Oxford County Homelessness Response Strategy

Preventing and Reducing Homelessness in Oxford

Oxford County
Growing stronger together

Contents

Acknowledgements

This Homelessness Response Strategy is the result of a collaborative effort between the County of Oxford, SHS Inc., community support agencies working in the housing and homelessness system, program funders, and individuals with lived experience of homelessness and housing precarity.

We appreciate the contributions of all participants, including the time and energy committed to ensure this Strategy reflects the needs and perspectives of the community.

Part 1

Introduction

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Toward a Homelessness Response Strategy for Oxford

Background

Oxford County is home to over 130,000 people in three urban and five rural municipalities. Like many other regions across Canada, the County has seen a sharp increase in homelessness and housing precarity due to the shortage of affordable and appropriate housing and the increasing cost of living.

This Homelessness Response Strategy outlines a plan to respond to the growing unsheltered and hidden homelessness across the County.

As homelessness continues to grow in prevalence and complexity, the County and partners in the community have shifted and adapted to assist in meeting the needs of those experiencing homelessness.

This collective effort has become the backdrop of this Strategy, prompting the development of a whole-of-community response, as partners across the system.

Building on Oxford's Housing and Homelessness Plan

This Strategy has been developed in collaboration with the community to support Goal 1 of the County's Housing for All: Housing and Homelessness Plan, which is to ***reduce homelessness through prevention***.

Reading this Strategy

This Strategy provides insight into the gaps and challenges that exist in the current system of homelessness supports and identifies actions to improve and actively address the identified gaps across the system. The document includes three parts:

Part 1 provides an overview of the approach taken to co-develop the Strategy with a range of representatives and participants in Oxford.

Part 2 explains the current reality of supports in Oxford, the policy and regulatory context, the detailed gaps and challenges, a case for action, and the opportunity at hand.

Part 3 offers a plan to guide the response to homelessness, including pillars (4), goals (8), strategies (20), and associated actions (49). Each goal contains the following:

- Desired outcomes that can be used to guide measurement and evaluation;
- Strategies to achieve the goal;
- Specific actions for each strategy.

A Human-Centred Strategic Framework

This Strategy was developed with lived experience at its core, ensuring a deeper understanding of the challenges faced. This approach informed the framing of this document around three key touchpoints in the homelessness system: **when individuals are at risk of becoming homeless, when they are actively experiencing homelessness, and when they are seeking housing and support to achieve stability.**

While this framing does not fully capture everyone's journey—people's experiences can vary significantly—it offers a framework for developing a strategic response considering diverse needs and goals.

These experiences are the primary lenses used throughout the Strategy to describe the current reality and articulate a future strategy for Oxford County.

Preventing Homelessness	This experience accounts for households that have never experienced homelessness but are at risk of losing their homes. The goal is to prevent experiences of homelessness entirely and ensure individuals remain housed.
Managing Experiences of Homelessness	This experience accounts for those actively experiencing homelessness and includes the ways in which individuals meet their daily needs, such as shelter, food, water, and income assistance. The goal is to manage day-to-day life and receive immediate and emergency support.
Accessing Housing & Services	This experience accounts for individuals at various stages who are actively looking to access housing and other services. It can also include individuals who have been matched to housing but face challenges or barriers to remain housed.

Peeling Back the Layers

There are multiple layers of processes, patterns, and personal complexities that present barriers to designing an effective homelessness response. We can navigate this better by looking at the homelessness-serving system through three different layers:

1. **Lived experience**: the stories of individuals experiencing homelessness in Oxford – their goals, priorities, challenges, and ideas.
2. **Service providers**: the experiences of organizations (and their staff) who provide a variety of support to the individuals who need them most – their goals, frustrations, and ways of working.
3. **System**: the tools, infrastructure, connections, and structure that hold all the supports together and how services and programs connect with each other.

These three layers help ensure that the Strategy is effective at different levels and is designed for success.

Methodology

Approach

To build broad buy-in and shared accountability, this Strategy was co-created with individuals experiencing homelessness, local service providers, and other actors in the housing and homelessness service systems. The goal of this approach was to co-create a Strategy that addresses the needs and concerns of those most greatly impacted. The work was undertaken in three phases:

Phase 1: Discovery

Understand the current state of homelessness supports through:

- *Reviewing existing policy*
- *Collecting community data (By-Name List data, system capacity)*
- *Conducting surveys and interviews (with providers and lived experts)*

Phase 2: Connecting the Dots

Build a collective picture of the gaps and opportunities through:

- *Hosting a community co-design workshop*
- *Analysing real-time data from Oxford's By-name list*

Phase 3: Generating Solutions

Craft recommendations specific to Oxford through:

- *Hosting a second community workshop to generate solutions*
- *Seeking feedback from others in the community and Council*

Research Questions

The Strategy development process focused on answering the following core research questions:

- **How do individuals in Oxford currently experience homelessness? What challenges do they face?**
- **What services are available in the community? Are these services sufficient to meet the needs of the community?**
- **How do service providers and programs currently connect with each other to deliver services to community members?**
- **How can the system improve to provide services and connect individuals to housing more effectively?**

Mixed Methods Approach

A mixed-methods approach was used to review the homelessness system and answer the research questions. The quantitative data work included a review of housing needs, the By-Name List, and the cost of inaction. In contrast, the qualitative review included extensive community engagement to better understand the implications of the data for individuals' day-to-day experiences.

The process engaged lived experts and over 25 organizations currently providing services in the County, including:

- Emergency shelter providers
- Transitional and supportive housing organizations
- Support agencies
- Food support organizations
- Youth-serving organizations
- Healthcare institutions
- Local municipal representatives

Part 2

Our Current Reality in Oxford

Contents

The Homelessness-Serving System in Oxford

The Policy Context

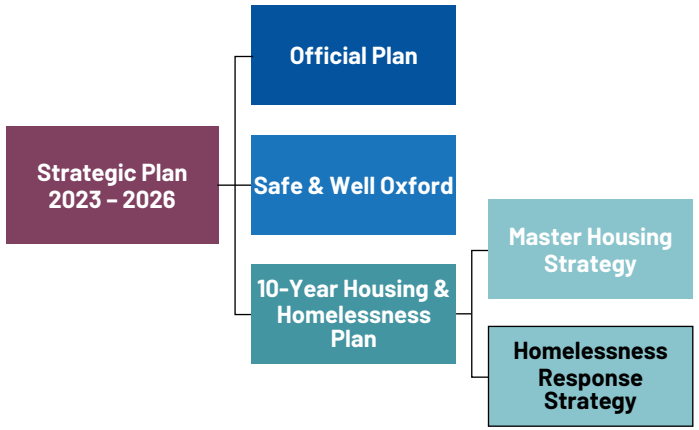
This Strategy supports the County in playing a key role in addressing the challenges related to experiences of homelessness.

The County's role in establishing this action plan should be consistent with existing policy frameworks. This section provides an overview of the key government players impacting the homelessness-serving system and their respective roles.

Oxford County

The County of Oxford, as the Consolidated Municipal Service Manager, is responsible for delivering community and social services throughout the Municipality. As part of its mandate, Oxford County Human Services administers and delivers various shelter programs, including social housing, new affordable housing, rent and bridge supplement programs, housing allowances, funding for emergency shelters, domiciliary housing, and other homelessness prevention programs.

This Homelessness Response Strategy sits within the context of Oxford's 10-Year Housing and Homelessness Plan, as illustrated below.



Recurring Themes Around Homelessness Prevention in Oxford

The following principles are commonly referenced across Oxford County's policy landscape and provide relevant insight into priorities and strengths within the County.

Shelter as a Priority. Addressing shelter needs, including the provision of affordable housing options and addressing and preventing homelessness, is a key priority.

Integrated Service Delivery. Oxford County places great emphasis on its integrated service delivery model, which strives for a one client, one file approach.

Coordination and Collaboration. Recognizing the importance of the County's partners in providing housing and support services, local plans and strategies frequently call for coordination and collaboration.

Monitoring and Data Collection. Documents emphasize the need for quality data collection, monitoring, and analytics, to ensure evidence-based policy and service delivery, along with the use and exchange of best practices.

Populations in Need. The documents highlight the importance of ensuring that the needs of vulnerable target populations are being met.

The Policy Context

Federal Government

The federal government influences homelessness services and prevention as a **legislator**, through the development of overarching policies, and as a **funder**.

The **National Housing Strategy Act, 2019,** sets out the federal government's housing policy and recognizes housing as a human right.

The federal government primarily influences housing and homelessness services through the related **National Housing Strategy (NHS)** and its associated programs and initiatives. Much of the NHS is focused on shaping housing supply, with its primary contribution to preventing and addressing homelessness being funding programs.

Reaching Home is the primary source of federal funding to address homelessness, and is designed for urban, Indigenous, rural and remote communities to address local needs. **Oxford County is not currently a recipient of Reaching Home funding.** Other programs include a Veteran Homelessness Program, and proposed funding for community action plans to address encampments.

Provincial Government

The provincial government similarly influences homelessness services and prevention as a **legislator**, through the development of overarching policies, and as a **funder**.

Ontario guides the administration of community housing and the planning and implementation of local homelessness services through the **Housing Services Act, 2011**. Through this Act, and related regulations, the province defines the roles of Service Managers, like the County of Oxford – for example, requiring the implementation of the By-Name List. The province further shapes housing and homelessness programs through **regular strategies** and associated legislative and funding updates.

The **Homelessness Prevention Program (HPP)** is an important funding program that supports Service Managers in providing emergency shelter, supportive/transitional housing and support services for those experiencing or at risk of homelessness. Oxford County receives funding under this program, with the majority allocated to community partners working in the homelessness system. While other funding programs focus more on community housing, some include programs that can address homelessness, such as rental assistance.

Setting up our County for Success

Administration and delivery of housing and homelessness services is directed locally by the County of Oxford as Service Manager, with funding support and legislative guidance provided by higher levels of government. As part of its mandate, Human Services plans, administers and delivers a variety of services, including providing and maintaining community housing, and developing and delivering programs and services that prevent and respond to homelessness, among others. While the County delivers some programming internally, they also **rely heavily on community partners** to deliver services to the community. The County also **collaborates with local area municipalities**, who deliver community services and enforce local by-laws, all which impact experiences of housing and homelessness.

As such, while the County of Oxford has significant capacity to shape and implement housing and homelessness programs, **key components of enabling a strong homelessness serving system include advocacy and communication with higher levels of government and coordination and collaboration with community partners and area municipalities**. The strategy recognizes the County's unique strengths alongside its connections to other stakeholders and systems.

Working to Deliver Homelessness Services in Oxford

Various service delivery systems, service providers, data and information sources, and processes currently exist in the County to deliver homelessness services to individuals at risk of or experiencing homelessness. This section provides a high-level overview of the system as it exists today.

System of Supports

The current system of supports for those experiencing homelessness is centred around three core components. Appendix 1 describes the services provided in more detail.

	Component	Description	System Connections	Oxford Examples	Goal
1	**Stabilizing supports**	**Stabilizing supports** can serve the goal of preventing homelessness. They provide specialized resources, tools, and expertise based on an Individual's unique circumstances. These supports also play a role in ensuring housing and well-being can successfully be maintained after experiencing homelessness.	Connections to these supports are often **dependent on the individual**. There is limited intentional integration between these supports and emergency supports.	• Ontario Works • Elgin-Oxford Legal Clinic • Salvation Army Woodstock's Food Bank program • Wellkin's School Community Intervention Program	*Preventing Homelessness*
2	**Emergency supports**	**Emergency supports** provide day-to-day support for basic needs (health, shelter, food). While these supports are not limited to individuals experiencing homelessness, they are often critical to support managing a loss of housing.	These supports tend to have the **strongest connections in terms of service planning and delivery**.	• The Inn and Day Space • DASO Shelter • Mobile Health Outreach Bus • Rapid Access to Addiction Medicine (RAAM) Clinic	*Managing Experiences of Homelessness*
3	**Housing**	**Housing supports**, including housing stability services and transitional, supportive, and affordable rental housing, are limited, and access can be challenging.	Given the nature of the individuals they serve, **supportive and transitional housing providers tend to be the most connected** to service providers in the system.	• Indwell – Blossom Park • Oxford County Community Health Centre's Housing Stability program • Transitional Housing	*Accessing Housing and Services*

Collective Effort towards a Shared Goal

There is widespread recognition that a response to homelessness requires a collective effort and a shared vision for success.

While service providers are working hard to achieve their objectives, they also recognize the collaboration that is necessary to reduce homelessness in Oxford. As a result, service providers have designed and implemented aligned programs that better meet their clients' needs, providing several examples of valuable connections in the system.

Coordinating Service Delivery

Several systems and strategies are currently in place in Oxford to promote coordinated service delivery of homelessness supports. These include Coordinated Access, co-located programs, co-delivered services, and referral pathways.

Coordinated Access

Coordinated Access enables service providers to match individuals experiencing homelessness to housing and supports that match their unique needs. It aims to connect the discrete organizations operating in the region and centralize efforts to coordinate services.

The By-Name List is a feature of Coordinated Access and works to collect the information required about individuals' unique situations and needs. Together, they are vital systems of service delivery that drive the response to homelessness.

Co-Located Programs

Co-locating programs involves service providers working in the same physical space. This allows for trust and relationship building, knowledge sharing, and easier referrals. The Livingstone Centre in Tillsonburg and nurse practitioner visits to the Day Space are successful examples of co-location enhancing service outcomes.

Co-Delivery of Services

Multiple service providers working together to deliver a service can demonstrate deep collaboration. E xamples include the Mobile Health Outreach Bus and the Mental Health Engagement and Response Team (MHEART) program.

Referral Pathways

Many service providers currently rely on referral pathways to assist clients with their needs. Common examples include referrals from primary care to CMHA's counselling program or the Oxford County Community Health Centre's Housing Stability program.

Data and Information

A key component of a system that supports seamless coordination is the collection and strategic use of data and information. This section provides an overview of the data tools used in the response to homelessness.

By-Name-List

The By-Name List is a **real-time list of individuals experiencing homelessness** within a service manager area. The By-Name List is intended to:

- help to **understand patterns of homelessness**;
- **connect individuals experiencing homelessness** to services and supports;
- **improve access and reduce barriers** to supports; and
- **monitor progress** related to homelessness prevention.

Homeless Individuals and Families Information System (HIFIS)

HIFIS is a data and case management tool that allows service providers to access the By-Name List data and provide real-time updates. While Oxford does not currently use this system, it is a valuable tool used by other communities.

Challenges and Gaps in Oxford's Homelessness Supports

A Range of Challenges

The homelessness-serving system in Oxford includes services, programs, and supports aimed at **preventing homelessness**, **managing experiences of homelessness**, and **accessing housing and services**. Service delivery is not always seamless—challenges and gaps exist, presenting challenges for individuals facing housing precarity and experiencing homelessness, as well as for organizations providing supports, and the overall function of the entire system.

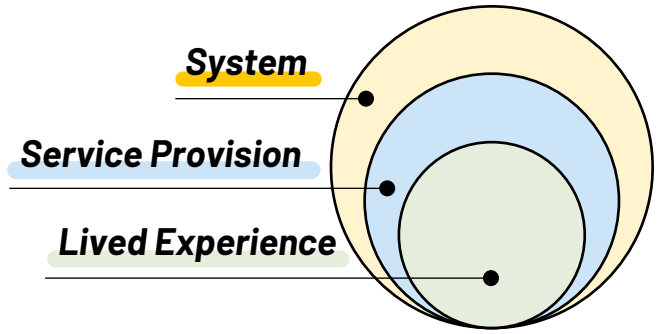
This section provides a **snapshot of the need** in Oxford and a suite of **ten gaps** in the current system.

Mapping Needs and Gaps across the System

The needs and gaps in this section are described through three system layers:

- **Lived experience gaps**
- **Service provider gaps**
- **System gaps**

The research and engagement process revealed that challenges faced by individuals experiencing homelessness are most often a result of the challenges faced by service providers and the way the system is currently working or designed. While interconnected, each system layer provides a unique lens of experience and helps build a holistic understanding of where challenges currently exist, how they are experienced, and how they might be improved.



Lived Experience

Challenges and gaps for those living unsheltered or facing housing precarity:

- **Gap 1:** Lack of secure tenure
- **Gap 2:** Inconsistent access to services
- **Gap 3:** Stigma and discrimination

Service Provision

Challenges and gaps for organizations providing supports:

- **Gap 4:** Lack of dedicated capacity to implement coordinated access systems
- **Gap 5:** External pressures influencing program design
- **Gap 6:** Lack of codified connections and knowledge sharing between partners
- **Gap 7:** Limited connections between healthcare and broader homelessness system

System

Challenges and gaps in how the system works as a whole:

- **Gap 8:** Coordinated Access unable to connect the circle of care
- **Gap 9:** Lack of system capacity to meet high need
- **Gap 10:** Lack of stable and affordable housing

A Snapshot of the Need in Oxford

Experiences of Homelessness

As of January 2025, there were **166 people known to be experiencing active homelessness**, based on the By-Name List (BNL). Of these individuals:

- **67%** were experiencing **chronic homelessness**
- **66%** had a diagnosed **mental illness,** and **88%** were experiencing a **mental health concern**;
- **69%** were experiencing a substance use concern**;**
- **9%** were identified as experiencing **domestic violence;**
- **11%** were **Indigenous;** and
- **8%** were **youth.**

In the **four-month period** between October 2024 and January 2025:

- **106 individuals were added** to the BNL, the majority of which were returning from inactive (37%) or newly identified (59%);
- **24** individuals were **housed;** and
- **54** individuals were **moved to inactive.**

Since the implementation of the BNL**, 95 individuals have been housed**.

Accessing Supports

Of those on the By-Name List, most are connected to the service delivery systems named in the previous section. Emergency services are often the easiest to access, with housing and stabilizing supports requiring more effort.

Emergency shelter use

There were approximately **34 guests per night in shelter** since the beginning of 2024, compared to 26 over the course of 2023.

- An additional 25 shelter beds were added in March 2024.

Residents spent approximately **26 days in shelter over the first three months of 2024**, compared to 35 over the course of 2023.

Entry points to housing and stabilizing supports

Outreach supports are a key entry point for individuals experiencing homelessness to access other supports they might need (e.g. counselling, income support, housing help), especially if they are unable to access shelters.

The Day Space in Woodstock is another important connection point in the community for those seeking support. Staff from other organizations are often present on-site or connected to Day Space staff to better support individuals.

Lived Experience

Gap 1: Lack of secure tenure

Insecure tenure and forced evictions

The increasing cost of living is leading to more cases of unstable and expensive housing, putting renters in precarious situations. This, coupled with a lack of protection for renters against rapid rent increases and unfair evictions, has widened the pathway to homelessness in the community.

A lack of affordable housing options across the County has exacerbated tenants' **vulnerability to eviction**, especially at the whims of market forces, landlords, and other external factors.

It has also led to the growth of **non-traditional housing situations** (e.g., room rentals, and rooming houses) that are not protected by the Residential Tenancies Act. This leaves tenants vulnerable to landlords and in situations where they must accept substandard housing or precarious leases.

Lack of accountability

There is a lack of accountability for those executing evictions without proper cause.

While there are existing services to help those facing evictions through the Elgin-Oxford Legal Clinic and Oxford County Community Health Centre, the Landlord-Tenant Board cannot **meet the current need** or provide decisions in a timely manner.

There is also a lack of data on evictions in the region, as they often occur informally and without being escalated to the Landlord-Tenant Board.

Low awareness of tenant rights

There is a widespread lack of awareness of tenant and housing rights in Oxford.

When faced with evictions, households often do not know **what is permitted by law or where to turn for help**. Individuals in non-traditional tenure situations often do not have proper leases governed by the Residential Tenancies Act and feel they have no avenues to assert their rights.

Programs like the Oxford Tenant Support Network exist to provide these avenues, but there is low awareness of this support.

Lived Experience

Gap 2: Inconsistent access to services

Lack of consistent service

The system of available supports can be quite complex, and assistance is required to know which supports are appropriate, and how to be connected to them. That said, service navigation and advocacy **support is not always guaranteed, and success can depend on the staff person's capacity at the time.**

Community members have also observed different services shutting down despite need, triggering a **fear of losing services individuals rely on**. A pattern of services shutting down, moving, or reducing capacity, builds an environment of instability, leading to a lack of awareness and confidence in the services that are available.

Experiencing access to inconsistent service can mean individuals often feel like **they are not being heard and are just being pushed around from service to service.**

Barriers to accessing services

There is a **reported lack of services available outside of Woodstock**, creating inconsistent access to services. This means individuals often must leave their communities to meet their needs, like housing, healthcare, and addictions treatment.

Program requirements, such as proof of residency (when individuals may have no fixed address) and identity documents (when individuals are vulnerable to theft or loss of items), all create barriers to accessing lifesaving services.

Individuals need to chase services

Certain services in Oxford, particularly food programs, are available only once or twice a week. This requires individuals to remember the schedule and travel to access them, putting the onus on unsheltered individuals **to find supports across the County.**

Those who are unable to be proactive in seeking support are often left unconnected or reliant on others in the community to inform them of programs that may be helpful.

Lived Experience

Gap 3: Stigma and discrimination

Stigma and discrimination in the community

The stigma and discrimination faced by individuals experiencing homelessness create major barriers to accessing housing and the services they need to survive, causing feelings of hopelessness and isolation.

Individuals report experiencing stigma and discrimination in their daily lives, which **has impacted their safety, their relationships, and their access to employment and housing opportunities**. Daily interactions in the community are often negative, making individuals experiencing homelessness feel unwanted and invisible. Community members living in encampments are often targeted by others and face the threat of theft and violence while trying to seek shelter.

Discrimination and negative experiences at hospitals have also exacerbated a mistrust of institutions and created barriers to seeking support. Individuals experiencing homelessness often turn to community health care as an alternative or forego treatment altogether.

Barriers to housing access

People face **stigma and discrimination** when trying to secure housing with private landlords, including via references, insurance and credit checks.

Harmful stereotypes about individuals experiencing **homelessness impact their chances of finding a home and a job**. Landlords often use credit and reference checks, which are not favourable to individuals experiencing homelessness. Housing applications can be regularly rejected, and employment opportunities are lost before the interview stage.

Lack of agency and control

For those living unsheltered or in encampments, **restrictions around gatherings add to feeling unwanted in the community**.

Program rules can also add to the lack of agency while navigating homelessness. For example, **shelter rules around entry and exit times can make individuals feel contained and restricted**.

Similarly, rules in transitional housing respecting visitors and space can **feel like individuals have no control over their lives**. This impacts the individual's emotional state and can also **threaten their housing situation**.

Service Provision

Gap 4: Lack of dedicated capacity to implement coordinated access systems

Lack of adequate staffing for coordinated access

The Coordinated Access systems being implemented in Oxford currently include **the By-Name List and the Coordinated Access table**, both of which require substantial capacity and resources to maintain.

The current By-Name List tool is labour-intensive to manage. It requires staff to clean the data, maintain the list so it is up to date, and perform trend analysis. Staff also need to build trust and buy-in among partners, provide direct support in collaboration with partners, and gather feedback from partners to improve processes.

The current resourcing of the By-Name List **does not enable or empower the County and community partners to seamlessly coordinate access** for individuals experiencing homelessness. Greater and sustained leadership, buy-in, and commitment are needed to fully implement the By-Name List and Coordinated Access. Without it, the tools and processes are not being used to their full potential.

Turnover disrupts coordination

Coordinated access requires institutional knowledge and maintaining contact across organizations. Turnover in the system has created a lack of continuity, making it **difficult for staff to know how to connect their clients to the right services.**

Community-based staff are often on annual contracts without long-term job security. This means constant staffing changes, which can lead to loss of institutional knowledge and relationships, as well as higher degrees of stress and burnout for all staff.

Static tools for a dynamic system

The tools currently being used to implement Coordinated Access (e.g. By-Name List spreadsheet) do not enable real-time data sharing, as the system is meant to do.

Currently, **maintaining the quality of the By-Name List requires a substantial effort from the County,** leaving less capacity for other important tasks. With the onus of coordination, data quality, and data use on the County, more staff are needed to support implementation, especially if HIFIS is adopted to help with data management.

Service Provision

Gap 5: External pressures influencing program design

Partners restricted by external pressures when designing programs

The creation of new programs and the adaptation of existing programs present opportunities to tailor program design to emerging and existing needs. In the past few years, community organizations have had to shift staffing and resources to better navigate the landscape of homelessness support.

Some examples of this include organizations shifting their social work caseloads to shorter-term counselling to serve more individuals, another organization moving away from providing landlord support because guaranteeing tenant success carries a liability, and a third organization narrowing its services to eviction prevention over others like housing search due to the growing situation of housing instability.

Another key pressure is shifting government priorities and the resulting funding, which can lead to instability and a **lack of certainty about which programs can be sustained**.

Capacity data not capturing realities

One of the pressures in shaping programs in Oxford comes from using data about program use to drive decision-making. While important, this data does not capture why people are not accessing the programs and services.

For example, there are programs in Oxford that individuals have found very helpful, but they are not advertised or promoted to avoid being over-subscribed. Program entry requirements (e.g., proof of residence) can also create barriers to accessing essential programs like emergency shelters.

Decisions that do not account for these realities can lead to important services being defunded or resources being reprioritized.

Funding impacts program requirements

Despite the need for accessible supports, a lack of stable and adequate funding often fosters a scarcity mindset and encourages program designs that limit access to necessary supports.

Partners frequently navigate requirements from two or three tiers of government, depending on their funding. This results in program entry requirements that exclude individuals instead of promoting flexibility to address diverse needs.

Service Provision

Gap 6: Lack of codified connections and knowledge sharing between partners

Coordinated Access not facilitating deep connections among partner organizations

Organizations providing homelessness-related supports are connected in some ways, but the system continues to **lack codified or formalized relationships**, **relying mostly on personal relationships** to coordinate supports and help individuals access housing. This requires staff to connect informally with each other to make referrals and build pathways between their services. **This results in service pathways existing between individual staff, not between organizations.**

In the current system, **individual staff bear the burden of maintaining and building new connections**. Thus, practices around By-Name List intake and updates are not widespread through the different partner organizations and if these critical staff turnover, there is a huge loss of institutional and system knowledge.

In service delivery terms, this means that some organizations are better able to connect their clients to access housing supports, whereas **others without connections to the County or knowledge of the system, struggle to provide the same information about what is available**.

No central source of information

Without too many formalized relationships and structures for collaboration, Oxford also **lacks a reliable and trusted source of information about available programs and services.**

Currently, many organizations try to maintain a list in-house but find it difficult to keep up with updates. They rely on personal relationships and informal connections to update these resource lists, creating gaps in their awareness.

Limited awareness within organizations

Community partners have different methods of information sharing within their organization. This leads to some discrepancy in staff awareness of the Coordinated Access and the By-Name List.

Organizations that have **systems in place for knowledge sharing within their organization** (e.g. Slack, information sessions, team meetings) are receiving referrals from the By-Name List from other programs. Organizations without these structures are finding knowledge of Coordinated Access in Oxford is limited to one or two staff.

Service Provision

Gap 7: Limited connections between healthcare and broader homelessness system

Hospitals are a critical point in journey but not Coordinated Access partners

Hospitals in Oxford are critical touchpoints for individuals experiencing homelessness. Healthcare institutions not only provide primary and emergency care, but also critical mental health and addictions support. While there is a mistrust of healthcare institutions among some people experiencing homelessness, **crisis situations can often lead them to the hospital** (e.g. through MHEART.)

However, Oxford hospitals are not currently Coordinated Access partners, indicating a critical gap in the network of service touchpoints in the community. After individuals are admitted to the hospital, staff in the community often lack any visibility into their client's situation, even at discharge. **The lack of connection between hospitals and the County and community partners exacerbates points of crisis and leaves individuals without supports once they are discharged and ready to re-enter the community.**

With the recent announcement of the Homelessness and Addiction Recovery Treatment (HART) Hub, there is an opportunity to improve the connection between healthcare, community partner organizations and emergency shelter providers.

Lack of alignment on privacy protocols and consent requirements

One of the prominent barriers in facilitating information sharing between healthcare institutions and community organizations is the privacy legislation that governs hospital practices. **The Personal Health Information Protection Act (PHIPA) provides strict guidelines for the way hospitals collect, use, and share personal health information**, adding to the complexity of collaborating with community and government partners with varying levels of privacy protocols.

Consent procedures and privacy protocols for Coordinated Access do not currently meet the standards of PHIPPA, creating a barrier to healthcare participation.

System

Gap 8: Coordinated Access unable to connect the circle of care

Partners lack insight into circle of care

The By-Name List is currently held by the County, with partners being 'contributors' of information. Not only has this limited buy-in from community partners, but it has also resulted in a **lack of ownership and accountability as partners do not have access to the List itself.** The lack of transparency has created barriers for frontline staff in partner organizations and disincentivized full participation in the implementation of the By-Name List.

On a practical level, the way the system is currently structured means **partners (including the County) are unable to see who else is supporting their client** and thus, are unable to strategically coordinate their services. Coordinated Access meetings are not enough to connect the dots. The current tools and system aren't inherently useful to community partners without access to information, leading to low uptake and buy-in.

Lack of transparent processes

The lack of transparent processes has had two key impacts, including;

- A lack of confidence in the data being collected, especially around the calculation of acuity scores
- Misinformation about the By-Name List and how the data is used, causing fear and avoidance of it.

Furthermore, the lack of a standardized assessment has emphasized the fragmented nature of the sector and led to people being asked the same questions multiple times.

Limited agreement on privacy

Mutual information sharing necessitates shared agreement on privacy and data sharing. Currently, **the data sharing agreement does not include all partners**, creating holes in the coordinated access system.

Further discussion is needed to negotiate the necessary privacy structures and find alignment across partners in different sectors.

System

Gap 9: Lack of system capacity to meet high need

System lacks capacity to support high acuity and chronic homelessness

Since the onset of the COVID-19 pandemic, community organizations have seen **the need for services grow exponentially in their communities**. They have also noted a **growth in the complexity of need across the board**, with individuals requiring multiple services at once.

Greater complexity of need, without adequate supports in place, have also made it difficult for individuals to find and maintain housing, particularly if individuals have experienced chronic homelessness. Those who have experienced **chronic homelessness typically require deeper support due to the difficult, and often traumatic, things they experience while homeless**. This requires deep wraparound support after they have been housed, including mental health and addictions support, healthcare, advocacy, and counselling, so individuals are supported to remain housed.

Annual funding structures

Annual funding structures have exacerbated this lack of capacity, as high acuity support, particularly in housing, requires longer-term wraparound supports.

Community partners are not able to guarantee the long-term supports individuals need partly because of **the lack of guaranteed funding for more than one year**.

Different terms of funding may be needed to support the provision of necessary support.

Competition over collaboration

Partners find they are often **placed in a competitive, rather than a collaborative environment**. To adequately fund and resource their programs, they must build their organization's competitive advantage, often containing them in silos.

Funding requirements, typically **around avoiding duplication of services, have also caused organizations to shift their priorities, leaving gaps in service** in Oxford.

In order to effectively address high acuity and more complex cases in Oxford, the system recognizes the need for collaboration.

System

Gap 10: Lack of stable and affordable housing

Limited availability of affordable housing options across the continuum

The greatest barrier to accessing housing in Oxford is the lack of available units, despite recent investments in increasing affordable housing supply.

Oxford's Housing Needs Assessment, completed in 2024 by NBLC, demonstrated a social and affordable housing market that was not able to meet the need in the community. With rapidly increasing rents in the last decade, approximately +6-7% annually in Woodstock, Tillsonburg, and Ingersoll, housing is no longer affordable for many. In addition, the **County's waitlist for Rent-geared-to-Income (RGI) housing has been relatively static, with approximately 1,600 households.**

The supply of deeply affordable housing is lacking, as the Housing Needs Assessment found that even **80% of Average Market Rent (the threshold used for affordable housing projects) is unaffordable to many in Oxford**. For example, individuals accessing Ontario Works will no longer receive a shelter allowance if they are unsheltered, bringing their **monthly payment down to $340**. Those eligible for a shelter allowance receive $733 monthly, which would still not be enough to cover 80% of AMR and other expenses.

Growing demand for transitional housing

Transitional housing in Oxford primarily exists in Woodstock, with only some units in Tillsonburg, and upcoming new units in Ingersoll. There is **high demand for transitional housing** as it provides a stable place to live with access to supports.

However, due to the lack of available affordable units, **individuals who complete a full year in transitional housing often have nowhere to go after**.

Another challenge in transitional housing is the **rigidity of the rules** (e.g. allowing visitors, living with a spouse), which limits the success of residents.

Lack of high acuity options

While processes such as the By-Name List are meant to prioritize those with the highest need, there continues to be limits with this system due to **a lack of options for high-acuity needs.**

The majority of supportive housing in Oxford is in Woodstock, with more recent investment in Tillsonburg and Ingersoll.

Despite recent investments, the number of supportive housing units is not sufficient to meet the need in the community. Additionally, the **depth of support service providers are able to offer is not enough** to meet the complexity of needs in the community.

A Case for Action

The Cost of Inaction

While the costs associated with a comprehensive approach to preventing and addressing homelessness are high, so too are the costs of inaction. Decades of research have emphasized the high costs associated with homelessness, as well as **the significant potential for savings and efficiencies when individuals are permanently housed with the proper supports in place**. These expenses and savings come from both the direct costs of homelessness, such expenditures on emergency shelter, as well as indirect costs associated with homelessness, including around healthcare, the justice system, and eviction-related expenses.

Direct Expenses

Direct costs related to homelessness can include expenditures on shelter and support programs and services (e.g. day programs, food banks), all of which drive significant costs. Previous studies have estimated that shelter costs are higher relative to both market rents and social housing costs. For example, a 2007 study of Toronto by the Wellesley Institute[1] estimated that the average monthly cost of a shelter bed was $1,932, compared to $701 for a rent supplement and $200 for social housing.

Healthcare Expenses

A strong link between homelessness and poor health outcomes has been established across multiple research studies[2] – a fact that was reaffirmed through our conversations. Homelessness impacts health in many ways, including poor nutrition, lack of proper rest, higher exposure to communicable disease and an inability to engage in proper health practices upon becoming sick, higher risk of violence, and difficulty maintaining a healthy social network, among others.

According to a study of people experiencing homelessness in Toronto in 2021 and 2022[3], the yearly average public **healthcare costs incurred by individuals experiencing active homelessness ($12,209) was 6-7 times and roughly $10,000 greater** than the same costs incurred by housed individuals ($1,769) and low-income housed individuals ($1,912). A significant difference remains even after accounting for comorbidities and the presence of mental health or substance use issues. Further, while the impacts are greatest during active experiences of homelessness, research suggests that healthcare costs decrease, but do not return to pre-homelessness levels, following active homelessness.

Justice-Related Expenses

Research has similarly demonstrated a two-way connection between homelessness and involvement with the justice system. Those who are homeless are more likely to be arrested and spend time in jail, while people in prison are more likely to become homeless upon release without the proper reintegration supports. A 2010 Canadian study[4] estimated that **roughly one in five prisoners (23%) were homeless when incarcerated**, and 32% would be homeless upon discharge, increasing the likelihood of re-offense. The average stay was a little over two months. According to Statistics Canada, as of 2022/2023 **the average daily cost per inmate in Ontario was $240. This translates to roughly $15,000 over a two-month period**.

Further, this figure does not include the associated costs to governments and to individuals around policing, legal proceedings, or other activities associated with criminalization. Similarly, **community strategies that criminalize homelessness, such as issuing tickets for panhandling, are also costly.**

The Cost of Eviction

Evictions also carry high costs, and significant savings can be borne by preventing them. For example, a 2005 study from CMHC[5] estimated the total costs to tenants, landlords, and government associated with evictions. **For tenants, the average financial cost associated with eviction was $2,233** due to loss of personal belongings and first/last months' rent, moving expenses, legal fees, and increased expenses associated with their new location (such as higher rents or transportation costs). In 2024 dollars, this translates to $3,360. For landlords, these costs were estimated at $6,588 ($9,910 in 2024) for a private landlord and $2,937 ($4,416 in 2024) for a social housing landlord due to legal fees, arrears, foregone rent, and repair costs, among others. **With regard to government costs, per diem costs associated with different accommodation and support options ranged from $11 to $88** ($17 to $132 in 2024).

A recent study similarly estimated significant savings associated with the BC Rent Bank program[6]. Over the 2023/2024 fiscal year, the program supported 1,513 households, of which an estimated 600 people were prevented from becoming homeless, and 1,000 households were prevented from spending significantly more on rent.

Overall, it was estimated that $27.5 million was saved, and that **each $1 invested resulted in $5 in savings for both the individuals and families impacted and in government spending**. Table 1 breaks down where the cost savings arose from.

Table 1: Breakdown of savings associated with the BC Rent Bank program, 2024

Category of Expense	Cost (Millions)
Private Costs (Tenants)	**$16.1**
Higher Rent	$14.9
Moving, Storage Costs & Lost Possessions	$1.2
Public Costs (Government)	**$11.4**
Emergency Shelter	$1.3
Health Care	$3.3
Housing Placement and Support	$1.7
Children & Youth Placed in Care	$5.1
Total	**$27.5**

Vancity Community Foundation (2024). Why Eviction Prevention Matters: The Social and Economic Benefits of BC Rent Bank in British Columbia.

Bringing it All Together

Between 2009 and 2011, the At Home/Chez Soi program worked with individuals with mental illness experiencing homelessness to assess the impacts of a Housing First program with associated supports, including Intensive Case Management and Assertive Community Treatment. Several streams of research providing insights into the costs of homelessness emerged from this work.

As part of this study, 990 participants across five cities (Vancouver, Winnipeg, Toronto, Montreal and Moncton), did not undergo the Housing First intervention, instead continuing on with their usual services. Based on data from these participants[7], it was **estimated that the per person costs of homelessness in 2016 dollars ranged from approximately $30,000 per year in Moncton to $56,000 per year in Toronto.** These figures represented a combination of costs from shelter, supportive housing, substance use treatment, varied healthcare related expenses, police and court appearances, incarceration, and social assistance. Adjusted to 2024 dollars, this translates to **$37,000 to $70,000 per year for each person with a mental illness experiencing homelessness.**

Similar research has estimated high costs associated with homelessness, including a study out of British Columbia[8] that estimated costs at $55,000 per person with a substance use or mental health issue experiencing homelessness in 2006 dollars ($81,000 in 2024 dollars), while another out of Calgary estimated a range in costs from approximately $72,000 per person to $135,000 per person in 2007 dollars, based on the degree of chronicity ($105,000 to $195,000 in 2024)[9]. **While estimates vary, this data overall emphasizes the high costs associated with homelessness.**

For the individuals who went through the Housing First program as part of At Home/Chez Moi, the cost off-sets associated with this intervention were measured[10]. The study found that in addition to improving housing stability and quality of life outcomes, costs were reduced in other services, including hospital visits, other medical services, emergency shelter usage, and jail time. Overall, the study estimated that **for every $10 spent** on the program, the average **reduction in other costs was $9.60 for high needs participants**, and **$3.42 for moderate need participants**. For the 10% of participants with the highest costs prior to intervention, there was a total savings of $21.72.

With regard to previous research, the same study out of British Columbia estimated that with adequate housing and supports, the per person cost would drop from $55,000 to $37,000, a savings of roughly $27,000 in today's dollars.

The Opportunity to Prevent and Reduce Homelessness

Vision for the Future

This strategy builds on the vision articulated in Oxford's Housing and Homelessness Plan – **to realize 'housing for all' by 2033.**

Specifically, the vision this strategy works towards is one where experiences of homelessness are brief or avoided altogether. It is of a community where people can easily find a place to live and be supported to remain in their homes.

By 2033, experiences of homelessness are brief, and people in Oxford can access seamless supports to find and keep their housing.

Principles for Action

To achieve this vision, there are six principles that have been co-developed with the community and guide how the strategies and actions should be implemented.

1. **Foster community awareness, mutual understanding, and empathy for those experiencing homelessness**
2. **Design for long-term and sustainable change informed by lived expertise and principles of health equity**
3. **Promote transparency, collaboration, and accountability among service providers**
4. **Prioritize dignity and self-determination of people experiencing homelessness**
5. **Ensure consistency of service across the system rather than a 'luck of the draw'**
6. **Have a bias towards flexibility and enable problem-solving to respond to individual needs.**

Improving Systems of Coordination

Oxford's current response to homelessness involves the County and service providers, often operating in silos, providing direct support to those who need help.

As organizations with different mandates and strengths work towards *similar* goals, there is a growing need to establish shared agreement on a vision and better coordinate how services work together to achieve that shared goal.

Partners in Oxford have shown willingness and commitment to be aligned in mission and work collaboratively but lack a system that supports coordinating in this way.

This strategy articulates steps that actors in Oxford can take to strengthen the connective tissue underpinning existing services. It focuses on systems of coordination to help recognize and leverage existing efforts and create an environment for their success.

Part 3

A Homelessness Response Strategy for Oxford

Contents

Vision

By 2033, experiences of homelessness are brief, and individuals in Oxford can access seamless supports to find and keep their housing.

FOUNDATIONAL SYSTEM ELEMENTS

Build system capacity

Ensure individuals working in the system have the capacity and resources they need to provide excellent customer service

Streamline service navigation

Create seamless connections between services so people have rapid access to the help they need

PILLARS

Preventing Homelessness

Managing Experiences of Homelessness

Accessing Housing & Services

PRIORITIES

Act before crisis

Uphold tenant rights

Help people grow

Provide equitable and stable access

Increase access to housing across the continuum

Support lasting housing stability

GOALS

Goal 1: In the future, everyone in Oxford can confidently access supports to maintain their housing and avoid experiences of homelessness when circumstances change

Goal 2: In the future, everyone in Oxford has secure housing tenure to prevent forced and unfair evictions

Goal 3: In the future, individuals experiencing homelessness feel confident and valued, and are well-supported to grow in the community

Goal 4: In the future, individuals experiencing homelessness have stable and equitable access to services (including temporary accommodation)

Goal 5: In the future, individuals can access permanent and stable housing in their communities to exit homelessness

Goal 6: In the future, individuals with a history of housing instability have the supports and resources they need to maintain their housing for the long-term

System Capacity-Building

Foundation A

In the future, individuals working in the housing and homelessness system have the resources and capacity they need to provide excellent customer service, resulting in positive impact on the lives of the people they serve.

Desired Outcomes

We strive toward the following outcomes related to this goal:

- Low turnover of staff across the system
- Effective use of the By-name List and Coordinated Access system across the County
- Sufficient funding to respond to community needs

Strategies and Actions

The following strategies and actions will help us reach our goal.

Strategies	#	Actions	Type of Action
Establish the necessary resources to implement the Homelessness Response Strategy	**A.1**	Realign County staff resources to facilitate the implementation of this Strategy and to increase long-term capacity for By-Name Data, Coordinated Access, and related systems.	Staff Capacity and Processes
	A.2	Establish a working group to implement the actions in this strategy, to be chaired by the County and include members from community partners.	Staff Capacity and Processes
Build stability and consistency in staffing and resourcing across the County	**A.3**	Advocate for increased federal and provincial funding for the County and service providers to build capacity to meet growing need, build a resilient workforce, and effectively respond to homelessness, including advocating for longer-term funding to ensure staff are not limited to annual contracts.	Advocacy
	A.4	Develop community partner guidelines for staff compensation in the sector, including access to benefits, and a greater support system for community-based staff and incorporate this into service provider funding agreements, where appropriate.	Policy or Program
Explore opportunities to improve efficiency and quality of programming	**A.5**	Create and prioritize opportunities for joint operational funding for coordinated service delivery, particularly to meet high acuity needs.	Financial
	A.6	Ensure sufficient communication and collaboration between County staff and community partners to ensure resourcing and capacity needs are met.	Staff Capacity and Processes
	A.7	Establish a formal and ongoing process for assessing and adjusting program rules (through service provider funding agreements) that reflect the needs of individuals experiencing homelessness in the County, drawing on By-Name and other data, community engagement, and best practices.	Policy or Program

Foundational System Elements

Streamlined Service Navigation

Foundation B

In the future, individuals experiencing or at risk of homelessness are rapidly and seamlessly connected to supports they need.

Desired Outcomes

We strive toward the following outcomes related to this goal:

- Decreased wait time to access key services
- Reduced time between referral and service delivery
- Stronger relationships and pathways between service providers
- Improved experience of accessing services in the community, demonstrated by positive feedback from those being helped
- Increased number of individuals connected to services

Strategies and Actions

The following strategies and actions will help us reach our goal.

Strategies	#	Actions	Type of Action
Improve the quality and use of By-Name Data and Coordinated Access in line with best practices	**B.1**	Implement Homelessness Individuals and Families Information System (HIFIS) in Oxford County to manage the By-Name List and support Coordinated Access, ensuring sufficient County staff capacity and consultation with community partners to ensure successful roll-out.	Tools and Infrastructure
	B.2	Implement further training and education on the By-Name List, HIFIS and Coordinated Access for all community partners with a focus on emphasizing the benefits of high-quality By-Name Data and ensuring consistent application within and across organizations.	Awareness and Education
	B.3	Work with community partners to update the centralized intake questionnaire, common assessment tool and data sharing agreement to ensure it meets all community partner needs and will be used consistently.	Tools and Infrastructure
	B.4	Integrate common requirements around the By-Name List and Coordinated access into homelessness service provider funding agreements, while working with community partners to ensure they have the necessary resources to implement these systems.	Tools and Infrastructure
Formalize connections between the County's homelessness serving system and interrelated systems	**B.5**	Work directly with Woodstock Hospital and organizations with increased reporting and confidentiality standards to support participation in the By-Name List and Coordinated Access, or where necessary, use of alternative tools (e.g. case conferencing) that can ensure connection between active clients and the broader homelessness serving system.	Tools and Infrastructure
	B.6	Establish partnerships with hospitals, treatment centres, and the justice system to develop procedures for institutional discharge planning that ensures ongoing connection to services and supports for individuals who may experience homelessness upon leaving the institution, including connections with the proposed HART Hub.	Policy or Program
Increase connection and information sharing between community partners	**B.7**	Create and maintain a County-owned, accessible, and up-to-date database of all partners and associated service offerings to support collaboration and outreach between partners, making sure it is reflective and accessible to both the homelessness serving system and other organizations.	Tools and Infrastructure
	B.8	Increase co-located services, providing increased opportunity for in-person outreach between organizations while ensuring an appropriate balance of services across municipalities.	Tools and Infrastructure

Learnings from Elsewhere

By-Name Data and Coordinated Access

Coordinated Access is a way for communities to bring consistency, equity and efficiency to homelessness service delivery and access. Common features include a centralized information system and inventory of housing resources, clear access points, common triage and assessment tools, consistently applied protocols, and supportive resources. A By-Name List, also known as By-Name Data, is a key component of Coordinated Access. It consists of real-time data of all individuals who are known to be experiencing homelessness in a community and have consented to data collection.

These systems are recognized as best practices across Canada, as evidenced by federal and provincial requirements, case studies, and the significant supports that have been developed around them, including from the Canadian Alliance to End Homelessness (CAEH) and Built for Zero Canada. When used properly with high-quality data, these systems can help triage and coordinate services for individuals experiencing homelessness, leading to better and quicker access to housing and services, help evaluate patterns of homelessness and the efficacy of programs, and support advocacy efforts.

The efficacy of these systems are heavily shaped by the quality and capacity with which they are designed and maintained. While the reward is high, properly implementing a Coordinated Access system requires significant resources. The following case studies describe communities that have experienced success in reducing chronic homelessness with help from Coordinated Access.

St. Thomas-Elgin. St Thomas-Elgin has celebrated significant reductions in chronic homelessness in recent years[11]. After establishing quality By-Name Data in 2021, they celebrated a reduction in chronic homelessness by 25% a year later. While known homelessness increased soon after, in part due to data and process improvements, they similarly saw a rapid 30% decrease from July 2023 to January 2024, finding homes for 126 people experiencing homelessness. St Thomas-Elgin has identified several factors that contributed to these successes, including expanded access points and mapping, increased outreach efforts to people living unsheltered or at risk of homelessness, better coordinated and expanded programs, efforts by the local emergency shelter to become low-barrier and housing focused, and new supportive housing units.

Brantford-Brant. Brantford-Brant rapidly implemented a quality By-Name List and Coordinated Access system to meet both provincial and Federal Reaching Home requirements, with support from CAEH and Built for Zero Canada[12]. While the community had a prior database tool and some strong relationships, they faced barriers such as shelters working in silos and slow and ineffective data sharing and management. The City put careful thought into implementation, breaking services into 3 different phases that align with a client's flow through the homelessness system of care. They first focused on understanding and refining the inflow process, then case planning and diversion services, and then on outflow and prevention services. Since implementing their system, they have celebrated improved collaboration between partners, better data quality, and more streamlined processes.

More examples. Built for Zero Canada provides trainings, case studies, and resources to support aligning Coordinated Access systems with best practices. This includes sample resources from other communities, such as data sharing agreements, vacancy forms, or implementation guides.

Discharge and Reintegration Planning

Many individuals experiencing housing precarity or homelessness interact with hospitals or the justice system, with many being discharged into homelessness, in some cases without connecting to a community's broader homelessness system of supports. Targeted discharge programs can help address this cycle and improve coordination between these systems.

London H2I Program. The H2I program was initiated in London, Ontario to address the pattern of individuals being discharged from hospital into homelessness[13]. The program integrated community agency staff into hospital units to assist hospitalized people experiencing homelessness secure housing and financial support and provide transitional support post-discharge. Healthcare providers and community stakeholders found the program effective in preventing people leaving the hospital from becoming homeless. Important features of the program included having community agency partners on-site in hospitals, using the Homeless Individuals and Families Information System (HIFIS), including various agencies and people with lived experience in advisory committees, offering healthcare staff easily accessible program information in case of turnover, and identifying specific needs of sub-populations such as youth. The program developed an Implementation Guide to help other communities seeking to develop similar homelessness prevention programs[14].

Community Reintegration Planning Table, Elgin-Middlesex. Community Reintegration Planning Tables (CRPTs), established by a partnership between Ontario and the Provincial Human Services and Justice Coordinating Committee in 2022, are intended to ensure a proactive, collaborative and inclusive plan is in place for individuals exiting corrections facilities who require reintegration supports.

A CRPT has been established in partnership with the Elgin-Middlesex Detention Centre to enable stronger relationships between the province, justice sector and community partners in order to improve system coordination, streamline referral processes, and support mutual understanding of practices[15, 16]. The Table includes many provincial, municipal and community service agencies across Middlesex and Elgin counties.

Homelessness Prevention

Act Before Crisis

Goal 1

In the future, everyone in Oxford can confidently access supports to maintain their housing and avoid experiences of homelessness when circumstances change.

Desired Outcomes

We strive toward the following outcomes related to this goal:

- Decrease in number of new shelter visitors
- Decrease in crisis encounters and hospital visits
- Increase in use of pre-crisis supports (such as housing stability, shelter diversion)
- Increase in public awareness about homelessness and available supports
- Increased mutual accountability among landlords and tenants to ensure successful tenancies

Strategies and Actions

The following strategies and actions will help us reach our goal.

Strategies	#	Actions	Type of Action
Increase access to financial assistance before crisis	**1.1**	Launch a rent bank program that offers emergency financial assistance to prevent arrears for eligible tenants	Financial
	1.2	Review program rules for existing financial assistance programs (e.g. rent supplements) to ensure accessibility and reliability for households in different situations	Financial
	1.3	Enhance capacity for Housing Stability programs, providing direct funding for staffing and building a dedicated team in connection with outreach efforts – related to **Action 6.2**	Financial
Build public awareness of available services and programs	**1.4**	Develop and implement an awareness campaign about preventing homelessness, including myth-busting about individuals experiencing homelessness, strategies to maintain housing in times of uncertainty, and potential avenues for support	Awareness and Education
	1.5	Create and maintain a 'cheat sheet' of existing programs that can support successful tenancies, including help with utility costs and first and last month's rent	Awareness and Education

Homelessness Prevention

Uphold Tenant Rights

Goal 2

In the future, everyone in Oxford has secure housing tenure to prevent forced and unfair evictions.

Desired Outcomes

We strive toward the following outcomes related to this goal:

- Increased awareness of tenant rights, including for those boarding or in shared living situations
- Decreased number of unfair evictions in Oxford
- Increased number of landlords and tenants accessing education programs
- Increased number of tenants able to stay housed long-term
- Increased number of referrals to Housing Stability programs

Strategies and Actions

The following strategies and actions will help us reach our goal.

Strategies	#	Actions	Type of Action
Create a Tenancy Resource Office to ensure accountability for landlords and tenants	**2.1**	Utilize staff resources to assist and educate both landlords and tenants, with a focus on providing pathways to mediation support	Staff Capacity and Processes
	2.2	Work with community legal clinics and other community partners to establish and/or increase capacity for programs that ensure tenants understand and can uphold their legal rights and that can help mediate disputes between tenants and landlords	Policy or Program
	2.3	Provide resources and guidelines for landlords and tenants, including for rooming houses, single-room occupancy housing, and other forms of tenancies that fall beyond the scope of the Residential Tenancies Act to ensure operators meet property and maintenance standards and tenants understand their rights and obligations.	Policy or Program
Increase awareness of tenant rights	**2.4**	As a part of **Action 1.4**, deliver education for landlords, tenants, local law enforcement, and other community members about tenancy agreements, information on rights and responsibilities and avenues for support.	Awareness and Education
Enhance access to legal aid	**2.5**	Advocate to provincial government for more funding for legal aid and legal support at the Landlord-Tenant Board	Advocacy

Learnings from Elsewhere

Education and Resources for Successful Tenancies

Education and awareness programs can help provide access to resources and information that can support successful tenancies. Such programs can take varied forms and often provide information on legal rights and obligations, local regulations and resources, and sample materials such as templates or info sheets.

RentSmart. RentSmart is a longstanding tenant and landlord education program that fosters stable housing and reduces evictions[17]. RentSmart has been implemented in communities across Canada and has previously been delivered in Oxford County. It includes a series of certification courses on tenant rights, budgeting, communication, and home maintenance that. RentSmart is currently operated through the Community Housing Transformation Centre who provides comprehensive training and ongoing support to local RentSmart Community Educators.

Best Practices for Housing Providers of the Waterloo Region Toolkit. The Waterloo Region Community Legal Services, in collaboration with the Region of Waterloo and other partners has developed a Best Practices for Housing Providers of the Waterloo Region Toolkit[18]. While targeted at housing providers, the toolkit includes valuable information for tenants and service providers. In addition to emphasizing the value in eviction prevention, it provides clear guidance on a range of topics that can support successful tenancies, including guidance on the Duty to Accommodate, considerations for newcomers, communication strategies, and rent payment strategies, among others. It further includes a series of resources and templates, including sample forms or policies and a tenant handout on lease obligations. Lastly it includes a list of community resources for both housing providers and tenants.

Framework for Multi-Tenant Houses, Toronto. The City of Toronto recently enacted a framework for multi-tenant houses that came into effect in 2024 to help ensure consistency in zoning and to manage safety concerns surrounding multi-tenant houses[19]. The framework includes licensing requirements for all operators, enforcement, a new multi-tenant housing tribunal, tenant supports for those facing eviction from a multi-tenant house and renovation supports.

As part of this program, the City launched a campaign to educate tenants, operators and owners, and the general public about the new regulations. It further informs tenants about their rights, tenant safety, and the resources and programs available to them, and provide operators information on how to achieve compliance, their obligations to tenants, and the supports in place to support operations.

Public Education and Awareness

Public education and awareness campaigns can promote awareness and dispel myths surrounding the experiences and causes of homelessness.

City of Toronto. The City of Toronto and the Toronto Alliance to End Homelessness launched a public awareness campaign in 2017[20]. The purpose of the campaign was to dispel myths surrounding homelessness and those who experience it and to begin dialogue on four new planned shelters. Advertisements placed across the city on transit, online, and social media challenged the concept of NIMBYism ("Not In My Back Yard") surrounding homelessness shelters. The campaign was the third instalment of the Toronto For All campaign, which aims to end all forms of discrimination and racism.

Redwood Park Communities, Simcoe. Redwood Park Communities, an affordable housing provider in Simcoe County, launched their YIMBY ("Yes in my Backyard") Campaign in 2019[21]. The YIMBY ("Yes in my Backyard") movement encourages residents to support more diverse housing opportunities that welcome more inclusive communities. Through flag raisings, lawn signs, social media, and an annual YIMBY week, the campaign seeks to share the message that when everyone has a safe, affordable, hopeful place to call home, the entire community benefits.

In May 2024, Simcoe County helped promote the latest YIMBY week, including through a flag raising ceremony, alongside a series of events throughout the week.

Help People Grow

Goal 3

In the future, individuals experiencing homelessness feel confident and valued, and are well-supported to grow in the community.

Desired Outcomes

We strive toward the following outcomes related to this goal:

- Increased community understanding and support for individuals experiencing homelessness
- Co-location of community support agencies, with a focus on transitioning individuals out of homelessness
- Increased number of individuals transitioning out of homelessness
- Increased number of individuals accessing preventative healthcare, leading to a decrease in emergency visits

Strategies and Actions

The following strategies and actions will help us reach our goal.

Strategies	#	Actions	Type of Action
Strengthen personal networks of support for individuals experiencing homelessness	**3.1**	Support the creation of a family reconnection program in the County to help youth re-establish family relationships and rebuild natural support systems.	Policy or Program
	3.2	Increase access to co-located community-based programs and opportunities for individuals experiencing homelessness to build connection and community, with a focus on transitioning individuals out of homelessness.	Policy or Program
	3.3	Build upon the successes of the Mobile Health Outreach Bus to expand cross-County outreach to individuals experiencing homelessness, following best practices around assertive and housing-focused engagement, including continued work through the County Outreach Team (with area municipal staff).	Staff Capacity and Processes
	3.4	Leverage and connect existing peer support programs to establish peer advocates for individuals experiencing homelessness in the community who can support with attending medical appointments, visiting the hospital, and other institutional interactions.	Policy or Program
Challenge stigma and discrimination in community	**3.5**	Build on **Action 1.4** to develop an educational campaign targeted to businesses, local law enforcement, and neighbours about homelessness, causes of homelessness, and compassionate responses to people experiencing homelessness.	Awareness and Education

Provide Equitable and Stable Access

Goal 4

In the future, individuals experiencing homelessness have stable and equitable access to services (including temporary accommodation).

Desired Outcomes

We strive toward the following outcomes related to this goal:

- Decreased number of individuals experiencing chronic homelessness
- Decreased number of encampments and individuals sleeping rough
- Reduced wait times to enter transitional/supportive housing
- Increased number of individuals completing a full year in transitional/supportive housing
- Increased number of individuals (especially youth, women, Indigenous peoples, 2SLGTBIA+) using community services
- Greater access to stable and equitable support services and basic needs (drinking water, washrooms, showers, laundry, storage)

Strategies and Actions

The following strategies and actions will help us reach our goal.

Strategies	#	Actions	Type of Action
Ensure person-centred services that prioritize dignity and respect	**4.1**	Collaborate with the Oxford OHT (through the proposed HART Hub) to ensure coordination with homelessness support services, including integration of client pathways specifically for individuals struggling with mental health and additions, and the transition of individuals into transitional and supportive housing.	Tools and Infrastructure
	4.2	Create County-wide service standards that enforce adoption of harm reduction / person-centred principles and practices in the delivery of housing and community services across Oxford, including prioritizing flexibility, self-determination, and dignity and ensure standards are incorporated into relevant funding agreements.	Policy or Program
	4.3	Increase access to washrooms, showers, and other necessities for individuals experiencing homelessness.	Policy or Program
	4.4	Develop a program to provide storage options for people experiencing homelessness, such as 'The Bin' in Los Angeles.	Policy or Program
Provide equitable access to stable emergency shelters	**4.5**	Expand existing emergency shelter programs to address gaps and barriers (accommodations for specific demographics, 24/7 single-location programming, limited stays), to support integration with the proposed HART Hub, including consideration for care pathways and transitions out of homelessness, and transitioning to a housing first approach.	Tools and Infrastructure
	4.6	Review and update policies at emergency shelters and transitional/supportive housing sites to reduce barriers to entry (e.g. identification and residency requirements, lack of designated area for safe use, hours of service, restrictions on family members staying together or visiting).	Policy or Program
Align HPP funding with strategic goals	**4.7**	Allocate a portion of annual HPP funding to community partners that are working to transition individuals out of homelessness by providing support services in conjunction with emergency shelter services and working in line with the actions of the Homelessness Response Strategy.	Financial

Learnings from Elsewhere

Housing-Focused Shelter

A housing-focused shelter is primarily focused on making homelessness as brief as possible by providing on-site supports and returning individuals to permanent accommodation. Housing-focused shelters focus on encouraging short stays with a rapid return to housing – as such they do not operate other programming such as rehabilitation, treatment, stabilization, or housing readiness that can interfere with ensuring stays are short-term.

The Canadian Alliance to End Homelessness, Canadian Shelter Transformation Network, and OrgCode Consulting have created a manual and guidelines for Housing-Focused Shelter[22, 23]. Housing-focus shelters must ensure they are low-barrier, provide consistent, transparent messaging of the shelter's goals, and emphasize social and community integration. Programming must take a harm reduction approach, follow the principles of Housing First, and be person-centred, collaborative, strengths-based, and trauma-informed, recognizing that longer stays can exacerbate trauma. A strong focus on diversion is also key to this approach - where diversion is not successful, intake should occur simultaneously with a planned shelter exit, if even at a high level.

These materials emphasize that the choice to transition to a housing-focused model is a significant one that requires due consideration. This a transition takes significant effort, planning and time, and requires an 'all in' approach. It requires significant transformation of principles, governance, and operation, and can be a challenging process. Further, barriers to the process can include entrenched expectations among staff, shelter users, and funding.

Housing-Focused Shelter Standards, Durham Region. In 2021, Durham Region began the shift toward a housing-focused approach through the implementation of housing-focused shelter standards, with support through the Canadian Alliance to End Homelessness's Built for Zero Canada program[24]. Durham Region has created Service Standards that direct all shelter operators in the region to follow the Canadian Shelter Transformation Network's Housing-Focused Shelter Manual.

With regards to length of stay, the Service Standards require shelters to use a person-centered approach based on each persons' unique strengths and support needs. Decisions are made using the VI-SPDAT score, length of time the person has been homeless, and level of support needed to exit homelessness successfully, among other conditions. Each person who stays longer than 30-days has their housing plan reassessed. Individuals using shelter services are to be discharged with a follow-up case plan in place, and the shelter is expected to coordinate with other service providers the individual is discharged to, where relevant.

Learnings from Elsewhere

Assertive Housing-Focused Outreach

Assertive outreach and housing-focused outreach are comparable terms that refer to a framework for outreach with individuals experiencing homelessness that focuses on both meeting the individual's immediate needs and working towards permanent housing solutions. Several characteristics distinguish assertive or housing-focused outreach from other forms of outreach, including its deliberate attempt to end homelessness for the individual, the use of an integrated approach that requires multi-disciplinary teams, and outreach with individuals over an extended time period to support not only their transition to housing, but their long-term housing stabilization[25].

Other key elements of effective outreach include a coordinated approach on behalf of the community as opposed to specific agencies, a housing first approach that does not impose preconditions on accessing housing, the use of person-centred, trauma-informed, and culturally responsive approaches, and an emphasis on safety and harm reduction[26, 27].

Niagara Assertive Street Outreach. The Niagara Assertive Street Outreach (NASO) is a collaborative effort between Niagara Region Community Services and three community agencies that engages with individuals experiencing unsheltered homelessness, including those who would otherwise be underserved in traditional settings[28,29]. The team aims to proactively engage with people sleeping rough to minimize harm while working towards long-term housing solutions. The program includes a standardized intake, triage and assessment, delivers case coordination in collaboration with other organizations, and provides an intensive and coordinated team approach to help individuals work towards personal goals.

The team has been recognized for its success with technological solutions, including connecting with intake via 211 Ontario, adoption of a hotspot mapping tool, and the use of HIFIS. Its collaborative efforts have also strengthened community partnerships, including between municipalities and housing and homelessness programs.

Streets to Housing, Hennepin County, Minnesota. The Streets to Housing program distinguishes itself from traditional models of outreach that focus on managing crisis by its explicit focus on resolving the crisis of unsheltered homelessness[30]. The team provides trauma-informed, housing-focused services through a seven-person outreach team that includes six system navigators and one opioid use disorder specialist. It also features representation from people with lived experience, as well as people of colour and people with substance use disorders, two groups that experience disproportionate rates of homelessness. Further, the program was developed by people actively experiencing unsheltered homelessness.

The team works with people before, during, and after they transition out of an encampment with the goal of moving them into housing. They also focus on meeting people where they want, whether in encampments of other sites such as libraries, with encampments having autonomy over when, how and where the team provides services.

Peer Outreach and Advocacy Programs

Peer support programs typically bring together people with similar experiences to provide emotional, practical, or other supports. While informal peer support can emerge naturally, structured programs can also train and support peer support workers. Peer support programs can vary both in the program audience, the types of supports offered, the level of commitment, and other considerations. In addition to enabling an empathetic, non-judgemental approach, such programs can help build confidence, self-esteem, and community for both the support worker and the individual accessing supports[31].

Peer support programs can include outreach components, such as reaching out to and connecting with hard-to-reach populations, as well as advocacy components, where the peer support worker can act as an advocate in helping the individual access services.

Homeless Health Peer Advocacy (HPPA) Program, London, UK. The Groundswell Homeless Health Peer Advocacy (HHPA) service in London, UK supports people experiencing homelessness to address physical and mental health issues through Peer Advocates[32]. The HHPA can provide a number of supports, including:

- Supporting a client to attend and understand appointments;
- Giving practical support in attending follow ups and hospital stays;
- Supporting a client to find out information about health and health services;
- Supporting a client to address their health issue;
- Paying for travel including taxis if needed.

Services are delivered through volunteer Peer Advocates who have lived experience of homelessness, with specialist Care Navigators or Case Workers in some areas, many of whom began as volunteers. Volunteers go through a rigorous selection process, a comprehensive training program, and receive ongoing support and supervision.

Peer Outreach Program, Toronto. While not focused on individuals experiencing homelessness, the Peer Outreach Program operated by Access Alliance Multicultural Health and Community Services is a similar program in Toronto[33]. The program responds to the needs of families in under-served and hard-to-reach communities in Toronto, including immigrant and refugee families. Peer Outreach Workers include women from high-need communities who participant in a multi-year Peer Outreach Worker Training Program as paid employees. Supports include:

- Outreach to isolated newcomer families;
- Providing information and referrals to health and social services;
- Helping to organize and facilitate workshops;
- Accompanying clients to agencies such as school and housing boards, social assistance programs, citizen and immigration services, etc.;
- Providing language support.

1 Phillips, R. and Parsell, C. (2012). The role of assertive outreach in ending 'rough sleeping'. *Aboriginal Policy Research Consortium International (APRCi)*

Safe Beds

Safe Beds is a provincially funded and regionally operated initiative developed to provide an alternative to incarceration, hospitalization and the justice system for community members experiencing a crisis related to substance use, mental health and/or homelessness. Versions of this program are offered across Ontario regions, in many cases by local Canadian Mental Health Associations (CMHAs) or similar organizations. Programs typically provide a voluntary short-term stay that offers a range of services, such as crisis stabilization, housing support, addiction support and more. While referrals are typically required from police, mental health crisis teams, or other health services, some programs permit self-referrals.

Windsor-Essex. CMHA Windsor-Essex offers a Safe Beds program with support from provincial funding. It opened in 2020 and expanded to a 24/7 operation with four beds in 2022[34,35]. The program provides a short-term stay of up to 30 days for those 16 years and older who are experiencing homelessness and an active mental health and/or addictions crisis and who are referred from the local police service or mental health crisis teams, among other eligibility requirements. Residents live in one of four private bedrooms with access to regular amenities and a range of services, including crisis stabilization, short-term housing support, addiction support, life skills development and community referrals. The team also works to secure new housing for their clients and has a "step down unit" for clients to stay in for up to 11 days where housing is not ready.

Guelph-Wellington. In Guelph-Wellington, the Safe Beds program is offered by Stonehenge Therapeutic Community with support from provincial funding[36,37]. Referrals are accepted from police, the Integrated Mobile police and Crisis Team, and regional hospitals. The program includes four, 24/7 beds and offers a range of service, including crisis stabilization, individual and group life skills development, access to support for acute health care and medication needs, and individualized treatment planning, among others. Clients can stay for up to 30 days, and the program offers connection with ongoing services post-stay and post-discharge follow-up support for one month.

Storage Solutions

Free, easily accessible, and safe options to store belongings could help address one of the barriers individuals experiencing homelessness face when accessing services.

Street Storage, London, UK. Street Storage is a London-based charity that provides free, secure storage of belongings, including storage of sensitive documents, for individuals experiencing homelessness[38]. Where needed, Street Storage also provides one-on-one advice, support and advocacy for individuals accessing their service.

The Bin, Los Angeles. The Bin is a program in Los Angeles developed by Chrysalis that offers free, safe storage facilities for community members, with a focus on supporting individuals experiencing homelessness[39]. As of 2021, Chrysalis was operating three locations in Los Angeles.

Accessing Housing and Services

Increase access to housing across the continuum

Goal 5

In the future, individuals can access permanent and stable housing in their communities to exit homelessness.

Desired Outcomes

We strive toward the following outcomes related to this goal:

- Experiences of homelessness are shorter
- Increased presence of supports in housing across the continuum
- Increased number of new units and secondary suites - e.g. my Second unit
- Increased number of affordable housing options
- # of landlords accessing rent supplements

[i]Housing Needs Assessment (2024). nblc.

Strategies and Actions

The following strategies and actions will help us reach our goal.

Strategies	#	Actions	Type of Action
Build and enhance pathways to exit homelessness	**5.1**	Complete a study on the potential benefits and risks of home sharing programs (like Sparrow), including the legal needs and implications, tools and mechanisms to help match residents to homeowners, and the funding and staffing required to implement.	Policy or Program
	5.2	Launch a pilot in partnership with a developer and non-profit housing/support provider, testing a head lease arrangement that allows providers to sublet units to their clients with embedded supports.	Policy or Program
	5.3	Continue to work in support of the Master Housing Strategy, with a focus on increasing the supply of various housing options, including supportive, transitional and affordable housing.	Tools and Infrastructure
	5.4	Transform emergency shelters to a housing-focused approach, building in community consultation, the use of best practices, and a focus on co-located support services.	Policy or Program
Increase the capacity and confidence of private landlords to offer rental units	**5.5**	Build on **Action 2.1** and assign resources to enhance landlord engagement in Oxford, including relationship-building to build a network of landlords that will provide non-discriminatory, safe, and affordable housing, with a focus on providing rent supplements.	Staff Capacity and Processes
	5.6	Build on **Action 2.3** and develop a landlord toolkit that provides tools and templates (e.g. lease templates, one-pager of financial supports, guide to rent supplements) for private landlords to streamline the process of offering a legal unit.	Awareness and Education

Accessing Housing and Services

Support lasting housing stability

Goal 6

In the future, individuals with a history of housing instability have the supports and resources they need to maintain their housing for the long-term.

Desired Outcomes

We strive toward the following outcomes related to this goal:

- Decreased number of individuals returning to homelessness
- Increased number of individuals accessing housing stability supports
- Increased number of individuals accessing life stability supports, such as financial education, life skills, counselling

Strategies and Actions

The following strategies and actions will help us reach our goal.

Strategies	#	Actions	Type of Action
Mobilize a cross-disciplinary Housing Stability team	**6.1**	Allocate funding to expand housing stability supports across Oxford County.	Financial
	6.2	Reassemble resources to develop/expand Housing Support and Stability team that will provide support in specific residential buildings and co-located support hubs (i.e. emergency shelters) comprised of multiple service providers, including mental health and addictions services, community health support, case management, and employment services.	Staff Capacity and Processes
Increase availability of wraparound supports in the community	**6.3**	Develop a life skills program that individuals who have been recently rehoused outside of County owned housing can access. This can include information about financial planning, managing at-home chores, purchasing and cooking food, and other relevant topics.	Policy or Program
	6.4	Advocate to the provincial government for increased funding for housing support across the continuum.	Advocacy

Homeshare Programs

Home sharing is a living arrangement where unrelated people live in a single dwelling, sharing common areas such as kitchen, bathroom and living room. This arrangement can help reduce housing costs as expenses are shared among the collective.

Sparrow, Canada. Sparrow is a homesharing program that seeks to make better use of underused residential spaces by freeing up empty bedrooms for rental[40]. The initiative targets homeowners with spare bedrooms and people seeking affordable housing options, including students, seniors, newcomers, and young professionals. Sparrow's main goals include:

- Providing a solution to housing affordability challenges by offering rentals at lower costs compared to traditional market rates.
- Helping homeowners earn supplemental income, improving their financial stability and ability to age in place.
- Increase housing supply by making additional bedrooms available to people needing affordable housing.

Canada HomeShare. Canada Homeshare is a not-for-profit homesharing program that matches older adult home providers with students to create mutually beneficial living situations[41]. The intention is to support aging in place for older adults while providing safe and affordable housing for post-secondary students. Canada Homeshare offers support throughout the process, including by vetting home providers and seekers, reviewing profiles, and offering help navigating the homeshare relationship. Canada Homeshare currently operates in several cities across Canada.

Part 4

Moving to Implementation

Contents

Understanding the Economic Impact

In addition to the immeasurable social benefits achieved through preventing and limiting homelessness, **this Strategy provides a real opportunity for cost avoidance, thus contributing to the long-term economic prosperity of the County.**

Reducing Chronic Homelessness

It is estimated that the average annual per-person cost to the County of individuals experiencing chronic homelessness in Oxford is $9,000*. As of January 2025, 112 individuals were known to be experiencing chronic homelessness – this translates to an **anticipated cost of $1,008,000 to support individuals experiencing chronic homelessness over the course of 2025.**

A key intended outcome of this strategy is to reduce the prevalence of chronic homelessness by ensuring that experiences of homelessness are brief and that individuals in Oxford can access seamless supports to find and keep their housing. As the County moves towards achieving the milestones set out by Built for Zero Canada, including those achieved by other municipalities across Canada, the opportunity for savings are apparent – **a 30% reduction in chronic homelessness could result in an estimated savings of $300,000, a 50% reduction could result in over half a million dollars saved.**

Savings from Prevention

The Strategy's focus on prevention and housing retention is anticipated to result in reduced costs elsewhere. As outlined in previous research, even where there was no risk of chronic homelessness, **eviction prevention can reduce the costs associated with evictions, including for tenants, landlords, and different levels of government**. For the County this could mean savings associated with reduced need for emergency shelter or other accommodation, reduced administrative or other costs for community housing providers, and reduced demand on housing placement and support services.

Similarly, **efforts to improve staff retention through increased stability and consistency can help to avoid the high administrative burden and costs associated with re-hiring and training**.

Finding Efficiencies

Many of the **actions identified in this Strategy are designed to deliver better cost efficiency in the long term**. Several strategies included in the foundational system elements will support reducing the duplication and administrative barriers identified by the County and community partners. Specific actions include:

- Exploring opportunities to improve efficiency and quality of programming;
- Improving the quality and use of By-Name Data and Coordinated Access; and
- Increasing connection and information sharing between community partners.

For example, by giving community partners more access to view and input data, the transition to HIFIS will reduce or eliminate the time County staff spend manually entering data and reporting on information by request.

*The methodology for estimating the per person cost among individuals experiencing homelessness is based upon existing research across Canada – while this data is used here to illustrate the potential savings associated with reducing chronic homelessness, it should not be considered sufficient for budgeting purposes. **For more information on the methodology used, refer to Appendix 2**.

Aligning this Strategy with Available Funding

The Strategy as an Advocacy Tool

In addition to the benefits associated with cost avoidance, this Strategy will align Oxford County with emerging best practices and standards. As a result, **it will better position the County to continue advocating for and participating in provincial and federal funding programs,** including the Homelessness Prevention Program and Reaching Home funding.

Provincial Funding Directives

The outcomes of this Strategy, including a strengthened focus on preventing and reducing homelessness, expanded and sustained systems such as the By-Name List and Coordinated Access, and the implementation of best practices will help ensure the County remains eligible for existing programs, and ready to access new program requirements or funding sources should they arise.

The province's primary funding program designed to address homelessness is the Homelessness Prevention Program (HPP). The HPP seeks to support service managers to provide affordable housing and support services for people at risk of or experiencing homelessness. **Funding is explicitly designed to be flexible so that service managers can make the most impact on *reducing and preventing* homelessness**.

Further, **the province has demonstrated their priority on the use of By-Name Data and Coordinated Access**. After first requiring the use of By-Name Lists in 2021, updated By-Name List requirements were implemented through the launch of the Homelessness Prevention Program, and the province recently reaffirmed their dedication through an investment to help the Canadian Alliance to End Homelessness work with communities to maintain and improve local By-Name List.

Today, the County makes use of Homelessness Prevention Program funding to support its homelessness serving system and has taken advantage of the programs offered by CAEH.

Federal Funding Directives

While not explicitly required under the Rural and Remote Homelessness (RRH) stream, **this Strategy will put the County more in line with other directives associated with Reaching Home**, including the use of Coordinated Access and an outcomes-based approach.

Reaching Home is the primary source of federal funding to address homelessness. While the County is not currently a recipient of Reaching Home funding, it is eligible to apply for project-specific funding through the RRH funding stream. **Many of the actions included in this strategy fall under eligible Reaching Home expenses**, including but not limited to:

- Short-term rental or financial assistance;
- Shelter diversion, such as reconnecting youth with natural supports or landlord liaison and interventions to prevent eviction;
- Discharge planning (including from hospital, corrections, and child welfare);
- Maintaining and/or improving core components of a Coordinated Access System; and
- Some administrative costs, including professional development and staff training.

Moving Forward

A Collaborative Process for a Holistic Response

This Homelessness Response Strategy outlines an ambitious plan to effectively respond to the needs of individuals experiencing homelessness by bringing together the strengths and capacities of partners across Oxford.

The process to develop this strategy relied on the active participation of lived experts, service providers, and other stakeholders. Together, the community collaborated to better understand community needs and work towards solutions. From these collaborative efforts, this Strategy puts forward **three pillars** that capture a range of experiences surrounding homelessness, including **homelessness prevention, managing experiences of homelessness, and accessing housing and services**. Underlying these pillars is the need to strengthen **two foundational system elements**, **building system capacity, and streamlining service navigation**. The strategies and actions included under these pillars and foundational system elements are designed to address the needs identified and maintain the shared principles developed together.

The success of implementing this strategy will rely on all relevant parties to come together and share accountability over the outcomes and the strategies detailed here.

Next Steps

This Strategy forms an integral component of the County's Housing for All framework and builds upon the actions laid out in the County's 2024-2033 Housing and Homelessness Plan to **further advance the goal of reducing homelessness through prevention**. It serves as a roadmap for the County for both immediate, mid-term, and long-term actions, recognizing both the urgent need within the community and the need for long-term investment and transformation. The County will continue to monitor the outcomes of this Homelessness Response Strategy, using the goals and desired outcomes included throughout the Strategy to measure progress.

The County will **work with community partners to continue building a shared vision and to implement the strategies and actions identified in this document**, recognizing the need for a whole of community response.

The County looks forward to continuing to work with other levels of government, our community partners, and the private sector to achieve the goal that by 2033, experiences of homelessness are brief, and people in Oxford can access seamless supports to find and keep their housing.

Supplemental Materials

Appendix

Contents

Appendix 1: Inventory of Services in Oxford

Deep Dive into Service Components

This section provides a more detailed overview and inventory of services available in Oxford that are vital components of the system.

This inventory helps to better understand the types of services that exist in Oxford, who provides them, and where they may be gaps or challenges in service provision.

Framework for Supports

The system of supports available in Oxford, when understood within the context of preventing and reducing homelessness, can be categorized into three main layers:

1. **Emergency supports,** which provide day-to-day support for basic needs (health, shelter, food). While these supports are not limited to individuals experiencing homelessness, they are often critical to support managing a loss of housing.

2. **Stabilizing supports,** which can serve the goal of preventing homelessness. They provide specialized resources, tools, and expertise based on a person's unique circumstances. These supports also play a role in ensuring housing and well-being can successfully be maintained after experiencing homelessness.

3. **Housing supports**, including housing stability services and transitional, supportive, and affordable rental housing, are limited, and access can be challenging.

This framework enables us to provide a more detailed breakdown of the key points of connections, for individuals accessing services and for organizations as they collaborate.

The following pages will dive deeper into each type of support and identify what that support looks like in Oxford.

Emergency Supports

This provides an overview of the system of emergency supports available in Oxford. These are the services providing immediate day-to-day help to individuals experiencing homelessness.

Emergency Shelters

Shelters in Oxford are operated by **Operation Sharing**, including a day space and night shelter in Woodstock, along with a temporary shelter in Tillsonburg in the winter. **DASO** also provides emergency shelter for women who are impacted by gender-based violence.

Mental Health and Addictions Supports

There are a range of mental health and addictions supports available in Oxford. **CMHA Thames Valley** is a key service provider in this sector with diverse service offerings, including peer support, capacity building, drop-ins, case management, and others.

Outreach Services

Outreach services were found to be the most effective way of connecting people to supports in Oxford. The County provides outreach services in collaboration with **the Oxford County Community Health Centre (OCCHC)** through the Mobile Health Outreach Bus.

Medical Services

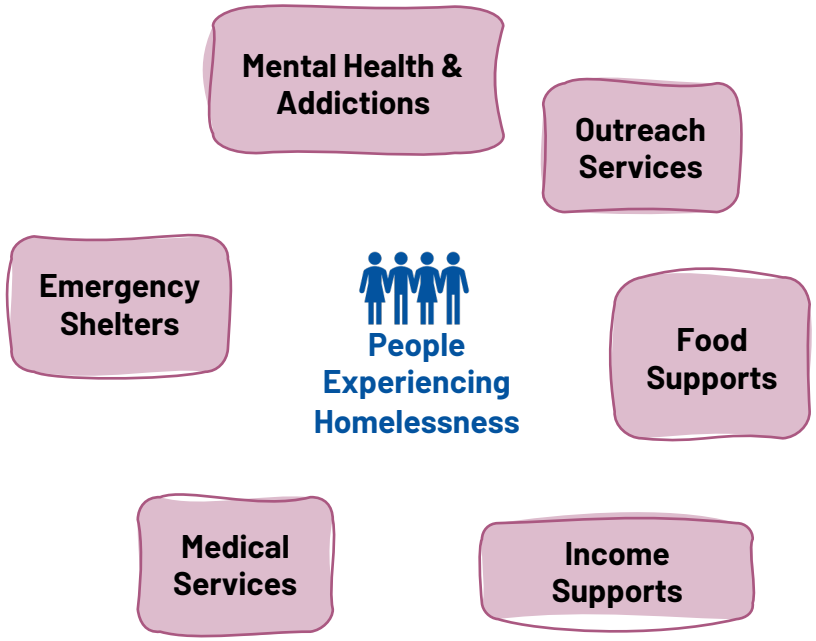
In addition to the three main hospitals in Oxford, **Oxford County Community Health Centre (OCCHC)** was a key access point for medical services in the community, from managing chronic disease to physiotherapy to mental health and addictions counselling**. Ingersoll Nurse-Practitioner Clinic** also provides folks access to primary care.

Food Supports

In addition to food programs by **Salvation Army and Operation Sharing**, there are a variety of **churches** that coordinate food support throughout the week, particularly in Woodstock and Tillsonburg.

Income Supports

OW and ODSP, administered by the County, are vital supports for people experiencing homelessness in Oxford. OW offices are also an important service access point in the community.



Stabilizing Supports

This provides an overview of the system stabilizing supports available in Oxford. These are the often the services that help build stability and can prevent homelessness from occurring.

Legal and Justice System

The **Elgin-Oxford Legal Clinic, Legal Aid, CMHA, and Community Options for Justice** provide legal and advocacy support for those interacting with the justice system.

Employment

There are employment readiness, skills building, and other relevant programs provided in Oxford by organizations such as **Community Employment Services (CES), Multi-Service Centre, and LEADS.**

Disability Supports

Community Living Tillsonburg, LEADS, Community Services Coordination Network serve the needs of people with disabilities in Oxford,

Youth Services

A variety of youth-focused organizations exist in Oxford, including mentorship programs, training and employment programs, and more. **Wellkin** has a decided focus on Child and Youth Mental Wellness.

Family Services

There are services for families available, including **Multi-Service Centre** for newcomers supports and **DASO** for women impacted by gender-based violence.

Information and Resources

The **Oxford Public Library** system is an important community information and resource hub in Woodstock, Tillsonburg, and Ingersoll.

Housing (and Supports)

This provides an overview of housing supports available in Oxford. These are the services providing medium to longer-term support towards finding and maintain housing.

Housing Stability Support

There are existing housing stability programs in Oxford, mainly the Housing Stability program **by OCCHC and the outreach support by the County.** OCCHC's program is focused on eviction prevention support.

Transitional Housing

Transitional housing options in Oxford County are primarily provided by **Oxford County Community Health Centre (OCCHC), Ingamo Homes, United Way Oxford, and the County** . This includes transitional living options in Woodstock, Tillsonburg and Ingersoll, as well as a transitional housing program specifically for youth.

Permanent RGI Housing

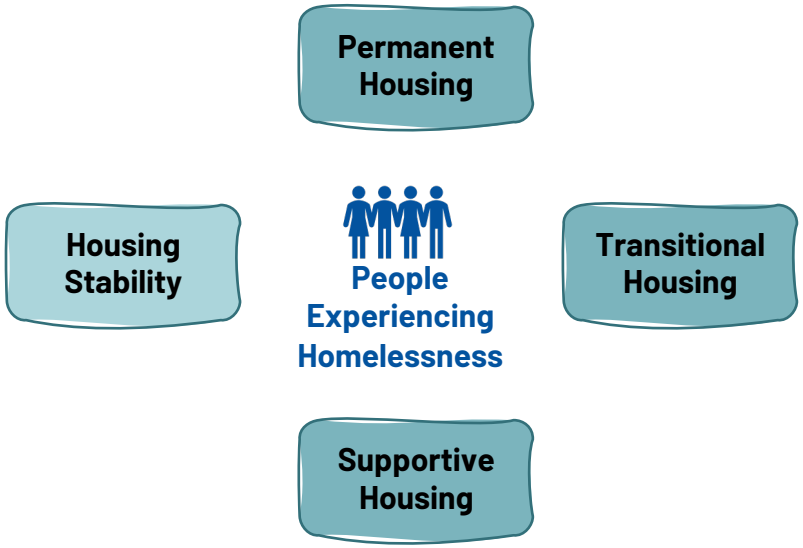
Community housing (rent-geared to income) in Oxford is helmed by **the County** and non-profit housing providers such as **Woodstock Non-Profit Housing**.

There are currently:

- 636 RGI units offered by Oxford County Housing.
- 600 RGI units offered by non-profit housing providers and housing co-operatives (some of which also provide affordable units targeted to moderate-income households).

Supportive Housing

Supportive housing providers in Oxford include **Indwell, Caressant Care and CMHA Thames Valley**.



Appendix 2: Estimating the Cost of Chronic Homelessness

Detailed Methodology

The methodology used to estimate the per person cost of individuals experiencing homelessness is based upon data of 990 participants across five Canadian cities as part of the At Home/Chez Soi program[42]. This study estimated the annual per person cost of individuals with mental illness experiencing homelessness who were accessing available programs and services in their respective municipality, without a housing first intervention.

Breaking costs down. In addition to providing a total cost to municipalities, data was broken down by a series of cost items. The cost items shown in Table 2 are understood to be administered at least in part by the County. Additional cost items from this analysis, including substance use treatment, ambulatory visits, hospital stays, and incarceration are not included. The study also measured costs associated with supportive housing, which has been excluded as this analysis focuses on individuals experiencing active homelessness, and social assistance and disability benefits, which for the purposes of this analysis are not assumed to change based on homelessness status.

Applying costs to the Oxford context. The study found a significant variation in costs across the five municipalities studied, however the cost for individual items, including the items included below, did not correlate directly with the size and/or rural or urban character of the five municipalities. As such, the average costs across the five cities (excluding obvious outliers) has been applied to the context of Oxford and costs have been projected forward to 2024 dollars using the consumer price index. Of note, while the study focused exclusively on individuals with mental illness, for the purposes of analysis these figures are being applied to all individuals experiencing homelessness. This is because the included costs are not assumed to vary significantly among individuals without mental illness, and due to the high prevalence of mental health issues among individuals experiencing chronic homelessness.

Breaking down costs by jurisdiction. In addition, several assumptions have been made about the proportion of each cost assumed by Oxford:

- The full cost of emergency shelter is assumed to be administered by Oxford County.
- It is assumed that the County administers 80% of the funding for other services for those experiencing homelessness, with the remaining funding coming from other levels of government or alternate sources.
- The County administers funding for ambulances and paramedics, which is assumed to make up 20% of the cost of emergency department visits and ambulances. The remaining 80% is assumed to be borne by emergency departments.
- The proportion of police and court appearances attributed to Oxford (20%) is intended to account for the costs associated with provincial offences administration.

Table 2: Per person average annual cost (2024 dollars) for individuals experiencing homelessness, broken down by item and applied to the County of Oxford

Cost Item	Cost (2024 Dollars)	% Administered by Oxford County	Cost to the County
Shelters	$4,578	100%	$4,578
Other (help lines, day centres)	$3,325	80%	$2,660
Emergency department visits and ambulance	$2,167	20%	$433
Police, court apperances	$6,709	20%	$1,342
TOTAL			**$9,013**

(Latimer, E.A., Rabouin, D., Cao, Z. (2017). Costs of services for homeless people with mental illness in 5 Canadian cities: a large prospective follow-up study. *CMAJ Open* Vol. 5(3).

Appendix 3: Further Reading

Overview

This section provides a detailed list of the resources, reports, and readings that have supported the development of this strategy. They can be used references and a list for further reading.

1 Shapcott, M. (2007). The blueprint to end homelessness in Toronto. *The Wellesley Institute.*

2 Gaetz, S. (2012): The real cost of homelessness: Can we save money by doing the right thing? *Canadian Homelessness Research Network Press.*

3 Richard, L., Carter, B., Nisenbaum, R. et al (2024). Disparities in healthcare costs of people experiencing homelessness in Toronto, Canada in the post COVID-19 pandemic era: a matched cohort study. *BMC Health Serv Res* 24, 1074

4 Kellen, A., Freedman, J., Novac, S., et al. (2010). Homeless and Jailed: Jailed and Homeless. *The John Howard Society of Toronto.*

5 Canada Mortgage and Housing Corporation (2005). Cost Effectiveness of Eviction Prevention Programs.

6 Vancity Community Foundation (2024). Why Eviction Prevention Matters: The Social and Economic Benefits of BC Rent Back in British Columbia.

7 Latimer, E.A., Rabouin, D., Cao, Z. (2017). Costs of services for homeless people with mental illness in 5 Canadian cities: a large prospective follow-up study. *CMAJ Open* Vol. 5(3).

8 Patterson, M., Somers, J., McIntosh, K., Sheill, A., & Frankish, J. (2008). Housing and Support for Adults with Severe Addictions and/or Mental Illness in British Columbia. *Centre For Applied Research in Mental Health and Addiction and Simon Fraser University*

9 Calgary Homeless Foundation (2008). Report on the cost of homelessness in the city of Calgary.

10 Goering, P., Veldhuizen, S., Watson, A., et al. (2014). National At Home/Chez Soi Final Report. *Mental Health Commission of Canada*

11 CAEH (2024). Bright Spot: St. Thomas-Elgin reduces chronic homelessness by 30% in just seven months.

12 CAEH (2022). Bright Spot: Brantford-Brant rapidly implements a By-Name List and Coordinated Access System despite COVID-19's challenges.

13 CMHC (2024). Health, Housing and Income: Collaborating to address homelessness for medical and psychiatric patients in the healthcare system.

14 Lawson Health Research Institute. Collaboration to address homelessness: Health, Housing, and Income (H2I): Implementation guideline.

15 St. Leonard's Community Services. Reintegration Program.

Appendix 3: Further Reading

17 Community Housing Transformation Centre. RentSmart webpage.

18 Waterloo Region Community Legal Services (2022). Best practices for housing providers of the Waterloo region: A toolkit.

19 City of Toronto. New framework for multi-tenant (rooming) houses webpage.

20 Simmons, T. (2017). The City of Toronto launches ads to dispel myths about the homeless. *CBC News*.

21 Redwood Park Communities. Yes! In my backyard webpage.

22 OrgCode Consulting Inc., Canadian Shelter Transformation Network and Canadian Alliance to End Homelessness (2019). Housing-focused shelter manual.

23 OrgCode Consulting Inc. (2022). An Introduction to low-barrer, housing-focused shelter.

24 Durham Region. Housing Focused Shelters.

25 Phillips, R. and Parsell, C. (2012). The role of assertive outreach in ending 'rough sleeping'. *Aboriginal Policy Research Consortium International (APRCi)*

26 United States Interagency Council on Homelessness. (2019). Core elements of effective street outreach to people experiencing homelessness

27 Mackie, P., Johnsen, S., and Wood, J. (2019). Ending street homelessness: What works and why we don't do it. *European journal of homelessness, Volume 13, No. 1*

28 CAEH (2021). Bright Spot: Kelowna and Niagara Region are using tech to help coordinate outreach.

29 Niagara Region. Assertive Street Outreach webpage.

30 United States Interagency Council on Homelessness and Hennepin County Office to End Homelessness (2024). Community spotlight: Comprehensive, coordinated, and ongoing housing-focused outreach.

31 Distress Centre (2024). 10 Benefits of Peer Support.

32 Groundswell. Homeless Health Peer Advocacy (HHPA) webpage.

33 Access Alliance Multicultural Health and Community Services. Peer Outreach Program webpage.

34 Maluske, M. (2023). 'I couldn't do it alone': How Safe Beds is changing lives in Windsor. *CTV News*.

35 CMHA Windsor-Essex County. Safe Beds Program webpage.

36 Guelph Wellington Ontario Health Team (2024). July 2024 Newsletter.

37 Stonehenge Therapeutic Community. Safe Beds webpage.

38 Street Storage. Street Storage webpage.

39 Spectrum News (2021). Safe storage options present opportunities for the homeless.

40 CMHC (2024). Sparrow: Homesharing offers a win-win solution for housing affordability.

41 Canada HomeShare. Canada Homeshare webpage.

42 Latimer, E.A., Rabouin, D., Cao, Z. (2017). Costs of services for homeless people with mental illness in 5 Canadian cities: a large prospective follow-up study. *CMAJ Open* Vol. 5(3).

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Oxford County
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