (AHANS) coordinates Registry Week.
[48] See 20,000 Homes Campaign By-Name List Question and Answer Document.

Figure 2: System-level inflows and outflows



Source: End Homelessness Edmonton

A Quality By-Name List ideally includes all people experiencing homelessness in the jurisdiction. However, communities typically start with a By-Name List focusing on a smaller geographic area or a specific sub-population of people experiencing homelessness and build to a complete By-Name List over time.

A comprehensive By-Name List contains all the information necessary to: (a) effectively refer people to, and move people through, a coordinated access system; and (b) reliably show inflow, outflow and actively homelessness information required to accurately measure progress to reducing homelessness and, ultimately, to reaching and sustaining functional zero.[49]

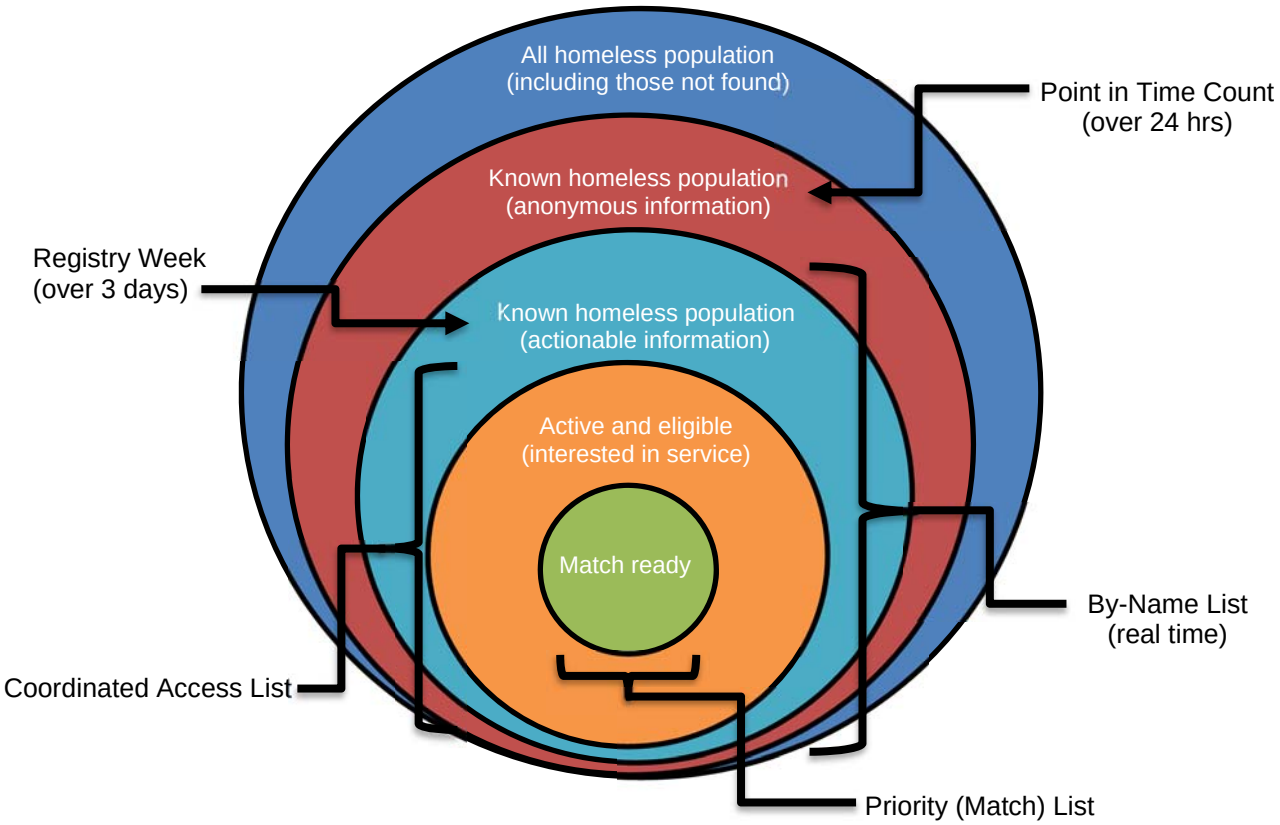
[49] See 2,000K Homes Campaign's over view Functional Zero Q&A

ATTACHMENT 5

Coordinated Access List and Priority List

The Coordinated Access List is a subset of the By-Name List that includes those that are active, eligible and interested in the housing support resources offered through the community's Coordinated Access System. A Priority List is a subset of the Coordinated Access List that identifies those with the highest priority for matching to available housing resources based on acuity and chronicity.

Figure 3: Homeless population data collection and Co-ordinated Access



Source: Adapted from 2000k Homes Campaign figure[50]

[50] See 20k Homes Campaign

ATTACHMENT 6

Shelter Use in Halifax

There are six emergency shelters in Halifax's urban core: Metro Turning Point and Salvation Army Centre of Hope serve adult males; Bryony House, Barry House and Adsum House serve women and children; and Phoenix Youth Shelter serves both males and females aged 16 to 24.[51]

Table 3: Quick emergency shelter facts (2017-2018) [52]

Shelter Beds	Age of Users	Profile of Users	Duration of Use	Frequency of Use	Returnee[53] Users
220 Total beds	52.8% Adult shelter users 25-49	70.7% Self-identify as male	40.1% Cumulative shelter stays 30+ days	5.1% Chronic shelter user	577 Total number of returnees
124 Beds for adult men	23.9% Youth shelter users 16-24	27.5% Self-identify as female	50.95 Cumulative shelter stay length (mean)	4.7% Episodic shelter user	44.9% High acuity (SPDAT)
60 Beds for women and children	19.2% Adult shelter users 50-64	1.8% Self-identify as other	19 Cumulative shelter stay length (median)	23.3% Chronic (3yr) shelter user	67 Mean length of absence (days)
16 Beds for male youths 16-24	2.7% Senior shelter users 64+	11.7% Self-identify as indigenous	1 Cumulative shelter stay length (mode)	35.9% More than one shelter stay	69.5 Mean cumulative length of stay (days)
4 Beds for female youths 16-24	1.4% Child shelter users	37.2% High acuity (SPDAT)			

Source: Halifax Shelter Use Report 2018

As noted in the Halifax Shelter Use Report 2018, nearly two-thirds (64.1%) of shelter users had only one shelter stay during 2017/18, and one-third of stays lasted a week or less.[54] Halifax`s shelter users spend an average of 50 days in shelter each year; however, the distribution is skewed toward short stays. Fully

[51] For comparative purposes, see the pan-Canadian Shelter Capacity Report 2016.
[52] These figures are based on 2017-2018 shelter use. Data was not available for Bryony House, therefore these results do not include information about people who stayed exclusively at Bryony House.
[53] Returnees are those users with more than one annual stay.
[54] A "stay" as defined as the nights spent in a shelter in a 30-day period. These could be continuous or split up over time.

half of shelter users spent less than 20 days in shelter over the course of a year, with over 200 spending just a single night in shelter. In 2016/17, 866 of the 1622 shelter users did not use a shelter in the previous or following year. In 2015/16, that number was 777 out of 1533. This means approximately half of shelter users have one stay and then are not seen at a shelter again.

ATTACHMENT 7

Overview of Acuity and Chronicity In Homelessness

Homelessness can be understood through both chronicity and acuity. Chronicity refers to the duration, or length of time in homelessness, including stays at shelter, sleeping rough or institutional stays (hospital, detox/treatment, remand/corrections). Homelessness has typically been classified by the following three typologies – chronic, episodic and transitional.

Chronic Homelessness	Continuously homeless for a year or more, or have had at least four episodes of homelessness in the past three years. To be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g. living on the streets) and/or in an emergency homeless shelter.[55]
Episodic Homelessness	Homeless for less than a year and has fewer than four episodes of homelessness in the past three years.
Transitional Homelessness	Homeless for the first time (usually for less than three months) or has had less than two episodes in the past three years.

Homelessness is not only understood by duration or episodes, it is also understood in terms of the acuity of individuals. Acuity includes systemic issues such as poverty, risk factors, mental health, substance abuse, domestic/interpersonal violence, medical concerns, age, life skills, employment history/potential, education and social supports.[56]

Using chronicity and acuity together, homelessness experiences can be plotted on two intersecting axes. (see Figure 4 below)[57] The horizontal axis plots chronicity. The further right along the axis, the longer an individual has been homeless (or the more "chronic" that individual is); the further left on the axis, the shorter or more transitional the experience of homelessness. The vertical axis plots acuity, where the higher the individual is, the more acute or more high-barrier the individual is; individuals lower on the axis are less acute.

[55] People experiencing chronic homelessness face long term and ongoing homelessness related to complex and persistent barriers related to health, mental health, and addictions
[56] Multiple homeless-serving agencies in Halifax use the SPDAT (Service Prioritization Decision Assessment Tool) to determine acuity and assist with assigning programs to individuals based on the level of need as identified through the assessment.
[57] See Calgary's System Planning Framework | March 2017

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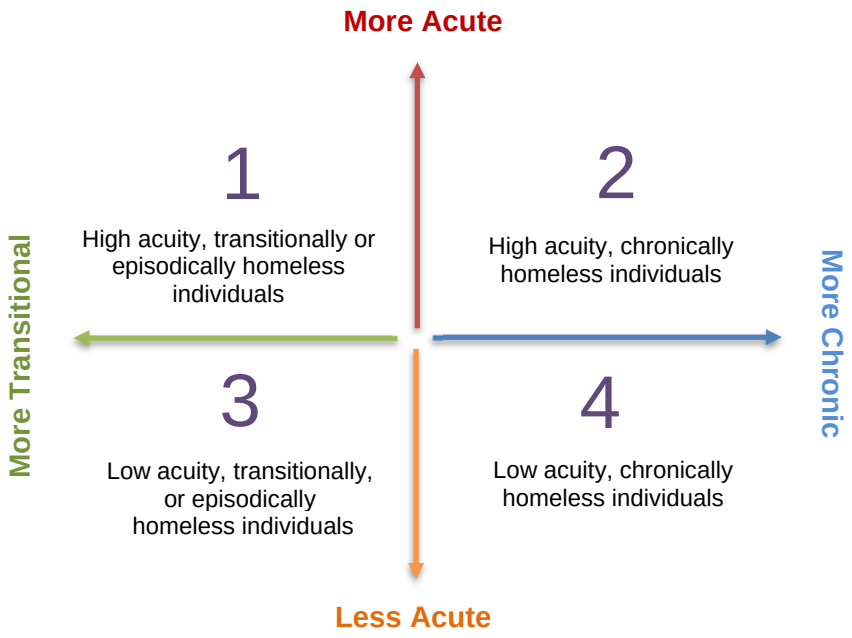
Figure 4: Chronicity and acuity in the homeless population



Source: Adapted from Calgary Homeless Foundation Figure

This suggests four categories of homelessness experience:

Quadrant	Description	Example	Possible Intervention
1	High acuity, chronically homeless individuals	Non-beverage alcohol drinker with undiagnosed schizophrenia, who cycles between shelter, hospital, and rough sleeping.	Permanent supportive housing, or assertive community treatment
2	Low acuity, chronically homeless individuals	Long term shelter stayer with high debt, alcohol dependence, but exhibits minimal barriers to maintaining housing.	Intensive case management
3	High acuity, transitionally or episodically homeless individuals	Person with PTSD, socially isolated, high substance use, and recent loss of housing.	Intensive case management

4	Low acuity, transitionally, or episodically homeless individuals	Migrant worker, minimum wage earning single parent with children.	Rapid rehousing or prevention

The advantage of this model is that it provides a framework to more accurately and appropriately discuss the variety in patterns of homelessness, as compared to traditional models that focused on length of time in homelessness alone. This allows for the discussion of solutions related to housing models and program types and to likewise account for the variability in client experience and client need in a way that does not solely focus on the variables of acuity and chronicity in isolation from each other. Rather, it frames these as mutually influential and equally relevant variables

ATTACHMENT 8

Key Homelessness Terms

Table 4: Key Housing and Homelessness Terms [58]

Term	Definition
Absolute homelessness[59]	Those living on the street with no physical shelter of their own, including those who spend their nights in emergency shelters.
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.
Adaptive Case Management	Adaptive Case Management programs offer client directed, flexible supports with time limited services and financial assistance to those experiencing homelessness, to secure and sustain housing. Targets people who are not high acuity and can live independently after a time limited financial intervention with support. The services provided to the client are adapted to the needs of the client at any given time in the program.
Assertive Community Treatment	Assertive Community Treatment (ACT) is an integrated team-based approach designed to provide comprehensive community-based supports to help people remain stably housed. These teams may consist of physicians and other health care provides, social workers and peer support workers. ACT teams are designed for clients with the most acute needs and may provide support on an ongoing basis.
At Risk of Homelessness	A person or family that is having trouble maintaining their housing and has no alternatives for obtaining subsequent housing. Circumstances that often contribute to becoming at risk of homelessness include: eviction; loss of income; unaffordable increase in the cost of housing; discharge from an institution without subsequent housing in place; irreparable damage or deterioration to residences; and fleeing from family violence.
Available Spaces	The number of program spaces to be filled through Coordinated Access and Assessment.
By-Name List	A By-Name List is a real-time list of all people experiencing homelessness in the community. It 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. This real-time actionable data supports triage to services, system performance evaluation and advocacy (for the policies and resources necessary to end homelessness).
Case Management	A process of service coordination and delivery on behalf of Clients which includes assessment of the full range of services needed by the Clients, implementation, provision of support, coordination and monitoring of services, and termination with appropriate referrals when the organization's direct service is no longer needed (Calgary Homeless Foundation, 2014).

[58] http://calgaryhomeless.com/wp-content/uploads/2014/05/System-Planning-Framework-May-2014.pdf
[59] Sometimes referred to as unhoused.

Chronically Homeless	Those who have either been continuously homeless for a year or more, or have had at least four episodes of homelessness in the past three years. To be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency homeless shelter. People experiencing chronic homelessness face long term and ongoing homelessness related to complex and persistent barriers related to health, mental health, and addictions.
Cohort	Similar programs are grouped together to form cohorts. Cohorts are created with the following considerations; sub-population, acuity and program type, and are used for comparison basis for Benchmarks and Key Performance Indicators.
Coordinated Access and Assessment	A single place or process for people experiencing homelessness to access housing and support services. It is a system-wide program designed to meet the needs of the most vulnerable first and creates a more efficient homeless serving system by helping people move through the system faster, reducing new entries to homelessness, and improving data collection and quality to provide accurate information on client needs.
Cyclical homelessness	When an individual or family moves in and out of various states of homelessness and housing such as moving from a motel to a low-cost rental to a point of incarceration to a shelter to a hospital stay, and so on. The cycle suggests that this is a pattern of housing status that can has some consistency in the movement between a homeless and housed state, even though the exact types of housing or homelessness may change.
Disabling Condition	A diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. A disabling condition limits an individual's ability to work or perform one or more activities of daily living.
Eligibility Requirement Program	This program has eligibility requirements, but does not dramatically impact the flow from Coordinated Access and Assessment, as these requirements could be changed in the next contract cycle.
Emergency Shelter	Any facility with the primary purpose of providing temporary accommodations and essential services for homeless individuals.
Episode of Homelessness	An episode of homelessness consists of a minimum of one (1) night of homelessness. Thirty consecutive days of non-homelessness must lapse before a new experience of homelessness is the start of a new episode of homelessness. Any stays that are separated by less than thirty days are part of a single episode.
Episodically Homeless	A person who is homeless for less than a year and has fewer than four episodes of homelessness in the past three years. Typically, those classified as episodically homeless have reoccurring episodes of homelessness because of complex issues such as addictions or family violence.
Family Unit	Those who are homeless and are: parents with minor children; adults with legal custody of children; a couple in which one person is pregnant; multi-generational families; part of an adult interdependent partnership. Many members of this group are women fleeing abusive domestic situations and are struggling to re-establish independent homes for themselves and their children.
Flow	Refers to the number of clients that will naturally cycle throughout the program, allowing more spaces for new clients.

Funded Program Spaces	Refers to funded spaces in a Housing First Program. Includes spaces for physical housing as well as for case management, rent supplements, and client supports.
Harm Reduction	Refers to policies, programs, and practices that seek to reduce the adverse health, social, and economic consequences of the use of legal and illegal substances and risky sexual activity. Harm reduction is a pragmatic response that focuses on keeping people safe and minimizing death, disease and injury associated with higher risk behavior, while recognizing that the behavior may continue despite the risks (BC Centre for Disease Control, 2011).
Hidden Homelessness (Invisible Homelessness)	When an individual or family does not access emergency shelters or sleep in visible public areas, usually because they are temporarily staying with friends or family.
Homeless Individuals and Families Information System (HIFIS)	An electronic database that collects and securely stores information about the unsheltered (absolutely homeless) population.
Homeless Management Information System (HMIS)	An electronic database that collects and securely stores information about the homeless population throughout the System of Care.
Homeless	Homelessness describes the situation of an individual or family without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it. It is the result of systemic or societal barriers, a lack of affordable and appropriate housing, the individual/household's financial, mental, cognitive, behavioural or physical challenges, and/or racism and discrimination. Most people do not choose to be homeless, and the experience is generally negative, unpleasant, stressful and distressing (Canadian Observatory on Homelessness, 2012).
Homeless System of Care	The continuum of program types funded to deliver services to those experiencing homelessness using best practices, key performance indicators and an organized and professional method of service delivery. The Homeless-Serving System of Care is only a part of the greater system of care. The homeless-serving serving system of care include 10 programs: prevention services, emergency shelter, outreach, affordable housing, transitional housing, coordinated access and assessment, adaptive case management, supportive housing, permanent supportive housing, and assertive community treatment.
Housing First	Adopting a Housing First approach means that permanent housing is provided directly from homelessness, along with needed support services, without the requirement of a transition period or of sobriety or abstinence. Support services may include intensive medical, psychiatric and case management services including life skills training, landlord liaison assistance and addictions counseling. Addressing these needs through support services helps people maintain their housing over the long term.
Housing Stability	The Housing Stability key performance indicator is measured by three areas: • Percentage of clients who remain consecutively housed in a program for at least nine /six months or more and are currently housed

	• Percentage of clients who have graduated the program and have not achieved nine/six months of housing in a program • Percentage of clients who completed program with a positive reason for leaving returning to shelter within one year
Intensive Case Management	Similar to Assertive Community Treatment (ACT), this model also provides outreach services, lower caseload ratios and coverage outside of regular working hours. The main difference from ACT is that services are not delivered by multidisciplinary teams and ratios are higher, usually 1 staff to 20 clients.
Length of Housing Stability	In housing programs, calculated as the number of days between program entry date and program exit date.
Length of Stay	The cumulative number of days a client or household is enrolled in a residential program per episode.
Length of Stay in Homelessness	The number of days in a homeless episode. The type of homelessness/shelter situation may vary significantly within the episode.
Low-barrier Program	These programs accept any clients from Coordinated Access and Assessment if space is available.
Non-Market Housing	Non-market housing varies in its operations, but commonly has rents below market value, may provide social services or supports, and is typically targeted to individuals and families with low-incomes. Non-market housing is typically described as subsidized, social or affordable housing units.
Occupancy	Represents the number of clients accepted into the housing program. Occupancy does not refer to the number of people housed. For example, scattered-site programs accept clients and then begin the housing search. Thus, clients can be in a program and receiving case management while they remain in homelessness.
Outreach	Outreach programs provide basic services and referrals to chronically homeless persons living on the streets and can work to engage this population in re-housing.
Period Prevalence Count	The proportion of the population that is homeless at some time during a given period (e.g. 12-month prevalence), and includes people who already are homeless at the start of the period as well as those who become homeless during that period.
Permanent Supportive Housing (PSH)	Long term housing for people experiencing homelessness with deep disabilities (including cognitive disabilities) without a length of stay time limit. Support programs are made available, but the program does not require participation in these services to remain housed.
Place-Based Housing	Refers to physical housing with program supports for individuals with high acuity.
Point in Time Count (PiT)	A PiT Count is used to enumerate sheltered and unsheltered homelessness in a community. PiT Counts also include an anonymous survey seeking information on the characteristics of a community's homeless population (e.g., age, gender, Veteran status, Indigenous identity). The PiT is usually completed on one day and provides a "snapshot" of homelessness in a community.
Prevention Services	Prevention Services offer short term financial assistance and limited case management to prevent housing loss due to a housing crisis.

Primary Prevention	The first level of prevention, focused on preventing new cases of homelessness or 'closing the front door' to the shelter.
Priority (Match) List	A subset of the Coordinated Access List that identifies those with the highest priority for matching to an available housing resource.
Rapid Rehousing Programs	Provide targeted and time-limited financial assistance, system navigation, and support services to individuals and families experiencing homelessness to facilitate their quick exit from shelter and obtain housing.
Recidivism	The rate in which a client receives a positive housing outcome and returns to shelter or rough sleeping.
Registry Week	A coordinated outreach and triage assessment process (held over several days) to gather actionable, person-specific data on people experiencing homelessness (within a defined geographic area). This information includes, at minimum, people's names and acuity.
Relative Homelessness	Those living in spaces that do not meet the basic health and safety standards including protection from the elements; access to safe water and sanitation; security of tenure and personal safety; affordability; access to employment, education and health care; and the provision of minimum space to avoid overcrowding.
Scattered-Site Housing	Individual housing units scattered throughout the city. Rental units are made affordable through accompanying rental subsidies (when in the private rental market) or are rented through non-profit housing providers.
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.
Sheltered Homelessness	When an individual/family is without a residence and spends the night in an emergency shelter or similar institution, including having no fixed address and staying overnight in a hospital, jail or prison.
Sober Programs	These programs require sobriety of clients. Thus, they have multiple barriers and restrictions and often serve low acuity clients due to the eligibility parameters. For example, the client must: be sober for a certain amount of days prior to entry and have an income of $1000 or a clean criminal record.
Successful Housing Outcomes	The positive destination for a client leaving a program. Positive destinations vary depending on the type of program the client is exiting. For instance, a client leaving a Housing & Intensive Supports program only has a positive outcome if they are going to own their own place, rent a place, or stay with family for a permanent tenure.
Supportive Housing (SH)	Supportive Housing (SH) provides case management and housing supports to individuals and families who are considered moderate to high acuity. In SH programs, the goal for the client is that over time and with case management support, the client(s) will be able to achieve housing stability and independence. While there is no maximum length of stay in SH programs, the housing and

	supports are intended to be non-permanent as the goal is for the client to obtain the skills to live independently, at which point the client will transition out of the program and into the community, where they may be linked with less intensive community-based services or other supports.
System of Care	A local or regional system for helping people who are homeless or at imminent risk of homelessness. A System of Care aims to coordinate resources to ensure community level results align with strategic goals and meet client needs effectively. The System of Care is composed of the following program types: housing loss prevention, coordinated access and assessment, emergency shelter, rapid rehousing, supportive housing, permanent supportive housing, and affordable housing.
System Planning	Creating a system of navigation for accessing services from many different agencies, resulting in a system of care.
Transitional Housing	Transitional housing refers to a supportive – yet temporary – type of accommodation that is meant to bridge the gap from homelessness to permanent housing by offering structure, supervision, support (for addictions and mental health, for instance), life skills, and in some cases, education and training
Transitionally Homelessness	Homeless for the first time (usually for less than three months) or has had less than two episodes in the past three years. The transitionally homeless tend to enter into homelessness as a result of economic or housing challenges and require minimal and one-time assistance.
Triaging	The process for determining the priority of clients based on the severity of their condition.
Unhoused	Those living on the street with no physical shelter of their own, including those who spend their nights in emergency shelters.
Violence against women (VAW) shelters	Facilities providing temporary shelter to single women or women with children fleeing domestic abuse. They may function in either a crisis capacity or as transitional or second-stage housing.
Vulnerability Index – Service Prioritization Decision Assistance Tool	The Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) was developed as a pre-screening tool for communities that are very busy and may not have the resources to conduct a full SPDAT assessment for every client. It was made in collaboration with Community Solutions, creators of the Vulnerability Index, as a brief survey that can be conducted to quickly determine whether a client has high, moderate, or low acuity. The use of this survey can help prioritize which clients should be given a full SPDAT assessment first. Because it is a self-reported survey, no special training is required to use the VI- SPDAT assessment.
Wrap-Around Supports	Services that help address a homeless individual's underlying causes of homelessness. These support services include medical and psychiatric case management, life skills training, landlord liaison assistance, and addictions counseling.
Youth Homelessness	A homeless youth is an unaccompanied person age 24 and under lacking a permanent nighttime residence. They can be living on the street, in shelters, couch surfing, in unsafe and insecure housing, and living in abusive situations. They may also be about to be discharged without the security of a regular residence from a care, correction, health, or any other facility.

ATTACHMENT 9

Strategic Plan to End Homelessness and Housing Poverty in Halifax Regional Municipality

The Affordable Housing Working Group (AHWG) and the Homelessness Working Group (HWG) i have developed work plans to guide their work based on a year of research and consultation with stakeholder groups and a wide array of community members. The plans are intended to guide efforts of the Housing and Homelessness Partnership, with task teams developed to focus on specific outcomes. After extensive community consultation, the HWG has developed a community plan to end homelessness in the Halifax Regional Municipality.

Goal 1: Sustain community assets in shelter, transitional, and permanent supportive housing

Target: In development

Key Activities:

- Assess and evaluate existing community assets contributing to ending homelessness
    - Define a list of existing facilities and non-profit housing sites, which contribute to ending homelessness in the HRM
    - Identify supports, services, and programs crucial to clients maintaining housing
    - Identify community assets that clients would benefit from having more of, and/or identify gaps
- Ensure quality, sustainable built form
    - Review annual operating budgets for funding of deferred maintenance and capital reinvestment
    - Create and fund a plan for resolving deferred maintenance
    - Develop an annual preventative maintenance program for facilities and non-profit housing providers to follow
    - Inspect each facility and non-profit housing sites, and create a capital replacement plan
    - Engage in capacity building in property management
    - Create a co-op of contractors to provide facilities management to service providers
- Ensure facility-related and capital operating costs are covered for shelters, transitional and permanent supportive housing
    - Determine the annual operating deficits of facilities and non-profit housing
    - Service providers work in collaboration with funders to create and fund sustainability plans
    - Negotiate block funding for facilities funded by per diem
- Develop a member-based association of all physical facilities, non-profit housing, and supportive services

Goal 2: Minimize new intakes into shelter system

Target: Decrease in shelter bed usage

Key Activities:

- Coordinate intakes and referrals pre-shelter
    - Facilitate agencies to use HIFIS 4.0 as their integrated data platform for shelter intake, housing support worker intake, and client assessment and case management
    - Research and develop best practices for data sharing protocols
    - Facilitate agencies to use SPDAT as a common tool for client assessment

    - Develop protocols and a centralized/coordinated approach to ensure that individuals are not discharged from an institution or care setting into homelessness
- Create an emergency fund to meet clients' needs to access and/or maintain housing
    - Launch an emergency fund pilot project
- Support the development of a poverty reduction strategy that addresses homelessness risk

Goal 3: Optimize lengths of stays in shelters to prevent harms associated with long shelter stays

Target: Decrease in the average length of stay in a shelter

Key Activities:

- Ensure core competencies of service providers, including shelter staff
    - Create and deliver a professional development program for service providers focused on service standardization of core competencies
    - Maintain accurate and up to date records of core competencies of certifications of service providers
- Coordinate intake and referrals in shelter
    - Create and maintain access to HIFIS 4.0
    - Train service provider staff in the use of VI-SPDAT
    - Assess all intakes using VI-SPDAT
    - Use inter-agency conferencing to place clients with the most appropriate service provider
- Create and maintain emergency housing
    - Create appropriate emergency housing options to address gaps for 2 parent families, male-led and female-led families with older male children, and people with disabilities

Goal 4: Minimize returns to shelter once housed

Target: Decrease in shelter use, returns and recurrence for individuals and families

Key Activities:

- Expand and coordinate Housing First
    - Create a single ICM team embedded with various service providers
- Enhance client supports
    - ICM/FACT/ACT to support high acuity individuals in a community setting
    - Increase the number of housing support workers to case manage lower acuity shelter users who are housed to help them stay housed
    - Access to emergency funds to stave off eviction
    - Support the development of a Poverty Reduction Strategy that addresses those experiencing, or at risk of homelessness in the HRM
    - Ensure clients have access to culturally appropriate supports, including translation services and spiritual supports
    - Identify and expand peer support opportunities to combat social isolation
    - Remediate bed bugs
    - Increase food security by ensuring access to affordable and nutritious food
    - Develop a bus pass system for low income residents
    - Increase life skills and opportunities for financial security
    - Increase social inclusion of those experiencing, or at risk of homelessness
    - Enhance addictions and mental health supports
    - Enhance social inclusion of clients
- Ensure capacity of housing supports to respond and adapt to systems change
    - Allow for transitional costs as service providers respond to environmental changes
    - Revisit role of emergency shelters in homeless serving system

ATTACHMENT 10

Homelessness Partnering Strategy Funding

Table 5: Designated Community of Halifax – Funded Projects and Programs[60]

Sponsor	Project	Description	Years	Funding
Shelter Nova Scotia	Herring Cove Apartments	Permanently supported housing for chronically and episodically homeless individuals.	2015-19	$1,623,847
	Intensive Case Management	Supports provided to chronically and episodically homeless individuals in scattered site apartments.	2016-19	$150,628
	Capital Investment	Refurbishment of Barry House (women's shelter) and Metro Turning Point (men's shelter). The project is cost shared with Housing Nova Scotia ($142,000).	2016-18	$155,000
	Capital Investment	Mero Turning Point & Sir Stanford Fleming House (transitional housing for men).	2017-18	$31,000
Adsum for Women and Children	Intensive Case Management	Support provided to high acuity women who are experiencing, or have experienced, frequent periods of homelessness in scattered site apartments or in AWC's own housing. The project is also supported by private donations.	2016-19	$88,544
	Diverting Families from Shelters to Housing	The objective is to either divert families from shelter stays or, if that is not possible, to make the shelter stay as short as possible. The initiative is supported by a private donor and reduced market rents from Killam Properties Ltd.	2017-19	$138,386
North End Community Health Centre	MOSH Housing First	Program supports ±60 high acuity individuals in scattered site apartments who have experienced long periods of homelessness. The Program is supported by housing subsidies from Housing Nova Scotia and clinical services staff seconded from the Nova Scotia Health Authority and a primary care nurse funded by the IWK & the United Way Halifax.	2015-19	$2,253,000
Salvation Army	Intensive Case Management	Supports provided to chronically and episodically homeless individuals in scattered site apartments.	2016-19	$148,396
YWCA Halifax	Housing Support	The projects provide housing placement & housing retention services and other supports to women at risk.	2016-19	$385,200
	Capital Investment	Provided funding for roof replacement at the Supportive Housing for Young Mothers apartments.	2017-18	$31,000
Elizabeth Fry Society	Housing Support	The projects provide housing placement and housing retention services and other supports to women leaving the justice system.	2016-19	$169,124
Affordable Housing Association	Data Base Integration	Contract with Barrington Consulting Group to consolidate 4 shelter data bases on a single web-based platform.	2016-18	$80,000

[60] See Designated Community of Halifax – Funded Projects/Programs

of Nova Scotia	Property Condition Assessment	Contract with exp. Services to complete building condition assessment & capital reinvestment planning for 21 properties owned by non-profit service agencies.	2017-18	$50,000
	Staff Development	Contract with Kiepek Consulting to provide motivational interviewing/assertive engagement training for 45 service agency staff.	2017-18	$4,297

Source: Affordable Housing Association of Nova Scotia