

## PH16.8 Attachment 2

Final Report

# COVID-19 Interim Shelter Recovery Strategy: Advice from the Homelessness Service System

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SEPTEMBER 2020

PREPARED FOR CITY OF TORONTO - SSHA  
AND UNITED WAY GREATER TORONTO  
BY BGM STRATEGY GROUP

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## FOREWORD FROM THE CITY OF TORONTO

Over the past few months, we have collectively taken swift and decisive action to mobilize what has been an unprecedented response to protect Toronto's most vulnerable people. We have tried to stay one step ahead of the pandemic and continue to adapt and evolve our response as the situation has continued to change rapidly.

This tremendous accomplishment would not have been possible without the tireless commitment, partnership and strong communication across the homelessness and health sectors. This has been no small task, however we continue to push forward, relentlessly, because we understand and recognize that the people we are committed to supporting depend on the services we provide.

Reflecting on this experience, it is clear that we cannot go back to the way things used to be once this pandemic is over. We have an opportunity to do things differently and when we take action collectively and mobilize towards a shared goal we can have a significant impact on the lives of people experiencing homelessness.

Looking ahead, we will continue working collaboratively with all of our partners to ensure we are prepared for a potential second wave of COVID-19. We will also leverage opportunities presented by the pandemic to shift the system towards preventing and ending homelessness by investing in permanent housing solutions that protect the health and well-being of people experiencing homelessness in Toronto.

While COVID-19 has magnified the issue of homelessness, as we shift toward recovery efforts, building on this foundation provides an opportunity to rebuild a better future for all.

I want to extend my sincere gratitude for your ongoing partnership and commitment to providing services to the most vulnerable members of our community.

**Giuliana Carbone**

Deputy City Manager, Community and Social Services, City of Toronto

## FOREWORD FROM UNITED WAY

COVID-19 has exposed something we have known for decades: our region is only as great as our ability to meet every resident's basic needs. It has revealed the inequity that exists in our region: home to great prosperity, and yet a place where too many struggle to find shelter.

We have seen how critical shelter is to a region's health. Supporting the GTA's recovery from COVID-19 means helping people experiencing homelessness find and keep housing. While the pandemic poses challenges at an unanticipated scale, it has led to solutions and opportunities that have only been imagined, but could now be realized.

The community sector plays a critical role in the solutions and service response for people experiencing homelessness. As the largest non-governmental funder of social services in the GTA, United Way partners with local governments and our network of agencies to meet urgent needs, contribute to longer term solutions for homelessness, and give people the wrap around support they need to stay housed.

By coming together across sectors -- health, community services, shelter providers and housing providers, different levels of government, and a range of funders – we can take an integrated approach to provide promise of real solutions to homelessness. By bringing forward the critical voices of Black and Indigenous populations who are disproportionately impacted by poverty and bear the brunt of COVID and homelessness, we can amplify their call for specific and concrete action.

As we meet these urgent needs in an unprecedented time, we find ourselves at a critical moment: the path we take will determine the very future of how we can build a GTA where everyone can thrive. We believe this report lays out the foundation for the right steps forward. United, we stand with our City partners to imagine a region where people no longer struggle to find stable and secure housing.

**Daniele Zanotti**

President and CEO, United Way Greater Toronto

## EXECUTIVE SUMMARY

This report offers advice to guide the City of Toronto Shelter Support and Housing Administration (SSHA), United Way Greater Toronto (United Way), community agencies, and other partners in responding to the COVID-19 pandemic in the shelter and homelessness service system over the next 12 months.

Since March, these partners have implemented a rapid and significant emergency response to protect those in shelter and respite services. We have seen silos across systems bridged as partners have worked collaboratively to provide the coordinated services demanded by the pandemic. Opening 30 new facilities and establishing transportation, screening and recovery programs all contributed to mitigating the spread of COVID-19 among people experiencing homelessness. More than 1,570 people have been housed between March and August, a 50% increase over the same period last year.

The scale of this mobilization reflects the intensity and urgency of need in the shelter system during this pandemic. COVID-19 is compounding the many challenges people experiencing homelessness already faced prior to the pandemic, creating new risks and vulnerabilities for this population. In addition to the risks the virus poses for people experiencing homelessness – many of whom have pre-existing health challenges – many shelter system clients are struggling with reduced access to services, isolation from community, worsened mental health, more limited access to safe indoor space, and heightened risk of violence. This is especially true for women in abusive situations and transgender, Black, and Indigenous individuals.

This strategy presents immediate priorities in the context of the pandemic and lays a foundation to build on in SSHA's upcoming five-year service plan. The advice offered in this report was generated through a process co-convened by SSHA and United Way, and led by a task force of leaders in the homelessness service system. The task force's input was supplemented with consultations with clients and people with lived experience, health partners, frontline staff, and other partners detailed in this report's Introduction. At the suggestion of Indigenous members of the task force, SSHA and United Way also convened a separate process to engage the Toronto Indigenous Community Advisory Board to create a separate, parallel strategy for Indigenous people experiencing homelessness, included on page 26 of this report.

The advice offered in this report reflects the collective expertise of contributors, lessons learned from the first phase of the pandemic, and established knowledge about solutions to prevent and end homelessness that COVID-19 has created even more urgency to implement.

The advice put forward in this report is summarized below.

## Priorities for action in the next 12 months

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### **Invest in housing and supports to decrease the volume and duration of need for emergency shelter.**

1. Shift resources from respite centres and shelters that are no longer viable to invest in housing supports.
  - 1.1. Develop and begin to act on an acquisition strategy for hotels, rooming houses, and other buildings, such as office spaces or residential buildings.
  - 1.2. Conduct a redevelopment plan to repurpose shelter space that is no longer viable into permanent housing infrastructure.
  - 1.3. Expedite development of modular housing units and work with community agencies to expedite housing already in the pipeline to provide safe space over the winter and beyond.
2. Explore an integrated approach to funding supports in shelter and in housing.
  - 2.1. Funders and providers work together to re-examine the system of supports needed for people in shelter and as they move into housing, with an aim to integrate and coordinate support dollars.

### **Deepen collaboration and coordination with health partners.**

3. Continue working with health partners, including Ontario Health and Toronto Public Health and others, to improve and expand Infection Prevention and Control (IPAC) measures in shelter and community settings.
  - 3.1. Continue IPAC measures that have been helpful, and work to make them more ingrained and consistently accessible throughout the shelter system.
  - 3.2. Work to broaden shared understanding about centralized protocol and guidelines for transfers to and from testing, and for actions to be taken in the event of positive test results.
  - 3.3. Provide more proactive, in-person IPAC and public health guidance tailored to the homelessness service sector.
4. Work with health partners to ensure all shelters are connected with a primary care provider.
  - 4.1. Implement the Coordinated Health Services for Shelter Clients Framework.

### **Shift the way we shelter people to provide COVID-safe, dignified options.**

5. Ensure people in encampments have a safe alternative and are supported to come indoors.
  - 5.1. Address issues in shelters driving the perception that encampments are safer in the pandemic.
  - 5.2. Increase presence for community organizations to proactively build relationships and options for people in encampments, and minimize the need for policing.
6. Repurpose funding for services that are no longer feasible post-COVID.
  - 6.1. Reimagine investments in programs that are no longer tenable in the pandemic before winter. Renewed programming should aim to provide housing and supports services that are low-barrier, consistent, and operate 365 days a year.

## **Minimize the flow of people into traditional emergency shelters.**

7. Prevent re-entries into traditional shelters or being unsheltered for those currently housed in hotels and other accommodations.
  - 7.1. Ensure the continuation of hotels and other housing strategies from the first wave of COVID-19.
  - 7.2. Ensure those in COVID response programs including hotels are assisted to move into permanent housing.
8. Prevent entries into the shelter system due to evictions and discharges from other systems.
  - 8.1. Convene a regional table focused on collaborative discharge planning.
  - 8.2. Expand financial supports for households at risk of eviction.

## **Priorities for action to address Black homelessness in the next 12 months**

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### **1. Address the disproportionate representation of Black people in Toronto's homeless population.**

- 1.1. Develop a distinct strategy to address Black homelessness in Toronto.

### **2. Promote Black leadership in homelessness services.**

- 2.1. SSHA and United Way can leverage their influence as funders to help community agencies diversify their boards, executive staff, and frontline staff.
- 2.2. Expand invitations to tender to include more Black-led organizations.

### **3. Collect and act on data to address inequitable outcomes.**

- 3.1. Implement a racial equity tool to collect data on racial disparities in the shelter system, and design interventions with Black leadership to act on this data.
- 3.2. Begin conducting a regular survey of Black service users and staff in the shelter system.

### **4. Work with the homelessness service system to ensure all providers operate from an anti-Black racism framework.**

- 4.1. SSHA and United Way can leverage their influencers as funders to ensure all homelessness service providers work with reputable advisors to develop an anti-Black racism strategy.

## **Priorities for action to address Indigenous homelessness in the next 12 months**

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### **1. Prioritize Indigenous-specific housing in strategies to secure more permanent housing infrastructure.**

- 1.1. Adopt an Indigenous-specific track to an acquisition strategy.
- 1.2. Create a plan for newly acquired housing to serve as long-term housing for Indigenous individuals that is owned and operated by Indigenous non-profit providers.

### **2. Expand Indigenous-led outreach and supports for Indigenous individuals during the pandemic.**

- 2.1. Ensure Indigenous providers operating new sites have autonomy to serve individuals through an abstinence-based approach.
- 2.2. Support Indigenous agencies to provide outreach and support to Indigenous individuals in encampments.
- 2.3. Sponsor an Indigenous-led low-barrier respite program.

**3. Establish protocol to ensure Indigenous individuals who have been moved into new housing are connected with an Indigenous provider.**

- 3.1. Establish clear protocol and communications channels to ensure that any time an Indigenous individual is moved (e.g. from an encampment to a hotel or other housing unit), an appropriate Indigenous provider is contacted to ensure the individual is offered access to Indigenous-led supports.

**4. Support Indigenous providers to act quickly and lead solutions.**

- 4.1. SSHA and all other relevant funders should continue to be flexible to enable Indigenous organizations and those closest to the frontlines to quickly identify and implement solutions, and respond to changing circumstances.



## INTRODUCTION

This report offers advice to guide the City of Toronto - Shelter Support and Housing Administration (SSHA), United Way Greater Toronto (United Way), agencies and other partners in responding to the COVID-19 pandemic in the shelter and homelessness service systems over the next 12 months.

This advice also offers a foundation for long-term collaboration on best practices, policy, and strategic investments to end homelessness in the Toronto region. The strategy outlined in this document is intended to prepare for the second wave of COVID-19 and bridge to the renewal of regular long-term planning upended by the pandemic. It concedes the likelihood that COVID-19 will be with us for some time, and hopes to build on the momentum, experience, and expertise that have been hard-won in a very short time. This strategy represents the sum of what we have learned so far, while recognizing we are still working in a situation of firsts.

Since the provincial state of emergency was declared in March, SSHA, United Way, and community partners have implemented a rapid and significant emergency response to protect people experiencing homelessness in Toronto and the staff who serve them. The pandemic has pushed the homelessness service system and its partners to accelerate integration and collaboration—especially the health sector—in real time. Community agencies and the municipal government have demonstrated a remarkable capacity to mobilize quickly and find creative solutions to meet urgent need. With more than 1,570 people housed between March and August, along with the creation of transportation, screening and recovery programs and establishing 30 new facilities, we have seen what political will and resources can accomplish.

At the same time, COVID-19 has highlighted areas in the homelessness service system that were already in need of redesign and brought a host of new challenges for the system and the people who rely on it. Physical distancing requirements have reaffirmed how dormitory-style shelters are not only counterproductive to supporting clients' health, wellbeing, and exits from homelessness, but in the pandemic have proven untenable. As people's access to trusted communities and supports was interrupted due to COVID-19 closures, the opioid epidemic continued: July marked the highest cluster of overdose fatalities since Toronto Public Health began tracking data three years ago.<sup>1</sup> The pandemic has reduced access to many services and safe spaces, especially for women experiencing domestic violence, members of the LGBTQ2S+ community, and Black, Indigenous, and People of Colour (BIPOC) individuals who already faced heightened risk of violence and additional barriers to accessing services. Breakdowns between jurisdictions and sectors—such as provincial systems discharging people into homelessness, or the health system lacking relationships with shelters to coordinate timely testing—quickly result in overcrowded downtown emergency departments and growth in encampments as people take solutions into their own hands.

During COVID-19, the consequences of action, or inaction, are evident and immediate. Further, the dangers in allowing homelessness to continue are now palpable to the broader community. As we move forward, a few things are clear:

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<sup>1</sup> Chris Fox, "Toronto Public Health issues warning after 15 suspected overdose deaths in a week," CTV News, July 17, 2020 (Accessed July 30, 2020), <https://toronto.ctvnews.ca/toronto-public-health-issues-warning-after-15-suspected-overdose-deaths-in-a-week-1.5028938>.

First, COVID-19 continuing to spread among individuals who lack access to safe housing is a risk not only to their lives, but also to the safety of the broader public, to the capacity of the health system, and to the reopening and recovery of the Toronto region's economy. For a city representing 20% of Canada's GDP, addressing COVID-19 in the homelessness sector in Toronto is a matter of national concern.

Second, though the COVID-19 emergency will pass, we need to act as though our response will be permanent. What we do in our pandemic response will create a new mold for homelessness services. We need to adopt approaches that will work during COVID-19 and not compound our challenges afterward. We need to make sure our pandemic response also moves us in the right direction to end homelessness, which includes addressing systemic racism that perpetuates homelessness so disproportionately for Black and Indigenous people.<sup>2</sup> This is an opportunity to set a direction that will be enduring.

Third, the solutions to homelessness and the spread of COVID-19 are one and the same. Safe and adequate shelter has proven to be the best line of defense against the virus. Protecting everyone from the spread of the virus necessitates a better response for people experiencing homelessness in Toronto. This response requires the cooperation of many actors: it requires a leap of trust from people experiencing homelessness, who have often been let down; leadership from every order of government; and the support and understanding of all Toronto residents that keeping everyone in the city safe is a shared responsibility, in every neighbourhood.

As two of the largest funders and collaborators of the local social services network, SSHA and United Way have partnered on this strategy because COVID-19, and our collective response, hinge on our interconnectedness. This strategy was built in consultation with a broad range of organizations and individuals who are all integral to the solution.

As we approach winter and a forecasted second wave of COVID-19, the challenges facing Toronto's shelter system, and their impacts on the individuals in this system and the broader public, will intensify. The COVID-19 emergency demands we sustain the significant interventions made to date and improve upon them. A pandemic response is only as strong as its weakest link. This strategy aims to strengthen our COVID-19 protections for the most marginalized.

**“Three months ago the idea of rapidly housing this number of people would have been unthinkable. Look at what has happened. It is an extraordinary testament that we do not have to accept homelessness as a reality.”**

-Policy expert

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<sup>2</sup> City of Toronto, “2018 Street Needs Assessment,” p. 14, 20, <https://www.toronto.ca/wp-content/uploads/2018/11/99be-2018-SNA-Results-Report.pdf>.

## About this strategy

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This advice was generated through a process co-convened by SSHA and United Way, and led by a task force of leaders in homelessness service sectors. The task force's input was supplemented with consultations with:

- Clients and people with lived experience.
- Executive staff of organizations operating shelters, respite centres, and hotels.
- Frontline staff across the homelessness, health, and broader community sectors.
- Health partners.
- Other municipalities within the region.
- Black-led and Black-serving organizations.
- The Violence Against Women (VAW) sector.
- Research and data specialists.
- SSHA staff.

At the suggestion of Indigenous members of the task force, SSHA and United Way also convened a separate process to engage the Toronto Indigenous Community Advisory Board to create a separate, parallel strategy for Indigenous people experiencing homelessness. This strategy can be found on page 26, while important considerations for Indigenous communities that relate to suggestions for the broader sector can be found throughout the main body of this report.

This report was written by BGM Strategy Group on behalf of all contributors. The wisdom is theirs; any errors are ours. A full list of all contributors consulted for this report can be found in Appendix A.

## PRIORITIES FOR ACTION IN THE NEXT 12 MONTHS

### Invest in housing and supports to decrease the volume and duration of need for emergency shelter

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Emergency shelters serve much like the emergency department in a hospital: they are an essential last resort in cases of immediate emergency, spaces for short term safety and recovery. The best path to permanent healing is to help people move on from them as quickly as possible.<sup>3</sup> The City of Toronto's *HousingTO: 2020-2030* recognizes this in committing to making individuals' stays in the shelter system rare, brief, and non-recurring.<sup>4</sup>

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<sup>3</sup> The Violence Against Women shelter sector operates on similar principles but a longer timeline. For women and families fleeing violence the VAW shelter sector provides a safe space and time for healing, and it is beneficial for women to remain for a longer period of time in the shelter as part of their healing than one would recommend in the emergency shelter system.

<sup>4</sup> City of Toronto, "HousingTO: 2020-2030 Action Plan," December 2019, p. 25, <https://www.toronto.ca/wp-content/uploads/2020/04/94f0-housing-to-2020-2030-action-plan-housing-secretariat.pdf>.

In 2019, 26,000 different people used Toronto’s shelter system, most of whom exited the shelter system within three months. A smaller group of approximately 5,000 people (22%) are chronically homeless and stay in the shelter system for six months or more.

Housing strategies need to account for the needs of both of these groups and their impacts on shelter capacity. Providing permanent supportive housing for the 5,000 people who remain in the shelter system for six months or more is critical both to meeting their needs, and ensuring the system has the capacity to perform its intended function of serving as a pathway to stable housing for those in emergencies. Securing units for rapid rehousing ensures that those in immediate emergencies do not have their situation compounded by new challenges in the shelter system, which evidence shows increases their likeliness of repeated, longer experiences of homelessness.

In Toronto, the average cost of operating a supportive housing unit is \$24,000 annually, while the average cost of operating a single shelter bed is \$40,000—nearly doubling to \$80,000 during the pandemic.<sup>5</sup> Even in the absence of a pandemic, people experiencing homelessness are hospitalized up to five times more often than the general public, typically for much longer stays, with an average monthly cost of \$10,900 per person.<sup>6</sup> These costs are amplified during the pandemic, when emergency departments are over capacity specifically with patients who are experiencing homelessness. Providing housing for people experiencing homelessness is not only imperative to saving lives, but also to recovering from budget deficits at all levels of government.

Transitioning investments from emergency responses to longer-term dignified housing saves money overall, but requires upfront investment that has hindered the shift, often making short-term and long-term solutions seem like a zero-sum game. COVID-19 has changed the economics: with shelters operating at a fraction of capacity to allow physical distancing and other infection prevention and control measures, it is now more economical to provide housing than emergency shelter. We have also seen in the first 100 days of pandemic response that swift action and successful housing of people experiencing homelessness is possible.

**“If you don’t house people, then you have vast bills for other kinds of services. If we continue to have people without the ability to self-isolate, we will all continue to have a depressed economy.”**

-Emergency department physician

The next 12 months are pivotal to embedding and furthering the shift to more long-term and dignified options that provide for greater safety and health through COVID-19 and beyond.

- 1. Reprofile operating resources from respite centres and shelters that are no longer viable with physical distancing in place to invest in housing supports.** Redistributing resources from respite centres and shelters that are not viable operating at partial capacity to

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<sup>5</sup> Figures provided by SSHA staff member, July 2020.

<sup>6</sup> Stephen Gaetz, “The Real Cost of Homelessness: Can We Save Money by Doing the Right Thing?” 2012, p. 5, 8, [https://www.homelesshub.ca/sites/default/files/attachments/costofhomelessness\\_paper21092012.pdf](https://www.homelesshub.ca/sites/default/files/attachments/costofhomelessness_paper21092012.pdf).

enable a range of housing strategies, including rapid rehousing, transitional housing, and permanent supportive housing.

Proposed actions:

- 1.1. **Develop and begin to act on an acquisition strategy for hotels, rooming houses, and other buildings such as empty office spaces or residential buildings.** This strategy should look for buildings that can offer blended opportunities for private space, as well as shared space for clients to have connection to community. This may entail adjustments or conversions of existing physical spaces that are relatively simple to achieve.

This strategy should build in consideration of potential community partnerships to enable non-profit ownership. Doing so will ensure investments made through this acquisition strategy contribute to strengthening the capacity of the non-profit sector and preserve assets for affordable housing in perpetuity.

Including rooming houses in this strategy will expand capacity in a critical part of the system that is in need. For many individuals, rooming houses are the only available housing option enabling them to avoid homelessness. Rooming houses are also particularly vulnerable to sale and redevelopment, which risks diminishing this already scarce resource.

**“We’ve been hearing ‘it’s simply not possible or realistic’ for years. Then suddenly it was. If we decide it’s a priority, we can do it.”**

-Policy expert

This strategy should also explore buildings across Toronto’s geography, including the downtown core. While living outside of the downtown core is suitable, and even preferable, for some individuals, for others, being moved into housing outside downtown severs their connection to important services and communities. An acquisition

strategy should include a range of geography that enables connection to community and services for all clients.

Recognizing SSHA and United Way do not provide capital funding, partnership and support from other areas of the City and other orders of government would be required to enable acquisition. SSHA could reprofile operating and support funding to pair with capital funding for acquisition.

- 1.2. **Conduct a redevelopment plan to repurpose shelter space that is no longer viable into permanent housing infrastructure.** Since March, approximately 2,300 spaces have been moved out of existing shelter programs to achieve physical distancing. Many of these shelters are operating at reduced capacity may not be financially viable, while many other shelters are not configured to support physical distancing and access to safe, private space. This creates an opportunity to repurpose shelters that are no longer viable into transitional or permanent supportive housing, and transition remaining shelter space away from a congregate, dormitory model towards physical layouts that promote safety and dignity while helping prepare clients to move into housing. SSHA has identified over 30

sites that could be repurposed into housing.

Repurposed shelter space could serve as permanent or transitional supportive housing, and should serve those with high supports needs who have remained in the shelter system during the pandemic, as rapid rehousing strategies are less appropriate for them. This action recognizes the subset of people who already use the shelter system as de facto permanent housing, and constructs appropriate housing around them, diminishing need for shelter capacity.

Repurposing shelter space will require:

- Creating a redevelopment plan of all identified shelters to determine their potential for conversion, and which locations to start with for speedy transition and to avoid displacing individuals.
- Working with City Planning, Toronto Building, Committee of Adjustment, and Housing Secretariat to accelerate the conversion of shelter space into permanent housing infrastructure.
- Consideration of the services and supports that will be required in these repurposed spaces, and working with the agencies who are currently operating these shelters to consider implications on their staffing and service delivery.
- Working with professionals with design expertise to ensure the repurposed spaces facilitate the support needs of the individuals who will be housed within, as well as the accessibility needs of aging clients and clients with disabilities. People currently occupying these shelters, many of whom have resided at these locations for a long time, should be central to the redesign process.

**1.3. Expedite development of modular housing units and work with community agencies to expedite housing already in the pipeline to provide safe space over the winter and beyond.** Modular housing units are inexpensive, can be implemented quickly, and could serve individuals currently in encampments. Alongside this model, the City of Toronto can reach out to community housing partners to expedite housing projects that are already underway. Together, these actions can grow housing stock immediately to serve individuals during the winter—stock that will also serve as permanent housing infrastructure. This will require utilizing operating funds for shelter and respite spaces that are no longer viable due to COVID-19.

## **2. Explore an integrated approach to funding supports—in shelter and in housing.**

Proposed action:

**2.1. Funders and providers work together to re-examine the system of supports needed for people in shelter and as they move into housing, with an aim to integrate and coordinate support dollars.** Funders such as United Way, the Ministry of Children, Community and Social Services, Local Health Integration Networks, and SSHA can work together with providers and people with lived experience to examine the system of supports available to people in shelter, and after exiting shelter to housing. Review across programs with an aim to improve shared effectiveness, eliminate duplication, improve integration, and adapt for changes to need or service organization as a result of the pandemic. Integrated reviews will also enable the reprofiling of operating funds from shelter support to housing support.

**“Most of the help I’ve received since the pandemic started has come from the community. These supports helped me with my fear of everything going on and kept me balanced.”**

-Shelter system client

These areas for action advance a new approach to providing housing and shelter for those in the shelter system. These actions can be pursued simultaneously and present solutions for different subpopulations. An acquisition strategy would enable a quick resolution to homelessness for refugees and others who can benefit from rapid rehousing strategies. Retrofitting shelters into permanent housing would recognize the reality of people experiencing chronic homelessness who are already living in shelters, and provide them with the physical space and supports to establish stability.

In moving forward with these actions, intentional consideration must be given to the distinct needs of these subpopulations, such as:

- Young people experiencing homelessness will require a youth-specific approach that intervenes before they become chronically homeless, with housing and supports that help them transition to independent living in a holistic sense.
- Women fleeing violence require VAW-specific supports to ensure their safety, or they will be unable to remain in their new housing.
- Indigenous individuals moving into new housing must have access to culturally appropriate, Indigenous-led supports.

The physical forms put forward in this section must be accompanied by appropriate supports and operating funding. Community agencies must be supported to provide clients with the full range of wrap-around supports they need—including health care and harm reduction services—as well as opportunities for connection to community to address the heightened social isolation and overdose risk that many individuals are experiencing during the pandemic.

Doing so will require cross-sectoral collaboration. New housing sites offer an opportunity to pilot interdisciplinary supports arrangements over the next 12 months that can be evaluated and expanded in SSHA’s upcoming five-year plan.



## Deepen collaboration and coordination with health partners

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COVID-19 has accelerated collaborative problem solving between the health and shelter systems and shown that partners in both systems have the ability to work together to develop quick, creative responses to meet need. The collaboration that has taken place during the pandemic has also highlighted existing areas for improvement in how people experiencing homelessness receive care within the health and shelter systems.

**“In spite of how difficult this has been for the people we serve and each other, there has been incredible commitment and amazing creativity coming up from so many partners.”**

-Physician

Health and shelter systems have a shared mandate in serving people experiencing homelessness: collaboration and coordination needs to be sustained and deepened over the next 12 months to minimize the spread of COVID-19. This moment also offers an opportunity to move forward with a more intentional framework to deliver new models of care that are centred on community need and elevate the expertise of the community sector in developing population health responses.

These actions reflect where efforts are currently needed, recognizing how rapidly knowledge and events can evolve during the pandemic. Consistent communication and clear roles and responsibilities have been, and will continue to be, the cornerstone of effective pandemic response to prevent infection and spread among people experiencing homelessness.

**3. Continue working with health partners, including Ontario Health and Toronto Public Health and others, to improve and expand IPAC measures in shelter and community settings.** IPAC measures established in the first wave of COVID-19 need to be sustained, and additional IPAC measures and resources need to be put in place as the pandemic continues to unfold.

Proposed actions:

**3.1. Continue IPAC measures that have been helpful, and work to make them more ingrained and consistently accessible throughout the shelter system.**

IPAC measures that have been recognized as helpful and important to continue include:

- Coordinating the provision of PPE for frontline staff and clients.
- Providing tools to screen and monitor clients and frontline staff.
- Operating specific programs for isolation and recovery.
- Transportation coordination programs to move clients from shelters and community settings to housing and other sites for physical distancing, isolation, or recovery.
- Facilitating access to testing and supporting mobile testing.

**3.2. Work to broaden shared understanding about centralized protocol and guidelines for transfers to and from testing, and for actions to be taken in the event of positive test results.**



Providers within both health and shelter systems have expressed receiving conflicting information from Toronto Public Health, the provincial government, and the Premier about when to do testing. The health and shelter systems should work to establish shared protocols with specific pathways to care, and provide clear, consistent communication about when to do testing and when to transfer individuals to appropriate sites.

Those in the health and shelter systems also need to have a shared understanding of protocol to clearly communicate with clients about why they are being tested, and any plans to relocate them. Many clients have not received clear communication, which has made testing and relocation traumatic.

### 3.3. Provide more proactive, in-person IPAC and public health guidance tailored to the homelessness service sector.

Shelters, drop-ins, and other community agencies need more intensive, in-person guidance beyond what more generic online resources offer, and would benefit from expanded public health expertise that can provide support and guidance for specific sites. Both clients and staff would benefit from in-person coaching and support to understand and apply physical distancing and IPAC advice in specific community-based settings, or how to negotiate noncompliance and prioritize public health advice in sometimes chaotic circumstances. United Way can leverage its convening and communications role to extend this expertise across shelter, VAW, and community sectors, to help others proactively implement IPAC measures.

- 4. Work with health partners to ensure all shelters, drop-ins and respites are connected with health care providers.** Much work has already been done to create a framework and guidelines for integration between the shelter and health systems. During the first stage of the pandemic, the ad hoc nature of shelters' relationships with health system partners was made plain in the time and trouble it took to form a response. Shelters with an established relationship responded faster, and the lack of health system connection to, and knowledge of, the shelter system was made manifest in events that St. Michael's Emergency Department came to call Code Orange: when the emergency department is over capacity, specifically with COVID-19 patients who are homeless.

Through the coordination of Ontario Health Toronto Region and planning tables, many shelters have connected with hospitals to facilitate testing and response in instances of positive cases. Over the next 12 months, connecting homelessness service users with a primary health care provider can serve as pilots to be expanded on in SSHA's upcoming five-year service plan—for example, by broadening these relationships to include a broader suite of health services required by clients experiencing homelessness, such as specific mental health services and geriatric care. Connection to vital health services must also consider harm reduction supports for people who use drugs, especially as overdose deaths have increased dramatically during the pandemic, as many individuals have been disconnected from their communities and harm-reduction services.

Proposed action:

#### 4.1. Implement the Coordinated Health Services for Shelter Clients Framework.

In 2018, SSHA, the Central East Local Health Integration Network (LHIN), and the Toronto Central LHIN developed an approach to planning and delivering coordinated health service delivery models, and to supporting care continuity for people who are living at shelters and as they transition to and from other settings.

Commitment to implementation of this Framework, first in new program sites without existing connections to community resources, then across the full shelter system—including VAW sector shelters will enable faster response times as the pandemic unfolds and greater continuity of care across settings for vulnerable populations, especially during the pandemic as individuals are being moved between different health and shelter settings. Rapid application of this Framework will require the LHINs/Ontario Health to designate lead health sector partners to work with SSHA in prototyping this Framework in shelters.

SSHA, United Way, and lead health sector partners should work together to ultimately implement the Framework across and beyond the shelter system to ensure people experiencing homelessness have equitable access to the full range of health services in shelter or community.

**“While COVID-19 has presented a particular set of needs for protecting the health of folks who are homeless, these needs are here all the time. The pandemic has just pushed them into acute care.”**

-Health system focus group participant

#### **Shift the way we shelter people to COVID-safe, dignified options**

United Way and the City of Toronto have both embraced a human rights-based approach to housing. Leadership of a human rights approach can be challenging but is all the more necessary during the pandemic. As The Right to Housing notes, “Human rights principles and oversight are especially critical in times of crisis, when groups facing marginalization and discrimination are at even greater risk of scapegoating and exclusion.”<sup>7</sup>

Individuals that make up the outdoor homeless population are often among the most marginalized members of society. In addition to experiencing homelessness, many of these individuals encounter racism, queerphobia—especially transphobia—and other threats to their safety and dignity inside shelters. The threat of COVID-19 spreading in shelters has also led many other individuals to identify a private tent as a safer option.

A human rights approach to serving individuals in encampments and shelter spaces requires:

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<sup>7</sup> Right to Housing Toronto. “The Right to Adequate Housing & COVID-19: A Human Rights Response to the Pandemic for the City of Toronto.” April 2020. <https://right2housingto.ca/wp-content/uploads/2020/04/R2H-based-COVID-response-R2HTO.pdf>.

- Addressing the issues in shelters causing people to seek shelter in encampments. It is the responsibility of the shelter system, health system, and government to ensure individuals experiencing homelessness can access shelter space with confidence in their safety.
- Ensuring the safety and survival of individuals who have sought shelter in encampments. We must protect, rather than penalize, individuals who cannot access shelter space or have left shelters due to the perception of unsafe conditions.
- Providing individuals in encampments and shelters with access to housing. Developing plans to move people into housing, with transparent goals and timelines and accountability to meeting these goals, will ensure all relevant partners can work together to end the need for encampments.
- Committing to ongoing meaningful engagement and participation of residents of encampments, recognizing them as human rights-holders and essential partners in any solution to serve them.

## 5. Ensure people in encampments have a safe alternative and are supported to come indoors.

Proposed actions:

### 5.1. Address issues in shelters driving the perception that encampments are safer in the pandemic.

Concerns about the shelter system include overcrowding, lack of individualized amenities, lack of security for one's belongings, and threat of aggression and violence from other shelter users. For many, encampments are perceived as a safer alternative. While encampments bring their own host of risks and dangers, the shelter system needs to

be seen to change before people in encampments will be convinced that they will be safer in shelter. Above all, system services must be, and be perceived as, pandemic-safe, or shelter users will continue to vote with their feet.

**“COVID has exposed a lot of danger that was always there in shelters but has been highlighted in the wake of the pandemic.”**

-Front-line staff member

### 5.2. Increase presence for community organizations to proactively build relationships and options for people in encampments to minimize the need for policing.

Additional energy and resources should be dedicated towards outreach through the Streets to Home program and other community agency-led efforts. Any approach must be client-centered and focused on health and wellbeing, and meaningfully engage people living outdoors in plans to connect them with housing or indoor shelter. United Way in its role as funder, members of the Toronto Drop-In Network, and other frontline agencies are well positioned to play a part in this work. Community agencies should work alongside public health professionals in encampments to identify priorities for essential supports in

outdoor settings, and to build trusting relationships to support the transition to indoor settings. Actions to further the safety of people while in encampments should be consistent with a human rights-based approach as described above.

Humanely addressing encampments requires collaboration across shelter, community, and health systems, and across numerous City divisions. More work needs to be done to coordinate and clearly communicate responses to encampments. Decisions made in the interest of public safety can have cumulatively detrimental impacts on the most vulnerable people.

**“I left the shelter for the streets because of how crowded it was. It felt unsafe and not clean. But now they took down my tent and all of my things.”**

-Shelter system client

**6. Repurpose funding for services that are no longer feasible post-COVID.** Funding for programs that cannot operate safely during the pandemic, should be redirected towards new programs that fulfill the same need, safely and consistently.

Proposed action:

**6.1. Reimagine investments in programs that are no longer tenable during the pandemic.** Renewed programming should aim to provide housing and supports services that are low-barrier, consistent, and operate 365 days a year.

Redesign investments in programs focused on providing safe indoor space and basic services. By November 1, 2020, approaches to these investments should:

- Enable overnight guests within static location(s) to minimize the need for people to travel across the city nightly in pursuit of shelter.
- Provide consistent services and days of service across location(s), while ensuring services are client-centered and not determined by a “one-size-fits-all” approach.
- Operate on a consistent schedule, 365 days per year, recognizing that more people perish from exposure in the summer.<sup>8</sup>
- Retain a low-barrier approach.
- Adopt a pandemic-appropriate program model.
- Include harm-reduction supports and overdose-prevention services.

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<sup>8</sup> City of Toronto, “Deaths of People Experiencing Homelessness,” accessed July 10, 2020, [https://public.tableau.com/profile/tphseu#!/vizhome/HomelessDeaths\\_Final/HomelessDeathsFinal](https://public.tableau.com/profile/tphseu#!/vizhome/HomelessDeaths_Final/HomelessDeathsFinal).

**“The seasonal ‘ramp-up/ramp-down’ has long been due for an overhaul. People are at risk during all seasons, so we need consistent services year-round.”**

-Service provider

Addressing discrimination within the shelter system is an urgent need that must also be part of any longer-term shelter system planning moving forward, including the upcoming SSHA five-year service plan. Black, Indigenous, and LGBTQ2S+ individuals are disproportionately represented in the homeless population as a result of discrimination and systemic racism. The shelter system is as likely as any other institution to perpetuate discrimination and racism, even without realizing it is happening.

Discrimination and racism within the shelter system not only undermines the safety and dignity of clients, but also creates barriers to accessing services that perpetuate inequitable outcomes. Given the overrepresentation of these groups among the homeless population, efforts to end homelessness must include specific measures to work with marginalized groups to identify barriers, and to address discrimination within the shelter system.

### **Minimize the flow of people into traditional emergency shelters**

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The advice included in this report so far will not be able to make a dent in keeping individuals experiencing homelessness and the broader public safe if many more are simultaneously entering the shelter system with nowhere else to go. This includes people re-entering traditional emergency shelters or becoming unsheltered if temporary hotels and other sites made available in the first wave of the pandemic are not maintained. It also includes new people becoming homeless.

**“If we don’t prevent evictions, there will be tents in the thousands. The impacts will be impossible to ignore.”**

-Street outreach worker

Recent surveys found that between 8% and 13% of Toronto renters were unable to pay their rent in either April or May—months where COVID-19’s economic impacts were just beginning to unfold.<sup>9</sup> The Toronto Foundation estimates that if the portion of Toronto renters unable to pay rent remains around 10% moving forward—a projection it calls “optimistic”—between 130,000 and 260,000 renters will be at risk of eviction.<sup>10</sup>

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<sup>9</sup> Toronto Foundation, “COVID-19 and Housing: Will New Opportunity Emerge From Crisis?” June 1, 2020, p. 1, <https://torontofoundation.ca/wp-content/uploads/2020/05/Final-BTC-housing-brief-for-release-June-1.pdf>.

<sup>10</sup> Ibid.

Minimizing the flow of people into the emergency shelter system is an essential part of responding to COVID-19 in the shelter system.

**7. Prevent re-entries into traditional shelters or being unsheltered for those currently housed in hotels and other accommodation.** Without a plan to continue housing strategies implemented during the first wave of COVID-19, the more than 2,000 people sheltered since March will be at risk of re-entering into being unsheltered, losing the supports they have been provided, and creating undo pressure on the traditional emergency shelter system still grappling with the pandemic.

**7.1. Ensure the continuation of hotels and other housing strategies from the first wave of COVID-19.**

Many people in hotels have made significant progress towards their personal goals and in establishing stability since being housed during the pandemic. Continuation of these accommodations is essential in concert with the proposal to invest in permanent housing infrastructure developed in this report. This will require sustained funding from other orders of government, and for SSHA to work with organizations operating hotels and other levels of government to develop a financial and service model that will ensure the continuation of hotel programs.

**7.2 Ensure those in COVID response programs including hotels are assisted to move into permanent housing.**

Even with temporary housing sites maintained for the duration of the pandemic, people living in these sites are still in need of a permanent home. Dedicated supports, enabled by the transition of funding from shelter to housing support, will help people currently in hotels and other temporary sites transition to permanent housing.

**8. Prevent entries into the shelter system due to evictions and discharges from other systems.**

Proposed actions:

**8.1. Convene a regional table focused on collaborative discharge planning.**

Challenges with discharge from corrections, health, and child welfare into homelessness are not new, but the pandemic brings new urgency to develop new solutions. The 2018 Toronto Street Needs Assessment found that 65% of people experiencing homelessness had been to an emergency department or had been hospitalized in the previous six months, while other research has found that up to 44% of people in Ontario corrections facilities are discharged into homelessness.<sup>11</sup> Anecdotal evidence during the pandemic

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<sup>11</sup> John Howard Society of Toronto, "Homeless and Jailed: Jailed and Homeless," August 2010, p.18, [http://johnhoward.on.ca/toronto/wp-content/uploads/sites/5/2014/09/JHS-Toronto\\_Report-Homeless-and-Jailed.pdf](http://johnhoward.on.ca/toronto/wp-content/uploads/sites/5/2014/09/JHS-Toronto_Report-Homeless-and-Jailed.pdf).

suggests a high proportion of those in encampments have been discharged directly from the health and corrections systems. Coordinating testing for those being discharged from higher-risk settings such as corrections facilities, as well as healthcare, shelter, and housing connections will minimize the risk of vulnerable people catching or transmitting COVID-19 upon release.

A collaborative discharge planning table would establish clear pathways for people being discharged and establish agreements across systems to guide mutual obligations towards shared clients. A regional table could incorporate regional referral processes, including escalation and resolution processes for discharge from provincial institutions across the region. This table should also include those who can influence policy and practices within the Corrections arm of the Solicitor General, in collaboration with frontline service agencies that work with these populations.

## 8.2. Expand financial supports for households at risk of eviction.

This may include:

- Broadening eligibility for Toronto's Rent Bank program.
- Converting Rent Bank loans to grants for tenants in arrears.
- Providing larger subsidies to recognize real monthly rental rates.
- Leveraging the Canada-Ontario Housing Benefit to enable people on the centralized waiting list to secure housing in more affordable communities.
- Increasing funding for Eviction Prevention in the Community (EPIC) as outlined in the *HousingTO: 2020-2030 Action Plan*.

This will require additional funding from the provincial and federal governments.

### Leveraging the role of drop-ins

Drop-ins are a key point of contact for individuals who are precariously housed and at risk of homelessness, and are uniquely positioned to play a role in supporting eviction prevention. United Way can work with drop-ins, many of whom have experienced service interruptions as a result of COVID-19, to redesign parts of the drop-in model for the pandemic.

In addition to potentially playing an expanded role in eviction prevention, drop-ins will require a reimagining of how their services are provided in the context of the pandemic. United Way and other funders of drop-ins should work with them to reimagine how they can continue to provide amenities, services, and opportunities for connection with community when individuals can no longer make use of drop-ins' physical space.



## PRIORITIES FOR ACTION TO ADDRESS BLACK HOMELESSNESS IN THE NEXT 12 MONTHS

Black people are the largest racial demographic group in the shelter system, making up 40% of those experiencing homelessness.<sup>12</sup> Those closest to Toronto's Black communities also estimate that there is considerable hidden homelessness among Black individuals as a result of systemic racism within the homelessness service system and cultural differences making them less likely to reach out through the traditional homelessness service system.

A distinct approach to serve Black people experiencing homelessness is overdue. Moreover, with Black communities in Toronto disproportionately impacted by COVID-19, this work must be accelerated.<sup>13</sup> The reality of anti-Black racism should be recognized and addressed across all the activities identified in this report. The following imperatives will help move the system in the right direction:

### 1. Address the disproportionate representation of Black people in Toronto's homeless population.

#### 1.1. Develop a distinct strategy to address Black homelessness in Toronto.

This strategy will help define priorities and approaches to better serve Black people experiencing and at risk of homelessness, and should include homelessness prevention measures as well as measures to better serve Black individuals experiencing homelessness.

This strategy should also include measures to address the current service gap for Black youth experiencing homelessness. Toronto currently does not have a homelessness organization with a mandate to serve Black youth. Youth experiencing homelessness require different interventions than the adult homeless population, while Black youth experiencing homelessness may also have distinct service needs from other youth experiencing homelessness.

This strategy should build on the 2017 *Toronto Action Plan to Confront Anti-Black Racism*, accelerating work to fully implement Recommendation #10: "Improve shelter and housing conditions to better support Black Torontonians." Black voices must be centred in the development of this strategy, with meaningful inclusion of Black service users and Black leaders in the community sector.

### 2. Promote Black leadership in homelessness services. Black-led responses should be prioritized across the advice offered above in this report, in addition to the following:

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<sup>12</sup> City of Toronto, "2018 Street Needs Assessment," p. 20, <https://www.toronto.ca/wp-content/uploads/2018/11/99be-2018-SNA-Results-Report.pdf>.

<sup>13</sup> Faiza Amin and Meredith Bond, "COVID-19 disproportionately impacting Black communities, people of colour in Toronto," City News, July 9, 2020, <https://toronto.citynews.ca/2020/07/09/race-data-covid-toronto/>.



### 2.1. SSHA and United Way can leverage their influence as funders to help community agencies diversify their boards, executive staff, and frontline staff.

Diversifying boards and executive staff will help promote Black leadership at both the organizational level and in collaborative planning exercises that convene executive staff from across the sector. Diversifying frontline staff is also critical to recognizing the importance of shared experience in support, and ensuring that Black individuals experiencing and at risk of homelessness are able to access services from providers who share cultural and experiential backgrounds, located in familiar communities.

Efforts to include more Black representation in board and staff positions must also be paired with work to create anti-racist environments within organizations and service settings.

### 2.2. Expand invitations to tender to include more Black-led organizations.

Cultivate Black leadership in homelessness services by extending invitations to respond to Requests for Proposals (RFPs) to Black-led organizations, including those that are not traditionally viewed as homelessness service providers. These organizations are distinctly positioned to develop solutions that meet the needs of their communities, and in many cases are already serving shared clients.

## 3. **Collect and act on data to address inequitable outcomes.** Actors in the homelessness service system has a direct responsibility to ensure that they are not themselves perpetuating inequitable outcomes. Ensuring data collection includes measures to identify inequitable outcomes in the journeys of Black individuals through the system is the first step. It is equally important to design and implement interventions based on this information.

### 3.1. Implement a racial equity tool to collect data on racial disparities in the shelter system, and design interventions with Black leadership to act on this data.

The US National Alliance to End Homelessness offers a racial equity data tool to identify where people of different races/ethnicities may be receiving inequitable treatment or having inequitable outcomes as they move through the homelessness service system.<sup>14</sup> This tool has been expanded to identify inequities in how people are connected with services and housing during the pandemic. This tool may offer a model to integrate with Coordinated Access, and to build on to identify other areas for intervention to address racial inequities in Toronto's homelessness service system.

### 3.2. Begin conducting a regular survey of Black service users and staff in the shelter system.

Gathering firsthand survey input from services users and staff in the shelter system would provide important qualitative data to accompany quantitative data gathered through a racial equity data tool, and serve as an important avenue to center Black voices in the design of solutions. This survey should be designed and adapted as needed with Black leadership, and conducted regularly to assess progress and identify where targeted efforts

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<sup>14</sup> Tool available at: <https://endhomelessness.org/resource/the-alliances-racial-equity-network-toolkit/>.

are needed.

#### **4. Work with the homelessness service system to ensure all providers operate from an anti-Black racism framework.**

##### **4.1. SSHA and United Way can leverage their influencers as funders to ensure all homelessness service providers work with reputable advisors to develop an anti-Black racism strategy.**

SSHA and United Way can create a mandate for agencies they fund to work with a reputable anti-Black racism advisory, such as the City of Toronto's Anti-Black Racism (CABR) unit. The CABR unit is responsible for rolling out Toronto's *Action Plan to Confront to Anti-Black Racism* and is strongly positioned to provide training to the sector to address anti-Black racism and better serve Black individuals experiencing homelessness.

**“We have a multicultural staff who are routinely insulted based on race and culture. If that’s happening to them, imagine how much worse it is for those who are most vulnerable.”**

-Shelter system staff member

Improvement in confronting anti-Black racism should be deliberate, explicit, and continual. Transparency about goals, actions, and outcomes, as well as accountability for results are essential.

Solutions to serving individuals experiencing homelessness during the pandemic and beyond must be based on a recognition of the unique experience of Black communities, the systemic racism at the root of their overrepresentation in the homeless population and in confirmed COVID-19 cases, and the additional barriers and challenges they face in the shelter, housing, and health systems. These solutions will need to empower Black leadership and elevate Black voices, while recognizing that responsibility for addressing anti-Black racism lies with those who benefit from and perpetuate it.

Considerations need to be made when creating services and solutions for Black individuals in the homelessness system. Black people are at greater risk of housing discrimination, criminalization, and being perceived as threats through unconscious bias or racism. Moving forward, SSHA, United Way and others providing services to Black individuals should dedicate explicit efforts in planning processes to address these considerations. For example, moving Black individuals in the shelter system into hotels presented distinct risks for those individuals, and required liaising with hotel owners and police to protect these individuals from discrimination.

## RECOGNIZING FRONTLINE STAFF

Frontline staff in the homelessness service system—including City of Toronto and community agency staff—have been at the forefront of responses to the pandemic in the system and continue to face pressing challenges head on. Frontline staff have demonstrated remarkable commitment and adaptability in responding to changing needs and work environments during the pandemic. City staff, redeployed to new roles in new settings, have taken the changes in stride and adapted quickly. City and community staff have borne punishing schedules in daunting circumstances in order to maintain essential services for Toronto’s most vulnerable.

As the pandemic wears on, frontline staff risk burnout. Our improved understanding of the impact of the social determinants of health on the incidence and severity of COVID-19 force a reckoning that frontline staff often are themselves at higher risk of the pandemic, even before factoring in daily work among the most susceptible.

Staff have gone above and beyond during the pandemic to keep clients safe and supported. We need to ensure staff themselves are safe and supported. This means:

- Continuing to secure personal protective equipment (PPE) for frontline staff.
- Working with providers and funders in the sector to ensure staff are able to work at one site exclusively.
- Expanding mental health and counselling supports for staff.
- Providing ongoing communication and on-the-job training to support staff as they adapt to new positions and/or protocols as the pandemic unfolds.
- Building capacity among staff to shift their mindset from crisis management to housing support.
- Reducing risks of return to work for staff who are often themselves low income, such as transportation or laundry supports.
- Ensuring staffing capacity is maintained and expanded as needed through a second wave through recruitment and training of new staff.

Staff are on the frontlines combatting the spread of coronavirus and will be at the forefront of mounting one of the strongest defenses against the virus’ spread: shifting the shelter system to providing longer-term, dignified, and distanced housing options.

# COVID-19 Interim Shelter Recovery Strategy

## INDIGENOUS STRATEGY

### INTRODUCTION

This report presents areas for action in the next 12 months to serve Indigenous individuals experiencing homelessness in the context of the COVID-19 pandemic. While some of the needs and causes of homelessness for the Indigenous homeless population overlap with those of the non-Indigenous population, many are distinct and arise from the impacts of colonialism, residential schooling, intergenerational trauma, the Sixties Scoop, and ongoing systemic racism and discrimination that permeates many institutions and service settings. Effectively serving Indigenous individuals experiencing homelessness requires anticolonial, Indigenous-led solutions.

Indigenous members of the task force that led the creation of this strategy emphasized the need for a separate process and section within this report focused on Indigenous homelessness. Consequently, a separate, parallel process was undertaken with Toronto's Indigenous Community Advisory Board (TICAB) to identify areas for action to serve Indigenous individuals in the context of the pandemic over the next 12 months, and to empower Indigenous organizations to lead solutions during the pandemic and beyond. This section presents the advice of the TICAB. Moving forward on this advice will require continued dialogue between SSHA, the TICAB, and the Toronto Indigenous Community Entity - Aboriginal Labour Force Development Circle around any decisions and implementation plans, as well as prioritization of engaging frontline outreach staff with clients to gather their input.

### **Needs facing Indigenous individuals experiencing homelessness during the pandemic**

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While many Indigenous individuals experiencing homelessness are facing similar challenges as the non-Indigenous homeless population, the pandemic has also brought about distinct challenges for Indigenous individuals, including:

- Reduced access to important spiritual and cultural practices due to public health guidance, such as in-person access to Elders, ceremony, sweat lodges, and drumming practices.
- Higher risk of COVID-19 for Indigenous individuals disproportionately represented in corrections facilities.
- Trauma associated with COVID-19 testing and tracing, given Indigenous individuals' experiences of racism and colonial policies and practices in the health care system.
- Added element of racism when it comes to policing presence in encampments.
- Reduced options for safe space for Indigenous women experiencing domestic violence.
- Reduced access to Indigenous-specific supports and approaches to recovery for those who have been moved into new shelter options, due to lack of abstinence-based options and lack of Indigenous agencies operating these new shelter spaces.

Indigenous individuals also make up a higher proportion of those sleeping outdoors and are therefore likely to make up a higher portion of those trying to survive during winter in encampments, especially during an anticipated second wave of COVID-19.

## Response to Indigenous homelessness during the pandemic

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Indigenous agencies have been able to work quickly during the pandemic to find creative solutions to meet need. Funders have been supportive by enabling increased flexibility. This has allowed providers to respond quickly during the pandemic, and has highlighted the resourcefulness and strengths of Indigenous agencies in meeting need.

At the same time, responding to need among Indigenous individuals experiencing homelessness during the pandemic has brought added financial costs that need to be supported to maintain this response. Additionally, like non-Indigenous providers, Indigenous providers have experienced a learning curve over time concerning best practices for IPAC and use of PPE. Indigenous providers have reported difficulty accessing support from Toronto Public Health, and have instead sought out partnerships with other health providers to provide resources and training around IPAC.

Alongside the challenges facing Indigenous providers and individuals experiencing homelessness, the pandemic offers new opportunities to amplify the expertise, creativity, and leadership of Indigenous agencies in responding to need through newly targeted investments and strategies. It also presents urgent need to immediately begin reimagining winter respite programs that have become untenable during the pandemic. In identifying actions to respond to need over the next 12 months, Indigenous providers echoed the input of many others involved in the process of developing this strategy: deeply affordable housing that connects individuals with the supports they need must be at the forefront of solutions for individuals experiencing homelessness, even more so during the pandemic.

**“We have to be proactive and look down the road. People sleeping outdoors don’t have the luxury of planning for winter. That’s our job. We have to be proactive for them.”**

-TICAB member

## P R I O R I T I E S F O R A C T I O N I N T H E N E X T 1 2 M O N T H S

- 1. Prioritize Indigenous-specific housing in strategies to secure more permanent housing infrastructure.** Steps taken to secure more permanent housing infrastructure in the next 12 months must include securing new buildings and sites to serve as Indigenous-specific housing during and after the pandemic. This is critical to enabling Indigenous individuals to be well served by rapid rehousing strategies during the pandemic, and equipping Indigenous organizations with housing infrastructure to meet need in the long term.

The proposed actions below must be pursued in ongoing discussion with Indigenous providers, recognizing that Indigenous providers are diverse and work with different approaches and client groups, and will not benefit from a one-size-fits-all approach.

Proposed actions:

### 1.1. Adopt an Indigenous-specific track to an acquisition strategy.

The acquisition strategy proposed in this report should prioritize purchases for Indigenous housing and create operating agreements with Indigenous providers to operate this housing. This could take the form of hotels or other settings that offer a blend of dignified private space and shared space. There is a great need for options that can be suitable for families. This may also entail reconfiguring space to facilitate spiritual or cultural programming and connection to community.

### 1.2. Create a plan for newly-acquired housing to serve as long-term housing for Indigenous individuals that is owned and operated by Indigenous non-profit providers.

The acquisition strategy should be developed with an aim to either immediately provide resources to enable Indigenous providers to purchase new buildings, or to transfer ownership to Indigenous providers to support Indigenous non-profit capacity.

## 2. Expand Indigenous-led outreach and supports for Indigenous individuals during the pandemic.

Proposed actions:

### 2.1. Ensure Indigenous providers operating new sites have autonomy to serve individuals through an abstinence-based approach.

While many Indigenous individuals benefit from harm-reduction supports, this approach can also be in tension with traditional approaches to healing and the preferences of some individuals. Operating agreements with Indigenous providers must ensure they have the autonomy to serve individuals through an abstinence-based approach based on what is most helpful for their clients in their journey, and ensure abstinence-based options are available as part of a diversity of responses that also include harm reduction.

### 2.2. Support Indigenous agencies to provide outreach and support to Indigenous individuals in encampments.

Indigenous individuals make up a higher proportion of those sleeping outside, and are more likely to experience racism from the policing presence in encampments. Steps taken to provide support to keep individuals in encampments safe and prepare them for housing must include resourcing Indigenous agencies to provide outreach and support to Indigenous individuals in encampments.

### 2.3. Sponsor an Indigenous-led, low-barrier respite program.

Invest in an Indigenous-designed and Indigenous-led response for culturally appropriate respite and overnight supports to extend community and shelter through the winter months. This should take place at a single site that is low-barrier and open 7 days a week.

- 3. Establish protocol to ensure Indigenous individuals who have been moved into new housing are connected with an Indigenous provider.** Indigenous individuals have been moved into housing during the pandemic without consistent protocol to ensure they are connected with appropriate Indigenous-led supports. These supports are critical to many Indigenous individuals experiencing homelessness, and especially for those who have recently been moved into housing and are adjusting to this significant transition.

Proposed action:

- 3.1. Establish clear protocol and communications channels to ensure that any time an Indigenous individual is moved (e.g. from an encampment to a hotel or other housing unit), an appropriate Indigenous provider is contacted to ensure the individual is offered access to Indigenous-led supports.

This protocol needs to be developed with consideration of different needs and circumstances among Indigenous individuals experiencing homelessness, such as Indigenous women who have experienced domestic violence, or individuals who would prefer to live in abstinence-based rather than harm-reduction settings.

**“We have to have someone who understands where a person is coming from, and where they want to go. If we don’t, they won’t be well-served and they won’t stay.”**  
-TICAB member

- 4. Support Indigenous providers to act quickly and lead solutions.** Increased flexibility during the pandemic has helped Indigenous providers exercise their expertise and leadership to implement creative solutions. Creating the conditions to enable Indigenous providers to lead solutions will be important to ensuring Indigenous individuals are well served by responses that are developed in a rapidly changing environment.

Proposed action:

- 4.1. SSHA and all other relevant funders should continue to be flexible to enable Indigenous organizations and those closest to the frontlines to quickly identify issues, implement solutions, and respond to changing circumstances.

This trust and flexibility should continue to inform relationships with Indigenous providers after the pandemic. Funders need to work flexibly with Indigenous providers to enable them to move quickly in response to needs as clients communicate them, and tailor certain responses on an individual, client-centered basis.

In addition to empowering Indigenous agencies with this flexibility and autonomy, shelter, housing, health, and community sectors should work with Indigenous agencies to identify ways to reduce red tape that often leads Indigenous providers to search out other solutions—for example, streamlining the referral process to quickly move clients into housing during the pandemic.



# COVID-19 Interim Shelter Recovery Strategy

## FINAL REPORT

### HOW OTHER SYSTEM PARTNERS CAN HELP

This strategy will help guide SSHA, United Way, and other partners as they shepherd the system through what is likely to be a trying year. During the first wave of COVID-19, system partners have been learning and working together at an accelerated rate to address urgent need. This period has highlighted the interdependency of these systems, and the need for mutual coordination and support to ensure mutual success.

Below are critical areas for other system partners to help advance solutions for people experiencing homelessness in the next 12 months:

#### Provincial government

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- Expand access to rental supports to prevent evictions and enable more people to be served through rapid rehousing strategies.
- Sustain moratorium on evictions until the economy has recovered.
- Provide more support dollars to ensure all individuals being moved into housing have the supports to help them stay there.
- Commit to having a health and housing plan in place for all individuals being discharged from provincial institutions.
- Improve housing and health stability by increasing social assistance rates to match the level of income support available through the Canada Emergency Response Benefit.

#### Federal government

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- Create a capital program for a not-for-profit housing acquisition strategy and shelter program.
- Provide adequate funding to maintain COVID-19 shelter programs.
- Expand the Canada-Ontario Housing Benefit to prevent evictions and enable more people to be served through rapid rehousing strategies.
- Provide more support dollars through Reaching Home to ensure all individuals being moved into housing have the supports to help them stay there.

#### Immigration, Refugees and Citizenship Canada

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- Work with municipalities to create a diversion from Toronto for refugees entering at the Quebec border. Refugees are more likely to experience periods of extended homelessness due to the lack of affordable housing in Toronto, but are reluctant to relocate once they have obtained an immigration lawyer and other supports in the city. Working to establish invitations from other municipalities will encourage refugees to settle in cities where they have lower barriers to housing.



- Provide temporary shelter to facilitate quarantine for anyone who does not have a permanent address.

### Other municipalities/regional governments in the Toronto region

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- Work with community and municipal partners across the region to develop shared shelter standards. These shelter standards should be developed immediately for all shelter settings and include measures to:
  - Address overcrowding and support a shift from a congregate, dormitory model.
  - Address the required amount of space between beds.
  - Identify programming that needs to be in place in these shelters.
  - Remove paternalistic service models, such as curfews, which can create barriers to clients accessing and remaining in their shelters.
  - Coordinate shelter referrals and discharges, particularly from hospitals.

### All orders of government

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- Collaborate on a flexible approach for supportive housing funding, to enable layering of housing and support funding to meet need on an individual, client-centered basis. While new funds are needed, greater flexibility to combine and layer current funding around the needs of individual clients would achieve greater impact with existing dollars.

### Health system actors

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- The LHINs/Ontario Health can make it a priority to implement the Coordinated Shelter Health Services Framework across the entire Toronto homelessness service system.
- Work with the City of Toronto and United Way to coordinate supports for individuals as they are moved into housing and ensure continuity of these supports.
- Support training opportunities for health practitioners to experience working in community settings serving people experiencing homelessness. This will enable more health practitioners, including those in planning roles, to have a deeper understanding of the distinct environment and expertise in the shelter system.
- Provide more targeted support and resources around IPAC in site-specific settings for homelessness service providers and community agencies serving vulnerable populations.

**“I have nowhere to wash my hands.”**

-Shelter system client

### Toronto Public Health

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- Develop a method to work with community agencies and health partners to implement contract tracing with marginalized populations.

### City Planning

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- Secondary plans for all neighbourhoods across Toronto should include supportive and/or transitional housing. Leadership from City Planning to establish this norm will help set

different expectations with the public, as well as expedite and decrease costs associated with the development approval process.

### **VAW system actors**

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- SSHA and the Ministry of Children, Community and Social Services should collaborate to coordinate approaches to serving women and their children fleeing domestic violence. This coordination should aim to extend consistent shelter standards across systems, connect women in the VAW system with City-operated housing opportunities, connect women in the City shelter system with needed VAW-specific supports and services.

### **Correctional system actors**

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- The Ministry of the Solicitor General, SSHA, and other correctional system actors should collaborate on approaches to serving people in correctional custody who will be released directly to the shelter system/have no fixed address, especially to:
  - Provide a safe shelter option for people immediately upon discharge as well as a pathway to supportive and/or affordable housing.
  - Ensure both abstinence-based and harm reduction-based options are available.
  - Provide connections to primary care, specialized/intensive case management support, and ensure medications are available to those who require them.
- The Ministry of the Solicitor General to transfer all responsibility for health and healthcare services in provincial correctional facilities to the Ministry of Health and Long-Term Care, in line with recommendation #27 of the Chapman Inquest.<sup>15</sup>
- Correctional Services Canada to provide sufficient resources and work with SSHA in conjunction with community partners to develop pathways for safe, affordable housing for people who have completed federal sentences and have no fixed address following their release from prison and/or community residential centres (halfway houses).

## **T R A N S F O R M A T I O N A L   S H I F T S**

All of the solutions put forward in this report are necessary. Some are also transformational. These solutions aim to respond appropriately to this acute emergency, while ensuring that we target investments and efforts in the direction of ending homelessness, rather than towards a continued reliance on temporary measures that are ill-suited to helping individuals avoid and exit homelessness.

Doing so will require some significant shifts in the way the shelter system operates—shifts that have long been recognized as necessary, and that have become even more urgent in the face of this pandemic. This section recognizes three transformational shifts put forward in this report, and the challenges and enabling factors involved in making these shifts.

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<sup>15</sup> Office of the Chief Coroner, “Verdict of Coroner’s Jury - Bradley John Chapman,” Ontario Ministry of the Solicitor General, December 2018 (accessed July 30, 2020), <https://www.mcscs.jus.gov.on.ca/english/Deathinvestigations/Inquests/Verdictsandrecommendations/OCCInquestChapman2018.html>.

## Refocusing shelter capacity

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Many individuals have come to rely on shelter and respite space as their housing. As shelter users have been housed or moved into hotel spaces during the pandemic, we have seen that many of these individuals have entered the shelter system for economic reasons and are capable of living independently when they have access to safe housing they can afford. The longer these individuals stay in the shelter system, the more likely they are to become entrenched in homelessness.

For shelter users who have pre-existing support needs before entering the shelter system, or develop these support needs while in the shelter system, shelter and respite spaces are ill-equipped to provide these supports and the housing stability individuals need to benefit from them. Not only does reliance on shelter and respite spaces for housing not serve these individuals well, it also overloads the shelter system's capacity to serve its intended purpose of providing safe, emergency space that serves as a link to permanent housing.

**“Shelters are not the solution — nor were they ever intended to be.”**

-Frontline staff member

This report advises shifting resources from shelters and respite centres that are no longer viable to invest in housing infrastructure and supports, including repurposed shelter space and new affordable and supportive housing units. Emergency shelter space will continue to be an important part of the homelessness service system. Pursuing this advice will simultaneously ease pressure on the shelter system, require less rather than more shelter capacity, and help return the shelter system to its intended purpose of serving as a link to permanent housing.

## Retooling Winter respite programs

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Winter is life-threatening to people experiencing homelessness in unsheltered locations, many of whom rely on Winter respite programs. During this pandemic, these programs have gone from life-saving to life-threatening. While many have been calling attention to the need to redesign these programs prior to the pandemic, the risk presented by COVID-19 has accelerated this need.

**“We need to re-envision what Out of the Cold can be. This builds on learnings over the last 20 years. We can build a better response.”**

-Service provider

Winter respite programs often involve crowded sites with minimal supports, and sometimes require individuals to rotate to different sites every night. Outbreaks of COVID-19 are inevitable in these conditions, and we have no choice but to provide safe indoor space elsewhere.

Partners delivering certain Winter respite services took the lead in recognizing the danger posed by this model by closing the season's programming early in March. This report advises that SSHA lead

the development of an alternative to this model by repurposing funding for these services towards housing and supports in environments that will be safer during the pandemic and all year round. This will require immediate and bold action that is related to both refocusing shelter capacity and working quickly to secure more permanent housing infrastructure.

## Working quickly to secure more permanent housing infrastructure

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Securing more permanent housing infrastructure will be critical to responding to the above challenges, as well as ensuring that resources spent on responding to the pandemic position us for long-term solutions to prevent and end homelessness.

The pandemic and its impacts on market conditions have opened up new opportunities to secure permanent housing infrastructure. Since March, SSHA has opened more than 30 new or expanded facilities to provide housing and safe shelter space during the pandemic. This includes 16 hotel program sites and one vacant apartment building. While continuing to lease hotels will be a cost-intensive strategy with no guarantee of permanency, purchasing hotels and other buildings is a unique opportunity offered by this situation that will be less expensive and more effective at meeting need, now and in the future.

This report proposes a number of actions to secure more permanent housing infrastructure with varying implementation timelines. We have seen in the first phase of the pandemic that we can move quickly to secure new housing units where there is political will and investment, and that there are ready partners on the ground who have proven their determination to make this possible. Expediting the development of modular housing and developing an acquisition strategy to seize immediate market opportunities are two key actions that will enable a refocusing of shelter capacity and retooling of the Out of the Cold program in advance of winter. Shifting investment towards these housing solutions will be critical to providing safe housing options to those who rely on shelter and respite space that is no longer viable, those currently in encampments, and those who enter the shelter system in the future.

**“Let’s invest in housing to decrease the need for shelter space. It’s not a trade-off. It’s shifting the impact.”**

-Service provider

Shelter and respite spaces were never meant to serve as long-term housing for individuals experiencing homelessness, yet we have been required to expand them in the absence of an adequate supply of deeply affordable and supportive housing. Access to these spaces has saved lives.

During this pandemic, however, these very spaces have themselves become life-threatening for people experiencing homelessness. Keeping people safe has required us to find new sites that offer safe, private space and reduce the need for individuals to travel throughout the city to access services. Many who have not been moved into housing have voted with their feet, recognizing that a private tent is safer than a shelter bunk bed in a pandemic.

These transformational shifts are interrelated and centred on addressing these realities. While these shifts are central to a successful emergency response, they are also central to reorienting the system towards preventing and ending homelessness. The solution for individuals experiencing homelessness during a pandemic is the same solution they need to avoid and exit homelessness: safe housing that they can afford, that provides them with the support they need.

## CONCLUSION

COVID-19 has required a rapid reimagining of how safe homelessness services are provided, demonstrating our ability to work across silos and systems in creative ways. Many of the responses demanded by this pandemic to keep individuals experiencing homelessness safe are the same responses that have long been recognized as imperative to shift from temporary emergency measures towards solutions that will prevent and end homelessness. The pandemic has deepened the necessity and created new opportunities to do so.

The pandemic has also illustrated the economic impacts of failing to provide people with safe housing. Providing people experiencing homelessness with housing reduces the transmission of COVID-19 in the shelter system and in the community, enabling the Toronto region to move towards economic recovery. Providing housing for people experiencing homelessness also creates savings for governments whose budgets are stretched due to COVID-19. Multiple studies have demonstrated that providing affordable and supportive housing has enormous cost reductions on our health systems, justice systems, and emergency services.<sup>16</sup>

This report presents the advice and expertise of individuals experiencing homelessness who are encountering these risks and challenges every day, of providers and leaders in supporting these individuals, and of health system partners whose work is intertwined with, and affected by, actions taken to address homelessness.

This advice is aimed at helping SSHA, United Way, and their partners sustain effective responses from the first wave of COVID-19, implement responses to meet incoming need during the winter and anticipated second wave of COVID-19, and leverage opportunities presented by the pandemic to shift the system towards preventing and ending homelessness. It is also of tremendous relevance to other systems and the general public, who will be affected by the actions taken moving forward.

Some of the advice put forward in this report would entail a reimagining of community agencies' roles and services models. While this advice has come from many of these agencies themselves, the transitions required to implement this advice are no easy task. Planning for these transitions must begin immediately. As we take action to reorient the system towards ending homelessness, we must also ensure this action is taken in collaboration with the sector and preserves and builds on the sector's hard-won capacity and expertise. As SSHA and United Way move forward, informed by the advice in this report, they will do so in continued dialogue with community partners who are at the forefront of implementing solutions and have generously contributed their expertise to this report.

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<sup>16</sup> Stephen Gaetz, "The Real Cost of Homelessness: Can We Save Money by Doing the Right Thing?" 2012, [https://www.homelesshub.ca/sites/default/files/attachments/costofhomelessness\\_paper21092012.pdf](https://www.homelesshub.ca/sites/default/files/attachments/costofhomelessness_paper21092012.pdf).

## Appendix A

# CONTRIBUTORS TO THIS REPORT

### MEMBERS OF THE TASK FORCE

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Tanner Tootosis	Wigwamen

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Neil Hetherington	Daily Bread
Rafi Aaron	Interfaith Coalition to Fight Homelessness
Sean Meagher	Convene TO

## **F O C U S   G R O U P S**

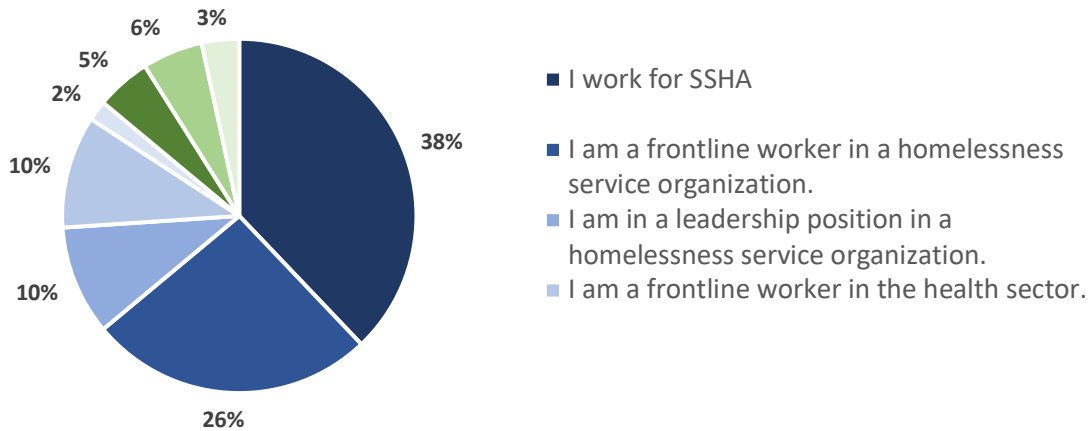
- Violence Against Women Network
- Black-led and Black-serving organizations
- SSHA staff
- Homelessness service agency frontline staff
- Shelter system clients



# Appendix B ONLINE SURVEY RESULTS

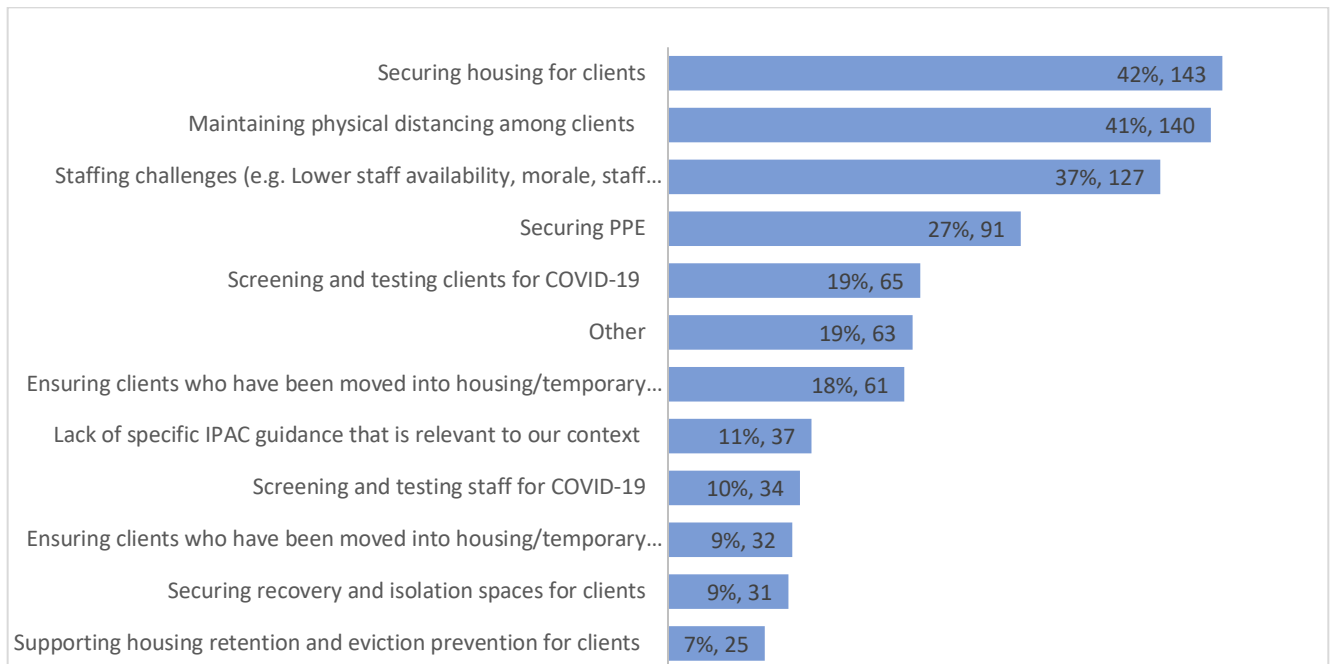
## SUMMARY

Total number of respondents: 380

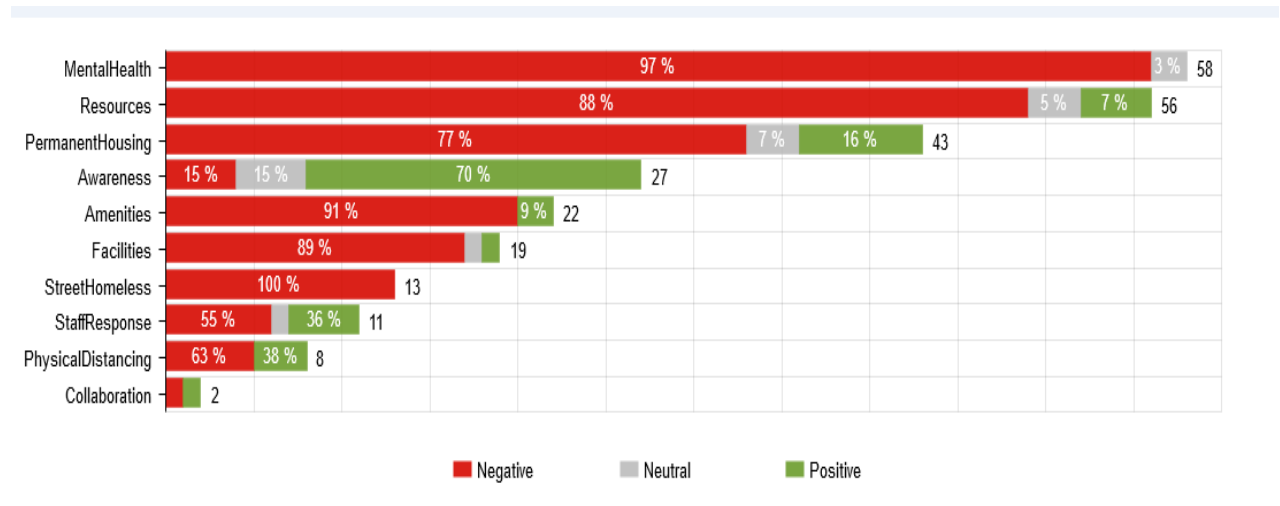


## SURVEY QUESTIONS

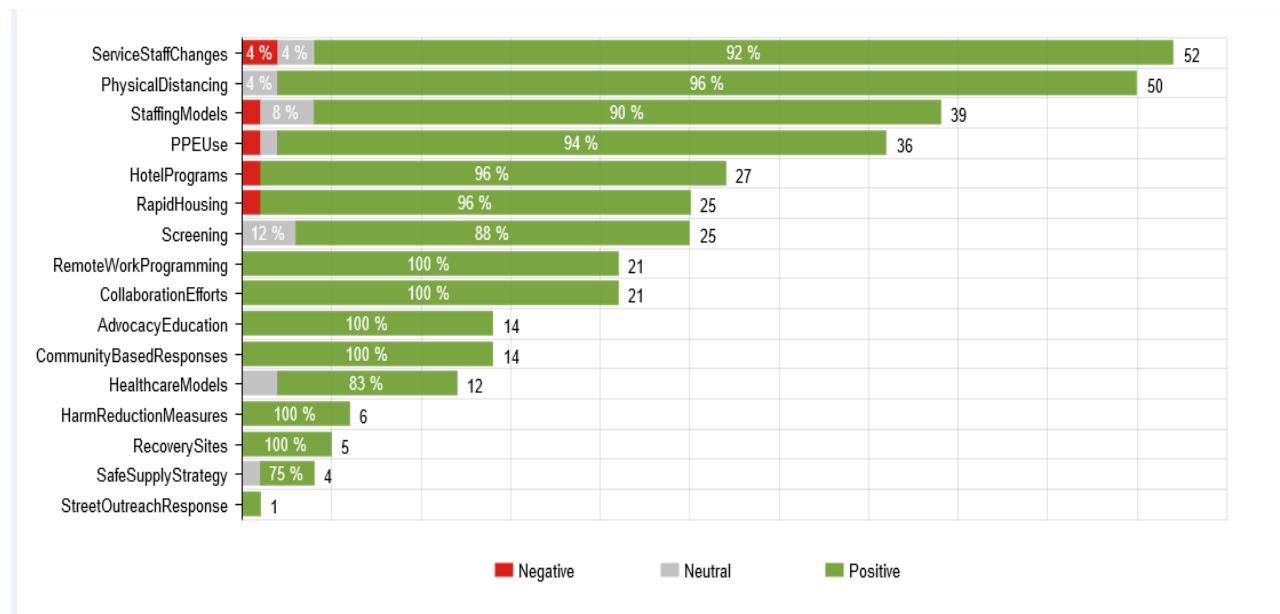
1. What have been the biggest challenges in your work during the pandemic so far?



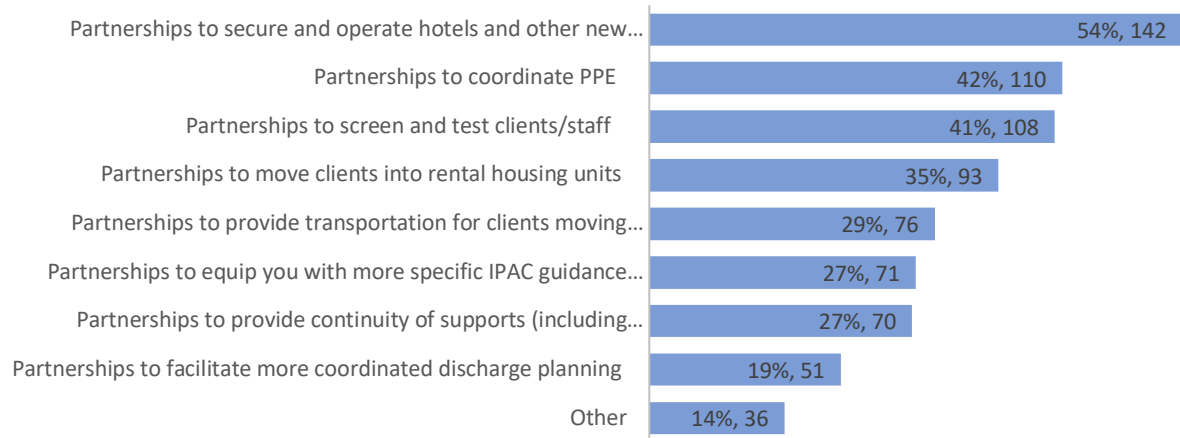
2. Are you seeing any trends in how need amongst people experiencing or at risk of homelessness is changing as a result of the pandemic?



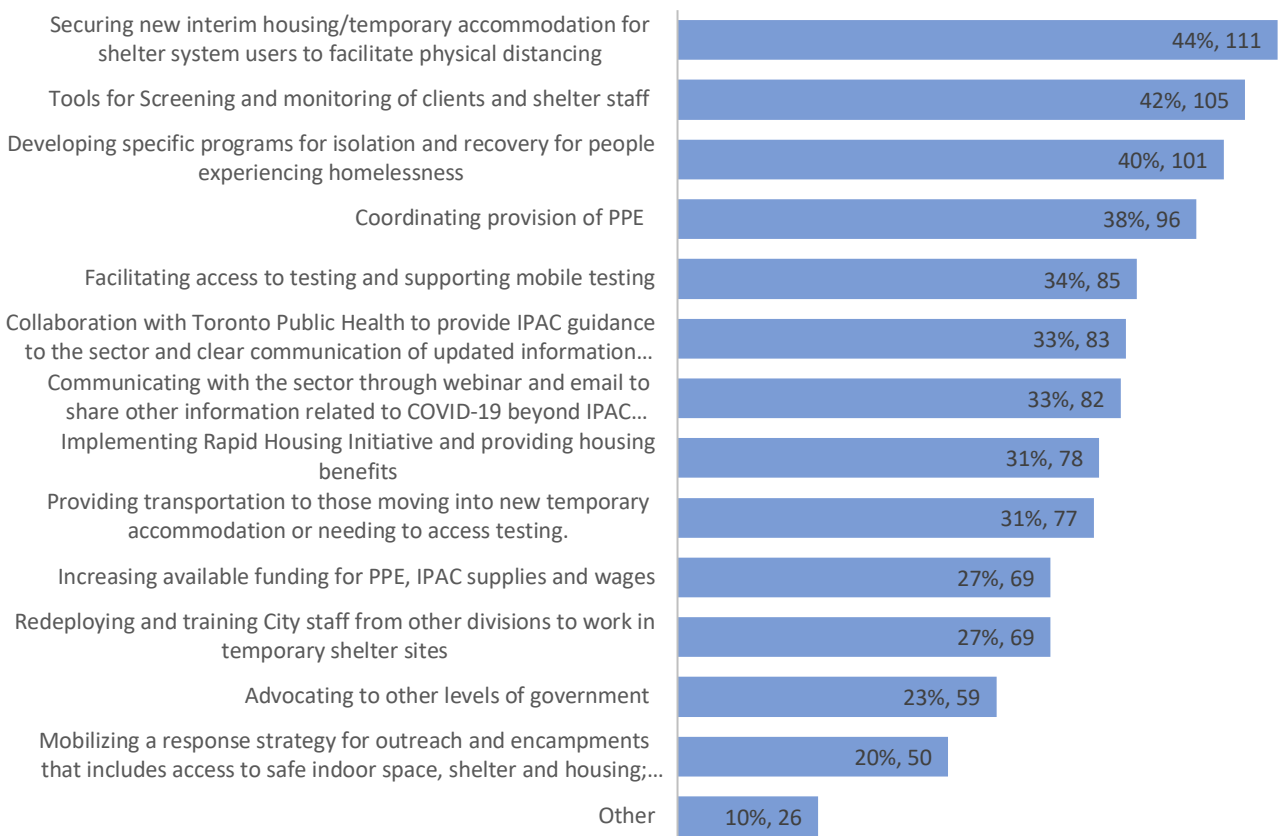
3. What are the top innovative or promising practices that your organization/department has implemented, or seen implemented elsewhere in response to COVID-19?



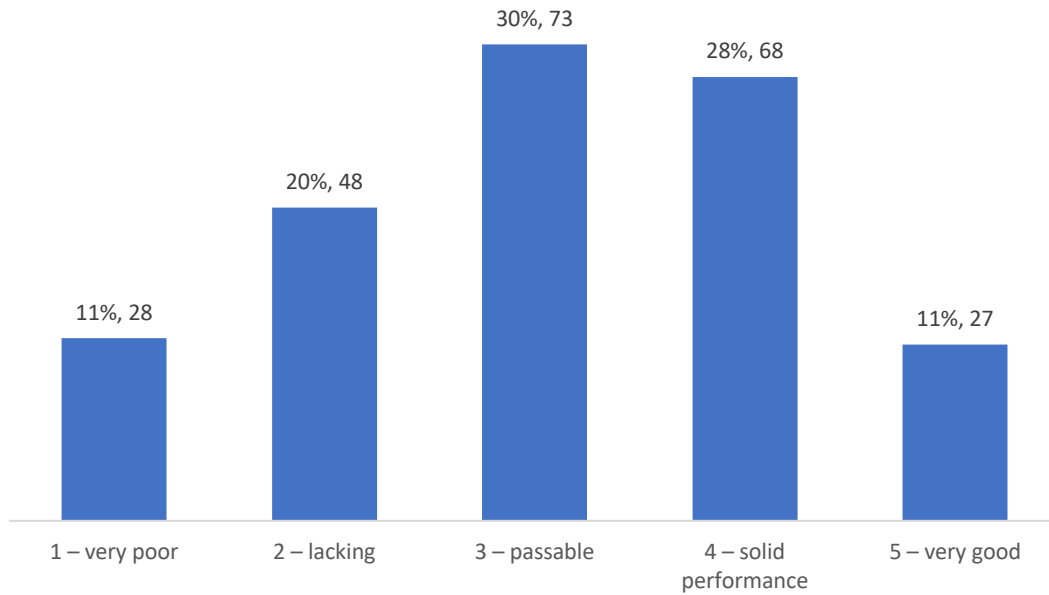
4. What partnerships and integration within your sector or across sectors has been helping you respond to COVID-19?



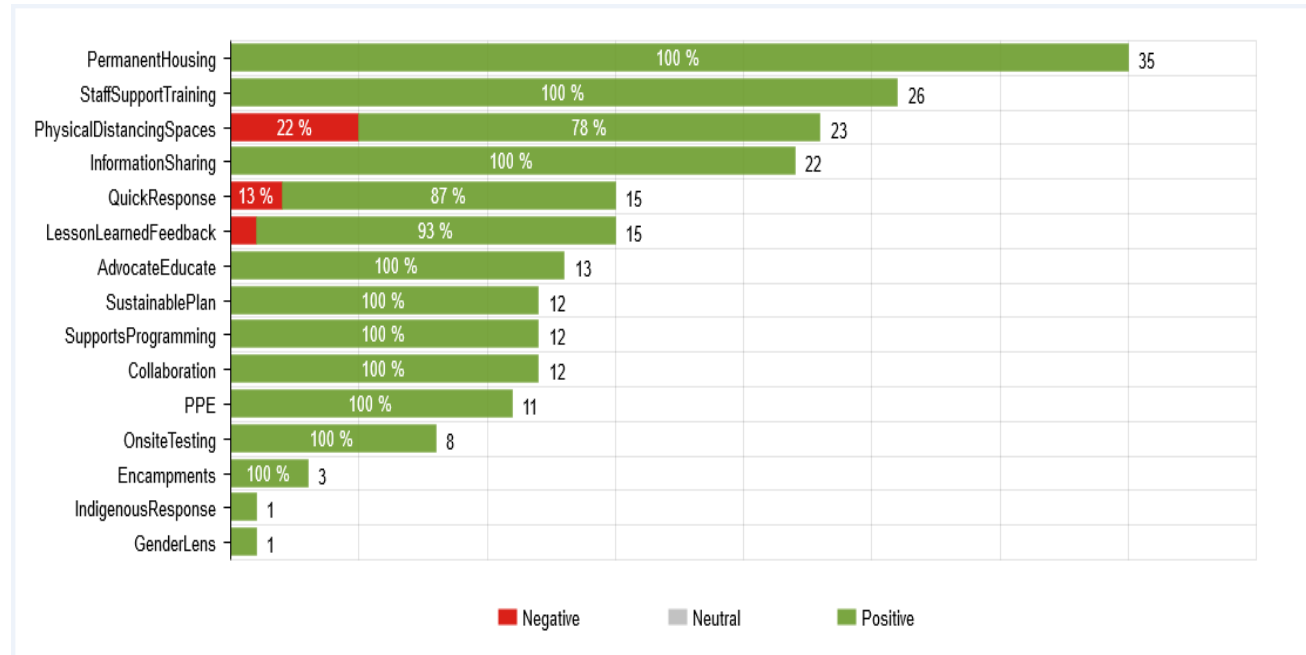
5. What aspects of SSHA's COVID-19 response have been helpful in your work to respond to COVID-19?



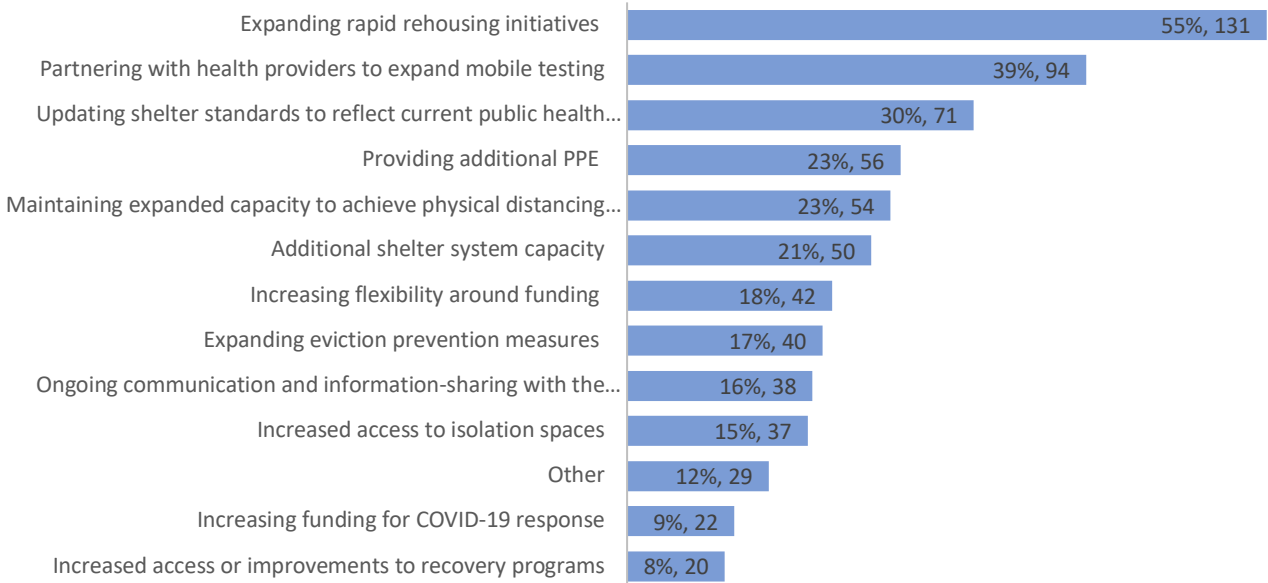
6. What is your impression of how effective SSHA’s COVID-19 response to support the homelessness sector has been in in the first 90 days?



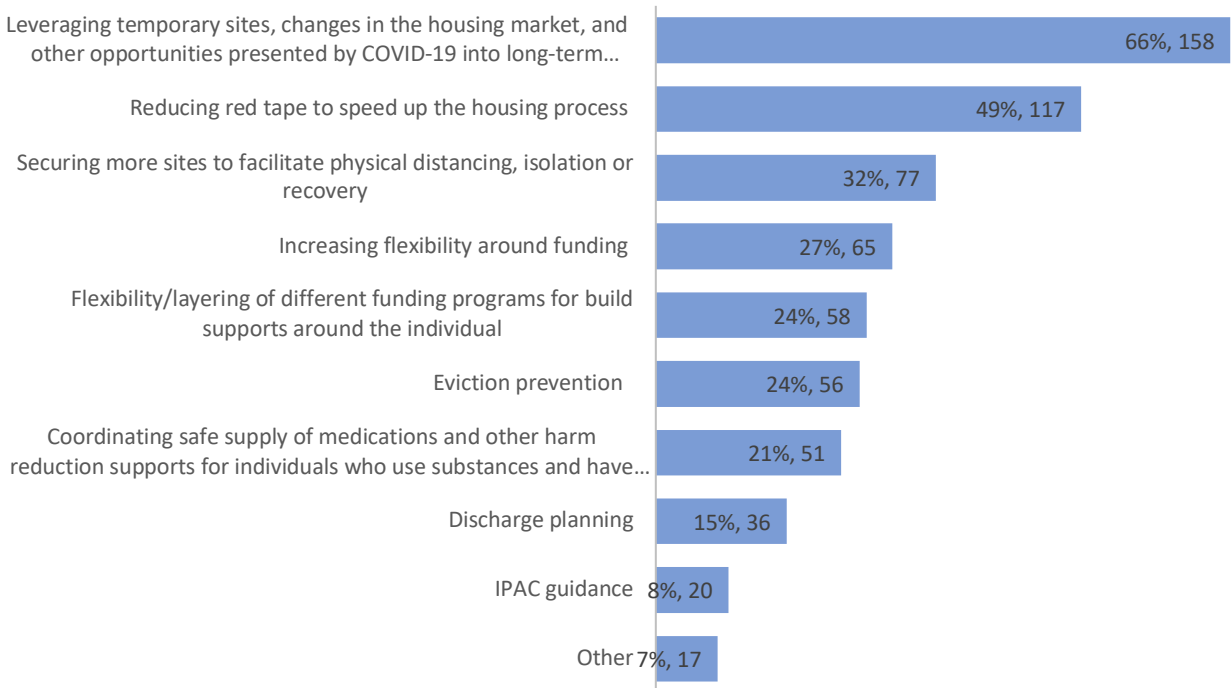
7. Please provide advice on how SSHA could improve our response for the next 6-12 months.



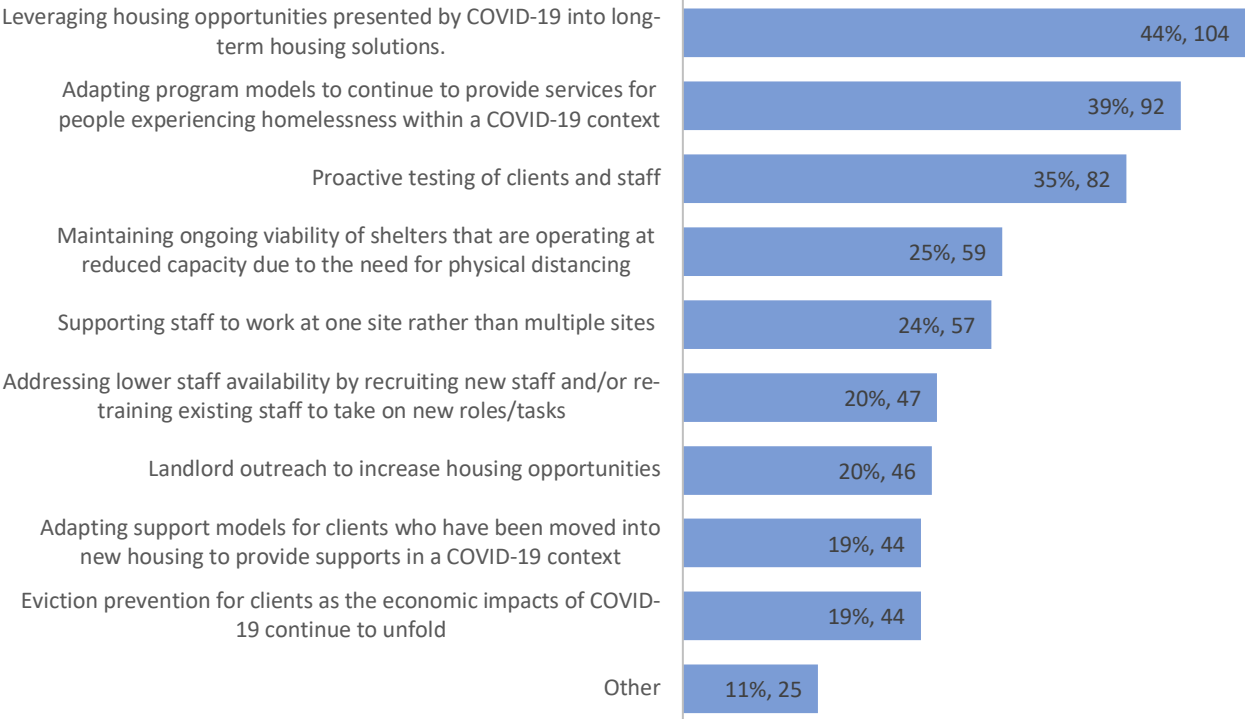
8. Where would additional support from SSHA make the biggest difference to continuing to protect people experiencing homelessness from COVID-19 over the next 6-12 months?



9. What areas are most in need of greater coordination between different levels of government in the next 6-12 months?



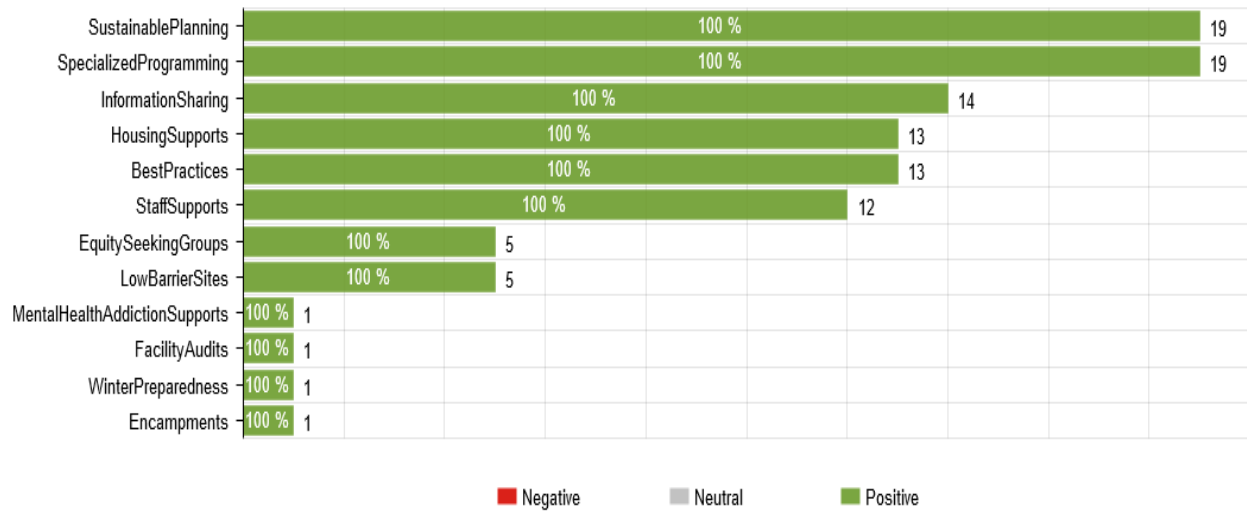
10. What will your top priorities over the next 6-12 months be?



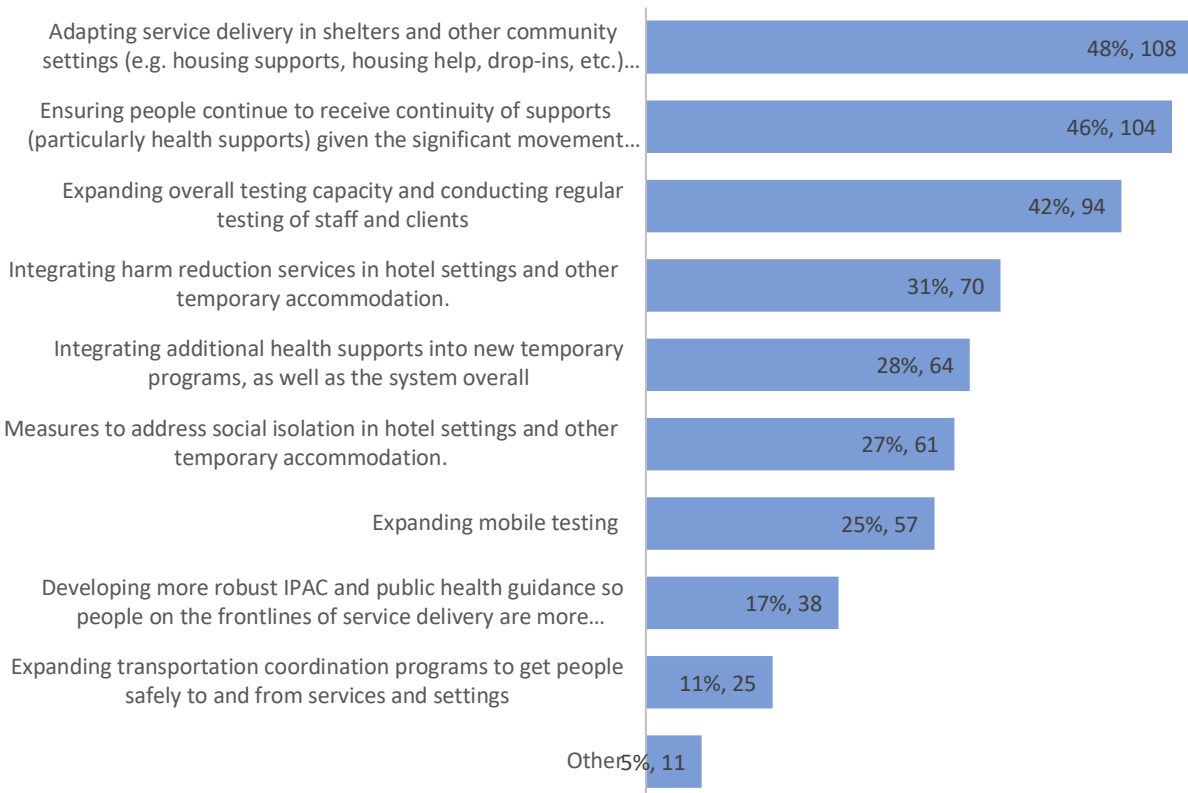
11. The COVID-19 Shelter Recovery Strategy currently has four priority areas for action over the next 6-12 months:

1. Infection prevention and health sector integration: Working with the health system to prevent and contain outbreaks, and lay the foundation for deeper, ongoing collaboration and coordination.
2. Housing opportunities and strategies: Meeting COVID-19 related housing needs, and leveraging opportunities presented by COVID-19 into long-term strategies to end homelessness.
3. Shelter capacity and systems integration: Strengthening the shelter system’s capacity to respond to COVID-19 over the next 6-12 months, building on the systems integration gains made in response to COVID-19, and using COVID-19 as an opportunity to reimagine the role of the shelter system.
4. Evidence-informed decision making: Gathering the data and research we need to monitor the implementation of the shelter recovery strategy.

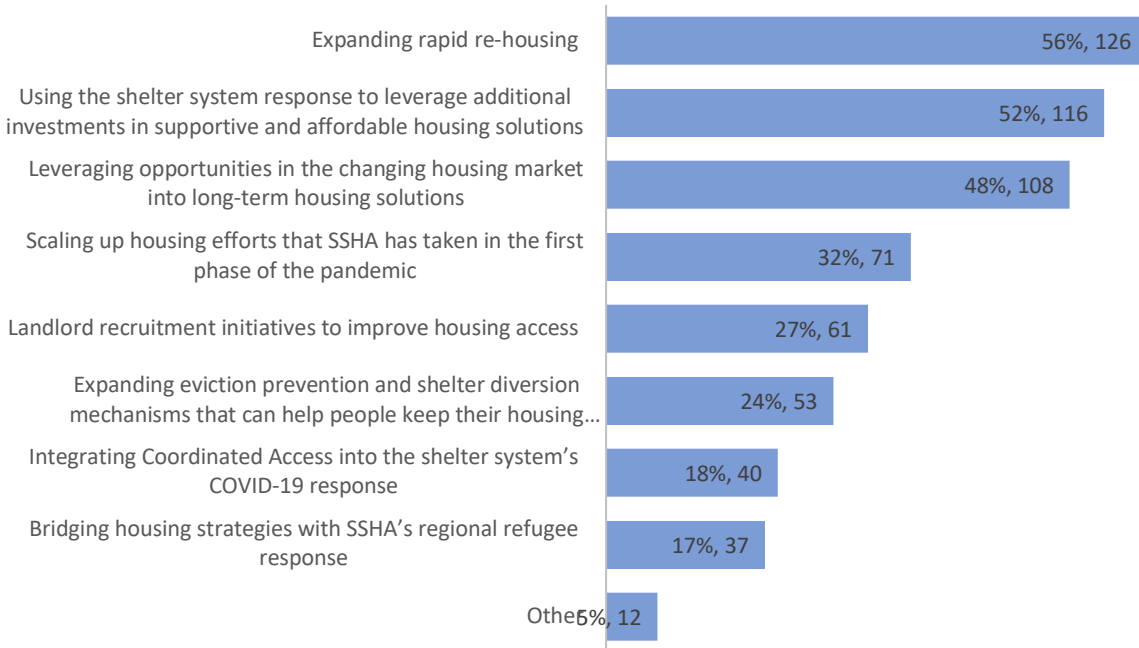
Is there anything else you think it would be important to add as a priority for the next 6-12 months?



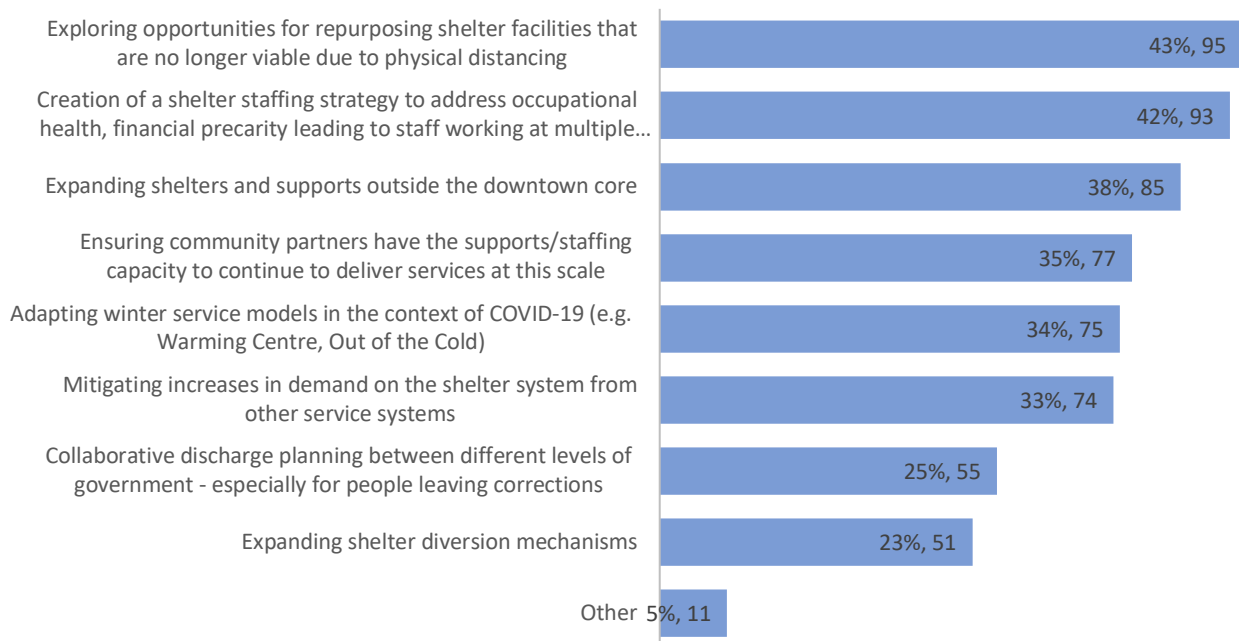
12. Priority area 1: IPAC and health system integration - What are the top three actions to take within this area? (Note: Some of these actions can be implemented by SSHA alone, while others require support or implementation from other partners or levels of government)



13. Priority area 2: Housing opportunities and strategies - What are the top three actions to take within this area? (Note: Some of these actions can be implemented by SSHA alone, while others require support or implementation from other partners or levels of government)

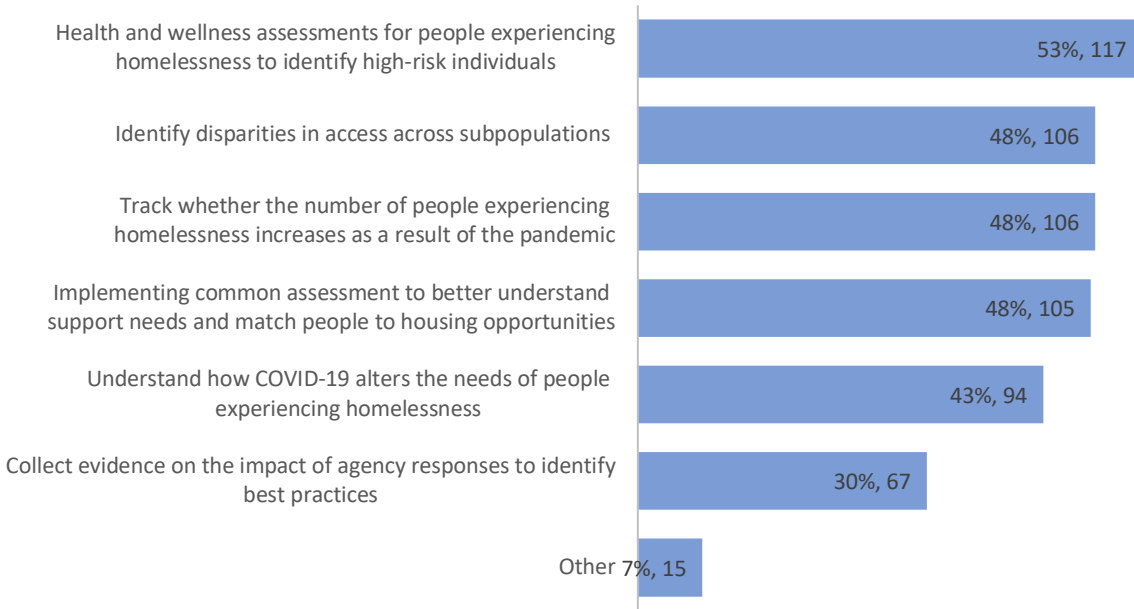


14. Priority area 3: Shelter capacity and systems integration - What are the top three actions to take within this area? (Note: Some of these actions can be implemented by SSHA alone, while others require support or implementation from other partners or levels of government)





15. Priority area 4: Data and evidence-informed decision making - What are the top three actions to take within this area? (Note: Some of these actions can be implemented by SSHA alone, while others require support or implementation from other partners or levels of government)



## Appendix C

# COORDINATED HEALTH SERVICES FOR SHELTER CLIENTS FRAMEWORK

*A Framework for Coordinated Health Services for Shelter Clients Between City of Toronto, Toronto Central Local Health Integration Network, and Central East Local Health Integration Network February 22, 2018*

### **Background**

In May 2017, a Shelter Health Services Advisory Committee comprised of the Toronto Central LHIN (TC LHIN), Central East LHIN (CE LHIN), City of Toronto, health service providers, and shelter operators was formed to oversee the development of a coordinated approach to health services delivery for shelter clients to improve access to services, health equity, client experience and system sustainability.

Guiding the work of the Shelter Health Services Advisory Committee is “An Accord for a Healthier Toronto Between City of Toronto and Toronto Central Local Health Integration Network – A Memorandum of Understanding” (January 2018) that defines their strategic and working relationship, and identifies the areas of joint focus and mutual priorities to improve outcomes for residents of Toronto. A shared priority is the establishment of this framework for a coordinated approach to delivering health services for shelter clients.

### **Purpose of this Framework**

The Shelter Health Services Advisory Committee has identified the key elements of this framework for coordinated health services delivery to be referenced by Working Groups comprised of shelter clients, local health service providers and shelter operators when designing local service delivery models. This framework specifies the common foundational elements that the TC LHIN and City of Toronto expect that health service providers and shelter operators will include in planning and delivering coordinated health service delivery models, to support care continuity for individuals who are living at shelters and as they transition to and from other shelters and/or housing. Hence, health services will follow the individual to various living settings and not be place-based.

Each of the framework elements are described in greater detail in a “Health Services for Shelter Clients Planning Guide, January 2017”, a resource that has been designed by the Advisory Committee to support the development of coordinated health service delivery models that are tailored to the profile and health service needs of clients at different shelters, and to leverage the array of health services that are available in the community (refer to Part D under Framework Elements below).

Coordinated health service delivery models will be developed, piloted, and evaluated by local Shelter Health Services Working Groups in the following five shelter locations. Each Working Group will proceed through the steps in the planning guide to design, pilot and evaluate a coordinated health services delivery model. Lessons learned will be shared within and across the five Working Groups, as well as with the Advisory Committee to inform improvements to the models, this framework and the planning guide.

It is recognized that the five pilot shelters represent only a small portion of the 60+ shelter operators in Toronto and therefore the Working Groups are advised to adopt a systems lens that considers what sub-region and pan-LHIN coordinated models of care might entail. In addition, this framework and the Planning Guide will be made available to all shelters and health service providers interested in planning coordinated health service models at the same time as the pilots. Regular status updates about this pilot will be provided to the Toronto Shelter Network, health service providers, and other venues, and input gathered from stakeholders as appropriate

Shelter	Provider	Sector	Size
<b>Birchmount Shelter</b> 3306 Kingston Road Central East LHIN	City	Older Men	100
<b>Hope Shelter (Open)</b> 29 Leslie Street Toronto Central LHIN – East SR	Salvation Army	Men	60
<b>Kennedy Road Shelter (Open)</b> 702 Kennedy Road Central East LHIN	Homes First Society	Women	90
<b>Runnymede Shelter (Q2/18)</b> 731 Runnymede Road Toronto Central LHIN – West SR	City	Men	50
<b>Warden Shelter (Q2/18)</b> 747 Warden Avenue Central East LHIN	Youthlink	Youth	55

**Framework Elements**

**A) Governance**

The figure below shows the governance, accountability and reporting structure for the Coordinated Health Services For Shelter Clients pilot initiative.

- Once the coordinated health service delivery models are designed and in place, the Advisory Committee and Working Groups for this initiative will sunset.
- The local health service providers and shelter operator staff will continue to work together to deliver coordinated health services in their respective neighborhoods.
- Local MOUs (refer to Part D below) between shelter operators and the lead health service provider will be established to specify the accountability relationship between the parties to deliver on their respective responsibilities and on their commitments to shared care.
- The lead health service provider may also have other agreements in place with other health service providers to ensure a comprehensive range of services is provided.
- The City of Toronto and the TC LHIN/CE LHIN will include expectations regarding coordinating service provision in their respective accountability agreements with shelter operators and health service providers.

**Governance**

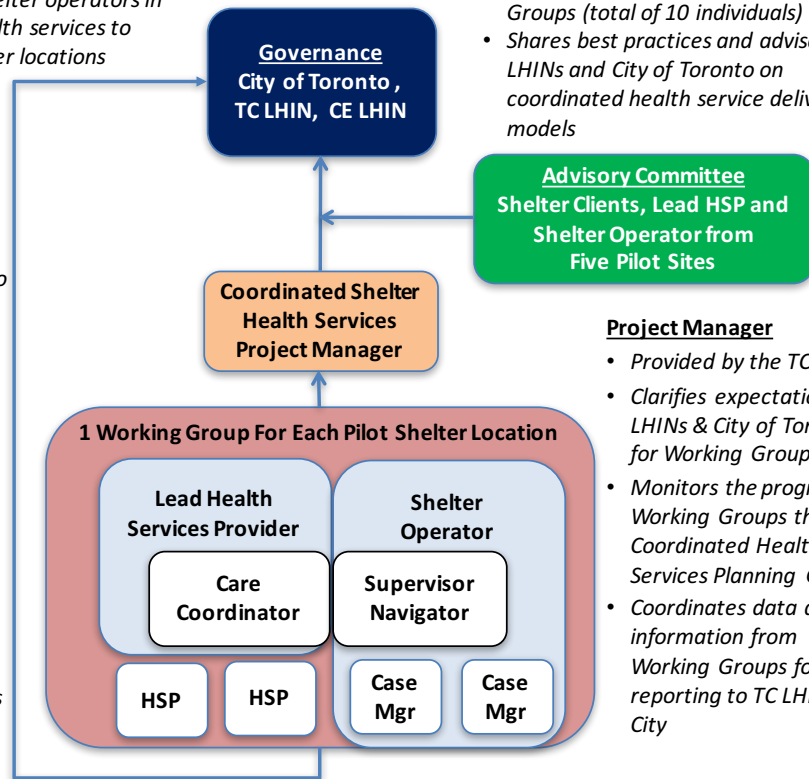
- TC LHIN and CE LHIN and City of Toronto jointly set expectations and oversee performance of health service providers and shelter operators in the coordinated delivery of health services to shelter clients in five pilot shelter locations
  - Reviews issues and gaps identified by local health service providers & shelter operators

**Working Group**

- TC LHIN & CE LHIN identifies Lead Health Services Provider to through EOI process
- Lead Health Services Provider coordinates with other HSPs to provide other services
- City of Toronto identifies Supervisor Navigator at each shelter. Navigator oversees Case Managers
- HSP Care Coordinator and Shelter Navigator to jointly assess, deliver and evaluate coordinated health services while at shelter and ensures care continuity in other settings
- Identifies and escalates LHIN & City issues gaps in service

**Advisory Committee**

- Consists of Lead HSP and shelter operator from each of 5 Working Groups (total of 10 individuals)
- Shares best practices and advises the LHINs and City of Toronto on coordinated health service delivery models



**Project Manager**

- Provided by the TC LHIN
- Clarifies expectations of LHINs & City of Toronto for Working Groups
- Monitors the progress of Working Groups through Coordinated Health Services Planning Guide
- Coordinates data and information from Working Groups for reporting to TC LHIN and City

- **Governance** – The Toronto Central LHIN/Central East LHIN & City of Toronto set expectations regarding outcomes and oversee work of health service providers and shelter operators on this initiative. Once a coordinated health service delivery model is designed for a shelter location, an accountability mechanism (e.g., stipulation in funding agreement) will put into in place between the LHIN and the lead or additional health service providers, and between the City and the Shelter operator. A regular process will be set-up for reviewing performance in delivering the coordinated care and to identify any gaps in service that need to be addressed by additional providers and/or funding.
- **Advisory Committee** – A Shelter Health Services Advisory Committee consisting of the lead health service providers and shelter operator from the five pilot shelter locations (a total of 10 individuals) will comprise the Advisory Committee. The Advisory Committee meetings will be a venue for Working Groups to share information and best practices with other Working Groups, and to provide guidance to the LHIN and City of Toronto on coordinated health service delivery models.
- **Working Group** – A Lead Health Services Provider and Shelter Navigator (see below) will work jointly with shelter clients, along with other health service providers identified, through the Planning Guide to design, develop and evaluate a coordinated health services delivery model. Regular progress updates are expected to be provided by the five pilot shelter site Working Groups to the Shelter Health Services Advisory Committee. Working Groups do not need to be formed net new; existing networks or other collaborative groups at the sub-region or local levels can be utilized to plan the coordinated health services delivery models.

- **Lead Health Services Provider** - A Lead Health Services Provider will be identified by the LHIN for each of the five shelter locations, through a Call for Expressions of Interest process, to work with the shelter operator to complete the work identified in the planning guide. The Lead Health Services Provider is expected to involve other health service providers in their neighborhoods or elsewhere in the City in the Working Group and in health services delivery (through formal agreements) to ensure that a comprehensive range of high quality health services are available for shelter clients to ensure coordinated care delivery while at the shelter and plans for care continuity once the individual leaves the shelter.
- **Shelter Supervisor Navigator** - The City of Toronto will ensure that each shelter has a “Supervisor Navigator” who will interface with the Lead Health Service Provider Care Coordinator. At each shelter, there will be a number of Case Managers reporting to the Navigator, who will provide housing case management services. The Shelter Supervisor Navigator will work closely with the Lead Health Services Provider to ensure that individuals receive health services while they are living at shelters and also as they transition to other living settings in the community.
- **Project Manager** – A project manager will be provided by the TC LHIN to facilitate the efforts of Working Groups. The project manager will clarify expectations with the Working Groups and obtain clarification from the TC LHIN, CE LHIN and City of Toronto, as well as monitor the progress of Working Groups for reporting to the TC LHIN, CE LHIN, City of Toronto, and Advisory Committee. The Project Manager will also support the evaluation of the models that are piloted.

**B) Coordinated Health Services Delivery - Shared Commitment and Roles & Responsibilities**

The table below describes the shared commitment between the TC LHIN, CE LHIN and City of Toronto, and the primary roles and responsibilities of health service providers and shelter operators for coordinated care delivery.

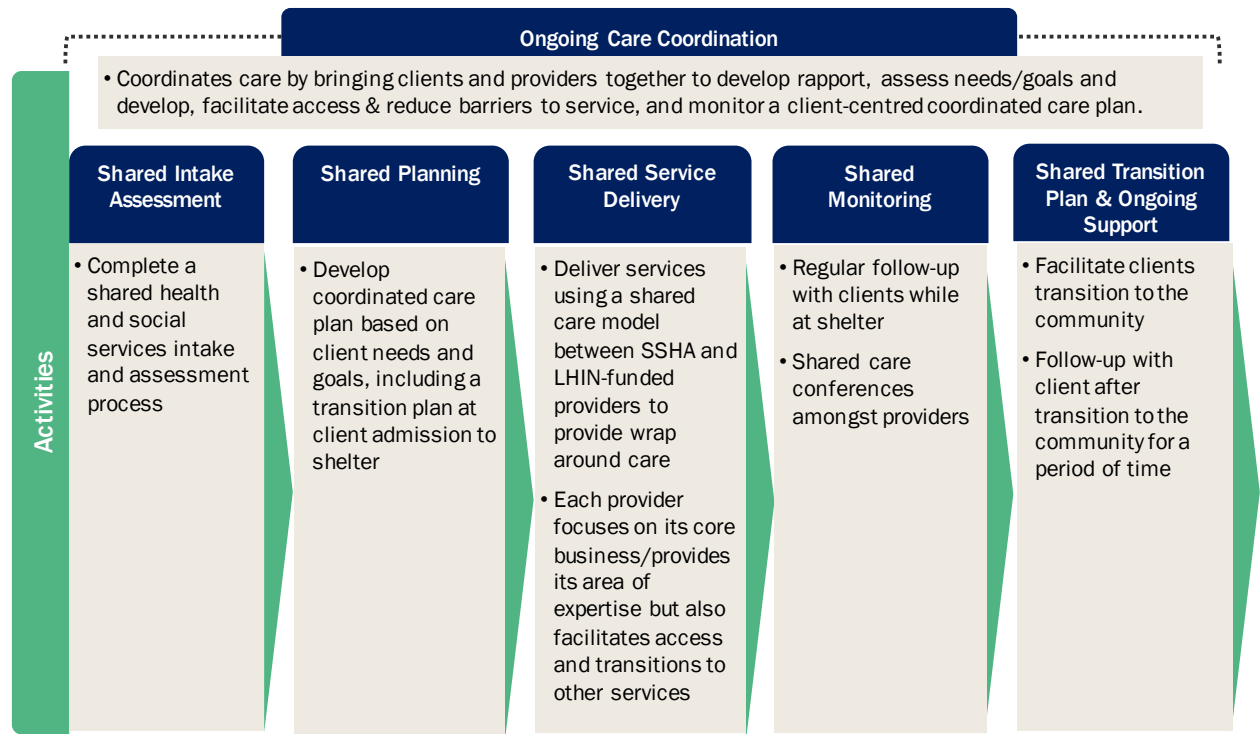
In essence, while each party has responsibility for delivering their core services, a seamless, team approach with health service providers and shelter operators working closely together is required to improve access to health services through a coordinated approach, while clients are living at shelters and as they transition to other settings.

Health service providers and shelter operators both also recognize that shelter users may have needs beyond health and housing services and will work together to identify and address these other needs with other system partners.

Shared Commitment Toronto Central LHIN, Central East LHIN & City of Toronto	
<ul style="list-style-type: none"> <li>• Joint governance and accountability for ensuring that health services are provided at the right place, right care, right time, while recognizing that shelters are for emergency and temporary accommodation</li> </ul>	
Health Service Providers	Shelter Operators
Health Service Providers & Shelter Operators jointly ensure coordinated health services planning and care continuity as clients transition between shelters and housing settings.	
<ul style="list-style-type: none"> <li>• Deliver health services</li> <li>• Provide navigation to other health services</li> <li>• Identify needs beyond health care and work with shelters to facilitate access to other services</li> </ul>	<ul style="list-style-type: none"> <li>• Deliver shelter and housing support services</li> <li>• Provide navigation to other housing support services</li> <li>• Identify needs beyond shelter and housing supports and work together with health service providers to facilitate access to other services</li> </ul>

**C) Coordinated Service Delivery Process**

The diagram below illustrates the specific functions that health service providers and shelter operators would provide together to ensure coordinated health services delivery. Ongoing care coordination resources (provided by the Lead Health Services Provider and shelter operator as per the diagram in Part A) above) will oversee the health and well-being of individuals while they are living at shelters and as they transition into communities. Shelter clients should be involved at every step of this process to ensure client-centred care.



**D) Memorandum of Understanding**

A Draft Memorandum of Understanding (Appendix A) has been developed to establish the terms, conditions and respective responsibilities of health service providers and shelter operators when collaborating in the design, pilot, and evaluate the local coordinated health service delivery model. The MOU includes: a shared vision; goals, values and principles; roles and responsibilities; and terms and conditions to enable collaborative working relationships.

The TC LHIN, CE LHIN and City of Toronto expect that each local Shelter Health Services Design Working Group will review the elements of this MOU as they work on designing and piloting a model, and a final MOU to be in place once the model has been determined. The MOU will be reviewed and updated yearly by the signatories; additional parties to the agreement may be added as appropriate.

## ***Planning Guide***

A “Guide to Developing Coordinated Shelter Health Services” has been developed with the expertise of the Shelter Health Services Advisory Committee to inform the efforts of local Working Groups. The guide includes the following key process steps, along with supporting information and tools:

- Establishing a working group
- Determining the profile of shelter users
- Assessing the strengths and challenges of health services for shelter clients
- Developing strategies and a model of coordinated health services delivery
- Developing implementation and evaluation plans
- Piloting the coordinated health services delivery model
- Evaluating and improving the coordinated health services delivery model and Memorandum of Understanding

Each Shelter Health Services Working Group is expected to use these process steps to guide the development of the most appropriate model of coordinated health services for their shelter locations and be able to provide a sound rationale for their proposed model and a sustainable implementation plan. As this guide is also being piloted, the Advisory Committee will also be seeking the feedback of Working Groups on this resource on a regular basis.

**Appendix A:**  
**DRAFT Memorandum of Understanding**  
**Between Health Service Providers and Shelter Operators**  
**for Coordinated Health Services Delivery**

**1.0 Background**

Individuals experiencing homelessness and utilizing shelters, whether on a temporary or ongoing basis can face significant challenges accessing the health services they need. The shared commitment and goal of the Toronto Central Local Health Integration Network (TC LHIN)/Central East Local Health Integration Network (CE LHIN) and Shelter Support & Housing Administration is client-centred care through the provision of the right health services, at the right place and at the right time to shelter users while recognizing that shelters are intended for temporary accommodation.

Locally, in neighborhoods in which shelters are situated, a coordinated approach to delivering health services amongst health service providers and shelter operators is needed to support the provision of client-centred accessible, comprehensive, coordinated and continuous services for shelter clients, while they are at shelters, and as people transition to other shelters and/or move to permanent housing settings in the community.

**2.0 Purpose**

This is an agreement between the \_\_\_\_\_ Shelter Operator and \_\_\_\_\_ Health Service Provider to reduce barriers and increase the access of health services for shelter clients.

The purpose of this agreement is to outline the aspects that will comprise a collaborating working relationship between the \_\_\_\_\_ Shelter Operator and \_\_\_\_\_ Health Service Provider which to reduce barriers and increase access to client-centred health services for clients while using the \_\_\_\_\_ Shelter.

**3.0 Term of this Agreement**

The term of this agreement shall be one year (April 1, 2018 to March 31, 2019) and subject to yearly renewal.

**4.0 Vision, Mission and Values**

The parties to this agreement will strive to achieve the following vision and goals and uphold the values and principles.

**4.1 Vision**

The vision for health services providers and shelter operators signing this agreement is:

- Shelter population needs are met through seamless collaboration between health, shelter/housing providers.

**4.2 Goals**

The goals of health service providers and shelter operators signing this agreement are:

- a. A joint approach to service delivery between health and shelter/housing providers to meet the needs of shelter clients
- b. Clear mandates, roles and responsibilities of health service and shelter/housing providers
- c. Joint accountability for shelter client outcomes



#### **4.3 Values**

The shared values guiding the work of health service providers and shelter operators signing this agreement are:

- a. Justice – shelter clients are treated fairly
- b. Human Rights – shelter clients have the same rights and freedoms as you and me
- c. Respect – shelter clients are accepted as they are
- d. Empowerment – shelter clients have a voice; they have autonomy and self-determination
- e. Equitable Access – shelter clients have the opportunity to access services just like any other population
- f. Person-Centred – services are designed to address the specific needs of shelter clients
- g. Collaboration – shelter clients, health service and housing providers work together to address client needs
- h. Innovation – new/creative approaches of service delivery for shelter clients are developed and implemented

#### **4.4 Principles**

The following principles will guide the efforts of the Working Group as they work together to design and deliver coordinated health services to shelter clients:

- a. Provide the right health services to shelter clients, in the right place, and at the right time, while recognizing that shelters are for emergency and temporary accommodation
- b. Design services based on client, not provider needs; involve shelter users in the process
- c. Adopt a low barrier lens when planning services, both those available in shelters and in the community
- d. Build the capacity of shelter clients to access community-based health services and provide supports that foster independence and empowerment
- e. Develop a system-wide response and be locally responsive to addressing the social determinants of health
- f. Start small and grow
- g. Adopt a common language
- h. Ensure services are evidence-based and evaluated
- i. Build on the strengths and expertise of stakeholders
- j. Develop a coordinated, city-wide approach by working with the five Toronto LHINS

#### **5.0 Respective Roles and Responsibilities**

\_\_\_\_\_ Shelter and \_\_\_\_\_ Health Service Provider agree to participate in a collaborative process to increase the access of shelter clients to health services. Aspects of this collaborative process include the following.

##### **5.1 Collaborative Health Service Model Design**

Responsibilities of both health service provider and shelter operators:

- a. Participate as an active member in the Working Group to design a model for coordinated health services delivery
- b. Collaborate to develop a profile shelter clients' health service needs

- c. Assess the capacity and capabilities of the health service provider's existing health services and identify challenges/gaps that need to be addressed
- d. Develop and implement joint strategies and a model to increase the access of shelter clients to health services

## ***5.2 Collaborative Health Service Assessment & Delivery***

### 5.2.1 Responsibilities of health service providers

- a. Provide required health care information to support the intake and settlement of the individual at the shelter (e.g., hospital discharge summaries, medications, other relevant health information)
- b. Provide shelter clients with choices and options regarding health services that they can access and support clients with navigating the health system
- c. Ensure the availability of appropriate health services, medical supplies, equipment and physical space for the private and safe provision of health services to shelter clients
- d. Work with shelter staff to support shelter clients with identifying and accessing non-health related services
- e. Ensure the continuity of health services as the client transitions to other settings (e.g., other shelters, permanent housing)

### 5.2.2 Responsibilities of shelter operators

- a. Provide health service providers with information about shelter clients, shelter environment, available health services, and other relevant supports at or outside of the shelter to support the access and continuity of health services for clients
- b. Provide the appropriate physical space within the shelter to health service providers to ensure privacy and confidentiality in the provision of health services
- c. Work with health service providers to identify and support shelter clients with accessing health services and/or other supports
- d. Provide shelter clients with access to supports to secure permanent housing
- f. Support shelter clients with accessing non-housing related services that are needed as the client transitions to other settings (e.g., other shelters, permanent housing)

### 5.2.3 Responsibility of both health service providers and shelter operators

- a. Contribute health service and shelter staff/professionals to work as members of an inter-professional team and specify the frequency and hours/volume of service of each type of staff/professional that will be dedicated
- b. Ensure that health service and shelter staff/professionals have the necessary training and competencies to provide services to shelter clients (e.g., trauma informed, low-barrier, harm reduction)
- c. Complete a joint assessment of client health needs using a common assessment tool to identify necessary health services
- d. Jointly determine whether the shelter is the appropriate place for the person given the profile and health service needs of the individual. If the shelter is not the appropriate place, jointly identify alternatives in the community

- e. Facilitate access to available health services (e.g., introductions to health service providers, transportation, accompaniment)
- f. Work with the shelter client to identify health and other goals to support access to health services and the individual securing permanent housing
- g. Participate as members of an inter-professional team, providing care to client on a regular basis and during transitions to other shelters or to permanent housing
- h. Jointly identify, coordinate and work together to address emergency and crisis health service needs of shelter clients. In the event one or more participants in this protocol is overwhelmed and cannot meet the needs of shelter clients due to the absence of staff, inaccessibility or lack of resources, other health service providers may be contacted to support the clients

### ***5.3 Collaborative Evaluation of Health Services Provision & Partnership***

- a. Share data and information using a joint tool and information system and through care regular check-in meetings (e.g., care conferences) to evaluate the accessibility and provision of health services
- b. Jointly complete an evaluation of the access, availability, quality, timeliness, efficiency, and coordination of health services to shelter clients and identifying strategies to address challenges
- c. The inter-professional team (and their respective agencies) will complete a joint self-assessment of the working relationships (and the partnership) between the health service provider and shelter operator, identifying strengths and improvements, and updating this agreement as necessary
- d. The health service provider and shelter operator will complete performance evaluations of its own agency staff, and their performance as per requirements set out in this agreement

### **6.0 Privacy & Confidentiality**

Staff/professionals of the Health Service Provider and Shelter Operator named in this agreement agrees to It is assumed that all parties to this agreement have existing privacy and security of information policies. This agreement does not alter those agencies' existing policies. The partners of this agreement understand and agree to abide by the requirements under the Personal Health Information Protection Act, 2004 (PHIPA).

### **7.0 Conflict of Interest**

Any situation in which the staff/professional employed by the Health Service Provider or Shelter Operator by virtue of the individual's position, has or may be perceived to have (by a reasonable and objective person in the circumstances), a conflict between his or her private or personal interest and the provision of services to shelter clients by the Health Service Provider or Shelter Operator, must be declared to the senior management of the respective organization and actions identified and implemented to address the real or perceived conflict of interest.

### **8.0 Decision-Making**

- a. Every effort will be made to reach consensus on decisions pertaining to this agreement
- b. If consensus cannot be reached, the matter will be escalated to the designed senior management of each party to arrive at an agreement. Once a decision is reached, all staff/professionals of the Health Service Provider and Shelter Operator will support the decision in public.

- c. If consensus cannot be reached by the senior management of the Health Service Provider and Shelter Operator, the TC LHIN/CE LHIN will facilitate negotiation. A regular evaluation of the decision-making process will be undertaken.

**9.0 Dispute Resolution**

When conflicts occur regarding the work between the parties to this agreement, the matters will be discussed promptly, respectfully and openly, with a focus on conflict resolution.

Concerns may be raised formally in writing or informally through meeting discussion and should be brought to the attention of the designated senior management representatives of the Health Service Provider and Shelter Operator

Unresolved issues that impact the provision of health services will be brought to the attention of the designated representative at the Toronto Central Local Health Integration Network.

**10.0 Termination of Agreement**

- a. Either party may terminate this Agreement at any time upon giving 12 weeks prior written notice to the other party.
- b. Except as stated in this Agreement and/or any specific written agreement between the parties, upon termination of this Agreement, neither party shall have any obligation or liability to the other.
- c. The Health Service Provider and Shelter Operator shall continue to perform the Services, as outlined in this Agreement, during any notice period.

**11.0 Signatures**

Organization	Name	Signature