Wellington-Guelph

Health and Housing Community Plan

June 2026

Table of Contents

Introduction

This Wellington-Guelph Health and Housing Community Plan (HHCP) serves as a shared roadmap for coordinated action across the health and housing sectors. The overarching aim of the plan is to improve health, housing stability, and wellbeing for residents of the Wellington-Guelph community who are experiencing/at risk of homelessness, including those who are experiencing precarious health and/or housing.

The plan supports the development of an integrated and equitable spectrum of health, housing, and community supports to address prevention, as well as the needs of those at risk of crisis due to the intersectionality of health and housing challenges (prevention and diversion); in crisis (acute intervention/support); and emerging from crisis and in need of ongoing health, housing, and social supports to maintain housing to continue on their journey to health, wellbeing, and independence. The HHCP responds to local needs, system gaps, and community priorities, as identified in the Health and Housing Symposiums. The HHCP is designed to be a *"living document"* that will continue to evolve and be updated ensure that it is responsive of local needs and changing contexts.

Vision

The Vision Statement for the Wellington-Guelph Health and Housing Community Plan was developed in collaboration with lived experts. A joint session bringing together members of the Planning Table and members of the Lived Experience Advisory Group was held to finalize the vision statement. The vision statement is a collective view of how we want our community to be. Our vision of the future is:

Everyone in Wellington County and Guelph has a safe place to call home in a loving and healthy community.

Mission

The Mission Statement for the Wellington-Guelph Health and Housing Community Planning Table was adopted by the Planning Table after the joint visioning session:

Grounded in trust, collaboration, and the wisdom of lived experience, our mission is to collectively create and support a system where every member of our community has equitable access to safe, dignified, and connected health and housing services.

Values

The values were developed in consultation with the Lived Experience Advisory Group as part of the facilitated discussions held to create a vision statement. The intention for these values to guide future conversations and decision making as the plan is implemented.

The Health and Housing Community Plan is underpinned by the following values and is designed to be:

Accessible	*Equitable*
Connected	*Responsive*
Dignified	*Safe*

Community Context

In 2016, Wellington-Guelph joined the Built for Zero-Canada Campaign (then called the 20,000 Homes Campaign), a national movement to end chronic homelessness. Health and Housing community partners continue to work together though our Coordinated Access System (CAS), to develop and implement data-driven approaches that focus on optimizing the local homelessness-serving system to end chronic homelessness in Wellington-Guelph.

Chronic homelessness describes situations where an individual has been homeless for six months or longer, or has experienced multiple, repeated episodes of homelessness totaling 18 months or more over the last three years.[1] Levels of chronic homelessness in Ontario have also increased, representing 53% of all homelessness in the province.[2]

The Wellington-Guelph By-Name Data (BND) is a real-time list of all people experiencing homelessness locally. The BND indicates that there have been recent increases in experiences of homelessness in our community. This trend has been noted across Ontario, with recent reports documenting a dramatic, nearly 50% increase in levels of homelessness between 2021-2025.[3] In 2021, an average of 124 individuals experienced chronic homelessness every month in Wellington-Guelph. By 2025, this monthly average had increased to 219 individuals per month, with many individuals on the Wellington-Guelph BND experiencing chronic homelessness. Local data also shows increases in youth and families experiencing homelessness and that Indigenous people continue to be over-represented in the population of people experiencing homelessness.[4]

Individuals experiencing chronic homelessness often have complex needs. In the 2024 Wellington-Guelph Point-in-Time Count, 71% of individuals reported a mental health issue, 73% reported having a substance use issue, and 43% reported another illness or medical condition. Two or more health challenges were identified by 79% of participants. Mental health challenges, substance use challenges, incarceration, landlord/tenant conflict and/or conflict with spouse/partner, parents, guardian, or others were identified by participants as contributing factors to most recent loss of housing.[5]

Since 2023, Wellington-Guelph has substantially increased the number and types of health and housing supports available to serve vulnerable community members as a community, including:

- expanding the number and type of emergency shelter beds
- adding new transitional housing with supports for adults (65 Delhi)
- creating two new purpose-built permanent supportive housing projects for adults (Grace Gardens and 10 Shelldale)
- transforming supportive housing units for youth (Bellevue)
- expanding rapid rehousing and diversion programming
- expanding access to the Housing Stability Rent Support (HSRS) Programme and other rent supports
- expanding emergency shelter services to include health care services
- developing an integrated health hub for youth-serving system (Wyndham House Concurrent Youth Hub), which provides integrated health services and supports across all youth serving emergency, transitional, and supportive housing
- developing a Homelessness and Addiction Recovery Treatment (HART) Hub that provides care, housing, and treatment for people with the most complex needs
- a recent investment of $4.48 million to support 100% of Wellington-Guelph residents to attain attachment to a primary care provider

Despite the substantial increase in the number and type of services that have been recently implemented, the increase in services available locally is outpaced by increased demands and need for health and housing services in our community.

The Need for Health and Housing Integration

Individuals experiencing/at risk of homelessness frequently have multiple health concerns.[6] The experience of homelessness or housing instability is widely recognized as a contributor to poor health.[7]

The relationship between health and housing is well-documented, with research showing that stable, appropriate, and safe housing can have a positive impact on health (including mental health and substance use disorders/addictions).[8] The reverse is also true in that unmet health needs, including mental health and substance use disorders/addictions can lead to housing instability and housing loss.

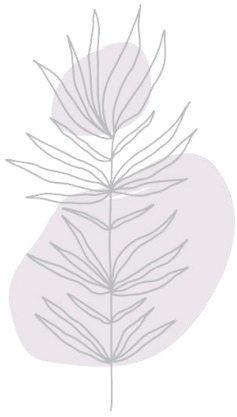
Individuals experiencing/at risk of homelessness may face barriers to accessing appropriate health care services and supports and/or appropriate housing, leaving them with unmet health and/or housing needs. Individuals with unmet health and/or housing needs often are forced to rely on emergency services, such as emergency shelters and hospital emergency departments (ED). By integrating health and housing services in Wellington-Guelph our community will be better positioned to meet the complex needs of individuals experiencing/at risk of homelessness to improve their health and housing outcomes.

Addressing Health and Housing Integration in Wellington-Guelph

The 2024 Health and Housing Symposiums invited health, housing, and Indigenous service providers, along with lived experts, community members, and elected officials to listen and learn together. The Symposiums facilitated discussions that helped to identify themes and common threads which were then organized into community priorities. These community priorities are identified as "action areas" in this plan and appear below:

- Comprehensive health services
- Data informed planning and decision-making (previously called mapping of services and data collection)
- Emergency responses to homelessness
- Housing options
- Indigenous-led solutions
- Integration of health and housing
- Mental health and substance use services
- Policy and funding advocacy
- Prevention interventions
- Provision of basic needs for people experiencing homelessness
- Public education
- Upstream prevention

The Wellington Guelph Health and Housing Community Planning Table (WGHCCPT or 'Planning Table') was formed following the Symposiums, in order to maintain and build momentum for collaborative work across the community. The Planning Table consists of health providers, housing providers, non-profits, rural partners, and municipal leaders. A Lived Experience Advisory Group (LEAG, previously called People with Lived Experience Advisory Group) was also developed shortly after the Symposiums in order to continue to support voices of lived experience experts in health and housing discussions.



Role of the Wellington-Guelph Health and Housing Community Planning Table

The Wellington-Guelph Health and Housing Community Planning Table was created following the Health and Housing Symposiums. The Planning Table provides advice, oversight, and actively contributes leadership to support both planning and action for the integration of health and housing services in Wellington-Guelph, based on consultation with lived experts. The Planning Table is co-chaired by the Administrator of Social Services, County of Wellington (serving Wellington and Guelph) and the Director of Transformation of the Guelph Wellington Ontario Health Team (GW OHT). The Planning Table supports partners across the health and housing systems to optimize the use of resources in support of equitable access to health and housing services and realize improved health and social outcomes for people experiencing homelessness and precarious health and housing in Wellington-Guelph. Membership of the Table includes executive decision-makers from partners that have a primary health and/or housing mandate, including health and housing service providers, rural partners, non-profits, and municipal leaders. Additional details about the group's mandate and membership can be found in Appendix A.

Role of the Wellington-Guelph Lived Experience Advisory Group

The Wellington-Guelph Lived Experience Advisory Group (LEAG) is comprised of a diverse group of individuals from both rural and urban backgrounds, who have accessed health, housing, or Social Services. This includes individuals who have experienced homelessness or housing instability, experienced challenges related to their health, mental health, substance use, and/or addictions. People with lived experience have expert knowledge of their communities, the problems they face, service gaps, and potential solutions. Research has shown that programmes and policies benefit from the involvement of those with lived experience.[9] Lived experience experts have valuable insights to share that can support decisions in the best interests of the Wellington-Guelph community.

The focus of the LEAG's work is to bring forward the perspectives of those with lived experience to help inform key aspects of service delivery, address barriers, and/or support effective planning and policy development. Although the work of the LEAG may help inform future community-based advocacy, it is not an advocacy group. The LEAG's Terms of Reference is attached as Appendix B.

Members of the Advisory Group:

- Actively participate in discussions and activities on a variety of topics related to health, housing and/or social services
- Share information on needs and gaps, bring forward recommendations, identify challenges, etc. based on personal experiences and knowledge but also that reflect a broader awareness of challenges, barriers and solutions of people accessing services
- Support the development of and/or participate in planning and carrying out of engagement activities to better understand the needs and service gaps in our area
- Participate in ad-hoc engagement activities including but not limited to focus groups or conversations about specific plans and programming that is under review or development
- Help identify common challenges and issues related to trends and system barriers
- Help identify and improve the understanding of community needs and service gaps
- Bring forward ideas and suggestions about topics that the Advisory Group could work on and how to connect with people with lived/living experience beyond the Advisory Group.
- Review/provide feedback on the function and purpose of the Advisory Group

The LEAG has been meeting regularly since its inception in September 2024. The LEAG has provided input on both action- and planning-oriented activities, as requested by the Planning Table. The group has provided input on a variety of topics that has informed activities of the Planning Table and its associated service providers. A list of the topics that the LEAG was consulted on and a summary of findings can be found in Appendix C.

Overarching LEAG Recommendations:

Responses to community needs are often fragmented, time-limited, bureaucratic and disconnected from lived experience. Actions and interventions must be flexible, coordinated, sustained and based on trust and relationships in order to realize the vision adopted by the Health and Housing Community Planning Table.

- Invest in people, not just programs
- Stabilize staffing and embed peer roles across systems
- Create coordinated service and program hubs (urban & rural) with predictable hours
- Integrate health, housing, outreach, and discharge planning
- Make after-hours support standard, not exceptional
- Measure success by individual stability and individual progress, not only program inputs

Lived experience validates current strategic plans, adds operational details on what works and identifies gaps that may be overlooked – ultimately strengthening the ability for plans to lead to effective implementation and system change.

How the Plan was Developed

The development of this plan was an iterative process and included multiple consultations with the Planning Table and the LEAG. The Health and Housing Community Plan was developed through a collaborative process to address health and housing integration in Wellington-Guelph.

The strategies and actions proposed in this plan are based on direction from the Planning Table, consultations with the LEAG, and other consultations with community partners/collaboratives working in alignment. The plan has embedded cross-cutting themes that are key from the perspective of lived experts, and specific recommendations that have been identified by the LEAG are included in the respective actions proposed below.

The focus and objectives of the different strategies and actions proposed in this community plan will differ across each of the 12 identified action areas. Some areas focus on building shared understanding and alignment, while others focus on service coordination, capacity-building, or policy and systems change.

This diversity of approaches allows partners to contribute in ways that match their organizational mandates, resources, and roles within the system, while collectively advancing a community-wide strategy. In this way, the plan supports flexible and responsive pathways to our shared vision.

Framework for Action

The framework for action adopted by the WGHHCPT consists of the Homelessness Prevention Framework and drivers for system change (enablers). The enablers of system change include actions related to data-informed planning and decision-making, policy and funding advocacy, public education, the integration of health and housing, and the continued integration of lived experience expertise as part of the plan's implementation process.

The Homelessness Prevention Framework

The Wellington-Guelph Health and Housing Community Plan is structured to align with the Homelessness Prevention Framework ('Prevention Framework'), developed by Stephen Gaetz and Erin Dej.[10] The Homelessness Prevention Framework focuses on the need to primarily invest in homelessness prevention, permanent housing solutions, and the health and other supports needed to help obtain and maintain housing. This approach has been adopted by the Planning Table and Wellington-Guelph Community Partners.

The Planning Table has adopted the Prevention Framework as a strategy to strengthen opportunities for collective impact. In addition to fostering collective impact, this Prevention Framework helps to organize and align ongoing work to address experiences of homelessness, precarious health and housing instability locally.

Establishing a shared focus ensures consistency, direction, and momentum in addressing key challenges in three pillars from the Prevention Framework:

- Prevention – Addressing root causes of homelessness, including unmet health needs, to reduce the number of individuals reaching a crisis point.
- Emergency Response – Providing immediate interventions to support individuals during crises.
- Health & Housing Supports – Ensuring access to essential services that facilitate stabilization and long-term recovery.

The prevention framework is oriented to system transformation through shifting resources to prevention and health/housing supports with less emphasis on emergency responses.

This holistic approach is in line with the Planning Table's commitment to prioritize prevention and support efforts, addressing root causes of homelessness and promoting long-term stability to prevent returns to homelessness, including those with mental health challenges and substance use disorders. Although there has been substantial focus and effort on system transformation in our community, due to the worsening of the housing crisis, it remains that much of the focus in our community has been on emergency response. Through this plan we actively seek to align and coordinate resources to address prevention and stability efforts. Resource coordination enables efficiency and ensures supports are directed to where they are most needed.

The Homelessness Prevention Framework and Housing First

The Prevention Framework complements the Housing First approach, which can be applied as an evidence-based model to house people with serious mental illness who are also experiencing chronic homelessness. Housing First provides immediate access to housing combined with intensive and individualized wrap-around supports. Helping individuals quickly access housing is based on the notion that housing provides a foundation and that health problems worsen the longer people experience homelessness.

Housing First has a recovery orientation, uses a harm reduction approach while focusing on client-led services that empower and support individuals to reintegrate into community through meaningful activities and self-determination.[11] Both the Prevention Framework and the Housing First approach prioritize a shift away from crisis and emergency responses, focusing on prevention and finding permanent housing solutions – towards *ending* rather than *managing* homelessness.

Application of The Homelessness Prevention Framework

The Prevention Framework is action-oriented and grounded in best practices from both health and housing sectors. It provides a shared foundation for guiding decisions, prioritizing initiatives, and ensuring a strategic approach to progress. Adding this structured approach to organized the plan ensures that all actions of the Wellington-Guelph Health and Housing Community Plan are:

- strategically aligned
- responsive to community needs
- positioned for sustainable impact

To identify and implement solutions to address the needs of people experiencing homelessness and precarious health and housing in Wellington-Guelph, the 12 action areas (listed on page 8) were aligned with the Homelessness Prevention framework:

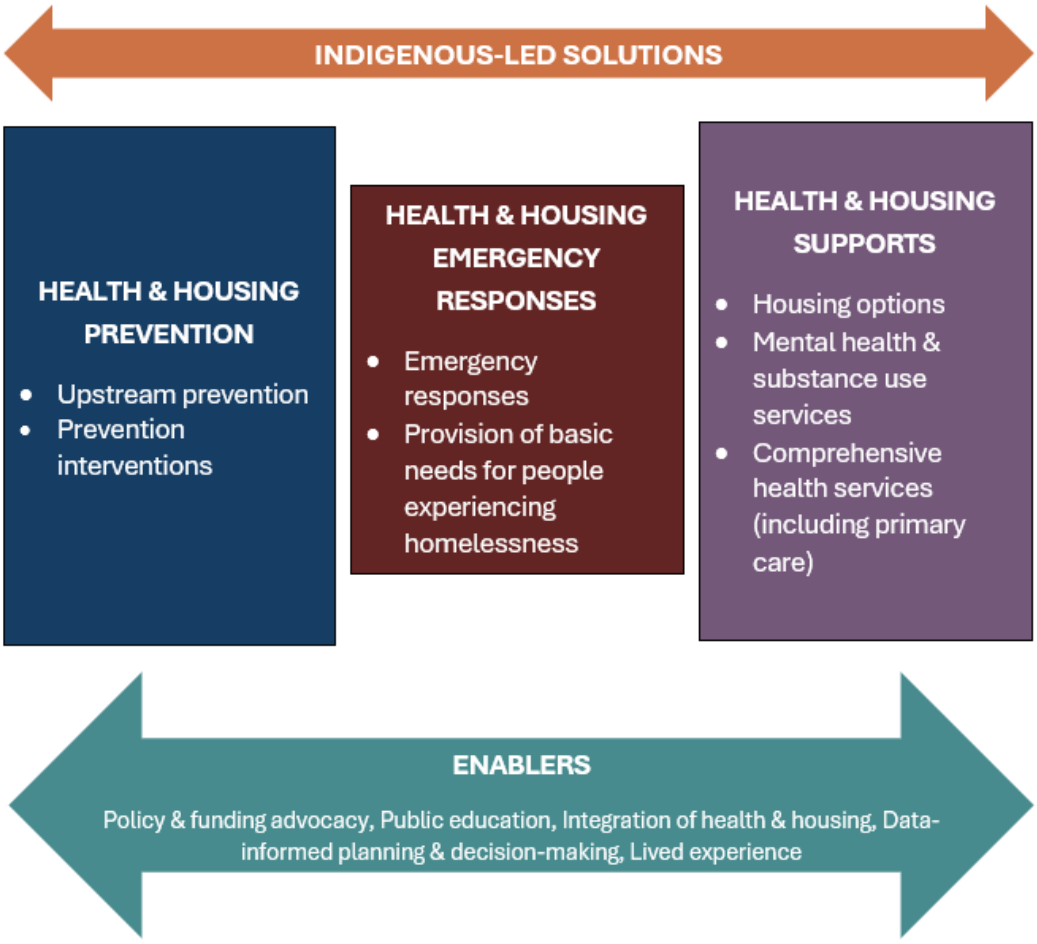


Figure 1. Adapted Homelessness Prevention Framework for Health and Housing Integration in Wellington-Guelph.

Each of the 12 action areas are categorized under the pillars of (1) prevention, (2) emergency responses, and (3) supports within both health and housing systems. By mapping the 12 action areas within this framework, it becomes easier to identify current areas of focus, assess potential gaps, and determine opportunities for greater impact.

Under the 'Prevention' category, both health and housing strategies emphasize upstream approaches designed to prevent individuals from entering homelessness and maintain health and wellbeing. Targeted prevention interventions are required to reduce instances of recurring chronic homelessness and unmet health needs.

The 'Emergency Responses' category represents the primary focus of current efforts. This includes crisis interventions within health and housing systems, as well as the provision of basic needs and emergency shelter/accommodations for individuals experiencing homelessness. Emergency responses that help to meet the basic needs of individuals, such as food and emergency shelter, while necessary, do not prevent homelessness. Supports provided in an emergency context, such as life skills, substance use, and mental health supports are not preventative unless individuals have immediate access to housing.[10]

The 'Supports' category focuses on ensuring that housing options are tailored to meet the needs of individuals experiencing homelessness and precarious health and housing. Furthermore, it encompasses mental health and substance use services, along with comprehensive healthcare solutions.

Beyond these three categories, the framework integrates Indigenous-led solutions as a standalone action area and enablers of system change, including policy and funding advocacy, public education, the integration of health and housing systems, and a focus on data-informed planning and decision-making. The 'enablers' span the prevention, emergency response, and support action areas, and are reflected in the strategies and action proposed below to ensure a holistic and inclusive approach to addressing homelessness in the Wellington-Guelph community.

Enablers: Drivers for System Change

Four of the action areas identified through the Symposiums (data-informed planning and decision-making, policy and funding advocacy, public education, and the integration of health and housing) have been identified as key enablers of system change. Lived experience was later identified and included as an enabler, upon consultation with the LEAG. These five enablers have been incorporated as part of/across the strategies proposed. They are necessary for health and housing strategies to be implemented successfully and drive coordinated action toward system change.

System change is enabled when strong data and shared decision-making guide action, when health and housing systems work in coordinated partnership, and when policy advocacy and sustainable funding remove structural barriers. Public education shifts community understanding and builds the mandate for change, while lived experience ensures reforms stay grounded in real needs and realities. Together, these enablers create the conditions for a responsive, equitable, and integrated system capable of delivering better outcomes.

Prevention Pillar

The prevention pillar includes two action areas: upstream prevention and prevention interventions. The desired outcome of this pillar is to have a proactive system that prevents homelessness before health/housing crisis, reduces returns to homelessness, and promotes long-term stability. The aim is to reduce inflow into homelessness by addressing root causes and strengthening early interventions.

Action Area 1: Upstream Prevention

Upstream prevention refers to proactive strategies that address structural and systems factors that contribute to health and housing insecurity and risk of homelessness. This includes a diversity of supports necessary for social inclusion and access to health care, wellness, including, child, youth and family support, and community programs to prevent homelessness, and where possible, reduce mental health challenges, and substance use disorders.[10]

Key themes from the Symposiums and discussion with the Lived Experience Advisory Group include:

- The need for child, youth and family supports, as well as access to culturally appropriate and inclusive community programs.
- Recognition that many individuals fall through the cracks before traditional services reach them.
- Income insecurity exacerbates housing precarity, food insecurity, and adversely impacts physical and mental health.
- Consensus that addressing root causes such as poverty, discrimination, trauma and isolation, is essential to prevention.

Challenges:

- Securing funding for long-term, sustainable upstream programming can be difficult when overall results are not expected for years or even decades.
- Many community resources continue to be focused on emergency response and downstream interventions.
- Fragmented service delivery and lack of integration across sectors makes coordination and continuity of care difficult.
- Existing services are concentrated in urban areas, which may leave rural residents underserved.
- Existing health and housing data is siloed, limiting data sharing and data-informed decision-making.

The goal of this action area is to reduce homelessness, mental health challenges, and substance use challenges by ensuring access to support and resources that promote social inclusion and enhance overall wellness.

Strategies proposed to address this goal include:

1.1 Strengthen coordination and system alignment

- Map existing health and housing prevention programs/supports, identify gaps and opportunities for coordination, improved access and navigation.
- Prioritize data collection and upstream programming among partners.
- Advocate for stable, upstream-focused funding models at local and provincial levels.
- Engage both rural and urban partners to meet community needs.

Lived Expert Recommendations

- Bring services to where people are by delivering mobile and onsite health, housing, and social supports in housing buildings, community centres, and daytime programs, including primary care, first aid, mental health, and psychiatric services for both housed and unhoused individuals.
- Peer supports should be embedded as a core component across systems.

1.2 Adopt an upstream prevention focus when addressing health and housing system response

- Support the implementation of prevention programs that address the structural causes of homelessness while promoting protective factors that support fostering resilience across the lifespan.
- Expand access to upstream services including early mental health supports, youth engagement programs, and wellness hubs.

Lived Expert Recommendations

- Life skills development, employment supports, and volunteer opportunities help build meaning, purpose, and community, strengthening social and economic integration and playing a critical role in homelessness prevention.

1.3 Continuous Improvement

- Build organizational capacity to deliver and evaluate upstream programming.
- Create a mechanism for organizations to report back to the WGHHCPT about the outcomes of upstream programming.
- Develop an evaluation framework, track activities and monitor outcomes across time.

Wellington-Dufferin-Guelph Public Health (WDGPH) and Growing Great Generations (GGG) is best positioned to lead this work, due to their strong multi-sectoral partnerships with Social Services, healthcare providers, and community agencies. This will result in programs and services that help individuals build resilience early in life and across the lifespan. Investing in upstream prevention to address the root causes of homelessness will shift our system from crisis response to sustainable wellness promotion. These efforts will strengthen community inclusion, reduce reliance on emergency services and ensure that vulnerable populations receive early, equitable and comprehensive support. Over time, this shift will promote a healthier, more connected Wellington-Guelph where every resident has the opportunity to thrive.

Action Area 2: Prevention Interventions

Prevention interventions are a critical part of an effective system to prevent and end homelessness. The majority of people experiencing homelessness in Wellington-Guelph are individuals with newly identified experiences of homelessness and individuals who previously experienced chronic homelessness returning to homelessness after being housed. Prevention interventions are critical to reduce the incidence of new homelessness and intensive health and social supports are needed to ensure people who are housed are able maintain housing.

Prevention interventions address structural and system factors to ensure access to appropriate health and housing supports for people who are at high risk of, newly experiencing, or who have previously experienced homelessness. This includes:

- early interventions such as early identification, eviction prevention and housing retention services for those at high risk of homelessness;
- facilitating effective transitions from public institutions or systems (e.g., transitions from hospital or jail to housing);
- and providing housing stability supports for people who have experienced homelessness, including accessible health services for assessment/treatment to prevent housing instability/returns to homelessness.

Local service providers are implementing effective, evidence-informed prevention interventions, yet their ability to scale these solutions for greater impact has been limited. Their work demonstrates strong leadership in prevention, setting an example both locally and nationally. Existing interventions include:

- diversion from homelessness and emergency shelters
- housing loss and eviction prevention
- rapid rehousing
- housing stability programmes
- Housing First
- Complex-capable health services tailored to the needs of individuals at risk of/ experiencing homelessness.

Current gaps and challenges in prevention interventions and areas needing stronger action include:

- curbing inflow from institutions, including mental health and custodial institutions
- early identification of individuals at risk
- a lack of Assertive Community Treatment-based Housing First models
- a lack of alignment between health supports and housing programs and interventions, especially at critical intervention points

Effective prevention interventions rely on active participation from systems and organizations beyond direct homelessness-service providers. Work is underway to expand and strengthen prevention work across broader systems and community partners.

Prevention Pillar

The goal of this action area is to ensure access to targeted, prevention interventions to prevent new experiences of homelessness and support housing stability for individuals at high risk of and with new/previous experiences of homelessness.

Strategies to meet this goal include:

2.1 Improve data collection and analysis capacity to identify trends and system gaps and pressures contributing to inflow.

2.2 Identify where we should scale efforts and/or introduce new interventions to address gaps.

2.3 Use of shared health and housing data and data systems to enable collaborative co-design of evidence-based, targeted interventions.

2.4 Monitor and integrate best/leading practices to ensure relevance and alignment with local needs.

2.5 Ongoing advocacy for greater funding and prioritization of prevention efforts.

Much of this work is already underway by the Community Advisory Board (CAB), different sub-working groups of the CAB, and by community partners doing this work. The CAB is a requirement of the Federal Reaching Home Funding Program. The CAB's intention is to give greater attention to this action area as part of their workplan. Additional key players necessary for action include the County of Wellington, in partnership with housing/diversion providers and health/custodial institutions.

By strengthening and coordinating prevention efforts across systems, using data to target resources, continuously improving and scaling effective interventions, and advocating for sustained investment, we will reduce inflow into homelessness and increase housing stability creating a more proactive, responsive system that prevents homelessness before it occurs and supports long-term stability for those most at risk.

Performance Indicators for Prevention Pillar (Action Areas 1 & 2)

- Length of housing placements
- Number of diversion and rapid rehousing housing placements, particularly for non-chronic individuals
- Number of health crises averted (eg. reduction in number of emergency services calls, Emergency Department visits, interactions with police, etc)
- Number of individuals experiencing chronic homelessness that maintain housing for 1-year
- Number of individuals on By-Name Data (including inflow - aged in, newly identified, returned from housing, returned from inactive)
- Number of integrated crisis interventions supports delivered (eg. in supportive housing programs)
- Percent of referrals to health services/supports that are accepted and receiving supports (relative to those determined to be ineligible or on a waitlist)
- Percent of shelter admissions relative to number of individuals requiring shelter
- Percent of shelter admissions relative to unsheltered homelessness

Emergency Response Pillar

The emergency response pillar includes two action areas: health and housing emergency responses and provision of basic needs. The desired outcome of this pillar is to have immediate connection to services necessary for stabilization integrated within health and housing systems, resulting in shorter, safer crisis experiences.

Action Area 3: Health and Housing Emergency Responses

This action area refers to shelter services and emergency supports, including integrated health services and crisis response, which are needed to respond to diverse needs of individuals and families experiencing homelessness. Care must be taken to provide dedicated resources to meet the unique needs of youth and families as well as to provide culturally appropriate and safe supports and services that are accessible to everyone who needs them.

The goal for this action area is to ensure that everyone can access safe, dignified, and accessible emergency interventions, including accommodations, integrated health services, and crisis response. Recognizing that we need to concentrate our efforts on prevention and stability, the strategies below will help to align and coordinate existing resources and services to better meet the needs of our community, while advancing long-term infrastructure and upstream solutions.

3.1 Address gaps, strengthen coordination, and system alignment:

- Map health and housing emergency response services, identify gaps and opportunities for coordination, improved access and navigation.
- Maintain and improve fidelity to community-based treatment models to meet complex needs of people experiencing/at risk of homelessness.
- Coordinate outreach and unsheltered homelessness check-ins between health and housing providers.
- Define pathways to housing and acute care, including clear linkages between the health and housing systems.
- Address gaps in availability of care to provide services beyond 9am-5pm on weekdays.

Lived Expert Recommendations

- Address gaps in 24/7 non-police crisis response.
- Outreach should be integrated across sectors and organizations and have coordinated staffing to avoid service duplication and fragmented supports.
- Outreach should be consistent in service delivery – predictable schedule, stable staffing, and consistent services and supports.
- Peer support workers and health professionals must be embedded in outreach teams. Outreach teams should coordinate with nurses, paramedics and mental health clinicians.
- Staff doing outreach must be able to provide direct services on the spot, and not only referrals. This includes medical help such first aid, wound care, mental health, administering medication, foot care etc. and other supports like applications for government benefits.

3.2 Integrate health and housing pathways

- Formalize dedicated shared clinical pathways across health care providers.
- Integrate health services within the emergency shelter and coordinated access systems.
- Increase intensive case management capacity in the emergency shelter to increase service uptake and engagement and reduce dropped care amongst complex population.
- Integrate housing within primary care, emergency health services, and crisis responses.
- Have clear pathway into housing for people leaving hospital and custodial institutions.
- Integrate crisis response and crisis management into health services provided in shelter, transitional, and supportive housing.

3.3 Improve quality, dignity, and collaboration

- Create shared intake and referral protocols between housing providers and health providers to streamline access.
- Develop community-wide standards for health and housing emergency response in our community (e.g., mental health and substance use disorder protocol).
- Develop discharge planning protocols for hospital emergency departments, psychiatric institutions, and custodial institutions to prevent exits into homelessness.
- Embed housing-focused navigators in hospitals and crisis response teams to support discharge, planning, and housing stabilization.
- Increase peer support programs in community, while ensuring that our peers are adequately supported. Peer support programs should be integrated into our broader service continuum whereby proactive engagement by peers can serve to increase access and uptake into complex-capable programs and services.
- Health and housing partners share system-level data, community insights, and lived experience, along with training, evidence and tools to guide collective planning and alignment.

Lived Expert Recommendations

- Bring services to where people are, co-locate services or use mobile service delivery models – this includes encampments, daytime programming spaces, housing buildings, and isolated rural areas.
- Outreach programs must be based on trust and relationships, and flexible to meet individual needs.
- Outreach should be delivered by stable staff teams with low turnover and predictable client roster/caseload.
- Training for outreach staff should be comprehensive and delivered across teams and organizations so that all staff in outreach roles have the same competencies and can provide consistent supports and services.
- Outreach workers should have the ability to accompany people to the ER, shelter, court or other appointments when trust or trauma is a barrier.

3.4 Advance upstream solutions and long-term supports

- Enhanced outreach services that have the ability to accompany healthcare providers to where people are in the community.
- Assign housing-focused navigators to hospitals and crisis response teams to support discharge, planning, and housing stabilization.
- Advocate for policy and funding to advance long-term infrastructure and upstream solutions.

Lived Expert Recommendations

- Embed ongoing post-housing supports to reduce the likelihood of eviction and strengthen housing stability.
- Embed supports across the system (e.g., in outreach, daytime programming spaces, social services, and health clinics), ensuring they are available at any point in a person's journey.
- Support should be flexible and individualized, focused on an individual's strengths and progress, rather than being punitive.

By promoting system alignment and integrating health and housing emergency responses, our actions will ensure that people experiencing/at risk of homelessness can meet their essential needs with dignity. This will reduce gaps, improve navigation, and increase connections between housing and health supports. Implementing these strategies will improve our community's response to crisis situations affecting people experiencing/at risk of homelessness. Actioning this work will require collaboration with health and housing partners, including but not limited to community paramedics, Guelph and County hospitals, community healthcare providers, mental health and substance use/addictions service providers, emergency shelter providers, custodial institutions, and justice partners.

Action Area 4: Provision of Basic Needs

The provision of basic needs for people experiencing homelessness refers to services and supports that provide safe, dignified access to basic needs such as food, water, laundry, and showers to individuals and families experiencing unsheltered homelessness. These services also include access to warming and cooling spaces as well as access to 24/7/365 washrooms for people experiencing unsheltered homelessness.

In our community, people experiencing homelessness face barriers to accessing basic needs like food, water, showers, laundry, and safe warming or cooling spaces. While services are more readily available in Guelph, rural areas of the County experience significant gaps, with limited access, coordination, and integration with health and housing supports. Addressing these needs with connections to long-term solutions is critical to reduce reliance on crisis services, while also improving day-to-day wellbeing and preventing new homelessness.

There are numerous basic needs services that currently provide essential supports across Wellington-Guelph. There are strong relationships and collaboration among some providers in the community. Existing coordination among partners can be improved upon, such as the Poverty Elimination Collaborative's weather responses and access guides/map that are well-utilized. Additionally, there is increased community awareness of the importance of linking basic needs to housing and health supports.

However, services are not consistently accessible, with gaps in hours, locations, and availability, especially in rural areas. Navigation can be challenging with duplication and uncoordinated efforts persisting. Stigma and discrimination, as well as accessibility limitations, creates additional barriers, preventing some people from accessing services. Basic needs provision often operates as stand-alone emergency responses rather than being integrated with health and housing pathways. Moreover, long-term infrastructure and upstream solutions can be overshadowed by a focus on crisis response and short-term funding.

The goal of this action area is to ensure access to washrooms, showers, water, food, laundry and warming/cooling spaces, while linking people to permanent housing and health solutions. In order to do this, community partners working in basic needs provision will collaborate to:

4.1 Strengthen coordination and system alignment

- Map basic needs services, identify gaps and opportunities for coordination, improved access and navigation.
- Maintain and enhance weather response and access guide resources.

4.2 Integrate basic needs with health and housing pathways

- Develop and promote service models where basic needs sites act as entry points to health and housing supports.

Lived Expert Recommendations

- Daytime programming and community hubs in both urban and rural areas are not only critical to meet basic needs but are also access points for the delivery of prevention-focused programs such as social services and health supports.

4.3 Improve quality, dignity, and collaboration

- Provide partners with system-level data, community insights, and lived experience, along with training, evidence and tools to guide collective planning and alignment.

Lived Expert Recommendations

- Basic needs are a human right. They must be met for dignity, safety, and the possibility of recovery and stability.
- People experiencing homelessness should feel a sense of belonging and community.
- Use flexible timelines that reflect the realities of people transitioning out of homelessness and operating in survival mode.
- Ensure access to care and safe spaces, medical and mental health services, safe indoor environments, survival items for those unsheltered, and places to rest and recover when sick.
- Provide consistent, low-barrier supports that people can rely on regardless of where they are in their housing journey including options such as warming and cooling spaces.
- Clearly communicate available supports through accessible channels — radio, posters, wallet cards, and centralized access points like daytime programming spaces, so people understand what services they can access.

4.4 Advance long-term infrastructure and upstream solutions

- Advocate for policy and funding to advance long-term infrastructure and upstream solutions.

By strengthening coordination, improving access, and integrating basic needs services with health and housing pathways, our actions will ensure that people experiencing homelessness can meet their essential needs with dignity. In the medium term, this will reduce gaps, improve navigation, and increase connections to housing and health supports. Over the long term, these efforts will prevent new homelessness, reduce reliance on emergency responses, and support the development of sustainable infrastructure and upstream solutions that promote community health, stability, and equity, particularly addressing disparities between urban and rural areas.

The Guelph & Wellington Poverty Elimination Collaborative and the County of Wellington in collaboration with direct service providers leading the provision of basic needs, and key players are positioned to influence system planning and resource allocation in this action area.

Performance Indicators for Emergency Response Pillar

- Acute length of hospital stay for those experiencing homelessness
- Acute length of stay compared to expected length of stay for high acuity individuals
- Admission to hospital for those experiencing homelessness
- Inpatient discharges for those experiencing homelessness with/without a discharge plan
- Length of time to become housed on the By-Name Data
- Number of ED visits for person experiencing homelessness
- Number of IMPACT calls requested/attended from shelter, transitional, or supportive housing programmes
- Number of individuals connected to acute care through housing programmes
- Number of individuals connected to housing programmes through acute care
- Number of individuals discharged from correctional facilities into homelessness with/without discharge plan for housing
- Number of individuals discharged from ED into homelessness
- Number of people accessing emergency shelter programs
- Number of people accessing IMPACT
- Number of people accessing Welcoming Streets
- Number of people requesting/accessing Here 24/7 services from shelter, transitional, or supportive housing programmes
- Number of people supported to become housed through client navigators (or housing-focused outreach)
- Number of people supported to become housed through diversion supports
- Number of people supported to become housed through rapid rehousing supports
- Number of people visiting ED who are experiencing homelessness
- Number of referrals from basic needs services to housing and health supports
- Percent of people served by ACT experiencing homelessness
- Percent of people served by FACT experiencing homelessness
- Percent of people served by IMPACT experiencing homelessness
- Percentage of 4+ ED visits for mental health and addictions-related concerns
- Re-admission rate for individuals discharged from hospital into housing

Supports Pillar

The supports pillar includes three action areas: housing options, mental health and substance use services, and comprehensive health services. The desired outcome for the supports pillar is to have a range of housing and health supports that meets diverse needs to promote stability and sustain recovery, while reducing reliance on emergency services.

Action Area 5: Housing Options

This action area refers to the different kinds of permanent housing (including subsidized housing and government-funded affordable housing) and a range of permanent supportive housing programs (which include supports designed to meet the diverse needs of individuals, including youth and seniors, and families facing health and housing complexity). Safe, stable, affordable, and appropriate housing requires that health supports and services for mental illness/ mental health challenges and substance use disorders be available in our community for everyone who needs them, regardless of housing status.

The goal of this area is to increase the availability and diversity of housing options to meet current housing needs.

A variety of housing types are needed across the continuum in our community, as demonstrated through the coordinated access system and the Homelessness Prevention data validated through Built for Zero and Reaching Home Canada. Acknowledging the shortage of sustained funding to support long-term housing plans, the subsidized/affordable housing has created significant bottlenecks. While housing providers remain committed to increasing housing options, addressing this challenge will require innovative funding approaches, such as stacking diverse funding sources, in partnership with municipal governments, community groups, non-profits, housing providers/co-operatives, and charities, to help advance investments from upper levels of government.

Similar innovative projects have recently been realized, including developments like Grace Gardens, Silver Maple Seniors Community, 10 Shelldale, Wyndham House, and 65 Delhi. These projects were successful due to partnerships that strategically addressed the gaps and need in our community.

Strategies to meet this goal include:

5.1 Strengthen system alignment for strategic planning and collaboration

- Collect, monitor, and report data to identify trends/gaps/forecasts, and inform strategic service system planning and housing policy development.
- Collaboration among community partners to identify and strategically address gaps.
- Align projects and initiatives with other strategic plans, including Housing Service's 10-Year Housing and Homelessness Strategic Plan.
- Engagement of single- and lower-tier municipalities to action municipal housing tools.

5.2 Advance permanent housing solutions, including permanent supportive housing.

- Build on existing housing needs analysis to identify type of housing options needed and diversity of need (i.e. resources to ensure housing retention).
- Partner with single- and lower-tier municipalities to map existing permanent housing stock and assess suitability for conversion or expansion.
- Align with municipal/provincial housing strategies and funding streams for new developments.
- Establish and/or foster partnerships with non-profits, Indigenous-led organizations, and developers to advance permanent housing solutions.

Lived Expert Recommendations

- Housing without support often leads to eviction or housing precarity. Invest in early intervention to prevent eviction when someone is at risk of losing housing.
- Housing retention supports are critical over the course of an individual's housing journey – supports should not stop once someone is housed.

5.3 Advocate for funding and sustainability

- Advocate for upstream, stable funding models to sustain permanent housing and reduce reliance on emergency shelters and temporary accommodations.

The County of Wellington's Housing Services Division is well positioned to lead this work, as the Consolidated Municipal Service Manager (CMSM) for Wellington-Guelph. Increasing the availability and diversity of housing options across the housing continuum will require data-driven planning, strategic alignment, and innovative partnerships, allowing for access to safe, affordable, and supportive housing that meets the unique needs of people experiencing/at risk of homelessness.

Action Area 6: Mental Health and Substance Use Services

This action area refers to the recovery-focused resources, services, and interventions needed to support individuals experiencing mental health and/or substance use disorders that aim to enhance a person's quality of life. These supports include a range of professional and evidence-based services, such as clinical treatment (bed-based services, day programs), assessment and diagnosis, harm reduction (e.g. needle exchange programs, overdose prevention etc.), psychiatry, group therapy, crisis intervention, peer and community supports, aftercare, safety planning, community-integration and social and structural supports.

Our community requires increased access to mental health and substance use/addictions services, as well as more complex-capable care. These services should be tailored to diverse community needs, including access to services in rural areas. The focus needs to be on person-centered and evidence-based approaches that integrate these services with housing.

Currently, we have established working groups and tables that can support collaboration and planning activities. There are already several examples of integration between health and housing partners as well as different health-service providers providing person-centered care. There has also been a recent increase in supportive housing models across Wellington-Guelph. Moreover, there is a commitment from health system partners to work together in innovative ways to support health of individuals and community, as well as a committed, talented and engaged workforce that is providing care to this population.

Despite strong commitment to improvement, change within the system often moves slowly. Differing interpretations of privacy legislation can create barriers to person-centered care and limit opportunities for integration, while persistent challenges remain in transitions from acute-to-community transitions. The demand for specialized programs continues to outpace available resources, contributing to workforce burnout and straining service delivery. At the same time, changes in harm reduction service availability increase risks for vulnerable populations, underscoring the need for sustained investment, clarity, and coordinated action across health and housing systems. The goal of this action area is to support equitable access to mental health and substance use services. Strategies to optimize mental health and substance use/addictions services include:

6.1 Strengthen coordination and system alignment

- Align the workplans of the various OHT Working Groups and Guelph Wellington Mental Health & Addictions System Planning Table.
- Support shared education across partners and purposefully create opportunities for collaboration and connection between partners.
- Enhance case conferencing tables to match and prioritize individuals' needs and preferences on the BND. Better equip them for housing retention efforts if they have disclosed mental health, substance use disorders, developmental disability, and acquired brain injury.

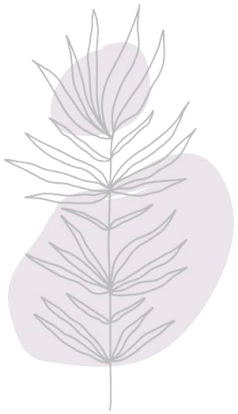
6.2 Address system gaps and identified community needs

- Identify and implement concrete, tangible projects directly tied to Symposium priorities (e.g., rural access, peer support integration, specialized services expansion).
- Relentless focus on improving transitions and integration between and across acute, community, and housing supports.

Lived Expert Recommendations

- Mental health care and addiction supports should be evidence-based and available readily on ongoing basis and not episodic or crisis-based only.
- Access to mental health care and addictions support must be evidence-based, safe, free, available, accessible, and flexible to meet individuals' needs as life circumstances change.

The Guelph-Wellington OHT is best positioned to lead this work. By aligning work across mental health and substance use/addictions tables and focusing on clear, actionable projects, we will reduce fragmentation, improve access to specialized and community-based services, and create more coordinated, person-centered pathways that lead to better experiences and outcomes for individuals across the community.



Action Area 7: Comprehensive Health Services

This action area refers to ensuring access to person-centred approaches and interventions that integrate various health supports to meet the unique needs of individuals/families experiencing or at risk of homelessness. This includes primary care, and services may require collaboration between providers, ensuring continuous and coordinated care. It may include a unified plan that is shared with everyone involved to avoid duplication of services and care gaps.

The goal of this action area is to ensure equitable access to comprehensive health services, including primary care. The GW OHT is best positioned to lead this work, with key players necessary for action including GW OHT Integrated Care Council & GW OHT Primary Care Network. Strategies to optimize comprehensive services include:

7.1 System Integration and Capacity-Building

- Work with existing and new primary care providers in GW to support onboarding/attachment, regardless of housing status.
- Support HART Hub including operationalization of withdrawal management, crisis stabilization beds.
- Operationalize recent investment of $4,479,600 to support 100% of Guelph Wellington residents to attain attachment to a primary care provider.

Lived Expert Recommendations

- Offer comprehensive onsite and mobile health services, including primary care, first aid, mental health care, psychiatric support, and harm reduction, tailored to the needs of each community.
- Include peers and/or lived experience experts' perspectives in planning, program service delivery, and evaluations.

Performance Indicators for Supports

- Improved partner-reported collaboration (via survey or structured feedback)
- Improved lived expert-reported collaboration (via survey or structured feedback)
- Increased availability of specialized services (e.g., wait times, service volume)
- Number and type of net new community housing units in development
- Number of existing affordable housing units renovated
- Number of new affordable housing units constructed
- Number of hospitals admissions for 'Ambulatory Care Sensitive Conditions' (ACSC)
- Number of households at risk of homelessness that are stabilized (includes eviction prevention services, and assistance with rental and energy arrears, and health/mental health, addiction services, crisis interventions)
- Number of households in RGI and affordable housing units
- Number of people (and households) supported by rent supplement (rent supplements are included in RGI counts)
- Number of people supported to become housed through diversion supports
- Number of readmissions to acute care
- Percent of individuals unattached to primary care in GW
- Number of individuals newly attached to primary care
- Number of assessments carried out (could be mental health, health)
- Number of individuals receiving community-based health care services, previously not accessed
- Increased housing stability (80% minimum 1-year housing retention)
- Total amount of funding secured from other levels of government

Action Area 8: Indigenous-led Solutions

Indigenous-led solutions is a standalone action area in our framework. It refers to solutions and services provided by the Indigenous-community to support access to culturally appropriate health and housing services that incorporate spiritual health, self-determination, and self-governance for Indigenous peoples experiencing homelessness and/or precarious health and housing.

The goal for this area is to enhance access to culturally appropriate health services and housing for Indigenous peoples with precarious health and housing, by supporting Indigenous-led solutions and establishing partnerships to develop tailored services and housing options. Performance indicators will be developed by the Indigenous Community.

The Symposium highlighted the need for Indigenous-led solutions in the Wellington-Guelph community. The Planning Table is collaborating with organizations that are also working on Indigenous-led solutions and services, including the GW OHT.

The GW OHT is working on Indigenous-led solutions to culturally appropriate primary care. This work was paused while the GW OHT developed a verification process and guidelines for engagement with our local Indigenous community. This work was resumed in late 2025 after Heart Work Consulting was hired by the GW OHT. Sharing Circles were organized with local Indigenous community members, leaders, and knowledge keepers to develop recommendations for the Health and Housing Community Planning Table. The report of these consultations can be found in Appendix D.

Recommendations for enhancing Health and Housing:

8.1 Ensure Indigenous Peoples can easily enter, move through, and remain connected to health, housing, and social systems without harm or exclusion.

8.2 Shift from Eurocentric, appointment-based care to relational, land-based, and whole-person approaches to health and wellness.

8.3 Stabilize health and wellness by ensuring access to safe, culturally appropriate housing connected to ongoing supports.

8.4 Build sustainable Indigenous capacity within health and housing systems to improve trust, safety, and outcomes.

8.5 Transform systems internally to prevent harm, address racism, and ensure policies align with lived realities.

8.6 Ground system change in relationships, reciprocity, and collective responsibility.

Enablers: Drivers for System Change

System-level actions that have not been captured in the prevention, emergency response, or supports pillars are detailed below.

Four action areas were originally identified as enablers: Policy & Funding Advocacy, Public Education, Integration of Health and Housing and Data-informed planning and decision-making. After consultation with the Lived Experience Advisory Group, lived experience was included as fifth enabler.

Performance indicators for the enablers will be developed by the Planning Table as the work at the system level continues over the next year.

Action Area 9: Policy & Funding Advocacy

This action area refers to the collective approaches taken by the Planning Table to advocate for policy reforms that address the systemic causes of homelessness, health, and housing instability. This may also include other approaches to increase local funding commitments for health and housing systems, as well as advocating for Federal and Provincial funding.

The goal here is to establish a collective approach to advocate for policy reforms and changes to funding to address local health and housing needs. Strategies include:

9.1 Coordinate advocacy efforts to address health and housing needs in GW to support alignment and collective action and impact.

- Develop a shared understanding of local needs using data, priorities, and opportunities for collaboration for a shared advocacy strategy, aligned with and supportive of the existing work of partners (e.g. Poverty Elimination Collaborative, Wellington Guelph Drug Strategy, etc.)
- Identify and share collaborative funding opportunities and coordinate the submission of aligned proposals, especially those addressing capital and operating costs.
- Develop a portfolio of projects for affordable housing to submit to Build Canada Homes and other funding opportunities.

Action Area 10: Public Education

This action area refers to collection actions taken by the Planning Table to raise awareness, minimize stigma, and respond to misconceptions about homelessness, mental health and substance use, and the need for community understanding and empathy for people experiencing homelessness, mental health, and/or substance use disorders.

The goal for this action area is to foster an increased understanding and empathy for people experiencing homelessness, substance use disorders, and mental health challenges in our community. Strategies include to:

10.1 Humanize experiences of mental health, substance use, and homelessness to build empathy

- Co-develop public-facing campaigns and educational materials in partnership with people with lived experience.
- Targeted messaging on topics including harm reduction, Housing First, complex mental health, poverty, and the root causes of homelessness.
- Develop local campaigns using research and evidence-informed sources, accessing existing research partnerships (e.g., Experiences of Homelessness in Mid-Sized Cities).

Lived Expert Recommendations

- Reduce stigma so that people who need help are empowered and encouraged to access services and supports when they need them.

10.2 Develop a shared communication approach to educate the public on initiatives that have made progress to foster understanding and optimism

- Collaborate with the LEAG and key partners to align and guide all messaging efforts.
- Use evidence and clear data to challenge stigma and correct misinformation.
- Use targeted, audience-specific communication strategies that tailor approaches to priority groups.
- Public education and awareness are needed to educate the public, service providers, and elected officials about homelessness and other social challenges, informed and led by lived experience.

Action Area 11: Integration of Health and Housing

The integration of health and housing refers to initiatives to address the siloed nature of services which contributes to inequitable access to health and housing services among individuals with precarious housing. Central to this work is the development of mechanisms to enhance service integration, facilitate multi-agency collaboration, and support access across different organizations/systems. Enhanced collaboration will leverage existing partnerships for integrated services, developing shared pathways and processes, and reorganizing resources to meet complex needs.

The goal of this action area is the integration between health supports and housing services by establishing a people-centered care team model in Guelph-Wellington that ensures individuals experience seamless access and navigation across health and housing systems. This is where the bulk of the Planning Table's work is, leaning on the 10 Principles of Integrated People-Centred Care as a strategic framework for integration.[12]

Proposed actions for the integration of health and housing include:

11.1 Strengthen coordination and system alignment

- Map existing health and housing prevention programs/supports, identify gaps and opportunities for coordination, improved access and navigation.
- Prioritize data collection and upstream programming among partners.
- Advocate for stable, upstream-focused funding models at local and provincial levels.
- Engage both rural and urban partners to meet community needs.

Lived Expert Recommendations

- Coordinate services, so each person requiring support has a coordinated circle of care with one worker designated as 'the lead' to help navigate complicated systems.
- Peer supports should be embedded as a core component across systems.

11.2 Develop coordinated service pathways for health and housing systems

- Support access to health services (including primary care, mental health, and substance use) for all residents of housing spaces/units.
- Improved flow of patients between community and hospital (Tier 4/5 + MHA System Planning Table).
- Develop innovative solutions to address system gaps, including pathways into/out of acute psychiatric care.
- Identify services necessary for high acuity individuals with complex needs in both the rural and urban areas and how to provide care.
- Needs to go beyond "access" to the availability of matched care that is complex capable (responsive, and coordinated with Housing First efforts).
- Service availability 5pm to 9am on weekdays and weekends.

11.3 Improve referral processes for health and housing services

- Coordinate outreach services to improve navigability of health and housing systems, particularly between primary care, community, and hospitals.

Lived Expert Recommendations

- Map clear referral pathways so providers know available housing, mental health, and safe-discharge options, including where unhoused individuals can go when experiencing health challenges.

11.4 Foster cross-sector collaboration in risk planning

- Support uptake and integration of shared risk planning through Community Assessment of Risk Protocol.

11.5 Enhance communication between health and housing providers

- Improved communication between primary care, mental health and housing services.

Action Area 12: Data Informed Planning & Decision-Making

This action area refers to an integrated approach to sharing data and information that promotes informed decision-making, grounded in high quality evidence and data. The goal of this area is to develop and maintain user-friendly service mapping and data collection on health and housing services that provides data necessary to make informed decisions.

Strategies for the Planning Table are:

12.1 Use real-time health and housing data to make evidence-informed decisions.

- Produce standardized monthly data snapshots that can be used to identify trends, system pressures, and progress.

12.2 Establish a Cross-Sector Data & Evidence Working Group that informs the Health and Housing Community Planning Table.

12.3 Formalize data-sharing agreements across health and housing for system integration.

Conclusion

This Wellington-Guelph Health and Housing Community Plan represents a shared commitment to create a more connected, accessible, and responsive health and housing system that meets people's needs in a dignified, equitable, and safe way. Through the collective work of partners across health and housing sectors, the voices of people with lived experience, this plan outlines a path forward for our community.

The actions identified in this plan acknowledge that system change requires varied types of work across actions areas: strengthening coordination and collaboration, addressing system gaps, improving service pathways, advancing long-term solutions, and advocating for policy change and sustainable funding. This plan supports partners to contribute in ways that reflect their roles, mandates, and strengths.

Moving forward, success will depend on sustained collaboration and a shared commitment to learning and adaptation. As we implement the actions outlined here, we will continue to monitor progress, respond to emerging needs, and refine our approach. By working collectively and intentionally, we can create a system where every person has access to the supports they need to achieve health, stability, and a safe place to call home.

References

[1] Housing, Infrastructure and Communities Canada. (2024). *Homelessness Glossary for Communities*. Retrieved from https://homelessnesslearninghub.ca/wp-content/uploads/2024/04/HPD-HomelessnessGlossaryForCommunities-July2024-EN.pdf

[2] Donaldson, J., Kandyba, L., Wang, D. (2026*). Municipalities Under Pressure One Year Later: An Update on the Human and Financial Cost of Ontario's Homelessness Crisis*. Helpseeker.

[3] Donaldson, J., Kandyba, L., Wang, D. (2026). *Municipalities Under Pressure One Year Later: An Update on the Human and Financial Cost of Ontario's Homelessness Crisis*. Helpseeker.

[4] Canadian Alliance to End Homelessness (2026). *Community data dashboard for Wellington-Guelph, ON* [Dashboard]. Microsoft Power BI. Retrieved March 2026, from https://app.powerbi.com/view?r=eyJrIjoiZGMyYmMyZWItMjFmMy00MGE3LWE1NzItYjdjNDc1NDZlYjkwIiwidCI6ImZlMTJjZTNhLWU2MzAtNDVjYi1hY2UxLTEzM2ZlNjBkYTEyMiJ9&pageName=7fcbd3e390b3777ef353

[5] County of Wellington. (2024). *Wellington-Guelph 2024 Everyone Counts - Point-in-Time Count*. Retrieved from https://www.wellington.ca/media/file/hs2024everyonecountspointintime.

[6] Hwang, S. W., (2001). Homelessness and health. *CMAJ, 164*(2), 229–233. https://pmc.ncbi.nlm.nih.gov/articles/PMC80688/

[7] Richards, J., Kuhn, R. (2023). *Unsheltered Homelessness and Health: A Literature Review. AJPM Focus, 2*(1) doi.org/10.1016/j.focus.2022.100043

[8] Wellesley Institute. (2012). Housing and Health: Examining the links. Retrieved from Home - Wellesley Institute

[9] Kopec, A., & Smith, A. (2024). *Lived Expertise in Homelessness Policy and Governance. Social Sciences, 13*(5), 271. https://doi.org/10.3390/socsci13050271

[10] Gaetz, S & Dej, E. (2017). *A New Direction: A Framework for Homelessness Prevention. Toronto: Canadian Observatory on Homelessness Press*. Retrieved from https://homelesshub.ca/wp-content/uploads/2024/04/COHPreventionFramework_1.pdf

[11] Gaetz, S., Scott, F., & Gulliver, T. (2013). *Housing First in Canada: Supporting Communities* to *End Homelessness*. Toronto: Canadian Homelessness Research Network Press.

[12] Sullivan-Taylor, P., Suter, E., Laxton, S., Oelke, N.D., Park E. (2022). Integrated People-Centred Care in Canada – Policies, Standards, and Implementation Tools to Improve Outcomes. *International Journal of Integrated Care, 22*(1):8. DOI: http://doi.org/10.5334/ijic.5943

Wellington-Guelph Health and Housing Community Planning Table

Terms of Reference

Approved by the WG HHC Planning Table on March 21, 2025

1.0 Purpose

Health and housing services in Wellington-Guelph were not designed with intention nor capacity to address the current magnitude and complexity of need that currently exists in our community. Services have instead evolved in response to repeated crises and emerging opportunities. As a result, the essential task of coordinating, optimizing and aligning efforts across the health and housing continuum is inherently complex. A whole-of-community approach is required to develop a 'Wellington-Guelph Health and Housing Community Plan' to address the needs of people experiencing homelessness and precarious health and housing in Wellington-Guelph. The Health and Housing Community Planning Table will support partners across the health and housing systems to optimize use of existing, and advocate for additional, resources to support equitable access to health and housing services and realize improved health and social outcomes for people experiencing homelessness and precarious health and housing in Wellington-Guelph.

2.0 Mandate

The Wellington-Guelph Health and Housing Community Planning Table (the Table) will provide advice, oversight and actively contribute leadership to support both planning and action towards a vision and community plan to integrate health and housing services in Wellington-Guelph based on consultation with/input from those with lived and living experience.

3.0 Scope

The vision and plan will consider health and housing in both the City of Guelph and the County of Wellington as well as the needs of families, youth, adults and seniors. The vision and plan will support the development of an integrated and equitable spectrum of social, housing and health supports to address prevention as well as the needs of those:

- at risk of crisis due to the intersectionality of health and housing issues (prevention and diversion)
- in crisis (acute intervention/support)
- emerging from crisis and in need of on-going health and housing and social supports to maintain housing in order to continue on their journey to health,wellbeing, and independence

As the vision for integrated health and housing services in Wellington-Guelph (as informed by the January and April 2024 Health and Housing Integration Symposiums and other consultations) is finalized, the Wellington-Guelph Health and Housing Community Planning Table will provide advice, guidance and oversight to the development of a community plan to achieve the vision for integrated health and housing services including:

- Inventory of existing tables working to address the needs/issues facing this population
- Mapping existing and needed health and housing services along the continuum
- Prediction/forecasting future needs and resources
- Identification of opportunities to further integrate health and housing functions including those identified in existing plans

- Opportunities to secure funding for new resources to address identified gaps in services
- Cost benefits analysis of investment in upstream prevention
- Identify facilitators and barriers to integrated care
- Other(s)

Once developed, the Table will oversee execution and evaluation of the plan. An evaluation framework (including KPIs) will be developed to support the on-going evaluation of progress of the Community Plan and vision.

The Wellington-Guelph Health and Housing Community Planning Table will also provide support and oversight to advance practical, real-time opportunities and activities to advance integrated health and housing, including:

- Coordinated access
- Planning and operationalization of changes to existing services and/or new initiatives/services that involve both health and housing services/partners
- Meeting the basic needs of people experiencing homelessness
- New shared services funding (eg.10 Shelldale)
- Strategize and collaborate to address emerging issues and opportunities
- Clarifying and improving Personal Health Information sharing/flow including the development of an approach to shared care planning
- Other(s)

The Health and Housing Community Planning Table will be supported by and support/oversee the work of the County of Wellington Community Planning Project Manager.

4.0 Responsibilities - Members of the Community Table will:

- Be jointly and collectively accountable to each other and persons with lived experience for achievement of the vision, plan and realization of improved health and social outcomes for persons with health and housing needs in Wellington-Guelph.
- Contribute bold and transformative leadership to find new, radically collaborative ways to address the integrated health and housing needs of the persons served by the health and housing system in Wellington-Guelph.
- Employ a strength-based approach to partnership development and maintenance by supporting and leveraging the strengths that each partner brings to the collaborative partnership table.
- Foster the development of culturally appropriate services
- In acknowledgement of the complexity of the system and issues that exist, will employ complexity theory and be intentional in designing a complex adaptive system of health and care and social supports and one that support the delivery of complex capable care/support.

- Practice distributed leadership by:
    - Ensuring bi-directional communication and engagement with their staff, boards and other stakeholders
    - Seeking, representing and empowering the voices, perspectives and wholistic needs of the persons served by their respective organizations as well as the staff who serve those individuals
- Support the development of a relational foundation and a “One Team” approach/culture by:
    - adopting and advancing a population health approach to planning and service delivery including equitable access to integrated health and housing within and across the in-scope resources
    - representing/supporting the Table’s shared purpose, objectives, directions, decisions and common voice.
- Relentlessly seek data and evidence to support decisions and directions
- Contribute to:
    - the development and distribution of Key Messages after each Community Planning table meeting.
    - a quarterly ‘Community Partner Meeting’ to engage enabling and impacted partners in the work of the Planning Table.

5.0 Governance and Decision Making

The planning table is self-governing and is accountable to the community. Consensus will be sought for all decisions. Consensus involves collaboration, not compromise; it requires focus on developing the relationships among stakeholders.

- If consensus cannot be reached, the decision will be made by voting – specifically, by majority (i.e., 50% plus 1) support from voting members in attendance.
- If after thorough review and discussion, a decision still cannot be reached by consensus, the (co)-chair(s) will put the issue to a vote.
- For decisions requiring a vote, each Direct Core Partner organization will be entitled to one vote.

If a decision is required/requested before a next scheduled Planning Table meeting, a decision will sought via e-mail. If consensus cannot be achieved by e-mail, the decision will either be deferred to the next scheduled Community Planning Table meeting or a special meeting will be arranged to support the required decision.

6.0 Conflict of Interest

Each member will, to the best of their ability, eliminate or minimize any conflict between the work of the Planning Table and its other contractual and service obligations and relationships. If a member becomes aware of any fact or circumstance that may harm that or another member’s ability to perform its roles and responsibilities, as described in this document, it will promptly notify the co-chairs of the Planning Table of the nature of the conflict and its anticipated impact so that the members of the Planning Table may consider how to remedy, mitigate, or otherwise address the fact or circumstance

7.0 Membership

Membership of the Table will include executive decision makers from partners that have a primary mental health and addictions and/or housing mandate. Members will make a strong commitment to attend meetings. When attendance isn't possible, members may designate a consistent delegate with decision making authority on behalf of their respective organization.

Position	Organization
Director of Transformation	Guelph Wellington OHT
Social Services Administrator	County of Wellington
Housing Services Director	County of Wellington
Housing Stabilization & Interim Supports Manager	County of Wellington
President and CEO	Wellington Health Care Alliance
Team Leader	Rural Wellington Community Team
Councillor*	City of Guelph Council
Executive Director	Wyndham House
CEO	Guelph Community Health Center
CEO	Stonehenge Therapeutic Community
Executive Director	Stepping Stone
CEO	Canadian Mental Health Association of Waterloo Wellington
VP Community Health and Wellness	Wellington-Dufferin-Guelph Public Health
Councillor*	County of Wellington Council
CEO	Thresholds Homes and Supports
Emergency Department and SA/DV Program Director	Guelph General Hospital
Chief of Psychiatry	Homewood Health Centre
Director	Guelph & Wellington Task Force for Poverty Elimination
Deputy CAO Public Services (on behalf of Guelph Wellington Paramedic Services)	City of Guelph
Chief Executive Officer	East Wellington Community Services
Executive Director	Community Resource Centre of North and Centre Wellington

*Elected officials are ex-officio members and represent interests of community/electorate

Representatives from stakeholder groups may be invited to attend meetings on an as needed basis.

Sub-working groups may be developed to address specific functions/activities in support of the community plan. However, the Table is committed to minimizing complexity and looking first at the mandate, membership etc. of existing groups to consider if/how existing groups could support then needed functions/work.

7.0 Terms of Reference Review

Terms of Reference will be reviewed annually.

APPENDIX B

Wellington-Guelph Lived Experience Advisory Group

Terms of Reference

Last Reviewed and Updated: September 25, 2024

1.0 Purpose

The Wellington Guelph Lived Experience Advisory Group ("Advisory Group") is being established by the County of Wellington Social Services to bring forward perspectives from individuals who have experience accessing health, housing, and/or social services programming in Wellington County or Guelph to help inform key aspects of delivery of health, housing, and social services, address barriers, and/or support effective planning and policy development.

2.0 Scope

The Advisory Group will inform planning and action towards a vision and community plan to integrate health and housing services in Wellington-Guelph through the Health and Housing Community Planning Table. The work of the Advisory Group may help inform future community-based advocacy, but it is not an advocacy group.

3.0 Responsibilities

The Advisory Group will:

- Meet approximately six times a year in person with potential for additional communications through email, online or phone meetings
- Co-create agendas for meetings with Social Services staff
- Develop its "house rules" or expectations together so that there is a common understanding of processes and expectations at meetings.
- Actively participate in discussions and activities on a variety of topics related to health, housing and/or social services
- Share information on needs and gaps, bring forward recommendations, identify challenges, etc. based on personal experiences and knowledge but also that reflect a broader awareness of challenges, barriers and solutions of people accessing services
- Support the development of and/or participate in planning and carrying out of engagement activities to better understand the needs and service gaps in our area
- Participate in ad-hoc engagement activities including but not limited to focus groups or conversations about specific plans and programming that is under review or under development
- Help identify common challenges and issues related to trends and system barriers
- Help identify and improve the County's understanding of community needs and service gaps

- Bring forward ideas and suggestions about topics that the Advisory Group could work on and how to connect with people with lived/living experience beyond the Advisory Group.
- Review/provide feedback on the function and purpose of the Advisory Group

The County of Wellington Social Services Department will:

- Adhere to the IAP2 spectrum of Public Participation to Inform and Consult
- Make available a Housing Services staff member and at least one additional staff member to support the work of the Advisory Group.
- Provide support for initial establishment and ongoing function of the Advisory Group
- Support initial and ongoing training and opportunities for mentorship, personal and professional growth of all members.

4.0 Confidentiality

Members are expected to maintain confidentiality and keep discussions, and any content shared at Advisory Group meetings confidential.

5.0 Membership

Any resident of Wellington County or Guelph, sixteen years of age or older who is currently accessing or has accessed health, housing and/or social services supports in Wellington County or Guelph can express interest in participating as a member of the Advisory Group.

The Advisory Group will consist of Core Members who will attend in-person meetings approximately six times a year, and an undetermined number of members who will not attend regularly scheduled in-person meetings but will share their feedback in other ways. Members are encouraged to commit to being involved for 2 years, but it is not required.

Periodic recruitment will take place to ensure the advisory group has enough members to support diverse perspectives.

Prioritization/key considerations for selecting members include:

- Diverse lived experiences, including individuals who have accessed different services (health, housing, other social services) as well as those from various demographic backgrounds (age, gender, ethnicity, sexual orientation, household type, immigration status) and various subgroups (such as individuals with disabilities and people with mental health and substance use challenges).
- Recent experience and experience in Guelph and Wellington County, which will help ensure the relevance of insights provided.
- Geographical representation, including individuals living in both the urban and rural areas of Guelph and Wellington County.
- People who have experience volunteering, working or who have previously advocated (formally or informally) on health, housing, and/or social services and can provide an informed perspective based on both their personal experiences and their broader understanding of systemic issues.

- People who are genuinely committed to improving policies and services for people accessing health, housing and/or social services.
- People who work well with others, including policy-makers and service providers.

6.0 Meetings

- The core Advisory Group will meet once per month from September to November and every other month from January to June.
- The schedule for the general members will be determined as opportunities for engagement arise.
- Timelines may shift depending on departmental and/or strategic priorities, available resources, and workloads.

7.0 Supports Provided

Gift Honorarium

- Core members will receive a gift honorarium of $50 per meeting by cheque or direct deposit. Members may choose to receive a grocery card for the equivalent amount if they prefer.

Transportation

- A gas card in the amount of $25 per meeting will be given to members driving their own vehicles if they reside in the County and are attending a meetings in Guelph, and vice versa, to compensate for mileage.
- Members residing in Guelph are expected to arrange their own method of transportation to attend meetings in Guelph. Taxi rides or specialized transportation requests can be considered on a case-by-case basis if there is a demonstrated need.
- Transportation for members residing in the County and/or members residing in Guelph and attending a meeting in the County can be arranged through the Rural Transportation Programme

Child Care

- Childcare costs can be covered through Ontario Works informal childcare funding for members in receipt of Ontario Works.
- For childcare costs for members who are not in receipt of Ontario Works, childcare costs can be reimbursed at an hourly rate equivalent to minimum wage to account for meeting time and travel to and from the meeting.

Training and Learning

- Core members will receive access to training, skills development, ongoing support, and other learning opportunities within the scope of the Advisory Group as available.
- County Social Services department staff can provide professional references for participating members.

Accessibility

- Meeting locations will be accessible (wheelchair access and accessible washrooms)
- Interpreters can be made available as needed
- Closed captioning will be available for video conferencing
- Documents can be provided in accessible formats
- If needed, personal assistants, caregivers and support staff can accompany members at meetings
- Dietary restrictions and preferences will be considered
- Members will be able to provide feedback on accessibility and suggest improvements
- Staff will work with members to provide other supports as needed

8.0 Reporting

Meeting notes and summaries of feedback will be shared with members after each meeting. Members can review and suggest changes as required.

9.0 Terms of Reference Review and Amendments

The Terms of Reference will be reviewed and revised as required by County of Wellington staff and Health and Housing Community Planning Table members. Any revisions and updates will be shared with the Advisory Group.

I agree to the terms outlined above:

Name

Signature

Today's Date:

APPENDIX C
Lived Experience Advisory Group Input Summary

The Guelph-Wellington Lived Experience Advisory Group (LEAG) has provided input as requested by the Health and Housing Community Planning Table (HHCPT) on the following topics:

- Winter Response Plan (September 2024)
- Unsheltered Homelessness Check-ins (October 2024)
- How We Work Together (October 2024)
- Daytime Programming (November 2024)
- Supports Needed to take Steps toward Permanent Housing (June 2025)
- Planning Table/Lived Experience Advisory Group Collaboration (June 2025)
- Understanding Lived Experience (September 2025)
- Health Supports and Services for People Experiencing Homelessness (November 2025)

The summary below is limited to the topics discussed at LEAG meetings, and input has been summarized and mapped to where it best fits under the three main focus areas identified in the Health and Housing Community Plan. Some input may appear across more than one focus area. The LEAG provided input on specific responses and interventions as requested by the HHCPT, with most discussions focused on emergency responses.

The members of the LEAG agree that homelessness and poverty are the emergency, and that trust, relationships and consistency are the intervention.

Key Considerations

- **Relationships, trust and consistency must be the foundation of every intervention, program, support and service.**
- **Any actions, interventions, services and programs identified in the HHCP must be coordinated, flexible, sustained, and based on trust and relationships.**
- **The needs of individuals living in rural areas are often neglected and current systems ignore the realities of the rural context.**

Emergency Response Focus

People must have their basic needs met

- Access to food, hot meals, washrooms, laundry, showers, and secure storage for belongings
- Access to medical care and mental health care
- Access to safe and accessible indoor spaces
- Access to items for survival if living unsheltered ("tangibles")
- Safe space to rest and recover when sick when hospital admission is not necessary

Bring services to where people are

- Services should be provided to people where they are – this includes encampments, daytime programming spaces, housing buildings and isolated rural areas
- Services must be available evenings and weekends, in addition to Monday to Friday, 9am to 5pm
- Health services provided onsite and in mobile service delivery models should include primary care, first aid, mental health care, psychiatric support, and harm reduction depending on the needs of the community.

Best practices for outreach

- Outreach should be integrated across sectors and organizations and have coordinated staffing to avoid service duplication and fragmented supports.
- Outreach should be consistent in service delivery – predictable schedule, stable staffing, and consistent services and supports
- Outreach programs must be based on trust and relationships, and flexible to meet individual needs
- Outreach should be delivered by stable staff teams with low turnover and predictable client roster/caseload
- Peer support workers and health professionals must be embedded in outreach teams, including nurses, paramedics and mental health clinicians.
- Staff doing outreach must be able to provide direct services on the spot, and not only referrals. This includes medical help such first aid, wound care, mental health, administering medication, foot care etc. and other supports like applications for government benefits.
- Training for outreach staff should be comprehensive and delivered across teams and organizations so that all staff in outreach roles have the same competencies and can provide consistent supports and services.
- Outreach workers should have the ability to accompany people to the ER, shelter, court or other appointments when trust or trauma is a barrier.

Crisis Response

- Need for 24/7 non-police crisis response.
- Mental health supports should be embedded in outreach, daytime programming spaces, in health clinics and medical facilities, and must be available at any point on a person's journey.

Discharges into Homelessness

- No one should be discharged into homelessness from hospital, treatment, or jail. Hospitals must track, reduce and prevent discharges into homelessness.

Communication

- Ensure that people who need the supports and services you offer understand what is available to them. Information should be clearly shared via radio, posters, wallet cards and centralized access points such as daytime programming spaces.

Prevention Focus

Income Insecurity

- Income insecurity exacerbates housing precarity, food insecurity, and adversely impacts physical and mental health.

Health Care

- People need access to primary care.
- People need access to mental health care and addictions support that is safe, free, available, accessible, and flexible to meet their needs as life circumstances change.
- Reduce stigma so that people who need help are empowered and encouraged to access services and supports when they need them.

Bring services to where people are

- Services should be provided to people where they are – this includes encampments, daytime programming spaces, housing buildings and isolated rural areas.
- Services must be available evenings and weekends, in addition to Monday to Friday, 9am to 5pm.
- Health services provided onsite and in mobile service delivery models should include primary care, first aid, mental health care, psychiatric support, and harm reduction, depending on the needs of the community.

Housing Supports

- Housing without support often leads to eviction or housing precarity. Invest in early intervention to prevent eviction when someone is at risk of losing housing.
- Housing retention supports are critical over the course of an individual's housing journey – supports should not stop once someone is housed.

Public Education & Landlord-Tenant Relationship Building

- Landlord-tenant mediation and relationship-building supports are needed to improve rapport and understanding between tenants and landlords to prevent housing loss and housing precarity.
- Public education and awareness are needed to educate the public about homelessness and other social challenges, informed and led by lived experience.

Daytime programming and Community Hubs

- Daytime programming and community hubs in both urban and rural areas are not only critical to meet basic needs but are also access points for the delivery of prevention-focused programs such as social services and health supports.

Skill-building & Social Inclusion

- Life skills workshops, employment supports, and volunteer opportunities help build meaning, purpose, community and social/economic integration that is critical to prevention.

Communication

- Ensure that people who need the supports and services you offer understand what is available to them. Information should be clearly shared via radio, posters, wallet cards and centralized access points such as daytime programming spaces.

Supports Focus

- Relationships, trust and consistency ARE the intervention

Service Coordination

- Services must be coordinated. Each person requiring support should have a coordinated circle of care with one worker designated as their lead to help navigate complicated systems.
- Staffing must be stable, with low turnover and the ability to support individuals long-term.
- Peer supports should be embedded as a core component across systems.

Bring services to where people are

- Mobile and onsite services brought to where people are make it more likely for individuals to access the supports they need. This includes the delivery of health, housing, and social services at housing buildings, community centres, and daytime programming spaces. Health services provided onsite and in mobile service delivery models should include primary care, first aid, mental health care, psychiatric support, even for those who are housed.
- Services must be available evenings and weekends, in addition to Monday to Friday, 9am to 5pm.

Mental Health Care

- Mental health care should be ongoing and not episodic or crisis-based only.

Housing Supports

- People need one consistent lead worker to accompany them on the housing journey.
- Timelines need to be flexible, recognizing that anyone who is transitioning out of homelessness is in survival mode.
- Tangible supports are needed, like housing start-up kits with basic home supplies as well as direct support to set up utilities, internet, and pay bills
- Supports must be embedded after someone is housed to reduce likelihood of eviction

Daytime programming and Community Hubs

- Consistent, predictable daytime programming hubs in each community are needed where people can have basic needs met, access supports and services, and build community. Regular gatherings, communal meals and volunteer opportunities increase informal supports and reduce social isolation.
- Support should be flexible and individualized, focused on an individual's strengths and progress, rather than being punitive.

Communication

- Ensure that people who need the supports and services you offer understand what is available to them. Information should be clearly shared via radio, posters, wallet cards and centralized access points such as daytime programming spaces.

Cross-cutting Considerations: Emergency Response, Prevention and Supports Focus Areas

There are a number of program and service delivery considerations from the LEAG that serve as foundational considerations across the Emergency Response, Prevention and Supports focus areas.

Relationships and Trust

- Consistent, predictable and long-term relationships with a worker or a small team are more likely to help individuals access supports and find stability.
- Trust is easily broken when there is a high turnover in staffing or when staff lack the authority or ability to provide the support that is needed.
- Peer support workers are an essential link across systems and should be embedded within the health and housing systems.

Mobile and Onsite Service Delivery

- Services must be brought to where people are to increase the likelihood that individuals who need supports are able to access them.

Lived Experience is Knowledge

- Lived experience is ongoing and diverse – it is not a static set of experiences.
- Input from people with lived experience must lead to action, otherwise trust erodes.

Systems Must Adapt to People

- Supports, programs and services must be flexible enough to accommodate individual needs and trajectories – ongoing adjustment is required along the journey for an individual to effectively stabilize.
- Linear, bureaucratic and complex rules-based systems often block stabilization and individual progress towards permanent housing and wellbeing.
- Systems must meet people where they are – LEAG members have shared the phrase "meet me in my mess" to illustrate this.

Service Access and Coordination

- Services and supports must be integrated and coordinated to avoid duplication, fragmentation and to address gaps.
- Supports across health, housing, mental health, addictions and emergency response must be available after regular business hours and on weekends – needs don't disappear after 5pm and on weekends.
- Referrals must always be warm hand-offs or individuals must be accompanied by a provider they trust in order for them to be effective.
- Information about supports and services is often fragmented and difficult to find/access- the digital divide makes it hard for individuals to access information and services that are offered online only. In-person, mobile and onsite supports are also needed.

Rural Inequities

- Wellington County is underserved as most services are concentrated in Guelph.
- Transportation is a major barrier for people living outside of Guelph.
- Unsheltered homelessness is dispersed and less visible in rural areas, which means that mobile services are critical in rural areas.
- Health and housing community planning specific to rural needs is needed.

Daytime Programming

- Daytime shelter is critical infrastructure across the prevention, emergency response, and supports core areas. It is a way to meet people's basic needs, while also acting as a centralized access point for health services, social services, community and social connection.

- Daytime programming must be low-barrier and drop-in, staffed by trained peers, volunteers and outreach workers.
- These spaces should be open for as many hours as possible in locations that are easy for individuals to access.
- Daytime programming should provide basic crisis intervention for those who require it, that is not police

Community, Purpose and Belonging

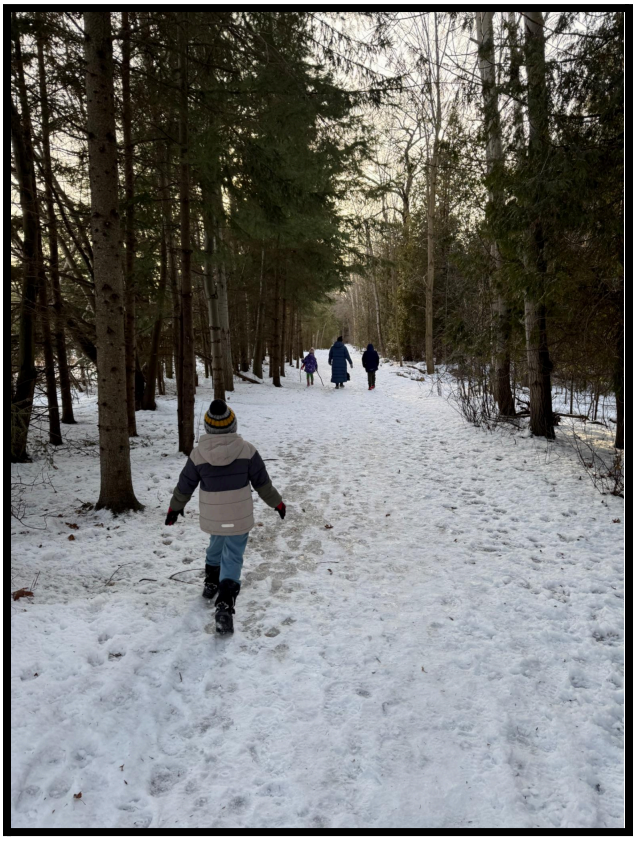
- Isolation is a major risk factor for relapse and housing loss - individuals need community, purpose and belonging.
- Low-barrier programming should be available to encourage volunteering and skill-building, social connection and community-building activities to build a sense of pride and ownership in housing.
- Transportation support must be available to reduce barriers to participation in programming.

APPENDIX D

Indigenous Community Engagement Circles for Health & Housing Planning Table, Guelph-Wellington Ontario Health Team

Prepared by: Katrina Graham RN, Heart Work Consulting

February 2026



“The Guelph Wellington Ontario Health Team (GW OHT) acknowledges the profound trauma and ongoing hardships experienced by Indigenous peoples in Canada. Our intention is to move forward by fostering education and a deeper understanding of Truth and Reconciliation, both individually and as healthcare providers. The GW OHT recognizes the systemic inequities that Indigenous peoples face in accessing culturally appropriate, responsive and safe healthcare. Our aim is to respect and explore the differences between our current healthcare system and Indigenous approaches to health, wellbeing, and care. We seek to acknowledge the two world views and walk together on this journey of Truth and Reconciliation, holding space for Indigenous voices and valuing Indigenous knowledge through a lens of accountability and relationality. Our intention to listen, learn, reflect and take action in ways that honor the unique gifts of Indigenous communities. We are committed to translating our learnings into meaningful action, ensuring that our efforts contribute to tangible improvements in Indigenous health outcomes and healthcare access. In alignment with Indigenous practices, we make this statement of intent with the understanding that it will evolve as we engage in continual reflection and deepen our understanding of how best to support Indigenous communities in our region and beyond” - GW OHT website, https://guelphwellingtonoht.com/2025/06/20/gw-oht-statement-of-intent/

We express our deep gratitude to the Guelph-Wellington Indigenous community and system partners for their invaluable perspectives on Health and Housing in Guelph-Wellington. These insights were gathered through the consultations hosted by the Guelph-Wellington Ontario Health Team. To dismantle colonial systems, we need to evaluate our own conscious and unconscious bias, and how this impacts the care we provide.

Circle Process:

The Indigenous Community engagements took place on Treaty 3, between the lakes Treaty. It is the Mississaugas of the Credit Traditional Territory and along the Haldimand Tract, the land of the Six Nations of the Grand River. Today we know this place as Guelph-Wellington, Ontario.

To begin each circle, the facilitator, Katrina Graham, informed participants that they would be asked a series of questions focused on health, primary care, and housing services within the Guelph-Wellington area. Circle process was used, which involves going around to each person, offering participants an equal opportunity to share their thoughts or pass. Katrina set the tone by establishing group norms, emphasizing:

- A trauma-informed approach will be used throughout the circle
- The circle is Indigenous-led, however working in partnership with the GW OHT and its Health and Housing Planning table.
- We informed the groups that the GW OHT is also looking to engage with Indigenous community to learn more about primary care needs.
- The OHT and partners are committed to a “nothing about us without us” approach, referring to Indigenous Peoples.
- Using "I" language when sharing stories.
- Maintaining confidentiality within the circle, understanding that themes and recommendations will be shared in a written document with the Guelph-Wellington

Ontario Health Team and its partners, to inform their work.

- Verbal consent to transcribe participant responses was secured from all attendees without objection. No participant identifiers will be provided in the feedback report.
- Finally, Katrina shared that participants will have an opportunity in the spring to review the collected information from both sessions and propose amendments.

Clarence Cachagee provided invaluable support throughout the circles. He began each session with a traditional opening and a Smudge Ceremony. Furthermore, he offered emotional support to participants who were sharing and experiencing strong feelings. Clarence concluded each circle with reflections before ending the time together.

Guelph-Wellington Ontario Health Team (GW OHT) lead, Emmi Perkins and GW OHT Equity, Diversity and Inclusion lead Christine Platt, explained the purpose of the Engagement Circle and provided insights into current projects, including system-wide updates.

During the Circle, community members and service providers identified significant gaps and systemic barriers within the health, housing, and justice systems that continue to negatively impact First Nations, Inuit, and Métis peoples in Guelph-Wellington. Participants shared that individuals are frequently moved from one organization to another without receiving meaningful or sustained support, often being discharged or released without a plan, stable housing, or follow-up care. This cycle contributes to increased harm, instability, and disconnection from community support.

Justice and court system gaps and barriers were identified in the engagement circle in Guelph. It is important to note that as the GW OHT is not responsible for implementing change to the justice and court system. The GW OHT is however able to support advocacy to improve the overlaps between justice, health and housing in care transitions such as when someone is released from incarceration and during court proceedings.

Guelph Circle Engagement: This circle was held at the Indigenous Community Space, St. Joseph's Health Centre, Guelph on December 16th 2025.

A total of 21 people attended the Guelph engagement session. The invitation was distributed through multiple channels:

- **Direct Email:** Sent to local health and housing organizations and individual Indigenous community members.
- **Word of Mouth:** Utilized by community members, specifically using phone calls, to share the information with older adults who don't use email.

Wellington County Circle Engagement:

This circle was held at the Aboyne Room, Wellington Museum and Archives, on February 11th 2026. This circle saw an attendance of 12 people. The methods for outreach were consistent with the Guelph session:

- **Direct Email:** Sent to local health and housing organizations and individual Indigenous community members.
- **Word of Mouth:** Employed by community members, primarily through phone calls, to inform older adults who don't use email.
- To note, driving and visibility were challenging due to snow, which may have caused some decrease in participation. Originally the engagement was scheduled for January 26th, however there was a snow storm the previous night and therefore the circle was rescheduled to February 11th 2026.

Both circles were held between 1:30pm-4pm. Transportation was provided for participants that required it, to reduce transportation barriers. Food was provided to help ground us, and allow for social time and sharing food, as this is important in our culture as Indigenous peoples.

Participants included: Self-identified First Nations, Métis and mixed ancestry Indigenous community members, and a variety of professionals from Health, Social Services, and Justice sectors. It is important to note that no self-identified Inuit community members joined these two circles.

"The land is our primary care"

Indigenous Community Engagement Key Themes & System Messages- Health, Housing & Primary Care | Guelph-Wellington

Indigenous Peoples in Guelph-Wellington are not asking for small program changes. They are calling for:

- Access to traditional healers, cultural supports, and appropriate spaces within health systems.
- Integrated, Indigenous-led navigation across health, housing, and justice systems.
- Safe, culturally grounded housing connected to health supports.
- Timely, relational, and wholistic care.
- Accountability for racism and systemic harm.
- Rural equity in service access.
- Bottom-up system redesign guided by lived experience.

Health and housing systems must shift from fragmented, eurocentric, policy-driven models toward relational, culturally grounded, Indigenous-informed systems of care

rooted in land, relationships, dignity, and collective responsibility.

1. Fragmented Systems Create Harm For Indigenous Peoples

Participants described a health, housing, and justice system rooted in eurocentric, rigid, and siloed models that are difficult to enter, navigate, and remain connected to.

> "The system is based on a very eurocentric model."
> "The policies are meant to create equity but are creating barriers and harm."

Key Issues:

- No centralized or Indigenous-specific pathway for access.
- Fragmented services with no circle-of-care model.
- Confusing eligibility criteria and new centralized social assistance processes.
- Paperwork, digital systems, credit checks, and appointment requirements block access.
- Measurables and funding models do not reflect Indigenous ways of knowing and being.
- Discharge from hospital or incarceration without coordinated housing, income, or care.
- ODSP is suspended during incarceration, leaving people with no income upon release.
- Increased overdose risk immediately following release from incarceration.
- Delayed psychiatric, fitness, forensic, and "Not Criminally Responsible" (NCR) assessments.
- Loss of addiction support groups post-COVID.
- Geographic inequities: limited or no services in Centre and North Wellington.
- Transportation barriers and long travel distances to current Indigenous supports.

Core Message:

Systems are reactive rather than preventative, and discharge people into homelessness, relapse, and re-incarceration instead of stabilizing them. Change must be **bottom-up**, grounded in lived experience:

> "Nothing about us without us."
> "We need to create change from the bottom-up."

2. Lack of Culturally Grounded and Wholistic Care

Participants emphasized that Indigenous health is relational, land-based, and must reflect the whole-person, it is not appointment-based or symptom-focused.

> "Our Primary Care comes from the Land, our Primary Care comes from Relationships."
> "Western models don't focus on our ways of healing."

Key Issues:

- Absence of Indigenous-led services in Wellington County.
- Limited access to ceremony, spirituality, and land-based healing.
- Cultural support is limited to business hours despite 24/7 needs.
- Over-prescribing of narcotics without addressing root causes.
- Lack of psychiatrists and providers trained in Indigenous health.
- Congregate living models are often culturally unsafe.
- Racism and discrimination within care settings.
- Indigenous roles undervalued or unsupported in organizations.

Core Message:

Care must address mental, physical, emotional, and spiritual wellness together. Indigenous knowledge systems must be recognized as essential, not supplemental.

There is a need for:

- Accountability mechanisms to prevent racist and discriminatory care.

- Equitable HR policies prioritizing Indigenous hiring, retention, and leadership.
- Indigenous-designated roles filled by Indigenous Peoples.

3. Urgent Need for Indigenous-Led Navigation & Peer Support

Across both sessions, Indigenous navigators and peer outreach workers were identified as critical system solutions.

> "Navigators help to break down the language that social, housing, and health care workers use."

Key Needs:

- Indigenous Navigators embedded in health care settings, hospitals, health services, shelters, housing services, and justice settings.
- Peer-to-peer Indigenous outreach workers are needed on the streets.
- Mobile Indigenous roles serving rural Wellington is needed.
- Centralized Indigenous navigation pathway across systems.
- Warm handoffs between Indigenous and non-Indigenous services.

Indigenous-led support at Thresholds on Delhi Street was highlighted as a positive local example of culturally grounded stabilization.

Core Message:

Navigation is not administrative support, it is cultural translation, advocacy, and relationship-building that saves lives.

4. Housing Must Be Safe, Flexible, and Integrated with Health

Housing was described as more than shelter, it must offer safety, dignity, belonging, and embedded supports.

> "The shelters here are too dangerous; people would rather stay in stairwells."

Heart Work Consulting for the Guelph-Wellington OHT 2026

> "There are Elders, families, and children on the streets here."

Key Issues:

- Unsafe congregate shelters.
- No shelter/housing options in Centre and North Wellington.
- Inadequate emergency and after-hours support.
- Rigid allocation systems in housing programs that are not reflective of Indigenous family structures and needs.
- Lack of oversight from housing programs and transitional care supports when someone with mental health or addictions is moving residences (for example, from a three bedroom to a one bedroom, due to change in family size)
- Credit checks and eligibility requirements block access.
- Individuals cannot maintain housing without embedded health and social support.
- Lack of alternative housing models (transitional, Elder, youth aging out of care, supportive with medical care), especially in Centre and North Wellington.
- Land-based housing and healing models are absent.

Core Message:

Housing stability requires integrated health and addictions support. Prevention must replace discharge-to-the-street practices.

Participants called for creative use of existing infrastructure:

> "Use what we have and do what we can with what we have."

5. Relational, Community-Based Ways of Caring

Participants emphasized relational accountability, reciprocity, and collective strength.

> "Together, we rise."
> "Teaching each other our systems, ways of being and knowing."

Key Messages:

- Indigenous communities operate through kinship and collective care.

- Street communities function through mutual support and respect.
- Relationship-based care models have eroded over time.
- Collaboration across organizations must be strengthened.
- Communication grounded in respect (including use of "I" language) is essential.
- Workers must listen deeply and believe lived experience.

Core Message:

Systems must move from transactional service delivery toward relational, community-rooted care models.

6. Internal System Change & Accountability

Service providers acknowledged that meaningful change requires transformation from within institutions.

> "Change the system from within the system."
> "We don't listen well, and we are not good at believing and seeing people as they are." (from a health and housing service provider).

Key Priorities:

- Review and revise rigid eligibility and discharge policies.
- Track and respond to system gaps.
- Address stigma related to substance use.
- Increase Indigenous workforce capacity.
- Ensure Indigenous leadership in decision-making.
- Embed accountability for anti-racism in policies and procedures.
- Shift funding and resource use to fill known gaps without waiting for new funding streams.

Core Message:

Systems must align policies with lived realities and embed accountability mechanisms to ensure harm is not reproduced.

Photo taken by Katrina Graham, Stream at Marden walking trail, Guelph/Eramosa

Alignment With Truth and Reconciliation Commission Calls to Action

The Indigenous Community Engagements took place on Treaty 3, between the lakes Treaty. It is the Mississaugas of the Credit Traditional Territory and along the Haldimand Tract, the land of the Haudenesaunee, Six Nations of the Grand River. Today we know this place as Guelph-Wellington, Ontario.

The recommendations emerging from this engagement directly support the implementation of the Truth and Reconciliation Commission of Canada's Calls to Action, particularly those related to health, justice, child welfare, and public service accountability. The actions outlined below reflect Indigenous-identified priorities and emphasize Indigenous leadership, cultural safety, and relational care.

TRC Calls to Action:

Call to Action 18

Acknowledge that the current state of Indigenous health is a direct result of colonial policies.

Alignment:

- Community members identified systemic harm caused by fragmented care, over-prescribing of medications, discharges and transitional care without support.
- Recommendations call for wholistic, culturally grounded health care that addresses root causes rather than symptoms.

Call to Action 19

Identify and close gaps in health outcomes.

Alignment:

- Establishing Indigenous-led services, Indigenous patient navigators and peer-to-peer outreach directly addresses gaps in access, continuity of care, and safety.
- Expanding 24/7 support responds to the reality that Indigenous health needs are not limited to business hours.

Call to Action 20

Recognize and address distinct health needs of First Nations, Inuit, and Métis peoples.

Alignment:

- Recommendations emphasize culturally relevant, Indigenous-specific health and housing supports in Guelph.
- The inclusion of ceremony, spirituality, Elders, and traditional healing reflects community-defined approaches to wellness.

Call to Action 22

Recognize the value of Indigenous healing practices and collaborate with Indigenous healers.

Alignment:

- Community members clearly stated that spirituality and ceremony are essential to healing.
- Recommendations include access to traditional healers, cultural supports, and appropriate spaces within health systems.

Call to Action 23

Increase the number of Indigenous professionals and ensure cultural humility and competency training.

Alignment:

- Creation of Indigenous health professional, navigator, outreach, and peer support roles responds directly to this Call.
- Ongoing cultural safety and anti-colonial, anti-Indigenous racism training for health and housing workers supports systemic change.

Call to Action 30

Eliminate the overrepresentation of Indigenous people in custody.

Alignment:

- Community members highlighted lack of support upon release from incarceration as a key contributor to harm.
- Recommendations call for coordinated, Indigenous-led transition support to prevent people from being released directly into homelessness and creating a cyclical pattern of harm.

Call to Action 34

Provide culturally relevant services for Indigenous offenders.

Alignment:

- Indigenous navigators and peer support workers within justice and health systems support culturally safe pathways and advocacy.
- Improved access to culturally safe psychiatric and risk assessments aligns with culturally appropriate justice responses.

Call to Action 35

Address the needs of Indigenous people with mental health issues in the justice system.

Alignment:

- Community-identified barriers to assessments and support are addressed through coordinated health-justice partnerships and culturally grounded care.

Call to Action 1 & 3

Reduce the number of Indigenous children in care and fully implement Jordan's Principle.

Alignment:

- Recommendations to eliminate discharges into homelessness and improve navigation through social assistance systems support family stability and safety.
- Indigenous Navigators help ensure timely access to support and reduce system delays that negatively impact families.

Public Service, Funding, and Accountability

Call to Action 43

Fully adopt and implement the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP).

Alignment:

- Recommendations emphasize Indigenous-led decision-making, governance, and community-defined success.
- The relational approach to care reflects Indigenous rights to culture, health, and self-determination.

Call to Action 45

Develop reconciliation frameworks with measurable goals.

Alignment:

- Next steps include creating Indigenous-defined indicators of success (safety, dignity, connection, healing), rather than solely system metrics.

Call to Action 57

Educate public servants on Indigenous history and anti-racism.

Alignment:

- Strengthening learning and accountability for health, housing, and justice workers directly responds to this Call.
- Training grounded in lived experience and Indigenous knowledge supports meaningful reconciliation.