Meeting People Where They Are: The S.O.S. Story of Community Impact

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Executive Summary

Supportive Outreach Services (S.O.S.) is a mobile, cross-sector initiative operating in Grey County, Ontario, that brings care directly to individuals facing homelessness, addiction, mental illness, and poverty. Emerging from a grassroots pandemic response in 2021, S.O.S. has evolved into a person-centered, harm reduction-oriented model grounded in mobility, relationship-building, and cross-sector collaboration.

This report presents the findings of a **qualitative assessment** conducted by researchers from the *Centre for Education Research & Innovation (CERI) at Western University*. The goal of the study was to capture and analyze the experiences of those involved in the S.O.S. initiative, both in delivering and receiving services.

Between **January and June 2025**, the study team conducted **31 interviews** (P1 – P31) with a diverse group of participants, including members of the mobile team, staff and leaders from partner organizations, county officials, and S.O.S. clients. Interviews were transcribed and analyzed by the research team. Preliminary findings were then shared with representatives from each stakeholder group, and their feedback was integrated into this final report. The project received ethics approval from the Research Ethics Board at Western University.

The analysis reveals a care model that operates differently from conventional health and social services. It succeeds not because it replicates existing systems, but because it reimagines them. Six key lessons emerged:

1. **Trust cannot be rushed** – Relationships are foundational, not optional.
2. **Partnerships are critical** – Impact is amplified through trust and collaboration.
3. **Leadership creates room for action** – Empowering leaders enable bold innovation.
4. **Flexibility is essential** – Effective care adapts; it doesn't follow a script.
5. **Mobility bridges gaps** – Geography should not determine access.
6. **Sustainability requires investment** – Goodwill is not a long-term strategy.

S.O.S. demonstrates the potential of mobile, grassroots, integrated models to transform lives and strengthen community resilience. As communities across Canada and beyond seek ways to address overlapping crises in housing, health, and social inclusion, the S.O.S. experience offers not just a promising model, but a powerful call to act differently.

Origins of S.O.S.: A Community Steps Up

In the early months of the COVID-19 pandemic, a public health outbreak in a rooming house in Grey County became the catalyst for an unprecedented collaboration. Roughly 30 individuals – many living with poverty, untreated mental illness, addictions, and experiences of sex trafficking – were placed under lockdown when the Public Health Unit attempted to prevent viral spread in a small rural community. Yet what began as an emergency containment measure sparked something far more enduring.

Within 24 hours, multiple agencies rapidly mobilized: healthcare providers, social services, charities, and public health converged to offer care, meals, supplies, and support on-site. For many residents, this was the first time their complex, interconnected needs were addressed in a cohesive, sustained way. According to providers' and clients' accounts, health outcomes improved, crises stabilized, and trust began to grow. As the crisis waned, one thing became clear: going back to "normal" was not desirable.

> *"We started to wind down and we knew we couldn't just go okay. Good luck. We were hearing from the police chief that crime had dropped considerably. And we also heard from public health that the health of the folks had massively improved."* (P2)

That temporary response evolved into **Supportive Outreach Services (S.O.S.)**, a mobile, multi-agency initiative designed to bring care directly to people who have long been excluded from traditional systems. These are individuals who are navigating deep social disconnection.

> *"S.O.S. is an outreach team that travels the county to provide services to folks that most likely wouldn't be provided services otherwise."* (P3)

S.O.S. is built on a **wraparound care model** that integrates harm reduction, primary health services, addiction medicine, housing supports, and social navigation: *"It brings services to the participants where they're needed most"* (P5). Its uniqueness lies not only in what it delivers, but in how: services are mobile, person-centered, and rooted in relationship.

> *"As its name implies, it explicitly provides services for people who do not have access... not only the medical piece, but also the social piece... the essentials of life."* (P6)

S.O.S. was never just a program. It was a response to a failure of existing systems, and an assertion that community services could do better when they acted together. The model proved not only possible but effective.

> *"A group of individuals came together... they built off potentially that paramedicine model... more support to mental health and addiction... outreach providing services in markets, encampments, and rural settings."* (P8)

Since then, S.O.S. has continued to evolve over the 4 years it has been in existence, scaling its operations through fixed-location drop-ins, referred to as "markets", expanding rural coverage, and influencing health system priorities across Grey County. Its ambition is not just to **stabilize lives**, but to **rebuild trust**, restore dignity, and offer a pathway, however gradual, back into systems of care.

> *"Our goal is always to get people to a point where they're able to connect to those traditional services... but also recognizing that some people are not planning to get to that stage right now."* (P22)

At its core, S.O.S. reflects a simple but powerful principle: **meet people where they are – literally and figuratively – and stay long enough to matter.**

What We Do Differently

Mobile Outreach

Mobile outreach in the S.O.S. initiative embodies a flexible, relationship-centered model of care, meeting people geographically – encampments, sidewalks, back alleys, bush trails, and parking lots – and emotionally, by respecting where they are in their lives. This model is designed specifically for individuals who are systemically excluded from traditional health and social services, particularly those who are unhoused, living with mental illness, or using substances.

Described by research participants as "street medicine", this approach redefines accessibility as deliberate presence within people's lived environments.

> *"It is health care where people are. And it's community care where people are.* ***And it's humanizing people where people are. And it's what it is, where it needs to be****, when it needs to be. And if it's just sitting around shooting the breeze and having a conversation and telling stories, that's what it is today. If it's wound care and stitches, that's what it is today."* (P2)

Outreach extends beyond health care, including social support, harm reduction supplies, and trauma-informed conversations. Rather than expecting individuals to visit clinics, the S.O.S. team travels across the county offering both scheduled visits and spontaneous support. As one mobile team member shared,

> "If they can't make it to our market or clinic, ***we'll figure out a way still to see them***" (P3).

The mobile team includes paramedics, nurse practitioners, mental health and harm reduction counselors, and social navigators, each bringing unique skills to a broad spectrum of care, from administering injections *"under a tree"* (P2) to providing ID support or housing navigation. These informal encounters *"that happen in the street"* (P3) build trust and create opportunities for more formal interventions when individuals are ready. As a Grey Bruce public health partner described,

> "When we get a cluster of overdoses in a specific area, often we send SOS to that area and they'll walk the streets and talk to people and offer services and ***maybe one person that they talk to will say, hey, I'm interested in some addiction medicine. I want to cut down my use***. I want to stop my use. How do I do that?" (P15)

By being mobile, S.O.S strives to "*not letting people fall through the cracks*" (P23).

The mobility of the team also addresses geographic barriers in a region with limited public transit. As one participant explained,

> "We operate in a very rural area... people may be in Walkerton and need to come to Hanover, which is 15 minutes away, but ***when all you have is your feet, it can make care difficult***" (P11).

In even more remote cases, reaching people means hiking into wooded areas or working with police and fire services using drones and ATVs to locate individuals in need more efficiently.

> "We've had the fire service take us out in the ATVs to reach encampments that are way into the bush. We've had the fire service also use drones so we can see ***the thermal action of spaces and find people because as you can appreciate, we have a lot of equipment to carry as well***" (P21)

Mobile outreach in the S.O.S. initiative is more than a logistical strategy – it is a principled commitment to presence, responsiveness, and equity. It reflects the belief that people should not have to earn access to care by overcoming systemic hurdles. Instead, as one mobile team member summarized it, "*we're filling a gap of being on the scene with the people in the locations that they are at*" (P22).

Harm Reduction, Respect and Trust First

At the heart of the S.O.S. initiative lies a radical commitment to harm reduction, respect, trust, and dignity. This approach recognizes that individuals facing systemic marginalization – whether through homelessness, addiction, or mental illness – are not problems to be fixed but people to be accompanied. S.O.S. operates from a "doing with" philosophy, rejecting traditional models that "do to" or "do for" people in favor of walking alongside them. It is not about rescuing, prescribing, or demanding change, but rather about forming relationships that enable people to reclaim power over their own lives.

S.O.S team and partners consistently emphasized that trust comes before treatment. As one leader shared,

> *"They don't come for healthcare... They come for a piece of pizza and a pair of socks.* ***Without looking after people's housing, food, basic needs, we waste a lot of time in health.*** *But they know now that when they come and talk to us at our market, that services aren't there to kick them off their caseload. They know that we have their best interests at heart to the best of our ability."* (P1)

These low-barrier interactions are intentional and offer soft entry points for connection. The key message delivered is that *"we don't give up on you"* (P2), highlighting persistence as a core value. Care is offered without expectation of change, abstinence, or conformity. This philosophy demands humility, presence, and patience, because as one mobile team member highlighted:

> *"It's a population that so many people do not understand and have zero respect for... I really want to* ***help people fight for what they deserve. And that is what this team does****"* (P3).

Harm reduction is the cornerstone of S.O.S's work ethic – both for the mobile team and the partners. It means mitigating all the harm – physical, emotional and social – that is incurring in somebody's life. This includes distributing safer-use supplies, advocating in hospitals, supporting people through trauma, and creating spaces for informal conversations. Everybody participating in S.O.S understands that *"you only really feel power operating when you're the one who doesn't have it"* (P13), emphasizing the importance of suspending judgement and restoring agency.

Trust therefore is both a goal and a tool for survival. It signals a profound shift: from treating people as service users to recognizing that *"no matter who someone is, they are worthy and deserving of respectful medical care"* (P23). And receiving the same trust and respect in response become gratifying:

> *"****How incredible it is just to know that this person trusts us that much*** *to call us when the system continuously fails these people over and over again"* (P22).

By consistently showing up and responding without preconditions, S.O.S. models what it means to genuinely *do with*: a quiet but powerful act of solidarity within a system that too often *does to*.

Cross-Sector Collaboration

Cross-sector collaboration is the structural foundation and cultural engine of the S.O.S. initiative. It transcends the limitations of siloed service delivery by fostering trust-based partnerships across healthcare, social services, public health, housing, charitable organizations, law enforcement, and grassroots groups. These collaborations are not just formal or contractual – they are personal, improvisational, and rooted in mutual respect.

As such, S.O.S. thrives because partners don't just share mandates, they share purpose. As a Grey Bruce public health partner explained,

> *"before the crisis, the meetings were more information sharing. Organizations would get together and just say, this is what we're doing.* ***Now, we're working together more than just telling each other what we're doing in our individual silos****"* (P15).

This marked a shift from transactional partnerships toward a network of shared stewardship. If there's a need, acting is a priority, as a Grey County leader described it,

> *"There are groups that talk a lot and then there's groups that do. And I think that* ***this is a group that does*** *and we don't just talk about it. We're action oriented."* (P17).

This integrative approach enables real-time, wraparound responses to emerging needs. Whether a client needs medical care, housing support, food, harm reduction supplies, someone from S.O.S can make it happen, because *"we know who to call… If you want to call the paramedics, I'm calling [Name], I'm not calling a phone number"* (P14), a Grey Bruce public health partner shared.

Relational proximity between partners is what allows them to bring complementary strengths: healthcare providers focus on evidence and outcomes, while community organizations contribute local knowledge, trust, and access, as this hospital leader explained:

> *"We have the access to education and resources. We offer a lot to the team in terms of training, logistical support, data analysis, but then the* ***community agencies bring that ear to the ground nimbleness*** *that's also really beneficial for a project such as this"* (P4)

This fusion makes it easier for people to access what they need, even when they didn't know they needed it: *"They might come for wound care but leave with a tax return or housing support"* (P5). The result is a responsive, resilient ecosystem that recognizes that *"sometimes the infection isn't the emergency. It's the hydro bill"* (P24) and *"that working in silos is not a successful way to bring services to people"* (P16).

Ultimately, cross-sector collaboration in S.O.S. reflects a shift in mindset: from systems working in silos to systems working as one. It models what happens when institutions build trust not just with clients, but with each other.

Low-Barrier and Creative Access to Services

The S.O.S initiative adopts a 'no wrong door' approach, eliminating typical procedural and psychological hurdles. While many traditional services require people in crisis to call, wait, and possibly get delayed callbacks, S.O.S clients are welcomed in any form of contact – walk-ins, informal peer referrals, or even Wi-Fi-based texts – without expectation or pressure for continued interaction.

> *"People are shocked when they* ***get a response in the moment****. We're doing treatment right in the moment"* (P3)

Immediacy and flexibility define S.O.S., allowing for services to intentionally remain low-pressure.

> *"We can help them feel comfortable accessing services and to know that there's no strings attached. Just because you came here today doesn't mean we have to see you again…* ***If this is a one-and-done, that's okay. We're just glad you came****"* (P3).

Barriers are not only removed; they are actively anticipated and worked around. Even structural constraints, like jurisdictional rules or mandates are met with creative workarounds. For example, as a Grey Bruce public health partner illustrated,

> *"The public health standards that we have to work with are pretty stringent and the eligibility requirements for things like naloxone, for example, can sometimes put us in a box where it's hard to get out of. But one thing that we have been able to figure out is that* ***if one group doesn't technically qualify*** *to be a naloxone distributor, then* ***another group or organization does****. "We just find the answer 'yes' however we can"* (P15)

Accessibility also means showing up in familiar places – encampments or community meal sites – where spaces are accommodated to provide services. For instance, at OSHaRE, a backroom intended for cooking classes was repurposed as a clinical space – complete with a sink, examination bed, and equipment – so individuals could meet a nurse practitioner or mental health worker where they already gather for meals. As per OSHaRE's philosophy, *"what we have, we share"* (P20).

Importantly, this flexibility is relational, not just logistical. People are met with compassion, consistency, and openness to possibility: *"you can't burn a bridge, and you can always come back"* (P2). This ethos extends to team problem-solving as well. As this partner explained:

> *"****We're trying to utilize some of our service providers differently*** *and bring them to the patient versus the patient coming to them when possible. Of course, that's not always going to be the most efficient thing, but it might be the more efficient use within our healthcare system when we're avoiding some of these unnecessary admissions and things like that"* (P12)

Low-barrier access, in the S.O.S. context is about dignity. It rebuilds trust in systems by showing up, saying yes, and making care easy to reach. The mobile team's and partners' breadth of lived experience and professional backgrounds make them realize that *"the tools that worked in the past are not fit for the challenges we have today"* (P18). S.O.S. meets that challenge by rewriting the rules both for efficiency and equity.

Quick Action, Continuity and Presence

S.O.S. operates with a rare combination of urgency and reliability. These qualities are essential when serving people who have experienced deep systemic neglect. The S.O.S's responsiveness isn't hindered by bureaucratic delays; immediate action is a cultural norm. As this mobile team member described it:

> *"We are of the opinion that* ***if somebody is ready for treatment tonight, we're going to treat them****. We're not going to sit around, have a conversation and check back in with you in two weeks"* (P10).

Consistency complements responsiveness, creating a dependable presence that becomes a lifeline: *"They know when we'll be there"* (P1). This responsiveness is supported by hyper-communication and decentralized leadership. From daily morning huddles to multi-agency events, partners stay coordinated and informed. Decisions are collaborative rather than unilateral: *"we make these decisions together"* (P9).

A dependable presence contributes significantly to trust-building with the clients. As one partner reflected, *"that's something that's been built over the four years we've existed"* (P22). S.O.S is not a new proposal or pilot. While partners had to navigate and negotiate corporate discrepancies, its longevity stems from sustained commitment and visibility. When crises occur, the response is collective and immediate. For example, as described by an S.O.S leader, during a fire that occurred in 2022,

> *"by 7am we had the church already available to us, called the police chief, called housing, called victim services. We already had nurse practitioners and mental health counselors, and our SOS team was going right to the site.* ***We literally set up an evacuation center in about two and a half hours****, fully supported with meals because OSHaRE showed up with food"* (P10).

However, S.O.S. doesn't just respond to emergencies, it stays, as illustrated by a member of the police service,

> *"I think it persisted because the community recognized the significant impact that it made* [during the Covid outbreak]. ***Our calls for [police] service dropped dramatically over that time*** *when everybody's basic needs were met."* (P5)

S.O.S offers continuity rarely seen in other systems. S.O.S partners described how returning clients are greeted with warmth and familiarity, without paperwork or repetitive questions.

> *"Someone might come, they might go through our intake process, they might use our service and then we don't see them for four months and then* ***when they come back it's almost like a welcoming party****, great to see you, where are you at? and how can we move forward?"* (P21)

This rhythm of quick action and enduring presence arises from shared purpose instead of rigid structures. That shared purpose – the kind that prompts people to answer the phone at 5 a.m. or on Christmas Day – is built not from mandates but from continuously showing up. Ultimately, continuity stems from commitment. By responding quickly, staying close, and refusing to give up, the S.O.S. team becomes more than a mobile outreach program. It becomes a dependable presence in an unpredictable world.

Lessons Learned

Trust Cannot Be Rushed

Trust cannot be commanded, expedited, or assumed; it must be patiently and persistently earned.

Especially among those who have been repeatedly let down by health, social, and legal systems, trust is a fragile and hard-won currency. It is not built through credentials or program flyers, but through quiet, relational moments: returning texts, remembering someone's name, or sitting in an emergency room during a crisis. As one client and one mobile team member described,

> Client: "***She saved my life***. *COVID happened. I lost my job. I was 18 weeks waiting for an appointment. I had no money. I went back to my old safety net dealing drugs and I fell back into that trap and I lost my housing. I lost myself. I was going to kill myself. I wouldn't be here if it wasn't for [Name].*" (P29)

> Mobile team member: *"We saw each other a few times before in public space settings. We didn't really talk much, and then one day he came to me, and he was like, "I'm not in a good space", and that was a click, I think.* ***We bonded very much over that, and I took him right up to the hospital. I sat with him the whole night and got him into his bed, and told him "you're safe, and everything's good, and I'll come check on you"****, We just clicked from there. When he received Sublocade (extended-release Buprenorphine injection) the next day, it completely transformed his life."* (P31)

Both S.O.S. mobile team and partners understand outreach is not a transaction; it's an act of solidarity. Not all the time is about offering a treatment, S.O.S might be approached because *"you're just someone they feel comfortable talking to"* (P3). These seemingly small offerings are acts that say: you matter here. Therefore, trust begins with presence, as one partner shared:

> *I know some of the folks that drop in here that are unhoused and are looking for resources. Sometimes they want to just talk. And OK, let's sit and have coffee because* ***I don't want the only interactions you and I have to be transactional****, that you come in and go. Do you have any socks? Do you have a backpack? Do you have a coat? Tell me about your day so that when I see them in the community on the weekends, it's hi, [Name]. How's it going? What are you doing?"* (P2).

Trust develops slowly, often over months of intermittent interactions. Clients may step away and return months later. This engagement requires humility to realize that *"it's a privilege to gain the trust of folks who have great reasons to hate healthcare providers"* (P9). S.O.S understands that many clients are not ready, or able, to immediately accept help. And that should not be equated to failure, but rather an understanding that it's not going to be successful right away, as an addictions physician remarked,

> *"People often are not going to be banging down your door, right away. It* ***takes a lot of time when you're starting something from the ground for it to actually pick up*** *but oftentimes all it needs is rethinking about, is the word out? have you communicated to the right people? are you actually engaging people?"* (P24).

This approach also demands reflection on the role systems have played in creating mistrust. *"We as healthcare providers were part of that system that made them disengage"* (P24). S.O.S. strives to break this cycle not by promising change, but by being the change: showing up, again and again, without pressure.

> *"Our team would not need to exist if everybody just got clean miraculously overnight but I think the harsh reality of addiction is that there are people who are going to grow up in this environment, live in this environment, and die in this environment because* ***that's their choice****"* (P22).

Ultimately, this lesson reframes success. It's not measured by appointments kept or referrals made, but by whether someone felt safe enough to return. *"The staff is always warm hearted and open minded. It's like talking to a friend more than to a professional. Sure, when I look at [Name], I see the uniform. But there is a person behind that uniform."* (P29) one client remarked.

This kind of trust, built slowly and with care, is the foundation for meaningful engagement. Trust, therefore, is not a prerequisite for outreach; it is its product. It grows quietly, in small moments over coffee, on sidewalks, and in the cumulative weight of simply being there.

Partnerships Are Critical

Strong partnerships, based on personal relationships rather than formal agreements, enable rapid, collaborative responses.

The work of S.O.S. is complex – and intentionally so. It addresses the layered needs of its clients. No single agency can do this alone. That's not a limitation. It's a lesson.

For S.O.S, knowing each other's names and numbers ensures seamless coordination across health care, social services, charitable organizations, and emergency response agencies. What makes S.O.S. work is not a single model or method, but an alliance: organizations, leaders, and front-line staff who bring their mandates to the table and are willing to stretch, adapt, and collaborate for the sake of community impact.

"*Relationships are everything,*" one S.O.S leader stated plainly (P1). This was echoed across roles and sectors: what sustains the work is not hierarchy but proximity and mutuality – from choosing to sit at the same table and act together. Whether it's distributing harm reduction supplies, addressing eviction, offering counseling, or running wound care clinics, each partner brings a unique strength. This approach was first evidenced during the Covid outbreak, as one partner described:

> *"what came out of that was that collaboration where* ***we all brought what we had to the table and made it work****."* (P20)

For an initiative like S.O.S. to succeed elsewhere, this kind of relational infrastructure would need to be cultivated with as much intention as the services themselves. Realizing that *"we don't need to hire more; we need to collaborate better"* (P24), is a good place to start.

Collaboration, however, doesn't come automatically. It requires conscious attention to power dynamics. Partners spoke candidly about early conflicts over different meanings of words, priorities, and values. As they recalled, *"the first year was muddy... corporate values did clash"* (P9). Progress came when partners committed to flattening hierarchies, embracing discomfort, and co-defining goals. Intentional strategies, such as hiring an external consultant, proved effective in helping the group reach such commitment, as one leader of a partner organization explained:

> *"We weren't really doing a great job of listening and understanding each other. that's when I thought let's see if we can get [Name] and everyone agreed.* ***[Name] did a fabulous job of helping everybody hear each other and understand each other's perspective****. [Name] met with the team for a full day workshop, another meeting after that and then we decided to hire her to go in on the huddles once a week just to keep everybody moving forward with the direction. And then we just never had any issues after that."* (P4)

Interdependence becomes even more critical in settings where resources are limited and silos can become walls. *"Take away all your resources,"* said one charity leader, *"and then you have to be connected"* (P2). The strength of S.O.S. lies in how its partnerships don't just share referrals; they share responsibility. In moments of crisis, they know who to reach out to because *"no one wants to go back to finding their clients alone"* (P14), as a Grey Bruce public health partner shared.

This lesson highlights that partnerships aren't just helpful; they're foundational. In rural, resource-limited settings, collaboration is the only way to deliver responsive, humane, and effective care. S.O.S. shows what's possible when organizations stop protecting their turf and start building common ground. Misunderstandings can arise when one agency assumes it understands the scope or accountability of another. These boundaries must be acknowledged and worked through in real time. Successful collaboration depends not only on shared goals, but on the willingness to engage in ongoing negotiation and mutual learning.

At its best, the S.O.S model brings together a wide range of agencies – each with different mandates and operational cultures – into a shared platform for collective problem-solving.

Leadership creates room for action

Effective leadership must be relational, not hierarchical, characterized by actively clearing roadblocks, empowering team actions, and modeling collaborative decision-making.

S.O.S leaders didn't just "greenlight" initiatives; they got their hands dirty, responded in real time, and created the conditions for others to lead. This form of leadership allowed S.O.S. to move quickly and adaptively, especially in the uncertainty of crisis. As a Grey County leader described,

> *"**I'm there to open the doors and clear away the roadblocks** and set the table for success—and keep them safe from things going sideways"* (P17).

This attitude translated in trust and respect for the frontline staff. If the frontline said something was a problem, they were believed by leadership. If they wanted to try and solve a problem in a particular way, leadership let them and encouraged them to do what was needed to make it work. This is an unusual 'style' of leadership. It was less about micro-managing and more about providing support for what the frontline needed to get the work done. As one mobile team member described:

> *"if there's anything that we need help advocating on a different level, because if you have to take an issue up to the head of [Organization], a frontline worker is going to get nowhere. You need people at the same level to talk to each other and sort the issue out. So that's really helpful for us **to know that our leaders have our back and can help us navigate some of that stuff**."* (P11)

Flattening the hierarchy became a value that trickled down to the mobile team as well. It helped then navigate the diverse nature of the team, where *"we make decisions together, whether you're an unregulated provider or a regulated professional... that really helps"* (P9). S.O.S team and partners repeatedly emphasized that strong leadership must be grounded in care, not position.

> *"Strong leaders are everything, **people who give a damn about what we're doing** and how much of an impact it will make"* (P22).

Importantly, S.O.S. wasn't driven by one visionary. It was carried by what many described as a "coalition of the willing." Leaders across paramedicine, healthcare, public health, social services, and charities shared a commitment to the work and to one another. *"Everyone really trusts his vision... and he got all the leaders on board,"* a leader of a partner organization noted (P12). And when leaders are on the same page, navigating uneven mandates and scope of boundaries becomes manageable, as one partner explained:

> *"Because of scenarios that have come up with SOS and trying to figure out which agencies do what and what's a good referral and what's not... **we don't want to send somebody in the wrong direction and then have to go to four different doors** to get a solution"* (P10).

The goal at the leadership group is not to erase the differences among organizations but to bridge them with humility and solidarity. The ripple effects of this approach have extended beyond S.O.S. itself. Paramedic practices changed, new space-sharing agreements were formed, and community councils created room for deeper dialogue, as illustrated by a Grey County leader.

> *"We struck a community services committee of council... **a safe place where we can have conversations about community-level issues**. You can't do that in a 10-minute delegation"* (P17).

The leadership that shaped S.O.S. – both the operational leaders that made things happen and the community leaders that backed them up – wasn't about having all the answers. It was about creating the space where others could lead, adapt, and thrive. *"Every community should have a [Name] and a [Name]. People who are willing to try"* (P12), said one partner. That willingness, and the integrity behind it, turned possibility into action.

Flexibility Is Essential

Flexibility across organizational, philosophical, and relational dimensions enables responsive care by adapting practices in real time to meet unpredictable community needs.

In contexts marked by instability, trauma, and system fatigue, rigid structures fall short. What S.O.S. demonstrates is that the need to adapt is

not a failure of planning; it is a strength of practice. Partners and frontline don't wait for perfect conditions. They know it's about doing the right thing, not waiting for permission to do it.

> *"If we wait for all the funding or policies to line up, things are never going to happen.* ***This group made it work with no dedicated funding at the start****"* (P7).

This adaptability is evident in practical choices. A backroom at a charity organization became a clinical space because *"that's what the community needed"* (P20). Similarly, in the earlier months as the Covid outbreak persisted, S.O.S learned what to pay attention to and how to work around the routines of the clients. For example, as one partner explained,

> *"The food was too healthy for their systems, which was an interesting thing to explore, so we added a little more junk food back in. We also started paying attention to the sleep cycle. So, breakfast at nine o'clock? They're not awake till 11am, so breakfast is at lunch, lunch is at 2pm, dinner is at 5pm, snack is at 10pm. And* ***that's how we shifted with the patterns of the building. We didn't try and make the building fit us****"* (P2)

Flexibility also shows up in team dynamics. Rather than being confined by job descriptions, mobile team members and partners stretch into one another's roles. *"If one organization can't do it, another one probably can,"* a Grey Bruce public health partner noted (P15). This mindset supports *"smearing the boundaries"* between agencies (P8), fostering shared responsibility and collective intelligence.

Sometimes, adaptability means bending formal rules. Many spoke of using relationships to bypass red tape: calling a contact directly, sharing informal updates, or reframing a request just enough to make it doable. As one person put it, *"I don't take no very well... if it's no this way, I reframe the question"* (P11). Multiple partners spoke about the willingness to use workarounds to navigate rooted barriers.

> *"Each agency has their own regulations and often one inhibits the activity of another...* ***these workarounds break the barriers down a little bit****"* (P5).

S.O.S. deliberately avoided the bureaucratic tendency to spend months planning through paralysis. As one leader said, the team had to *"tighten down the bolts as they fly"* (P1). This responsive improvisation has become a sustaining cultural feature. Not every idea works, and that's accepted. The goal is not perfection, but responsiveness, creativity, and commitment.

> *"We'll try to do this.* ***We'll get it wrong a bunch of times and we'll try again****... that is also a really critical piece, having a team that's willing to try."* (P12).

This isn't disorder; it's dynamic competence. Partners stay aligned with their mission even as their methods evolve. When people don't fit systems, systems must bend. *"We're doing things we've never done before, with people we've never worked with,"* one partner observed (P18). That willingness to adapt – not just once, but again and again – is what makes care both possible and real.

This lesson reframes flexibility not as a lack of structure, but as a form of competence. It requires judgment, courage, and trust to let go of rigid plans and instead meet reality as it unfolds.

Mobility Bridges Gaps

Mobility bridges geographical, systemic, and relational gaps, enabling access and building trust by bringing services typically unreachable by conventional means.

In rural and under-resourced regions, where public transportation is minimal or nonexistent, mobility becomes a structural solution to systemic exclusion. *"We don't have any public transportation that can get you to every part of the area,"* one Grey Bruce public health partner explained. *"Just that SOS will go where they're needed is incredible"* (P15).

By moving through towns, backroads, encampments, and informal gathering spaces, the mobile team collapses both physical and psychological distance. This presence changes what's possible. It allows people to access care who might never walk into a clinic or might have been left behind, as illustrated by one client.

> *"I'm from Owen Sound, I've been here for 23 years, grew up in the community. Originally back in like 2021 is when I was first homeless and then just like throughout coming to OSHaRE and Safe and Sound, I ran into the SOS ladies. I was diagnosed first with anxiety and depression when I was 18. I guess, over the past like 12 or 13 years dealing with addiction issues and stuff.* ***Once it's new at first, you know, it's skeptical, right? But more and more people feel more comfortable with S.O.S.*** *When I had my seizures, my friends didn't even know whether to get some help.* ***They left my apartment with the door open and just left me there because they were worried about being arrested. It's changed a lot over the past couple of years.*** *Whenever I see them, pretty much just stop and say hi. It's phenomenal."* (P28)

But mobility is more than a delivery method; it's a mechanism for relational engagement. The mobile team meets people where they are – literally and emotionally – and stay with them through moments of crisis or hesitation. *"One of the really good stories,"* recalled a provider, *"was someone we met living under a bridge. He got housed, got on Sublocade (extended-release Buprenorphine injection), and eventually went back to work and reconnected with his son"* (P3).

Mobility also allows S.O.S. to function as a transitional layer: not quite crisis response, not quite long-term care, but the connective tissue linking people to both. *"SOS is kind of that engagement piece"* (P24), one addictions physician noted. This was evident at the end of the Covid outbreak when S.O.S itself became the transition plan to be able to continue supporting clients, as one leader described,

> *"We came together as a team to respond to the emergency. And then we ended up coming once a week and then once every other week.* ***And that's when we stayed****."* (P10)

The mobile team serves as a portal through which clients can access a range of services: housing, addiction treatment, ID support, and mental health care, often in a single encounter. It also facilitates real-time collaboration among agencies that rarely operate side by side. As one partner indicated, *"we're kind of the middleman that connect the services"* (P25).

Because the team moves, it can respond to gaps that other agencies cannot. For example, during a situation where a woman was fleeing sex trafficking, the mobile team stepped in and filled the gap, as one partner organization leader described.

> *"Last week they phoned me because they were trying to get a cab for a woman who was fleeing a trafficking situation in [Town]. And, they end up going and picking up the woman. They cannot just drop everything and do it, but in the absence of there being anything local for that,* ***they're definitely picking up the pieces****"* (P16)

This capacity to pivot is grounded in deep trust and a shared belief that care should not depend on geography, paperwork, or eligibility criteria.

Mobility in the S.O.S. model is an equity strategy. It shifts the burden from the person to the system. It turns access into presence. It bridges otherwise disconnected organizational mandates. And it proves what's possible when care is designed to move toward the people who need it most, in the ways they can actually receive it.

Sustainability Requires Investment

Sustainability depends on consistent investment – not only financial, but structural, educational and emotional – to maintain service continuity, bring awareness, prevent burnout, and support effective collaboration.

While the S.O.S. initiative emerged from grassroots energy and urgent community need, its long-term viability cannot rest on goodwill alone. Participants consistently emphasized that despite the passion and dedication of the team, sustaining impact over time requires infrastructure, education, policy support, and stable funding.

> *"I hope we go seven days.* ***It is just so disheartening to leave on a Thursday afternoon leaving people in the lurch for Friday, Saturday, Sunday****. It's really challenging to come in Monday and see, perhaps who has passed away. That's probably one of our biggest emotional struggles. All the work we do Monday to Thursday that falls apart on Fridays."* (P9)

The need for 7-day service is urgent. The sorts of problems marginalized groups experience are not restricted to Monday to Thursday 0800-1600 hours or can't wait until Monday or for an appointment in 2 weeks. Therefore, the lesson is about recognizing this model as essential, not auxiliary, which requires investment.

S.O.S. has proven that mobile, community-based care is a vital part of a resilient and equitable system but cannot happen when services are offered in silos. Isolated medical interventions are insufficient when housing, income, food, and trust are also in crisis.

> *"People say, why does this keep happening? Well, it's because the system's broken. We look at it one piece at a time, not as a system. Sometimes healthcare, we always think that we're most important and we have it all figured out and we don't.* ***There's an opportunity out there around municipalities and charitable organizations but if you don't engage them, nobody knows any different****."* (P1).

Without sustained backing, however, this opportunity remains vulnerable to burnout and under-recognition. *"Funding is always number one. People don't like it when they don't have job security. That's really hard on our team to sustain"* (P22). Mobile team members and partners also spoke to the need for emotional sustainability. The work is emotionally heavy and it doesn't just impact clients. It lives in the bodies of the people doing the work. *"Being self-aware to get the right support... these are all really important, serious things we should be talking about more,"* one partner shared (P21).

Beyond workforce investment, sustainability also requires systems-level infrastructure. Many S.O.S members highlighted challenges caused by fragmented documentation and data systems. As one mobile team member explained,

> *"We all document on different systems... I can't see EMS notes, they can't see ours, it's a big barrier"* (P21).

Shared digital infrastructure, though less visible, is critical to supporting integrated, interdisciplinary care. All the members in the mobile team need to be recognized as being within the circle of care and be able to access and document on a shared information system. While this issue is partially a legislation and partially a silo 'culture', the need for access is a must for efficiency and for good care.

Finally, sustainability depends on shifting public understanding and reducing stigma. Participants noted how political resistance and community misunderstanding impede both funding and public support. Building political and community will require ongoing public education about the deeper realities behind visible suffering. One client shared what it feels from their position:

> *"People look at you differently. I enjoy the shock that people have when they look at me, because I always get the* ***"you're too pretty to be homeless"****. Even when people hear that I'm homeless, they look at me and you can read their face. That's what they're thinking.* ***But homelessness doesn't decide who gets to be homeless or not.****"* (P27)

Changing that narrative – publicly and politically – is part of the work. Because sustainable funding flows where trust and understanding exist, this should start by acknowledging that there are different perspectives in the community's understanding as to what causes people to become marginalized and what is effective in changing it. *"There hasn't been a lot of community interest in mental health or addictions until SOS came along. And I think it's giving people an understanding"* (P4) of what it takes, one partner leader highlighted. As an addictions physician also illustrated,

> *"I think sometimes I've seen a Rapid Access Addiction Medicine (RAAM) will open up and then for a month we won't see many people and it gets shut down. But I don't think enough time has been given.* ***It takes a lot of time when you're starting something from the ground for it to actually pick up*** *and then you're overwhelmed, like SOS is now, right. It started slow but then word got out, it built trust, people know that they can come and will be dealt with. So now they've got hundreds of people coming to their market"* (P24)

If other communities want to build something like S.O.S., they need a long view, a strong backing of community leaders, an appreciation for improvisation and a willingness to invest in it. As one partner said plainly: *"If another community wants to do it, don't think that you're going to fix everything if you're not actually resourcing it"* (P13). That's the heart of this lesson. Innovation cannot rest on enthusiasm alone; it requires backing. And it demands stable investment in people, infrastructure, relationships, education and the trust that holds it all together.

Call to Action

S.O.S. has shown what's possible when systems move toward people – when care is mobile, relational, and rooted in trust. It is not just a model; it is a commitment to dignity, presence, and equity in places where those values have too often been absent.

That commitment was recognized in 2024 with the *Ontario Health System Quality and Innovation Award* in the Population Health category. This provincial honour affirms what S.O.S's mobile team, partners, and clients already knew: S.O.S. is not only changing lives; it is reshaping what effective, compassionate, and integrated care can look like.

Now, the question is not whether S.O.S. delivers what is purported to deliver; it's whether there's courage to sustain it.

With the support of community champions, partners, funders, and policymakers, S.O.S. will be able to continue to innovate and grow to ensure that no one is left behind simply because they are hard to reach.

It's time to start building the kind of system that shows up... and stays!

Stories from the Field

Personal stories like these are at the heart of S.O.S.'s perceived success: building trust with individuals who have traditionally been left behind, and restoring dignity, access, and hope through mobile, compassionate outreach.

Beyond the Meal: What Collaboration Makes Possible

At OSHaRE, the work began with meals. Twenty-five thousand of them, delivered to community members who needed nourishment, routine, and care. But for years, the question lingered – spoken out loud or implied in passing:

"So, you're just feeding them. How are you helping them get better?"

The question was well-meaning but incomplete. The truth was, hunger was never the whole story. Guests weren't struggling because they didn't know how to cook. They were struggling because they had no food to cook, no fridge to store it in, no roof to keep it safe.

"They need food before they can cook."

That's where S.O.S. came in.

With S.O.S., the landscape changed. Meals became a starting point, not a finish line. Now, OSHaRE staff could say: yes, we provide food. But also, we connect people with mental health support. With housing. With ID clinics, addiction care, transportation, even help with paperwork. And we do it together: in one room, in one system of trust.

"Now I'm able to talk about that collaboration... mental health help, financial help, housing help... all of us in one room."

The ripple effects of this model reach beyond clients to the surrounding community. OSHaRE works closely with nearby businesses – warning them when a large event is planned, checking in about concerns, cleaning up afterward. But the tension remains. Some still struggle to see the long arc of change. They want immediate fixes. They want the discomfort to disappear.

"We try and pull them into understanding the bigger picture... but definitely, we have some businesses who struggle with understanding how it's making a difference."

The staff at OSHaRE see that difference every day. It's not always dramatic. Often, it's small: a guest showing up again. Asking for help. Making eye contact. Trusting.

That's what S.O.S. made possible – not just a service, but a shared language of care.

"I Know the People Who Can Help You"

The call came from a client.

Not a caseworker, not an agency - just someone who had once been helped by S.O.S. and now saw someone else in crisis. A woman was being trafficked in a town outside the formal geographic boundary of S.O.S.'s mandate. She didn't know where to go. But someone who barely knew her did.

"I know the people who can help you."

For the S.O.S. team, there was no debate. Geography might define services on paper, but it doesn't define community or obligation. "*That's just not an option to say no to that,*" one team member said.

So, they mobilized.

Each of the team members played a different role. One sat with the woman and called the local women's center, helping navigate her path to shelter. The social navigator contacted housing authorities to flag the unsafe unit where she'd been held because others might still be inside. Another team member drove her to safety. The nurse practitioner assessed her for opioid withdrawal and offered medical support. The woman chose to detox on her own – an act of quiet defiance and extraordinary strength.

But the journey didn't end there.

After an altercation at the shelter, she found herself unhoused again. It was unacceptable to the team. She was too high-risk to be left behind. So, they reached out to victim services. No one waited because it wasn't within their 'mandate'. No one asked, "Whose job is this?"

"Someone was thinking about X, someone else about Y... without all of us, I don't think it's possible."

It wasn't just the actions that mattered; it was the source of the call. A peer. A client. Someone who had experienced S.O.S.'s care firsthand and believed in it enough to pass it on. That one call captured everything this model stands for: presence, trust, humanity, and the knowledge that someone will answer when you need help, even if you're not on the map.

No Closed Door

Her job started with socks and soap. Just the basics: hygiene kits, warm clothes, the essentials someone needs when they're coming out of trafficking or rough sleeping. But as the needs deepened, so did her role. Today, the social navigator is a quiet powerhouse within the S.O.S. team, helping people rebuild not just stability, but identity.

She now runs the ID clinic.

"Sometimes that means digging into CAS records. Sometimes that means calling friends and family."

She helps people get their birth certificates, health cards, photo IDs, and SIN numbers – documents that most people take for granted, but which are essential for accessing housing, income support, and a bank account. Without ID, there is no entry point. With her, there is.

When someone reaches a stable point – housed, on medication, mentally ready – she begins the deeper work: life skills, self-reflection, coaching.

"Can they sit with themselves? Do they know what drives them? Do they know what their values are?"

It's delicate, trauma-informed work. Sometimes it means helping someone file court paperwork to get their kids back. Sometimes it's advocacy with Ontario Disability Support Program (ODSP) for medical transportation. Sometimes it's driving them an hour away just to ensure a form is filed in time. The list is long, but she doesn't flinch.

"My role is kind of all over the board. I fit in wherever everybody else doesn't."

And she gets it – deeply! Because she's been there. She's been unhoused, struggled with mental health and knows what it took to give up her children and get her kids back. That lived experience shapes how she listens, how she shows up, and how she respects people who aren't ready yet.

"Sometimes we have to remember that we have to take a step back."

But S.O.S work extends beyond individual support. S.O.S. mobile team and partners know that referrals alone aren't enough if they send someone on a four-door goose chase. So, Grey Bruce United Way, one of the major S.O.S partners, created something new: The Unmuting – an annual gathering where representatives from every agency come together, share real client scenarios, and map what each one can and can't do. Sticky notes become systems change.

"So that we know... they can give you X, Y, Z—but they can't give you A."

Now, when S.O.S mobile team calls a partner, doors open.

"Honestly, I can call almost any agency and say, 'Hey, it's [Name] from S.O.S.,' and hear: 'Great. What can I help you with?' There are few closed doors at this point."

This is the S.O.S. model in action: care that starts with socks and ends with systems-level trust. It's not just what S.O.S does; it's what it represents: a community that finally works together.

“I Was You Five Years Ago”

It started with a conversation in the field – just a check-in between a member of one of the partner organizations and a client.

“On Tuesday, when I go to AA, I’m getting my 30-day chip.”

Everything stopped.

The S.O.S partner paused, met his eyes, and said what so few had probably said before:

“Oh my God, that’s fantastic. Congratulations. That’s a lot of work.”

And in that moment, something shifted. The man lit up. His story poured out: how he’d come up from Guelph with a friend, both of them hoping to get clean. But when his friend chose to keep using, he asked for a separate motel room. He didn’t want to risk sliding backward.

“Sure, no problem,” they said. “We want to help.”

The S.O.S. team supported him into housing. A local partner helped furnish his new apartment—sourcing what he needed from nearby thrift stores. Simple things, maybe. But to him, it meant everything. It meant his kids could visit. For the first time in a year, he would be a father with a home.

And then, at an AA meeting, while sharing his story, another man approached him.

“I was you five years ago. I now own my own business. I’m a bricklayer. You got a job? Come work for me.”

A full-circle moment. A person lifting another. A chain of lived experience and earned trust.

The service provider who witnessed it was speechless – goosebumps and awe.

This is what S.O.S. makes possible. Not just shelter, not just services, but space for transformation, dignity, and hope. A model that says: you are not alone. Your story matters. And someone who has walked your path is ready to help you take the next step.

From Panic to Purpose

When she arrived in Owen Sound, she didn't know where to go or who to trust. She had been dropped off in front of the women's shelter in the middle of the night with all her belongings after being kicked out by her ex-partner. It was a state of complete disorientation – she'd only spent an hour in the town before being stranded. By sunrise, panic was setting in fast.

That morning, someone called S.O.S. Within hours, she met the team that would change her life.

They didn't come with forms or judgment. They came with a tent, sleeping bags, tarps, and kindness. They helped her find a place to pitch her tent safely, showed her where to go, and most importantly, reminded her she wasn't alone.

"I see them every two weeks, if not more," she said later. *"They've listened to me cry, complain, laugh and they always show up."*

She quickly became more than a recipient of services. She became a bridge in the community. She started collecting drugs from others and bringing them for testing to keep her peers safe. *"It was a safety thing,"* she said. *"If you know what's in the drug, you know how to help someone who's gone down."*

She became a go-to person. *"People won't go to professionals,"* she explained, *"but they'll come to me. Then I take what I hear and I bring it to S.O.S., so they can help, without people needing to ask."*

S.O.S. met her needs beyond immediate survival. When her prescriptions were stolen, they provided replacements. When she had infections – dental, bladder, even a cat bite – they made sure she got the right treatment, on the same day. When she lost her glasses, they helped her get a new pair. *"Not being able to see is terrifying when you're homeless,"* she said.

But it wasn't just material support. S.O.S. offered her something deeper: trust. They remembered her name, her story, her needs. *"That's the difference,"* she said. *"You walk into most places and you're just another homeless person. Here, I'm* [Name]."

She started spreading the word. She reminds people when it's market day. She pitches services to others like a passionate ambassador. She'll tell you where to go for groceries, how to use the drug testing machine. *"I'm the loudspeaker for people who are too scared to speak,"* she joked.

But what's not a joke is how close she came to falling through the cracks. *"If S.O.S. hadn't been there that first morning, I don't know what would've happened,"* she said.

Now, she's a leader in her community – still navigating homelessness, still facing daily hardship, but holding space for others. *"We're a different kind of community,"* she said. *"Most people don't understand us. But S.O.S. does."* And in a world where she once couldn't see the road ahead, she now walks it with clarity, connection, and purpose.