

Homelessness Collective Impact Committee

FINAL REPORT 2025



Message from the Co-Chairs

As we reflect on the work of the **Homelessness Collective Impact Committee (HCIC)** since its formation in 2021, we want to extend our deepest gratitude to all committee members – frontline workers, dedicated professionals, government departments, local organizations, and people with lived experience voices – who came together to drive meaningful change for our most vulnerable unhoused community members.

Through these collective efforts, we have **deepened our understanding of systemic gaps, developed innovative models like the Care Centres, advocated for solutions, and strengthened cross-sector collaboration.** Many of the initiatives we've explored—such as the **Indigenous Care Centre, Medical and Mental Health Care Centre, and expanded shelter and stabilization supports**—have gained traction and will continue to evolve through the work of various organizations and community partners.

At this stage, we believe we have taken the HCIC as far as we can in its current form. Rather than continue meeting without a clear next phase, we have made the decision to formally dissolve the HCIC.

That said, the work is far from over. The lessons, recommendations, and collaborations fostered within this committee will continue to shape Kingston's approach to addressing homelessness. As we wrap up, we are sharing a **final report** that captures key learnings, data, and advice for the future.

As we bring the work of the **HCIC** to a close, we want to take a moment to reflect on all that we have accomplished together since 2021. This committee was founded on the belief that **collaboration, shared learning, and a commitment to action** could drive meaningful change in how we support the most vulnerable members of our community. Thanks to your dedication, expertise, and tireless efforts, HCIC has played a crucial role in shaping homelessness response efforts in Kingston.

Over the past four years, HCIC has:

- Fostered a **cross-sectoral approach**, bringing together service providers, municipal leaders, and health experts to align efforts.
- Provided vital input into new initiatives, including the **Medical & Mental Health Care Centre (MMHCC) and the Indigenous Care Centre (ICC).**
- Strengthened **data-driven approaches**, helping to track trends and advocate for better solutions.
- Elevated the voices of **people with lived experience**, ensuring that the strategies developed truly reflect their needs.
- Championed **stigma reduction efforts**, including supporting the **Support Not Stigma** campaign.

These accomplishments are a testament to the power of **collective impact**. The insights, strategies, and relationships built through HCIC is our collective legacy and will continue to inform future efforts to address homelessness in Kingston.

We are incredibly grateful to all participants for the contributions, passion, and unwavering commitment to this cause. It has been an **honour to co-chair this committee** and work alongside such dedicated individuals. We'd like to extend a special thank you to **Kaitlin Gibson, from United Way KFL&A, who has supported us through this process.**

As a final step, we are sharing a **report** that captures our key learnings, data insights, and recommendations for the future. We encourage you to review it and consider how you can continue to champion the important work that HCIC has advanced.

Thank you to all committee members for your dedication and for being part of this journey. We look forward to seeing the continued impact of your efforts in the years ahead.

With gratitude,

Susan Stewart & Bhavana Varma
Co-Chairs, Homelessness Collective Impact Committee

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Executive Summary

Since its inception in 2021, the Homelessness Collective Impact Committee (HCIC) has played a leading role in advancing collaborative, coordinated efforts to address homelessness in Kingston and the surrounding area. The committee brought together a diverse group of professionals, service providers, policymakers, and individuals with lived experience to design systemic, evidence-based approaches to complex homelessness challenges.

Over the past four years, HCIC deepened the community's understanding of systemic gaps, advocated for local solutions, and supported the development of innovative service models—most notably, the Indigenous Care Centre (ICC) and the Medical and Mental Health Care Centre (MMHCC). These efforts were grounded in harm reduction, trauma-informed care, cultural safety, and anti-oppressive principles.

This final report summarizes HCIC's key findings, achievements, and recommendations. It incorporates current data, international comparative models, and community-based knowledge to provide a roadmap for Kingston's continued response to homelessness. It also explores the phenomenon of compassion fatigue—among frontline workers, policymakers, and the public—and its implications for policy and public discourse.

While systemic barriers remain, the report highlights both, the urgent need, and the real opportunity to shift from short-term interventions to long-term, evidence-based housing solutions. The recommendations presented reflect the shared responsibility of municipal, provincial, and federal governments, service providers, and the broader community.

Kingston stands at a critical juncture. We have strong foundations in the community, and a clear, collective understanding of what works. As a city, we are primed to work together on sustained investment, coordinated action, and compassion.

Background and Purpose of HCIC

HCIC was established in response to the increasing number of individuals experiencing homelessness and the growing complexity of their needs. The committee sought to design, develop, and adapt a system of care that is people-centered and solution-focused. Its guiding principles included harm reduction, trauma-informed care, cultural competency, and anti-oppressive practices.

The committee's primary objectives were:

- Designing a system for chronic homelessness prevention and intervention
- Providing resources to stabilize vulnerable individuals
- Ensuring lived experience voices informed strategies
- Developing a framework for tracking progress and impact

Understanding the Local Landscape:

Kingston's Homelessness Data

Key Data and Trends

At least 235,000 Canadians experience homelessness annually; approximately 35,000 people are without shelter every night¹. **In 2024, over 81,000 people in Ontario** were homeless -- a 25% increase over two years² -- more than half were chronically homeless. Homelessness has a significant impact on individuals, families, and communities. It negatively impacts people's physical health, mental health, and quality of life. It also compromises a person's chances to engage in employment and positive family and social relations.¹

Findings from the Kingston 2024 Point-in-Time Count:

A Point-in-Time (PiT) Count is an estimate of people experiencing homelessness in a community on a single night and helps communities to better understand that population through information collected in a detailed survey. Kingston's most recent Point-in-Time Count, administered through United Way's Reaching Home initiative, identified 339 individuals experiencing absolute homelessness in 2024—a 153% increase from 2021.

- 75% of respondents reported mental health challenges, up from 65% in 2021.
- 75% of youth respondents reported mental health challenges (lower than 83% in 2021).
- The overall number of youth surveyed in 2024 was significantly lower than 2021.
- 67% identified substance use issues.
- 26% identified as Indigenous, down from 31% in 2021, still a significant overrepresentation compared to Kingston's Indigenous population of 3.4%.
- 36% of respondents were under 25 when they first experienced homelessness.
- When asked about barriers to housing, a majority of respondents reported not enough income (96%) and rents being too high (84%).

Findings from the Kingston By-Name List Data (February 2024):

A By-Name List (BNL) is a real-time, up-to-date list of individuals experiencing homelessness in a community. It's a crucial tool for coordinated access and prioritization within the homelessness response system, helping connect people with appropriate housing and support services. The By-Name List, maintained through the City of Kingston, confirms approximately 400 individuals are chronically homeless.

- Kingston By-Name List (February 2024):
 - 531 total homeless individuals (up from 390 in 2023)
 - 329 chronically homeless
 - 112 Indigenous (21%)
 - 52 youth and 3 veterans verified
 - Average duration of homelessness: 230 days

Clarifying the Scope of the Housing Need

In March 2023, Kingston city staff presented a staff report to Council in response to a direct question: “What would it take to end homelessness in Kingston?” The response estimated that 1,500 to 1,600 new housing units would be needed. It would require over \$60 million in investment to provide supportive housing and wraparound services. This estimate accounted for both capital construction and the ongoing operating costs needed to keep people housed and supported.³

While this figure reflects the broader need for **deeply affordable housing** across income groups, it may be misinterpreted as the cost to end homelessness specifically.

In reality, **By-Name List (BNL)** and **Point-in-Time (PiT) Count** data indicate that approximately **350 individuals** in Kingston are experiencing **chronic homelessness**. These individuals face the most complex barriers to housing, including mental health challenges, substance use, and prolonged disconnection from stable housing.

Evidence-based models, such as Housing First, emphasize the importance of prioritizing this group with low-barrier, supportive housing and integrated wraparound services. This targeted approach—proven effective in cities like Houston and countries like Finland—avoids overwhelming the public or decision-makers with generalized estimates that can undermine urgency or discourage action.^{4, 5}

By aligning investment and strategy with the actual scale and nature of the issue, Kingston has the opportunity to move beyond inflated projections toward realistic, focused, and measurable solutions that can make a lasting difference.

Public and Policy Response to Homelessness

The need for an effective response to homelessness cannot be overstated. A Toronto Public Health study found that in 2024, the median age of death for unhoused women was 36, and 50 for men—compared to 85 and 78, respectively, in the general population.⁶ These tragic disparities highlight the urgency of housing interventions. However, a myriad of factors is contributing to the failed response to homelessness.⁶

Moral Distress

The general public and policymakers often experience emotional exhaustion from prolonged exposure to suffering. As the visibility of homelessness increases, frustration, disengagement, and misinformed policy responses often follow.

At the same time, moral distress among frontline workers is on the rise. Frontline workers face moral distress and ethical frustration when they are unable to act according to their values. It is the conflict between what professionals believe should be done and what they are able to do due to systemic constraints and creates real trauma

in service providers who are working with people who are homeless and experiencing complex barriers.

Public fatigue, driven by prolonged exposure to homelessness, has led to emotional detachment, myths, and punitive responses. Compassion fatigue affects not only frontline workers but also policymakers and the public. This emotional numbness, coupled with moral distress among service providers, results in short-term thinking and disengagement. Encampments and visible poverty trigger frustration, and cities often respond with evictions rather than housing.

This cycle undermines long-term solutions. Rather than acting on evidence, governments often shift toward enforcement models. Yet, international models show that housing-first approaches grounded in dignity, trust, and coordinated support consistently outperform punitive alternatives.

Public Perception and Policy Implications

- **Frustration and disengagement:** The growing number of encampments and shelter shortages often lead to public frustration, with some assuming that homelessness persists due to personal failings rather than systemic barriers.
- **Misinformation and stigma:** Myths such as “people choose to be homeless” fuel punitive policies that criminalize survival behaviours, including panhandling and encampments.
- **Short-term fixes vs. long-term solutions:** Increased emergency shelters and encampment clearances may provide temporary relief for housed residents but do not address the root causes of homelessness.

Housing First and Systemic Approaches

HCIC emphasized a Housing First model, which prioritizes stable housing as a fundamental human right before addressing addiction, mental health, or employment challenges. Studies, including Canada’s At Home/Chez Soi project, show that Housing First reduces chronic homelessness, emergency room visits, and justice system interactions.⁷

Kingston has made efforts to adopt Housing First principles; however certain practices hinder the impact:

- Encampment evictions often occur with minimal notice and without immediate housing offers—displacing individuals and breaking trust.
- Some shelter policies—such as those restricting access for couples, pets, or individuals requiring harm reduction—discourage use and disproportionately disadvantage people with the highest acuity, often leaving the most vulnerable unsheltered.
- Enforcement-first approaches risk legal and ethical issues; the Ontario Human Rights Commission has raised concerns about potential Charter violations⁷.

While systemic insights offer valuable lessons, Kingston's local response has also evolved through coordinated planning. The following section highlights HCIC's accomplishments and the impact of its collaborative work across sectors.

HCIC Accomplishments and Impact

1. Strengthening Cross-Sector Collaboration

HCIC provided a forum for over 35 organizations across health, housing, social services, and municipal governance. This strengthened inter-agency coordination, allowing for more integrated service delivery.

2. Supporting the Development of New Models

- **Harm Reduction and Trauma-Informed Care:** Ensuring services meet people where they are without unnecessary barriers.
- **Wraparound Support Services:** Housing, mental health care, addiction services, employment programs, and cultural support tailored to diverse needs.
- **A 'No Wrong Door' Approach:** Enabling access to services regardless of where individuals seek help.
- **Expansion of Shelter and Stabilization Supports:** Assisted in shaping local shelter strategies and additional resources for people with high acuity needs.

3. Championing Connection and Care Centres (see Appendix C)

HCIC supported the development of Connection and Care Centres, which provide a safe space to stabilize individuals, connect them to services, and help them transition to housing. The guiding philosophy behind these centres includes:

- **Indigenous Care Centre (ICC):** Designed to provide culturally appropriate and holistic services for Indigenous individuals experiencing homelessness.
- **Medical and Mental Health Care Centre (MMHCC):** A low-barrier facility offering health and social supports to individuals with complex needs.

4. Advancing Stigma Reduction

HCIC worked on shifting public narratives through education and information at all meetings, expressing support for initiatives like the *Support Not Stigma* campaign, encouraging a more compassionate and evidence-based discourse around homelessness, mental health, and substance use.

5. Shelter Needs Assessment Report (May 2024)

As part of the work of MMHCC, a pilot project was undertaken by KCHC, and funded by United Way KFL&A. This needs assessment was conducted over a two-month period, with the primary goal of assessing the healthcare status and health care needs of underhoused and unhoused individuals utilizing Adelaide Shelter.

Building on Success

HCIC reviewed the existing network of care hubs in Kingston, including:

- **One Roof (Youth Services Hub)** – Home Base Housing
- **Integrated Care Hub (including Consumption Treatment Site)** – AMHS-KFLA
- **Women Empowered Hub** – Elizabeth Fry Society
- **A Great Start for Families Kahwà:tsire Ronwatiyenawá:se Centre** – FACSFLA
- **Peer to Community** – a research project that is part of Dr. Carrie Anne Marshall's *Transitioning from Homelessness* study

Proposed Connection and Care Centres:

Two Connection and Care Centres are proposed to help people feel supported and find their way out of homelessness. HCIC spent considerable time fleshing out what would help provide supports to people who are homeless. More details can be found in Appendix C.

- **Medical and Mental Health Care Centre (MMHCC)** – Coordinating acute care and wraparound supports
- **Indigenous Care Centre (ICC)** – Providing culturally safe and status-blind services for Indigenous individuals

Recommendations for Future Action

In addition to the important work already underway by frontline agencies—supported by the City of Kingston, Reaching Home, United Way, and other funders—this report offers the following recommendations for consideration and to guide future action.

1. **Institutionalize HCIC's Key Learnings**
 - Integrate HCIC's frameworks into municipal and regional homelessness strategies.
 - Ensure that lived experience consultation remains central to policy development.
2. **Sustain and Expand Care Models**
 - Secure long-term funding for the Indigenous Care Centre, which is being developed.
 - Secure resources and explore making Medical & Mental Health Care Centre a reality in order to secure primary and wraparound care for the unhoused.
 - Increase investment in stabilization and transitional housing services, along with a focus on affordable housing for the most chronic and vulnerable unhoused people.

3. **Enhance Coordinated Access and Data Utilization**
 - Strengthen tracking and connection with individuals moving through the homelessness system to improve service delivery.
 - Expand real-time data sharing among agencies.
 4. **Prioritize Long-Term Solutions Over Punitive Measures**
 - Expand investments in Housing First, permanent supportive housing, and wraparound services.
 - Advocate against punitive approaches such as encampment clearances, ticketing, and criminalization of homelessness.
 5. **Expand Harm Reduction Housing and Supports**
 - Create housing and service options for individuals with addictions and mental health challenges, grounded in harm reduction principles.
 - Develop targeted supports for people who face barriers to traditional shelters due to mental illness or substance use.
 - Invest in additional spaces - low-barrier, permanent housing and shelters that embed harm reduction approaches.
 - Maintain a relentless focus on individuals experiencing chronic homelessness, particularly those with co-occurring conditions.
 6. **Continue Public Education and Stigma Reduction Efforts**
 - Build on HCIC's efforts to address stigma through ongoing public education campaigns, lived experience storytelling, and engagement strategies that shift perceptions about homelessness and those experiencing it.
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Conclusion and Next Steps

With HCIC formally dissolving, the responsibility for advancing these efforts will be distributed among partner organizations. The knowledge, collaborations, and strategies developed by HCIC provide a solid foundation for ongoing work in homelessness prevention and intervention.

We express our deepest gratitude to all HCIC members, partner organizations, and individuals with lived experience who contributed to this work.

Appendix A: Comparative Models

Houston, Texas

Houston reduced its homeless population by over 60% from 2011 to 2022 by fully implementing a coordinated Housing First system. Key features included: unified coordination among over 100 agencies, centralized data tracking, rapid rehousing and permanent supportive housing, strong political leadership, and a commitment to pairing encampment reductions with housing offers. Houston's model demonstrates the power of scale, coordination, and leadership.

More detail is provided in Appendix B.

At Home/Chez Soi (Canada)

This federally funded research initiative (2009–2014) assessed Housing First in five Canadian cities. It showed that participants who received immediate housing and wraparound supports experienced:

- 73% housing retention after two years
- 50% fewer hospital and ER visits
- Significant mental health improvements
- Net savings of \$2.10 for every \$1 invested (for high-needs individuals)

Finland

Finland is the only European country where homelessness is declining. Their approach includes:

- Unconditional access to permanent housing
- Large-scale investment in social and supported housing
- Eliminating emergency shelters in favour of homes
- Integrated services and strong national leadership

Finland's experience illustrates that solving homelessness is possible with long-term commitment and system-wide transformation.

Appendix B: Houston Model

Houston has been recognized for making considerable progress in reducing homelessness through a coordinated, housing-first approach. Here's how they did it:

1. **Housing First Model** – Instead of requiring people to meet certain conditions (like sobriety or employment) before getting housing, Houston focused on providing permanent housing first, then offering supportive services.
2. **Collaboration Among Agencies** – More than 100 local organizations, including government agencies, nonprofits, and faith-based groups, worked together under one unified system, the *Continuum of Care*, rather than competing for resources.
3. **Centralized Homelessness System** – The city created a single database to track individuals experiencing homelessness and prioritize them for housing based on need.
4. **Public-Private Partnerships** – Houston leveraged federal funding (such as HUD grants) and private donations to expand affordable housing and support services.
5. **Permanent Supportive Housing (PSH) and Rapid Rehousing** – The city invested in PSH for those with chronic homelessness and mental health issues, while also using rapid rehousing programs to quickly move individuals into homes.
6. **Reducing Encampments with Housing Offers** – Instead of just clearing homeless encampments, Houston paired closures with direct housing offers, ensuring people had a place to go.
7. **Strong Political Leadership** – Mayor Sylvester Turner and other local leaders committed to a long-term plan, working across political and organizational lines.

As a result, Houston reduced its homeless population by **over 60%** in about a decade. While challenges remain, its approach has become a model for other cities.

Houston's **Rapid Rehousing (RRH)** and **Permanent Supportive Housing (PSH)** programs are key to its success in reducing homelessness. Here's how each works:

Rapid Rehousing (RRH)

RRH is designed to help people who are newly homeless or facing short-term homelessness get back into stable housing quickly.

How It Works:

- Individuals or families experiencing homelessness are identified and assessed through the coordinated entry system.
- They receive short-term (typically 3–12 months) rental assistance and case management services.
- The goal is to help them become self-sufficient by connecting them to employment services, financial counseling, and healthcare.
- Once stable, participants take over rent payments or transition to other assistance if needed.

Key Features:

- No preconditions (e.g., sobriety, job status).
- Housing is found in the private rental market, with landlords incentivized to participate.
- Case managers help with job placement, childcare, and other needs to prevent a return to homelessness.

Permanent Supportive Housing (PSH)

PSH is aimed at individuals experiencing chronic homelessness, especially those with disabilities, mental illness, or substance use disorders.

- **How It Works:**
 - People with the highest needs are prioritized.
 - They receive **long-term, subsidized housing** with no time limit, combined with supportive services.
 - Services include mental health care, substance use treatment, healthcare, and life skills training.
 - The goal is stability rather than forcing immediate self-sufficiency.
- **Key Features:**
 - Uses a **Housing First** approach—housing is provided **without** requiring sobriety, employment, or mental health treatment upfront.
 - Many PSH units are in dedicated buildings, but some are in scattered-site apartments with support services delivered on-site.
 - Funded through HUD programs, Medicaid, and private grants.

Impact

- RRH helps people exit homelessness quickly, often within weeks or months.
- PSH dramatically reduces chronic homelessness by keeping vulnerable individuals housed long-term.
- Houston's homelessness dropped by 63% from 2011 to 2022, thanks to these programs.

Many cities have Rapid Rehousing (RRH) and Housing First programs, yet Houston has seen much greater success in reducing homelessness. What set Houston apart was how they **coordinated, scaled, and executed** these programs. Here's what they did differently:

1. True System-Wide Collaboration

Most cities have multiple organizations working on homelessness, but they often compete for funding or operate in silos. Houston **forced** over 100 organizations (nonprofits, faith-based groups, government agencies) to work as one unified system under **The Way Home**, its regional homelessness response.

- Instead of individual agencies controlling their own housing programs, Houston created a centralized homeless database (Homeless Management Information System, HMIS) to track and prioritize individuals based on need.
- Funding was pooled and strategically allocated, rather than agencies competing against each other for resources.

2. Housing at an Unprecedented Scale

Many cities place people in housing **slowly**, but Houston **rapidly scaled up** permanent housing solutions:

- Between 2012 and 2022, they housed **25,000+ people**, dramatically reducing street homelessness.
- They partnered with landlords to secure **thousands of apartments** in the private market rather than waiting for new units to be built.
- The city repurposed vacant buildings and hotels into **Permanent Supportive Housing (PSH)**.

3. Encampment Reduction with Housing Offers

Instead of just clearing homeless encampments like many cities do, Houston **paired every encampment closure with immediate housing offers**.

- Outreach teams engaged encampment residents in advance, ensuring they could **go directly into housing** instead of just being displaced.
- This reduced visible street homelessness without increasing arrests or displacement, a key failure in other cities.

4. Mayor-Led Political Will & Funding Alignment

Many cities struggle because local governments, nonprofits, and HUD programs aren't aligned. Houston took a **top-down, committed approach**:

- Mayor Sylvester Turner made homelessness a top priority and worked across city, county, state, and federal levels.
- They consolidated funding from HUD, private donors, and local sources into one coordinated system—allowing for streamlined spending.

5. High-Touch, Long-Term Case Management

Houston emphasized **ongoing case management** to prevent people from cycling back into homelessness:

- Even after being housed, individuals received **intensive case management for at least two years** (much longer than in other cities).
- Support services included job placement, mental health care, and addiction treatment—ensuring housing stability.

The Result?

- 63% reduction in homelessness (2011–2022).
- Fewer tent cities and encampments.
- A functional end to veteran homelessness.

Houston's success wasn't just about adopting Housing First—it was about fully integrating it into a unified, well-funded, and highly coordinated system that actually moved people into housing at scale.

Appendix C: Connection and Care Centres

Connection and Care Centres provide a safe space to support and stabilize people who are chronically unhoused so that they can access housing that meets their needs and increase the likelihood of retaining this housing.

Purpose of Connection and Care Centres

Connection and Care Centres can:

- Support people to be housing-ready
- Provide life skills for people who are unhoused to support themselves
- Connect people to services through a coordinated hub model
- Coordinate and provide wraparound care with multiple services

Other Services

In addition to the Connection and Care Centres (existing and new) there are a number of shelters, drop-ins and services in Kingston. Building on the success of other centres/hubs in Kingston, we looked into the need to address pressing gaps with new Connection and Care centres.

Principles for Connection and Care Centres

- Low barrier (not no-barrier)
- Harm reduction
- Trauma informed
- Anti-oppression (culturally safe, anti-racist)
- Anti-stigma
- Client-centered
- Accessible
- “No wrong door” approach

A low-barrier approach is a way to meet people where they are at, without negatively affecting other guests or staff. It provides an environment where people can maintain a sense of autonomy while offering safety, a sense of community and support. A low-barrier space has a minimum number of expectations or requirements. (No-barrier spaces would be a space where no requirements are placed on guests.)

Harm reduction seeks to reduce negative consequences associated with substance use; all persons are treated with respect and provided with equal access to services. Recipients of these services may be encouraged, but not required, to reduce their consumption of harmful substances.

Trauma-informed practices promote a culture of safety, empowerment, and healing. Physical and emotional trauma can cause ongoing stress and affect a person’s functioning and well-being. Trauma-informed practices enhance people’s actual and

perceived safety and security needs, providing an opportunity for them to express their feelings, validating those feelings, and helping them be able to predict and prepare by explaining the next steps in the process and their role in that process. People experiencing homelessness usually have extensive histories of trauma.

Anti-oppression practices acknowledge the oppression that exists in our society, aiming to mitigate the effects of oppression and equalize the power imbalances that exist between people. giving people the tools needed to better understand how power and privilege work within society at all different levels. It supports programs and practices that can shift dynamics in ways that decrease and eliminate oppression.

Anti-stigma approaches recognize the importance of addressing stigma to promote recovery and improve access to care. People with lived and living experience of mental health illnesses, substance use concerns, and/or people who are unhoused, often feel devalued, dismissed, and dehumanized by community members, health care and other frontline staff.

Client-centered approaches ensure that all services are centered around each client's wholistic needs. Services are co-designed with participants. Since HCIC does not directly have program participants, agencies have consulted with people with lived experience at different times during the development of this model.

Accessible spaces reduce and remove barriers for people with disabilities to become more accessible and inclusive for everyone.

No wrong door recognizes that every person's journey is unique and the solutions that would help them are unique as well. This approach can help people understand their options, support their decision-making, and facilitate their access to the services they need, and takes the burden off the individuals seeking services.

INDIGENOUS CARE CENTRE

An Indigenous Care Centre will be status-blind, serving people who identify as Indigenous and are unhoused or at risk of becoming homeless. This will complement the new Friendship Centre.

Indigenous Care Centre Working Group is made up of the Kingston Native Centre and Language Nest, Tipi Moza, Tsi Kanonhkwatsheriyo Indigenous Interprofessional Primary Care Team, Correctional Service Canada.

In addition to some common challenges (navigation between service locations, shortage of addictions and mental health workers, inadequate housing, competitive wages), people who identify as Indigenous often face additional challenges and barriers to accessing services. As such, this centre will:

- Build trust through a culturally appropriate one-stop shop offering all services, and related funding.
- Involve Correctional Service Canada to address the disproportionate number of Indigenous people incarcerated.
- Learn from Odawa Native Friendship Centre, Gignul Housing, and Wabano Centre as reference to see how they created their approaches.
- Introduce the harm reduction drum to engage people in healing during ceremonies.
- Address the challenge of finding units for those who relapse, and face long wait list.
- Prioritize space for youth and family needs; and
- Ensure access to land for cultural/ spiritual needs.

The Indigenous Care Centre would ideally have:

- A kitchen on site to allow for culturally appropriate food.
- Outdoor space for programming, garden space, medicine garden, etc., with an enclosed courtyard.
- Culturally appropriate supports (i.e., elder, knowledge keeper, food, non-traditional medicine).
- Connection to people's history and identity.
- Status card assistance.
- Proper ventilation for smudging; and
- Language and culture education and reintegration.

MEDICAL AND MENTAL HEALTH CARE CENTRE

Building on discussion and input at HCIC meetings, a working group was formed to develop the model, and included representatives from the following organizations:

- Addictions & Mental Health Services (including Integrated Care Hub, ACT team)
- City of Kingston
- Home and Community Care Support Services SE
- Home Base Housing
- KFL&A Public Health
- Kingston Community Health Centres (including Street Health)
- Kingston Health Sciences Centre (including Detox)
- Lionhearts Inc.
- Providence Care
- Queen's School of Medicine
- Trellis HIV & Community Care
- Tsi Kanonhkwatsheriyo Indigenous Interprofessional Primary Care Team
- United Way of KFL&A

Who could this Centre serve?

Unhoused people, often chronically homeless, have one or more of the following:

- Higher acuity needs
- Complex mental health needs
- Substance use disorders
- Have been discharged from hospital, with care needs
- Palliative care
- Mobility or other issues (including seniors)
- Diagnostic needs
- Chronic conditions
- Require wound care
- Require pharmacy planning, dispensation

MMHCC is not intended to be:

- Community clinic for the general public
- Long-term care facility
- Permanent housing
- Hospice

MMHCC would not replace the emergency department or hospital, though it may alleviate some of the pressure on emergency or discharge planning.

Recognizing there is currently no new infusion of funding for this centre, the model will have to be built on redeployment/ reallocation of existing services. (These portable services will likely not be available every day of the week.)

- Psychiatry
- Addiction services
- Access to Nurse Practitioners/Physicians
- Access to Personal Support Workers
- Wound care
- Public Health
- Bloodwork – ways to collect and provide results
- Medication and plans, dispensation of meds
- Paramedical services

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