

Health impacts of homelessness and update on the Downtown CORE pilot

Date: March 12, 2026

To: Board of Health

From: Medical Officer of Health

Wards: All

SUMMARY

At the end of January 2026 there were 11,094 people experiencing homelessness in Toronto¹ - a circumstance that can lead to extensive health harms and negatively impact the health trajectory of an individual over their lifetime. When compared to their housed counterparts, people experiencing homelessness are at increased risk of dying prematurely and suffer a higher incidence of chronic and acute health conditions including infectious disease, diabetes, cardiovascular disease and respiratory disease.

This report provides a short overview of the health impacts of homelessness and identifies key actions taken by Toronto Public Health to protect and promote the health of this population. This includes a summary of Toronto Public Health's evaluation of the Downtown Community Outreach Response and Engagement (CORE) pilot program. The Downtown CORE pilot pairs public health nurses with police constables to deliver integrated, low-barrier, mobile outreach and case management services to individuals experiencing homelessness and challenges with mental health and substance use in the Yonge-Dundas (Sankofa Square) area. The evaluation found that the program is connecting clients with medical care and social supports and identified opportunities to strengthen and refine the model. This report explores opportunities to extend this pilot program.

RECOMMENDATIONS

The Medical Officer of Health recommends that:

1. The Board of Health request the Medical Officer of Health to extend the Downtown Community Outreach Response and Engagement (CORE) pilot program and report back to the Board of Health in Q3 2027 with final recommendations on the program.

2. The Board of Health request the Medical Officer of Health to continue collaborating with health system partners and relevant City of Toronto divisions and agencies on initiatives to improve the health and wellbeing of people experiencing homelessness.

FINANCIAL IMPACT

There are no financial impacts associated with the adoption of the recommendations in this report.

\$1.3 million in gross expenditures and 8.0 positions for the Downtown CORE program are included in Toronto Public Health's 2026 Operating Budget. The program is cost-shared between the City of Toronto and Ontario's Ministry of Health.

The Medical Officer of Health will report back on next steps and any associated financial impact for the Downtown CORE program in Q3 2027.

The Chief Financial Officer and Treasurer has reviewed this report and agrees with the information as presented in the Financial Impact Section.

DECISION HISTORY

On November 24, 2025, the Board of Health considered the 2025 Our Health, Our City Annual Progress Report that provided updates on the current mental health and substance use landscape, highlighted progress toward strategic goals, and provided an update on the implementation of the Downtown Homelessness and Addiction Recovery Treatment (HART) Hub. <https://secure.toronto.ca/council/agenda-item.do?item=2025.HL29.1>

On July 7, 2025, the Board of Health requested the Medical Officer of Health to report back in Q1 of 2026 with evaluation results and recommendations for the next steps of the Downtown Community Outreach Response and Engagement (CORE) program. The Board of Health also directed the Medical Officer of Health to pursue opportunities to participate in a neighbourhood impact study led by the Downtown Yonge Business Improvement Area. City Council authorized the continued implementation and operation of the program on July 23 and 24, 2025. <https://secure.toronto.ca/council/agenda-item.do?item=2025.HL26.4>

On June 25 and 26, 2025, City Council approved the creation of the Downtown HART Hub and received the accompanying report from the Acting Medical Officer of Health. <https://secure.toronto.ca/council/agenda-item.do?item=2025.HL25.2>

On January 20, 2025, the Board of Health considered Item HL21.5 which included feedback from Toronto Public Health's Health and Homelessness Working Table and requested that the Medical Officer of Health report back to the Board in Q1 of 2026. <https://secure.toronto.ca/council/agenda-item.do?item=2025.HL21.5>

On November 18, 2024, the Board of Health considered the 2024 Our Health, Our City Annual Progress Report. The report highlighted the Downtown CORE pilot program as part of an update on the Strategy's strategic goal to advance community safety and wellbeing for everyone. <https://secure.toronto.ca/council/agenda-item.do?item=2024.HL18.2>

On January 6, 2023, the Board of Health considered Item HL1.6 and requested that the Medical Officer of Health develop a working table to conduct a review of the intersection of health and homelessness and provide the results of the review and any recommendations for a report back to the Board. <https://secure.toronto.ca/council/agenda-item.do?item=2023.HL1.6>

COMMENTS

Toronto Public Health (TPH) is committed to advancing the health and wellbeing of people experiencing homelessness and is working collaboratively with divisional partners to achieve the City's objective: for any experience of homelessness to be rare, brief, and non-recurring.

This report provides an overview of the health impacts of homelessness, identifies key actions taken by TPH to protect and promote the health of this population through a combination of surveillance, direct program delivery, and collaboration with City partners. The report also explores opportunities for extending the Downtown Community Outreach Response and Engagement (CORE) pilot program.

Homelessness & Health

Extensive evidence shows that the physical and mental health outcomes of people experiencing homelessness are worse than the general population. When compared to their housed counterparts, people experiencing homelessness are at increased risk of dying prematurely and suffer a higher incidence of chronic and acute health conditions including infectious disease, diabetes, cardiovascular disease and respiratory disease.²³⁴⁵⁶⁷ The median age at death for people experiencing homelessness in Toronto in 2024 was 50 years for males and 38 years for females.⁸ For comparison, the median age at death for the general population in Toronto was 78 years for males and 85 years for females in 2022.⁹ In Toronto, acute drug toxicity remains the leading cause of deaths among people experiencing homelessness, contributing to 55% of the reported deaths in 2024.¹⁰

While the health impacts of homelessness likely vary across the range of homelessness (e.g., sheltered, unsheltered, etc.), a recent study comparing people experiencing homelessness in Toronto found that compared to two housed groups, participants experiencing homelessness had significantly higher rates of asthma, chronic lung disease, history of stroke, chronic neurological disorder, liver disease, HIV/AIDs, mental health or substance use disorders, a history of COVID-19 infection, and health care utilization.¹¹ They were also less likely to be formally attached to a primary care physician.¹²

A health incident or disease can also be more severe for people experiencing homelessness due to the additional impact of poverty, delays in seeking care, nonadherence to treatment, or the adverse health effects of homelessness itself.¹³

Factors specific to the experience of unsheltered homelessness, such as heightened exposure to environmental hazards (e.g., extreme temperatures, substandard living conditions), violence, lack of communication or transportation options, lack of identification or documentation, and stigma can also result in healthcare service avoidance or substandard care.¹⁴

Impact Across the Lifespan

Pregnant individuals, children, youth, adults and older adults will all have unique health needs across their lives. The health impacts of homelessness are also different across the lifespan, and prevention – especially for youth – is critically important. According to data collected through the Nationally Coordinated Point-in-Time Count of individuals experiencing homelessness:

- Youth were more likely than other age groups to have a learning or cognitive limitation or report a mental health concern.¹⁵
- Although substance use issues were most common among adults aged 25-49, over half of youth respondents (56%) reported experiencing substance use issues.¹⁶

The stage of life when an individual experiences homelessness for the first time can also impact their health trajectory. For example, first experiences of homelessness earlier in life are associated with a greater risk of experiencing two or more health challenges at the same time.¹⁷ In general, the earlier a person first experiences homelessness, the more likely they are to also experience chronic homelessness later in life.¹⁸

An early experience with homelessness can also impact other social determinants of health, which leads to additional negative impacts on an individual's health trajectory. For example, men who experience homelessness as children are less likely to be employed as adults, and the employment gap is even larger for women who experience homelessness as children.¹⁹

Overrepresented Groups

According to the recent 2024 Street Needs Assessment, specific groups continue to be overrepresented among people experiencing homelessness. At the time of the survey, 9% of respondents identified as Indigenous, yet Indigenous people represent 3.2% of the Toronto population. Racialized people and Black people are also overrepresented, with 77% of survey respondents identifying as racialized and 58% identifying as Black. There are also increasing numbers of respondents who identify as 2SLGBTQ+ (22%), which has nearly doubled since 2021. The health outcomes for these different groups also vary.

Healthcare Costs

The health impacts of homelessness are clear, and the downstream healthcare costs of homelessness are also substantial. Annual healthcare expenditures can be roughly seven times higher for people experiencing homelessness compared to housed and low-income housed individuals.²⁰ One recent study estimates \$69.8 to \$99.7 million dollars in annual healthcare costs for homelessness in Toronto.²¹

Public Health and Homelessness

Toronto Public Health plays a critical role in surveillance and leads the collection and sharing of health-related data for people experiencing homelessness. Given the extensive health and social impacts of homelessness, these data are important for understanding the healthcare needs of this population.

To help monitor the health outcomes of people experiencing homelessness in Toronto, TPH has developed several data-related initiatives that look at a range of topics including deaths, births, and suspected overdose incidents in shelters. Death data are updated twice a year on a public-facing dashboard, and includes information on counts, gender, cause of death, and location of incident leading to death. TPH also works closely with partner divisions such as Toronto Shelter and Support Services (TSSS) on data initiatives. This information is easily accessible to researchers, the public, and City division partners and is routinely used to inform City programs, services, and policy development.

Promoting and Protecting Health

In addition to data surveillance, TPH promotes the health of this population through a range of programs:

- **The Homeless At Risk Prenatal (HARP)** service (part of the Healthy Babies, Healthy Children program) is a community-based visiting program delivered by Public Health Nurses that supports individuals who are pregnant and experiencing homelessness including those living in encampments, respite centres, and adult-only shelters. The Public Health Nurse liaisons are connected to specific shelters and enable referral pathways, outreach and coordinated service planning to enhance access to prenatal and early parenting support.
- The **Nurse-Family Partnership (NFP)** program provides intensive home-visiting support to individuals 21 years and younger, experiencing their first pregnancy. Program data indicates over 40% of NFP clients lived at an addressed affiliated with a shelter, highlighting the significant overlap between young parenthood and homelessness.
- The **Tuberculosis (TB)** program works with persons experiencing homelessness who have been diagnosed with TB, by providing intensive nursing and social work support.

- The **Vaccine Preventable Disease (VPD)** program offers a Vulnerable Population Immunization Clinic during the fall season to help increase respiratory vaccination coverage, prevent shelter outbreaks, and enhancing the overall health outcomes for this population.

TPH also works to protect the health of this population at key moments such as outbreaks and extreme weather events, and through new programs such as the Downtown CORE pilot program:

- The **Communicable Disease Investigation and Outbreak Liaison (CDIOL)** program leads the public health management of outbreak investigations within the shelter system and supports respiratory-season preparedness.
- The **Communicable Diseases and Infection Control (CDIC) program** responds to reports of diseases of public health significance among people experiencing homelessness. For example, response to the 2024-2025 shigella outbreak in the shelter population was led by TPH with support from Toronto Shelter and Support Services and in partnership with other agencies.
- TPH **mobile dental services** provide preventive, minimally invasive, and restorative dentistry directly in community settings such as community health centres and shelters. This program supports individuals whose chronic oral health issues are often untreated due to homelessness or unstable living situations.
- TPH has developed a **Hot Weather Response** procedure to increase TPH staff awareness of heat related vulnerabilities and to ensure staff are able to alert their clients most at risk of heat-related illness.
- While each City division and partner agency develops and delivers their own cold weather response activities, TPH coordinates annual updates to the **City's Cold Weather Response Plan**. TPH also conducts surveillance to monitor the health impacts of cold and provides information to prevent and treat cold weather injuries and illnesses.
- The **Downtown Homelessness and Addiction Recovery Treatment (HART) Hub** provides clinical and support services to address mental health and substance use in the downtown core, along with referral pathways to wraparound services and housing.
- TPH **Harm Reduction Outreach Teams** work across the city distributing harm reduction supplies, providing health education and referrals to a range of services and supports including housing, primary care and treatment.
- The **Downtown Community Outreach Response & Engagement (CORE) pilot program**, jointly led by TPH and the Toronto Police Service (TPS), pairs public health nurses (PHNs) with police constables to deliver integrated, low-barrier, mobile outreach and case management services to individuals

experiencing homelessness and mental health and substance use challenges in the Yonge-Dundas (Sankofa Square) area.

Downtown Community Outreach Response and Engagement (CORE) Pilot Program

Downtown CORE was launched in December 2024 as a one-year pilot program to provide on-the-spot support and connect individuals with complex health issues and experiencing homelessness with health, social, and wraparound services. The initial pilot period was planned to conclude December 31, 2025, but was extended until March 31, 2026. TPH completed an evaluation to help inform next steps.

Evaluation Scope and Methods

The TPH evaluation of the Downtown CORE pilot program aimed to understand:

- Client demographics and services provided
- Impact on meeting clients' medical and non-medical needs
- Facilitators and barriers to service delivery

The evaluation drew on surveys with clients (n=77), focus groups with TPH program management and TPH's PHNs involved in the Downtown CORE program, and program data (e.g., Electronic Medical Records data).

Client Demographics

The Downtown CORE client base is 67.5% male and 32.5% female. The average client is around 40 years of age and has experienced homelessness for one to five years. The most frequently reported reasons for homelessness were relationship or family breakdown, loss of housing, and challenges related to substance use and addiction.

Services Provided

Between January 14, 2025, and January 13, 2026, PHNs documented 8,431 client interactions across 568 shifts, averaging 15 interactions per shift. Most interactions were initiated by Downtown CORE staff (7,576, 90%). Supports provided to clients during shifts involved medical support (368 shifts, 63% of all shifts) and psycho-social support (553 shifts, 97% of all shifts).

PHNs responded to 12 overdoses, facilitated the emergency transport of 20 clients to the hospital, and distributed 2,415 harm reduction supplies, 459 naloxone kits, 1,395 clothing items, and 5,827 snacks or food items.

Between December 17, 2024 – January 16, 2026, there were 265 case management clients. Downtown CORE's case management is intended to provide up to 90 days of support to help individuals navigate health and social services and track progress toward jointly developed client-centred goals. Case management support most often involved helping clients access emergency/transitional shelters, primary care, identification services, income supports and accompanying clients to appointments. The

Downtown CORE team has supported securing housing for nine clients through case management services.

The program expanded PHN nursing functions to include the provision of basic wound care services in February 2026 and immunization services are forthcoming, allowing for more on-the-spot clinical care.

Impact on Client Medical and Non-Medical Needs

The evaluation found that the most beneficial impacts of the program were addressing clients' substance use and addiction needs and connecting them to housing and identification services. The program's PHNs addressed clients' immediate medical needs through overdose response, emergency care and supply distribution.

Clients identified addiction and mental health as their most pressing medical needs, and 52% of those surveyed reported that the program helped them with these issues. PHNs' insights validated these findings and identified other client health needs including oral health, venous insufficiency, sexual transmitted and blood-borne infections (STBBI), overdose risk, environmental exposures, barriers to primary care, and reduced cognition related to brain injury or long-term substance use. Clients reported that their greatest non-medical needs were related to housing and identification services, and 61% indicated that the program provided support in these areas.

Facilitators and Barriers to Service Delivery

The Downtown CORE team's service delivery was facilitated by its proactive outreach model in which PHNs are meeting clients where they are to provide on-the-spot support, including assistance with appointments and referrals, and advocating for clients. Other factors that supported service delivery included the development of referral pathways and community partnerships, collaboration between TPH and TPS, extended service hours, and the use of an electronic data system.

PHNs reported challenges with linking clients to primary care and other medical services in a timely manner, related to limited availability of low-barrier primary care options. Many clients missed scheduled appointments or were lost to follow-up due to an inability to locate individuals or other challenges such as incarceration.

Other obstacles to service delivery included difficulties accessing services (e.g., fixed appointment slots, multi-step processes, limited housing resources), challenges with PHN recruitment, lack of a physical space to meet with clients when providing care outdoors, and challenges with staying in touch with clients or ensuring seamless transitions to other agencies.

Police constables collaborate with PHNs to support a safe environment for clients, staff, and the broader public. They also have an intended role in assisting with system navigation for services within the purview of TPS such as legal aid, victim services and supports for veterans experiencing homelessness. PHNs observed that several constables developed strong rapport with clients and were able to provide support such as navigating legal issues and responding to client questions. However, the evaluation

identified opportunities to strengthen client-centred and collaborative service delivery by TPH and TPS staff, including continuous learning opportunities to build a shared understanding of client needs, strengthening role clarity, ensuring consistent trauma-informed and stigma-free client engagement, and improving communication (e.g., regular check-ins).

Downtown Yonge Business Improvement Area Evaluation

The Downtown Yonge Business Improvement Area (BIA) is commissioning a separate evaluation of the Downtown CORE program. TPS is engaged in this evaluation. TPH has participated in the evaluation by sharing program data and through staff involvement in the evaluation activities including interviews and focus groups. As of March 11, 2026, TPH has not yet received the BIA evaluation findings. Toronto Public Health will review and consider the evaluation findings once they are available.

Recommendations for Next Steps for the Downtown CORE Program

The TPH evaluation results provide insight into how the Downtown CORE pilot program has been meeting the needs of people experiencing complex health issues and homelessness. The evaluation demonstrates that the program is successful at connecting clients to medical care and social supports, while also highlighting key areas for program refinement and improvement.

Based on these findings, TPH recommends extending the Downtown CORE pilot to September 2027. This will allow additional time to implement enhancements to improve service delivery, continuing to refine and review the program model based on client needs and staff input. This extension would provide opportunities to examine the impact of recently implemented services (e.g., wound care and immunization) and review the staffing model. As part of the recommended pilot extension, and in consultation with staff and partners, TPH is planning a slight adjustment to the Downtown CORE program boundary (Attachment 1) to improve service coverage to better meet clients where they live, gather, and access supports, and to strengthen coordination with key community organizations and City divisions.

Continued Collaboration Across the City

Toronto Public Health works in close collaboration with colleagues across the corporation and within the healthcare sector to improve health outcomes for people experiencing homelessness.

This report builds on previous feedback from the Toronto Public Health's Health and Homelessness Working Table, which met over 2023-2024 and focused on specific health issues or populations, such as healthy environments, chronic disease, and mental health and substance use. Working Table participants emphasized the need for enhanced multi-sector collaboration going forward, as well as improved access to and coordination between healthcare and social services.

Although the Working Table has concluded, Toronto Public Health is currently engaging with Toronto Shelter and Support Services (TSSS), Social Development (SD), Housing

Secretariat (HS), and Toronto Paramedic Services to improve interdivisional outreach and case coordination. TSSS remains a key health care partner as shelters are an incredibly important setting for delivering health promotion, outbreak management and care coordination.

Toronto Public Health will continue working as a strong partner with City divisions and agencies to help prevent and protect against the impact homelessness can have on an individual's health, as we work together to ensure experiences of homelessness in Toronto are rare, brief and nonrecurring.

Toronto Public Health Strategic Impact

This report includes an overview of the health impacts of homelessness and provides an update on the Downtown CORE pilot program.

This report advances the following priorities of the Toronto Public Health Strategic Plan 2024-2028:

2. Promote health and well-being across the lifespan, including reducing the burden of chronic and infectious disease across the lifespan.
3. Promote the conditions to support positive mental health and reduce the harms of substance use, including delivering public health interventions that promote mental health.
4. Advocate to advance health equity, including assessing and reporting on health inequities and population health needs.

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SIGNATURE

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ATTACHMENTS

Attachment 1: Proposed Downtown CORE program boundaries map

- 1 Shelter System Flow Data – City of Toronto
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- 8 Deaths of People Experiencing Homelessness Dashboard, City of Toronto
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18. Ibid
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