Court File No. COA-25-CV-0166

COURT OF APPEAL FOR ONTARIO

B E T W E E N:

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Appellants

- and -

CITY OF HAMILTON

Respondent

APPELLANTS' APPEAL BOOK AND COMPENDIUM – VOLUME 8

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Court File No. CV-21-00077817-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, ET AL.

Applicants

-and-

CITY OF HAMILTON

Respondent

AFFIDAVIT OF STEPHEN GAETZ

SWORN JUNE 14, 2022

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colborne

I, Stephen Gaetz, of the City of ~~TORONTO~~ in the Province of Ontario, AFFIRM AND SAY:

1. I have personal knowledge with respect to the facts set out below, except where stated otherwise. Where the information is not based on my personal knowledge, it is based upon information provided by others which I believe to be credible and true.

Credentials and Nature of Work

2. A copy of my *Curriculum Vitae* is attached hereto as **Exhibit "A"** to my affidavit.

3. I am a full Professor in the Faculty of Education at York University, in Toronto, Ontario, where I have been on the faculty since 2000. I am also President and CEO of the Canadian Observatory on Homelessness ("COH"), a research institute with a mandate to work in collaboration with partners to conduct and mobilize research to have an impact on solutions to

homelessness. [1] As President of the COH, one of my key projects is the Homeless Hub (www.homelesshub.ca), an innovative web-based research library internationally recognized as a leading example of innovation in knowledge mobilization. I also co-lead, and am Scientific Director of, Making the Shift – A Youth Homelessness Social Innovation Lab ("Making the Shift").[2] In 2021, the United Nations Economic Commission for Europe established the Toronto Centre of Excellence on Youth Homelessness Prevention at Making the Shift.[3]

4. I have had a long-standing interest in understanding homelessness – its causes, how it is experienced, and potential solutions. My interest began when I worked in the homelessness sector for seven years in the 1990s, which gave me extensive insight into the causes and conditions of homelessness, as well as institutional responses to homelessness. My expertise extends to the structure and operations of the homeless shelter system. I began to develop this expertise when I worked at the Shout Clinic (1993-1999), where I focused on youth homelessness, and at the Queen West Community Health Centre (1999), where I focused on adult and family homelessness. In both positions I regularly visited emergency shelters for youth, adults and families. Since that time, I have continued to visit emergency shelters across Canada and internationally and have developed further expertise on the characteristics and operations of shelters, as well as on the perspectives of individuals and families who use them because they are without housing.

[1] "About Us: Canadian Observatory on Homelessness," Homeless Hub, 2021, https://www.homelesshub.ca/about-us/about-the-coh#:~:text=The%20Canadian%20Observatory%20on%20Homelessness%20(COH)%20is%20a%20non%2D,with%20lived%20experience%20of%20homelessness.

[2] "What is Making the Shift: Youth Homeless Innovation Lab," Making the Shift, accessed June 5, 2022, https://makingtheshiftinc.ca/what-is-making-the-shift/.

[3] United Nations Economic Commission for Europe, "UNECE Establishes Toronto Centre of Excellence on Youth Homelessness Prevention at York University," June 16, 2021, https://unece.org/housing-and-land-management/press/unece-establishes-toronto-centre-excellence-youth-homelessness.

5. My program of research has been defined by my desire to "make research matter" through conducting rigorous scholarly research that contributes to our knowledge base on homelessness and is mobilized so that it has an impact on policy, practice and public opinion. In particular, I focus on research designed to move away from our current response which focuses on emergency services and supports such as shelters and day programs to a response that focuses on prevention and sustainable exits from homelessness. As an internationally recognized leader and innovator in the area of knowledge mobilization, I have pioneered efforts to bring together researchers, practitioners, policy makers and people with lived experience of homelessness to participate in a broad agenda of community-engaged scholarship and knowledge creation designed to contribute to solutions to homelessness. In 2016 I was awarded a Research Impact (Connection) award by the Social Sciences and Humanities Research Council of Canada, and in 2017 I was made a Member of the Order of Canada.

Defining homelessness

6. The Canadian definition of Homelessness is as follows:

> Homelessness describes the situation of an individual, family or community without stable, safe, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it. It is the result of systemic or societal barriers, a lack of affordable and appropriate housing, the individual/household's financial, mental, cognitive, behavioural or physical challenges, and/or racism and discrimination. Most people do not choose to be

homeless, and the experience is generally negative, unpleasant, unhealthy, unsafe, stressful and distressing (1). [4]

7. Homelessness describes a spectrum of housing and shelter circumstances, with people being without any shelter at one end, and being insecurely housed at the other. This spectrum includes:

a) **Unsheltered**, or absolutely homeless and living on the streets or in places not intended for human habitation, including encampments;

b) **Emergency Sheltered**, including those staying in overnight shelters for people who are homeless, as well as shelters for those impacted by family violence;

c) **Provisionally Accommodated**, referring to those whose accommodation is temporary or lacks security of tenure; and

d) **At Risk of Homelessness**, referring to people who are not homeless, but whose current economic and/ or housing situation is precarious or does not meet public health and safety standards.

8. For many people homelessness is not a static state but rather a fluid experience, where one's shelter circumstances and options may shift and change quite dramatically and with frequency.

9. According to the Canadian definition of homelessness, the risk factors that contribute to vulnerability to homelessness include:

a) Housing precarity;

[4] Stephen Gaetz et al., "Canadian Definition of Homelessness," *Canadian Observatory on Homelessness*, 2012, https://www.homelesshub.ca/sites/default/files/attachments/Definition%20of%20Homelessness.

b) Precarious employment;

c) Sudden unemployment with few prospects and little to no financial savings or assets, or social supports to turn to for assistance;

d) Supported housing with supports that are about to be discontinued;

e) Households facing eviction, lacking the resources needed to afford other housing including social supports, or living in areas with low availability of affordable housing;

f) People with severe and persistent mental illness, active addictions, substance use and/or behavioural issues;

g) Division of household caused by situations (such as separation, divorce, conflicts between caregivers and children, or roommates moving out);

h) Violence / abuse (or direct fear of) in current housing situations; and

i) Institutional care that is inadequate or unsuited to the needs of the individual or family.

The Causes of Homelessness

10. There is no single cause that explains everyone's experience of homelessness. Pathways into and out of homelessness are neither linear nor uniform. Individuals and families who wind up homeless may not share much in common with each other, aside from the fact that they are extremely vulnerable and lack adequate housing and income and the necessary supports to ensure they stay housed.

11. Nevertheless, using a social-ecological model, we can explain the causes of homelessness as the outcome of a complex and intricate interplay between **structural factors**, **systems failures**, and **individual circumstances**. [5]

12. **Structural factors** include economic, systemic, and societal issues that affect outcomes and opportunities for young people and their families" (18).[6] Because these factors occur at a societal level, individuals and families cannot control these factors and the impact on their lives, and people have limited ability to change them. Structural factors not only affect people experiencing homelessness, but much larger segments of the population. Key structural factors that contribute to homelessness include social and economic conditions like poverty, violence, inadequate education, underemployment, and lack of affordable housing. Other contributing factors include discrimination in the form of homophobia, transphobia, racism, and bullying. Ongoing racism and the experience of colonialism are at the core of experiences of homelessness for many Indigenous people and their families. These structural factors not only contribute to housing precarity for individuals and their families but can manifest at the community level as well.

13. **Systems failures** refer to those situations where inadequate policy and service delivery contribute to the likelihood that someone will become homeless. Systems failures that contribute to homelessness occur when individuals and families experience:

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[5] Stephen Gaetz and Erin Dej, "A New Direction: A Framework for Homelessness Prevention," *Canadian Observatory on Homelessness Press*, 2017, https://www.eenetconnect.ca/fileSendAction/fcType/0/fcOid/360050555503230772/filePointer/360050555503230803/fodoid/360050555503230797/COHPreventionFramework.pdf; Stephen Gaetz et al., "Duty to Assist–A Human Rights Approach to Youth Homelessness," *Canadian Observatory on Homelessness* Press, 2018, https://www.homelesshub.ca/sites/default/files/Duty_to_Assist.pdf

[6] Gaetz and Dej, "A New Direction", 18.

1. **Barriers to accessing public systems** (e.g., health, social services, legal supports) that they are entitled to, or where the supports they get are inadequate in protecting the person from homelessness; these barriers are unequally distributed, with some groups facing greater disadvantage than others.
2. **Failed transitions from publicly funded institutions and systems**: including (for example) child welfare, hospitals, and corrections; inadequate discharge planning and support means that many individuals fall into homelessness upon leaving such systems because they lack other options.
3. **Silos and gaps both within and between government funded departments and systems, and also within non-profit sectors**: the division of services, funding, and data into silos impedes collaboration and undermines the ability of communities and government to take an integrated systems approach to complex social problems; it also creates untold problems for individuals and families who struggle to get their needs met, specifically creating challenges for people to identify, access, and navigate necessary services and supports.

14. **Individual and relational factors** refer to the personal circumstances that place people at risk of homelessness, and may include:

1. **Personal or family crises**: such as emergencies (e.g., house fire, community evacuation, sudden unemployment, eviction) or personal crises (e.g., family break-up or intimate partner violence).
2. **Housing precarity and insecurity**: the Canada Mortgage and Housing Corporation defines a household as being in "core housing need" if an individual or family's housing: "falls below at least one of the adequacy, affordability, or suitability

standards and would have to spend 30% or more of its total before-tax income to pay the median rent of alternative local housing that is acceptable (meets all three housing standards)".[7]

3. **Interpersonal and relational problems**: includes ongoing family conflict, interpersonal violence and abuse, involvement with the criminal justice system, and/or mental health, addictions, and justice problems among other family members.
4. **Interpersonal violence**: People experiencing interpersonal violence or abuse (or living in direct fear of violence or abuse) in their current housing situations may be at risk of homelessness.
5. **Trauma**: the relationship between homelessness and trauma is bidirectional; trauma in the form of adverse experiences is both a risk factor for, and a potential outcome of, homelessness, and can lead to mental health challenges and behavioural changes that can impair decision making.

Who is homeless in Canada and who stays in homeless shelters?

15. Homelessness is a widespread social concern in Canada and many other developed countries. More than 235,000 people in Canada experience homelessness in any given year, and 25,000 to 35,000 people may experience homelessness on any given night.[8] A study by the Government of Canada identified that in 2016 there were an estimated 129,000 unique emergency

[7] Canada Mortgage and Housing Corporation, "The National Housing Strategy Glossary of Common Terms," 2022, https://www.cmhc-schl.gc.ca/en/nhs/guidepage-strategy/glossary.
[8] Stephen Gaetz et al., "The State of Homelessness in Canada 2016," *Canadian Observatory on Homelessness Press*, 2016, https://homelesshub.ca/sites/default/files/SOHC16_final_20Oct2016.pdf; Employment and Social Development Canada, "Everyone Counts 2018 Highlights: Preliminary Results from the Second Nationally Coordinated Point-in-Time Count of Homelessness in Canadian Communities," *Government of Canada*, 2019, https://publications.gc.ca/site/eng/9.874995/publication.html.

shelter users, and just over 14,000 Canadians stayed in an emergency shelter on any given night[9]. This suggests that almost half of all Canadians who experience homelessness in a given year do not access emergency shelters at any time during the year, which begs the question as to why they do not.

16. In 2018 the Government of Canada conducted a national Point in Time Count ("PiT Count") in over 60 communities across the country on a single day. The PiT Count revealed that the homeless population in Canada is quite diverse, in terms of age, gender, and ethno-racial background.[10]

17. **Chronic Homelessness**: PiT Count respondents were asked how long and how many different times they experienced homelessness over the past year. Six or more months of homelessness was considered chronic homelessness, three or more episodes lasting less than six months of homelessness was considered episodic homelessness. People experiencing chronic homelessness accounted for 60% of all respondents whereas episodic homelessness accounted for 8% of all respondents.[11]

18. **Gender**: The majority (62%) of PiT Count respondents identified as male, 36% identified as female and 2% identified as trans male, trans female, transgender, non-binary, androgynous, gender fluid, two-spirit, genderqueer or gender non-conforming, or provided another response not listed on the survey.[12] While the percentage of women in the homeless emergency shelter

[9] Annie Duchesne, Ian Cooper, and Nancy Baker, "The National Shelter Study: Shelter Use in Canada 2005-2016," *Employment and Social Development Canada*, 2021. 8, https://publications.gc.ca/collections/collection_2021/edsc-esdc/Em12-17-2020-eng.pdf.
[10] Employment and Social Development Canada, "Everyone Counts 2018 Highlights".
[11] Employment and Social Development Canada, "Everyone Counts 2018 Highlights".
[12] Employment and Social Development Canada, "Everyone Counts 2018 Highlights".

population across Canada appears to be lower than men, the unique circumstances facing women must be addressed. Women are at increased risk for hidden homelessness, living in overcrowded conditions or having sufficient money for shelter, but not for other necessities. In addition, according to the 2009 General Social Survey, 6% of women report some form of intimate partner (spousal) assault.[13] Family violence is a major cause of homelessness for women, and while some women make use of Violence Against Women shelters, others wind up using homelessness shelters. A 2010 PiT Count of women staying in found that abuse was the most commonly cited reason for admissions (71%) and the majority (60%) had not reported this to the police.[14] When women become homeless, they are at increased risk of violence and assault, sexual exploitation and abuse, which may explain the lower numbers of women in the shelter system.[15] Many women will go to lengths to avoid the shelter system, including staying in dangerous and unhealthy relationships and/or making arrangements to move in with a partner (even when that situation is unsafe) rather than submit to the incredible risk of violence and exploitation on the streets. Many women will choose to live in encampments surrounded by friends for protection.

*Note that respondents who identified as male and female may include cisgender and transgender people. As a result, this report may undercount the number of people who may identify as gender diverse. Gender for dependents was identified by their parents or guardians.

[13] Marie Sinha, "Measuring Violence Against Women: Statistical Trends," *Juristat: Canadian Centre for Justice Statistics* (2013): 1.

[14] Marta Burczycka and Adam Cotter, "Shelters for Abused Women in Canada, 2010," *Statistics Canada*, 2011. https://www.publicsafety.gc.ca/cnt/cntrng-crm/plcng/cnmcs-plcng/rsrch-prtl/dtls-en.aspx?d=PS&i=63570487.

[15] Stephen Gaetz, Bill O'Grady, and Kristy Buccieri, "Surviving Crime and Violence: Street Youth and Victimization in Toronto," *The Homeless Hub Press*, 2010, https://yorkspace.library.yorku.ca/xmlui/bitstream/handle/10315/29374/Surviving%20the%20Streets.JFCY_.September16.2010.pdf?sequence=1.; Emily Paradis and Janet Mosher, ""Take the Story, Take the Needs, and DO Something": Grassroots Women's Priorities for Community-Based Participatory Research and Action on Homelessness," *Canadian Homelessness Research Network Press*, 2012, https://yorkspace.library.yorku.ca/xmlui/bitstream/handle/10315/29386/CBPRwomenhomeless_report_0.pdf?sequence=1&isAllowed=y.

19. **Gender Identity**: When PiT Count "respondents were asked about their sexual identity or orientation, over 20% of youth identified as bisexual, gay, lesbian, asexual, pansexual, two spirit, queer, questioning, or provided another response not listed on the survey. When considered together with gender diverse responses, 21% of youth identified as LGBTQ2. LGBTQ2 responses were less frequent with age, accounting for 11% of responses from adults, 6% of responses from older adults, and 5% of responses from seniors." (9).[16]

20. **Age**: "Dependents and unaccompanied youth each comprised 13% of PiT Count respondents. Adults were the largest group, accounting for nearly half (49%) of those identified. Over 1 in 5 (22%) were older adults and 3% were seniors" (8).[17]

21. **Indigenous identity**: Indigenous Peoples are disproportionately represented in the homeless population in Canada. "Nearly one third (30%) of [The PiT Count] respondents identified as Indigenous, with the majority identifying as First Nations. In contrast, approximately 5% of the Canadian population identifies as Indigenous in the 2016 census, suggesting an overrepresentation of Indigenous Peoples experiencing homelessness. This percentage was higher among those who were staying in unsheltered locations (37%) and among those who were staying with others (43%). This suggests that shelter-specific statistics are likely to underestimate the extent of Indigenous homelessness" (11). [18] Indigenous Peoples' experiences of poverty and homelessness are firmly rooted in colonial practices and systemic discrimination. The experience of colonialism (resulting in intergenerational trauma), poverty, as well as extreme racism in many

[16] Employment and Social Services Development Canada, "Everyone Counts 2018 Highlights," 9.
[17] Employment and Social Services Development Canada, "Everyone Counts 2018 Highlights," 8.
[18] Employment and Social Services Development Canada, "Everyone Counts 2018 Highlights," 11.; Statistics Canada, "Focus on Geography Series, 2016 Census," *Statistics Canada Catalogue no. 98-404-X2016001*, April 18, 2019, https://www12.statcan.gc.ca/census-recensement/2016/as-sa/fogs-spg/Facts-CAN-eng.cfm?Lang=Eng&GK=CAN&GC=01&TOPIC=9.

Canadian cities creates more limited opportunities and greater risk of homelessness. It also means that many Indigenous people will avoid using homeless shelters or other services designed to support people who are homelessness.

22. People with a Disability: **A large number of people experiencing homelessness also have physical, mental, developmental or learning disabilities that impact on mobility, experience of pain, energy levels and / or decision making (note this information does not come from the PiT count study but other research). A study in New York found that one-fifth of surveyed homeless adults residing in shelters reported a disease or disability that restricted their functioning[19]. "In a national survey of homeless service user in the United States, 46 percent reported one or more chronic, debilitating conditions including arthritis, rheumatism, or joint problems (24%); high blood pressure (15%); and problems walking, a lost limb, or other handicap (14%)[20].**

The Homelessness Emergency Shelter System – an overview

23. According to Employment and Social Development Canada, in 2016 there were "over 15,400 emergency shelter beds at about 400 emergency shelters across Canada" (7).[21] "The number of shelters and beds remained relatively stable between 2005 and 2016, but demand for shelter beds increased. The average occupancy rate at Canada's emergency shelters in 2016

[19] Barrow et al. "Mortality among homeless shelter residents in New York City." *American Journal of Public Health*. April 1999. 89(4): 530.
[20] National Council on Disabilities. Guide to disability civil rights laws, April 2002: www.ncd.gov/newsroom/publications/disabilityrights.html; US Department of Justice. Americans with Disabilities Act, ADA Home Page: www.usdoj.gov/crt/ada/. 2.
[21] Annie Duchesne, Ian Cooper, and Nancy Baker, "The National Shelter Study," 7.

was 91.0%, an increase of almost 10 percentage points since 2005" (8).[22] On an average night in 2016, just over 14,000 Canadians stayed in an emergency shelter.[23]

24. Emergency shelters are designed to provide temporary shelter with minimum supports for people who do not have access to housing that is safe, affordable and appropriate. Not all emergency shelters are the same. They vary in the number of beds they offer, and in Canada the range is from less than ten beds to over 600 at The Drop In (Calgary). Emergency shelters are potentially funded by different orders of government, as well as charitable donations (especially for shelters affiliated to religious organizations). Some municipalities have "shelter standards" which govern the operations of emergency shelters that those municipalities provide direct funding to. The City of Hamilton had such a plan, called the "Blueprint for Emergency Shelter Services". However, this document is no longer available online and it is not clear if there are any current standards.

25. Bearing in mind that there is variation in how shelters operate, there are some common characteristics:

a) **Emergency shelters** provide beds for people experiencing homelessness to sleep on during the night. This may include bunk beds, single beds, cots or mats on the floor.

b) Most shelters are set up for **single individuals**, with **separate shelters for men and women**, and a smaller number targeting women fleeing violence, unaccompanied youth, and families.

[22] Annie Duchesne, Ian Cooper, and Nancy Baker, "The National Shelter Study," 8.
[23] Annie Duchesne, Ian Cooper, and Nancy Baker, "The National Shelter Study."

c) People are typically provided shelter in a **congregate setting**, meaning that two or more people share the same room. In some cases, this means more than 50 people in a single congregate setting.

d) Some shelters **limit the number of nights** an individual can stay.

e) Intake to the shelter begins in the evening on a **first come first served** basis. When the shelter is full, people are turned away, without any assessment of relative need or priority.

f) There is typically a **curfew**, after which people will not be admitted.

g) Some but not all shelters provide an **evening meal**, and in some cases a **breakfast**. Because of budget constraints, the quality of food provided by shelters is generally low and can contribute to malnourishment.[24]

h) At most shelters, people are **discharged in the morning** and are not allowed back in until the evening, **regardless of the weather**, whether a person is **ill** or has a disabling condition.

i) Shelters will usually **admit people with serious mental illnesses** but are not medical institutions. They generally do not have in-house staff who are trained medical professionals, and many staff – particularly on the night shift – have minimal training. Because of low pay, there is typically a significant amount of turnover.

j) Shelters are generally not able to accommodate people who are experiencing homelessness and at the same time have **nighttime jobs**.

[24] Naomi Dachner et al., "An Ethnographic Study of Meal Programs for Homeless and Under-Housed Individuals in Toronto," *Journal of Health Care for the Poor and underserved* 20, no. 3 (2009): 846-853.; Stephen Gaetz et al., "" Managing" homeless youth in Toronto: mismanaging food access and nutritional well-being," *Canadian Review of Social Policy* 58 (2006): 43.

k) Shelters typically have **rules and restrictions** – in some cases informal practices – allowing staff to discharge those accessing the shelter, for a range of reasons, including fighting, being disruptive, coming in drunk or having used drugs. As one organization states: "These rules and restrictions are well-intended but can prevent people from accessing shelter beds. … For example, many mass shelters don't allow pets — and for good reason, if you can imagine a mass shelter with dozens of dogs running around on the loose. But for the homeless with pets, who wouldn't imagine giving up their only companion, where do they go for shelter?" (sec. 2). [25]

l) Some shelters do not allow people to bring in **personal possessions** outside of the clothes on their back.

m) Some shelters have **historically condemned homosexuality** and require residents to not openly display their orientation, which exposes LGBTQ2S people to potential ridicule and attacks.

n) Generally, **drinking and drug use** are not allowed inside a shelter, and some will bar people who are suspected of drinking from entering the shelter.

Shelters and the spread of infectious disease

26. Shelters, in terms of their design and operations, can pose public health challenges. Compromised health and well-being are a consequence of overcrowded living conditions, lack of access to safe and private spaces, reliance on shelters and drop-ins to meet daily needs, and barriers to accessing services. As I have written:

[25] Pallet, "Why People Experiencing Homelessness Don't Accept Shelter," May 20, 2020, sec. 2, https://palletshelter.com/blog/why-the-homeless-dont-accept-shelter/.

While these services have been designed to meet the immediate needs for shelter, warmth, food and companionship, these same services are constituted in ways that undermine individual autonomy, privacy, safety and freedom of movement. The design of these services often places people in vulnerable circumstances that may exacerbate the spread of infectious disease … (20)[26]

27. In addition, Rowan et al. state:

Congregate shelters for PEH (People experiencing homelessness) are often crowded indoor environments with poor ventilation through which hundreds of people may pass each day, eating and sleeping in close proximity. The frequency of close contact with others in this high-density indoor environment greatly increases the risk of transmission of respiratory pathogens (1-2). [27] …

28. "In overcrowded shelters and drop-ins, infection control becomes an obvious challenge (Duchene, 2010), as does the issue of quarantine and isolation, since most shelters have not been designed with infection control in mind. Increased attention to supporting hygienic practices and better ventilation will be necessary, along with plans to ensure that agencies have quick access to medical and hygiene supplies and food, and space to store them. All these needs have resource implications for a sector with inadequate funding"[28]

[26] Stephen Gaetz and K. Buccieri, "The Worst of Times: The Challenges of Pandemic Planning in the Context of Homelessness," In *Pandemic Preparedness and Homelessness: Lessons from H1N1 in Canada,* eds. Kristy Buccieri, and Rebecca Schiff (Toronto: Canadian Observatory on Homelessness, 2016), 13-32, 20, https://www.homelesshub.ca/sites/default/files/attachments/LessonsfromH1N1-Chapter_1.pdf.
[27] Sarah E. Rowan et al., "Lower Prevalence of Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) Infection Among People Experiencing Homelessness Tested in Outdoor Encampments Compared with Overnight Shelters: Denver, Colorado, June-July 2020," *Clinical Infectious Diseases* (2022), ciac039, https://doi.org/10.1093/cid/ciac039.
[28] Stephen Gaetz and K. Buccieri, "The Worst of Times: The Challenges of Pandemic Planning in the Context of Homelessness," In *Pandemic Preparedness and Homelessness: Lessons from H1N1 in Canada,* eds. Kristy Buccieri, and Rebecca Schiff (Toronto: Canadian Observatory on Homelessness, 2016), 13-32, 20,

29. Pandemics such as COVID-19 can pose grave risks for homeless individuals, particularly in the context of staying at a homeless shelter. While in many communities' efforts have been made to improve hygiene practices, reduce the number of beds etc., homeless shelters by design exacerbate risk in the context of a pandemic. As I have written:

> We know that at the best of times, the health of homeless people is compromised by situational factors (such as nutritional vulnerability and compromised immunity), structural factors (such as lack of income and inadequate housing), and pre-existing health conditions. Yet ultimately what underlies their vulnerability is not simply the characteristics and behaviours of the population. We need to consider the ways in which the infrastructure we have built to respond to homelessness — in particular, our reliance on emergency services that are often characterized by overcrowding, congregate living and resources inadequate to maintaining hygiene — organize the lives of people who are homeless to exacerbate this vulnerability and create the possibility of potential disaster in the event of a serious infectious disease outbreak (13). [29]

Reasons why the shelter system may be incompatible with an unhoused person

30. There are many rational reasons why individuals and families might choose not to stay at a homelessness shelter, and these reasons are usually related to the operational features of shelters described above. Reasons for not wanting to stay in a shelter include:

1. **Fear**: Individuals accessing shelters may know other residents who they are afraid of for one reason or another (e.g., the person is violent, there is a previous conflict, etc.);

https://www.homelesshub.ca/sites/default/files/attachments/LessonsfromH1N1-Chapter_1.pdf. 23

[29] Gaetz, and Buccieri, "The Worst of Times", 13.

other residents may not be known to the individual, and they may have trouble assessing the potential risk a stranger may present; finally, because shelter residents are often exposed to racist, homophobic and transphobic attacks (sometimes physical) by other residents, and in some cases by staff, many people would rather take their chances living outside of shelters than to stay at one.

2. **Risk of criminal victimization**: People experiencing homelessness are more likely to be victims of crime, including assault and sexual assault, than are people who are housed.[30] Surrounding oneself with friends can be a protective factor, and this is easier to achieve if one lives outside of a shelter setting.

3. **Not being able to stay with friends**: In general, most people would prefer to stay with friends rather than with strangers, which is hard to do in a shelter; lacking control over who is living with you in a congregate environment can be very scary and stressful.

4. **Negative prior experiences of public institutions**: Repeated negative experiences with public services can lead people to reject accessing public services, or to see that they have any value; many people will choose to *not* access homelessness shelters, but

[30] Stephen Gaetz, Bill O'Grady, and Kristy Buccieri, "Surviving Crime and Violence"; Bill O'Grady, Stephen Gaetz, and Kristy Buccieri. "Can I see your ID: The policing of youth homelessness in Toronto." *Justice for Children and Youth and Homeless Hub Press*, 2011, https://homelesshub.ca/sites/default/files/CanISeeYourID_execsummary.pdf.; Bill O'Grady, Stephen Gaetz, and Kristy Buccieri, "Legal and Justice Issues: Policing Street Youth in Toronto," In *Youth Homelessness in Canada: Implications for Policy and Practice*: eds. Stephen Gaetz, Bill O'Grady, Bill Buccieri, Krista Karabanow, Jeff Marsolais, and Allyson Marsolais, (Toronto: Canadian Homelessness Research Network Press, 2013), 335-352.; Sylvia Novac et al., "More Sinned Against than Sinning? Homeless People as Victims of Crime and Harassment," In *Finding Home Policy Options for Addressing Homelessness in Canada*: eds. David Hulchanski, Philippa Campsie, Shirley Chau, Stephen Hwang, and Emily Paradis, (Toronto: Cities Centre, University of Toronto, 2009), 660-671.

rather seek other options including sleeping outdoors or living in homelessness encampments, where they can exercise more control over their lives.

5. **Pets**: People who experience homelessness often have pets for companionship (like anyone else) but also to enhance their personal safety; the exclusion of pets from shelter means they may not choose shelter.

6. **Personal belongings**: Because many shelters **do not have facilities to store personal belongings**, many people will avoid using shelters. Also, within shelters, people are often afraid of having the few personal belongings they can bring into the shelter stolen. For instance, people will often sleep with their shoes on for fear someone else will steal them. Eugene Stroman, a homeless person in Houston, Texas, described why he did not like to stay in a shelter:

> There are … reasons to say no when officers offer to bring you to shelter. Agreeing to go to a shelter in that moment means losing many of your possessions. You have to pack what you can into a bag and leave the rest behind, to be stolen or thrown away by City workers. For me, I would have lost my bulky winter clothes, my tent, my non-perishable food, and the bike parts I used to make repairs for money. You give up all this property just for the guarantee – if you trust the police – of a spot on the floor for one

night. It's not really a "choice" for me to give up all those resources. I needed to make smart survival decisions (8). [31]

7. **Separating couples**: Individuals who are romantically coupled – whether gay or straight – cannot sleep in the same bed.; or couples consisting of a male and a female, they are not able to stay in the same shelter because shelters are generally exclusively for men or women only.

8. **Noise**: Shelters can be very noisy during the night, because of snoring, shouting, or people with mental health challenges being in destress.

9. **Mental health**: The high frequency of mental illness and cognitive impairment among the homeless population can make it difficult for some people to function in a shelter setting, and to adhere to public health recommendations; the COVID-19 pandemic and its necessary public health measures have had a negative impact on mental health in the Canadian population, including those who are experiencing homelessness.[32]

10. **Shelter rules**: The rule-bound nature of staying in an institutional setting such as a shelter can be experienced as problematic and infantilizing; few adults would be fine with curfews, rules regarding whether they can drink or not, demands that they must leave their residence first thing in the morning regardless of the weather, how well they

[31] National Law Centre on Homelessness and Poverty, "Tent City U.S.A.: The Growth of America's Homeless Encampments and How Communities are Responding," 2017, 8. https://homelesslaw.org/wp-content/uploads/2018/10/Tent_City_USA_2017.pdf.
[32] Aganeta Enns et al., "Evidence-Informed Policy Brief-Substance Use and Related Harms in the Context of COVID-19: A Conceptual Model," *Health promotion and chronic disease prevention in Canada: research, policy and practice* 40, no. 11-12 (2020): 342-349.

feel, whether they had a traumatizing experience the previous day, whether they have health challenges or disabling conditions that make movement challenging.

11. **Communicable disease**: While one can catch a communicable disease in many places, many people who are homeless are aware that this risk can be amplified within a shelter setting; it was therefor not at all surprising to see the rise of homelessness encampments during the COVID-19 pandemic, as many people were making the very rational decision to avoid congregate settings such as emergency shelters in order to reduce their risk of infection.

Health and Well-Being of People who Experience Homelessness

31. The population of people experiencing homelessness in Canada is characterized by markedly worse health outcomes than the general population, with lower life expectancy and significantly higher rates of chronic disease as well as mental health and substance abuse conditions. The relationship between homelessness and health is complex and is said to be "bi-directional" - homelessness causes poor health and poor health can lead to homelessness.[33]

32. There is considerable evidence that homelessness is associated with poor health, a compromised immune system and barriers to accessing health services.[34] Negative outcomes

[33] Public Health Ontario, "Homelessness and Health Outcomes: What are the Associations," April, 2019, https://www.publichealthontario.ca/-/media/documents/E/2019/eb-homelessness-health.pdf.

[34] Manal Guirguis-Younger, Stephen Hwang, and Ryan McNeil, eds., *Homelessness & health in Canada* (Ottawa: University of Ottawa Press, 2014).; James Frankish, Stephen Hwang, and Darryl Quantz, "Homelessness and Health in Canada: Research Lessons and Priorities," *Canadian journal of public health* 96, no. 2 (2005): S23-S29.; Dina Kulik et al., "Homeless Youth's Overwhelming Health Burden: A Review of the Literature," *Paediatrics & child health* 16, no. 6 (2011): e43-e47.; Stephen Hwang et al., "Health Care Utilization Among Homeless Adults Prior to Death," *Journal of Health Care for the Poor and Underserved* 12, no. 1 (2001): 50-58.; Lynn Rew, "Characteristics and Health Care Needs of Homeless Adolescents," *Nursing Clinics* 37, no. 3 (2002): 423-431.; Josephine Ensign, and Michelle Bell, "Illness Experiences of Homeless Youth," *Qualitative Health Research* 14, no. 9 (2004): 1239-1254.; Jean-François Boivin et al., "The Health of Street Youth," *Canadian journal of public health* 96, no. 6 (2005): 432-437.; Stephen Hwang, "Homelessness and Health," *Cmaj* 164, no. 2 (2001): 229-233.; Elise Roy et al.,

include, but are not limited to, greater incidences of illness and injury, chronic medical conditions, including heart disease, diabetes, seizures, arthritis and musculoskeletal disorders,[35] dental and periodontal disease,[36] nutritional vulnerability,[37] and higher mortality rates.[38]

The Street Health Report 2007 is a Canadian study in which 360 homeless people were intercviewed in Toronto. "74% of the homeless people we interviewed had at least one serious physical health condition, and 52% of the total sample had two or more. For people without any serious health conditions, the average time homeless was 3.7 years. The average length of time homeless for people with at least one serious health condition was 5.1 years. The significant difference between these two averages suggests that being homeless for a longer period increases one's likelihood of serious illness."[39]

"Mortality in a Cohort of Street Youth in Montreal," *Jama* 292, no. 5 (2004): 569-574.; Naomi Dachner, and Valerie Tarasuk "Homeless Youth, Nutritional Vulnerability, and Community Food Assistance Programs," In *Youth Homelessness in Canada: Implications for Policy and Practice*: eds. Stephen Gaetz, Bill O'Grady, Bill Buccieri, Krista Karabanow, Jeff Marsolais, and Allyson Marsolais, (Toronto: Canadian Homelessness Research Network Press, 2013), 335-352.

[35] Shirley Harris, Carol Mowbray, and Andrea Solarz, "Physical Health, Mental Health, and Substance Abuse Problems of Shelter Users," *Health & Social Work* 19, no. 1 (1994): 37-45.; James Frankish, Stephen Hwang, and Darryl Quantz, "The Relationship Between Homelessness and Health: An Overview of Research in Canada," In *Finding home: Policy options for addressing homelessness in Canada*, edited by David Hulchanski, Philippa Campsie, Shirley Chau, Stephen Hwang, and Emily Paradis, (Toronto: Cities Centre, University of Toronto, 2009), 660-671.

[36] Stephen Gaetz, and Jack Lee, "Developing Dental Services for Street Youth," *Ontario dentist* 72, no. 9 (1995): 34-37.; Jack Lee, Steve Gaetz, and Fred Goettler, "The Oral Health of Toronto's Street Youth," *Journal (Canadian Dental Association)* 60, no. 6 (1994): 545-548.

[37] Stephen Gaetz et al., "" Managing" Homeless Youth in Toronto".; Valeri Tarasuk et al., "Food Deprivation is Integral to the 'Hand to Mouth' Existence of Homeless Youths in Toronto," *Public Health Nutrition* 12, no. 9 (2009): 1437-1442.

[38] Travis Baggett et al., "Mortality Among Homeless Adults in Boston: Shifts in Causes of Death Over a 15-Year Period," *JAMA internal medicine* 173, no. 3 (2013): 189-195.; Angela Cheung, and Stephen Hwang, "Risk of Death Among Homeless Women: a Cohort Study and Review of the Literature," *Cmaj* 170, no. 8 (2004): 1243-1247.; Stephen Hwang, "Mortality Among Men Using Homeless Shelters in Toronto, Ontario," *Jama* 283, no. 16 (2000): 2152-2157.; Stephen Hwang, "Mental Illness and Mortality Among Homeless People," *Acta Psychiatrica Scandinavica* 103, no. 2 (2001): 81-82.

[39] Erika Khandor, and Kate Mason, "The Street Health Report 2007," *Street Health*, accessed June 7, 2022: https://www.streethealth.ca/downloads/the-street-health-report-2007.pdf. 21

33. Moreover, the Street Health Report found 41% of homeless people reported that they were usually in pain, and of that group 46% described it as moderate and 35% as severe (amongst the general population the rates are 8% and 2%).[40] The study authors stated: "These high levels of pain and discomfort among the homeless population suggest that many people may have disabilities and medical conditions that are not acknowledged, diagnosed or treated" (21).[41]

34. The homeless population in Ontario and Toronto experiences disproportionately high rates of HIV, AIDS and Hepatitis-C.[42] In a 2007 study which surveyed 368 people experiencing homelessness in Toronto, 23% of respondents reported having Hepatitis C (compared to 0.8% in Canada's general population), 2% reported being HIV positive (compared to 0.006% in Toronto's general population) and 1.1% reported having AIDS.[43] These numbers can be reasonably extrapolated to Hamilton. These chronic health conditions significantly compromise a person's immune system, predisposing them to increased mortality risks from COVID-19.

35. A large proportion of people experiencing homelessness have physical, mental, developmental and/or learning disabilities that impact on mobility, experience of pain, energy level and/or decision making. In a national survey of homeless service user in the United States, 46% reported one or more chronic, debilitating conditions including: arthritis, rheumatism, or joint problems (24%), high blood pressure (15%), and problems walking, a lost limb, or other handicap (14%).[44]

[40] Erika Khandor, and Kate Mason, "The Street Health Report 2007,"
[41] Erika Khandor and Kate Mason, "The Street Health Report 2007", 21.
[42] Erika Khandor and Kate Mason, "The Street Health Report 2007".
[43] Erika Khandor and Kate Mason, "The Street Health Report 2007".
[44] Susan Barrow et al., "Mortality Among Homeless Shelter Residents in New York City," *American journal of public health* 89, no. 4 (1999): 529-534.

36. According to one study conducted in Toronto, 43% of homeless respondents reported arthritis or rheumatism, 23% reported problems walking, a lost limb, or another physical handicap, 20% reported heart disease, and 17% reported high blood pressure. Encampments can provide reprieve from the need to constantly be moving and carrying belongings.[45]

37. The 2018 Toronto Street Needs Assessment further shows that people who were sleeping outdoors experienced a higher prevalence of medical conditions when compared to those staying in city-administered shelters. People sleeping rough were more likely to have one or more type of health condition (80% vs. 52%), a chronic or acute medical condition (38% vs. 29%), a physical disability (37% vs. 20%), an addiction (57% vs. 22%) and a mental health issue (56% vs. 26%). These figures can be reasonably extrapolated for Hamilton. All these health factors indicate that homeless people sleeping outdoors and in encampments are generally in poorer health than the broader homeless population, ultimately leaving them more susceptible to complications or severe symptoms from COVID-19.[46]

38. "In general, 30-35% of those experiencing homelessness, and up to 75% of women experiencing homelessness, experience mental illnesses. 20-25% of people experiencing homelessness suffer from concurrent disorders (severe mental illness and addictions)" (para. 3).[47] Approximately 30% of people who are homeless suffer from mental illness[48] and/or substance use

[45] Susan Barrow et al., "Mortality Among Homeless".
[46] "Street Needs Assessment 2018," City of Toronto, Accessed June 7, 2022, https://www.homelesshub.ca/sites/default/files/attachments/99be-2018-SNA-Results-Report.pdf.
[47] Canadian Observatory on Homelessness, "About Homelessness: Mental Health," 2021, para. 3, https://www.homelesshub.ca/about-homelessness/topics/mental-health.
[48] Vicky Stergiopoulos et al., "Assessing the Mental Health Service Needs of the Homeless: A Level-of-Care Approach," *Journal of Health Care for the Poor and Underserved* 21, no. 3 (2010): 1031-1045.; Geoffrey Nelson, Tim Aubry, and Adele Lafrance, "A Review of the Literature on the Effectiveness of Housing and Support, Assertive Community Treatment, and Intensive Case Management Interventions for Persons with Mental Illness Who Have Been Homeless," *American Journal of Orthopsychiatry* 77, no. 3 (2007): 350-361.

disorders.[49] Post-Traumatic Stress Disorder ("PTSD") is very common among people experiencing homelessness, with one study in Australia reporting that 79% of women who had experienced homelessness also had experiences of PTSD.[50] Homelessness itself, through the loss of stable shelter, inability to meet basic needs, threats to personal safety and impact on pre-existing mental health conditions, can be a traumatizing event.[51] Mood disorders (depression and bipolar disease), schizophrenia and substance-induced psychosis are all much more prevalent in the homeless population when compared to the general population. Cognitive impairment due to acquired brain injuries is an extremely common condition among the homeless population, with 58% of homeless men and 42% of homeless women reporting an acquired brain injury.[52]

39. A report from the National Alliance to End Homelessness in the United States suggests that data clearly shows that substance abuse and overdose disproportionately impacts people experiencing homelessness.[53] A large study of individuals experiencing homelessness treated by Boston Health Care for the Homeless in 2003-2008 found drug overdose to be a leading cause of death with opioids present in 81% of overdoses.[54] Emerging evidence from San Francisco[55],

[49] Michelle Grinman et al., "Drug Problems Among Homeless Individuals in Toronto, Canada: Prevalence, Drugs of Choice, and Relation to Health Status," *BMC public health* 10, no. 1 (2010): 1-7.; Thomas Kerr et al., "Injection Drug Use Among Street-Involved Youth in a Canadian Setting," *BMC public health* 9, no. 1 (2009): 1-7.; Iris Torchalla et al., "Substance Use and Predictors of Substance Dependence in Homeless Women," *Drug and alcohol dependence* 118, no. 2-3 (2011): 173-179.

[50] Katheryn Taylor and Louise Sharpe. "Trauma and post-traumatic stress disorder among homeless adults in Sydney. Australian & New Zealand". Journal of Psychiatry, (2008). 42(3), 206-13.

[51] Tanya Gulliver, and Alicia Campney, "Healing the Pain and Hurt: Dealing with the Trauma of Homelessness," accessed June 7, 2022, https://homelesshub.ca/sites/default/files/23%20-%20Trauma%20Informed%20Services.pdf.

[52] Stephen Hwang et al., "The Effect of Traumatic Brain Injury on the Health of Homeless People," *Cmaj* 179, no. 8 (2008): 779-784.

[53] National Alliance to End Homelessness, "Opioid Abuse and Homelessness," April 5, 2016, https://endhomelessness.org/resource/opioid-abuse-and-homelessness/.

[54] Travis Baggett et al., "Mortality Among Homeless Adults."

[55] Dan Simon, "The Impact Homelessness and the Opioid Crisis are Having on San Francisco Streets," *CNN Health*, December 30, 2018, accessed June 7, 2022, https://edition.cnn.com/2018/12/27/health/drug-use-san-francisco-streets/index.html.

Vancouver,[56] and Hamilton[57] suggests that the opioid crisis has had a greater impact on the homelessness community, although there is not yet published research to verify these claims.

Overall, the homeless population has a reduced life expectancy when compared to the general population. Baggett et al. 2018 found that those who are homeless or vulnerably housed in Canada have a mortality rate from cardiovascular disease that is 2-3-fold higher than the rest of the population in Canada.[58] A Canadian study in 2009 found that: "Homeless and marginally housed individuals living in shelters, rooming houses, or hotels have significantly higher mortality rates than individuals with incomes in the lowest fifth of the distribution. The probability that a 25 year old living in shelters, rooming houses, or hotels would survive to age 75 was only 32% for men and 60% for women compared with 51% and 72%, respectively, in the lowest income fifth."[59]

40. Poor physical and/or mental health is a clear challenge for people experiencing homelessness. In addition to poor health, these factors can affect decision-making, ability to keep track of timing and mobility, the latter particularly important for people who do not have the money to take public or private transit.

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[56] Christine Coulter, "Vancouver's Housing and Opioid Crises are Linked, Says Addictions Expert," *CBC News*, November 20, 2017, accessed June 7, 2022, https://www.cbc.ca/news/canada/british-columbia/vancouver-s-housing-and-opioid-crises-are-linked-says-addictions-expert-1.4410822.

[57] Teviah Moro, "Opioid Crisis: Life and Death on Hamilton's Streets," *The Hamilton Spectator,* June 22, 2018, accessed June 2, 2022, https://www.thespec.com/news/hamilton-region/2018/06/22/opioid-crisis-life-and-death-on-hamilton-s-streets.html.

[58] Travis Baggett et al., "Mortality Among Homeless Adults."

[59] Stephen Hwang, Russell Wilkins, Michael Tjepkema, Patricia J O'Campo and James Dunn, "Mortality among residents of shelters, rooming houses, and hotels in Canada: 11 year follow-up study." *BMJ* 2009; 339 :b4036 doi:10.1136/bmj.b4036.

41. People who are homeless also experience barriers to accessing health care, including discrimination, and lacking funds for prescriptions. Guirguis-Younger, McNeil & Hwang write:

> Paradoxically, whereas homeless populations have high levels of health services utilization, especially emergency department and in-patient care, they frequently have unmet health needs due to the barriers that they face to accessing care and adhering to treatment. The reasons for this are complex and, to a great extent, largely the product of the challenges experienced by homeless persons. For example, the daily struggle for survival, such as addressing immediate needs (e.g., food, shelter etc.), often takes precedence over health needs, leading homeless persons to delay seeking treatment. Furthermore, researchers have found that homeless persons often feel unwelcome in health care settings due to discrimination and subsequent to these experiences are less likely to seek care (2-3).[60]

Further complicating these risks is the fact that homeless populations are often quite diverse. Several sub-populations, including Indigenous peoples (who make up less than 5% of the population but 30% of the homeless population) [61], LGBTQ2S youth and women, face special challenges because of their unique status including discrimination, and may experience additional barriers to accessing health services and social supports.

The Service Prioritization Decision Assistance Tool (VI-SPDT)

[60] Manal Guirguis-Younger, Stephen Hwang, and Ryan McNeil, "Homelessness and Health in Canada," 2-3, *Internal citations omitted.
[61] Stephen Gaetz et al., "The State of Homelessness in Canada."

42. Communities in Canada and the United States are using coordinated access systems to optimize the homelessness sector to distribute access to scarce housing resources to those in greatest need. In both countries, communities are required to use standardized assessment tools in order to prioritize individuals and families for access to housing supports, and in particular the strongly evidenced-based intervention, Housing First. Homeless service providers try to measure "vulnerability" as a central factor in deciding how to allot their limited housing resources.

43. The most widely used assessment tool in both countries is the Vulnerability Index – Service Prioritization Decision Assistance Tool ("VI-SPDAT"), the first version of which was released the in 2013. This is an assessment tool developed by two private consulting firms – Community Solutions, and OrgCode. The proprietors of VI-SPDAT stated it is designed to help communities assess vulnerability and risk, measured by length of time homeless, and acuity of mental health problems or addictions. The VI-SPDAT uses a survey/interview approach that includes 27 items to produce a score for each individual so that they can be prioritized and ranked. The stakes are very high for VI-SPDAT – the score and ranking can determine whether and when an individual will receive the housing and supports needed to exit homelessness.

Does the VI-SPDAT work?

44. There has long been skepticism by researchers and experts on the psychometric properties of assessment about the validity of VI-SPDAT and its ability to objectively assess vulnerability and needs.[62] As Brown and Cummings state:

[62] Tim Aubry et al., "Screening for Housing First," *Canadian Observatory on Homelessness,* 2015, accessed June 7, 2022, https://www.homelesshub.ca/sites/default/files/attachments/ScreeningforHF-Dec8.pdf.; Rachelle Levitt, "Assessment Tools for Allocating Homelessness Assistance: State of the Evidence," *U.S. Department of Housing and Urban Development*, February, 2015, https://www.huduser.gov/publications/pdf/assessment_tools_Convening_Report2015.pdf.

> In addition to its ease of use and other potential strengths, the VI-SPDAT has gained traction due to the developers' assertions that it is "evidence-informed" and the strongest tool available based upon its evidence and testing. However, the evidence base for the VI-SPDAT versions 1 and 2 is largely unclear (sec. 3). [63]

45. The VI-SPDAT has never been validated by independent researchers with expertise in the psychometric properties of assessment. However, in the last several years there have been a series of peer-reviewed articles published by independent researchers that explore the validity of the VI-SPDAT[64]. There is a consensus across this body of research that the VI-SPDAT is not valid and does not achieve what it claims it can do. Key conclusions from this research suggest:

1. **The VI-SPDAT does not fully measure vulnerability**: "The Socialization and Daily Functions domain and health-related items on the Wellness domain demonstrated particularly poor validity" (sec. 4).[65]

[63] Molly Brown, and Camilla Cummings, "New Research on the Reliability and Validity of the VI-SPDAT: Implications for Coordinated Assessment," *Canadian Observatory on Homelessness*, July 5, 2018, accessed June 7, 2022, sec. 3, https://www.homelesshub.ca/blog/new-research-reliability-and-validity-vi-spdat-implications-coordinated-assessment.

[64] Brown and Cummings, "New Research on Reliability".; Brown, Molly et al., "Reliability and Validity of the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) in Real-World Implementation," *Journal of Social Distress and the Homeless* 27, no. 2 (2018): 110-117.; Ecker, John, Molly Brown, Tim Aubry, Katherine Francombe Pridham, and Stephen Hwang. "Coordinated Access and Coordinated Entry System Processes in the Housing and Homelessness Sector: A Critical Commentary on Current Practices." *Housing Policy Debate* (2022): 1-20. https://doi.org/10.1080/10511482.2022.2058580.; Courtney Cronley, "Racial and Gender Bias in the VI-SPDAT," *Canadian Observatory on Homelessness*, January 20, 2021, accessed June 7, 2022. https://www.homelesshub.ca/blog/racial-and-gender-bias-vi-spdat#:~:text=There%20is%20evidence%20of%20racial,higher%20on%20the%20VI%2DSPDAT.; Courtney Cronley, "Invisible Intersectionality in Measuring Vulnerability Among Individuals Experiencing Homelessness–Critically Appraising the VI-SPDAT," *Journal of Social Distress and Homelessness* 31, no. 1 (2020): 23-33.; Marybeth Shinn, and Molly K. Richard, "Allocating Homeless Services After the Withdrawal of the Vulnerability Index - Service Prioritization Decision Assistance Tool," *American Journal of Public Health* 112, no. 3 (2022): 378-382.; Catriona Wilkey et al., "Coordinated Entry Systems Racial Equity Analysis of Assessment Data," *C4 Innovations*, October, 2019, https://c4innovates.com/wp-content/uploads/2019/10/CES_Racial_Equity_Analysis_2019-.pdf.

[65] Brown and Cummings, "New Research on Reliability," sec. 4.

2. **The ability to capture an adequate assessment of an individual or family using the VI-SPDAT has been questioned**: Communities that use the VI-SPDAT have critiqued its ability to accurately uncover the circumstances of individuals and families[66] and domestic violence survivors.[67]

3. **The VI-SPDAT doesn't produce consistent results**: "In terms of reliability, we found individuals that were administered the VI-SPDAT twice did not produce consistent scores. In fact, 89% produced either higher or lower scores during their second administration" (sec. 4).[68]

4. **There is evidence of racial bias in the VI-SPDAT**: "Both Black and White women reported similarly high odds of homelessness due to trauma, but white women scored consistently higher on the VI-SPDAT" (sec. 4)[69]; an evaluation of several U.S. communities utilizing the VI-SPDAT in coordinated systems found a general pattern of significantly lower scores among individuals and families who were Black, Indigenous, and people of color compared to those who were White, with major implications when scarce resources are being allocated, since "If biases persist within the assessment and coordinated entry process, over time more Black people who are

[66] Caroline Balagot et al., "The Homeless Coordinated Entry System: the VI-SPDAT and Other Predictors of Establishing Eligibility for Services for Single Homeless Adults," *Journal of Social Distress and the Homeless* 28, no. 2 (2019): 149-157.
[67] Kristie Thomas et al., "No Easy Decisions: Developing an Evidence-Informed Process to Allocate Housing Choice Vouchers to Survivors of Intimate Partner violence." *Housing Policy Debate* 30, no. 5 (2020): 783-805, https://doi.org/10.1080/10511482.2020.1755336
[68] Brown and Cummings, "New Research on Reliability," sec. 4.
[69] Cronley, "Racial and Gender Bias," sec. 4.; Cronley, "Invisible Intersectionalities in Measuring".; Wikey et al., "Coordinated Entry Systems."

experiencing homelessness will be without housing for longer periods of time compared to their white counterparts*"* (9-10).[70]

46. In conclusion the scholarly research on the VI-SPDAT suggests that the VI-SPDAT has considerable weaknesses in its validity and reliability, and when applied it can perpetuate systemic racism.

What is a homelessness encampment?

Following from the typology laid out in the Canadian Definition of Homelessness[71], people living in encampments would be considered part of the "Unsheltered population", which includes people who lack housing and are not accessing emergency shelters or accommodation, except during extreme weather conditions. In most cases, people are staying in places that are not designed for or fit for human habitation.

47. Homelessness encampments are defined as locations where one or more homeless people live in an unsheltered public, semi-public or privately owned area such as the streets, campgrounds, under bridges, undeveloped properties, abandoned buildings, vehicles, or parks. People living in encampments may live in tents, make-shift structures made of cardboard, wood, or other materials, or live in the open.

48. Homelessness encampments are not new.[72] During the Great Depression, for instance, there was a large homeless encampment occupying the southern part of Central Park in New York.

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[70] Cronley, "Invisible Intersectionality in Measuring," sec. 9-10.

[71] Stephen Gaetz, Carolann Barr, Anita Friesen, Bradley Harris, Charlie Hill, Katheryn Kovacs-Burns,, Bernadette Pauly, Bruce Pearce, Alina Turner and Allkyson Marsolais, (2012) *The Canadian Definition of Homelessness*. Canadian Homelessness Research Network.

[72] Chris Herring, "The New Logics of Homeless Seclusion: Homeless Encampments in America's West Coast Cities," *City & Community* 13, no. 4 (2014): 285-309.

Since the rise of modern mass homelessness, we have begun to see the emergence of and growth of homelessness encampments in cities across Canada and the United States, particularly over the past decade. The recent pandemic has led to the rapid growth of homelessness encampments in many Canadian cities.

The structure and organization of homelessness encampments

49. The internal organization and motivations of residents significantly vary among encampments. Some encampments have a strong social structure and organization, sometimes with oversight or assistance from local charitable or faith-based organizations. Residents may be required to assume for day-to-day operations, including security patrols and other duties.[73] Residents may vote in governance decisions, and they may be expected to attend weekly resident meetings in accordance with an encampment-wide code of conduct.[74] A key informant conducting research on encampments described the social structure established by a group of mothers staying with their children in a recently cleared encampment in Oakland, California. Residents of the encampment prohibited drug use and shared responsibility for childcare. These expectations promote a sense of community and have been credited with helping encampment residents "feel human" and believe that they have something to contribute (349).[75] However the potential for exploitation exists in encampments.

[73] Chris Herring, and Manuel Lutz, "The Roots and Implications of the USA's Homeless Tent Cities," *City* 19, no. 5 (2015): 689-701.; Tony Sparks, "Citizens Without Property: Informality and Political Agency in a Seattle, Washington Homeless Encampment." *Environment and Planning A: Economy and Space* 49, no. 1 (2017): 86-103.
[74] Sparks, "Citizens Without Property."
[75] Tony Sparks, "Neutralizing Homelessness, 2015: Tent Cities and Ten-Year Plans," *Urban Geography* 38, no. 3 (2017): 348-356, 389.; Rebecca Cohen, Will Yetvin, and Jill Khadduri, "Understanding Encampments of People Experiencing Homelessness and Community Responses: Emerging Evidence as of Late 2018," *U.S. Department of Housing and Urban Development*, June 24, 2020, http://dx.doi.org/10.2139/ssrn.3615828.

The rise of homelessness encampments during the COVID-19 Pandemic.

50. There can be no doubt that the number of encampments grew dramatically across Canada during the COVID-19 pandemic, but this should not have come as a surprise. In fact, it was entirely predictable. In a book chapter on homelessness and pandemics authored by myself and Kristy Buccieri, we suggested that:

> One lesson emergency planners have learned is that complex disasters have a way of evolving along unanticipated lines — and a pandemic is certainly a complex disaster. Compromised health and overcrowded living conditions may make people who are homeless particularly vulnerable in the event of a pandemic, forcing them to make different decisions because of their circumstances. Factors that impact on decision-making include having fewer options (for example, regarding shelter and transportation), limited access to resources or the ability to prepare in advance (by stockpiling food and other necessities), and being unable to adhere to forced or voluntary quarantine without a home of their own. Because of overcrowded conditions and safety concerns, many people who are homeless will limit their use of such services or avoid them altogether (25-26). [76]

51. The perception of people experiencing homelessness that they would be safer during the COVID-19 pandemic living in an encampment is not incorrect. One study in Denver Colorado with a large-scale sample found that the rate of COVID-19 was lower for people living in encampments compared to those who stayed at homeless shelters: "A higher proportion of persons tested at overnight shelters were SARS-CoV-2 seropositive compared with those tested at encampments (21.5% vs 8.7%, $P = .006$)." (3).[77]

[76] Gaetz, and Buccieri, "The Worst of Times," 25-26.
[77] Rowan et al., "Lower Prevalence of Severe Acute Respiratory Syndrome Coronavirus 2," 3.

The benefits of an encampment for people experiencing homelessness

52. There are three main reasons why people experiencing homelessness may choose encampments over other alternatives such as homeless shelters:

53. ***First***, **homelessness shelters do not meet people's needs**. There are compelling and rational reasons why people would choose to not stay at homelessness shelters:

> Shortcomings in the shelter system are consistently identified as a primary factor that "pushes" people to congregate in encampments. Many communities have literal shortages in the capacity of the shelter system to provide beds for everyone experiencing homelessness. In other communities, shelter beds are available but go unused because of regulations or conditions that are incompatible with potential clients' expectations or needs. Exhibit 2 lists some of the reasons cited in the literature and in key informant interviews why people experiencing homelessness may eschew shelters in favor of encampments (4).[78]

Exhibit 2. Shortcomings in the Shelter System

Specific shortcomings in the shelter system that may contribute to increased numbers of people congregating in encampments:

- A supply of shelter beds insufficient to meet the demand; this problem may be exacerbated by limited funding for emergency shelters and by community opposition to creating new or expanded shelter and bridge housing facilities or permanent supportive housing.
- Restrictions in shelters that would result in separation from a partner, family member, or pet.
- Shelter entry/exit times and locations that are inconvenient or incompatible with people's daily routines, including work schedules.
- Concerns about the security of personal belongings; restrictions on the ability to store belongings and difficulty moving belongings in and out of shelters on a daily basis.
- Concerns about personal safety and exposure to germs and disease within shelters.

[78] Cohen, Yetvin, and Khadduri, "Understanding Encampments of People," 4.

- Specific barriers to entry, including sobriety requirements and entry fees.
- General perceptions of shelters as "inhospitable," "alienating," "demeaning," and offering little or no support or case management to find permanent housing (5).[79]

54. ***Second*, encampments provide a sense of safety and community**. People experiencing homelessness are more likely to be victims of crime. While there is still risk of crime in encampments, people still find them safer in part because they are able to surround themselves with people of their choosing. Romantic couples are not forced to stay apart, friends can be with friends, people can look out for each other and watch over personal belongings if people need to leave an encampment temporarily. Collectively people can begin to develop a sense of community:

> People who stay in encampments may see them as offering greater safety and protection from police harassment and aggression, and from assaults or the theft of belongings, than if they were unsheltered on their own. This sense of "safety in numbers" may be particularly prevalent in long-standing and highly organized encampments, in which residents have established around-the-clock security patrols and mutually enforced norms and standards for behavior. In high-cost cities in particular, individuals' decision to congregate in an encampment may be influenced by the behavior of their peers, according to a key informant who is conducting research on encampments. Once a critical mass of people has determined that encampments are a way of dealing with their housing crisis, others may feel emboldened to follow suit. Some cities respond to the presence of an established encampment by providing bathroom facilities and other basic services, making

[79] Cohen, Yetvin, and Khadduri, "Understanding Encampments of People," 5.

> encampments seem to be a reasonable alternative to constant moving, threats of eviction, or shelters (5). [80]

In summary, there is often a sense of community that develops among encampment residents, and people come to rely on one another to watch their belongings when they leave the encampment site (although thefts do take place), to supervise drug consumption and respond to overdoses, and to share resources. Perspectives from individuals living in tent cities in the US have revealed that encampments can provide a sense of safety and autonomy that is not felt in shelters.

55. ***Third, encampments accommodate the desire for autonomy and privacy***. As discussed above, homelessness services are typically rule-bound environments that restrict what people can do and when. Individuals are subject to curfews, restrictions on drinking alcohol or using other substances, and are not able to stay with partners or friends, and do not have control over what you they can do and when:

> In contrast to the rules that govern many aspects of shelter stays, staying in an encampment means that people can generally come and go as they please. The ability to exercise autonomy and freedom of movement appears to be a powerful factor that draws some people to encampments[81]. This independence is sometimes eroded in communities that "normalize" encampments, introducing regulations that restrict residents' activities in the

[80] Cohen, Yetvin, and Khadduri, "Understanding Encampments of People," 5,
*Internal citations omitted.

[81] National Law Center on Homelessness and Poverty. 2014. Welcome Home: The Rise of Tent Cities in the United States. Washington, DC: National Law Center on Homelessness and Poverty.
Sparks, T. 2017a. Citizens Without Property: Informality and Political Agency in a Seattle, Washington Homeless Encampment. Environment and Planning 49 (1): 86–103. doi:10.1177/0308518X16665360.

> process. When that happens, encampments may in effect become an extension of the same shelter system that people reject in favor of encampments. [82]

Addressing encampments through law enforcement.

56. The presence of homelessness encampments makes the issue of homelessness publicly visible. Responses to homelessness in such circumstances are often framed by discourses that stigmatize people experiencing homelessness, and often result in the use of law enforcement to contain and eradicate encampments, without resolving the underlying conditions that perpetuate the homelessness of residents of encampments. The problem is not that people are choosing to live in tents in parks because they are law breakers or don't like to follow rules, it is that people lack money and resources to access and maintain stable housing. Their poverty gets framed as a nuisance and disorder, resulting in the use of law enforcement to address a social and economic problem:

> Encampments are often portrayed publicly through three closely linked narratives—individual deficiencies, mental health and substance use, and criminalization—which often inform governmental, community, and non-profit responses to these sites. Despite the fact that people experiencing homelessness are no more likely to break the law, except for laws that punish people for living outdoors, community opposition to encampments is often based in fears of increasing crime rates and jeopardizing public health and safety (989). [83]

[82] Cohen, Yetvin, and Khadduri, "Understanding Encampments of People," 6
[83] Nicholas Olson, and Bernadette Pauly, "Homeless Encampments: Connecting Public Health and Human Rights," *Canadian Journal of Public Health* 112, no. 6 (2021): 989.
*Internal citations omitted.

57. A report by the National Law Center on Homelessness and Poverty discusses the negative impacts of the criminalization of homelessness and encampments:

> Many communities have responded to the growth of encampments described above by increasing the number, and the enforcement, of laws criminalizing homelessness. These policies are tremendously expensive for communities, and involvement in the criminal justice system often results in the further entrenchment of homelessness. It costs time and money to extricate oneself from the criminal justice system; criminal records make it more difficult to find jobs or housing. Sweeps of encampments without ensuring adequate notice and alternative housing can be life-threatening for the individuals living there. A handful of communities have begun looking at more constructive, less punitive approaches. [84]

Guidance and Protocols for Addressing Homelessness Encampments in Canada and the United States

58. In 2015, the U.S. Interagency Council on Homelessness issued *Ending Homelessness for People Living in Encampments: Advancing the Dialogue*, which contains a useful checklist approach for communities addressing homeless encampments. The guidance first sets forth several underlying principles, including:

1. The forced dispersal of people from encampment settings is not an appropriate solution or strategy, accomplishes nothing toward the goal of linking people to permanent housing opportunities, and can make it more difficult to provide such lasting solutions to people who have been sleeping and living in the encampment (2). [85]

[84] National Law Centre on Homelessness and Poverty, "Tent City U.S.A.," 28.
[85] United States Interagency on Homelessness, "Ending Homelessness for People Living in Encampments: Advancing the Dialogue," August 13, 2015, accessed June 7, 2022, 2, https://www.usich.gov/resources/uploads/asset_library/Ending_Homelessness_for_People_Living_in_Encampments

2. Providing lasting solutions and ending the homelessness of people living in encampments requires a thoughtful, coordinated, and collaborative plan and process to ensure that people can be linked to appropriate housing options and that the presence of encampments in the community can be resolved (3).[86]

59. Based on these principles, the guidance offers an action planning checklist based around four key elements:

1. **Preparation and Adequate Time for Planning and Implementation**: Action plans for creating and providing housing solutions for people living in encampments should ensure that there is adequate time for strategizing, collaboration, outreach, engagement, and the identification of meaningful housing options. Adequate time is essential to achieve the primary objective of meeting the needs of each person and assisting them to end their homelessness.
2. **Collaboration across Sectors and Systems:** Action plans should include collaboration between a cross-section of public and private agencies, neighbors, business owners, and governmental entities, based upon on where the encampment is located. The action plan should feature strong communication among a broad range of community service providers and managers of the permanent housing resources that are being utilized in order to maximize efficiency, align resources, and address system gaps.
3. **Performance of Intensive and Persistent Outreach and Engagement:** Action plans should involve agencies that have strong outreach experience and demonstrated skills

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[86] United States Interagency on Homelessness, "Ending Homelessness for People," 3.

in engaging vulnerable and unsheltered people. Effective outreach is essential for effectively connecting people with coordinated assessment systems, resources, and housing options.

4. **Provision of Low-Barrier Pathways to Permanent Housing**: Action plans should focus on providing people with clear, low-barrier pathways for accessing and attaining permanent housing opportunities and should not focus on relocating people to other encampment settings (3-4).[87]

60. Leilani Fahra, former UN Special Rapporteur on the right to adequate housing, and Kaitlin Schwan authored *A National Protocol for Homelessness Encampments in Canada* in 2020. They identified the following eight principles to guide governments and other stakeholders in adopting a rights-based response to encampments.

Principle 1: Recognize residents of homeless encampments as rights holders. All government action with respect to homeless encampments must be guided by a commitment to upholding the human rights and human dignity of their residents. This means a shift away from criminalizing, penalizing, or obstructing homeless encampments, to an approach rooted in rights-based participation and accountability.

Principle 2: Meaningful engagement and effective participation of homeless encampment residents. Residents are entitled to meaningful participation in the design and implementation of policies, programs, and practices that affect them. Ensuring meaningful participation is central to respecting residents' autonomy, dignity, agency, and self-determination. Engagement should begin early, be ongoing, and proceed under the principle that residents are experts in their own lives. The views expressed by residents of

[87] United States Interagency on Homelessness, "Ending Homelessness for People," 3-4.

homeless encampments must be afforded adequate and due consideration in all decision-making processes. The right to participate requires that all residents be provided with information, resources, and opportunities to directly influence decisions that affect them.

Principle 3: Prohibit forced evictions of homeless encampments. International human rights law does not permit governments to destroy peoples' homes, even if those homes are made of improvised materials and established without legal authority. Governments may not remove residents from encampments without meaningfully engaging with them and identifying alternative places to live that are acceptable to them. Any such removal from their homes or from the land which they occupy, without the provision of appropriate forms of legal protection, is defined as a 'forced eviction' and is considered a gross violation of human rights. The removal of residents' private property without their knowledge and consent is also strictly prohibited. Common reasons used to justify evictions of encampments, such as 'public interest,' 'city beautification', development or re-development, or at the behest of private actors (e.g., real estate firms), do not justify forced evictions.

Principle 4: Explore all viable alternatives to eviction. Governments must explore all viable alternatives to eviction, ensuring the meaningful and effective participation of residents in discussions regarding the future of the encampment. Meaningful consultation should seek to maximize participation and should be supported by access to free and independent legal advice. Where personal needs differ amongst residents of encampments such that a singular best alternative is not unanimous, governments will have to develop several solutions each of which is consistent with the principles outlined in this Protocol.

Principle 5: Ensure that relocation is human rights compliant. Considerations regarding relocation must be grounded in the principle that "the right to remain in one's home and community is central to the right to housing."2 Meaningful, robust, and ongoing engagement with residents is required for any decisions regarding relocation. Governments must adhere to the right to housing and other human rights standards when relocation is necessary or preferred by residents. In such cases, adequate alternative housing, with all necessary amenities, must be provided to all residents prior to any eviction. Relocation must not result in the continuation or exacerbation of homelessness, or require the fracturing of families or partnerships.

Principle 6: Ensure encampments meet basic needs of residents consistent with human rights. Canadian governments must ensure, at a minimum, that basic adequacy standards are ensured in homeless encampments while adequate housing options are negotiated and secured. Governments' compliance with international human rights law requires: (1) access to safe and clean drinking water, (2) access to hygiene and sanitation facilities, (3) resources and support to ensure fire safety, (4) waste management systems, (4) social supports and services, and guarantee of personal safety of residents, (5) facilities and resources that support food safety, (6) resources to support harm reduction, and (7) rodent and pest prevention.

Principle 7: Ensure human rights-based goals and outcomes, and the preservation of dignity for homeless encampment residents. Governments have an obligation to bring about positive human rights outcomes in all of their activities and decisions concerning homeless encampments. This means that Canadian governments must move, on a priority basis, towards the full enjoyment of the right to housing for encampment residents. Any

decision that does not lead to the furthering of inhabitants' human rights, that does not ensure their dignity, or that represents a backwards step in terms of their enjoyment of human rights, is contrary to human rights law.

Principle 8: Respect, protect, and fulfill the distinct rights of Indigenous Peoples in all engagements with homeless encampments. Governments' engagement with Indigenous Peoples in homeless encampments must be guided by the obligation to respect, protect, and fulfil their distinct rights. This begins with recognition of the distinct relationship that Indigenous Peoples have to their lands and territories, and their right to construct shelter in ways that are culturally, historically, and spiritually significant. Governments must meaningfully consult with Indigenous encampment residents concerning any decisions that affects them, recognizing their right to self-determination and self-governance. International human rights law strictly forbids the forced eviction, displacement, and relocation of Indigenous Peoples in the absence of free, prior, and informed consent. Given the disproportionate violence faced by Indigenous women, girls, and gender diverse peoples, governments have an urgent obligation to protect these groups against all forms of violence and discrimination within homeless encampments, in a manner that is consistent with Indigenous self-determination and self-governance (2-4). [88]

[88] Leilani Farha, and Kaitlin Schwan, "A National Protocol for Homeless Encampments in Canada: A Human Rights Approach," *UN Special Rapporteur on the Right to Housing*, April 30, 2020, accessed June 7, 2022, 2-4, https://www.make-the-shift.org/wp-content/uploads/2020/04/A-National-Protocol-for-Homeless-Encampments-in-Canada.pdf.

Sworn remotely by Stephen Gaetz at the Town of Colborne, in the Province of Ontario, before me on June 14, 2022 by "zoom" videoconference in accordance with O. Reg. 431/20, of Administering Oath or Declaration Remotely.

Stephanie Cox

Commissioner for Taking Affidavits

Stephanie Cox, LSUC 65464F



Stephen Gaetz

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THIS IS EXHIBIT “A” TO THE
AFFIDAVIT OF STEPHEN GATES
AFFIRMED REMOTELY BEFORE ME AT
THE CITY OF COLBORNE DURING A “ZOOM” VIDEOCONFERENCE
IN ACCORDANCE WITH O.REG. 431/20,
ADMINISTERING OATH OR DECLARATION REMOTELY
THIS 14TH DAY OF JUNE, 2022

Stephanie Cox

STEPHANIE COX
LSO NO. 65464F
Commissioner for Taking Affidavits, etc

CURRICULUM VITAE

A) PERSONAL

1. NAME

Stephen Anthony Gaetz
Faculty of Education
York University
631 Kaneff Tower
4700 Keele St.
Toronto, ON M3J 1P3
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2. CURRENT POSITION

Professor, Faculty of Education, York University

President and CEO, Canadian Observatory on Homelessness

Research Director, Making the Shift – Youth Homelessness Social Innovation Lab

Director, Toronto Center of Excellence on Youth Homelessness Prevention at York University (Toronto Centre of Excellence). United Nations Economic Commission for Europe.

3. DEGREES

1990 Ph.D. Anthropology York University, Toronto
Dissertation title: *Community Action and the Provision of Youth Services in Cork, Ireland*

1985 M.A. Anthropology York University, Toronto
Dissertation title: *Youth Expression in the Eighties: A Network Analysis of Punks in Toronto*

1983 B.A. Anthropology (Honours) University of Calgary

4. EMPLOYMENT HISTORY

2014 -	Professor – Faculty of Education, York University
2005 - 2014	Associate Professor - Faculty of Education, York University
2012 - 2013	Associate Dean, Research and Professional Development - Faculty of Education, York University
2007 – 2011	Associate Dean, Research and Professional Development – Faculty of Education, York University
2000 - 2005	Assistant Professor - Faculty of Education, York University
2000 -	Appointment to the Faculty of Graduate Studies, York University
1999 - 2000	Community Development Officer - Community and Neighbourhood Services Department, City of Toronto
1999	Coordinator, Homeless Initiative - Queen West Community Health Centre
1993 - 1999	Health Promoter - Shout Clinic, Toronto, Ontario
1992 - 1993	Lecturer - Department of Anthropology, York University
1990 - 1992	Post-Doctoral Fellow - Department of Anthropology, York University

5. HONOURS AND AWARDS

2020	York Research Chair in Homelessness and Research Impact
2020	York University Research Leader Award
2019	York University Research Leader Award
2017	York University Research Leader Award
2016	Member of the Order of Canada
2016	Dean's Research Award – Faculty of Education
2016	York University Research Leader Award
2015	SSHRC Research Impact – Connection Award
2015	York University Research Leader Award
2013	Faculty of Education Merit Award - $3000
2012	Faculty of Education Merit Award - $2000
2011	Faculty of Education Merit Award - $2000
2010	Faculty of Education Merit Award - $2000
2009	Faculty of Education Merit Award - $2000

2008	Faculty of Education Merit Award - $2000
1990 - 1992	Social Sciences and Humanities Research Council of Canada Postdoctoral Fellowship
1986 - 1989	Social Sciences and Humanities Research Council of Canada Doctoral Fellowship
1986	Ontario Graduate Scholarship (declined)
1985	Ontario Graduate Scholarship

ADVISORY PANELS and COMMITTEES

2018- present	Government of Canada –Reaching Home's Data Strategy Advisory Committee
2017-18	Government of Canada – Advisory Committee on Homelessness
2016-17	Government of Canada – Advisory Committee on Poverty Reduction Strategy
2015	Province of Ontario - Expert Advisory Panel on Homelessness
2013-14	Canadian Mental Health Association – Advisory Committee on Housing First

B SCHOLARLY AND PROFESSIONAL CONTRIBUTIONS

1. SUMMARY OF PUBLICATIONS AND PROFESSIONAL CONTRIBUTIONS

Books: 1
Edited books, special issues of journals: 5
Articles in refereed journals: 42
Chapters in books: 22
Professional Reports: 45 (Peer reviewed: 13)
Conference presentations: 166
Keynote addresses: 31
Invited presentations: 207
Webinars: 18
Book Reviews: 2
Curriculum Materials: 7
Other publications: 8
Blog posts: 32

CITATIONS

	All	Since 2017
Citations	4491	2531
h-index	29	23
i10-index	54	44

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2. PUBLICATIONS:

Books and Monographs

Gaetz, Stephen (1997) *Looking Out for the Lads: Community Action and Youth Provision in an Urban Irish Parish.* St. John's, Nfld.: Institute of Social and Economic Research 235 pg.

Edited books, special issues of journals:

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Gaetz, Stephen (2015) "A pragmatic, humanistic and effective approach to addictions: The Importance of Harm Reduction" in, Inclusion Working Group, Canadian Observatory on Homelessness (Eds.), Homelessness is Only One Piece of My Puzzle: Implications for Policy and Practice. Toronto: The Homelessness Hub Press. P. 104-112

Gaetz, Stephen (2015) "Conclusion: Listen up! The role of dignity, respect and inclusion in our response to homelessness" in, Inclusion Working Group, Canadian Observatory on

Homelessness (Eds.), Homelessness is Only One Piece of My Puzzle: Implications for Policy and Practice. Toronto: The Homelessness Hub Press. P: 162-175

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3. PRESENTATIONS and PUBLIC LECTURES

Conference Presentations

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Gaetz, Stephen (2021) *Research Impact and Homelessness.* Campaigning: A Case Study on Homelessness Advocacy (On Line). February 25, 2021

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Gaetz, Stephen & Redman, Melanie (2020) *Preventing Youth Homelessness through Duty to Assist*. Atlantic Summer Institute on Healthy and Safe Communities (On Line). August 14, 2020

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Gaetz, Stephen & Redman, Melanie (2019) *Designing the Adaptation of a Duty to Assist in Canada.* Edmonton: National Conference on Ending Homelessness (CAEH). November 4, 2019

Gaetz, Stephen; Redman, Melanie & Sheryl Green (2019) *Making the Shift – A Youth Homelessness Social Innovation Lab.* Edmonton: National Conference on Ending Homelessness (CAEH). November 4, 2019

Gaetz, Stephen (2019) *Implementing Housing First for Youth..* Melbourne Australia. Victorian Homelessness Conference. October 15, 2019

Redman, Melanie & Stephen Gaetz (2019) *Designing the Adaptation of a Duty to Assist in Canada.* European Observatory on Homelessness Research Conference. Helsinborg, Sweden. September 20, 2019

Gaetz, Stephen & Redman, Melanie (2019) *Ending Youth Homelessness.* The Voices of People with Lived Experience. Charlottown, PEI: Atlantic Summer Institute Supportive Environments for Child and Youth Mental Health: Our Shared Responsibility! August 20, 2019

Redman, Melanie & Gaetz, Stephen, (2019) *A Way Home.* Hinkley Island, England: Under One Roof: Homeless Link Annual Conference. July 3, 2019

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Gaetz, Stephen (2018) *Making Research Matter! The Canadian Observatory on Homelessness.* Hamilton, Ontario: Canadian Alliance to End Homelessness Conference. November 6, 2018

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Redman, Melanie & Stephen Gaetz (2018) *A Way Home: Updates from Canada*. Edinburgh Scotland: National Conference on Ending Youth Homelessness. Sept 18, 2018

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Gaetz, Stephen & Redman, Melanie (2018) *Transforming Systems for Change: Lessons from Canada*. New York: National Symposium on Solutions to End Youth Homelessness. April 30, 2018

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Gaetz, Stephen & Dej, Erin (2017) "Homelessness Prevention – From Framework to Action". Winnipeg, Manitoba. Canadian Alliance to End Homelessness Conference, October 26, 2017

Gaetz, Stephen & Schwan, Kaitlin (2017) "Preventing Youth Homelessness- 1o things we can do". Winnipeg, Manitoba. Canadian Alliance to End Homelessness Conference, October 25, 2017

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Gaetz, Stephen (2017) "Understanding Youth Homelessness in Canada – The first national survey". Barcelona, Catalonia. European Observatory on Homelessness Conference, September 22, 2017

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Gaetz, Stephen (2017) "Homelessness Prevention and Housing First for Youth". CHRA Congress Halifax, ON. May 4, 2017

Gaetz, Stephen (2016) "Housing First for Youth". *New Directions – National Conference on Homelessness*. Edinburgh Scotland. November 10, 2016

Gaetz, Stephen (2016) "Knowledge Mobilization and Design Thinking". Tackling Homelessness: Developing and Sharing Best Practice. Bristol, UK. November 8, 2016

Gaetz, Stephen (2016) "Homelessness Prevention 101". *Canadian Alliance to End Homelessness conference*. London, Ontario. November 3, 2016

Gaetz, Stephen (2016) "The State of Homelessness in Canada 2016". *Canadian Alliance to End Homelessness conference*. London, Ontario. November 3, 2016

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Gaetz, Stephen (2016) "Criminalizing Homelessness in Canada: The Impact on Homeless Youth". *International Community Corrections Association*. Toronto, ON October 4, 2016

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Gaetz, Stephen (2016) "Rural Homelessness and Housing First for Youth". *Rural Sociological Society Conference*. Toronto, ON. August 8, 2016

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Redman, Melanie & Gaetz, Stephen (2016) "*A Way Home". FEANTSA Policy Conference.* Brussels Belgium. June 10, 2016

Gaetz, Stephen & Redman, Melanie (2016) "Housing First for Youth in Europe – A Human Rights Approach" *Rock Trust – Ending Youth Homelessness National Conference.* Edinburgh Scotland. June 6, 2016

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Gaetz, Stephen (2015) "Panel: Exploring effective systems responses to homelessness - systems, planning and coordination" *CAEH 2015 – National Conference on Ending Homelessness.* Montreal, Que. October 19, 2015

Gaetz, Stephen (2015) "A Framework for Systems Integration" *CAEH 2015 – National Conference on Ending Homelessness.* Montreal, Que. October 19, 2015

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Gaetz, Stephen (2015) "Criminalizing Homelessness in Canada: What happens when we use policing as a strategic response to youth homelessness?." *International Academy of Law and Mental Health Congress.* Vienna, Austria. July 17, 2015

Gaetz, Stephen (2015) "Oh Canada! Lessons on Housing First from the Canadian Response to Homelessness." *Housing First Day conference,* Utrect NL. July 6th, 2015

Gaetz, Stephen (2015) "A Framework for Housing First for Youth." *Housing First Day conference,* Utrect NL. July 6th, 2015

Redman, Melanie & Gaetz, Stephen (2015) "Building Links for the Prevention of Youth Homelessness." *FEANTSA Conference.* Paris, June 20th, 2015

Gaetz, Stephen & Redman, Melanie (2015) "Youth Homelessness in Canada: Does Challenging Measures that Criminalize Youth Homelessness Work?", *Housing Rights Watch Conference.* Paris, June 18th, 2015

Gaetz, Stephen (2015) "Panel presentation – The Criminalization of Youth Homelessness." *The Legal Needs of Street Youth conference.* London, UK June 17, 2015

Gaetz, Stephen (2015) "Solving Youth Homelessness – Lessons from Canada" Homelessness in a Global Landscape Conference – Institute of Global Homelessness, Chicago, IL., June 2st, 2015

Gaetz, Stephen (2015) "Understanding and measuring homelessness in Canada" Homelessness in a Global Landscape Conference – Institute of Global Homelessness, Chicago, IL., June 1st, 2015

Gaetz, Stephen (2015) "Canadian Point-in-Time Count – Implementation Toolkit" *Government of Canada – Homelessness Partnering Strategy – HPS PiT Count Workshop.* Winnipeg, MN May 1, 2015

Gaetz, Stephen (2015) "From Child Protection to Youth Homelessness: Can we turn off the taps?" *Canadian Housing and Renewal Association National Conference on Housing and Homelessness.* Winnipeg, MN April 30th, 2015

Gaetz, Stephen (2015) "Canadian Point-in-Time Count – Implementation Toolkit" *Government of Canada – Homelessness Partnering Strategy – HPS PiT Count Working Group.* Ottawa, ON April 9, 2015

Gaetz, Stephen (2015) "Solving Youth Homelessness. Lessons from Canada" *Ending Family and Youth Homelessness.* National Alliance to End Homelessness. San Diego, CA. February 19, 2015

Gaetz, Stephen (2014) "Canadian Point-in-Time Count Methodology and Toolkit" National Conference on Ending Homelessness. Vancouver, BC. November 5, 2014.

Gaetz, Stephen (2014) "Can we think about a Housing First strategy for Youth?" National Conference on Ending Homelessness. Vancouver, BC. November 4, 2014.

Gaetz, Stephen (2014) "Thinking about an End to Youth Homelessness" National Conference on Ending Homelessness. Vancouver, BC. November 3, 2014.

Gaetz, Stephen (2014) "Housing First for Youth" National Conference on Ending Homelessness. Vancouver, BC. November 3, 2014.

Gaetz, Stephen (2014) "Young, Female and Homeless" One in Four Convening on Unaccompanied Homeless Women. Harvard, Oct. 24, 2014.

Gaetz, Stephen (2014) "Can Housing First work for youth?". *8th National Conference on Homelessness*. Brisbane Australia, September 12, 2014

Gaetz, Stephen (2014) "Preventing Youth Homelessness - What do we know? What should we do?" *8th National Conference on Homelessness.* Brisbane Australia, September 11, 2014

Gaetz, Stephen (2014) "Oh Canada! Housing first and the evolution of the Canadian response to Homelessness". *8th National Conference on Homelessness.* Brisbane Australia, September 11, 2014

Gaetz, Stephen (2014) "A Framework for Housing First for Youth". *National Alliance to End Homelessness conference*. Washington, DC. July 29, 2014.

Gaetz, Stephen (2014) "Why youth homelessness is different than adult homelessness". *National Alliance to End Homelessness conference*. Washington, DC. July 29, 2014.

Gaetz, Stephen (2014) "Thinking about . . . Youth Homelessness" *Western Next Practices Colloquy*. Lost Angeles, June 18, 2014

Gaetz, Stephen (2014) "A Safe and Decent Place to Live: Understanding youth homelessness in urban and rural areas of Canada". *Youth Housing and Homelessness Conference.* Ottawa, June 23, 2013

Gaetz, Stephen (2014) "Preventing Youth Homelessness" *FEANTSA Youth Homelessness Study Session*. Budapest, Hungary. March 4, 2014.

Gaetz, Stephen (2014) "Research Impact! How research can contribute to ending homelessness." *Housing First Conference*, Kelowna BC. February 27, 2014.

Gaetz, Stephen (2014) "Housing Options for Youth". National Alliance to End Homelessness, Ending Family and Youth Homelessness Conference. New Orleans, LA. Feb 17, 2014.

Gaetz, Stephen. (2014) "Rethinking Our Response to Youth Homelessness" *Ending Youth Homelessness in Red Deer conference*. Red Deer Alberta. January 29, 2014.

Gaetz, Stephen (2013) "Towards a Prevention Framework for Homeless Youth". *FEANTSA Conference on Youth Homelessness.* Prague, Czech Republic. November 9, 2013

Gaetz, Stephen (2013) "Making Research Matter! How Research Can Contribute to Ending Homelessness." *Homelessness Partnering Strategy – National Workshop on Housing First. Ottawa,* ON, November 1, 2013

Gaetz, Stephen (2013) "Research Matters: The Canadian Homelessness Research Network." *National Conference on Ending Homelessness*. Ottawa: October 28th, 2013

Gaetz, Stephen (2013) "The State of Homelessness in Canada, 2013." *National Conference on Ending Homelessness*. Ottawa: October 28th, 2013

Gaetz, Stephen (2013) "A Framework for Preventing Youth Homelessness", *Next Practices*. Boston, USA. October 25th, 2013

Gaetz, Stephen (2013) "Knowledge Mobilization as Design", *York Symposium on the Scholarship of Engagement*. York University, Toronto Canada. October 2, 2013

Gaetz, Stephen (2013) "Adaptation and Implementation Challenges for Housing First", *Housing First. What's Second?* FEANTSA European Research Conference - Berlin, Germany, September 20th, 2013

Gaetz, Stephen (2013) "Family Matters – Youth Homelessness and Family Reconnection". National Alliance to End Homelessness Conference. Washington, DC., July 20th, 2013

Gaetz, Stephen (2013) "Rethinking Models of Prevention, Accommodation and Support for Homeless Youth" *International Homelessness Research Conference*, Philadelphia, Pennsylvania, June 3, 2013

Gaetz, Stephen (2013) "The Real Cost of Homelessness" *Canadian Economics Association conference*, Montreal, May 30, 2013

Gaetz, Stephen (2013) "The Bottom Three Feet of the City: Youth Homelessness and Geographies of Exclusion". *Canadian Anthropology Society meetings*. Victoria, May 10, 2013

Gaetz, Stephen (2013) "Research Impact! Using Research to Support the Work of CABS". *Canadian Housing and Renewal Association – Community Advisory Body Meeting*. Ottawa, May 6, 2013

Gaetz, Stephen (2013) "Reimagining our Response to Youth Homelessness?" *Social Planning Council of Hamilton, Community Meeting.* Hamilton April 24, 2013

Gaetz, Stephen (2013) "The Real Cost of Homelessness" *Northern Housing Conference*, Whitehorse, Yukon. March 25, 2013

Gaetz, Stephen (2013) "A Framework for Preventing Youth Homelessness" *Ending Family and Youth Homelessness*, National Alliance to End Homelessness. Seattle WA, Feb 21, 2013

Gaetz, Stephen (2012) "Supporting Transitions to Adulthood: The Foyer". *Ontario Non-Profit Housing Association Conference*. Toronto. November 17, 2012.

Gaetz, Stephen (2012) "Making Research Matter – Creating impact for Housing and Homelessness Research". *Ontario Non-Profit Housing Association Conference*. Toronto. November 17, 2012.

Gaetz, Stephen (2012) "Homelessness, Social Exclusion and the Risk of Tuberculosis Infection". *Tuberculosis in Canada: Detection, Intervention and Compliance.* Centre for Disease Modelling. Ottawa: November 15, 2012

Gaetz, Stephen (2012) "Stopping the Problem Before it Starts. A Prevention Response to Youth Homelessness" *Pushing the Limits conference*. United Way of Calgary and Area. October 18, 2012

Gaetz, Stephen (2012) "The Possibilities of Connection: Linking schools, community organizations and families in addressing youth homelessness in Australia and the UK" *Pushing the Limits conference*. United Way of Calgary and Area. October 17, 2012

Gaetz, Stephen (2012) "Supporting Transitions to Independence. The Foyer." Woods Homes Provincial Youth Shelter Symposium. Calgary, September 20th, 2012

Gaetz, Stephen (2012). "Do we need a big bridge to cover a small gap since we're all on campus or do we need a small bridge to cover a large gap between research and practice?" *Knowledge Mobilization Forum,* Ottawa. June 17, 2012

Gaetz, Stephen (2012). "Responding to H1N1 in the Context of Homelessness in Canada". *Pan-inFORM – Indigenous Populations Health Protection – IPHP.* York University, May 7, 2012

Gaetz, Stephen (2012). "Thinking about Program Evaluation in the Homelessness Sector", *Homelessness Community Advisory Board Meeting*, St. John's, Nfld. May 4, 2012

Gaetz, Stephen (2012). "Towards a Canadian Definition of Homelessness" *Homelessness Community Advisory Board Meeting*, St. John's, Nfld. May 4, 2012

Gaetz, Stephen (2012). "Reimagining our Response to Youth Homelessness" *Canadian Housing Renewal Association.* St. John's Nfld., May 3, 2012.

Gaetz, Stephen & MacKinnon, Martha (2012) "Educating the Homeless Student. Pedagogical and Legal Issues." *Canadian Association for the Practical Study of Law in Education.* Ottawa, April 30, 2012

Gaetz, Stephen (2012). "Ending Homelessness – The role of data, evidence and knowledge mobilization" *Seven Cities on Housing and Homelessness – Leadership Summit.* Calgary, Alberta. April 16, 2012

Gaetz, Stephen (2012). "Knowledge Transfer and Networking Between Communities of Practice" *Espace public et sans domicile fixe: La Recherche S'Expose.* St. Etienne, France. March 7, 2012

Gaetz, Stephen (2012). "Making the Case for Housing First: What can Research Offer?" *Espace public et sans domicile fixe: La Recherche S'Expose.* St. Etienne, France. March 7, 2012

Gaetz, Stephen (2012). "The Housing Crisis and Homelessness: The Canadian Homeless Hub and Lessons For Ireland" New Housing Poverties in Contemporary Ireland. Cork, Ireland. March 2, 2012

Gaetz, Stephen (2011). "Reimagining our Response to Youth Homelessness: A Canadian and Global Perspective". *CMHC – National Housing Research Committee Meeting.* Ottawa, Nov. 8, 2011

Gaetz, Stephen (2011). (Chair and Session Organizer) "New Directions in Research on Youth Homelessness in Canada" *CMHC – National Housing Research Committee Meeting.* Ottawa, Nov. 8, 2011

Gaetz, Stephen (2011). "Reimagining our Response to Youth Homelessness in Canada". *ONPHA Conference*, Niagara Falls, ON. October 30, 2011

Gaetz, Stephen & O'Grady, Bill (2011). "Can I See Your ID? Policing and the Criminalization of Youth Homelessness in Canada". *Without a Home – Current Issues in Homelessness.* York University,Toronto, October 6, 2011.

Gaetz, Stephen (2011). "Responding to H1N1 in the Context of Homelessness in Canada". *Health Systems Research on H1N1 – Knowledge Exchange Workshop (CIHR)*. Ottawa. September 20, 2011

O'Grady, Bill & Gaetz, Stephen (2011). "Being Served and Protected: Un-housed youth's experiences with the Toronto Police Service". *American Bar Association Meetings*. Toronto, August 5, 2011

Gaetz, Stephen (2011) "Mobilizing Homelessness Research" *2011 Ontario Education Research Symposium.* Toronto. January 27, 2011

Gaetz, Stephen (2010). "Research and Policy". *The Road Home Conference on Homelessness*. Edmonton, Alberta. November 17

Gaetz, Stephen (2010). "Youth, Housing and Homelessness". *The Road Home Conference on Homelessness*. Edmonton, Alberta. November 16

Gaetz, Stephen (2010). "TEDx Presentation - Making Research Matter: Mobilizing Homelessness Research". Ctrl+Alt+Delete TEDx York U. November 4

Gaetz, Stephen (2010). Closing Plenary: "The Engaged Researcher" *l'itinérance. Défis théoriques et méthodologiques. Rethinking Homelessness. Theoretical and Methodological Challenges*. UQAM, Montreal, October 29

Gaetz, Stephen; Waegemakers-Schiff, Jeanette & Schiff, Rebecca (2010). "Pandemic preparedness for homeless persons in various Canadian cities". *l'itinérance. Défis théoriques et méthodologiques. Rethinking Homelessness. Theoretical and Methodological Challenges.* UQAM, Montreal, October 27

Gaetz, Stephen (2010). "Making Research Matter – Mobilizing Research to Help End Homelessness" *Calgary Homeless Foundation Research Conference*. Calgary, October 10, 2010

Gaetz, Stephen (2010). "Safe Streets, livable streets, *whose* streets? The law and order response to youth homelessness in Canada" *The Joe Doherty Seminar. The Changing Urban Frontier and Youth Homelessness* St. Andrews, Scotland. Feb. 10, 2010

Gaetz, Stephen (2009). "A Safe and Decent Place to Live". *Practice and Policy Innovations: Incorporating Socially Marginalized People in Housing and Communities.* Bellagio, Italy. November 5, 2009

Gaetz, Stephen (2009) The Canadian Response to Homelessness – Expensive but is it effective?" Tax Expenditures and Public Policy in Comparative Perspective Conference. Toronto, ON. September 10, 2009

Gaetz, Stephen (2009). "*Creating Agents of Change: Bringing Homelessness into the Classroom".* BC Teachers Federation Leadership Conference,. Vancouver, BC, August 2009

Gaetz, Stephen (2009). *Mobilizing Homelessness Research in Canada*. Growing Home: Housing and Homelessness in Canada. Calgary, February 2009

Gaetz, Stephen (2009). *Canadian Homelessness Research Network: Making Research Matter*. Growing Home: Housing and Homelessness in Canada. Calgary, February 2009

Gaetz, Stephen & Bill O'Grady (2008). *Youth Homelessness and Incarceration*. Raising the Roof - Partners Solving Youth Homelessness. Toronto, Nov. 2008

Gaetz, Stephen (2007). *The Homeless Hub: Canadian Homelessness Research Clearinghouse Project.* Ontario Municipal Social Services Association Annual Meeting. Toronto, Canada October, 2007

Gaetz, Stephen & O'Grady, Bill (2007). *Health among Toronto Street Youth: An Analysis of Immigrant & Non-Immigrant Youth.* ISA Research Committee on Family Studies Health in Families, Healthy Families: Gendered Explorations, Toronto, Canada

Gaetz, Stephen (2006). *Homelessness in Canada.* International Homelessness Seminar held in London, UK

Gaetz, Stephen (2006). *Developing a Clearinghouse of Homelessness Research in Canada.* Workshop: International Comparative Perspectives on Homelessness. 11th International Metropolis Conference. Lisbon, Portugal (October)

Gaetz, Stephen (2005). *Making Research Matter: The Emergence of Research as a Factor in Solving the Homelessness Crisis in Canada.* Breaking New Ground: Innovation in the Public Sector, International Conference, Cork Ireland (September, 2005).

Gaetz, Stephen & O'Grady, Bill (2005). *Diversity and Making Money: Race, Gender and the Economy of Young Homeless Workers in Toronto.* Canadian Conference on Homelessness. Toronto (May)

Naomi Dachner, Valerie Tarasuk, Jinguang Li, Stephen Gaetz & Blake Poland (2005). *Food Insecurity and Nutritional Vulnerability Among Homeless Youth in Toronto.* Canadian Conference on Homelessness. Toronto (May)

Naomi Dachner, Valerie Tarasuk, Stephen Gaetz & Blake Poland (2005). *An Examination of Community Efforts to Help Meet the Food Needs of Homeless People in Toronto.* Canadian Conference on Homelessness. Toronto (May)

Gaetz, Stephen (2004). *An Urban Other: Street Youth and Criminal Victimization in Toronto.* Association of Canadian Studies in Ireland. Cork, Ireland (April).

Gaetz, Stephen (2003). *Street Justice: Alternative Education and Social Inclusion.* Expanding Paradigms: What is Education Anyway?, Graduate Student Conference, York University. Toronto, Ontario.

Gaetz, Stephen & O'Grady, Bill (2002). *Street Youth and Gendered Work*. The Congress of Social Sciences and Humanities conference. Toronto, Ontario.

Gaetz, Stephen (2001). *Starting a Professional Development School*. International Conference on School Effectiveness and Improvement Annual Meeting. Toronto, Ontario.

Gaetz, Stephen & O'Grady, Bill (1999). *"Making a buck" - Income Generating Strategies of Street Youth in Toronto.* American Society of Criminology Annual Meeting. Toronto, Ontario.

Gaetz, Stephen (1999). *Developing Dental Services within a Community Health Centre Context*. Association of Ontario Health Centres Annual Meeting. London, Ontario.

Gaetz, Stephen (1998). *Street Youth and Sexuality*. Guelph Conference and Training Institute on Sexuality. Guelph, Ontario.

Gaetz, Stephen (1996). *Community Development and Lesbian, Gay and Bisexual Youth*. Other Young Lives II Conference. Toronto, Ontario.

Gaetz, Stephen & Travers, Anna (1996). *Are Street Youth a Community? Challenging Notions of Community Development*. Association of Ontario Community Health Centres Conference. Toronto, Ontario.

Gaetz, Stephen (1993). *Planning Community-based Youth Services in Cork, Ireland.* Canadian Association of Anthropology and Sociology. Toronto, Ontario.

Gaetz, Stephen (1991). *Turning Rebellion into Money: an Analysis of the Commodification of Punk Culture.* Critical Anthropology conference. Toronto Ontario.

Gaetz, Stephen (1986). *The Economy of Punks in Toronto*. Canadian Anthropological Association Meetings. Toronto, Ontario.

Gaetz, Stephen (1985). *Punks in Toronto*. North East Anthropology Association Meetings. Buffalo, N.Y.

Keynote Addresses

Gaetz, Stephen (2021) "Impact of Homelessness and Extreme Poverty on Involvement with the Criminal Justice System." *Annual Justice and Treatment Partnership Conference, Toronto (On Line) – December 7, 2021*. (Keynote Address)

Gaetz, Stephen & Redman, Melanie (2021) "Towards the Transformation of Our Response to Youth Homelessness". Australia – National Youth Homelessness Virtual Conference. June 15, 2021. (Keynote Address)

Gaetz, Stephen & Redman, Melanie (2020) "Making the Shift – A Youth Homelessness Social Innovation Lab and the Duty to Assist". London, UK: *Homelessness Prevention Conference | CRISIS*. March 20, 2020. (Keynote Address)

Redman, Melanie & Stephen Gaetz (2020) "Making the Shift – A Youth Homelessness Social Innovation Lab". Cardiff, Wales: *Preventing Youth Homelessness 2020*. March 9, 2020. (Keynote Address)

Gaetz, Stephen & Redman, Melanie (2019) "A Roadmap for the Prevention of Youth Homelessness". Sydney, Australia: *NSW Homelessness, AGM*. October 21, 2019. (Keynote Address)

Gaetz, Stephen (2019) "Lessons from Canada: Progress, Challenges, Next Steps". Melbourne Australia: *Victorian Homelessness Conference*. October 14, 2019. (Keynote Address)

Redman, Melanie & Stephen Gaetz (2019) "Creating Research Impact: Making the Shift, A Youth Homeless Social Innovation Lab". Toronto, York University: *Faculty of Education Launch*. Sept. 4, 2019. (Keynote Address)

Gaetz, Stephen (2018) "Can We End Youth Homelessness in Canada?". Toronto, ON: *The Jackman Lecture: York University*. December 4, 2018. (Keynote Address)

Gaetz, Stephen & Redman, Melanie (2018) "A Way Home: Transforming Systems for Change". Antwerp, Belgium: *Launch of A Way Home Europe*. Sept 17, 2018. (Keynote Address)

Redman, Melanie & Stephen Gaetz (2018) "What the Future Looks Like? A Roadmap for the Prevention of Youth Homelessness". New York: *Point Source Symposium on Solutions to Youth Homelessness*. Thursday, February 22, 2018. (Keynote Address)

Gaetz, Stephen & Redman, Melanie (2018) "What the Future Looks Like? A Roadmap for the Prevention of Youth Homelessness". Ottawa: *Coming Up Together Conference on Youth Homelessness.* Thursday, February 22, 2018. (Keynote Address)

Redman, Melanie & Stephen Gaetz (2018) "What the Future Looks Like? A Roadmap for the Prevention of Youth Homelessness". Toronto: *Homelessness Partnering Strategy / Government of Ontario Homelessness Conference*. January 23, 2018. (Keynote Address)

Gaetz, Stephen (2017) "Preventing and Ending Homelessness" Toronto, Ontario: *ICFHT AGM.* Monday, October 23, 2017. (Keynote Address)

Gaetz, Stephen (2017) "The *SHIFT* to end homelessness". Edmonton, Alberta: *Douglas R.W. Wilson lecture* Thursday, October 19, 2017. (Keynote Address)

Gaetz, Stephen (2015) "A Way Home" *OMSSA Conference on Homelessness Prevention, Toronto, ON.* November 25, 2015. (Keynote Address)

Gaetz, Stephen (2015) "Preventing Youth Homelessness through School-Based Initiatives." *Graduate Student Conference in Education*, York University, Toronto, ON, November 19, 2015. (Keynote Address)

Gaetz, Stephen (2015) "Knowledge Mobilization and Design Thinking: Towards Enhancing the Impact of Homelessness Research". *The North American HIV/AIDS Housing Summit VII.* Washington DC., September 15. (Keynote Address)

Gaetz, Stephen (2015) "Oh Canada! What we have learned, Where we are going …" *Launch of Edmonton Plan to Prevent, Reduce and End Youth Homelessness*. Edmonton, AB., June 10th, 2015. (Keynote Address)

Gaetz, Stephen (2015) "10 things I've learned about Youth Homelessness" *Youth Services Access and Design Forum – Homeward Trust*. Edmonton, AB., June 10th, 2015. (Keynote Address)

Gaetz, Stephen (2015) "Oh Canada! Lessons on Housing First from the Canadian Response to Homelessness" *Housing First: The Solution to Rough Sleeping? Pathway,*

Focus Ireland, City of Dublin. Dublin, Ireland., *June 26th,* 2015. (Keynote Address)

Gaetz, Stephen (2015) "Understanding Youth Homelessness in Canada" *Re-Imagining Youth Homelessness in Ottawa*. Calgary Homeless Foundation Research Symposium, Calgary, AB. April 22nd, 2015. (Keynote Address)

Gaetz, Stephen (2014) "Understanding Youth Homelessness in Canada" *Re-Imagining Youth Homelessness in Ottawa*. Youth Services Bureau, Ottawa. November 17th, 2014

Gaetz, Stephen (2014) "Thinking About Youth Homelessness" *Attacking Rural Homelessness in Lanark County*. Perth, Ontario. October 20, 2014. (Keynote Address)

Gaetz, Stephen (2014) "Oh Canada! Housing first and the evolution of the Canadian response to Homelessness". *8th National Conference on Homelessness.* Brisbane Australia, September 11, 2014. (Keynote Address)

Gaetz, Stephen (2014) Keynote Inaugural lecture of the Star Institute. Li Ka Shing Knowledge Institute, Toronto. On. September 30, 2014. (Keynote Address)

Gaetz, Stephen (2013) "Homelessness in Canada", *International Homelessness Research Conference*, Philadelphia, Pennsylvania, June 3, 2013. (Keynote Address)

Gaetz, Stephen (2013) "Research Impact! How Research Can Contribute to Ending Homelessness". *Southern Alberta Research Symposium*. City of Lethbridge, May 20, 2013

Gaetz, Stephen (2012) "Research Impact! How Research Can Contribute to Ending Homelessness". (Keynote Address) *Calgary Research Symposium*. Calgary Homeless Foundation. November 29, 2012

Gaetz, Stephen (2012) "What if every child had a caring adult in their life?" (Keynote Address) *Pushing the Limits conference*. United Way of Calgary and Area. October 17, 2012 (Keynote Address)

Gaetz, Stephen (2012) "What Works and For Whom? Developing a Framework for Promising Practices". (Keynote Address) *Workshop on Homelessness: Sharing Promising Practices*. Homelessness Partnering Strategy. October 11, 2012. (Keynote Address)

Gaetz, Stephen (2012) "Can We Reimagine our Response to Youth Homelessness?" *Woods Homes Provincial Youth Shelter Symposium.* Calgary, September 20th, 2012. (Keynote Address)

Gaetz, Stephen (2012). "Family Matters: Rethinking the role of family in our response to youth homelessness". Keynote panel. Graduate Students Conference in Education 2012: *Education in a Changing World.* York University. April 27, 2012. (Keynote Address)

Gaetz, Stephen (2010). "The Engaged Researcher: Making Research Matter" (Keynote Address) *Calgary Homeless Foundation Research Symposium*, August, 2010. (Keynote Address)

Gaetz, Stephen (2008). *Making Research Matter: Mobilizing Homelessness Research to End Homelessness.* Calgary Homeless foundation Research Symposium. Calgary, Canada. August, 2008. (Keynote Address)

Invited Public Lectures

Gaetz, Stephen (2022) "Can we end youth homelessness in Canada? " *Office of the President Salon*, York University. February 3, 2022

Gaetz, Stephen (2021) *"UN Sustainable Development Goals: Poverty and Homelessness*." *SDG Action Networking Series,* Government of Canada SDG Unit (ESDC). January 27, 2022,

Gaetz, Stephen (2021) "Building Large Scale Grants". *Vice President of Research and Innovation Event*, York University. December 2, 2021.

Gaetz, Stephen (2021) "PREVENTING Youth Homelessness … Why do it? " *Choices for Youth AGM,* St. John's Nfld. Oct 2, 2021

Gaetz, Stephen (2021) "Knowledge Mobilization and Youth Homelessness Prevention." *LivEx Group Meeting*, York University, Toronto (OnLine). September 3, 2021

Gaetz, Stephen (2021) "What *IS* Youth Homelessness Prevention?" *Innovation York*, York University, Toronto (OnLine). July 7, 2021

Gaetz, Stephen and Redman, Melanie (2021) "Launch of the Toronto Charter Centre on Youth Homelessness Prevention". *York University, Toronto and the United Nations Economic Commission for Europe* (OnLine). June 16, 2021

Gaetz, Stephen and Redman, Melanie (2021) "Making the Shift – Youth Homelessness Social Innovation Lab." *Province of Ontario, Ministry of Housing*, Toronto (OnLine). Tuesday, June 7, 2021

Gaetz, Stephen (2021) *Understanding Research Impact*. Making the Shift Board of Directors, Toronto (OnLine). March 24, 2021

Gaetz, Stephen (2020) *Building Winning Large Scale Grants.* Research Commons Workshop, York University, Toronto (OnLine). December 99, 2020

Gaetz, Stephen (2020) *Covid 19 and Youth Homelessness.* Faculty of Education, York University, Toronto (OnLine). September 19, 2020

Gaetz, Stephen (2020) *Why do research on youth homelessness prevention?.* LivEx Group, York University, Toronto (OnLine). September 19, 2020

Gaetz, Stephen & Redman, Melanie (2020) *Making the Shift, A Youth Homeless Social Innovation Lab. Problematic substance use, Housing and Homelessness.* Ottawa: Health Canada – Elicit Substance and Cannabis Unit. February 6, 2020

Redman, Melanie & Stephen Gaetz (2020) *Making the Shift, A Youth Homeless Social Innovation Lab. Networks of Centres of Excellence.* Ottawa: Health Canada. January 17,

2020

Gaetz, Stephen & Anika Mifsud (2019) *Migration and Homelessness in the Greater Toronto Area.* Toronto: United Way of Greater Toronto. December 9, 2019

Gaetz, Stephen & Redman, Melanie (2019) *Creating Research Impact: Making the Shift, A Youth Homeless Social Innovation Lab.* Toronto: Graduate Program in the Faculty of Education. November 13, 2019

Redman, Melanie & Stephen Gaetz (2019) *Designing the Adaptation of a Duty to Assist in Canada.* Toronto Canada: A Way Home Funders' Table. October 24, 2019

Gaetz, Stephen (2019) *Lessons from Canada: Progress, Challenges, Next Steps.* Melbourne, Australia: Salvation Army, October 17, 2019

Gaetz, Stephen & Redman, Melanie (2019) *Getting Organized through Collective Impact.* Melbourne, Australia: Salvation Army, October 17, 2019

Redman, Melanie & Stephen Gaetz (2019) *Roadmap for the Prevention of Youth Homelessness.* Melbourne, Australia: Salvation Army, October 17, 2019

Gaetz, Stephen & Redman, Melanie (2019) *Upstream: Taking Social Innovation Abroad.* Geelong Australia: Upstream Colloquium. October 16, 2019

Redman, Melanie & Stephen Gaetz (2019) *Creating Research Impact: Making the Shift, A Youth Homelessness Social Innovation Lab. Toronto, Ontario: Meeting with Anna Bailao, Deputy Mayor, City of Toronto.* October 7, 2019

Gaetz, Stephen (2019) *Homelessness in Canada: What We Know, What We Can Do.* Toronto, Ontario: SHAD Lecture, York University. July 16, 2019

Gaetz, Stephen & Redman, Melanie (2019) *The Roadmap for the Prevention of Youth Homelessness* Dublin, Ireland: Focus Ireland. June 26, 2019

Redman, Melanie & Stephen Gaetz (2019) *Understanding Youth Homelessness.* Dublin, Ireland: Trinity College Lecture. June 25, 2019

Gaetz, Stephen (2019) *Understanding Youth Homelessness.* Toronto, Ontario: Bridgeable. May 21, 2019

Gaetz, Stephen & Redman, Melanie (2019) *A Duty to Assist – How We Can End Youth Homelessness.* Toronto, ON: A Way Home Advisory Committee. May 16, 2019

Gaetz, Stephen (2019) *A Duty to Assist – How We Can End Youth Homelessness.* Toronto, ON: National Learning Community on Youth Homelessness Meeting. May 13, 2019

Gaetz, Stephen (2019) *Making the Shift – A Youth Homelessness Social Innovation Lab.* Toronto, ON: National Learning Community on Youth Homelessness Meeting. May 13, 2019

Redman, Melanie & Stephen Gaetz (2019) *A Duty to Assist – How We Can End Youth Homelessness.* Hamilton, ON: Street Youth Planning Collaborative. May 1, 2019

Gaetz, Stephen (2019) *What the Future Looks Like – Preventing and Ending Youth Homelessness in Canada.* Toronto, Ontario: Academy of Lifelong Learning Lecture: University of Toronto February 6, 2019

Gaetz, Stephen & Redman, Melanie (2019) *The Development of Highly Qualified Personnel.* Geneva, Switzerland: United Nations Economic Commission of Europe. February 19, 2019

Redman, Melanie & Stephen Gaetz (2019) *Making the Shift – Towards a UN Charter Centre on Homelessness.* Geneva, Switzerland: United Nations Economic Commission of Europe. February 19, 2019

Gaetz, Stephen & Redman, Melanie (2019) *Canadian Observatory on Homelessness.* Geneva, Switzerland: United Nations Economic Commission of Europe. February 19, 2019

Gaetz, Stephen (2019) *Making the Shift – A Youth Homelessness Social Innovation Lab.* Toronto, Ontario: Social Innovation Seminar, Trillium Fountation. February 6, 2019

Redman, Melanie & Stephen Gaetz (2018) *Making the Shift – A Youth Homelessness Social Innovation Lab.* Ottawa, Ontario: Conference Board of Canada. December 6, 2018

Gaetz, Stephen (2018) *A Duty to Assist – How We Can End Youth Homelessness.* Toronto, ON: Youth Homelessness Funders Table. October 31, 2018

Gaetz, Stephen & Redman, Melanie (2018) *Making the Shift: Youth Homelessness Social Innovation Lab*. Ottawa, Ontario: Government of Canada, Employment and Social Development Canada. October 16, 2018

Redman, Melanie & Stephen Gaetz (2018) "LGBTQ2S Youth and Youth Homelessness. Dublin, Ireland: Focus Ireland meeting. June 16, 2018

Gaetz, Stephen & Redman, Melanie (2018) "The relationship between involvement in Child Welfare and Youth Homelessness". Toronto: Ontario Association of Childrens' Aid Societies. March 7, 2018

Turner, Alina & Gaetz, Stephen (2018) "Building Regina's Plan to Prevent and End Homelessness". Regina: Systems Planning Meeting. February 15, 2018

Gaetz, Stephen (2018) "The Legal and Justice Issues of Youth who Experience Homelessness". Vancouver: American Bar Association Meeting on the Legal Needs of Street Youth. February 1, 2018

Gaetz, Stephen (2018) "A Way Home Canada". Kelowna: Launch of A Way Home Kelowna. January 18, 2018

Gaetz, Stephen (2018) "Housing First for Youth". Kelowna: Launch of A Way Home Kelowna. January 18, 2018

Gaetz, Stephen (2018) "Preventing youth homelessness – Five things we can do". Kelowna: Launch of A Way Home Kelowna. January 18, 2018

Gaetz, Stephen & Redman, Melanie (2017) "THIS is Housing First for Youth" St. John's, Nfld: Choices for Youth Meeting of NL Working Group on Youth Homelessness. December 8, 2017

Redman, Melanie & Gaetz, Stephen (2017) "Making the Shift – Preventing and Ending Homelessness in Canada" Toronto: Province of Ontario Poverty Reduction Strategy. August 18, 2017

Gaetz, Stephen (2017) "Partnerships" Toronto: NCE Planning Day August 15, 2017

Gaetz, Stephen (2017) "Clusters and Themes" Toronto: NCE Planning Day August 14, 2017

Gaetz, Stephen (2017) "Making the Shift Overview" Toronto: NCE Planning Day August 14, 2017

Redman, Melanie & Gaetz, Stephen (2017) "Making the Shift – Preventing and Ending Homelessness in Canada" Toronto: Making the Shift Kick-Off. August 14, 2017

Gaetz, Stephen (2017) "A Framework for Housing First for Youth" Toronto: Making the Shift Training Day. August 13, 2017

Gaetz, Stephen & Redman, Melanie (2017) "Making the Shift" Toronto: Trillium Foundation. July 19, 2017

Gaetz, Stephen & Vasko, Stephanie (2017) "Knowledge Mobilization and Design Thinking" Toronto: REALIZE. July 10, 2017

Redman, Melanie & Gaetz, Stephen (2017) "A Way Home and Collective Impact" Toronto: Trillium Foundation. July 10, 2017

Gaetz, Stephen & Redman, Melanie (2017) "Making the Shift – Preventing and Ending Youth Homelessness in Canada" Dublin: Trinity College. June 27, 2017

Redman, Melanie & Gaetz, Stephen (2017) "Making the Shift – Can we make homelessness prevention a priority?" Dublin: Trinity College. June 27, 2017

Gaetz, Stephen & Redman, Melanie (2017) "Housing First for Youth" Utrecht, Netherlands June 22, 2017

Gaetz, Stephen (2017) "Understanding Youth Homelessness" Budapest, Hungary: FEANTSA Youth Homelessness Study Group. June 12, 2017

Gaetz, Stephen (2017) "Housing First for Youth" Budapest, Hungary: FEANTSA Youth Homelessness Study Group. June 13, 2017

Gaetz, Stephen & Redman, Melanie (2017) "Coming Together to End Youth Homelessness in Peterborough " Peterborough, Ontario. May 22, 2017

Gaetz, Stephen (2017) "Without a Home – The National Youth Homelessness Survey " Toronto, Ontario: National Learning Community on Youth Homelessness. May 10, 2017

Gaetz, Stephen & Redman, Melanie (2017) "Making the Shift Launch – Strategy Session"

Toronto: Catherine Donnelly Foundation. April 21, 2017

Gaetz, Stephen (2017) "Addressing Youth Homelessness in Canada" Toronto: Covenant House AGM. April 19, 2017

Gaetz, Stephen & Redman, Melanie (2017) "Youth Homelessness Social Innovation Lab" Ottawa: Homelessness Partnering Strategy. April 18, 2017

Redman, Melanie & Gaetz, Stephen (2017) "A Way Home Advisory Committee Meeting" Toronto: Catherine Donnelly Foundation. April 6, 2017

Gaetz, Stephen & Redman, Melanie (2017) "Coming Together to End Youth Homelessness in Elgin County " Elgin County. April 3, 2017

Redman, Melanie & Gaetz, Stephen (2017) "Reimagining our Response to Youth Homelessness " Toronto: *Ontario Ministry of Housing*. March 25, 2017

Gaetz, Stephen & Redman, Melanie (2017) "The Canadian Observatory on Homelessness and A Way Home - " Toronto: *Danish Study Tour*. February 16, 2017

Gaetz, Stephen (2017) "Knowledge Mobilization and Design Thinking" Toronto: *Divided City / United City*. February 14, 2017

Gaetz, Stephen & Czech, Wally (2017) "Professional Knowledge Transfer: Housing First for Youth". London, ON. January 22, 2017

Gaetz, Stephen (2017) "Housing First for Youth: Employment Training Program Design Sprint". London, ON. January 18, 2017

Redman, Melanie & Gaetz, Stephen (2016) "Implementing New Community Planning Tools on Youth Homelessness". Homelessness Partnering Strategy/ Ontario Ministry of Housing Conference Toronto, ON. January 11, 2017

Gaetz, Stephen & Redman, Melanie (2016) "A Way Home". Home Depot Canada Foundation, Board Meeting. Toronto, ON. December 13, 2016

Redman, Melanie & Gaetz, Stephen (2016) "Coming Together to End Youth Homelessness in Elgin County". St. Thomas, ON. November 30, 2016

Gaetz, Stephen & Redman, Melanie (2016) "Coming Together to End Youth Homelessness in Renfrew County". Arnprior, ON. November 23, 2016

Gaetz, Stephen (2016) "Homelessness in Canada: Understanding the National Context". Raising the Roof AGM. Toronto, ON. November 24, 2016

Gaetz, Stephen (2016) "Homelessness Prevention 101". *Leo Burnett*. Toronto, Canada. October 31, 2016

Gaetz, Stephen; Tim Richter and Erin Dej (2016) State of Homelessness in Canada release. Ottawa Ontario

Redman, Melanie & Gaetz, Stephen (2016) "Coming Together to End Youth Homelessness in Washington State". Seattle WA. October 12, 2016

Gaetz, Stephen & Redman, Melanie (2016) "Coming Together to End Youth Homelessness in Winnipeg". Winnipeg, MN. October 11, 2016

Redman, Melanie & Gaetz, Stephen (2016) "Coming Together to End Youth Homelessness in LANARK County". *A Way Home Lanark County.* Perth, ON. October 7, 2016

Gaetz, Stephen & Redman, Melanie (2016) "A Way Home". *Catherine Donnelly Foundation – Funders Table*. September 16, 2016

Gaetz, Stephen (2016) "Responding to Youth Homelessness – What We Should Know, What We Should Do". Young Street Mission Board Meeting. Toronto, ON. September 27, 2016

Redman, Melanie & Gaetz, Stephen (2016) "Reimagining our response to youth homelessness" Focus Ireland. Dublin, Ireland June 27

Gaetz, Stephen & Redman, Melanie (2016) "Housing First for Youth in Europe – A Human Rights Approach" Rock Trust. Edinburgh, Scotland. June 6, 2016

Redman, Melanie & Gaetz, Stephen (2016) "A Way Home". *Catherine Donnelly Foundation – Funders Table*. May 4, 2016

Gaetz, Stephen. (2016) "Knowledge Mobilization and Design Thinking." National Learning Community on Youth Homelessness meeting. May 25, 2016

Redman, Melanie & Gaetz, Stephen (2016) *"A Way Home". Downtown Women's Centre.* Los Angeles, CA. April 7, 2016

Gaetz, Stephen (2016) "Knowledge Mobilization and Design Thinking – Making homelessness research matter!" Graduate Seminar. April 5, 2016

Gaetz, Stephen (2016) "Knowledge Mobilization and Design Thinking – Making homelessness research matter!" OISE CEPP Seminar. March 30, 2016

Gaetz, Stephen & Redman, Melanie (2016) "A Way Home". *FEANTSA Youth*. Budapest Hungary. March 14, 2016

Redman, Melanie & Gaetz, Stephen (2016) "Advocacy, Change and Coalition Building". *FEANTSA Youth.* Budapest Hungary. March 14, 2016

Gaetz, Stephen & Redman, Melanie (2016) "Building your coalition through Collective Impact". *FEANTSA Youth.* Budapest Hungary. March 13, 2016

Gaetz, Stephen (2016) A Framework for Homelessness Prevention. FEANTSA. Brussels, Belgium. March 3, 2016

Gaetz, Stephen. (2016) "Knowledge Mobilization and Design Thinking – How to make homelessness research *matter*!." *Rosa Bruno-Jofre Symposium in Education*. Toronto, Ontario, February 25, 2016

Gaetz, Stephen. (2016) "Knowledge Mobilization and Design Thinking – Towards Enhancing the Impact of Research on Policy and Practice." York University, January 20,

2016

Redman, Melanie & Gaetz, Stephen (2016) *A Way Home.* Mental Health Commission Housing First Regional Training meeting Ottawa, ON. December 7, 2015

Gaetz, Stephen (2015) "The Big Picture: Mobilizing PiT Count Results." *HPS Point in Time Count Workshop*. Toronto ON, November 25, 2015

Gaetz, Stephen (2015) "Towards a National Research Agenda." *National Learning Community on Youth Homelessness Conference*, St. John's, NL. November 24, 2015

Gaetz, Stephen (2015) "A Framework for Preventing Youth Homelessness." *National Learning Community on Youth Homelessness Conference*, St. John's, NL. November 24, 2015

Gaetz, Stephen & Redman, Melanie (2015) "A Way Home." *National Learning Community on Youth Homelessness Conference*, St. John's, NL. November 23, 2015

Gaetz, Stephen (2015) "The Big Picture: Mobilizing PiT Count Results." *HPS Point in Time Count Workshop*. Vancouver, BC. November 18, 2015

Redman, Melanie & Gaetz, Stephen (2015) "A Way Home – Supporting Community and Government Planning" *Funders Together meeting*. Toronto, ON September 29th, 2015

Gaetz, Stephen & Redman, Melanie (2015) "From Child Protection to Youth Homelessness: Can we turn off the taps?" *Meeting of Provincial and Territorial Advocates for Youth.* St. John's Nfld. September 13, 2015

Gaetz, Stephen (2015) "Housing Options for Youth." *Yonge Street Mission*. September 9, 2015

Gaetz, Stephen (2015) "Research in Canada: The Canadian Observatory on Homelessness." *Impuls, Netherlands Centre for Social Care Research, Radboud University Medical Centre,* Utrect NL. July 6th, 2015

Gaetz, Stephen & Redman, Melanie (2015) "A prevention-Based Approach to Youth Homelessness" *Trinity College, Dublin.* Dublin, Ireland. June 25th, 2015

Redman, Melanie & Gaetz, Stephen (2015) "Reimagining our Response to Youth Homelessness" *Trinity College, Dublin; Focus Ireland*. Dublin, Ireland. June 24th, 2015

Gaetz, Stephen & Redman, Melanie (2015) "Reimagining our Response to Youth Homelessness" *Raikes Foundation / Campion Foundation meeting*. Seattle WA., June 4th, 2015

Redman, Melanie & Gaetz, Stephen (2015) "A Way Home – Supporting Community and Government Planning" *Raikes Foundation / Campion Foundation meeting*. Seattle WA., June 4th, 2015

Gaetz, Stephen & Redman, Melanie (2015) "Addressing Homelessness through Community Planning" Yellowknife Community Forum. Yellowknife NWT., May 14th, 2015

Gaetz, Stephen (2015) "Reimagining our Response to Youth Homelessness" C*atherine Donnelly Foundation Meeting.* Toronto, ON., May 28th, 2015

Gaetz, Stephen (2015) "Reimagining our Response to Youth Homelessness" *Funders Together Meeting.* Boston, MA. May 6th, 2015

Gaetz, Stephen (2015) "Preventing Youth Homelessness through school-based initiatives" *Working Upstream - Preventing Youth Homelessness through School-Linked Services.* Canadian Observatory on Homelessness Toronto, ON. April 24th, 2015

Gaetz, Stephen (2015) "Oh Canada! Understanding homelessness and the Canadian response" *Toronto Public Library.* Toronto, ON. April 21st, 2015

Gaetz, Stephen (2015) "10 things I've learned about Youth Homelessness" Samuel W. Shaw School. Calgary, AB. April 17th, 2015

Gaetz, Stephen (2015) "Canadian Definition of Homelessness" Ontario Advisory Panel on Homelessness. Toronto, ON. March 15, 2015

Gaetz, Stephen (2015) "Canadian Point-In-Time Count – Methodology and Toolkit" Hamilton Aboriginal Homelessness Symposium. Toronto, ON. March 27, 2015

Gaetz, Stephen (2015) "Canadian Point-In-Time Count – Methodology and Toolkit" COH / Homeless Hub. Toronto, ON. March 24, 2015

Gaetz, Stephen (2015) "Canadian Definition of Homelessness" Ontario Advisory Panel on Homelessness. Toronto, ON. March 15, 2015

Gaetz Stephen (2015) "Taking a Human Rights Approach to Youth Homelessness". *FEANTSA Youth Homelessness Network Meetings.* Strasbourg, France. March 10, 2015

Gaetz, Stephen (2015) "Ending Youth Homelessness" Ministry of Municipal Affairs and Housing, Province of Ontario. Toronto, ON. March 4, 2015.

Gaetz, Stephen (2015) "Understanding Constellations of Activity" Mobilizing Local Capacity meeting. Toronto, ON. March 3, 2015.

Gaetz, Stephen, Pollett, Sheldon (2015) "Coalition to End Youth Homelessness: Coalition Structure" Mobilizing Local Capacity meeting. Toronto, ON. March 3, 2015.

Gaetz, Stephen, Pollett, Sheldon (2015) "The Vision: Coalition to End Youth Homelessness:" Mobilizing Local Capacity meeting. Toronto, ON. March 3, 2015.

Gaetz, Stephen. (2015) "Homelessness in Canada. What do we know, what can we do?" *Toronto Public Library*. Toronto, ON, February 26, 2015.

Gaetz, Stephen (2015) "Oh Canada! Understanding homelessness and the Canadian response." Toronto Public Health. Toronto, ON. February 25, 2015.

Gaetz, Stephen (2015) *"Knowledge Mobilization and Design Thinking: Towards enhancing the impact of research on policy and practice".* Graduate program in Education, February 4th, 2015

Gaetz, Stephen (2015) *Towards an IGH Web Presence",* Institute of Global Homelessness meeting. London, UK. January 27, 2015

Gaetz, Stephen (2015) *"Oh Canada! Lessons from the Canadian Response to Homelessness",* University College Cork, City of Cork, Cork Ireland. January 20, 2015

Gaetz, Stephen (2015) *"Canadian Point in Time Counts – Methodology and Toolkit",* Ottawa Alliance to End Homelessness. Ottawa, ON. January 12, 2015

Gaetz, Stephen (2014) "The State of Homelessness in Canada 2014", *City of Toronto Affordable Housing Office*. Toronto, ON. December 3rd, 2014

Gaetz, Stephen (2014) "Canadian Observatory on Homelessness – Research Agenda", *Newfoundland Housing and Homelessness Network*. St. John's, Nfld. December 5th, 2014

Gaetz, Stephen (2014) "Towards a Strategy to End Youth Homelessness", *Newfoundland Housing and Homelessness Network*. St. John's, Nfld. December 4th, 2014

Gaetz, Stephen (2014) "Youth Homelessness – What do we know? What do we need to do?", *Newfoundland Housing and Homelessness Network*. St. John's, Nfld. December 3rd, 2014

Gaetz, Stephen (2014) "Acuity Assessment and Housing First for communities" *Newfoundland Housing and Homelessness Network*. St. John's, Nfld. December 3rd, 2014

Gaetz, Stephen (2014) "Canadian Point in Time Counts: Methodology and Toolkit" *Newfoundland Housing and Homelessness Network*. St. John's, Nfld. December 3rd, 2014

Gaetz, Stephen (2014) "Leaving Home: Youth Homelessness in York Region" *United Way York Region.* Aurora, ON November 27th, 2014

Gaetz, Stephen (2014) "Housing First in Canada – Is it the solution?" *ACTO National Housing Day Symposium*. Toronto, ON. November 20th, 2014

Gaetz, Stephen (2014) "A Research agenda for Ending Youth Homelessness" *National Learning Community on Youth Homelessness Meeting*. Montreal, Quebec. November 20, 2014.

Gaetz, Stephen (2014) "An End to Youth Homelessness" *Re-Imagining Youth Homelessness in Ottawa*. Youth Services Bureau, Ottawa. November 17th, 2014

Gaetz, Stephen (2014) "A Prevention Framework for Youth Homelessness" *Re-Imagining Youth Homelessness in Ottawa*. Youth Services Bureau, Ottawa. November 17th, 2014

Gaetz, Stephen (2014) "Preventing Youth Homelessness" *Attacking Rural Homelessness in Lanark County*. Perth, Ontario. October 20, 2014

Gaetz, Stephen (2014) "The Real Cost of Homelessness" *Victoria Chamber of Commerce*. Victoria, BC. October 16, 2014

Gaetz, Stephen (2014) "Coming of Age – Addressing Youth Homelessness" *Vancouver Foundation Community Meeting*. Vancouver, BC. October 15, 2014

Gaetz, Stephen (2014) “Housing First, What’s Next?” *Community Legal Clinic of York Region*. October 1, 2014.

Gaetz, Stephen (2014) “Housing First in Canada” *RENT – Training day on Housing First*. September 22, 2014.

Gaetz, Stephen (2014) “The Kids Aren’t Alright: Understanding Youth Homelessness in Winnipeg” *Winnipeg Chamber of Commerce*. Winnipeg, Mn., September 4, 2014

Gaetz, Stephen (2014) “Making A Difference – The role of financial institutions” *Assiniboine Credit Uniion community meeting*. Winnipeg, Mn., September 4, 2014

Gaetz, Stephen (2014) “A Safe and Decent Place to Live - Care, respect and dignity in responding to the needs of homeless youth” *RAY community meeting.* Winnipeg, Mn., September 3, 2014

Gaetz, Stephen (2014) “Youth Homelessness 101: What are the causes and conditions?” *RAY community meeting*. Winnipeg, Mn., September 3, 2014

Gaetz, Stephen (2014) “Getting Ready for Housing First”. *Community meeting,* Fredericton, New Brunswick, June 25, 2014

Gaetz, Stephen (2014) “Understanding Housing First”. *Community meeting,* Fredericton, New Brunswick, June 25, 2014

Gaetz, Stephen (2014) “A Safe and Decent Place to Live: Care, respect and dignity in responding to the needs of homeless youth.” *Harris Centre,* St. John’s Newfoundland. June 16, 2014

Gaetz, Stephen (2014) “Trends in Homelessness in Canada” *Community meeting,* St. John’s Newfoundland.

Gaetz, Stephen (2014) Host: Cafe Scientifique "Ending Homelessness Through Housing First: Lessons Learned from the Toronto Site of the At Home/Chez Soi Project" *MHCC At Home/Chez Soi - Toronto Site* Centre for Social Innovation. Tuesday, April 29th, 2014

Gaetz, Stehen (2014) “State of Homelessness in Canada.” *York Region Human Services Planning Board meeting.* April 15, 2014

Gaetz, Stephen (2014) Host: Panel of key participants. *Mental Health Commission of Canada, official launch of the final report on the At Home/Chez Soi project.* Ottawa: April 8, 2014

Gaetz, Stephen (2014) Panel participant: *The Aging Homeless: Best Practices for End of Life Care* Panel Discussion. Li Ka Shing Knowledge Institute St. Michael's Hospital, Toronto. March 25, 2014

Gaetz, Stephen (2013) “The Role of Research in Addressing Homelessness”. *Ministry of Municipal Affairs and Housing,* Toronto, ON. November 28, 2013.

Gaetz, Stephen (2013) "Reimagining Our Response to Youth Homelessness" *Covenant House*, Toronto, ON, October 27, 2013

Gaetz, Stephen (2013) "Youth Homelessness in York Region. United Way of York Region. Markham, ON. October 25, 2013

Gaetz, Stephen (2013) "Making Research Matter! How Research Can Contribute to Ending Homelessness*", Aboriginal Homelessness Research Network meeting*, Calgary, AL, October 18, 2013

Gaetz, Stephen (2013) "Canadian Homelessness Research Network: Sustaining Complex Partnerships" *SSHRC Partnership Grant Start-up Meeting*, Montreal, Que, October 16, 2013

Gaetz, Stephen (2013) "Making Research Matter! How Research Can Contribute to Ending Homelessness." *Homelessness Partnering Strategy – National Workshop on Housing First*. Ottawa, ON, October 4, 2013

Gaetz, Stephen (2013) "The State of Homelessness in Canada". *Municipality of Kitchener-Waterloo*. Waterloo, ON., Oct. 3, 2013

Gaetz, Stephen (2013) "Ending youth Homelessness – Approaches, Successes and Challenges". *Homeward Trust Community Meeting*, Edmonton. September 6, 2013

Gaetz, Stephen (2013) "The Victimization of Homeless Youth: Crime, Violence and Policing". *Ontario Ministry of Municipal Affairs*. Toronto. February 7, 2013

Gaetz, Stephen (2013) "The Real Cost of Homelessness", *Community Forum*, Uxbridge Ontario. February 6, 2013

Gaetz, Stephen (2013) "Supporting Transitions to Adulthood: The Foyer". *City Seminar*, York University. January 11, 2013

Gaetz, Stephen (2012) "Reimagining Or Response to Youth Homelessness". *United Way, York Region*. Markham. November 26, 2012

Gaetz, Stephen (2012) "The Real Cost of Homelessness: Can We Save Money and Do the Right Thing?" *Canadian Forum on Civil Justice*. November 22, 2012

Gaetz, Stephen (2012) "The Real Cost of Homelessness: Can We Save Money and Do the Right Thing?" *Peel Region*. November 9, 2012

Gaetz, Stephen (2012) "The Canadian Homelessness Research Network". *City of Toronto, Community and Recreation Committee*, September 19th, 2012

Gaetz, Stephen (2012) "What is the meaning of Social Profiling?" *Abused, Neglected, Arrested: Impact of social profiling of people who are homeless.* Hosted by the Wellesley Institute and the Sanctuary. Toronto, September 6, 2012

Gaetz, Stephen; O'Grady, Bill & Buccieri, Kristy (2012). "Can I See Your ID? Policing and the Criminalization of Youth Homelessness in Canada". Office of the Independent Police Review Director (Staff). Toronto, July 12, 2012.

Gaetz, Stephen; O'Grady, Bill & Buccieri, Kristy (2012). "Can I See Your ID? Policing and the Criminalization of Youth Homelessness in Canada". Office of the Independent Police Review Director (Board of Directors). Toronto, June 25, 2012.

Gaetz, Stephen (2012). "Making Research Matter: the Canadian Homelessness Research Network" *Graduate Program in Education Winter Colloquium: Engaged Scholarship – Research Impact on Solutions to Homelessness.* York University, Toronto. Thursday, March 29, 2012

Gaetz, Stephen (2012). "Thinking about knowledge mobilization and engaged research. Lessons from the Canadian Homelessness Research Network" *EDU / LAPS / YorkU Libraries, Research Support Series "Knowledge co-creation and knowledge mobilization"* York University, Toronto, ON. March 20, 2012

Gaetz, Stephen (2012). "Research on Youth Homelessness and Policing". *Hot Spot Youth and Policing Roundtable Meeting.* Toronto, ON. February 27, 2012

Gaetz, Stephen (2011) "Mobilizing Homelessness Research" Toronto: 4th Annual CHRN National Advisory Body meeting. October 8, 2011

Gaetz, Stephen (2011) "Reimagining our Response to Youth Homelessness: A Canadian and Global Perspective". *Greater Victoria Coalition to End Homelessness.* Victoria, BC. July 6, 2011

Gaetz, Stephen & Michaela Hynie (2011) "Understanding Program Evaluation for the Homelessness Sector". Toronto: City of Toronto. May 26, 2011

Gaetz, Stephen (2011) "Family Matters! Homeless youth and Eva's Initiatives "Family Reconnect" Program". Toronto: Eva's Initiatives. April 10, 2011

Gaetz, Stephen (2010) "Homelessness Partnering Secretariat and the Canadian Homelessness Research Network Meeting" Homelessness PAertnering Secretariat, Ottawa, January 18, 2011

Gaetz, Stephen & Bill O'Grady (2010) "Surviving Crime and Violence – Street Youth and Victimization in Toronto" Justice for Children and Youth meeting. Toronto October 23, 2010

Gaetz, Stephen (2010) "Poverty Reduction, Homelessness and Affordable Housing" Province of Ontario Lunch and LearnToronto, June 28, 2010

Gaetz, Stephen (2010) "Responding to Homelessness – Distributed Leadership as a solution?" City of Toronto, Toronto, June 25, 2010

Gaetz, Stephen & Bill O'Grady (2010) "Surviving Crime and Violence" Community town hall. Toronto. June 17, 2010

Gaetz, Stephen (2009) "Thinking about Poverty, Pandemics and Homelessness" Departmental Research Seminar, Department of Anthropology, York University, Toronto, October 15, 2009

Gaetz, Stephen (2008). *Ending Homelessness: Innovation and Research.* SHIFT: Sharing Homelessness Innovation for Toronto. City of Toronto. October 15, 2008

Gaetz, Stephen (2007). *The Homeless Hub – Mobilizing Research on Homelessness.* CMHC National Housing Research Committee. Ottawa, Ontario. October

Gaetz, Stephen (2007). *Homeless Youth.* KM in the AM - Knowledge Mobilization Breakfast. Markham, Ontario. September

Gaetz, Stephen (2005). *Working with Homeless Youth*. Children and Youth "At Risk" Conference, York University.

Gaetz, Stephen (2003). *Street youth, Children's Services and Access to Protection.* Helping Children Who Live in Toxic Situations - Conference sponsored by the American Orthopsychiatric Association and the Sparrow Lake Alliance. Toronto, Ontario. October

Gaetz, Stephen (2003). *Street Justice: Working with Youth who are Homeless.* Building on successes: An agency forum on homelessness - Conference sponsored by the City of Toronto and HRDC Canada. Toronto, Ontario. February

Gaetz, Stephen (2003). *Building Bridges: Street Youth and the Police.* Common Cause: Youth Safety in the City - Conference sponsored by the City of Toronto. Toronto, Ontario. January

Gaetz, Stephen (2002). *Youth Leadership: Including Street youth in the Development of Health Promotion Materials.* Westview Project 10th Anniversary Conference. Toronto, Ontario. September

Gaetz, Stephen (1999). *Planning and Developing Dental Services for Marginalized Populations*. Rexdale Community Health Centre. Toronto, Ontario. September

Gaetz, Stephen (1999). *Working with Street Youth in Toronto.* Eva's Place Annual General Membership Meeting. Toronto, Ontario. May

Gaetz, Stephen (1998). *Developing a Strategy for Street Youth Employment*. Planning in Health Promotion and Population Health Workshop on the Social Services System. University of Toronto.

Gaetz, Stephen (1998). *Thinking about Street Youth and Health Care*. Faculty of Medicine, University of Toronto. April

Gaetz, Stephen (1998). *Working with Street Youth*. Faculty of Social Work, University of Toronto. May

Gaetz, Stephen (1997). *Health Issues of Street Involved Youth*. Canadian Mental Health Association. Toronto, Ontario.

Gaetz, Stephen (1997). *Health Issues of Street Involved Youth.* Hospital for Sick Children. Toronto, Ontario.

Gaetz, Stephen (1996). *Planning a Dental Service for Street Youth*. Central Toronto Dental Hygienist's Society. Toronto, Ontario. November

Gaetz, Stephen (1996). *Planning a Dental Service for Street Youth.* Newmarket: York Region Dental Hygienist Society. Newmarket, Ontario.

Gaetz, Stephen (1996). *Developing Health Promotion Materials with Street Youth*. Planning in Health Promotion and Population Health Workshop, University of Toronto. Toronto, Ontario.

Gaetz, Stephen (1996). *Planning a Dental Service for Street Youth*. Faculty of Dentistry Student's Association. University of Toronto.

Gaetz, Stephen (1995). *Planning a Dental Service for Street Youth*. Durham Dental Hygiene Component Society. Oshawa, Ontario.

Gaetz, Stephen (1995). *Planning a Dental Service for Street Youth.* Halton Peel Dental Hygienist's Society. Mississauga, Ontario.

Gaetz, Stephen (1995). *Planning a Dental Service for Street Youth.* Halton-Peel Dental Nurses and Assistants Association. Mississauga, Ontario.

Gaetz, Stephen (1995). *Oral Health of Street Youth*. Toronto Academy of Dentistry (central). Toronto, Ontario.

Gaetz, Stephen (1995). *Planning a Dental Service for Street Youth*. Toronto North Dental Hygienist's Society. Toronto, Ontario.

Gaetz, Stephen (1995). *Planning a Dental Service for Street Youth.* Central Toronto Dental Hygienist's Society. Toronto, Ontario.

Gaetz, Stephen (1995). *Providing Health Services for Street Youth*. Hospital for Sick Children. Toronto, Ontario.

Gaetz, Stephen (1995). *The Oral Health Needs of Street Youth*. Ontario Dental Association. Toronto, Ontario.

Gaetz, Stephen (1994). *Working with Street Youth*. Series of 6 workshops presented to Metro Toronto Police, 52 Division. Toronto, Ontario.

Gaetz, Stephen (1994) . *Outreach to Straight Male Youth*. Paper presented at the "Get Down to it; Conference on Youth Health Issues", City of Toronto, Department of Public Health. Toronto, Ontario.

Gaetz, Stephen (1994). *Street Youth and Health Care*. East York Department of Public Health. Toronto, Ontario.

Gaetz, Stephen (1992). *Reaching Males through Family Planning Clinics*. East York Department of Public Health. East York, Ontario.

Webinars

Gaetz, S., Redman, M. (2020). *The Role of Research in Youth Homelessness and Prevention: Presentation to the LivEx Network.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/418446312

Redman, M., Gaetz, S., Baab, C. H., Huys, J., Vandergrift, K. (2018). *Putting UN General Comments 21 on Children in Street Situations to Work for Canadian Children and Youth!* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/320579465

Gaetz, S., Redman, M., Schwan, K., & French, D. (2018). *The Roadmap for the Prevention of Youth Homelessness.* Toronto, ON: Canadian Observatory on Homelessness Press. https://www.youtube.com/watch?v=7uKcpIMBygI

Gaetz, S., Turner, A., Elliott, D., & Reilly, J. (2018). *Homeless-Serving System Governance and the HPS Renewal.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/298453641

Gaetz, S., Redman, M., & Ali, N. (2018). *Without a Home - 2nd National Survey on Youth Homelessness.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/269522436

Redman, M., Gaetz, S., Turner, A. (2018). *Systems Planning 101 Webinar - Building Systems Capacity.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/269525431

Gaetz, S., Redman, M. (2018). *THIS is Housing First for Youth: A Program Model Guide Webinar.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/269529941

Gaetz, S., Redman, M., Buchnea, A. (2018). *Getting Ready: Without a Home 2019 Guide for Participating Agencies.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/306444255

Gaetz, S., Redman, M. (2017). *A New Direction: A Framework for Homelessness Prevention Webinar*. Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/218991959

Gaetz, S., Redman, M. (2017). *Introducing new protections services for 16-17 year old youth in Ontario: Impacts and opportunities for youth service providers.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/269533266

Gaetz, S., Redman, M. (2017). *Collective Impact and Youth Homelessness Community Planning.* Toronto, ON: Canadian Observatory on Homelessness Press. https://youtu.be/MMnggSezNmY

Gaetz, S., O'Grady, B., Kidd, S., & Schwan, K. (2016). *Without a Home: The National Youth Homelessness Survey Webinar (Nov 18).* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/269522436

Redman, M., Gaetz, S. (2016). *Launch of a Proposal for Federal Reinvestment in Youth Homelessness (April 13)*. Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/162783375

Gaetz, S., Pollett, S., McMillan, L. (2015). *A Way Home: A New Coalition to Prevent, Reduce and End Youth Homelessness*. Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/143613851

Gaetz, S., Jackson, N., Czech, W., & Turner A . (2015). *Using Point-in-Time Counts to Measure Progress Towards Ending Homelessness Webinar.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/124415829

Gaetz, S., Coffey, M., MacKenzie, D. (2015). *Working Upstream: Preventing Youth Homelessness Through School-Linked Service Models – Part 1.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/130210235

Gaetz, S., Coffey, M., MacKenzie, D. (2015). *Working Upstream: Preventing Youth Homelessness Through School-Linked Service Models – Part 2.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/130438273

Gaetz, S., MacDonald, J., McKitterick, M., Morton, E. (2014). *Webinar: Coming of Age: Reimagining the Response to Youth Homelessness in Canada.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/89446604

Gaetz, S. (2014). Webinar: A Safe and Decent Place to Live: Towards a Housing First Framework for Youth. Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/92675319

Gaetz, S., Doberstein, C., Belanger, Y., MacDonald J., Bellot, C. (2014). *Launch of the Canadian Observatory on Homelessness.* Toronto, ON: Canadian Observatory on Homelessness Press.

Abramovich, A., Tarasuk, V., Dachner, N., & Gaetz, S. (2013). *Book Launch: Youth Homelessness in Canada.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/65264084

Gaetz, S. (2011). *Can I see your ID? Policing and the criminalization of youth homelessness in Toronto.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/31793667

Book Reviews

Gaetz, Stephen (2013) Kristina E. Givson (2011) “Street Kids – Homeless Youth, Outreach and the Policing of New York’s Streets.” *European Journal of Homelessness* , Volume 7, No.

2, December 2013: 439-443

Gaetz, Stephen (2011) MaryEllen Hombs "Modern Homelessness". European Journal of Homelessness: Volume 5, Issue 2 (December 2011): 241-243

Curriculum Materials

Gaetz, Stephen (2009). "Homelessness Curriculum for Teachers and Students". http://homelesshub.ca/Education/

I directed the development of this resource centre for educators and students interested in exploring the issue of homelessness through a variety of subject areas. Assisted teachers in preparing the following curriculum units: "An Integrated Unit for Elementary School; Exploring Homelessness through the Artist's Hands; Integrating Homelessness Issues into Family / Social Studies; Integrating Homelessness Into Civics Classes; The Study of Homelessness in English and Media Class; Understanding Homelessness Through Drama.

In addition, I also authored supporting resources for teachers and students on the following topics:

- What is Homelessness?
- Who are Homeless People?
- Who are Street Youth?
- Why do Young People Become Homeless?
- Why do Street Youth Panhandle?
- Do Homeless Youth Get Enough to Eat?
- Attitudes about Homelessness

Blog posts

Gaetz, S., Redman, M. (2019). *Announcing the Launch of Making the Shift!* Toronto, ON: Canadian Observatory on Homelessness Press. https://www.homelesshub.ca/blog/announcing-launch-making-shift

Gaetz, S., Redman, M. (2019). *What's the Future of Homelessness Prevention? Adapting the Welsh "Duty to Assist" for Canada.* Toronto, ON: Canadian Observatory on Homelessness Press. https://www.homelesshub.ca/blog/whats-future-homelessness-prevention-adapting-welsh-duty-assist-canada

Gaetz, S., Redman, M. (2019). *Reflections on Reaching Home, the Government of Canada's New Homelessness Strategy.* Toronto, ON: Canadian Observatory on Homelessness Press. homelesshub.ca/blog/reflections-reaching-home-government-canada's-new-homelessness-strategy

French, D., Gaetz, S., & Redman, M. (2019). *Youth continue to be outnumbered! Our response to the Federal Government's National Point-in-Time Count*. Toronto, ON:

Canadian Observatory on Homelessness Press. https://www.homelesshub.ca/blog/youth-continue-be-outnumbered-our-response-federal-government%E2%80%99s-national-point-time-count

Gaetz, S., Redman, M. (2019). *The Making the Shift Lab in Action: 6 Months In.* Toronto, ON: Canadian Observatory on Homelessness Press. https://www.homelesshub.ca/blog/making-shift-lab-action-6-months

Ferguson, C., Gaetz, S., & Redman, M. (2019). Experiments in Paradigm Shifting: How Service Design Can Inform the Duty to Assist Policy. Toronto, ON: Canadian Observatory on Homelessness Press. https://www.homelesshub.ca/blog/experiments-paradigm-shifting-how-service-design-can-inform-duty-assist-policy

Gaetz, S. (2018). *It's time for a change: Report of the Advisory Committee on Homelessness.* Toronto, ON: Canadian Observatory on Homelessness Press. https://www.homelesshub.ca/blog/it%E2%80%99s-time-change-report-advisory-committee-homelessness-0

Gaetz, S., Redman, M. (2018). *Announcing the Launch of Making the Shift!* Toronto, ON: Canadian Observatory on Homelessness Press. https://www.homelesshub.ca/blog/announcing-launch-making-shift

Gaetz, S., Redman, M. (2017). *Towards a Canadian Youth Homelessness Data Dashboard.* Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/towards-canadian-youth-homelessness-data-dashboard

Gaetz, S., Redman, M. (2017). *Announcing the Launch of Making the Shift!* Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/announcing-launch-making-shift

Dej, E., Gaetz, S. (2017). *Looking Forward: Shifting Towards Homelessness Prevention.* Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/looking-forward-shifting-towards-homelessness-prevention

Gaetz, S. (2016). *Let's Talk Housing & Prevention.* Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/lets-talk-housing-prevention

Gaetz, S., Redman, M. (2016). *Towards an Ontario Strategy to End Youth Homelessness.* Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/towards-ontario-strategy-end-youth-homelessness

Gaetz, S. (2016). *OF COURSE, we need a separate definition for youth homelessness*. Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/course-we-need-separate-definition-youth-homelessness

Gaetz, S., Redman , M. (2016). *Opportunity Knocks: A Proposal for Federal Investment to Prevent and End Youth Homelessness.* Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/opportunity-knocks-proposal-federal-investment-prevent-and-end-youth-homelessness

Gaetz, S. (2016). *Why is the harm reduction model so important?* Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/why-harm-reduction-model-so-important

Gaetz, S. (2015). *What is homelessness?* Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/what-homelessness

Gaetz, S. (2015*). Launch: Community Workspace on Homelessness.* Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/launch-community-workspace-homelessness

Gaetz, S. (2015). *Let's do things differently! 'A Way Home' and the promise of ending youth homelessness.* Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/lets-do-things-differently-%E2%80%98-way-home%E2%80%99-and-promise-ending-youth-homelessness

Gaetz, Stephen (2014) Ask the Hub - Are governments supportive of the harm reduction approach? Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Prevention Toronto: Homeless Hub

Gaetz, Stephen (2014) Ask the Hub - Does Housing First "Leave Youth Behind"? Toronto: Homeless Hub

Gaetz, Stephen (2014) Housing First CAN work for young people, but let's make sure we get it right Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Transitional Housing Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Discharge Planning for Hospitals and Mental Health Facilities Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Coordinated Assessment Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Outreach Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Transitions from Child Protection Toronto: Homeless Hub

Gaetz, Stephen (2014) Ask the Hub - Can We End Youth Homelessness? Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Youth Homelessness Toronto: Homeless Hub

Gaetz, Stephen (2014) Ask the Hub - What's new on the Homeless Hub? Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Discharge Planning – Health and Mental Health Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Harm Reduction Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Retooling Emergency Services Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Addressing Legal and Justice Issues Toronto: Homeless Hub

Gaetz, Stephen (2013) The Debate is Over! Housing First Works! Toronto: Homeless Hub

Gaetz, Stephen (2013) Addressing Youth Homelessness: Research Points the Way Toronto: Homeless Hub

Gaetz, Stephen (2013) Things Need to Change Toronto: Homeless Hub

Gaetz, Stephen (2012) Creating Research Impact - How We Make Homelessness Research Matter Toronto: Homeless Hub

Gaetz, Stephen (2012) Foyers give young people a safe and decent place to live, learn and grow Toronto: Homeless Hub

Gaetz, Stephen (2012) Youth Homelessness and Labour Market Integration Toronto: Homeless Hub

Gaetz, Stephen (2012) Canada now has a shared definition of homelessness – but, do we even need one? Toronto: Homeless Hub

Gaetz, Stephen (2012) New Canadian Alliance to End Homelessness will make an impact! Toronto: Homeless Hub

Gaetz, Stephen (2011) The rich get richer and the homeless get fined Toronto: Homeless Hub

Gaetz, Stephen (2011) Solving youth homelessness in Canada Toronto: Homeless Hub

Gaetz, Stephen (2011) Feed the homeless at own risk... Toronto: Homeless Hub

Gaetz, Stephen (2011) Can housing first work if there isn't enough affordable housing? Toronto: Homeless Hub

Gaetz, Stephen (2010) Jail is not a solution for our homelessness problem Toronto: Homeless Hub

Gaetz, Stephen (2010) Does the right to protection from crime and violence apply to all youth ... even homeless youth? Toronto: Homeless Hub

Gaetz, Stephen (2010) Should we give money to panhandlers? Toronto: Homeless Hub

Gaetz, Stephen (2010) The beginnings of a Leadership Academy Toronto: Homeless Hub

5. PROFESSIONAL SERVICES

Conference Organizing Committee

2013 *International Homelessness Research Conference*, Philadelphia, June 3, 2013

2010 *Repenser l'itinérance. Défis théoriques et méthodologiques. Rethinking*

Homelessness. Theoretical and Methodological Challenges. (Organizing Committee) UQAM, Montreal, October 27-30

2004-05 *Canadian Conference on Homelessness: Stories, Research, Solutions* (Chair) York University, 2005.

1995 *Other Young Lives Conference on Lesbian, Gay and Bisexual Youth*, Toronto, February, 1995.

1994 *Get Down to it! Conference on Youth Health Issues,* City of Toronto, Department of Public Health, November, 1994.

Editorial Board:

2006 Guest Editor: Special Issue on Homelessness - *Canadian Review of Social Policy*, 2006, No. 58

2008-09 Editorial Board – Finding Home book project (David Hulchanski, PI)

6. PUBLIC APPEARANCES

Press (newspaper, television and radio) (*selected – stopped tracking in 2015)

2015 "Unstoppable real estate market displaces Beatrice House shelter". Denise Balkissoon. *The Globe and Mail*. June 19, 2015

2015 "Five years of Hamilton police ACTION team: How is it working?" Nicole O'Reilly, *Hamilton Spectator*. May 26, 2015

2015 "Counting the homeless: What's the point of Point-in-Time?" Mark Rendell, *EDGE*, May 21, 2015

2015 "Homeless killings, assaults highlith the perils of life on the streets". John Hembrey, *CBC News*. May 5, 2015

2015 "A national housing strategy: Without one Calgary suffers". James Wilt. *Rabble.ca* April 30, 2015

2015 "Street people susceptible to violent crime" Kathleen Saylors. *Winnipeg Free Press*. April 28, 2015

2015 "From burnings to beatings, homeless people face violence on the streets". Michael Tutton. CTV News. April 26, 2015

2015 "Toronto legal clinic helps homeless fight unpayable 'nuisance' tickets" Toronto legal clinic helps homeless fight unpayable 'nuisance' tickets" Laurie Montsebratten, *Toronto Star*, Mar 9, 2015

2015 "Homelessness – Hardly home free" Debora Van Brenk. London Free Press. February 9th, 2015

2015 "Toronto experts advise Ontario on how to end homelessness" Laurie Montsebratten, *Toronto Star*, February 9, 2015

2015 "Toronto seized under 11th extreme cold alert this winter." Daily Times. Jan 31, 2015

2015 "Suburban homelessness is a problem often neglected in Toronto" , Markus Gee, *The Globe and Mail*, Jan 14, 2015

2015 "Hamilton activists push Liberals to scrap panhandling laws", Teviah Moro, *Hamilton Spectator*, Jan 6, 2015

2014 "Safe Streets Act should be repealed" *CBC Toronto*. December 15, 2014

2014 "Panhandling tickets saddle Toronto's homeless with debt: York professor" *Metro* (Toronto). December 15, 2014

2014 "Michael Bryant urges repeal of law that 'criminalizes homelessness'" *Toronto Star*. Toronto, ON., December 15, 2014

2014 "Repeal 'Rotten' Safe Streets Act, says former Ontario Attorney General" *Canadian Press*. Toronto. December 15, 2014

2014 "Expert optimistic N.L. can reduce youth homelessness" *The Telegram*. St. John's, Nfld. December 4, 2014

2014 "Momentum building for youth homelessness plan in York Region" *Yonge Street*. Toronto, December 3, 2014

2014 "'Housing First' the focus as homelessness experts meet in Ottawa (with video). *Ottawa Citizen*, Ottawa ON. November 17, 2014

2014 "What would it cost to dramatically reduce homelessness? About $46 per Canadian a year". *Ottawa Citizen*, Ottawa ON. October 29, 2014

2014 "Tory's focus on housing welcomed by national homelessness advocate". *York Guardian*, Toronto ON. October 30, 2014

2014 "$46 more per Canadian per year can vastly cut homelessness, new report says", Toronto Star, October 29th, 2014

2014 Tory's focus on housing welcomed by national homelessness advocate". *York Guardian*, Toronto ON. October 30, 2014

2014 "Homelessness groups want each Canadian to contribute Tory's focus on housing welcomed by national homelessness advocate". *York Guardian*, Toronto ON. October 30, 2014

2014 "Report tackles homelessness crisis", Calgary Herald, Oct. 29, 2014

2014 “Solving homelessness could cost you just $46“, Winnipeg Sun, Oct. 30, 2014

2014 “Study: Helping homeless won't break bank” Chronicle Herald, Oct. 30, 2014

2014 “Add $46 a year per Canadian to housing budget, cut homelessness: report”, Hamilton Spectator, Oct. 30, 2014

2014 “'$106 A YEAR' ; Homelessness groups ask Canadians for help” Edmonton Sun, Oct. 30, 2014

2014 “Tory's focus on housing welcomed by national homelessness advocate” York Guardian, Oct. 30, 2014

2014 “Is $46 per Canadian too much to spend?” Daily News Nanaimo, Oct. 30, 2014

2014 “Range of homelessness solutions needed“ Times Colonist Oct. 30, 2014

2014 “Extra $46 per Canadian could help homeless: study” Cape Breton Post, Oct. 30, 2014

2014 “Add $46 a year per Canadian to housing budget, cut homelessness: report “ St. John’s Telegram, Oct. 30, 2014

2014 “Use surplus to aid affordable housing, report says”, Guelph Mercury, Oct. 30, 2014

2014 “Groups want $106 per Canadian to fight homelessness” The Sault Star; Pembroke Observer; The Owen Sound Sun Times; Niagara Falls Review; Northbay Nugget, Belleville intelligencer; Brockville Recorder and Times; Simcoe Reformer; Welland Tribute; Woodstock Sentinel Review; Stratford Beacon; Sudbury Star; Orilla Packet and Times Oct. 30, 2014

2014 “Study: Extra $46 per Canadian could Reduce Homelessness” Blackburn News, Oct. 29, 2014

2014 “Extra $46 per Canadian could help homeless: study “ Caledon Enterprise, Oct. 29, 2014

2014 “Homelessness Report Out Today “ BT Vancouver , Oct. 29, 2014

2014 “Groups want each Canadian to pay $106 a year to reduce homelessness”, Canoe, Oct. 29, 2014

2014 “Thunder Bay homeless shelters operating beyond capacity “ CBC Thunder Bay, Oct. 29, 2014

2014 “Canadian homelessness: $46 a person would help, report says” CBC, Oct. 29,

2014 “Add $46 a year per Canadian to housing budget, cut homelessness: report” City News, Oct. 29, 2014

2014 “Report calls for increased investment in affordable housing”, CTV, N.D.

2014 “Add $46 a year for each Canadian to housing budget, cut homelessness: report“,

CTV Winnipeg, Oct. 29, 2014

2014 "Extra $46 per Canadian could help homeless: study", Durham Region, Oct. 29, 2014

2014 "Add $46 a year per Canadian to housing budget, cut homelessness: report", Edmonton Journal, Oct. 29, 2014

2014 "York research group releases report on homelessness in Canada", Excalibur, Nov. 12, 2014

2014 "Tackling homelessness is everyone's business" *Winnipeg Free Press*. Winnipeg, MN September 5, 2014

2014 "Homelessness is our problem too" *Winnipeg Free Press*. Winnipeg, MN September 30, 2014

2014 "Poverty Reduction Reboot" The Agenda. TVOntario, Sept 22, 2014

2014 "St. John's youth homelessness above national average" The Telegram. St. John's, Nfld, June 17, 2014

2014 "Helping Hidden Lives" The Agenda. TVOntario, Sept 22, 2014

2014 "'Housing First" approach may put homeless youth last, report warns" CTV news, April 21, 2014

2014 "Canada failing homeless youth, report charges" *Toronto Star*. Toronto, ON March 3, 2014

2013 "Canada's Homeless" CBC The National. June 19, 2013

2013 "Homelessness in Canada" CTV National. June 19, 2013

2013 "Canada Homelessness Study: 30,000 on the streets, in shelters on a given night" Toronto Star. June 20, 2013

2013 "Homelessness Affects 200,000 in Canada" Canadian Press story, in newspapers across the country. June 19, 2013

2013 "National report on homelessness says Alberta leads the fight" Calgary Herald June 19, 2013

2013 "Canada's Homeless" CBC Radio (four times, different communities) June 19, 2013

2013 "New Study 'Shatters Myths' of Homelessness in Toronto" Metro Toronto, January 10, 2013. Interviewer, Jessica Smith

2012 "Responding to youth homelessness" Radio Canada (television and radio). Montreal. November 15, 2012. Interviewer, Julie-Anne Lamoureux

2012 News1130 Radio, Vancouver. October 12, 2012. Interviewer, Renee Bernard.

2012 "Cities leading fight against homelessness may surprise you" News1130 Radio Newsletter, Vancouver. October 12, 2012. Interviewer, Renee Bernard.

2012 "Policing Toronto's Panhandlers". Toronto Sun. October 7, 2012. Writer, Simon Kent

2012 "Homelessness, Defined" Novae Res Urbis, October 5, 2012. Interviewer, Jake Tobin Garrett

2012 XFM News, Antigonish NS. October 3, 2012: Interviewer, Brittany Cavanagh

2012 "New Canadian research on costs of homelessness" The American Round Table to Abolish Homelessness. October 4, 2012. Issue XX

2012 CBC Yellowknife. October 3. Interviewer: Mark Winkler

2012 "The Current" – CBC News. September 28, 2012.

2012 Media Mornings, Vancouver's Co-op Radio 100.5 FM. September 27, 2012. Interviewer, Jane Bouey

2012 CBC News, Vancouver. September 27, 2012. Interviewer, Robert Zimmerman

2012 People First Radio, CHHLY, Nanaimo. September 27, 2012. Interviewer, Kevin Midbo

2012 CFAX 1070AM Interview Request, Victoria. September 25, 2012. Interviewer, Sonia Lowe

2012 "Housing homeless cheaper, more effective than status quo: study" Globe and Mail. September 24, 2012. Heather Scoffield, Canadian Press/Globe and Mail

2012 "BC could learn from Alberta how to save on costs of homelessness: expert" Metro Vancouver. September 24, 2012. Interviewer: Kate Webb

2012 Regina Leader-Post. September 24, 2012. Interviewer: David Fraser

2012 AM 800 CKLW, Windsor. September 24, 2012. Interviewer, Rusty Thomson

2012 The Todd Veinotte Show. (Rogers Cable, Atlantic Canada) September 14, 2012. Reporter: Todd Veinotte

2012 As it Happens, (CBC) Toronto, September 14, 2012., Anchor Laura DiBatista

2012 "Critics say new definition of 'homeless' too broad, includes those only 'at risk'." National Post (front page). September 12, 2012. Writer, Tristin Hopper

2012 CBC Morning News, Whitehorse. May, 23, 2012

2011 "Conservatives quietly fund massive homeless housing pilot project – At Home/Chez Soi" Canadian Press. December 26, 2012. Writer, Heather Scoffield.

2011 "Report says homeless youth are unfair police targets. Canadian Press / CTV

News. November 10, 2011. Writer, Heather Scoffield.

2011 "Is the homeless veteran problem set to explode?" The Canadian Press, Nov. 7, 2011. Writer: Heather Scoffield

2011 "Time on the streets not easy for the uninitiated" Toronto Sun. August 20, 2011. Writer, Terry Davidson

2011 "Poll calls for tougher panhandling laws" Canoe News. September 14, 2011. Writer: Jenny Yuen

2010 Metro Morning, Toronto, September 27, 2010, Anchor/Reporters: Matt Gallaway

2005 Canada Now (local) (CBLT-TV), Toronto, 20 May 2005, 06:32PM, Anchor/Reporters: Diana Swain, Christina Birak.

2005 MORNING NORTH (HR1) (CBCS-FM), SUDBURY, 18 May 2005, 06:32AM, Anchor/Reporters: MARKUS SCHWABE, RUTH REID.

2005 Metro Morning, Toronto, 18 May 2005, Anchor/Reporters: Andy Barrie, Martina Fitzgerald

2005 London News (CBCL-FM), 18 May 2005, Anchor/Reporters: Carrie McKee, Jean Carter

2005 Ottawa Morning (CBO-FM), Ottawa, 25 May 2005, 06:21AM, anchor/Reporters: Anthony Germain

1999 Guest on Metro Morning (CBC Radio). Topic: "Street Youth and Making Money".

1999 Guest on TVO Studio 2. Topic: "Safe Streets Act".

1998 Guest on TVO. Parent Connection. Topic: "Squeegee Kids".

1995 Guest on Metro Morning (CBC Radio). Topic: "Street Youth and Oral Health".

* Note: I have not actively kept track of media contacts until this past year

7. FUNDING

Summary:

Research funding received as Principal Investigator: **$46,461,458**
Research funding received as Co-Investigator or Partner: **$6,599,836**
Program Evaluation Contracts: **$1,049,791**
Total: $54,111,085

Research Grants

2022 *The Canadian Observatory on Homelessness (COH) - Mobilizing Partnerships to Prevent and End Homelessness*
SSHRC Partnership Development Grant
Stephen Gaetz (Principal Investigator)
Amount: $2,499,457.

2021 *Making the Shift – Youth Homelessness Demonstration Lab* (extension)
Social Development Partnership Program, Government of Canada
Stephen Gaetz (Co-Principal Investigator); Redman, Melanie, A Way Home Canada (Co-Principal Investigator)
Amount: $3,700,000

2021 *Designing Canada's long-term affordable housing approach*
SSHRC Partnership Development Grant
Stephen Gaetz (Co-Applicant); Abe Oudshoorn, Western University (Principal Investigator)
Amount: $199,114

2021 *Beyond Agency: How does Knowledge Mobilization Advance Social Innovation in Communities?*
SSHRC Insight Development Grant
Stephen Gaetz (Co-Applicant); Jacqueline Sohn, York University (Principal Investigator)
Amount: $50,000

2020 *Enhanced Surveillance for Chronic Disease Program (ESCDP) "Homelessness Counts"*
Public Health Agency of Canada - The Enhanced Surveillance for Chronic Disease
Stephen Gaetz (Co-Applicant); Cheryl Forchuk, Western University (Principal Investigator)
Amount: $995,281

2020 *Making the Shift – Youth Homelessness Demonstration Lab* (extension)

Social Development Partnership Program, Government of Canada
Stephen Gaetz (Co-Principal Investigator); Redman, Melanie, A Way Home Canada (Co-Principal Investigator)
Amount: $3,800,000

2019 *Making the Shift – Youth Homelessness Demonstration Lab* (extension)
Social Development Partnership Program, Government of Canada
Stephen Gaetz (Co-Principal Investigator); Redman, Melanie, A Way Home Canada (Co-Principal Investigator)
Amount: $2,900,000

2019 *Interventions research in homelessness, housing, and health*
Foundation Grant – CIHR
Stephen Gaetz (Partner); Stephen Hwang, University of Toronto (Principal Investigator)
Amount: $3,972,033

2019 *Homelessness; Housing First; Social Service System Coordination*
SSHRC Partnership Development Grant
Stephen Gaetz (Partner); John Graham, UBC - Okanagan (Principal Investigator)
Amount: $192,900

2019 *Working upstream to prevent and end youth homelessness: mapping existing policies and practices to build better educational responses in Canada*
SSHRC Partnership Development Grant
Stephen Gaetz (Partner); Jacqueline Kennelly, Carleton University (Principal Investigator)
Amount: $199,550

2019 *Migration of People Experiencing Homelessness in Greater Toronto*
United Way of Greater Toronto
Stephen Gaetz (Principal Investigator)
Amount: $30,000

2019 *Indigenizing Coordinated Access in Hamilton*
Hamilton Indigenous Community Advisory Body
Stephen Gaetz (Principal Investigator)
Amount: $61,432

2018 *Making the Shift – A Youth Homelessness Solutions Impact Accelerator*
Networks of Centres of Excellence Program – Government of Canada
Stephen Gaetz (Co-lead applicant); Redman, Melanie, A Way Home Canada (Co-lead

applicant)
Amount: $17, 901, 337
#900-2018-202

2017 *Making the Shift – Youth Homelessness Social Innovation Lab*
Social Development Partnership Program, Government of Canada
Stephen Gaetz (Co-Principal Investigator); Redman, Melanie, A Way Home Canada (Co-Principal Investigator)
Amount: $7, 908, 405

2017 *Defining an End to Homelessness*
Homelessness Partnering Strategy, Employment and Social Development, Government of Canada
Stephen Gaetz (Principal Investigator)
Amount: $431,211

2017 *Point in Time Count toolkit and technical support*
Homelessness Partnering Strategy, Employment and Social Development, Government of Canada
Stephen Gaetz (Principal Investigator)
Amount: $126,149

2017 *Youth Homelessness Prevention Framework Consultation*
Home Depot of Canada Foundation
Stephen Gaetz (Principal Investigator)
Amount: $61,732

2016 *National Youth Homelessness Survey*
Home Depot of Canada Foundation
Stephen Gaetz (Principal Investigator)
Amount: $81,000

2016 *Housing First for Youth and Employment – Design Charet*
Home Depot of Canada Foundation
Stephen Gaetz (Principal Investigator)
Amount: $18,500

2016 *Computer simulation modeling to address homelessness*
Social Sciences and Humanities Research Council of Canada
Stephen Gaetz (Co-Investigator); Eric Latimer (McGill: Principal Investigator)
Amount: $196,043

2016 *Enhancing the Influence of Engaged Scholarship*
Social Sciences and Humanities Research Council of Canada
Stephen Gaetz (Co-Investigator); Naomi Nichols (McGill: Principal Investigator)
Amount: $69,933

2015 *Toolkits for Youth Homelessness Employment and Housing Programs*
Home Depot of Canada Foundation
Stephen Gaetz (Principal Investigator)
Amount: $35,000

2015 *Social Sciences and Humanities Research Council (SSHRC) Impact Award – Connection.*
Social Sciences and Humanities Research Council of Canada
Stephen Gaetz (Principal Investigator)
Amount: $50,000
#780-2016-0009

2015 *Point-in-Time Homeless Count Training and Support for Designated Communities of the Homelessness Partnering Strategy*
Community Development and Homelessness Partnering Directorate, Government of Canada
Stephen Gaetz (Principal Investigator)
Amount: $367,576

2014 *Understanding Youth Homelessness: A youth focused Point-in-Time methodology and toolkit*
Laidlaw Foundation
Stephen Gaetz (Principal Investigator)
Amount: $20,000

2014 *Inspiring Local Communities: Toolkits for developing innovative models of housing and support for homeless youth*
The Home Depot Canada Foundation
Stephen Gaetz (Principal Investigator)
Amount: $35,000

2013 *The Canadian Observatory on Homelessness: Creating Policy Impact*
SSHRC Partnership Grant
Stephen Gaetz (Principal Investigator)
Amount: $2,502,967
#895-2012-1012

2013 Transforming Treatment Services and Housing for People with Mental Illness in

Canada: A Systems Approach to Integrated Knowledge Translation
CIHR – Partnerships for Health Systems Improvement
Stephen Gaetz (Co Investigator); Nelson, G., Stergiopolous, V., Goering, P. (Principal Investigators)
Amount: $194,970

2013 *York Symposium on Engaged Scholarship*
SSHRC Connections Grant
Stephen Gaetz (Principal Investigator)
Amount: $31,187

2013 *Housing First Promising Practices Case Studies*
HRDC Homelessness Partnering Strategy
Stephen Gaetz (Principal Investigator)
Amount: $60,000

2012 *Canadian Observatory on Homelessness*
SSHRC Partnership Grant - Letter of Intent
Stephen Gaetz (Principal Investigator)
Amount: $20,000

2012 *Knowledge Mobilization for housing and economic vulnerability*
SSHRC Public Outreach Grant
Stephen Gaetz (Principal Investigator)
Amount: $141,798
#604-2011-0016

2012 *Navigating the Road to Reintegration*
SSHRC Partnership Development Grant
Stephen Gaetz (Co-Investigator); Bill O'Grady (Principle Investigator)
Amount: $198,960

2012 *Developing a Foyer: A Horizontal Pilot Project*
HRDC Homelessness Partnering Strategy
Stephen Gaetz (Principal Investigator)
Amount: $29,640

2011 *Youth Homelessness e-book project*
HRDC Homelessness Partnering Strategy
Stephen Gaetz (Principal Investigator)
Amount: $35,132

2011 *Promising Practices in the Homelessness Sector*

HRDC Homelessness Partnering Strategy
Stephen Gaetz (Principal Investigator) Michaela Hynie, Bernie Pauly, Daphne Winland, Jeannette Waegemakers-Schiff (co-investigators)
Amount: $84,920

2010 *Building Program Evaluation Capacity in the Homelessness Sector*
HRDC Homelessness Partnering Strategy
Stephen Gaetz (Principal Investigator)
Amount: $79,465

2010 *Responding to H1N1 in the Context of Homelessness in Canada*
Canadian Institutes of Health Research
Catalyst Grant: Pandemic Preparedness
Stephen Gaetz (Principal Investigator)
Amount: $100,000

2009 *The provision of charitable food assistance in Canada: forging a more adequate response*
Canadian Institutes of Health Research
Stephen Gaetz, (co-investigator); Valerie Tarasuk, (principal investigator). Blake Poland, A. Hamelin, Alex Ostry, K. Raine, P.L. Williams
Amount: $ 314,521

2009 *Understanding Pandemic Preparedness in the Context of the Canadian Homelessness Crisis*
Canadian Institutes of Health Research
Catalyst Grant: Pandemic Preparedness
Stephen Gaetz (Principal Investigator)
Amount: $100,000

2009 *Ending Homelessness: "What works and for whom?" A Knowledge Mobilization Partnership*
Collaborative Faculty Incentive Grant
York University / University of Victoria
Stephen Gaetz, Bernie Pauly (Principal Investigators)
Amount: $30,000

2008 *Canadian Homelessness Research Network.*
SSHRC Strategic Knowledge Cluster Program
Stephen Gaetz (Principal Investigator)
Amount: $2,097,039
#857-2007-0015

2008 *The Homeless Hub: A Knowledge Mobilization Project*
Homelessness Partnering Strategy
Human Resources & Social Development Canada
Stephen Gaetz (Principal Investigator)
Amount: $90,420

2007 *Canadian Homelessness Knowledge Impact Initiative.*
Housing and Homelessness Branch
Human Resources & Social Development Canada
Stephen Gaetz (Principal Investigator)
Amount: $145,371

2006 *Attending to social vulnerabilities in tuberculosis transmission: A synergistic model of qualitative and quantitative methods.*
SSHRC Research Initiative Grant
Stephen Gaetz (Principal Investigator)
Amount: $40,000

2005 *Institutional Discharge and Homelessness: A Look at Canadian Corrections in the Public and Private Spheres*
National Homelessness Initiative National Research Program
Homelessness and Justice Domain
Stephen Gaetz, Bill O'Grady (Principle Investigators).
Amount: $136,276

2004 *Canadian Conference on Homelessness:*
- National Homelessness Initiative (HRSD): $225,000
- Canada Mortgage and Housing Corporation: $49,000
- National Homelessness Initiative - Ontario Directorate: $45,923
- Ontario Ontario Mental Health Foundation: $25,000
- City of Toronto: $15,000
- Wellesley Central Health Corporation: $15,000

Total amount: $375,923

2004 *A Pilot Study of Local Responses to the Food and Nutrition Needs of Homeless Youth*.
Canadian Institutes of Health Research:
Stephen Gaetz, Blake Poland (co-investigators); Valerie Tarasuk, (principal investigator).
Amount: $98,294

2004 *Literature Review of Research on Homelessness in Canada.*
York Incentive Grant:
Stephen Gaetz (Principal Investigator).

Amount: $5000

2003 *A Study of Community Responses to the Food and Nutrition Needs of Homeless People in Southeast Toronto.*
Wellesley Central Urban Health Grant Initiative:
Stephen Gaetz, Blake Poland (co-investigators); Valerie Tarasuk, (principal investigator)
Amount: $50,000

2003 *Developing a Virtual Clearinghouse of Research on Homelessness*.
Wellesley Central Urban Health Grant Initiative:
Stephen Gaetz, Alice Broughton (Sherbourne Health Centre), Wengari Murkuri (Street Health).
Amount: $15,000

2002 *Food: Nutritional Vulnerability and Social Exclusion among Homeless Youth*. Canadian Institutes of Health Research:
Stephen Gaetz, Blake Poland (co-investigators); Valerie Tarasuk, (PI).
Amount: $227,758

1999 *Community Economic Development and Street Involved Youth*
Homeless Initiative Fund - City of Toronto / HRDC.:
Stephen Gaetz (Principal Investigator).
Amount: $24,000

Program Evaluation Contracts 2016-19
Note that these contracts are with the Canadian Observatory on Homelessness and though in many cases I am listed as Principal Investigator, I may have had limited involvement with the projects.

2019	Penny Lane Evaluation. (Boys and Girls Clubs of Calgary)		$20,340
2019	Program Review of Eva's Family Reconnect & Evaluation of YOUth BelongProject (Eva's)		176,000
2019	ICM Evaluation (Homes First)		$10,666
2019	Development of Survey and Outcome Measuring (Red Door Shelter)		$10,412
2019	Evaluation of Supportive Training, Social Enterprise (Choice for Youth)		$40,000
2019	Evaluation of YES Transitional Housing (Peterborough)		$25,000
2018	Evaluation of LGBTQ Transitional Housing (EGALE)		$80,875

2018	Host Homes evaluation (Raising the Roof)		$49,998
2018	Bridging the Gap – Host Homes Evaluation (Raising the Roof)		$50,000
2018	Evaluation of Youth Services Host Home Program (One Roof Hamilton)		$105,321
2018	Evaluation of A Way Home Toronto (Covenant House)		$35,500
2018	Family Homelessness (City of Toronto)		$38,375
2018	Evaluation of Low Barrier Services (City of Toronto)		$49,575
2017	EPIC Evaluation (City of Toronto)		$57,533
2017	Outcomes Framework (Eva's Initiatives)		$20,540
2017	Evaluation of Grants Program (HDCF)		$19,057
2017	Evaluation of Hire Up (Impakt)		$57,300
2017	CMHA TCM Evaluation (Ottawa Mission)		$42,345
2016	Region of Peel		$90,430
2016	St. John's		$28,274
2016	Training and Technical Assistance Evaluation (Canadian Alliance to End Homelessness)		$42,250

TOTAL REVENUE: $1,049,791

Contract Research

2011 Towards a Canadian Definition of Homelessness
HRDC Homelessness Partnering Initiative
Stephen Gaetz (Principal Investigator).
Amount: $8,000

2011 Plans to End Youth Homelessness in Canada - A Review of the Literature
Eva's Initiatives and Virgin Unite
Stephen Gaetz (Principal Investigator).
Amount: $7,500

2001 *Street Involved Youth and Access to Justice*.
Justice for Children and Youth Foundation:
Stephen Gaetz (Principal Investigator).
Amount: $30,000

1995 *Research on youth values in Toronto.*
Cultural Analysis Group, N.Y, N.Y.
Daphne Winland, Stephen Gaetz (Principal Investigators)
Amount: $2400

1991 *Effectiveness of Refugee Sponsorship Programmes.*
Employment and Immigration Canada
Daphne Winland, Stephen Gaetz (Principal Investigators)
Amount: $5000

Travel/Development Grants

2004 Conference travel support: *Faculty of Education*, ORS (York University): $1,700.00.
Conference paper presentation "*An Urban Other: Street Youth and Criminal Victimization in Toronto.* Association of Canadian Studies in Ireland, Cork, Ireland

2002 Faculty of Education Minor Research and Development Grant: $2500.00.
Stephen Gaetz and Don Dippo (principal investigators). *TL Kennedy Research Project*.

2001 Faculty of Arts International Working Group - International Pilot Projects.$6000.00.
Stephen Gaetz and Penny Van Esterik (principal investigators). *Others in our Midst: Cross-Cultural Practices of Communicating about Cultural Differences.*

2001 SSHRC Small Research Grant: $2500.00.
Broken Promises The Educational Experiences of Homeless Youth in Toronto.

C. TEACHING

1. UNDERGRADUATE PROGRAMME

Courses Taught

2018	ED/EDFE 1101 3.0 Adolescent Development and Health. Course Director (Fall session)
2017	ED/EDFE 1101 3.0 Adolescent Development and Health. Course Director (Fall session)
2016	ED/EDFE 1101 3.0 Adolescent Development and Health. Course Director (Fall session)
2015	ED/EDFE 1101 3.0 Adolescent Development and Health. Course Director (Fall session)
2014	EDUC 3310 3.0 Adolescent Development and Health.
2012	EDUC 3310 3.0 The Adolescent and the Teacher.
2001-2006	EDUC 3310 3.0 The Adolescent and the Teacher (TL Kennedy site).
2001-2006	EDUC 3310 3.0 The Adolescent and the Teacher (Keele site).
2002	EDUC 3310 3.0 The Adolescent and the Teacher (Durham site).
2001-2003	ED/CMYR2400 3.0 Communication and the Education Process (TL Kennedy site).
2001-2003	ED/CMYR2400 3.0 Communication and the Education Process (Keele site).
1996 (winter)	ANTH 4210.03F Other Young Lives: Anthropology and Youth Cultures. York University.
1993-1994	ANTH 2010B.06 Anthropology of Youth Culture. York University.
1992 (fall)	ANTH 2000A.03 Anthropology of Youth Culture. York University.

2. GRADUATE PROGRAMME

2020 EDUC 5935 30. Understanding Youth Homelessness - *Its causes and conditions, and what we can do about it.* Course Director (Summer session)

2019 EDUC 5935 30. Understanding Youth Homelessness - *Its causes and conditions, and what we can do about it.* Course Director (Summer session)

2019 EDUC 5930 3.0 Engaged Scholarship: Bridging the gap between academia, policy and practice through *Knowledge Mobilization*. Course Director (Winter session)

2018 EDUC 5930 3.0 Engaged Scholarship: Bridging the gap between academia, policy and practice through *Knowledge Mobilization*. Course Director (Winter session)

2017 EDUC 5935 3.0. Understanding Youth Homelessness - *Its causes and conditions, and what we can do about it.* Course Director (Summer session)

2016 EDUC 5930 3.0 Engaged Scholarship: Bridging the gap between academia, policy and practice through *Knowledge Mobilization.* Course Director (Winter session)

2016 EDUC 5935 3.0 Understanding Youth Homelessness - *Its causes and conditions, and what we can do about it.* Course Director (Summer session)

2014 EDUC 5930 3.0 Engaged Scholarship: Bridging the gap between academia, policy and practice through *Knowledge Mobilization*.

2011 - 14 EDUC 5435 3.0 Studies of Adolescence and Cultural Experience

2006 EDUC 5435 3.0 Studies of Adolescence and Cultural Experience

2001-2006 EDUC 5430 3.0 Social Deviance, Resistance and Schooling.

2001 EDUC 5120 6.0 Theory and Research in Language, Culture and Teaching.

3. POST-DOCTORAL FELLOWS

Hart Walker (2021 – Present)

Karen Naidoo (2021 – Present)

Emmanuel Banchani (2021 – Present)

Ahmad Bonakdar (2021 – 2022)

Jackie Sohn (2019- present)

Meryl Burato (2018 – 2021)

Anika Mifsud (2018 – 2020)

Rachel Caplan (2018 – 2020)

Erin Dej (2016-2018)

Kaitlin Schwan (2017 – 2020)

Naomi Nichols (2014-2015)

4. GRADUATE SUPERVISION

Doctoral Programme Supervision and Committees

Supervision (Current)

Michael Kenney (2014-21) Faculty of Education

Committee Membership (Current)

Supervision (Completed)

Sabina Mirza (2012-21) *Exploring Schooling and Educational Attainment Through the Experiences of Homeless Youth.* Faculty of Education, York University

Amanda Noble (2012-2018) *Housing First and 'Ending' Youth Homelessness in the Neoliberal Era: A Case Study of the Infinity Project & Calgary's 10-Year Plan to End Homelessness.* Faculty of Education, York University.

Maria Lucia DiPlacito (2010-2015) *Campus Mental Health: Implications For Instructors Supporting Students.* Faculty of Education, York University.

Kristy Buccieri (2007-2012) *Caught Somewhere Between Public and Private: How Patriarchy, Heteronormativity and Neoliberalism Collude to Keep Homeless Youth In and Out of Place.* Faculty of Education, York University.

Committee Membership (Completed)

Jason Webb (2021) Working for Citizenship in the Liminal Space - Social Reproduction in the Emergency Family Shelter System Supervisor: Amber Gazso, Sociology, York University

Dustin Graham (2020) *Reclaiming student voices on school-based, mental health impacts: youth reflections, lived experiences and recommendations for transforming Ontario secondary schools.* Supervisor: Chloe Brushwood-Rose. Faculty of Education, York University.

Kathleen Worton (2018) *Knowledge mobilization for complex community interventions: Examining how peer learning strategies influence local implementation of Housing First.* Supervisor: Geoffrey Nelson. Department of Community Psychology. Wilfred Laurier University. Waterloo Ontario

Rebecca Houwer (2017) Enacting justice-focused sustainabilities through community-engaged learning and action in postsecondary education: The NOISE for Social Change Project. Supervisor: Steve Alsop, Faculty of Education

Lauren Joly (2017) Understanding Romantic Relationships and Resilience Among Street-Involved Youth: A Quantitative and Qualitative Exploration. Supervisor: Jennifer Connolly Clinical-Developmental Psychology, York University

Megan Sandhu (2016) *University-Community Partnerships: An Action-Humanities Approach to Addressing Homelessness.* Supervisor: Markus Reisenleitner. Faculty of Liberal Arts and Professional Studies.York University.

Kaitlin Schwan (2016) *Why Don't We Do Something? The Societal Problematization of "Homelessness" and the Relationship between Discursive Framing and Social Change.* Supervisor, David Hulchanski. Department of Social Work, University of Toronto.

Carrie Anne Marshall (2015) *Occupation, Homelessness, and the Transition to Becoming Housed in Chronically Homeless Persons in a Small Urban Context*. Supervisor: Rosemary Lysaght, Queens University

Michelle Wyndham-West (2014) *Is it worth the shot? Ontario women's negotiations of risk, gender and the Human Papillomavirus (HPV) Vaccine.* Supervisor: Naomi Adelson, Department of Anthropology, York University

Lisa Romano-Dwyer (2012) *"And I can get anyone into Hamlet." Using Humanities-Based Approaches After Expulsion for School Violence: A Hermeneutical Transformation of Safe Schools.* Supervisor: Alison Griffith. Faculty of Education.

Gregory Knoll (2012) *Stages of Change Training for Youth Outreach Workers: Bridging Research, Theory and Practice.* Graduate program in Psychology, York University

Naomi Nichols (2011) *All My Life I've Slipped Through the Cracks" The Social Coordination of "Youth Work". Faculty of Education, York University*

Christopher Smith (2008). *A User's Guide to the City: "Juice Bars', 'Liquid Handcuffs' and the Disorder of Drugs.* Communications Studies, York University

Bronwyn Low (2001). *Spoken Word: Exploring the Language and Poetics of Hip Hop Popular*. Faculty of Education, York University**.**

Dean's Representative

Margaret Jean Mitchell (2002). *Roads, Restlessness and Relationships: An Urban Settlement in Post-Colonial Vanuatu.* Department of Anthropology, York University.

Internal / External Examiner

Lauren Joly (2018) *Understanding Romantic Relationships and Resilience Among Street-Involved Youth: A Quantitative and Qualitative Exploeration.* Graduate Program in Clinical Psychology. Supervisor: Jennifer Connolly

Geoff Sorge (2011) *Cognitive Abilities and Rational Thinking Variables as Predictors of Antisocial/Risky Behaviour*. Faculty of Health, York University.

Jim Steiben (2010) *Neurophysiological Mechanisms of Emotional Regulation for Subtypes of Externalizing Children.* Department of Psychology, York University

Anna Ning (1999). *Embodying the Myth of Healthiness: Conformity, Resistance and Complicity in Narratives of Addiction and Recovery*. Department of Anthropology, York University.

External Examiner

Darren Stonehouse (2021) The Neoliberal Representation of Homelessness and its Alignment with Material Conditions and Lived Experiences in Victoria, Australia. La Trobe University, Melborne, Australia.

Jennifer Bell (2019) Solina Richter, Sarah Stahlke, Department of Nursing, University of Alberta

Heather M. Patterson. (2016) *Attachment Styles, Psychological Functioning, and Resilience Factors among Street-involved Youth: Describing Youth who Access Community Agency Support.* Department of Psychology. Memorial University of Newfoundland

Michelle Wyndham-West (2015) Sarah Benbow (2015) *Mothers Experiencing Homelessness: Social Exclusion, Resistance, and Health.* Nursing, Western University. December, 2015

Erin Dej (2015) Seeking Inclusion in the 'Land of Broken Toys': Negotiating Mental Health Managerialism Among Homeless Men and Women. Department of Criminology, Université d'Ottawa - University of Ottawa

Lorcan Patrick Byrne (2014) *Between Respectability and Disgrace: Schismogenesis & the Regeneration of Inequality, Stigma and Social Exclusion in Limerick.* University College Limerick, Ireland

Felicia Garcia (2013). *Coping and Suicide Amongst 'the Lads': Expectations of masculinity in post-traditional Ireland* . Department of Anthropology. University of Maynooth, Ireland

Abe Oudshoorn (2011) *Client-Provider Relationships in a Community Health Clinic for People Experiencing Homelessness: A Critical Ethnography. Department of Nursing, University of Western Ontario*

Dennis Staunton (2008). *The Occupational Benefits of Getting a University Degree Later in Life as a Mature Student.* Department of Applied Social Studies. University College Cork, Ireland

Masters Programme Supervision and Committees

Supervision (Current)

Sarah O'Connor – Public Policy

Committee Membership (Current)

Arnel Borras – Health

Supervision (Completed)

Cody Samuelson (2021) *From Reaction to Action: The Kelowna Journey Home Systems Approach.* Development Studies, York University.

Rayna Slobodian (2019) *Rich and Poor Divide: How Portreayals of the Poor and Poverty in News Media Perpeduate Stigma and Inequality.* Faculty of Education, York University.

Bahen, Julia (2016) *Ending the Cycle: Incarceration, Reintegration, and Discharge Planning.* Faculty of Environmental Studies, York University

Isaac Coplan (2014) *Youth Homelessness in Ontario – Knowledge Mobilization, Systems*

Integration and Social Media to #EndYouthHomelessness. Faculty of Environmental Studies, York University

Marylou DiPlacito (2009) (M.Ed. Thesis) *A Parent's Journey, An Adolescent's Hardships: The Impacts of Parental Illness on Schooling.* Completed, November, 2009. Faculty of Education, York University

Jodi Barrett (2009). *Vital Links: Connecting Homeless Families with Education.* (M.Ed. Thesis). Completed, September, 2009. Faculty of Education, York University

Fatima Hussein (2008). *The Economic and Social Consequences of Mental Illness with Homelessness as a Demographic Index.* (MA, Thesis). Completed, September, 2008. Critical Disabilities Studies, York University.

Patricia Baird (2007) *The Need for a Harm Reduction Approach to Substance Use in Ontario Schools. Why the Message, 'Just Say No' to Drugs is Ineffective for Youth.* (M.Ed., MRP). Completed, April, 2007. Faculty of Education.

Tally Wolf (2007) *Starred Students at Teva* (M.Ed. Thesis). Completed, March 2007. Faculty of Education.

Ellen Walton (2007) *Sambos, Mandingos, and Gangstas in Toronto's Education System: Exploring Social Relations and the Impact of Identity and Black Masculinity in Schools.* (M.Ed., MRP). Completed, January, 2007. Faculty of Education.

Sharon McCleave (2006) *The Provision of Dental Care for Homeless Youth: Exploring an Educational Model of Service Learning for Dental Students.* (M.Ed. Thesis). Completed, December 2006. Faculty of Education.

Shelly Mediratta (2006) *Identity Abandonment: Trying to make sense of myself and the need for an anti-bias curriculum in Ontario A conceptualization of identity.* (M.Ed. Major Research Paper). Completed, September 2006. Faculty of Education.

Gemma Bose (2006) *Navigating the Educational System for Racial Minority Students and Racial Minority Teachers* (M.Ed. Major Research Paper). Completed, September 2006. Faculty of Education.

Chantal Tremblay (2006) *Leaving High School: On Becoming More Resilient to Verbal Abuse After the Adolescent Years.* (M.Ed: Major Research Paper). Completed, July 2006**.** Faculty of Education.

Jennifer Gee (2005) *Bigger isn't always better: Ideal school size and the Ontario Government's educational funding formula.* (M.Ed. Major Research Paper). Completed, October 2005. Faculty of Education.

Bita Sarabi-Khosravi (2005) *Resistance and second language learning: reflections on possible 'resistant' acts in second language classrooms.* (M.Ed. Major Research Paper). Completed, September 2005. Faculty of Education.

Anne Pohl (2004) (co-supervisor with Celia Haig-Brown) *Opening Respectful Encounters with Inner City, At-Risk Youth in Toronto's Schooling Institutions*. (Thesis). Completed, September, 2004. Faculty of Education.

Maria Melessanakis (2004) *Paradise Envisioned is Seldom a Paradise Realized: The Perspectives of Teacher Candidates on the Impact of Professional Development Schools - A Literature Review and Canadian Case Study.* (Thesis). Completed, May, 2004. Faculty of Education.

Nancy Carvalho (2004). *The Over Representation of Young People with Learning Disabilities in Youth Detention Centres*. (Major Research Paper) Faculty of Education.

Brian Weinstock (2003). *Rethinking Mortadella: Progressing Toward a Critical Multicultural Pedagogy.* (Major Research Paper). Faculty of Education.

Committee Membership (Completed)

Veronica Lockyer (2021) The Violence of Not Being Heard - Rural and Urban Youth, Differing and Similar Oppressive Obstacles. Completed: December 2021. Supervisor: Theresa Holmes. Department of Anthropology, York University.

Meagan La Plante (2017) Rapid Rehousing Practice at a Shelter for Homeless Youth. Supervisor: Girah Bhatt, Royal Rhodes University, Victoria BC

Kathryn Hardill (2016) *That Look That Makes You Not Really Want to Be There: Health Care Experiences of People Who Use Illicit Opioids in Small Urban and Rural Communities - A Critical Social Theory Analysis.* Faculty of Health (Nursing) York University

Mary Choy (2014) *Re-Conceptualizing "Contributing": Homelessness and Unpaid Labour in a Neo-liberal Climate* Completed: November, 2015. Supervisor: Amber Gaszo, Sociology, York University

Tracey Methven (2012) *A Hub School – The Heart of a Community Conceived For and With Stakeholders of Keelesdale-Eglinton West.* (MRP). Completed, September 2012. Supervisor, Don Dippo, Education

Darlene Mooney (2012) *Crown Wards Leaving Care: A Stakeholders' Discussion of their Readiness.* (Thesis). Completed, January 2012. Supervisor, Naomi Norquay, Education

Lauren Joly (2011) *Evaluating Outreach Programs for Street Involved Youth: A Quantitative and Qualitative Review of the Research.* (Thesis) Completed, July, 2011. Supervisor, Jennifer Connolly, Psychology

Sabina Mirza (2010) *South Asian Celebrations in Adolescent and Children's Literature.* (Major Research Paper). Completed, July 2010. Supervisor, Karen Krasny

Suba Jeyaratnam (2010) *A Critical Analysis of the Relationships between Homelessness and Disability among Immigrant Women in Toronto Community Agencies and Shelters.*

(Major Research Paper). Completed, July 2010. Supervisor, Nancy Halifax, Critical Disabilities Studies.

Jennifer J. Logan (2010) *"There's no place like home": A Snapshot of the Settlement Experiences of Newcomer Tibetan Women in Parkdale, Toronto.* Completed, June 2010. Supervisor, Valerie Preston, Geography.

Tina E. Wilson (2009) *In Their Own Best Interests? Textually Mapping Governmentality in the Lives of Young People Without Stable Housing in Canada*. University of Toronto. Adrienne Chambon (Suervisor) Faculty of Social Work, University of Toronto.

Rasulan A. Hoppie (2009) *Moving on up? Black Families' Pursuit of the Suburban Dream and Implications for their Children.* Completed, December 2009. Supervisor, Carl James, Faculty of Education

Yimin Du (2009) *Global Stability of TB Models: Heterogeneous Populations and Resistance.* Completed, December 2009. Supervisor, Jianhong Wu. Graduate Program in Mathematics, York University.

Ilona Abramovich (2008) *Young, Queer and Homeless in Toronto: Where is the Support?* Completed, August 2008. Supervisor, Nancy Halifax. Graduate Program in Critical Disabilities Studies, York University.

Amy Brandon (2007) *The Mis-/Under-Representation of Youth in Canadian Federal Policy and Policy Development.* Completed: February, 2007. Supervisor, Don Dippo, Faculty of Education

Jeewan Chanicka (2006) *The Jihad In Me: A Reflective Journey on the Role of Islamic Epistemology as a Guiding Framework for Student Engagement and Teacher Resistance in a Post September 11th World.* Completed: December, 2006. Supervisor: Carl James, Faculty of Education

Ramon San Vicente (2006) *Old School, New Rules: Redefining Black Males, Hip Hop Culture and Public Schooling*. (Thesis) Completed: December, 2006. Supervisor: Joy Manette, Faculty of Education

Sandra Mayberry (2006) *Constructing and Managing Behaviour in Ontario Schools: An Institutional Ethnographic Study*. (Thesis) Completed: April, 2006. Supervisor: Alison Griffith, Faculty of Education

Maureen Chard (2006) *Constructing and Managing Behaviour in Ontario Schools: An Institutional Ethnographic Study*. (Thesis) Completed: April, 2006. Supervisor: Alison Griffith, Faculty of Education

Katherine Miles (2006) *The Significance of Social Integration Strategies for ESL Students in Mainstream Classrooms*. (MRP). Completed: May 15, 2006. Supervisor: Connie Mayer. Faculty of Education.

Pamela Dogra (2006) *The Way I See It: Stories of Learning and Teaching*. (MRP) Completed: May, 2006. Supervisor: Isabel Killoran. Faculty of Education

Mike Malcolm (2006) *Toronto Schools and the Creation of the Deviant School Profile and Identity: the implications of the social construction of the deviant identity on student success.* (MRP) Completed: April, 2006. Supervisor: Carl James. Faculty of Education

Lisa Varghese (2006) *Finding a "Home": thinking Through the Issues and Complexities of South Asian Adolescent Conduct in Today's Greater Toronto Area* (Thesis) Completed: April, 2006. Supervisor: Carl James. Faculty of Education

Thomas Douglas (2005). *Finding the One (in ten): Early Identification of Teacher Candidates With Maximal Social Justice Education Praxis Potential.* (Thesis) Completed: April, 2005. Supervisor: Patrick Solomon. Faculty of Education

Robert W. Young (2005). *"You Can't Make Me" Punishment and Pedagogy in the Prison Classroom.* (Thesis) Completed: May, 2005. Supervisor: Susan Dion. Faculty of Education

Susan Clarke (2005). *Interpreting the Reggio Emilia approach: Implications for reducing violence and aggression in early childhood.* (Thesis) Completed, February, 2005. Supervisor: Carol Anne Wien. Faculty of Education

James Rhee (2004). *Relationships and Reflection - Two Keys of Teacher Response to Student Behaviour*. (Thesis) Completed, September 2004. Supervisor: Isabel Killoran. Faculty of Education.

Claudia Johnson (2004). *What's Power and Authority Got To Do With It? Making Meaning From Students' Understanding of Student-Teacher Relationships.* (Thesis) Supervisor: Susan Dion. Faculty of Education.

Marisa Panaroni & Sally Rivers (2004). *Transforming novel studies through anti-bias instruction*. (Major Research Paper) Completed, September 2004. Supervisor: Isabel Killoran. Faculty of Education.

Nazreen Motiar (2003). *Use them or lose them: The state of elementary school librarians.* (Major Research Paper) Completed, September 2003. Supervisor: Isabel Killoran. Faculty of Education.

Dean's Representative

Loriann Hottot (2002). *Complexity and Contradiction in the Construction of Femininity*. (Thesis). Supervisor, Alison Griffith. Faculty of Education.

Internal / External Examiner

Kathy Hardill (2016) *"That Look That Makes You Not Really Want to Be There": Health Care Experiences of People Who Use Illicit Opioids In Small Urban and Rural Communities – A Critical Social Theory Analysis.* Faculty of Health (Nursing) York University

Julia Riddell (2014) The Development of Self in Relationships: Youth's Narratives of Change Through a Residential, Wilderness and Family Therapy Intervention. Masters of Arts (Psychology), York University. November, 2014

Bertie Friedlander (2006) Successful Aging - An Analysis of People and Places Dedicated to Learning Programs for Seniors. Masters of Arts (Anthropology) April, 2006

Clifford Agburu (2005) The Dilemma of Alcohol Addiction: A Disability Without Disability Benefits in Ontario. Masters of Arts (Critical Disability Studies), York University.

Andrew Taylor (2005). *Negotiating Harm Reduction: Risk, Bodies and Youth Substance Users.* Masters of Arts (Anthropology), York University.

Caroline McIssac (2003). *Romantic Dissolution and Depressive Problems in Adolescence: A Developmental Analysis.* Masters of Arts (Psychology), York University.

External Examiner

Meagan E. La Plante (2017) Rapid Rehousing Practice at a Shelter for Homeless Youth. Master of Art in Leadership. Royal Rhodes University. Supervisor: Gira Bhatt

Kim Stanford (2002). *The Right (to) Pleasure: A Participatory Foucaultian Exploration of Youth Drug Users' Experience with Harm Reduction.* Masters of Public Health Sciences, Public Health Sciences, University of Toronto.

5. RESEARCH TRAINING through RESEARCH ASSISTANTSHIPS PhD (26); MA (53); Undergraduate (14)

Doctoral Research Assistantships

Afsaneh Bohouli (2013/14)

Christyne Hebert (2013/14)

Kandirra Wilson (2012/13)

Carey Doberstein (2012/13)

Caryl Patrick (2011/12)

Cheryl Athersych (2011/12)

Sabina Mirza (2011/12, 2012/13)

Julia Sinclair-Palm (2011/12, 2012/13)

Jennifer King (2010/11)

Amanda Noble (2011/12, 2012/13, 2013)

Naomi Nichols (2010/11, 2011/12)

Andrew Grimo (2010/11)

Claire Major (2008/09, 2011/12)
Karen Kugelmass (2010/11)
Kristy Buccieri (2008/09, 2009/10, 2010/11, 2011/12, 2012/13)
Jaime Yard (2008/09)

Masters Research Assistantships

Ryan Walters (2013/14)
Fleurie Hunter (2013, 2013/14))
Nick Spohr (2012/13)
Meezan Elgen (2012/13)
Nicki Pariser (2012/13)
Mary Choy (2011/12)
Stefania Jakovlevski (2011/12)
Amanda Dunn (2010/11, 2011/12)
Pulak Bakshi (2010/11, 2011/12)
Jessica Whelan (2010/11, 2011/12)
Christopher Ho (2009/10, 2010/11, 2011/12)
Sabina Mirza (2008/09, 2009/10, 2010/11)
Jesse Newell (2008/09, 2009/10, 2010/11)
Fizza Haider (2008/09, 2009/10)
Vivian Kwouw (2008/09)
Maya Shapiro (2008/09)
Susan Appotive (2007/08)
Isaac Coplan (2013/14)
Kami Chisholm (2013/14)
Jason Bertkin (2012/13)
Sanya Vukas (2012/13)
Andrew Nolan (2012/13)
Michael Gonzales (2012/13, 2013/14)
Allison Leslie Fischer (2011/12)
Jenna Maley (2010/11)
Kirk Hatcher (2010/11)
Tara Patton (2010/11)
Delaney Downer (2009/10, 2010/11)
Janice Fennell (2009/10)
Diwei Wang (2008/09, 2009/10, 2010/11)
Magdalene Garda (2008/09, 2009/10)
Sran Gurgeet (2009/10)
Spy Denhomme-Welch (2008/09)
Shari Grayson (2007/08)

Undergraduate Research Assistantships

Alexander Moldovan (2013/14)
Alicia Campney (2013/14)
Ashley Abbasi (2013/14)
Jesse Donaldson (2013)
Oxana Roudenko (2012)
Monique MacLeod (2012)
Sebastien Wan (2012)
Jesse Thistle (2012)
Gerald Wan (2011, 2012)
Esther Townsend (2011)
Matthew Aaron (2003, 2004, 2005)

D) SERVICE

1. UNIVERSITY SERVICE:

Administrative Roles

2012-2013	Associate Dean, Research and Professional Development – Faculty of Education (six months)
2007-2011	Associate Dean, Research and Professional Development – Faculty of Education (four years) (Note: I have not included committees I sat on in my role as Associate Dean (2007-2011))

Committee Membership

2009-2013	York Centre for Education and Community (Executive Committee and External Advisory Committee)
2008-2013	York Homelessness Research Network
2011-2013	York Institute for Health Research (Executive Committee)
2010-2011	Lifelong Learning, Partnerships & Outreach
2010-2011	York Mental Health Strategy Working Group
2010-2011	York University, Dispute Resolution Committee
2009-2011	GRIP committee
2003-2011	International Advisory Group - RPD – Faculty of Education
2003-2006	Visiting Scholars - Graduate Programme (Chairperson) – Faculty of Education
2003-2004	Awards Committee - Graduate Programme (Chairperson) – Faculty of Education
2003-2011	Coordination and Planning – Faculty of Education
2002-2003	Visiting Scholars - Graduate Programme
2001-2002	Awards Committee - Graduate Programme
2001-2002	Ethics Review Committee – Faculty of Education
2000-2001	Admissions Committee - Graduate Programme – Faculty of Education
2000-2001	Tenure and Promotions Committee – Faculty of Education

Program Development

2008 York Centre for Education and Community – ORU Proposal (successful)

2003-2005 Children at Risk Symposium programme development.

2003-2007 Harm Reduction certificate programme development.

2003-2004 Community-Based Research seminar series programme development.

2003-2005 Canadian Conference on Homelessness.

2. COMMUNITY SERVICE:

Board of Directors - Community Organizations

2014 – 2016 *Raising the Roof*, President

2010 - 2019 *York Region Human Services Planning Board*

2012 – 2018 *Canadian Alliance to End Homelessness*. Board of Directors (Secretary, and Founding Member)

2007 - Present *Raising the Roof.* Board of Directors

2007 - Present *Canadian Housing Renewal Association.* Policy Advisory Committee

2003 - 2007 *Central Toronto Community Health Centres.* President of Board of Directors.

2002 - 2007 *Central Toronto Community Health Centres*. Board Member.

Community Planning Committees

2015-16 Province of Ontario *Provincial Expert Panel on Homelessness*

2002 – 2004 *City of Toronto Mayor's Community Safety Awards Committee.*

1999 *SWYM Consortium.* - Squeegee Initiative.

1998 Toronto *Community and Social Planning Council.* - Squeegee initiative.

1997 – 1998 *Shout Clinic / SETO*

1997 – 1998 Wellesley / St. Michaels Hospital Ambulatory Care Needs Assessment.

1994 *SETO*. Homeless Emergency Access project.

1987-1988 *Togher Community Association*. Cork, Ireland (1987-88).

TAB 98

Court File No. CV-21-00077817-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, ET AL.

Applicants

-and-

CITY OF HAMILTON

Respondent

ACKNOWLEDGMENT OF EXPERT'S DUTY

1. My name is Stephen Gaetz. I live in Colborne, in the Province of Ontario.

2. I have been engaged by or on behalf of the Hamilton Community Legal Clinic to provide evidence in relation to the above-noted court proceeding.

3. I acknowledge that it is my duty to provide evidence in relation to this proceeding as follows:

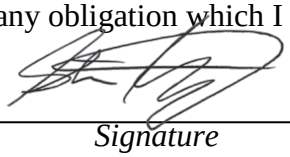
   (a) to provide opinion evidence that is fair, objective and non-partisan;

   (b) to provide opinion evidence that is related only to matters that are within my area of expertise; and

   (c) to provide such additional assistance as the court may reasonably require, to determine a matter in issue.

4. I acknowledge that the duty referred to above prevails over any obligation which I may owe to any party by whom or on whose behalf I am engaged.

Date June 14, 2022



Signature

TAB 99

Court File No. CV-21-77187

ONTARIO

SUPERIOR COURT OF JUSTICE

B E T W E E N:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLEN GNATUK, TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD

Applicants

- and -

CITY OF HAMILTON

Respondent

--- This is the Cross-Examination of DR. STEPHEN GAETZ, a witness on behalf of the Applicants herein, on his affidavit, sworn June 14, 2022, taken via Zoom videoconference, on Friday, the 30th day of August, 2024.

APPEARANCES:

SUJIT CHOUDHRY — For the Applicants
SHARON CROWE

BEVIN SHORES — For the Respondent

CURTIS SELL — Community Legal Clinic of
MICHELLE SUTHERLAND — York Region

Also Present:

Jojo Johnson — Articling student, Gowling WLG (Canada) LLP

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--- Upon commencing at 9:03 a.m.

DR. STEPHEN GAETZ; Affirmed.

CROSS-EXAMINATION BY MS. SHORES:

1 **Q.** Good morning, Dr. Gaetz. As I introduced offline, my name is Bevin Shores, my pronouns are she and her, I'm one of the lawyers from the City of Hamilton in this matter. And we're here this morning to cross-examine you on your affidavit, sworn June 14, 2022.

So, can we start by getting you to, please, state your full name for the record.

A. My full name is Stephen Anthony Gaetz.

2 **Q.** And are there any names that you like to go by or any pronouns that you wish to share?

A. He and him for pronouns. And you can call me anything -- people usually use Stephen but...

3 **Q.** I will probably call you Dr. Gaetz out of force of habit and I hope, I hope you don't take offence to the formality.

A. No, that's not a problem.

4 **Q.** Okay. And as we confirmed offline, Dr. Gaetz, you're alone in the room that you're participating from this morning?

A. I'm alone in the room.

5 **Q.** Okay. Where are you participating from this morning?

A. Colborne, Ontario, which is where I live.

6 **Q.** And you're aware that you're to have no assistance in giving your answers today?

A. That's right.

7 **Q.** You've told us offline that you have an electronic copy of your affidavit with you. And I'll also confirm that we've discussed that if you do refer to any other materials in giving your answers, we need to state what you're referring to, make it an exhibit and explore how it informs your evidence; is that understood?

A. That's understood.

8 **Q.** Okay. Dr. Gaetz, you've been affirmed to tell the truth today?

A. Yes.

9 **Q.** What do you understand your role is in this litigation?

A. Well, I'm a researcher, so I am to provide evidence from the perspective of a research -- researcher as to the matters at hand.

10 **Q.** And have you been qualified to

give evidence in court before as an expert witness?

A. Yes, I have.

11 **Q.** In which courts?

A. Oh, Ontario, in Nova Scotia, in Yellowknife. Probably other places, I don't have the details at hand.

12 **Q.** Which court in Ontario, do you know, Superior Court, Provincial Court?

A. I believe Superior Court and Provincial Court.

13 **Q.** Okay. And in what areas have you been qualified to give evidence in court as an expert witness?

A. As a researcher, my expertise is on homelessness, its causes, its conditions, and the potential solutions to the problem of homelessness. So, depending on the case, some have been looking at things like people and panhandling or soliciting funds on the streets, people's access to medical marijuana while they're in emergency shelters, these kinds of thing.

14 **Q.** Dr. Gaetz, I'm going to share my screen and put up your affidavit and a couple of other documents.

A. Okay.

15 **Q.** So, on the screen you should be able to see, hopefully, the first page of your affidavit, sworn June 14, 2022?

A. Mm-hmm.

16 **Q.** Sorry, you have to give a verbal answer.

A. Oh, yes.

17 **Q.** Thank you. And in the version that we received, there was no curriculum vitae appended to it, even though it says it's attached as Exhibit "A." We were ultimately provided with one in 2023 in the course of receiving some motion materials. So I've tabbed over to the curriculum vitae.

A. Okay.

18 **Q.** Is this your CV, Dr. Gaetz?

A. Yes, it is.

19 **Q.** And when would that have been current; do you know?

A. Well, it would have been up to date as of the date that you received it. You said 2023, so, you know, time has passed, there's new publications and things like that that would be in it.

20 **Q.** So it would have been --

A. In one that was current today.

21 **Q.** Okay. Dr. Gaetz, do you

remember -- and the reason I'm asking, I'm not trying to be unfair to you, is, just based on the dates on your CV, it looks like it may be current to 2022?

A. Right, yes.

MR. CHOUDHRY: Counsel, if I -- excuse me, if I may. Counsel, if we could stipulate that this was the CV that was current when Dr. Gaetz provided his affidavit, it was admitted in error, but it's current as of, as of when he provided his affidavit.

THE DEPONENT: That's right, I agree.

BY MS. SHORES:

22 **Q.** So this is your affidavit, to the best of your knowledge, from approximately June of 2022?

A. That's right.

23 **Q.** Okay.

A. Yes.

MS. SHORES: Okay. So let's mark, Dr. Gaetz, your CV as Exhibit 1 to the cross-examination.

EXHIBIT NO. 1: Dr. Stephen Anthony Gaetz's affidavit, sworn June 14, 2022.

BY MS. SHORES:

24 **Q.** And another document, Dr. Gaetz, that I'll take you to, also wasn't included with your report, this is a Rules of Civil Procedure, Form 53 -

Acknowledgement of Expert's Duties that I've placed -- placing on the screen. Are you able to see that?

A. I am indeed, yes.

25 **Q.** Okay. And it's dated June 14, 2022. Do you remember when it was signed?

A. No. I'm assuming it was the date but I don't recall.

26 **Q.** Okay. And in the lower right-hand corner, is that your signature?

A. Yes, it is.

MS. SHORES: So, we will mark as Exhibit 2 the Form 53 signed by Dr. Gaetz.

EXHIBIT NO. 2: Form 53 - Acknowledgement of Expert's Duties, signed by Dr. Gaetz.

BY MS. SHORES:

27 **Q.** Dr. Gaetz, I want to take you back to your CV, if I may.

A. Okay.

28 **Q.** Actually, before I do that, just on the topic of the Form 53, Dr. Gaetz, at the time that you wrote -- or the time you swore your affidavit, what instructions were provided to you specifically with respect to the evidence contained in your affidavit?

A. There were a couple of questions, which I can't recall, so...

29 **Q.** Okay. And those questions are addressed in the content of your affidavit?

A. Yes.

30 **Q.** And the factual assumptions that your opinions are based on those are set out in your affidavit?

A. Yes.

31 **Q.** So, similarly, the documents relied on informing the opinion set out in your affidavit, those are also indicated in your affidavit?

A. Yes. And as a researcher, what's particularly important is the evidence behind statements that get made. So -- yeah. Yes.

32 **Q.** So, in other words, Dr. Gaetz, if I understand you correctly, you're saying that the citations and footnotes in your affidavit are that evidence?

A. They are that evidence. As well, that, as a scholar, my knowledge of homelessness extends beyond the publications that I've produced. So I have expertise in the area of homelessness and, as I said, its causes, its conditions and responses to homelessness. Not all of that has wound up in a

publication but is nevertheless evidence, evidence-based --

33 **Q.** Okay.

A. -- as opposed to just opinion.

34 **Q.** Understood. But if there are any documents that you've relied on informing your opinion, those are in -- those are cited in your affidavit, correct?

A. That's right.

35 **Q.** And in terms of the opinions that are contained in this affidavit, you didn't conduct any fresh research of your own in order to do so, correct?

A. That's correct.

36 **Q.** So, now I'm going to go back to your CV, Dr. Gaetz. So, you're a professor with the Faculty of Education at York University?

A. Yes.

37 **Q.** And you're still the president and CEO of the Canadian Observatory on Homelessness?

A. Yes.

38 **Q.** You're still the research director at Making the Shift - the Youth to Homelessness Social Innovation Lab?

A. Yes.

39 **Q.** And you're still the director of

the Toronto Centre of Excellence on Youth Homelessness Prevention at York University?

A. Yes.

40 **Q.** Okay. And when it says, "United Nations Economic Commission for Europe," is that a different role or is that also part --

A. No, that's the body that designates you as a Centre of Excellence, it's a United Nations' body.

41 **Q.** Understood. And these -- York University, I'm aware, is in Toronto. And you give your address as the York University campus in Toronto on Keele Street; is that where you're based?

A. Yes.

42 **Q.** Now, reviewing your CV, Dr. Gaetz, is it fair to say that your work has been almost exclusively on the topic of homelessness?

A. Yes.

43 **Q.** Okay. You paused there a bit, you can expand if you want to.

A. Well, my writing on youth often applies more broadly, so that's dealing with developing adolescents and young adults, and is relevant in those areas as well, so yeah. And, also, like, talking about how public systems operate. The research is relevant

beyond the field of homelessness but my -- the bulk of my work is in that area, definitely.

44 **Q.** Okay. And going to number three on your CV, your list of degrees, so you have a PhD, an MA and a BA, all of them are in Anthropology?

A. That's right.

45 **Q.** Okay. So your background is Anthropology?

A. My research background is Anthropology but it is -- it's more complicated than that, in that the methodologies of Anthropology guide much of my work but it has evolved considerably methodologically and in terms of disciplinary relevance since 1990.

46 **Q.** And so speaking of methodology, is that the connection to your current role as a professor within the Faculty of Education?

A. Not specifically. It's a -- education is an interdisciplinary subject, to which many different methodologies can apply. And that is true of homelessness as well. They're complex issues for which different methodologies provide different kinds of evidence.

47 **Q.** So perhaps you can explain to me then, what is the connection between your current role

as a professor with the Faculty of Education and your work studying homelessness?

A. Well, I'm a professor in, as you say, in the Faculty of Education. So in that capacity, I have responsibilities within the Faculty, for instance, to teach, that's about a third of my responsibility; to conduct research, is about a third; there are also service obligations on behalf of the Faculty of Education, both internal to the Faculty, so chairing committees, I was associate dean for a number of years, plus committee work regarding the broader university. That my homelessness research doesn't focus specifically on schooling is not an issue because that's the nature of being a professor in Faculty of Education.

However, I should point out that I have done research and published on the role that schools can and should play in addressing homelessness.

48 **Q.** And when you're teaching in your role as a professor of Faculty of Education, what is the nature of the courses that you teach?

A. In the last ten years, it's, for the most part, been on adolescents, at the undergrad level. And at graduate level, a course on youth homelessness and another course on knowledge

mobilization, which is how we take research and make it matter to different audiences.

49 **Q.** Okay. So, that's a point I'm going to return to shortly but before we get there, I wanted to ask you another question about your CV. So, I've taken you to the -- 57, going by the pages at the very bottom, under the heading "Funding."

A. Right.

50 **Q.** So, at the top, there's a summary, and you've got it broken down in three categories - "Research funding received as Principal Investigator," "Research funding received as Co-Investigator or Partner," "Program Evaluation Contracts," and then the "Total."

Research funding, I think I can figure out what that is. But for program evaluation contracts, are those basically for, like, consulting type work?

A. The Canadian -- or the Homeless Hub, which is our web-based interface, and the Canadian Observatory on Homelessness, we operate something called "Hub Solutions," which does contract work around graphic design but also around issues that involve basically doing contractual work with -- it could be the City of Toronto, it could be an organization in

York Region. But doing program evaluation, which is largely what it results in, which is, you know, an evidence form of research, ideally done by a third party.

51 **Q.** So, in other words, they'll contract you to do research in order to evaluate a program that they're considering or have implemented, something like that?

A. That's -- yes, that's right.

52 **Q.** Now, according to the summary at the top of page 57 of your CV, you've obtained a total, at least as of mid-2022, $54,111,085 in research funding?

A. That's correct.

53 **Q.** And if I'm just taking the first four, so the research grants from 2021 and 2022, I added them up, and I got 6,448,571 in grant money just for that period of time; does that sound about right?

A. That sounds about right. Although you need to know that the way funds are allocated by Research Funding Council, a grant I received in 2019, for instance, may still be funding operations in 2022 --

54 **Q.** I see.

A. -- like, Making the Shift.

55 **Q.** So, for example, you said 2019, and I just scrolled down, there's one called "Making the Shift - Homelessness Demonstration Lab," [as read] that's a $2.9 million grant, and that could still have been providing funding throughout the period of time in 2021 and 2022?

A. That's right.

56 **Q.** Okay. And to date, you've continued to obtain research grants for your work?

A. Yes -- yes, the work requires funding. We have research -- researchers, we fund graduate students, postdoctoral fellows, those kinds of things. And then there's operational costs of doing research, including providing, for instance, stipends to the research participants, that kind of thing. So to do these large scale projects, you need infrastructure to make them happen.

57 **Q.** And "stipends," you mean participation money for the people who, for example, answer surveys?

A. That's correct.

58 **Q.** Now, Dr. Gaetz, I said I would circle back to the question of the impact of research, and so I've just, I've just changed my window sharing. Going to your CV, I'm going to turn to page 26. And

the second item down, if you can see that, you did a TEDx Presentation, Making Research Matter - Mobilizing Homelessness Research; is that correct?

A. That's correct.

59 **Q.** Okay. Now, I think I've found that TEDx talk. So I'm going to place this up on the screen here. So this is, this is YouTube; are you able to see that?

A. I am.

60 **Q.** Okay. And it says, "TEDx YorkU 2010 - Stephen Gaetz - Research Matter," that would be the item on your CV?

A. Yes.

61 **Q.** Okay. And if I scroll down to the caption here, it's a little bit small type, but the tag is "Making Research Matter: How the mobilize research to have a greater impact on the homelessness crisis."

A. Right.

62 **Q.** That's the tag line of your presentation?

A. Right.

63 **Q.** And the topic of that presentation?

A. Yes.

64 **Q.** Okay. And on the screen, it's a

bit blurry, but that's, that's you?

A. Yes, that's me.

65 **Q.** Okay. Now I'm going to -- you may see, I've got this video cued up to 14 minutes and 46 seconds into the video. I'm going to play this very briefly, and then I'd like the recording to be played on the record, and then I'll ask you a question about it.

A. Okay.

--- Video played.

DR. GAETZ: This kind of information. And so how are we doing then, to wrap up here, is it working? Well, since that first conference, we've now had two more conferences, right. The conferences aren't enough. What I'm seeing across Canada is a growing connection between the research community and the policymakers and service providers - in Victoria, B.C., St. John's, Newfoundland. A couple of years ago, the Government of Canada wanted to close down a program called "Insite," in Vancouver, which is a safe injection site. The research community pulled together 30 top articles that showed why this is a good program and fought back, so research became a stick to beat back bad decisions.

--- Video ended.

BY MS. SHORES:

66 **Q.** So I've now -- you were able to hear that clip from your presentation, Dr. Gaetz?

A. Yes.

67 **Q.** Okay. And you said, if I'm quoting you, "Research became a stick to beat back bad decisions"; you agree?

A. Well, that's a bit of hyperbole, but I think research can and should influence policy and practice. So, you know, that language might be a little over the top but you have to understand you're referring to a TED Talk, which is a different kind of presentation than I would normally give.

68 **Q.** So I'm going to take you back, Dr. Gaetz, to your affidavit. I'm just closing some windows here so my computer doesn't freeze. Start with paragraph 7.

A. Right.

69 **Q.** At paragraph 7 of your affidavit, you describe that, "Homelessness describes a spectrum of housing and shelter circumstances."

A. Mm-hmm.

70 **Q.** And one of them is "Unsheltered, or absolutely homeless and living on the streets or in places not intended for human habitation, including

encampments."

And then you also go on to describe "Emergency Sheltered, Provisionally Accommodated or At Risk of Homelessness."

So you'd agree with me that not all homelessness is unsheltered homelessness, correct?

A. Absolutely, yes, I agree with that.

71 **Q.** And your affidavit doesn't address what portion -- what proportion of people experiencing homelessness are unsheltered, correct?

A. This definition does -- did not have that kind of data because it needed to be more of a conceptual piece. The figures, if I were to have put this in, would be rather stale-dated as things went on. And there may be differences between communities. Overall there's more similarities than there are differences but there are sometimes more, you know, differences. So the definition is meant to be broad enough to refer to different kinds of circumstances that people might find themselves in.

You know, I'll give you an example in Toronto, because of the location of Pearson Airport, we all are aware that many refugees wound up in the homeless shelter system in Toronto -- or I assume

people are aware of that. We had a lot of people come and it overwhelmed our shelter -- or our settlement -- refugee settlement system. And so that skews Toronto's data in terms of people who are homeless because of, you know, migrating, for instance, which wouldn't be reflected necessarily elsewhere. But overall I would say there's a -- as I said, there are more similarities than differences.

72 **Q.** And, Dr. Gaetz, just to the point of there being differences within communities, your affidavit doesn't address specifically with respect to Hamilton what proportion or percentage of people experiencing homelessness are experiencing unsheltered homelessness, correct?

A. No, my affidavit doesn't. And the one thing that's a challenge in Canada is the quality of data that we have regarding the numbers of people who are homeless. It's improving a lot with the introduction of the Point in Time Counts. And Point in Time Counts are more likely to capture some of the population that is unsheltered, for instance, and some of the population that's provisionally accommodated but there's a lot of hidden homelessness as well. Though the affidavit doesn't speak specifically to Hamilton, there is -- I'm quite familiar with Hamilton, and

there's not a lot that makes me think that Hamilton has particular characteristics that would put it out of line with what we know about homelessness in other Canadian communities.

73 **Q.** I'm going to go to paragraph 12 of your affidavit, where you describe structural factors. And this is in the context of the preceding paragraph, which states -- or, sorry, which attempts to explain or overview -- give an overview of explaining the causes of homelessness. So with respect to structural factors, at the fourth sentence, you state, "Other contributing factors include discrimination in the form of homophobia, transphobia, racism, and bullying." But I notice you didn't cite any sources for that statement. And, particularly, you haven't cited any research or scholarly works about whether or how much discrimination in the form of homophobia, transphobia, racism or bullying contributes to homelessness, correct?

A. I haven't indicated it there, that is true, but I am -- as a scholar, I'm aware of the body of research and can speak with a high degree of certainty that there is a considerable body of research regarding homophobia and transphobia as contributing to the risk of homelessness, as well as racism, racism

against black people but also against Indigenous people, that is pretty well established in the research body that these things are factors. And then a history of bullying is also an example of the kinds of individual experiences that maybe have structural roots, as well. So though there's not citations there -- I mean, I could give you citations or recommend you go to certain researchers who would be able to speak to that. We're currently publishing -- we are currently publishing an article out of the Canadian Observatory on Homelessness on black youth and their experience of homelessness, as well. So there is a body of research. The purpose of this affidavit was not to be a PhD dissertation with a literature review of every single point, right, it was to provide the broader strokes. And, also, recall my point earlier that my job is a scholar, as a researcher. And so my knowledge of the issues that are in here, and that make me confident to stand behind them, is that I have expertise in this area as a researcher. So I know the body of researcher -- of research, and I know -- stand behind these definitions and issues. The Canadian definition of homelessness is now official definition for StatsCan and Government of Canada. So these things have been taken on not just by researchers but also

have an impact on government and service provision as well.

74 **Q.** At paragraph 13 of your affidavit, under subparagraph 1, you identify, under the heading "Systems Failures" --

A. Right.

75 **Q.** -- "Barriers to accessing public systems (e.g., health, social services, legal supports)." And you state, "These barriers are unequally distributed, with some groups facing greater disadvantage than others."

And, again, here you haven't quantified which groups are at a greater disadvantage or to what extent they may experience greater disadvantage, correct?

A. I haven't in that statement, no. Again, this is drawn from a conceptual document that isn't, you know, like, intended to be stacked with research. But I stand behind these, absolutely. And just the -- you know, some of the examples of the subpopulations mentioned in the previous question would definitely apply here. It's well understood, for instance, how Indigenous people face incredible barriers receiving health services -- not just receiving them and having access to them but

experiencing them in a way that diminishes them, through the racism that continues to operate in our society in all kinds of places, including public sectors.

76 **Q.** At paragraph 14, you identify individual and relational factors. And going down to subparagraph 5, one of the factors you've identified is "Trauma," and state, "The relationship between homelessness and trauma is bidirectional; trauma in the form of adverse experiences is both a risk factor for, and a potential outcome of homelessness, and can lead to mental health challenges and behavioural changes that can impair decision making."

But I noted, Dr. Gaetz, that you didn't cite any sources that correlate homelessness and trauma or speak to a specific causal link between the two; is that correct?

A. I haven't cited sources but I can assure you there is a huge body of literature on this. The -- I'll give you an example. We know that young people who have adverse childhood experiences, so that may be a physical, sexual, emotional abuse, and neglect are more likely to experience all kinds of negative outcomes as they get older, including a higher risk of addictions, higher risk of unemployment, higher risk of

obesity, higher risk of early death, and a higher risk of homelessness. That body of research is very extensive. And, you know, following the rules of science, it's like the strongest evidence that we have now, that a lot of that exists outside of the home. You know, there's both research within -- from scholars on homelessness but also the research that's done on adverse childhood experiences, which, you know, focuses -- that manifests itself at the individual level, as well, is very consistent on this.

77 **Q.** So thank you for that example, Dr. Gaetz. I'm going to take you to next to paragraph 15 of your affidavit, under the heading "Who is homeless in Canada and who stays in homeless shelters?" The first sentence in paragraph 15 you state -- or actually, sorry, to contextualize my question, I'm actually going to go to the second sentence. So you state, "A study by the Government of Canada identified that in 2016 there were an estimated 129,000 unique emergency shelter users, and just over 14,000 Canadians stayed in an emergency shelter on any given night. This suggests that almost half of all Canadians who experience homelessness in a given year do not access emergency shelters at any time during the year, which begs the question as to why they do not."

And then taking you back up to the first sentence -- sorry, the second sentence, you state, "More than 235 [sic] people in Canada experience homelessness in any given year, and 25 to 35,000 people may experience homelessness on any given night." [As read]

So, Dr. Gaetz, if I'm understanding you correctly, you're doing some math here and stating that if there's 235,000 people in a given year or 25 to 35,000 people on any given night, and 129 approximately -- 129,000 approximately per year or 14,000 per night are in shelter, that's about roughly half of them, correct?

A. Right.

78 **Q.** Okay. And there's no indication here how many of the 235,000 people in any given year or the 25 to 35,000 on any given night, there's no indication how many of those people were experiencing unsheltered homelessness at the time, correct?

A. No. Methodologically, one of the challenges of doing research on enumerating homelessness is that a lot of homelessness is hidden. And so I mentioned in a previous response that one of the positive outcomes of doing Point in Time Counts is that it includes more people who are unsheltered,

captures more of them, doesn't capture all of them, but captures more of them. And so that kind of data is considered more accurate than if you just relied on the Government of Canada's survey of people who stay in emergency shelters. So it informs our understanding of the problem but it doesn't capture everything. So I'll give you an example here, we know that in Canada 40 -- over 40 per cent of all currently homeless youth had their first experience before the age of 16. So 40 per cent. That's a horrifying stat. Twelve year olds, 13 year olds, 14 year olds were homeless and unattached to their family. In Canada, we do nothing for that group. And most homelessness services start at 16, 18 or 21. And so the infrastructure that we have in place gives us an indication of who's homeless, but the lack of infrastructure then obscures important things, like, that all these young people are experiencing homelessness. There's no services for them, nobody is helping them, and they're going to become the chronically homeless people of the future. So, so there's a complexity to thinking about who's homeless but not showing up on the shelter data, that kind of thing.

79 **Q.** Dr. Gaetz, if I can just take something that you said there, you said "there's no

services." You're not speaking specifically about the City of Hamilton, are you?

A. I'm not speaking specifically about Hamilton, I would say that's true across Canada.

80 **Q.** Across Canada. You mentioned -- well, before I take you to the Point in Time Counts, because I did want to ask you about that though, when you say, Dr. Gaetz, in paragraph 15 of your affidavit, you raise the question of almost half of all Canadians not in a shelter -- I'm sorry, almost half of all Canadians experiencing homelessness who are not in a shelter, you would agree that some of them may not be in a shelter because they're not experiencing unsheltered homelessness to begin with, correct?

A. No, it would be that they are experiencing unsheltered homelessness, because we wouldn't count them as homeless if they weren't, right. So it fits within the definition.

81 **Q.** So you're saying that in the Stats. Canada definition, that's counting only people who are experiencing unsheltered homelessness?

A. In the StatsCan definition? No, it's -- oh, no, no, no, it's the full Canadian definition of homelessness that you have here. It includes all the different levels, right. So -- and

including being sheltered, provisionally accommodated, and to some degree at risk of homelessness. But that is the definition now that is the official Canadian definition.

82 **Q.** Okay. So if only approximately half of them, according to your rough math, are staying in shelter, the question is, it's possible that some people aren't staying in shelter because they weren't experiencing unsheltered homelessness to begin with; they may be staying with someone, they may be couch surfing, they may be in transitional housing, something else?

A. That's still homelessness.

83 **Q.** Right. We're not debating that, it is still homelessness. But the question was about unsheltered homelessness.

A. Yeah, there would be a difference between -- like, the definition, it has more specificity if you were to see the full definition. But, yes, it -- there's differences. But one thing to bear in mind when looking at these kind of questions is people's pathways into and out of homelessness may mean that they experience, over a single year or over their lifetime, multiple forms of homelessness, right. So some -- you know, a young person might be couch surfing

but then eventually wind up sleeping in the field behind a school, then may eventually wind up in, you know, an emergency shelter. And that's the same for people at any age, that it's very typical that people's experience of homelessness is varied and not just linked to one kind of experience of homelessness.

84 **Q.** Okay. But when we're saying on any given night just over 14,000 Canadians stayed in an emergency shelter, so we're talking about a given night, out of the 25 to 35,000 people experiencing homelessness, you're not saying here, at paragraph 15 of your affidavit, that the remaining 19 to 29,000 people are all experiencing unsheltered homelessness, correct?

A. Well, that math is incorrect, what you just said. But -- so, you know, 16 --

85 **Q.** Sorry, 9,000 to 19,000, yes.

A. Yes, okay. So, yes, we are -- but it includes not just, you know, unsheltered homelessness, right. If people aren't in a shelter, it doesn't mean that they're unsheltered, or that that's their -- the kind of homelessness they're experiencing.

86 **Q.** Now, I want to take you to -- you mentioned a point in time count, Dr. Gaetz, so I did want to take you to, to those. So, at footnote 8, in

the second citation in footnote 8, you cite the Employment and Social Development Canada, 'Everyone Counts 2018 Highlights.'" So I want to take you to that. Give it a moment to load up.

So, I've now placed this document on the screen, is this the 2018 Everyone Counts Highlights that's cited in your affidavit?

A. Yes.

87 **Q.** Now, if we go to page 6, Figure 1, there's an infographic that says, "Overnight Locations." And according to this, it looks like it says 14 per cent people were in unsheltered locations?

A. Right.

88 **Q.** Do you have any reason to believe that that is inaccurate?

A. It's probably a low count.

89 **Q.** So you believe that this is not accurate?

A. Well, because methodologically, identifying everybody who's homeless but not in the shelter is problematic. It's easy when they're in the shelter, because they're, they're there, their name is on a list. But given the various situations under which people may be living in unsheltered conditions, you know, we can detect and find and identify some but

not all of them.

MS. SHORES: All right. So I'm going to mark as Exhibit 3 the Everyone Counts document.

EXHIBIT NO. 3: Employment and Social Development Canada, 'Everyone Counts 2018 Highlights.'"

BY MS. SHORES:

90 **Q.** Taking you back, Dr. Gaetz, to your affidavit at paragraph 18, and, again, still discussing the Everyone Counts document, you state that, "The majority (62%) of the Point in Time Count respondents identified as male, 36% identified as female."

So, you'd agree that the proportion of women or people who identify as female in the population of people experiencing homelessness is comparatively fewer than in the overall population, correct?

A. Yes.

91 **Q.** I'm sorry, did someone say something? Sorry, Dr. Gaetz, I thought -- it must have been something on my end. At paragraph 18, in the third sentence from the end, you have stated, "When women become homeless, they are at increased risk of violence and assault, sexual exploitation and abuse, which may explain the lower numbers of women in the

shelter system."

I notice the use of the word "may," do I take it to mean that this does not conclusively explain the lower numbers of women in the shelter system?

A. I think that the evidence is quite strong on that. And I have done research in that area, and it's pretty clear. Certainly, the data around increased risk of violence and assault and sexual exploitation and abuse, there's a strong body of literature there. There's also literature that demonstrates -- and I've published this kind of work as well, a study in 2004, that identified that women will often, as it says in the next sentence, "go to great lengths to avoid the shelter system," [as read] for all kinds of reasons, and may make decisions that, that -- like, for instance, to stay with a partner who is abusive because their thinking is that there's greater risk of me being on the streets -- there's greater risk to my safety in that situation. So people -- so part of that hidden homeless population is women who need an alternative to the household they're in but they stick it out, because of fear of what would happen if they were on the streets.

92 **Q.** And, Dr. Gaetz, you've used the

phrase "on the streets," and that's also the terminology used in your affidavit. I can tell you I also reviewed the sources that you cited at footnote 15, and those sources, I'll put to you, speak to the risk of violence and exploitation on the streets but not specifically in the shelter system, correct?

A. There -- I -- I believe that they are focussing -- I'd have to go back and read it, because people often use the terminology -- and did in the past more than would be the case now -- used the terminology of "on the streets" to refer to homelessness writ large, rather than just the experience of being unsheltered, right. So I'd want to have a closer look at those to determine how, how that's been framed. I've used that terminology in the past broadly myself, it's not as accurate, right. And also bear in mind that there is a bidirectional flow into the shelter system, right. Women who are on -- sleeping in unsheltered situations, it doesn't mean that they've never been in a shelter, nor does it mean that they will never wind up in a shelter. And what the challenge is, we don't necessarily have good data to parse out that, that flow. You know, so, so hopefully in the future we'll have a better take on that.

93 **Q.** At paragraphs 19 through 22 of your affidavit, Dr. Gaetz, you identify other factors, scrolling a bit, but -- so gender identity, age, Indigenous identity. And, again, here, your citations are all to the Everyone Counts Point in Time Count report.

A. Right.

94 **Q.** And that report, that report looks at 61 communities across Canada, correct?

A. That's right.

95 **Q.** And one of those communities is Hamilton, correct?

A. Yes.

96 **Q.** All right. But it's not specifically discussing the situation in Hamilton?

A. My understanding that it isn't. But I'm guessing that the City of Hamilton produced its own Point in Time Count report.

97 **Q.** Certainly. But the Everyone Counts reports and the figures that you're citing in your affidavit are not specific to Hamilton?

A. They're not specific to Hamilton but I would assume that -- I wouldn't make the assumption that each Point in Time Count in every community makes that community at -- special, a

snowflake, right. Like, there's more in common across the different communities than there is differences. And so though this report does not speak directly to Hamilton, I can, with a high degree of certainty, say it is relevant to understanding Hamilton, nonetheless.

98 **Q.** And --

A. Like, if you do a national survey with 2,000 people, we're able to extrapolate, with varying degrees of confidence, depending on the sample size, whether the views of those people or the experiences of those people can be generalized beyond that, right. And so the sample size for the Point in Time Count is high enough that you could have a high degree of confidence that generally the results in that Point in Time Count will also not be totally out of whack with what's found in Hamilton.

99 **Q.** Thank you, Dr. Gaetz. At paragraph 23, under the heading "The Homelessness Emergency Shelter System - an overview," you, again, begin by citing an Employment and Social Development Canada report, stating that, "There were 'over 15,400 emergency shelter beds at about 400 emergency shelters across Canada.'"

And in this paragraph, you're going on to describe some statistics. These are across Canada,

not specific to the City of Hamilton, correct?

A. Let me look. Yeah, that's right.

100 **Q.** At paragraph 24, the last sentence, referring to "shelter standards," you state, "The City of Hamilton had such a plan, called the 'Blueprint for Emergency Shelter Services.' However, this document is no longer available online and it is not clear if there are any current standards."

You're not aware, I take it, of the emergency shelter standards for the City of Hamilton?

A. Since that time, no. If I put that in there, yeah. I haven't been following Hamilton in particular.

101 **Q.** And so at paragraph 25 you state, "Bearing in mind there is variation in how shelters operate, there are some common characteristics." And you go on to list, in several subparagraphs, characteristics which you state are the features of emergency shelters.

But I take it from your affidavit and your previous answer, you're not describing the shelters in Hamilton specifically, correct?

A. I'm not describing the shelters in Hamilton specifically but that doesn't negate this evidence at all. There's nothing that makes me feel

that the shelter system in Hamilton is different than other places in Canada.

Over the course of my career, right, so I started working in the homelessness sector in the 1990s, and since that time, I have -- I can't tell you how many emergency shelters I've been in. When you go to a conference that's on homelessness, usually the host city -- like, I'm going to one in Budapest -- they will take us on a tour of shelters and we'll talk to people who live there, we'll talk to people -- to staff there, and, you know what, it's the same old thing every time. And it usually ends with, you know, would you like to see our bedbug protocol, that kind of thing. And so I'm talking about international differences the same as in Canada, right. I don't think we can make any conclusion that what the shelter system is like in Hamilton is somehow special or distinct.

There's a long history of emergency shelters in Canada, and many of them are well meaning but I think that that whole system is highly problematic. And I have done enough talking with people, you know, and -- both service providers but also residents, and I think that the way I've described the shelter system there is fair -- very accurate.

102 **Q.** So let's take some of these. For example, subparagraph d), "Some shelters limit the number of nights an individual can stay."

Do you know, Dr. Gaetz, whether any of the shelters in Hamilton limit the number of nights an individual can stay?

A. I do not know that.

103 **Q.** Subparagraph f), where you say, "There is typically a curfew, after which people will not be admitted."

Do you know that in any shelter in the City of Hamilton people are not admitted after a said curfew?

A. I would say with a high degree of certainty that is the case, but I don't have a particular example of that. I would be shocked if that wasn't the truth.

104 **Q.** And perhaps you may be shocked by some of the evidence that the shelter providers have given in this proceeding.

A. I may or may not be, but, as a researcher, I would say that one has to be careful when you're talking about, you know, people who work in shelters or run shelters because they will have an interest in portraying the situation in a particular

way, right. The history of shelters in Canada is deep, and there's a consistent type of practice that happens, you know, that -- and so I'm going to go with that kind of research experience ahead of what a shelter provider might say.

105 **Q.** I'm going to put a document up on the screen. Dr. Gaetz, this is a document called "Hamilton's Emergency Shelter Standards," dated September 2023. Have you ever seen this before?

A. I haven't.

106 **Q.** I put it to you, Dr. Gaetz, that this document is a document by the City of Hamilton that sets out the standards for shelters that receive funding by the City of Hamilton and that operate within the City of Hamilton homelessness serving system. Do you have any reason to disagree with that?

A. That's what this document is? Yeah, no, I -- most cities have shelter standards. And so I've seen -- I'm more familiar with Toronto shelter standards, so I'm aware of the kinds of things that they operate -- I think to understand about emergency shelter standards is that though they purport to be like ironclad, you have to do this if you want funding from the city. Not all shelters are directly funded, like, their core budget doesn't necessarily come from

the municipal government, right. Many are -- rely on charitable donations and other sources of income. Most have multiple sources of income. And so the standards are there but, like, with all of these things, there will be reason to -- what I'd want to know is, how consistent are they in the application of those standards.

107 **Q.** And, Dr. Gaetz, you don't have any data or any knowledge of how consistent these shelters in Hamilton are in adhering to these standards, do you?

A. No, I don't.

108 **Q.** I'm going to take you to paragraph 26 of this document, which I'll mark as Exhibit 4. So this document states, at Item "3.4 Curfew and Overnight Passes," it states, under "Standard Statement," "Emergency shelters may require clients to return to the shelter to access their bed by a certain time. Curfews are a tool for managing safety, reducing interruptions during the night for clients, and managing shelter occupancy."

The second paragraph, and I'm skipping over -- for the record, I'll state I'm not reading this entire thing -- "In shelters where a nighttime curfew exists, provisions will be in place to accommodate clients who expect to be late for reasons such as work,

accessing medical services, family reunion, etc. Emergency shelters may grant extensions to curfew or overnight passes to accommodate clients at their discretion." [As read]

So you'd agree, at least, that this shelter standard doesn't provide that no admissions are to be made after curfew, correct?

A. It uses the language of "may" rather than that they "must."

109 **Q.** Well --

A. So that makes it a discretionary choice on the part of the shelter --

110 **Q.** Well, it does not, respectfully --

A. -- it's not the proper gauge.

111 **Q.** -- Dr. Gaetz, the first sentence of the second paragraph states, "In shelters where a nighttime curfew exists, provisions will be in place to accommodate clients who expect to be late," correct?

A. It says that provisions will be in place but it doesn't specify what those are.

EXHIBIT NO. 4: Document titled "Hamilton's Emergency Shelter Standards," dated September 2023.

BY MS. SHORES:

112 **Q.** So let's go back to your

affidavit. You state, at subparagraph h), "At most shelters, people are discharged in the morning and are not allowed back in until the evening, regardless of the weather, whether a person is ill or has a disabling condition."

Do you know that that is the case for the shelters in the City of Hamilton?

A. I would assume it is and would be skeptical of claims otherwise. The -- there's long been calls for emergency shelters to be open 24 hours a day, because it's enforced movement, which is not desirable for the residents, but that's very expensive, right. And I'm not aware of any communities in Canada where this is not the case. There may be an odd shelter here and there but I would say that it's definitely not standard practice.

113 **Q.** Well, again, Dr. Gaetz, I'm going to take you to the shelter standards for the City of Hamilton previously marked as Exhibit 4, this is item "3.3 Daytime Access," at page 25 of the PDF, which states, "At shelters -- well, let -- third paragraph down, "Clients will have access to hygiene facilities such as toilets, sinks, and showers at all times and in rare instances that access is not possible during daytime hours, emergency shelter operators will provide

clients with information on drop-in programs and other services with hygiene facilities that clients can access during daytime hours."

So you'd agree here that this shelter standard does provide for daytime access, at least for hygiene facilities such as toilet, sinks and showers, correct?

A. Okay, there's several things here. One is that, you know, in rare instances where access is not possible, that's more squishy language.

But the other thing is, like, you can't conflate having access to toilets, sinks or showers with access to the shelter. What if I want to be in the shelter to just -- because I'm depressed and I want to sleep, but I don't want to talk about my depression with my -- with the staff? What if I'm feeling sick? What if I'm scared to go out? You know, like, the -- this is -- if this is considered access to the shelter during the day, that's, like, very kind of, you know, limited, extremely limited notion of what access to shelter mean.

For instance, I live in a house, right, we have two bathrooms in the house, I am -- I can leave during the day, but there is no condition or rule between the members of my family that I can only come

in to use the bathroom or the shower. Like, that is not normative in society. Access to the shelter means access to everything and the services that are there 24 hours a day; and this document is not saying that at all.

114 **Q.** Now, Dr. Gaetz, you asked, you think rhetorically or hypothetically what if I'm feeling depressed, what if I'm, what if I'm ill? The second paragraph of this document -- or of this page of the document, "At shelters where daytime access is limited, provisions will be in place for people who work overnight shifts or who are ill and need a place to rest (provided they are not in need of medical care). Some emergency shelter operators may require a doctor's note specifying the medical need and timeline for accommodating clients during the day."

So, again, you'll agree that there is a provision that may be made for people to rest and access the shelter during the day, correct?

A. It's full of conditions. My wife doesn't require that I get a doctor's note specifying my illness, okay. So, like, this is, this is not normative in terms of housing standards and practices in Canada. You also have to understand that many people who are homeless have experienced trauma, as we

mentioned before, and many will have had difficult encounters with public systems, from health care to the policing and emergency shelters. And so the idea that they have this procedure they have to go through to get access to the shelter during the day, that may require that they go externally and get a doctor's note -- and I'd like to know where is the doctor that's going to do that, are they going to wait in emerg.? Most people who are homelessness don't have a family doctor. This is masking as a liberal document that looks out for people and that the shelters are helpful; it ignores that the provisions are not normative in terms of how people access housing in the rest of Canada, how you do, how I do, how do the staff at the City of Toronto. You know, like, this is, this is not what it seems, right. And that's why we have to parse the language very carefully. This would be -- this would not be necessarily atypical but I would not ever say that this means people have access to the shelter during the day. It's all conditional. And, you know, like, if, if, if I'm not working, I might want to just rest today, I may not want to -- you know, like, there's all kinds of reasons why any of us use our housing how we want, right. This is really, really the kind of thing you would not see with -- as I say, it's not the rules in

my house, and I'm pretty sure it's not the rules in your house, right. And so let's not pretend that this is really about daytime access, it's about a very limited and conditional kind of access to the shelter.

115 **Q.** And speaking of daytime access, you'll agree that this document, at the last paragraph under the heading "Standard Statement," says, "During Cold Weather or Heat Alerts, it is necessary that all shelters attempt to relax service restrictions and extend daytime hours wherever possible to minimize risk factors to people experiencing homelessness. When unable to admit a client during the Cold Weather or Heat Alert emergency shelter operators will provide clients with information on drop-in programs and warming and cooling centres." [As read]

So, again, you'd agree that there is provision being made for daytime access, correct?

A. No. No, I would not. I would actually say that this is more squishy language, "Shelters shall attempt to provide -- or "to relax service restrictions." [As read] In their own document, it says there's service restrictions, right. Like, that sentence says there exists service restrictions that could be relaxed. That's not the same as daytime access, right. And so giving people a

list of places to go I think is insulting to those people. You know, that many people experiencing homelessness have disabilities, and the services aren't all in one area. And so during a winter storm, if you're to say, "You can't come in here but you can go across town to that other shelter," and then say, "We helped the person, we advised them," that's not access at all. That's, I think, de-humanizing and, again, is totally against norms that we have about how to access -- you know, if you don't have a home, it doesn't mean that you should be subjected to, like, rule-bound, you know, de-humanizing situations in an emergency shelter. Right, this is one of the problems in Canada, we've relied on these public systems that we think are doing so well and are all about, you know, helping clients but every -- if you read that paragraph -- or those -- this section very carefully, it's very revealing the degree to which the shelters do not mimic having your own place in any way. That level of rules and restrictions, all in favour of the shelter, and all the squishy language about "may" or "should attempt" to do things, that's not good enough, right. My wife doesn't -- isn't responsible for making an attempt to let me use the house during the day. I don't know if you have a partner but you wouldn't

accept that either. And yet here we are with a system that's, like, yes, there's daytime access. I don't call this daytime access, it's very conditional, it's rule-bound, it's expecting people who may be very alienated from public systems and have horrible experiences, it's expecting them to make decisions and do things that I think are really, really difficult and inappropriate while they're in the crisis of homelessness.

116 **Q.** So, Dr. Gaetz, is it your belief that the emergency shelter system is supposed to replicate housing?

A. I don't think -- I think that our response to homelessness should be focussed on ensuring people have access to real housing and that we should stop pretending that emergency shelters are a reasonable alternative for people, right. It's -- so to your question, should it replicate housing, the only thing that would replicate housing would be housing.

117 **Q.** Well, Dr. Gaetz, I want to --

A. Emergency shelters --

118 **Q.** -- make sure that you understood my question because my question was, is it your belief that the shelter system is intended to replicate housing?

A. It's, it's intended to put in place emergency supports. But the conditions should be done with dignity and should, as close as possible, be normative, right. And so I don't think that we can let shelters off the hook by saying, Well, we're not intended to be housing, people wind up staying in shelters in some cases for, for years, for decades, and we still call it an emergency service, right. I'm saying that that whole infrastructure and that approach to homelessness that we've been buying into for years is highly problematic. And, you know, shelters aren't replicating housing, is the question. Could they? I would rather that we eliminate shelters and house people instead. I don't think that shelters can ever provide the kind of support. You know, they're like -- they're institutions, it's institutional care for people -- or not even care, it's institutional support, at best, for people who are experiencing homelessness, who are expected, I guess, to say I don't deserve anything better than this.

119 **Q.** At paragraph -- subparagraph k) of paragraph 25, you state that, "Shelters typically have rules and restrictions." And in your last answer to me you referred to being, I think, "rule-bound," was the phrase that you used.

Continuing on with sentence one of subparagraph k), "In some cases informal practices - allowing staff to discharge those accessing the shelter, for a range of reasons, including fighting, being disruptive, coming in drunk or having used drugs."

Certainly your evidence, Dr. Gaetz, isn't that the rules are in place simply so that staff can have an excuse to discharge people though, is it?

A. The -- 90 -- or I'm making up this number. Actually, let me start again. We -- what's listed here doesn't surprise me at all. It provides a lot of leeway to the staff to discharge people for different reasons. If you talk to people experiencing homelessness who have been discharged from shelters, it's often for very frivolous reasons. The rules are there to protect the shelter staff, that's what they're there for. They're not there to respect the dignity of the people who are using that service. It doesn't have to be that way. There's examples in Canada of shelters who have a zero discharge into homelessness policy, which means that even if there's trouble going on or difficulty, we, we have to not make the person even more homeless. So I think the rules and restrictions are another example of norms -- the -- ignoring

normative behaviour in situations. People get discharged because the staff don't like them or they talk back. You know, the grounds under which people can be discharged is really broad, right. You're a lawyer, right, you can see that that's a wide range of things. Like, coming in drunk or having used drugs - how are you going to determine if someone's used drugs, do the shelters do blood tests?

120 **Q.** Well, Dr. Gaetz, you don't know that coming in drunk or having used drugs is a reason for discharge of any shelter in Hamilton, do you?

A. It says this in the third row, "coming in drunk or having used drugs." If that was --

121 **Q.** Dr. Gaetz, this is your affidavit.

A. Oh, okay. Oh, okay.

122 **Q.** Right in your affidavit.

A. I got confused. Well, I'm standing by this, right. Like, I don't have any reason to believe that this is not the case in the shelters in Hamilton. It's -- I've never -- outside of a few examples that I mentioned, you know, where there's zero discharge into homelessness, this is standard practice.

123 **Q.** But, Dr. Gaetz --

A. Standard practice. And I would be very skeptical of if a shelter said that this doesn't

happen. I would be very skeptical if a shelter said, Oh, we have clear rules that are always followed by staff. I know lots of cases where people will -- have been discharged and, you know, the reason will be a trumped up thing that just allows them to discharge them. And sometimes getting the person to discharge themselves, because they're so frustrated that they'll leave.

124 **Q.** And even though you don't have direct knowledge of the policies or adherence to the policies in the City of Hamilton, you believe that's the case because you're skeptical of the shelter operators, correct?

A. It's not that I'm skeptical, it's that the research -- I come from a research perspective. There's evidence of this. It's not just skepticism. It is -- I think that --

125 **Q.** Well, Dr. Gaetz, where --

A. -- would be incumbent upon --

126 **Q.** -- is the research? Where is the research?

MR. CHOUDHRY: Excuse me, excuse me, Ms. Shores, I think Dr. Gaetz was finishing his answer. Could we please let him complete his answer.

THE DEPONENT: Yeah. So as an --

you've -- I've been called as an expert witness, so on a -- my expertise is on homelessness, the experience of people while they're homeless, including the experience in the shelter system, and it's also expertise on the response to homelessness. And the emergency shelter system is the number one response to homelessness in Canada. Overwhelmingly, we spend multiple millions of dollars annually, that's where most of the investment and most of the practice is. So as an expert witness and a researcher, what I'm presenting to you is what I know to be the case. It's not -- I'm not suggesting it or it might be like this, this is what is clear. And if you were to talk to people who experience homelessness across Canada and service providers, I'd say you'd get a, you know -- people would agree with this. This is based on -- as I've said, you have no idea how many shelters I've been in in my life, and they all have rules, all of them. They all will discharge people into homelessness. It's part of what happens when you have public institutions where it may be a little more chaotic, right, that people then fall into using rules and regulations to control what can be -- for the staff maybe be stressful situations, but it's based on the well-being of the staff more than it is of the clients.

BY MS. SHORES:

127 **Q.** But, Dr. Gaetz, you don't have any evidence to point to with respect to adherence of the shelters in Hamilton to their own policies, correct?

A. Hamilton specifically, I don't. But, again, I do -- like, you have to -- as a researcher, you can't just dismiss my knowledge and experience of this as hearsay. And I'm saying to you that this is typical, that -- I've only seen a couple of places in my travels, and what's great is that they do exist, where there's zero discharge into homelessness. Like, it is typical, that's the norm. It's normative within the logic of the emergency shelter to have rules and to be able to discharge people for a whole number of things, and typically that ability to discharge leaves a lot of discretion up to the staff in question, right. So, so having said that, unless there's incredible solid evidence, and I'd want to be able to review it, I would be shocked if Hamilton somehow was different than the rest. There's nothing that I've heard from people in Hamilton about that, and so I'm going to go with what my research evidence is, which is that this is standard practice.

128 **Q.** And, Dr. Gaetz, is it your evidence that the rules that are typically in place in

shelters are not there to protect other occupants of the shelters?

A. There, there may be cases when there's physical conflict between people but very little is done to ensure safety for clients in shelters, right. So if there's a fight --

129 **Q.** What do you mean by --

A. -- there might be a staff intervene. But here's what -- here's a thing to consider, okay. Like, when someone goes into a shelter, what's that like? They might go in and -- most of them have congregate sleeping arrangements, so there's more than one person in the room. You can go in there, the shelter might have beds for 30 people, you may know 15 of them, you may be terrified of eight of them, there's another person over in the corner who is coughing and is clearly very sick, there's people screaming at night, right, and so, you know, that's a very difficult situation to live under. So to suggest that these efforts by, you know, evicting people is somehow driven by the need to protect clients, it's like they're not protected, they're not protected, you know. Like, here's the thing I like to say to people, you know, it's hard enough to live with other people when you choose them, right, like a partner or

roommates, that kind of thing. When you're in a shelter, there is no choice, you're surrounded by people, as I say, who may pose a threat to you, that you're afraid of, that they're sick, all of these things, right. So shelters cannot get around that as long as they operate under these conditions. It's why we have to not imagine that shelters are a positive solution for people experiencing homelessness.

130 **Q.** But on the topic of rules, Dr. Gaetz, you mentioned things like people, people shouting, people who are ill, rules, you would agree, would help mitigate some of the effects of that setting; would they not?

A. Well, it depends what the rule is, right. But if the rule is that you can potentially be discharged into homelessness and the -- you know, like it's -- can I ask you a question?

131 **Q.** I'm --

MR. CHOUDHRY: Dr. Gaetz --

MS. SHORES: -- not obliged to answer it.

THE DEPONENT: Okay. It's okay. I'd be interested, anyway, to see if those shelter standards speak to that question of, question of under what circumstances people can be evicted or --

BY MS. SHORES:

132 **Q.** Well, let's look at that, because I believe that they do. So at paragraph -- or page -- I believe what we're talking about are service restrictions, which is under heading 3.7 at page 29 and 30 of the document. "Services restrictions, it says, "are primarily utilized in situations where other interventions and responses do not resolve behaviours or circumstances that pose significant risk to the safety and well-being of the client, other shelter stayers, staff, shelter property and/or the community. Service restrictions may also be issued due to ongoing behaviour which interfere with shelter operations, illegal activities, court order, significant damage to property, or prolonged refusal to engage [in] program requirements. Emergency shelter operators must balance the well-being of individual clients against risk of harm to other clients, staff, guests, volunteers and neighbours, as well as their obligations under the *Occupational Health and Safety Act.*

"All emergency shelters will follow the City of Hamilton's service restriction policy and appeal process. The service restriction policy provides guidance for emergency shelter operators and staff on best practices and considering when issuing

restrictions, including:

Bullet point, "The process for approving, reviewing, documenting and appealing service restrictions."

Second bullet point, "Informing clients of the service restriction policy and appeals process at intake, or as soon as feasible.

"How and when clients will be informed of a service restriction."

And I've stopped to read the bullet points but it refers to the Hamilton homelessness serving system service restriction policy, which I'll bring up momentarily.

So, I have now placed on the screen City of Hamilton Service Restriction Policy for Emergency Shelters. Mark this as Exhibit 5.

EXHIBIT NO. 5: City of Hamilton Service Restriction Policy for Emergency Shelters.

BY MS. SHORES:

133 **Q.** Under the heading "Guiding Principles" -- well, let me ask you this: Dr. Gaetz, have you seen this document before?

A. No, I haven't.

134 **Q.** Are you -- so I take it you're not familiar with it?

A. I'm not familiar with this document, no.

135 **Q.** You have not reviewed the service restriction policy for the City of Hamilton shelters?

A. No.

136 **Q.** Under Guiding Principles, this document states, "Service restrictions should primarily be utilized in situations where there has been, or is been a significant risk of, harm to other clients, guests, and/or staff. Service restrictions may also be issued due to ongoing behaviours which interfere with shelter operations, illegal activities, court order, significant damage to property, or prolonged refusal to engage in program requirements. Service restrictions are not to be applied in instances where a client is turned away to shelter due to ineligibility based on demographic factors or medical accommodations beyond the capacity of the agency mandate. Staff and management responsible for issuing and reviewing service restrictions will be mindful of the following guidelines when applying this policy." [As read]

And then it sets out another -- a series of guidelines, among which, I'll draw your attention to the fourth one, "Service restrictions are not to be used as a punitive measure."

You agree it says that?

A. I do agree it says that. However -- if I can just pause there. You know, I've spent a lot of time looking at policies and things like this and talking about policies within particular institutions. And so these policies may exist but the question is to what degree are they followed. One of the things that -- as I mentioned before, you know, people often get discharged for things that are trumped up and are used as punitive measures. You know, people are human beings who work in shelters, they may like some clients and dislike others. They're not necessarily trained on de-escalation and how to deal with situations. Again, in -- I didn't get a chance to read it all because you went by certain sections, but, again, as with many policies, there's a lot of wiggle room here and a lot of squishy language around requirements. There is -- the thing -- for instance, that people should be allowed to -- or if they're evicted, that they should have -- be able to appeal the situation, really masks -- you know, this is very much a privileged-based statement. You know, that people who are used to being treated poorly in public institutions are not likely going to appeal a decision, right. Because that would be interesting to -- you

know, they're not likely to appeal because they won't trust the system. It's like in Ontario they used to have the requirement until ten years ago that if you had a problem with a police officer and felt mistreated, including were assaulted, you had to go into a police station and fill out a one-page form which had this much information about you and this much information about the complaint. Public systems find ways of creating rules and language and policies that are protecting the public system more than the clients. And so I'm not, I'm not really impressed by this, nor do I trust that that's followed, because my knowledge of what happens in other jurisdictions and other shelters is that even when from, you know, the leadership and at a policy level it's clear to really -- to not discharge people into homelessness, or only in the most extreme cases, because people are working in a chaotic environment, it's going to happen all the time. You've got language in there about being disruptive to the operations of the shelter, right. The language is all about, you know -- from my perspective -- not -- I mean, there is about, like, harm to other people, right, but I would not stand behind this as, like, a glowing example of how to think about service restrictions, it's really built around

the needs of the shelter.

137 **Q.** And with respect to service restrictions types, going on to page 4 of Exhibit 5, this document sets out a series of ways in which, it states, "Access to location may be limited or denied," the first one is "Postponement Period/Warning: A brief period in which the client is asked to leave the premises with a view of taking time and space to de-escalate their current behaviour. In such intense situations, the client will be invited to return when they feel better equipped to engage appropriately in the environment. Postponement period/warnings cannot exceed 12 hours in length and will not be issued overnight."

So you'd agree that at least this level of service restriction, when imposed, isn't discharging people into homelessness, they can come back?

A. Well, one has to considerer the weather and things like that. And the one thing I want to suggest, so, like, how many -- I'm not sure how many pages in this document.

138 **Q.** It's a ten-page document.

A. Ten-page document, okay. So one thing you need to understand with emergency shelters, I mentioned that they're very chaotic environments,

there's a lot of staff turnover, there's minimal professional development, and we're sitting here imagining what happens in a shelter based on what a policy says. And I think it's important to note that policies do not policy -- policies can inform practice, they don't determine practice. Given that -- you know, in an emergency shelter you'd have staff for, like, the operating hours but before night, you have temporary staff who work the overnight shift, you have, you know, people who are part-time, people who are doing it as a short-term job, people cycling in and out of those roles, I'm -- I would go to the point of saying I very much doubt that your average shelter worker has seen this document or read the ten pages and then internalised it. So the fact that there's a policy there, with squishy kind of conditions, that is, in essence, designed to protect the shelter, I don't think we should be considering this to be a positive, nor do I have any confidence that it's applied with the let -- not just with the letter of the policy but the intent of it.

139 **Q.** Dr. --

A. I just can't imagine that Hamilton is so unique that they stand out in Canada, they stand out internationally for a progressive approach to

dealing to service -- dealing with service restrictions.

140 **Q.** Dr. Gaetz, you indicated skepticism that any shelter workers in Hamilton are familiar with the service restriction policy, but you don't actually know whether they're familiar with the service restriction or not --

A. I think one can infer through experience, I've worked with the City of Toronto, I've worked in the homelessness sector, I've been around this, I would say that this is true in most sectors, right. Like, staff -- York University has got reams of policies, including ones that are directed at me, people like me, at professors, do I sit around and say I need to look at the policy - on very rare occasions. Like, this is how --

141 **Q.** Well, if it was something --

A. -- institutions operate.

142 **Q.** -- that needs to be implemented --

MR. CHOUDHRY: Excuse me, Ms. Shores, and Dr. Gaetz too, I'd also ask you as well, I think this is quite energetic, and so let's make sure everyone can complete their sentences before we answer, that's fair.

THE DEPONENT: Right.

MR. CHOUDHRY: But you were finishing, sir.

THE DEPONENT: Yeah, just I, I think that -- there's a whole amount of research on public institutions, institutional ethnography is a whole methodology that's dedicated to this. I'm more familiar with it with reference to schools. But, generally, the research on this kind of thing, on, you know, institutional policies is that they're generally -- the existence of a policy does not necessarily mean that the practice follows it, nor does it mean that it's sufficiently clear that it actually governs the behaviour of staff, nor is there -- actually, I don't know, I'd have to see, is there a requirement for staff training -- ongoing staff training? There are some of the things in there that I find, you know, troubling too, that on intake people are, you know, told about the service restrictions. You know, somebody who is going into a homeless shelter, like, the last thing they're going to be thinking about is their service restrictions. So these kind of things are, like, to me, it's a classic example of bureaucratic policy making that I have -- personally I don't have any confidence that this means that Hamilton emergency shelters stand out in the world as

being ones where they are at the leading progressive edge of a service restriction.

BY MS. SHORES:

143 **Q.** Dr. Gaetz, you don't cite in your affidavit any research or scholarly works about the extent to which shelters comply with their own policies surrounding service restrictions?

A. I don't have that in there but I'm -- I don't think that -- you know, like, I wasn't asked to put that in there. But I think, you know, research on public institutions would be very consistent with what I'm saying.

144 **Q.** At par --

A. And so I think -- I don't -- as a researcher, I would say be very careful in assuming, like, a policy like this operationally on the ground operates in compliance with the intent of this. Yeah, and I'm not even sure about the whole intent of it, I have not read it. So, yeah, I wouldn't go down the road of assuming that because this policy is in place that rules are followed, that people don't get discharged for frivolous reasons, including that the staff don't like the person. You know, there's no mention in here, that I saw anyway, that people who have mental health challenges or a brain injury or

other disabling conditions, that those things are taken into account. You know, like, that -- it's not -- again, the policy isn't speaking to the people who live there, except in framing them as a problem that has to be controlled and how can we do it in the most effective way. That's what this is about. And I don't need to cite a bunch of research on this, I can tell you that there's, you know, whole disciplines that look at, you know, how public institutions operate and the role of policy in it. This is not something new or novel we're looking at here. There's lots of words there, but I don't trust that that means that Toronto is safer or more respectful -- or Hamilton, I should say, than any other place, right. The existence of a policy like that does not mean that people are treated with dignity.

145 **Q.** And, Dr. Gaetz, though there is a difference between a policy being imperfectly or occasionally not adhered to and being completely ignored, correct?

A. Well, that's on a spectrum, right --

146 **Q.** Yes.

A. -- and it's also situational, right. So, you know, so I would say that it wouldn't

be unusual for the policy to be ignored, it wouldn't be unusual for the staff who are expected to deliver the policy to have never really maybe even seen this, it would be unusual -- or it wouldn't be unusual for them to have seen it and been asked to read it but they didn't, right. It's not --

147 **Q.** And you don't have --

A. -- it's not stirring pros, right. And -- no, but I do have experience with how organizations operate, a lot of my research is on the responses to homelessness, right, and that includes, largely, looking at the role of emergency shelters as our main response. And we have to be careful in looking at and understanding emergency shelters, that there's a public understanding of emergency shelters. A lot of them are faith based, it's not necessarily a bad thing, but that this is somehow an alternative to housing -- a solution that involves housing, that this is really good for people, it provides safety and care, it provides a safe environment. Not every person who is being bullied in a shelter is going to tell the staff, right, it's a institutional setting. And so we have to be mindful of that and careful not to impose our imaginary thoughts about what a shelter is like, and that it's all about doing good for people, when it

may be an extremely troubling kind of approach.

148 **Q.** Dr. Gaetz, just to close off this line of questioning, you can't say with any certainty the extent to which the shelters in Hamilton do or don't abide by the policies that they have on paper, can you?

A. I would say with a high degree of certainty that they don't.

149 **Q.** Based on what?

A. Based on my experience of 30 years of both working in the homelessness sector but doing research on responses to homelessness, and doing research with people who have experienced homelessness.

150 **Q.** And based on no specific research or investigation of the shelters in the City of Hamilton?

A. The research is more than just the published outputs, right. Like, research is a process that involves many -- you know, looking at many different kinds of evidence, trying to sort out what evidence is best, but also being able to look at what do we know about, in this case, how do public institutions operate, right. So, so it's with that that I say with confidence that it's -- that it's highly unlikely that Hamilton stands out, because what

would be the conditions that would make people who work at shelters in Hamilton different than in Calgary or Regina, right. They're going into these jobs, low-paying jobs, they won't be in the job that long, for most cases, right, there's a lot of policy there, right, and I'm pretty sure that -- I mean, I don't know -- and how many managers would know this? Like, people will read it, but it's different -- if you think about what's in that document you just showed me, I could read that, I could be working in a shelter, but I'm pretty sure that within a week I would have forgotten most of the content, right. So let's not conflate the existence of a policy paper with the actual practice on the ground. And we have to be very careful on that. And I think that that there is so much evidence on the need to be careful on that that I would say, yeah, there's -- that they have a policy doesn't mean that that's how -- doesn't mean the practice is a fair one.

151 **Q.** But the question, Dr. Gaetz, was whether you have any knowledge of adherence in the City of Hamilton's shelters specifically.

A. I don't have any knowledge of the adherence, but I do have knowledge of what is typical in the homelessness sector, right. And so that's

important. And that knowledge is the knowledge that I'm going to rely on more than hearsay that in Hamilton it's somehow special. There's nothing that I -- and I've worked with community partners in Hamilton over the years, there's nothing that would lead me to say, Wow, Hamilton is at the cutting edge of this, right. Like, as I said earlier, I do know some places that have very progressive approaches to, you know, these kinds of things but they're few and far between, they are outliers in the extreme.

152 **Q.** Dr. Gaetz, you haven't spoken to any of the shelter providers in the City of Hamilton?

A. Not recently, not in the last five years.

153 **Q.** And you haven't reviewed any, sort of -- the training protocols for the shelters in the City of Hamilton?

A. I haven't, but my understanding is a lot of them are based on the training that happens in the City of Toronto, I could be wrong about that.

154 **Q.** You --

A. So, no, I haven't done that, but my, my point still stands. I don't -- you know, like, you have, in front of me, reviewed policy, right, I've looked at it, and it fell in line with exactly what I

expected - squishy language, you know, you know, around the degree to which one is required to follow something or do something. And the policies, if you read them from a critical perspective, the policies are there for the benefit of the shelter providers. They're not -- it's not a statement of rights for people experiencing homelessness, it doesn't really speak much to the process of what that's going to be like. It creates -- you know, when I see things like, We'll give you a list of shelters to go to, and it's cold, or a day program, like, you know, this is standard institutional policy work which is, you know -- I think we are in a very dangerous place when we overread the likelihood that these policies are being applied at all, let alone in a way that takes into account the needs of the client.

155 **Q.** At paragraph 26 through to paragraph 28 of your affidavit, you describe, under the heading "Shelters and spread of infectious disease" -- well, you describe shelters and the spread of infectious disease but, Dr. Gaetz, you're not an epidemiologist, correct?

A. I am not an epidemiologist but I have done research on the homeless response and pandemics going back to 2010. And in fact -- and have written about it, published it, and so I, I do have a

sense of that. I am not an epidemiologist, but I trust what epidemiologists say, they are researchers as well. But my work has been more on looking at how -- what might happen if there's a pandemic, and what does that mean for this -- the sector, to service provision, to people who experience homelessness.

And I'll give you a quick example, right, our public health policies -- all policy has an imagined person that it's addressing, right. Our public health policies imagine a person with housing. So, you know, during H1N1, you'd have public health posters that say, Here are the things you need to do to avoid getting H1N1. So, you know, wash your hands regularly, eat on clean surfaces, if you get sick, contact a doctor, if you get sick, stay home and in bed, try to avoid being around other people. And all of those things, I've got examples of these posters, and you'd see them with, you know, the most recent pandemic as well, they -- as I say, they imagine a housed person, because none of those things are possible with a guarantee if you're homeless, not one of them, right. And so, so in the advent of the COVID, you know, pandemic, I was very much watching and waiting to see what would happen, because one of the big worries is that during a pandemic, when there are

curfews and people are expected to be home, that they might force people who are homeless into shelters, right, where their health is at risk. So I have -- I'm not an epidemiologist but I am certainly a scholar of responses to pandemics.

156 **Q.** And you're also, Dr. Gaetz, not a public health physician, correct?

A. No, but I don't think I need to be, to comment on what's happening.

157 **Q.** In your affidavit, Dr. Gaetz, you don't discuss any studies about spread of infectious disease in or around encampments, correct?

A. No, that's correct.

158 **Q.** You can't say whether shelters are worse or better?

A. Oh, are shelters are worse or better, okay. I've -- it's -- this is a generalization question, which is hard to generalize, either on the side of what shelters do or what an encampment is like. So I'd be very careful around making any kind of generalizations. And I think that one of the things that has struck me is, as a scholar, is why the sudden growth in encampments over the last five years. There have always been --

159 **Q.** If I may, Dr. Gaetz --

A. No, no, I just --

160 **Q.** -- I think I need to clarify the question I was asking you but go ahead.

A. Okay. So, you know, the question -- the -- you know, there have been encampments in the past, right, but you had this happen across Canada, right. And if the shelters were seen to meet the needs of clients during the pandemic, then one would be surprised that people are making alternative choices as to where they're going to sleep and with whom, not necessarily in the same tent, but, like, how that's going to work. And so there -- I know there's health risks with being inside of a shelter even when they moved the beds a little bit apart, you know, and there will be risks as well with people in encampments.

161 **Q.** At paragraph 29 of your affidavit, Dr. Gaetz, you reference pandemics such as the COVID-19 pandemic and state, "Homeless shelters by design exacerbate risk in the context of a pandemic."

Do you have any knowledge of whether or to what extent those risks may have been mitigated in the shelters in the City of Hamilton?

A. I, I know what they were trying to do but whether they mitigated the risk, you would have to have research on that to show that.

162 **Q.** Are you aware --

A. And so --

163 **Q.** -- that there was a study conducted in Hamilton in 2021 on exactly that?

A. What's that --

MR. CHOUDHRY: Ms. Shores, Ms. Shores, may I ask that you put the study to the witness if you're going to ask him about it.

MS. SHORES: I will. Just give it a moment to load up.

BY MS. SHORES:

164 **Q.** So I'm placing on the screen here a document titled "Pandemic Planning in Homeless Shelters: A pilot study of a COVID-19 testing and support program to mitigate the risk of COVID-19 outbreaks in congregate settings," author -- the corresponding author of this study is a Dr. Timothy O'Shea MD, who I believe is a witness in this proceeding.

Dr. Gaetz, are you familiar with this study?

A. No.

165 **Q.** The other doctors who are the authors of this study are: Claire Bodkin, I believe also a witness in this proceeding; Vaibhav Mokashi,

V-A-I-B-H-A-V M-O-K-A-S-H-I; Kerry Beal; Jill Wiwcharuk, also a witness in this proceeding; Robin Lennox; Dale Guenter; Marek Smieja.

And the abstract, I'm reading from page 3, states, "We tested 104 residents and 141 staff for COVID-19 who failed daily symptom screening in homeless shelters in Hamilton, Canada. We detected one resident (1%), seven staff (5%) and one case of secondary spread. Shelter restructuring to allow physical distancing, testing and isolation can decrease outbreaks in shelters."

Are you familiar with the conclusions of this study, Dr. Gaetz?

A. Yeah, but I have a lot of questions about it.

166 **Q.** Well, let's see if the conclusions portion of -- or the discussion portion, rather, of the study answers any of those. So I'm directing you to page 8 of the study.

A. Okay.

167 **Q.** Under "Discussion," it states, "We have thus far been successful in preventing large outbreaks in the shelter setting despite identifying positive cases in both staff and residents. Our results emphasize the importance of taking a proactive,

aggressive approach to outbreak mitigation in high risk settings. While there has certainly been some random chance, we postulate that four factors have been particularly important in increasing our chances of success."

And they go on to describe "increased capacity of shelter space, access to rapid assessment and testing, restructuring of physical spaces, and rapid turnaround of test results." [As read]

But returning to the first sentence under the heading Discussion, the authors state that they have been "thus far successful in preventing large outbreaks in the shelter setting." [As read]

Do you have any reason to disagree with their findings?

A. Well, it would go against the body of research on COVID-19. Can you tell me, I saw that it was published in 2020, when was the data gathered; do they have a methodology section?

168 **Q.** They do have a methodology section, so I've scrolled to page 4, I'm just going to zoom out some more that can be visible.

A. Okay.

169 **Q.** So scrolling down --

A. Okay, so wait, wait, wait. So it

says here between March 17th and April 30th. Now, you are aware that in Ontario the first lockdown was in the end of March, this is like very early on in the pandemic, when the data was gathered, which would make me wonder why we're looking at it. Okay, keep going.

170 **Q.** I've for the record scrolled now to page 6.

A. Yes, so this is right at the very start of the pandemic. There's got to be better data than this. I would not generalize from this. When looking at research, you know, we know this from -- if we're looking at environmental research, you know, or any -- vaccines, that kind of thing, outlier data should be tossed aside, right. We shouldn't hook our analysis based on a single study, particularly one that is so early in the pandemic that I don't -- I'm surprised that people would be making any kind of generalizations about that, right. Like, you have to really look at -- you know, we know from research that the percentage of people who are homeless who got COVID, like, it started to really rapidly increase as the pandemic proceeded, that some subpopulations more likely than others. So a study that's done like, you know -- literally the, the first lockdown was, like, March 22nd or something of 2020. So this is -- I'm not

convinced, right. You have to -- if you're looking at this kind of stuff, you have to look at the weight of evidence, right. And a single article doesn't convince me at all, that this is something that one should even be, in this case, be paying attention to.

EXHIBIT NO. 6: Document titled "Pandemic Planning in Homeless Shelters: A pilot study of a COVID-19 testing and support program to mitigate the risk of COVID-19 outbreaks in congregate settings," corresponding author - Dr. Timothy O'Shea. Other doctors who are the authors of this study are Claire Bodkin, Vaibhav Mokashi, Kerry Beal, Jill Wiwcharuk, Robin Lennox, Dale Guenter, Marek Smieja.

BY MS. SHORES:

171 **Q.** I'm going to take you back to your affidavit, Dr. Gaetz, at paragraph 30, under the heading "Reasons why the shelter system may be incompatible with an unhoused person."

A. Right.

172 **Q.** Now, and you go on in paragraph 30 to identify reasons for not wanting to stay in a shelter and state that "these reasons are usually related to the operational features of shelters."

But you'd agree that these reasons are not only related to the operational features of

shelters, correct?

A. Yeah, I guess so.

173 **Q.** And, again, Dr. Gaetz, not to belabour the point, but you're not a medical doctor, you're not discussing health outcomes in paragraph 30, correct?

A. Just wait a second, let me go back to what I just said, "Yeah, I guess so." I think -- I want to take that back. I would say that there -- this is a complex thing, but most certainly, you know, the, the prac -- I forget what you said, if you were -- scrolled up a bit. You know, the operations of the shelter and the way it's structured is a problem. We just spoke about this earlier, it's a problematic response to homelessness, and then you lay on top the experience of a pandemic. And so with a population that is used to be marginalized, I stand by these statements. And I can't what your last question was.

174 **Q.** Well, I'll restate it for you. The question was: Those operational features are not the only reasons that people may not want to stay in a shelter, correct?

A. There can be other reasons. I think one of the challenges is people not be given options, right, so they do things even though they

would rather not but there's not another option, or they're forced into places, right. Like, I've seen with, you know, encampments being shut down where it's like people are driven to emergency shelter, and they might be like, This is the last place I want to be. So, so it's certainly -- it may not be everything but it's certainly the operations of the shelter are important to consider in terms of the decisions people are going to make.

175 **Q.** And, again, Dr. Gaetz, you're, you're not a medical doctor, you're not discussing health outcomes at paragraph 30 of your affidavit?

A. Okay, the -- I would argue the previous article you showed was, you know, not a -- obviously a sociologist didn't right that either. Right, so medical knowledge can produce some kinds of things. No, I'm not a medical doctor but I'm able to read research and -- and so I, I don't -- I think we get into a trap if we exclude people's opinions if they're not in a particular profession. Because pretty soon --

176 **Q.** Well, Dr. --

A. -- then we can only talk about ourselves.

177 **Q.** Well, Dr. Gaetz, this is a legal

proceeding and there are particular limitations on qualification as an expert witness. You're not a medical doctor, correct?

A. I'm not a medical doctor.

178 **Q.** And at paragraph 30 of your affidavit, you're not discussing health outcomes, correct, you're describing -- and, again, using your words -- "reasons for not wanting to stay in a shelter," correct?

A. That's right, I'm not -- I -- I'd have to read -- or if you scroll through the rest, I didn't mention any of that, health outcomes. I certainly would have in the past with the other articles -- or articles that I've written on, on that.

179 **Q.** Well, I'm going to take you to a few of these subparagraphs of paragraph 30. You state, at the last sentence of subparagraph 1, "Shelter residents are often exposed to racist, homophobic, and transphobic attacks (sometimes physical) by other residents, and in some cases by staff."

You're not aware of whether that's ever happened at a shelter in Hamilton, are you?

A. Well, that's -- that kind of specificity, I don't have in front of me evidence that that's happening but, like, you can, when you take

sociological perspective, generalize and suggest that it's likely that this is going to happen, right, because --

180 **Q.** But --

A. -- because -- wait, just please let me finish. The -- if, if one supposes that these things don't happen, there would have to be evidence from a policy practice accountability perspective that would outline that the staff at this institution are somehow operating in a different way than is the standard, than is the norm in this public institution. So, you know, like, hospitals will have rules about how to treat patients and, you know, don't act in ways that are racist or transphobic or that kind of thing, but we know from evidence that these things still happen in hospitals. So, again, to go back, there's -- we -- the fact that there's nothing special that I've seen that speaks to how in Hamilton people are treated differently within the homelessness sector would lead me to conclude that, yes, these things are happening and probably happening on a daily basis.

181 **Q.** But, Dr. Gaetz, you haven't cited even any sources to say that racist, homophobic, and transphobic attacks happen in shelters anywhere?

A. There's, there's absolutely

evidence of that from other scholars. Dr. Alex Abramovich, who does research on LGBTQS people and the shelter system, would have reams of information to that effect. There would be research on blacks and their experience of shelter. So I have absolute confidence in -- you know, that the evidence speaks to that as an ongoing problem.

182 **Q.** There's evidence that is not referenced in any way in your --

A. It doesn't have to be referenced. So scholars -- you have me here as an expert witness, and my expertise is in the experience of homelessness and the causes of homelessness, and the response to homelessness. And so I'm paying attention to all of that, and so that's my expertise and that counts as evidence.

183 **Q.** Respectfully, Dr. Gaetz, that's up to the hearing judge.

At paragraph 30(2), you identify "risk of criminal victimization" as another reason.

A. Yes.

184 **Q.** But I want to be clear, you don't state here, and in the sources you cite, I reviewed them and I didn't see that they say that the risk of criminal victimization is greater in a shelter than

outside a shelter on the street, correct?

A. It would -- not specifically, but I have conducted extensive research on criminal victimization, and people will speak of the locations where it happens, right. And it does happen -- but it isn't -- I haven't got it like broken out into, you know -- it's a reality of life on the streets. You know, the -- with the research we've done on criminal victimization, we use, you know, the definitions of crime used by Government of Canada and have data that they've collected on criminal victimization and have been able to compare the experiences that people have when they're homeless versus people like us who are not homeless, and they're exponentially more likely to experience criminal victimization. That is likely to happen in multiple contexts. So I would not say it only happens in shelters, I would not say it only happens on the streets but it most certainly happens. And the existence of the shelter and the structure of the shelter is not significant to mitigate against the fact that people experience these things and are fearful when they're forced or only offered the opportunity of shelter in a congregate setting. We're putting people in the situation of potential harm.

185 **Q.** When you say "the existence and

structure of a shelter is not sufficient to mitigate," and I may not be quoting that back to you verbatim, what are you basing that on? You haven't cited any studies or scholarly works about the incidents of criminal victimization in a shelter.

A. No, I haven't done that but, but there's research out there. And the -- when we've talked with people, it happens, they will talk about it being in shelters too. Right, like, think about it, if there's, like, 30 people, as I said before, in a shelter, right, you've got a complex group of people with complex problems, and, you know, which would also be true in encampments, right, and so we know statistically that they're exponentially more likely than people who are housed to be victims of all kinds of crime, from assault to robbery to, you know, to being sexually assaulted, like, across all of these things. And women -- this is the interesting thing in our research, in the general population, men are more likely to report being victims of crime, particularly young men, with our research, it was women who were more likely, right. So, so, yeah, that's -- we can't definitively say that it's either more likely or less likely to happen in the shelter compared to an encampment but we can say, I think with a fair degree

of confidence, that it's going to happen somewhere, and probably in multiple locations. So, you know, with our research, people reported lots of different contexts in which they would experience it. And why I argue that the shelter is part of the problem is because that's what we offer people who are homeless as a response, right. So if you are -- if you've experienced criminal victimization in the past, and all you're offered is that, you may be reluctant to take up that offer, or you're going to put up with it and then be a victim of a crime.

186 **Q.** If I can take you to subparagraph 9 of paragraph 30, you describe "Mental health," and state, "The high frequency of mental illness and cognitive impairment among the homeless population can make it difficult for some people to function in a shelter setting."

Just taking that piece there, Dr. Gaetz, is what you're saying basically that some people are too mentally ill or too cognitively impaired to follow the rules and protocols in place in a shelter setting?

A. It's more complicated than that, because people have many different conditions that can be impairing -- lead to cognitive impairment, right.

And so -- and how it manifests itself will shift and change. But we do know that that is a factor that is important. You know, when we put people in institutional contexts, again, the imagined person isn't somebody with mental illness, it's somebody who will be able to follow rules if they read the policy or whatever, right. And so, you know, the research is pretty clear that there are conditions that people have, including -- you know, Stephen Hwang, who's a medical scholar on homelessness, has done, like, groundbreaking research on incidents of acquired brain injury, and he's done follow-up studies on it for at least the last probably 20 years, right. And we know that acquired brain injury does lead to impairment in decision making, it leads to impulse control, and it leads to early mortality, right. And so a high percentage of the homeless population falls into that category. So we have to assume that that's going to have an outcome -- just that, just that condition is going to have an outcome on how people are able to manage themselves in the context of an emergency shelter.

187 **Q.** Okay. But when you say, Dr. Gaetz, "manage themselves," what do you actually mean there?

A. Okay, I'll put it -- yeah, let me strike that. That people are going to have difficulty following the rules and conditions of the shelter, and may resist and may find it highly uncomfortable. I can't imagine what it would have been like during the pandemic to be in a room with -- as I keep -- I keep going to the 30, you know, people, but be in a shelter with 30 people and, you know, ten of them are coughing, like, and clearly very ill, you know, and regardless of putting the cots 6 feet apart or having a special room where people who are super sick go, that's a, you know, that's a pretty risky proposition in terms of reduction of the spread of disease and would be, like, highly stressful, right. You know, one can recall the first time you saw somebody who wasn't -- you were on a subway or something -- wasn't wearing a mask and was coughing, and how that might just set you back. Can you imagine if you were walking into a homeless shelter where it was even more problematic.

MR. CHOUDHRY: Ms. Shores, if I may, just a logistically issue, it's been two hours now that the witness has been testifying non-stop, I think that's a lot for any person. And I know -- I imagine you have more questions but I thought it would be good to take a break, to let him use the washroom, get a

glass of water. Would that be possible?

MS. SHORES: Off record.

--- Off-the-record discussion.

--- Recess taken at 11:12 a.m.

--- On resuming at 11:18 a.m.

BY MS. SHORES:

188 **Q.** Dr. Gaetz, I'm taking you to subparagraph 10 of paragraph 30 of your affidavit, referring to shelter rules. And we've discussed shelter rules previously before, and I think as an example you sort of drew a comparison between things that housed people experienced. But, you know, I'll put it to you, Dr. Gaetz, that you're describing a lot of what people in general deal with on the day to day, people have to get up and go to work, even with health challenges or disabling conditions, people are expected home at a particular time or if they're getting back late, they're expected to be quiet because other people are trying to sleep. Like, surely you're not saying that people experiencing homelessness shouldn't have to follow rules?

A. Well, I think people understand that there are rules and that there may be consequences, and those can be determined in different ways. But I think that I would be loathed to say that

the comparison with what I have to do and the rules that I have to follow are different. So starting with the safety thing, once again, one of the key things that helps me feel safe is I have a door that's my door that I can close and lock. That's absent when you're homeless. I can follow rules about when to drink. I don't have an addiction. If I did, that might be challenging. But I can choose where to drink. I can drink at home. I can drink in a bar. I can do those things. If you are homeless, you don't necessarily have those options. And so you might wind up drinking in the shelter, because that's where you are. You might have mobility issues. There's all kinds of things. So, you know, I have rules, there are laws. People who experience homelessness generally understand that there are rules. Their ability to follow them may be impaired by their mental health challenges and by their distrust of the institution that they're engaging with. I can't stress enough how much distrust there is. You know, that people -- as I have been saying, we can't compare staying in a shelter with housing, it's not. So people will break rules, they'll break rules inadvertently, but the consequences are different. I've never been kicked out of my house. Lots of people in housing have been kicked out of their house but I

haven't, right. And so I know what rules are but the consequences can be greater, I think, if you're experiencing homelessness, with the challenges that come with complex health and social issues.

189 **Q.** I'm going to take you, Dr. Gaetz, to paragraph 32 of your affidavit.

A. Okay.

190 **Q.** The second paragraph of which you refer to the Street Health Report 2007.

A. Right.

191 **Q.** Which -- and you footnoted it at 30 -- at footnote 39 here. I'm going to take you to that document. So I'm placing this up on the screen, Street Health Report 2007; is that the document you referred to?

A. It is.

192 **Q.** Okay. Now, just in terms of the methodology of the report, I'm taking you to page 9 of the -- or, sorry, 7 of the report, page 9 of the PDF. The first paragraph, it describes that this is a "Street Health survey." And specifically it states, "The Street Health survey was conducted over a three-month period between November 2006 and February 2007. We surveyed a representative sample of 368 homeless adults at meal programs and shelters in

downtown Toronto about their health and access to health care."

So, Dr. Gaetz, based on, based on the report, or what's written in the Street Health survey report, the methodology didn't include verifying the accuracy of the answers given to the survey, correct?

A. Oh, well, I'm not sure how you would do that. I mean, a survey by design is intended to get people's opinions on things. Whether people are telling the truth or not, that's a factor that, you know, goes into doing surveys. I don't, I don't think their methodology is problematic. But if you were to take that point that you have to follow up and ensure that what people said is accurate, you would never get any research done. Like, that's not the standard that's expected in terms of quantitative methodology. There are things you can do with your methodology that, kind of, can help try to identify, you know, to some degree, whether the person is speaking accurately about something by having questions in different parts of the survey that are asking the same thing but using different language, and then you compare. And people sometimes do that kind of thing. I think one of the things that makes this study very -- you know, makes me trust the methodology is, one of the ways to mitigate

against concerns around accuracy is sample size. And 368 is a very large representative sample, which strengthens one -- you know, like, if it was, like, they talked to 32 people, it might still come out with interesting results but I'd have more faith when you have a sample size like that.

193 **Q.** Okay. And this survey in particular is about people's health and their access to health care --

A. Yes.

194 **Q.** -- so just in terms of verifying the accuracy, and this is -- I just want to set some parameters about what the research is and what it isn't. The person responded, for example, that they had a particular condition or diagnosis. According to the methodology, the researchers weren't going to verify that, correct?

A. Well, that's a very -- absolutely, because health care information is private. But I'll give you an example from the At Home/Chez Soi Project, which is the largest study ever done on housing first, anywhere in the world. It was done in Canada in five cities. And Eric Latimer, who is an economist at McGill, was interested in engagement with public services on, you know, health care but also the prison,

law enforcement. And one of the challenges with doing research on health is people's recall, right. So if you were to ask me when -- this is something my wife and I were talking about, like, a couple of weeks ago, she said, "You're due for your check -- physical this year."

And I said, "No, I went last year."

And she was like, "I don't think you did, I think it was two years ago."

And so, so that's a challenge -- that's not about people being deceitful, it's about people being able to time things and place things. And so one of the things Eric Latimer did for his study is he got access to the health records, right. And you have to get permission from the survey respondent and connect with the system, right. And he found that generally what people reported in their recall during the surveys was generally accurate up to about three months, and then it started to fray. So comparing what the person said about, "I went to an emergency room, it was a month ago and for this condition," you can -- it was very -- he was actually surprised at how reliable it was for, like, three months of recall, and then it gets lesser reliable. So, so that's an important consideration. But that's an example that shows that,

you know, in that case with the At Home/Chez Soi Project, which is dealing with the same population basically, people are -- that people's reports are trustworthy. The timing of things, if there are questions about timing, are probably not, but generally people are answering in a way that they believe to be truthful and accurate.

195 **Q.** But, Dr. Gaetz, the specific question about this Street Health survey, you described how the other study, the At Home/Chez Soi Project, included review of medical records, that wasn't a component of the 2007 Street Health survey, correct?

A. I would say that that would be the case of 99 per cent of all health research. Because health research -- and so I would -- you know, this study would be in that same league. I -- what I would be wary of is drawing a conclusion that the data isn't valid, because it's following standard health research practices. It's not an outlier approach that they're taking, it's a standard one. And we don't want to toss out the vast majority of health research because they don't have access to the protected administrative data. That makes for the best research.

And just as an aside going forward, there's more efforts to link administrative data, which

will allow us to do that kind of analysis in a much more accurate way but it's -- given the current situation, this is not a typical way to do health research.

196 **Q.** But, again, Dr. Gaetz, just talking about what the study is and what it isn't, the authors of the 2007 Street Health survey did not verify the accuracy of the answers?

A. They didn't because that's not standard practice in research.

197 **Q.** Dr. Gaetz, in your affidavit, at the second paragraph of page 32, there's a note that if you hover over it, it says, "Gessie Stearns wrote: The resource for the citation: 'Street Health Bulletin 2005' is no longer archived/link broken at the site provided. I have found a newer version of the report, and changed the text and citation."

Do you know who Gessie Stearns is?

A. I actually don't.

198 **Q.** Did Gessie Stearns make changes to your affidavit?

A. I would say I have no way of knowing that because I don't know who that is. I would point out that I didn't hover over that, and so I don't know if a change was made. And I don't -- you know.

There wasn't necessarily -- like, if I'm going to prepare something for this, I don't think that it's -- I'm pretty -- I'm not sure if the rules are that in the preparation of this document I have to not talk to anybody or verify the content. I mean, that's -- as a researcher, that's what I would do generally. It could be -- I'm bad with names though, to be honest, so...

199 **Q.** Well, I suggest to you, Dr. Gaetz, that Gessie Stearns is another witness in this proceeding; do you have any knowledge of that?

A. I, I don't.

200 **Q.** Dr. Gaetz, did you write your affidavit?

A. Yes, I did.

201 **Q.** To your knowledge, had the affidavit been altered before you swore it?

A. Absolutely not. I don't have any knowledge of that.

202 **Q.** Let's go to paragraph 3 [sic] of your affidavit. You again are referring to the Street Health report, and state, "The Street Health Report found 41% of homeless people reported that they were usually in pain, and of that group 46% described it as moderate and 35% as severe (amongst the general population the rates are 8% and 2%)."

Again, the researchers in this study, they weren't diagnosing the pain or the causes of the pain, correct?

A. That's right.

203 **Q.** At paragraph 34, you're speaking of some statistics regarding HIV, AIDS and Hepatitis-C, and specifically regarding the homeless population in Ontario, Toron -- in Toronto. At the last -- second last sentence, you state, "These numbers can be reasonably extrapolated to Hamilton," but you don't state on what basis you conclude that those figures can be extrapolated for Hamilton, correct?

A. Again, it's based on the idea that generally the conditions of homelessness are similar, you can, like, lump them in. Like, Hamilton would be more like Toronto than it would be Regina, because it would have fewer Indigenous people in the sample. But generally the conditions -- you know, like, if, if you have a sample that large, that's pretty convincing, and you could expect similar results in other jurisdictions.

204 **Q.** At paragraph 35 of your affidavit, you describe, "A large portion of people experiencing homelessness have physical, mental, developmental or learning disabilities that impact on mobility,

experience of pain, energy level and/or decision making. In a national survey of homeless service user -- I think maybe you mean users -- "in the United States, 46% reported one or more chronic, debilitating conditions including: arthritis, rheumatism, or joint problems, high blood pressure, and problems walking, a lost limb, or other handicap."

The citation for this is footnote No. 44, which is an article Susan Barrow et al., "Mortality Among Homeless Shelter Residents in New York City," from the American journal of public health in 1999.

A. Right.

205 **Q.** So, Dr. Gaetz, the source that you're citing for this statement is a study not only from the U.S. but from New York City, correct?

A. Right.

206 **Q.** And it's from 25 years ago, 1999?

A. Right. It is -- I would -- oh, okay, I thought you had a question there.

MR. CHOUDHRY: Well --

THE DEPONENT: What I would say, I've been looking at this recently, there is quite a body of research on the relationship -- relationship between homelessness and disabilities, including one that I looked at recently, I think it was the Mental Health

Commission of Canada had done that. So there's a body of research that would -- you know, if I were to do this affidavit again, I would update it with the relevant Canadian data. So there was a time when there wasn't as much research on that but now it's pretty significant body of research. And it would report, again, like multiple kinds of disability, intersecting kinds of disability, these kinds of things. And I can find that research if you need me to do that.

207 **Q.** At paragraph 39 of your affidavit, the third sentence, so continuing on to the next page, you state, "Emerging evidence from San Francisco, Vancouver, and Hamilton suggests that the opioid crisis has a greater impact on the homelessness community, although there is not yet published research to verify these claims." [As read]

And with respect to Hamilton, footnote 57, footnote 57 goes to an article from the Hamilton Spectator, written by Teviah Moro, titled "Opioid Crisis: Life and Death on Hamilton's Streets."

So, in fairness to you, Dr. Gaetz, you do state that there's not yet published research, but your source with respect to Hamilton is a newspaper article, correct?

A. Right. That's right. There's,

there's a lot more research on that now than when I wrote this, including the -- you know, the Province of Ontario has a website that does a deep dive, that you can kind of localize and look at places like Hamilton. So, yeah, so that's the case.

208 **Q.** At paragraph 41 of your affidavit, in the what I'll call the middle paragraph, there's a pull quote here from the source Guirguis-Younger, McNeil & Hwang, the last sentence of that pull quote reads: "Furthermore, researchers have found that homeless persons often feel unwelcome in health settings -- "health care settings due to discrimination and subsequent to these experiences are less likely to seek care."

I want to ask about that. So, your -- the source that you've cited from this passage is the -- so it's footnote 60 for the record. The author is Guirguis-Younger, Hwang & McNeil, "Homelessness and Health in Canada." I think that's chapter 2, page 3. So let's go to that, because I want to talk specifically about discrimination. Give this a moment to load up.

So I've now placed on the screen, "Homelessness and Health in Canada," by Guirguis-Younger, McNeil & Hwang. Scroll down.

University of Ottawa Press 2014. You'll agree that's the document referenced in your affidavit?

A. Yep.

209 **Q.** Okay. So, if we go to page 3, the last sentence of the full paragraph, I think this is the citation you were referring to --

A. Right.

210 **Q.** -- because it's verbatim: "Furthermore, researchers have found that homeless persons often feel unwelcome in health care settings due to discrimination and subsequent to these experiences are less likely to seek care."

So, you said, yes, that's what the citation is referring to?

A. Yes.

211 **Q.** Okay. So the authors of this paper cite, for that statement, "Wen, Hudak and Hwang 2007." So if we go to the end of that section and find Wen, Hudak and Hwang, it appears to be referring to the article authored by Wen, Hudak and Hwang called the "Homeless People's Perceptions of Welcomeness and Unwelcomeness in Healthcare Encounters."

You agree with that?

A. Uh-huh.

212 **Q.** All right. So let's take a look

at the Wen, Hudak and Hwang article. So I've placed up on the screen here a document called the "Homeless People's Perceptions of Welcomeness and Unwelcomeness in Healthcare Encounters." Authors are Wen, Hudak and Hwang. And it's published 2007 Society of General Internal Medicine.

You see that there?

A. Yep.

213 **Q.** Okay. You would agree this is the article cited in "Homelessness and Health in Canada"?

A. Yes.

214 **Q.** Okay. So I want to talk about -- so, again, this is, this is the citation that is relied on for the statement that "homeless persons often feel unwelcome in health care settings due to discrimination."

If we go to page 2 of this study, under the heading "Results" and "Experiences of Unwelcomeness," the authors (Wen, Hudak and Hwang) describe, and I'll read from here -- just bear with me a moment, I've lost my place. Second to last paragraph, in the second column, second sentence, the authors state, "Participants identified various characteristics that accounted for what they believed to be discriminatory treatment, most commonly

homelessness (n=9) and low social class (n=9). Additional reasons, each mentioned once, were drug addiction, mental illness, race and age.

"For many -- the authors continue in the next paragraph -- "perceived discrimination in health care settings was understood as part of a widespread societal pattern of discrimination against homeless persons. Six participants spontaneously related discrimination in health care settings to their general life experiences." And then they go on to give an example from one of the participants.

The question for you, Dr. Hwang, is -- or, sorry, not Dr. Hwang, Dr. Gaetz. I saw the name "Hwang" on my screen and read it.

Dr. Gaetz, the question for you is, this study by Wen, Hudak and Hwang is speaking about perceptions of discrimination in the health care system, correct?

A. Right.

215 **Q.** Okay. So what these authors are describing in Wen, Hudak and Hwang is not instances of verified discrimination but what participants in the survey believed to have been discriminatory treatment, correct?

A. Yes.

216 **Q.** I want to go back to your affidavit. Again, paragraph 41 but the last sentence, you state, "LGBTQ2S youth and women, face special challenges because of their unique status including discrimination, and may experience additional barriers to accessing health services and social supports."

A. Mm-hmm.

217 **Q.** But again, Dr. Hwang -- or, Dr. Gaetz, you haven't cited any research or scholarly works to indicate --

A. Yes --

218 **Q.** -- to what extent discrimination accounts for these barriers, correct?

A. I haven't cited it. But, again, it's not a PhD dissertation. There is a very significant body of research that speaks around the discrimination that LGBTQ2S youth and women face in accessing health, in, you know, even how intakes are done, these kinds of things. And so there is an evidence base there for that, for sure.

The thing about people's recall is that, you know, methodologically, if you were to go and review and talk to the hospital staff, you may not get any closer to knowing that -- or being able to verify that that happened the way it did. But there are other

manifestations of it that are worth noting. And this is from Stephen Hwang's research too, that people who experience homelessness often are more likely -- use health care services more than people who aren't, but most of it is through emergency room, that's their gateway to the health care system. So that's an access question that raises questions about discrimination. You know, that if I had to -- and this is an issue we hear about in Ontario, but people experiencing homelessness generally don't have a family doctor, lots of other Ontarians don't. Sometimes their experience of the emergency room is traumatic, in that they have been taken there by paramedics because of suicidal ideation and they may be roughed up and, you know, treated in ways that are harmful. I've seen with my own eyes when I worked at Shout Clinic, when they come in -- this is not knocking the service providers, but if a person resists when they're being what's called "formed," which is sent for a mental health assessment, people often resist, right, and it's an unpleasant experience which then can be generalized to experience in the health care system, you know, writ large. And so I say that to just suggest that that feeling of discrimination and not accessing the supports you need is a complex one but can't be reduced down to, like,

you know, he said, she said, you know, they're just making a subjective claim, I think we have to -- when people who are marginalized are complaining about discrimination and access to health, we need the best research possible but I think we have to take seriously those claims in that it's highly unlikely that hospitals or the police department or schools proactively ensure that clients or students or people being -- engaging in the police are protected against discrimination based on these things that are broadly happening in society, right. So I think we would be more surprised if people said there was no discrimination. So I trust what people said.

MS. SHORES: So, we'll mark the Wen, Hudak and Hwang article as Exhibit 7 to Dr. Gaetz's examination.

COURT REPORTER: Sorry, it's just the court reporter, I think it's Exhibit 6.

MS. SHORES: Exhibit 6, I think, was the COVID-19 study.

COURT REPORTER: Okay. Maybe -- I'll have to check with the transcript but maybe it wasn't identified on the record as Exhibit 6.

MS. SHORES: Oh, okay. I have -- apologies, Dr. Gaetz. I have Exhibit 1 is the CV,

Exhibit 2 is Form 53, Exhibit 3 is the Everyone Counts document, Exhibit 4 is shelter standards, Exhibit 5 is service restriction policy, Exhibit 6 is COVID-19 study, and then Exhibit 7, Wen, Hudak and Hwang.

COURT REPORTER: Thank you.

MS. SHORES: Hopefully that's correct.

EXHIBIT NO. 7: Article titled "Homeless People's Perceptions of Welcomeness and Unwelcomeness in Healthcare Encounters," authored by Chuck K. Wen, Pamela L. Hudak, and Stephen W. Hwang.

BY MS. SHORES:

219 **Q.** Okay. Let's move on to paragraph 43. So, Dr. Gaetz, at paragraph 43, you're describing the VI-SPDAT. And in the last sentence of paragraph 43 you state, "The stakes are very high for VI-SPDAT - the score and ranking can determine whether and when an individual will receive the housing and supports needed to exit homelessness."

Dr. Gaetz, you're not familiar with how or to what extent the VI-SPDAT is used to determine access to housing and supports in the City of --

A. I have --

220 **Q.** -- Hamilton?

A. -- actually a lot of experience on this issue. It's government --

MR. CHOUDHRY: Dr. Gaetz, I'm sorry -- Dr. Gaetz, I'm sorry, I don't think you let Ms. Shores complete her question.

THE DEPONENT: Oh, sorry.

MR. CHOUDHRY: Could I please, could I please ask that you just give her a pause before you --

THE DEPONENT: Okay.

MR. CHOUDHRY: Okay.

THE DEPONENT: Okay.

BY MS. SHORES:

221 **Q.** So, yes, Dr. Gaetz, the question was with respect to how it's used with respect to housing and supports in the City of Hamilton.

A. Yes, I can speak to that.

222 **Q.** And what is your knowledge about how the VI-SPDAT is used with respect to housing and supports in the City of Hamilton?

A. The VI-SPDAT was invented as an assessment tool and process to help determine who should be prioritised to receive housing first. And since that time, it has been expanded to be used in the homelessness service context to assess people for access to a whole bunch of things. And Government of Canada requires, for instance, that in any community that receives federal dollars, people need -- for their

housing first programs, they need to use the VI-SPDAT, which -- which leads me to believe that in Hamilton it's likely used in ways similar to everywhere else across the country, it's used very broadly and is, unfortunately, a pseudoscientific approach to assessment that doesn't follow any of the rules around how assessments should work, but it's still broadly used. And that's a whole other story.

223 **Q.** Broadly used and, as you identified, required by the Government of Canada as a condition of funding?

A. Well, they require that an assessment -- a common assessment tool is used. They don't specify which one. But the marketing of this is, like, off the charts. And so that's the most commonly used assessment to support housing placement in Canada by far, in spite of research that's emerged that shows that it's not effective as an assessment tool and that it also, you know, bears the existence of systemic racism in how it works. So it continues to be used partly because there hasn't been something that's emerged in its place, but it's not a scientific tool by any means.

224 **Q.** And, Dr. Gaetz, you're not saying, or at least I don't take you to say that you believe

that in the City of Hamilton the VI-SPDAT is used to determine whether people receive housing or supports needed to exit homelessness, correct?

A. It's more complicated than that, in that people are advised to use it as -- to contribute to decision making. And -- but what can happen is it leads to rankings -- so it produces a numerical result, right. So if you're -- with cutoffs, right. So, like, if you get a score of 52, you're eligible for housing first. If you get a score below 52, you're on the wait list and could be there until you -- until you're sick enough and homeless enough to get the service. And so it's likely used in ways similar there as elsewhere. In some cases, people use it as one factor in making determination. In other cases, they have a list and they rank people and it's just like, you know, Blare is number seven on the list, they get the next access. So it's not used with precision. It's not measuring what it pretends to. So it's used as something that I find -- again, with my focus on responding to homelessness, I find it troubling that it's used at all and continues to be used.

225 **Q.** At subparagraph 3 of paragraph 45, one of your comments is that, "The VI-SPDAT doesn't

produce consistent results."

The VI-SPDAT is basically a questionnaire, correct?

A. That's right.

226 **Q.** Okay. And so one of these inconsistencies can be that people can retake it, answer differently and get a higher score?

A. Mm-hmm. That's exactly right. And, you know, one of the things that happen is people learn to game it, right. That they talk to each other, and it's like, you know, if you say that you have an addiction problem, you'll get a higher score, right. So the longer people experience homelessness, the more they'll learn about how to use that tool to access different kinds of supports.

227 **Q.** I'm going to take you, Dr. Gaetz, to paragraph 49 of your affidavit, under the heading "The structure and organization of homeless encampments." And one example you give, about half way through the paragraph, is -- I'm sorry, the second sentence of the paragraph, "Some encampments have a strong social structure and organization, sometimes with oversight or assistance from local charitable or faith-based organizations. Residents may be required to assume for day-to-day operations, including security

patrols and other duties."

I think there might be a typo?

A. Yeah, there's a word missing.

228 **Q.** Assume responsibility for?

A. Yeah. Yeah.

229 **Q.** Okay. And, again, Dr. Gaetz, so this -- there's a footnote here, footnote 73. Footnote 73 goes down to an article by Herring and Lutz, "The Roots of Implication -- "Roots and Implications of the USA's Homeless Tent Cities."

And then another article, Tony Sparks, is "Citizens Without Property: Informality and Political Agency in a Seattle, Washington Homeless Encampment."

So these two examples are from the U.S., correct?

A. Mm-hmm.

230 **Q.** You have to say yes or no.

A. Oh, yes. Yeah, sorry.

231 **Q.** And, again, Dr. Gaetz, you haven't investigated in the City of Hamilton whether there are -- whether the -- whether there are encampments with this social structure and organization with people assuming roles for day-to-day operations, correct?

A. You're correct, I haven't done

research on that end, and don't know the details to be able to make a claim.

232 **Q.** But you would agree with me that, referring back to some of the evidence that you've given before about people being too impaired by their mental challenges to follow rules in a shelter setting, those same people are probably also not going to be able to assume responsibility for things like security patrol and other duties, correct?

A. I can't speak to that with certainty because there's a difference between being in a institutional context that is structured and rule-bound and being in another context where you have more say and potentially the -- you're feeling more respected. Now I, I can't say for certain that that's the case, because I haven't done research on that, but I do think that different contexts produce different kinds of action and behaviour. If people are in an environment where they see it as an institutional setting, they may behave differently, may be able -- like, just because someone has mental health problems doesn't mean that they're always going to have problematic encounters with other people, that kind of thing. So -- and -- so -- but the answer to your question is, I don't -- I can't speak to the situation

in Hamilton in that regard.

233 **Q.** And at the third sentence, in paragraph 49, again, you describe, as an example, that residents in some of these encampments, the ones that you're referring to in your example, "may vote in governance decisions, they may be expected to attend weekly resident meetings in accordance with an encampment-wide code of conduct."

So, again, Dr. Gaetz, you'd agree that not everybody is going to be able to abide by an encampment-wide code of conduct?

A. I would say that, but I think, you know, one could say that about any context in any group of people. I do think that there's -- like, the key difference for me is that shelters are, again, an institutional response to homelessness. And it could be that in context where people feel more like, Oh, I have my own room, which may be a tent, but it's a -- you know, it's my own place, there are other people like me, it may produce different ways of engagement, right. Because it's about -- a lot of it's about -- comes down to trust, right. And, like, what -- if you don't trust an institution, you're -- I'm guessing you're probably less likely to go along with how they want to run things. If you have a greater level of

trust, because people are making personal choices, right, in terms of having a tent or not, it may produce a different kind of outcome in terms of collaboration. So, so -- and this may be answered in research.

Eric Weissman is a scholar at University of New Brunswick who has done a lot of research on encampments and what he calls intentional communities, right, where people set out in a very deliberate and organized way to either have, like, a, you know, an encampment or, like, tiny homes placed together, and then people kind of work to develop collaborative approach -- it doesn't solve everything. I don't think his research suggests that it's magic, but I think the feeling is that it's preferable for a lot of people, not everyone obviously, but preferable than being in an emergency shelter.

234 **Q.** In the last sentence of paragraph 49 you state, "However, the potential for exploitation exists in encampments."

A. Yes.

235 **Q.** And, Dr. Gaetz, you'd also agree that the potential for violence exists in encampments?

A. It does. These things also happen in emergency shelters as well. And the -- my

understanding of encampments is the characteristics of each individual ca -- you know, there's commonalities but there are differences, as well. One of the things I've seen in the data on encampment is that young people are less likely to be in them, which kind of surprised me. And that may due -- I don't know what that's due to but it could be for lots of different reasons.

236 **Q.** You would agree, as well, that there's a potential for a theft to happen in encampments?

A. Yes.

237 **Q.** There's a potential for assaults to happen in encampments?

A. Yes.

238 **Q.** And there's potential for drug use to occur in encampments?

A. Yes. And bear in mind that not all drug use is illegal. But the -- those kind of questions are tricky because you could be describing riding on the subway, and that these things could happen, right. And so I guess the, the challenge would be discerning is it the context that's producing these, is it the characteristics of the population who's living in these places that produce the risk, what

exactly contributes to it.

239 **Q.** I'm going to take you, Dr. Gaetz, to paragraph 53 of your affidavit, which is the second paragraph under the heading "The benefits of an encampment for people experiencing homelessness." And at paragraph 53, you state, "In other communities -- and, sorry, three sentences in to paragraph 53: "In other communities, shelter beds are available but go unused because of regulations or conditions that are incompatible with potential clients' expectations or needs."

So, in other words, people choose not to stay in shelter for these reasons, correct?

A. Yes, people make choices, right. And there will be people who do not want to be in an emergency shelter, and we've discussed some of the reasons why that might be.

240 **Q.** And in paragraph 53, you go on to list in Exhibit 2 -- click back over. "Exhibit 2 lists some of the reasons cited in the literature and in key informant interviews why people experiencing homelessness may eschew shelters in favor of encampments."

And then Exhibit 2 is reproduced below. The citation for that is Cohen, Yetvin, and Khadduri,

"'Understanding Encampments of People,' page 4." [As read]

So I want to take you to that.

A. Okay.

241 **Q.** So I've placed up on the screen a document, "Understanding Encampments of People Experiencing Homelessness and Community Responses, Emerging Evidence as of Late 2018." Author is Rebecca Cohen, Will Yetvin, and Jill Khadduri.

This is the document cited in your affidavit?

A. Yes.

MS. SHORES: So we'll -- before I forget with the exhibits, we'll mark that as Exhibit 8.

EXHIBIT NO. 8: Document titled "Understanding Encampments of People Experiencing Homelessness and Community Responses, Emerging Evidence as of Late 2018," authors Rebecca Cohen, Will Yetvin, and Jill Khadduri.

BY MS. SHORES:

242 **Q.** And if we go to page 4, page 4 of the actual report, I think we find the source for the quotes in your affidavit. So, the authors state here, "Exhibit 2 lists some of the reasons cited in the literature and in key informant interviews why people

experiencing homelessness may eschew shelters in favor of encampments."

And then continuing on to page 5, it looks like Exhibit 2 is the Exhibit 2 that's reproduced in your affidavit, correct?

A. Yeah, I believe so. Yes.

243 **Q.** So, if we go back up to the top of page 4, just to set the context for Exhibit 2 and the authors' comments, under the heading "Understanding Encampments," the authors state, "This section describes what we know as of late 2018 about encampments: Why there has been a sudden increase in encampment homelessness in the past few years and how encampments vary in resident characteristics, in social structure, and regionally. As discussed herein, conditions can be harsh, volatile, and unhealthy. Still, people may live in encampments (rather than shelters or in other unsheltered locations) for a variety of reasons, including factors that lead them to reject other types of shelter and factors that attract them to encampments. Section 3 will cover what we know about emerging community responses to encampments."

So, according -- if I understand this correctly, according to this, the authors are discussing here why people choose to live in

encampments, correct?

A. That's right.

244 **Q.** Okay. They're not making a qualitative assessment of whether encampments are better objectively than shelter, correct?

A. Yes, I don't think that's what they're doing.

245 **Q.** And taking you back to your affidavit, there's some further discussion of this source in particular. So at paragraph 52, you say, "There are three main reasons why people experiencing homelessness may choose encampments over other alternatives such as homeless shelters."

So at paragraph 53, you discuss, "Homeless shelters do not meet people's needs."

Paragraph 54, "Encampments provide a sense of safety and community."

Paragraph 55, "Encampments accommodate the desire for autonomy and privacy."

And if we go back over to the source document, the Cohen and Yetvin, these -- those subheadings, I'll call them, are in the document. So, "The shelter system falls short," on page 4; "Sense of Safety and Community," on page 5; and "Desire for Autonomy and Privacy," on page 5, as well.

A. Mm-hmm.

246 **Q.** I wanted to take you to the next subheading on page 6 though, which I didn't see discussed in your affidavit. So at page 6, the authors state, under a subheading "Access to Illegal Substances: Residents of encampments may or may not be using illegal substances. Nothing in the literature suggests that most or even many encampments are where people congregate primarily to support their drug addiction. That said, in at least one high-profile example, the location of an open-air drug market directly influenced the formation and continued existence of an encampment, according to a key informant studying encampments. In that instance, the availability of a dependable supply of heroin close-by led addicts to stay in encampments in the Kensington area of Philadelphia even though the city had available shelter space."

You didn't include that as a potential reason that people choose to live in encampments, did you?

A. No, I didn't. And I think because it's -- it simplifies our understanding of addictions and what people do and why. And so it's possible that people are using encampments that way, but I would have

to say, you know, we know people in prison can access drugs, people in shelters can as well. So there may be cases of that but I, I worry when those kind of things are presented as a reason, because then it leads us to go to the place of blaming the victim. There's so much stigma around use of illegal substance and substance-use disorders, historically those roots run deep, and I'm not sure we have -- maybe we do -- I'm not sure that the use of substances is greater amongst -- in fact, I think they didn't have evidence of it either -- is greater amongst people who are in shelters versus in encampments. It could be true, I don't know. But I think that with the lack of -- yeah, I'd want to see what more research has to say about it before I would consider that important.

247 **Q.** I'm going to take you back to your affidavit, Dr. Gaetz, at paragraph 56. So, at the last sentence of the first paragraph of paragraph 56, you state, with respect to people in homeless encampments, "Their poverty gets framed as a nuisance and disorder, resulting in the use of law enforcement to address a social and economic problem."

I want to talk with you more about what you mean by poverty getting framed as nuisance and disorder. Are --

A. Okay.

248 **Q.** Well, perhaps you can explain --

A. Yeah, I can explain that. I think that there is a history of demonizing people who experience homelessness. There's a whole theoretical argument around folk devils and moral panics, and how as society we claim outsider groups as being problematic and requiring a solution. And historically in Ontario, this has been the case. Modern mass homelessness is relatively recent phenomena, it started in the late '80s, early '90s. Prior to that, there were people experiencing homelessness but there was no homelessness problem. By the mid-1990s, it was a big problem in cities from Hamilton to Calgary, and it was a visible problem, right. So what happened at a policy level is that municipalities and the province decided that panhandling and squeegeeing was a sign of moral disorder. People were saying I'm afraid to go downtown now because I see homeless people, whereas if they hadn't, like, five years ago. People used to say things like, Oh, you know, I live in Buffalo and I'm afraid to go to Toronto to shop because they have homeless people, which I'm wondering, like, what was Buffalo like, that kind of thing. So I did a lot of research at that time around that, and that led to the

Safe Streets Act, which was a provincial legislation that basically meant to criminalize the money-making activities of people experiencing homelessness with very loose language like "people who are panhan -- and it's coming up now with the safe injection sites -- "people who are panhandling or squeegeeing near an intersection, a bank, near a bank entrance, or anywhere where the public frequents," this is the language in the original legislation, "anywhere the public frequents must be, you know, addressed with a penalty, a financial penalty," which is against the Criminal Code, by the way. And so that got passed. And in that time, the percentage of -- you know, the following ten years, we have data on this, the percentage of people panhandling and squeegeeing continued to drop but the number of tickets continued to rise. So it was used as a way of harassing people, getting them out of the way. We want to render homelessness invisible. One can argue that part of the goal of the shelter system is to render it invisible. And so my thinking around encampments is it's a return to the visibility of a problem, that people may be fearful of, that may respond to in all kinds of ways, people don't like it. And if I can quote the opening -- Jim Flaherty wrote the legislation for the Province of Ontario in the Safe

Streets Act, so I'm going to paraphrase what he said. He said, When people no longer feel safe to drive their cars or walk down the streets, it's time for government to act. And on surface level that sounds like it makes sense. But what it's really saying and raising the question is, if I'm afraid to go down the street because I know there's a homeless person there, if I'm afraid of somebody because of the colour of their skin or the clothes they wear, it's incumbent upon the government to do something about my fears, which is not true, right. If we went down that road, as a society, you could imagine how chaotic it would be. So I'm raising that as a question then around encampments. You know, like, I think -- I'm not going to weigh in -- I'm not going to say encampments are lovely things or that they're a real solution to homelessness, but I do think their visibility rattles people and may have consequences that are -- people are justifiably annoyed by, but, to me, it raises the question here we are in 2024, almost September, I can't believe it, but we're still focussing on responding to homelessness in the wrong way. And, and so will the visibility that's provided by encampments contribute to people thinking about homelessness more, I'm not sure that's true. But I would, I would say that that part of the response is

the public doesn't want to see these things and public is afraid of -- many people are afraid of low-income people, many people are afraid of people who are black, many are afraid of people who are homeless. Many people who are homeless are in distress. And I've talked with Sean Kidd, who's a clinical psychologist, and I said, "It seems like there's more of that in Toronto now than there used to be."

And he said, "Absolutely, because of our failure to support these people, right."

So just as -- sum it up, I think, you know, the encampments make people uncomfortable. All of this though, including my critique of the shelters, is like why don't we do something about it that houses people.

249 **Q.** So, Dr. Gaetz, you said a few things there that I would like to take you through. So first you reference the Safe Streets Act. So may I presume that when you're talking about poverty getting framed as nuisance and disorder, you're not talking about things that are actual criminal offences like theft or assault, correct?

A. That's right.

250 **Q.** And you also referred to consequences that I think you said -- and, again, this

may not be verbatim -- "consequences of encampments that people are justifiably annoyed by," and I want to engage with you on that a little bit further. Because I'll put it to you, Dr. Gaetz, that it's not the only reason that some people may fear homelessness or encampments, is only that they're uncomfortable with the visibility of poverty, but people also fear that they might be attacked by someone who is exhibiting unpredictable behaviour or they might be injured by encountering discarded drug paraphernalia; you'll agree that those are justified, wouldn't you?

A. Yeah, and those would exist whether there were encampments or not, those fears.

251 **Q.** I want to take you to the second paragraph of paragraph 56 of your affidavit, which appears to be another quote. In the middle, the authors of the quote state, "Despite the fact that people experiencing homelessness are no more likely to break the law, except for laws that punish people for living outdoors, community opposition to encampments is often based in fears of increasing crime rates and jeopardizing public health and safety."

That sentence in particular I'd like to ask you about. So the footnote goes to footnote 83, an article by Olson and Pauly, "Homeless Encampments:

Connecting Public Health and Human Rights."

So I want to take you to that. And in particular, once this loads up, Dr. Gaetz, I'd like to explore with you the source for the statement that "people experiencing homelessness are no more likely to break the law, except for laws that punish people for living outdoors."

So the citation in your affidavit, Dr. Gaetz, is page 989. So let's take you to the document. Placed up on the screen here, Olson and Pauly, "Homeless encampments: connecting public health and human rights," from the Canadian Journal of Public Health (2021).

You'll agree this is a document cited in your affidavit?

A. Yes.

MS. SHORES: Okay. So we're going to mark this as Exhibit 9.

EXHIBIT NO. 9: Document titled "Homeless encampments: connecting public health and human rights," from the Canadian Journal of Public Health (2021), authored by Nicholas Olson and Bernadette Pauly.

BY MS. SHORES:

252 **Q.** And if we go to page 989 of the

document, so at the upper right-hand corner it says, "989." And I believe the quote from your affidavit is from the second paragraph in the second column under the heading "Dominant discourses surrounding encampments," in the middle of that paragraph, "Despite the fact that people experiencing homelessness are no more likely to break the law, except for laws that punish people for living outdoors."

And then the authors give a parenthetical citation to Rankin, 2019; do you see that?

A. Right, I do.

253 **Q.** Okay. So I want to explore the source for this, as I said. So let's go to Rankin (2019). If we go to the references section of this article, Rankin (2019) is an article called "Punishing homelessness," in the New Criminal Law Review.

A. Right.

254 **Q.** So I'd like to take you to that. So, again, this is on the question of the source for the statement that "people experiencing homelessness are no more likely to break the law, except for laws that punish people living outdoors." So in Rankin -- well, first, let's establish this, sorry.

So, this is a document called

"Punishing Homelessness," by Sara K. Rankin. And at the very bottom of the first page, it says it's in the New Criminal Law Review, copyright 2019. So this is the article cited in the Olson article?

A. Yes.

255 **Q.** Okay. So if we go to -- I believe I found the location where this citation comes from in the Olson article, and I'll take you there, it's on page 29, but I'm going to take you to page 3 of the PDF first. The last sentence here, on page 3, says, "Approximately 25-50 percent of the general homeless population has a criminal history," and it goes down to footnote 13.

A. Okay.

256 **Q.** And, "Oftentimes sparked -- I'll just continue the sentence here, "Oftentimes sparked by arrests for non-violent offenses associated with homelessness, such as camping or begging."

One thing that jumped out at me about this statement is the author, Rankin, doesn't say that this criminal history is only sparked by arrests for non-violent offences associated with homelessness, correct?

A. Yep.

257 **Q.** And the author doesn't state what

percentage of the general population overall has a criminal history but I think it's safe to say it's probably less than 25 to 50 per cent?

A. I would -- yeah, I would say that.

258 **Q.** So I said I'd take you to the -- what I think is the actual citation from the Olson article, so I'll take you there now. So I'm at page 29 of the PDF, page 127 of the actual journal. And the author here states, in the second sentence of the second paragraph, "But a person who is homeless is no more likely to be a criminal than a housed person, with one legal exception: Camping ordinances."

So that looks like that's the source of that statement in the Olson article.

A. Right.

259 **Q.** Now, I want to go into the source that Rankin cites for that statement, so she cites footnote 160, which refers back to note 44, so let's go there. So footnote 44 -- and, sorry, she said it was the Olson and MacDonald from footnote 44. So, Justin Olson and Scott MacDonald, Seattle University Homeless Rights Advocacy Project, Washington's War on the Visibly Poor: A Survey of Criminalizing Ordinances & Their Enforcement.

So I want to take you to that paper.

So, again, we're still trying to track down the source for the statement that "people experiencing homelessness are no more likely to break the law, except for laws that punish people for living outdoors." So I'm placing another document on the screen. And before I get too far, let's mark these as exhibits. So we've got Exhibit 10 will be the Rankin article.

EXHIBIT NO. 10: Rankin (2019), article called "Punishing Homelessness," in the New Criminal Law Review.

BY MS. SHORES:

260 **Q.** And now I'm going to put before you the Seattle University School of Law article, "Washington's War on the Visibly Poor: A Survey of Criminalizing Ordinances & Their Enforcement," authors Olson and MacDonald, the Seattle University School of Law. And at the bottom, it says, "Seattle University School of Law Legal Paper Series # 15-19, Published by the SU Homeless Rights Advocacy Project."

So, you'd agree this is the source cited in Rankin at footnote 44, Olson and Scott [sic]?

A. Yes, it seems to be. This is quite an adventure.

261 **Q.** It is quite an adventure. Have

you reviewed this paper before?

A. No, I haven't. Not that I recall. But as I said earlier, I'm not good with names.

262 **Q.** Okay. Well, let's go to -- let's continue our journey and see if we can find where this source comes from. Now, this paper says -- again, it's from the Seattle University Homeless Rights Advocacy Project. This doesn't appear to be a peer-reviewed journal, does it?

A. I'm not familiar with the journal, but it's -- I have no way of knowing.

263 **Q.** And in fairness, I don't even know if it is a journal, it just says it's part of the Legal Paper Series, correct?

A. Ah, right. Yeah, that's right.

264 **Q.** So we don't, we don't even know if it is peer reviewed?

A. Often paper series are prepublication efforts, right. So people are testing out ideas and that kind of thing. So this likely would fit in that context. It's not a scholarly journal submission.

265 **Q.** All right. So, I'm going to take you to the Executive Summary here, because when I looked at this page -- this paper, I confess, I wasn't

able to find anything in it discussing criminality or lack thereof of people experiencing homelessness. So if we go to the Executive Summary, it states, "Throughout the country, there are laws punishing behaviors that are necessary for survival. For those without shelter, there is no alternative but to conduct these behaviors in public. Camping outdoors, urinating in public, sitting or lying down on sidewalks - these laws target homeless people either in practice or outright. But until now, no one knew how widespread these laws are throughout Washington, or how they are being enforced. This brief answers these questions."

So, I'll suggest to you, Dr. Gaetz, that this paper is looking at enforcement of laws in Washington State but it's not considering rights of criminal behaviour, or lack thereof, among the homeless population in general, correct?

A. Yes, it's focussing on what we call the "criminalization of homelessness," which is either the creation of new laws and ordinances that target the activities of people experiencing homelessness or the disproportionate use of existing laws to harass and target people experiencing homelessness. And so they're trying to get at, like, the examples of laws in Washington but putting it in

the broader context of the United States.

MS. SHORES: So, I'm going to mark this as Exhibit 11.

EXHIBIT NO. 11: Seattle University School of Law Legal Paper Series # 15-19, published by the Seattle University Homeless Rights Advocacy Project, titled "Washington's War on the Visibly Poor: A Survey of Criminalizing Ordinances & Their Enforcement," authored by Justin Olson and Scott MacDonald.

BY MS. SHORES:

266 **Q.** But we're still on a quest to find out the primary source for the statement that people experiencing homelessness are no more likely to engage in criminal behaviour, except for ordinances that penalize homelessness. So I'm going to take you back to Rankin, the Rankin article of 2019, so that's Exhibit 10, because Rankin does go on to elaborate on her point. So after paragraph 160, she goes on and says, "People who are homeless break that law by being homeless. Criminal records for homeless single adults are overwhelmingly due to misdemeanour offenses related to living outdoors, such as trespass."

A. Yep.

267 **Q.** I'm going to come back to that.

The next sentence she states is, "A person who is homeless is no more likely to perpetrate a violent crime than a housed person." And she cites footnote 162.

So, again, we're still trying to figure out, again, the source for the statement that "people experiencing homelessness are no more likely to break the law, except for laws that punish people living outdoors."

So let's go to footnote 162, "Myths and Facts of Homelessness in Washington State: Building a New Public Narrative to Combat Criminalization and Advance Real Solutions."

I'm going to pull this up here.

MR. CHOUDHRY: Ms. Shores?

MS. SHORES: Yes.

MR. CHOUDHRY: I just wanted to ask, I know that this -- you have quite a lot of detail question here, I'm also looking at the time, it's 12:30 --

MS. SHORES: Would you like to take a break?

MR. CHOUDHRY: -- I think we've been on this particular auricle for about 15 minutes, or these series of articles for at least 15 minutes if not 20

minutes. And I'm wanting to ask, I think we should give the witness a break. I think he needs -- it's 12:30, I think he should be able to actually eat a little bit of food, because he's been at this since nine o'clock and I think it's only reasonable.

And I also need to ask you, and I know that you can't control how the witness responds to your questions and where things go but I have a sense of -- can we have a sense of how long you intend to spend with this witness, because we're now -- I know that these tend to go longer than we have all planned, but this has gone quite a bit longer and I just want to make sure that Dr. Gaetz is still available.

MS. SHORES: I think the transcript will reflect why this examination has gone on longer than anticipated. I have a few more, a few more questions on this particular topic, and then a few more questions after that.

MR. CHOUDHRY: So can you give us a sense of how long you're going to be?

MS. SHORES: I can't, because, again, I'm only half of the equation.

MR. CHOUDHRY: Yeah, I get it. But, you know, because I -- I just want to make sure, Dr. Gaetz, are you still available, sir? I know that we --

this is well past the time that we thought you would be here.

THE DEPONENT: Well, I've -- you know, there's already one appointment that I've missed. I wouldn't want to be going too much longer. I'll try to be crisper in my responses.

MR. CHOUDHRY: Well, could we give you ten minutes to get a bit of food, a bit of water, just because it's been going for quite a while?

THE DEPONENT: Okay.

MS. SHORES: I'm quite happy taking a break.

MR. CHOUDHRY: Thank you.

MS. SHORES: All right. Off record.

--- Recess taken at 12:30 p.m.

--- On resuming at 12:36 p.m.

BY MS. SHORES:

268 **Q.** So, before we took our break, Dr. Gaetz, I was asking you about the footnote 162 to Rankin (2019), which is cited as the source for the statement, "A person who is homeless is no more likely to perpetrate a violent crime than a housed person." So that source goes to, again, "Myths and Facts of Homelessness in Washington State: Building a New Public Narrative to Combat Criminalization and Advance

Real Solutions." So that actually goes to a hyperlink. I've downloaded the article but I want to click on the hyperlink. And we can actually see it open up here. So this is, I've pulled up now, a fact sheet called "Myths and Facts of Homelessness in Washington State"; do you see that?

A. Mm-hmm.

269 **Q.** Yes?

A. Yes, I see that.

270 **Q.** Okay. Now, according to the end of this fact sheet, it states, "Content was adapted from the Interfaith Task Force on Homelessness. This factsheet is part of an Advocacy Toolkit to Combat the Criminalization of Homelessness by the Washington Low Income Housing Alliance."

So, again, the source for the statement in Rankin is a fact sheet, correct?

A. I guess so, yes.

271 **Q.** Now if we go back up to page 2 of the fact sheet, it states, "MYTH: People who are homeless are violent, dangerous, and/or are lawbreakers.

"FACT: While a larger number of people experiencing homelessness have substance abuse disorders than the general population, a person who is

homeless is no more likely to be a criminal than a housed person, with one legal exception: camping ordinances."

A. Okay.

272 **Q.** So, that's almost verbatim -- I'm messing up my windows here. That's almost verbatim, Dr. Gaetz, here to what Rankin has written on, again, page 29 of the PDF, page 127 of the article --

A. Right.

273 **Q.** -- "A person who is homeless is no more likely to be criminal than a housed person, with one legal exception: camping ordinances."

So, you'd agree with me, Dr. Gaetz, that it appears that the source for this statement in the Rankin article, which is in turn cited in Olson, which is in turn cited in your affidavit, appears to be this fact sheet, which is not a journal article, is not peer reviewed, and is not sourced, correct?

A. It appears that that's so, yes.

274 **Q.** Now let's go back to the Rankin article, because I said I would come back to footnote 161 and the sentence that precedes it. Rankin states, "People who are homeless break that law by being homeless. Criminal records for homeless single adults are overwhelmingly due to misdemeanor offenses related

to living outdoors, such as trespass."

And, again, this does seem to inform the general sentiment, so I want to explore this. Footnote 161 refers to the article by Fischer at note 13, specifically at page 251. And for the record, I'll read the narrative at footnote 161, it says, "Social science studies have found that individuals experiencing homelessness are at risk for engaging in non-violent criminal activity, and that 'homeless jail inmates were more likely to have been arrested for nuisance offenses (e.g., camping without a permit, indecent exposure) than domiciled inmates.'"

So, let's just pause there, because, again, the author is stating, "Criminal records for homeless single adults are overwhelmingly due to misdemeanor offenses related to living outdoors," but, again, they're not stating it's only for offences relating to living outdoors, correct?

A. That's right.

275 **Q.** So let's go to footnote 13. So, footnote 13 has several articles, but the Fischer article in particular that was cited goes on to the next page. So we've got Sean N. Fischer et al, "Homelessness, Mental Illness, and Criminal Activity: Examining Patterns Over Time," the American Journal

of -- not sure what that abbreviation is, so we'll let it load up. Ah, the American Journal of Community Psychology (2008). So, pulled this article up.

Now, before I move on, I'm going to mark the fact sheet as Exhibit 12.

EXHIBIT NO. 12: Fact sheet titled "Myths and Facts of Homelessness in Washington State: Building a New Public Narrative to Combat Criminalization and Advance Real Solutions."

MS. SHORES: And this article here, "Homelessness, Mental Illness, and Criminal Activity: Examining Patterns Over Time, by Sean N. Fischer et al, American Journal of Community Psychology (2008).

So, again, you'll agree that's the article cited in footnote 15 -- or 13, rather, in Rankin? Yes?

A. Oh, yes, I agree.

MS. SHORES: Okay. So we'll mark that as Exhibit 13.

EXHIBIT NO. 13: Article titled "Homelessness, Mental Illness, and Criminal Activity: Examining Patterns Over Time," by Sean N. Fischer et al, American Journal of Community Psychology (2008).

BY MS. SHORES:

276 **Q.** Now, this article, according to

its title, examines homelessness, mental illness and criminal activity. So, there's a few passages here that I want to take you to. The first one is on the first page under the heading "Non-Violent Criminal Activity." And the authors state -- and, again, this appears to have been what was quoted in Rankin -- "Previous studies have found that homeless individuals are at risk for engaging in non-violent criminal activity."

So, again, the authors here aren't saying that these are only for offences relating to existing homeless, correct?

A. Correct.

277 **Q.** Now I want to go to the findings of this article, which we'll find on page 262 of the journal, page 12 of the PDF, the very first sentence, the authors state, "Findings supported our hypothesis that both street homelessness and sheltered homelessness would be associated with higher likelihoods of committing non-violent crimes that may be related to subsistence strategies, but that this relationship would be weaker for sheltered homelessness since institutional supports may lower the need for subsistence-driven crimes (e.g., breaking into buildings to find shelter)."

So -- or, sorry, and they say, again, "Since results indicated that the likelihood of committing a non-violent crime increases as homelessness increases, a strong argument can be made that homelessness encourages non-violent crime."

So, again, Dr. Gaetz, I'll put it to you that these authors of these studies that's cited in Rankin, that is cited in Olson, that is cited in your affidavit suggest that the likelihood of committing a non-violent crime increases as homelessness increases; you'd agree?

A. Yes.

278 **Q.** And with respect to the authors findings on violent crime, I'm going to take you to the next page, so 263 of the article, page 13 of the PDF, if we go to the second paragraph on the page, the authors state, "We detected no significant interactions between symptom severity and type of homelessness for either outcome." It appears they're referring to the previous sentence. They state, "Prior research has found that homeless mentally ill individuals are more likely to commit violent crimes than non-homeless mentally ill individuals. This study suggests that homelessness and mental illness have additive, as opposed to multiplicative, effects."

So, again, you'll agree here that the authors of this study have found that homeless mentally ill individuals are more likely to commit violent crimes than non-homeless mentally ill individuals, correct?

A. Yes.

279 **Q.** So, to turn this back to where we started on our journey, the statement in your affidavit was, "Despite the fact that people experiencing homelessness are no more likely to break the law, except for laws that punish people living outdoors," we traced the source to that to a fact sheet that wasn't peer reviewed, and we've also identified, based on the Rankin article, the article by Fischer which suggests that street homelessness is associated with higher likelihoods of committing non-violent crimes, and that mentally ill individuals who experience homelessness are more likely than mentally ill individuals who are not experiencing homelessness to commit violent crimes.

So, I'll put it to you, Dr. Gaetz, that it's not entirely correct that people experiencing homelessness are no more likely to break the law, except for laws that punish people for living outdoors; isn't that correct?

A. I will give a qualified yes.

There's some complexity there that gets lost, and that's important to consider. So there -- this is a question for criminologists. And none of the researchers that I recognize there are criminologists. I have done research on the bidirectional relationship between homelessness and prison, and there's factors that are confounding. Now, I'm not going to make the claim that people experiencing homelessness are committing violent crimes, but the question around breaking the law is an important one, that criminologists, you know, will comment on. So, breaking the law, certainly people who experience homelessness encounter police much more often than, I would say, you or I ever would, because they're visible, the police know who they are, they're doing things that they have to do in public because they don't have private space, so whether that's consuming substances or drinking or sleeping even, right.

And so I mentioned before the criminalization of homelessness, means that many more people who are homeless are given -- are given tickets, which they can't afford to pay, are much more likely to wind up in jail, but that doesn't -- isn't an indicator that they're committing more crimes. We know through criminological research that people who are black in

U.S. are much more likely not only to be charged with drug offences but to be convicted and jailed for substance use, even though research on substance use shows that people who are black are less likely to use substances. So there's other factors there. When you have people who are identified as a public nuisance by the police, there could be efforts driven by the police or the public to do something about it, and law enforcement becomes a way we respond to homelessness. So all of these laws -- the point that I think would be more important than focussing on, like, do homeless people commit more crimes than non-homeless people, but they are more likely to get ticketed, our research shows, absolutely, that that's the case, that they get tickets, not just for homelessness-focussed laws but for things like jaywalking, sleeping in a park, all of these things that are laws on the books, so they get disproportionately impacted by that. And having a lot of tickets means that -- that you can't afford to pay is going to get you in trouble, because municipalities, they sell the unpaid tickets to collection agencies, right, and people can wind up being arrested and they have all these unpaid tickets and wind up going to jail for tickets. So the question of are they more likely to commit violent acts, that's an open one, I, I don't

know the answer but I'm sure there's lots of criminological research on that. But that issue of getting -- you know, that these laws and the enforcement of these laws that are driven by trying to move people who are homeless on or get them out of public sight, that's a real thing and there's evidence for that.

280 **Q.** And, Dr. Gaetz, you've referred to tickets and the laws that, as you described it, criminalize homelessness, but you haven't referred to, certainly not in your affidavit, any studies that address how likely people experiencing homelessness are to be charged with criminal offences, such as theft, assault and so on, correct?

A. There, there is literature on that, I just don't have any at the tip of my -- you know, but, again, like, being arrested for criminal charges is not a neutral objective thing, right. Like, what are the -- you know, there are, in Toronto, stores that now sell mushrooms, right, and the police have basically taken a decision not to enforce that law. So how -- what gets enforced is not dependent on what laws are on the books. Who gets enforced -- or, you know, who gets charged and -- is not neutral, right. And, you know, there's a question around policing in all of

this, right. And so the more we identify people as a problem, the more the public is going to complain to the police, Why aren't you doing something about it, the more they're going to respond to the complaints. It's a very complex thing, but I think it's very clear that -- the main point here, that the laws that are punishing people for living outdoors, that kind of thing, or being homeless or being visibly homeless or being seen to be homeless, especially when that intersects with other factors, such as being Indigenous or being black, that's important to consider, right. It's -- policing is not objective or neutral, its never been and never will be. And so people are -- certain subpopulations are disproportionately charged with crimes, that does not mean that they commit them at a greater rate than other people.

281 **Q.** Well, Dr. Gaetz, I've just taken you, I think, four sources deep into a study that did look at at least some rates of criminal activity among people experiencing homelessness and did suggest that even controlling for offences related to existing while homelessness, there was a greater propensity in non-violent crime and violent crime, when we're talking about mentally ill individuals.

A. But are we, are we measuring --

sorry, I'm interrupting you.

282 **Q.** No, go ahead, that was my question, go on.

A. Well, you know, if we're measuring breaking the law, getting ticketed, getting arrested, when we're measuring it, that's not, that's not an unbiased objective measurement of criminality. It reflects the police's priorities, it reflects who is the population and how are they viewed. I've never got a ticket for jaywalking. I've never received a ticket for loitering. I've never received a ticket for standing in front of an alley, which by the way is a law, right. I have never had those things happen to me. I've received speeding tickets on occasion. But those other ones, those -- what they call in the U.S. "misdemeanors," but those small offences, those tend to target people. You know, if you're black in Toronto or Hamilton, you're probably more likely to have more encounters with police. The more encounters you have with police increases the likelihood that you're going to be charged with a crime, right. So it's not an unbiased process by any means, and it's important to take that into account when trying to determine are people who experience homelessness committing more crimes, because all of those laws limit -- that target

people who are homeless, none of them mention the word "homelessness," but they're status offences nonetheless, the status is being homeless. And so, so, you know, the question of more violent crime is one thing, but who gets tickets, you know, there -- we've seen -- we did interviews with young people around this issue, and some of them would have, like, you know, over 50 tickets, one guy had them all pasted in a book, saved them all, couldn't pay off any of them. And so -- but that's a policy and a strategy of police around how to control what happens on the streets, who's on the streets and where they're on the streets.

283 **Q.** But theft, for example, Dr. Gaetz, you'll agree isn't a violent crime but it's also not a crime of existing while homeless, correct?

A. Yeah, there's all kinds of laws that are crimes while -- that aren't about people -- technically about their homelessness - the jaywalking tickets, right, the sleeping in public, you know, these aren't about homelessness but they're used on homeless people, right. And this is -- like, the criminological research on marginalized populations receiving undue attention from police is quite significant.

284 **Q.** But let's, for example, go back to Fischer. So if we're at the Fischer article again,

Exhibit 13, on page 251 of the journal, page 1 of the PDF, last sentence of that page, "Snow and Mulcahy (2001) showed that homeless individuals may adopt new subsistence strategies, including illegal strategies such as theft, when previous strategies are blocked (e.g., a new city ordinance restricting panhandling)."

So, again, Dr. Gaetz, I suggest to you that this study, which is, you know, three or four levels deep, but the origin is a paper that you cited in your affidavit, this study suggests that it's not only the petty tickets, like jaywalking or loitering, this is theft, that these authors are saying studies show that homeless individuals may adopt, correct?

A. It's correct, and I actually agree with that and have written about that. The point is though that all this background sets the stage for someone to go, "I need money and this is the only way I can do it," right. So when we take away panhandling, when we take away squeegeeing, when we, you know, take away these kinds of things, you know, yes, it can have those kind of impacts, but we have to be very careful to not go, "That person's a thief and a bad person because of it." It's the fact that they're homeless and our response to homelessness is so pathetically inept and unethical, I would argue, that people are put

in a position of having to make decisions about money making that you and I wouldn't make because we're not homeless. So that's important. And we've -- you know, again, the evidence is pretty clear here, that, you know -- I'm not going to say no homeless person ever committed theft, but if other options that are safer are eliminated, you're going to, you know -- and people are desperate and people are ill and people are marginalized, I don't think we should be surprised that that's going to happen. What it suggests in a way is that our efforts at criminalizing homelessness are actual -- actually not crime reduction strategies but crime production strategies, right. So that, you know, we have to come back to how we treat people when we're homelessness is, is what should really be going on here in this conversation, and that it does have these outcomes, you know, one of which is more tickets and more arrests, but it also potentially, you know, has impact on the kinds of things people do to make money, right. And so is that the problem -- is that a bad person we're talking about or is it a person in a situation where the options they've been given are totally inadequate to meet their needs, right. Is it an indictment of the individual, which is blaming the victim to some degree, or is it an indictment of a

response to homelessness, and that we keep pretending that we're doing the best we can and helping people, when we're putting them in horrible, difficult situations that are unsafe, that lead to all kinds of decisions. We've been talking about not just around crime, right, but that people make decisions that are survival based. And so if we want to reduce the risk of these kinds of things, I would say why don't we focus on housing people.

And I'm going to close -- not that you don't have any more questions, but I'm going to close this commentary. I mentioned a researcher called "Eric Latimer," economist from Montreal. He wrote an article in 2017 comparing the cost of keeping someone in a state of homelessness for one year in five Canadian cities. And the cost was through the emergency services that people used, shelters, day programs, that, but it was a cost of increased health care, because health and well-being worsens when you're homeless, and it was the cost of being involved with the criminal justice system. And he found that it costs $59,000 a year to keep someone in a state of homelessness in Toronto, $59,000. And so it's a very expensive solution, this emergency response system. But with that $59,000, even in this context where rents

are incredible high, you can house that person and throw two social workers on their back and produce better outcomes. But we don't have those better outcomes. And so the problem, I would say, is not to focus on individuals and whether they're good or bad or committing crimes, it's not to focus on the choices of where they want to sleep, the problem is to focus on what the heck are we doing here, right. It's an expensive, harmful way of dealing with a problem that produces all these sideways' unanticipated consequences.

285 **Q.** Dr. Gaetz, at paragraph 56 of your affidavit, which is the paragraph I was asking you about, there's another one of these notes, and it says, "Author: Gessie Stearns. Please provide source, citation and page number."

Again, I have to ask you, did anyone named "Gessie Stearns" change or edit your affidavit?

A. No. I have no idea how that got there and -- yeah, I don't know. I've never heard of the person.

286 **Q.** Paragraph 57 of your affidavit, you refer to, "A report by the National Law Center on Homelessness and Poverty which discusses the negative impacts of the criminalization of homelessness and

encampments." [As read] The citation is footnote No. 84, that's the "National Law Centre on Homelessness and Poverty, 'Tent City U.S.A.,'" that's the American National Law Centre on Homelessness and Poverty --

A. Yep.

287 **Q.** -- correct?

A. That's right, yeah.

288 **Q.** Okay. And that report doesn't discuss Canada or Canadian law, correct?

A. No. Well, you know what, it has been a long time since I looked at it, I'll take your word for it that it doesn't. As a scholar, I just want to say, I don't only rely on Canadian research. So I think if I were to do this again, I would consider that, but we look at research from different jurisdictions and evaluate does this make sense -- would this make sense in the Canadian context or is it, like, completely outside of the realm. But I personally don't think that there's anything flawed. The thing about the United States, it's much bigger, there's much more resources put into research. So -- and the research conducted is more broad. So I wouldn't want to ignore that kind of research either.

289 **Q.** Well, Dr. Gaetz, when we're talking about criminalization specifically, the

criminal laws in America are much different than they are in the U.S. -- or in Canada, aren't they?

A. No, that's not true.

290 **Q.** That's not?

A. They are in some cases, that's -- they are in some cases. But things like the Safe Streets Act in Ontario, much of that is copied from American legislation. So in saying it's not true, it's more complex is more what I should say. There's a lot of similarities, there's differences, absolutely, I wouldn't deny that. There are differences but there's a lot of similarities. And there's similarities around homelessness even, right, so -- but I wouldn't make it so it's one or the other, right.

291 **Q.** I'm not sure I understand your answer to that question, Dr. Gaetz.

A. The --

292 **Q.** Are you saying that the laws in the U.S. specifically around criminalization, the criminal law, is sufficiently similar to Canada that you can extrapolate?

A. We would have to look at the case in particular, but, as I said, it's clear that American legislation that criminalizes homelessness has had an impact in Canada and influences the language and the

intent of the law. And so, you know, we, we have to be mindful that jurisdictional differences are important, but it's not always the case that they're so significantly different that we can't -- we're comparing apples and oranges.

293 **Q.** You're not a lawyer, Dr. Gaetz?

A. I am not a lawyer.

294 **Q.** You're not a legal scholar?

A. I -- criminology is part of what I do, and I'm not a legal scholar either.

295 **Q.** At paragraphs 58 through 60 of your affidavit, there's several paragraphs under the heading "Guidance and Protocols for Addressing Homelessness Encampments in Canada and the United States." Just in broad terms, Dr. Gaetz, are these paragraphs included in here as your direction or suggestion for what Hamilton ought to do?

A. I believe -- now bear in mind I wrote this several years ago. So I believe what I was trying to do is frame, regardless of the jurisdiction, things that need to be considered in working with encampments.

296 **Q.** So --

A. And, obviously, I think it would -- well, I shouldn't say "obviously," but the

idea would be that they contribute to, you know, conversation about how to approach these things, there may be contextual factors that have to be taken into account, but I don't think we need, like, a separate analysis for each municipality in Canada, the differences between them aren't that great.

297 **Q.** In other words, Dr. Gaetz, paragraphs 58 through 60 of your affidavit are your policy recommendations, correct?

A. Well, this one here looks like it comes from the USICH, *Ending Homelessness for People in Encampments.* Can you scroll down.

298 **Q.** Let me put it this way, so paragraph 58 is, I believe, what you were referring to.

A. Yeah. Okay, "Based on these principles, the guidance offers an action planning checklist based around four key elements," that could be from the same document. To be honest, it's been several years since I wrote this.

299 **Q.** So, again, Dr. Gaetz, why are these paragraphs in your affidavit?

A. Because they -- you know what, here's one of the things I've learned being a scholar, especially a scholar on responses to homelessness, that looking at international examples doesn't represent a

weakness but, in fact, is very helpful on framing and thinking about what you're going to do in Canada. And, in fact, most of the big "uh-huh moments" I've have as a researcher, looking at homelessness, have come from looking at what people do in other countries. A country like Wales, which you would never think is a leader on homelessness, they're huge, innovative. There's all kinds of examples. And so going to -- you know, researchers will go to international research, and there can be useful things there, even though it comes from the United States, there are things that are useful. So I, I don't apologize for that, I think that's a strength of, you know, the research method, you know, that we want to be able to look at different jurisdictions and are there things we can learn that would be helpful in Canada.

300 **Q.** And looking at these other jurisdictions, Dr. Gaetz, you're including this information as your recommendations for what should be done in Canada?

A. I didn't list them as recommendations.

301 **Q.** Then why are they in your affidavit, that's what I'm trying to nail down?

A. No, no, no, but I don't think I

used the word "recommendation."

302 **Q.** I don't know that you did either, and that's what I'm trying to figure out, is --

A. Well, I'm saying that these are things that we should consider, right. Recommendations, writing recommendations is a particular kind of technical language, which this kind of document doesn't follow that. I didn't make those as recommendations in the traditional sense, because recommendations should identify who we're talking about, who's the recommendation for, who's responsible for responding -- or for this. So they are drawing from, you know, what we've learned and should inform -- without being official recommendations, but should inform based on what the research says, things that we should consider when we're exploring what encampments involve, what should be done about them. But they're not technically, I wouldn't call them "recommendations." It doesn't mean that they're not offering thoughts and assistance and research-based ideas about how these things should be approached.

303 **Q.** Okay. Thank you, Dr. Gaetz. You've understood all of my questions today?

A. I did.

304 **Q.** Are there any of your answers that

you wish to change?

A. By this point I can't remember them.

305 **Q.** I'm sure you'll advise your counsel if you do, and that can be dealt with in the ordinary course under the Rules of Civil Procedure.

A. Okay, thank you.

MS. SHORES: Thank you. I have no further questions for you. And thank you for your time today, Dr. Gaetz.

THE DEPONENT: Thank you.

MR. CHOUDHRY: Dr. Gaetz, I just need two minutes to look at my notes. I know we've kept you a long time but -- and I don't intend to keep you much longer, but I just want to collect myself to make sure I'm as efficient as possible, okay?

THE DEPONENT: Okay.

MR. CHOUDHRY: So just -- if you could hold on just two minutes, all right. Thanks.

THE DEPONENT: Sounds good.

--- Off-the-record discussion.

RE-EXAMINATION BY MR. CHOUDHRY:

306 **Q.** Okay. So, Dr. Gaetz, I just have a couple of questions by way of re -- this is called "redirect."

A. Okay.

307 **Q.** Okay. And so the first is a set of questions about your affidavit. So, as you know, you've been under oath and you're still under oath and you've been testifying about your affidavit. And I just want to put it on the screen again. Dr. Gaetz, can you see my -- oops, excuse me.

A. Yes.

308 **Q.** This is your affidavit?

A. Yes.

309 **Q.** And so at one point Ms. Shores has asked you about twice if you wrote this affidavit.

A. Yes.

310 **Q.** And so I just want to ask you follow-up questions based on her questions to you. So my first question is, did you review this affidavit in preparation for your cross-examination today?

A. Yes, I did.

311 **Q.** And when you reviewed it, did you recognize it as your affidavit?

A. Absolutely.

312 **Q.** Did you sign this affidavit?

A. Yes, I did.

313 **Q.** And let me just ask you here, going to take you to the last page, is this your

signature?

A. Yes, it is.

314 **Q.** Okay. And just to be clear, do you stand by this affidavit?

A. Yes, I do.

315 **Q.** Thank you. I have one more question, which is about the study that my friend referred you to by Drs. O'Shea and colleagues.

A. Right.

316 **Q.** I believe she referred you to a version that she found online. We've been able to find the published version of the article. And unless my friends have any objection, we'd like to mark this as an exhibit to the cross-examination, because this is actually the published version of this study.

MS. SHORES: You can mark it at least for identification, and then put it to the witness to authenticate.

BY MR. CHOUDHRY:

317 **Q.** Okay. So, doctor -- so, Dr. Gaetz, do you see this -- so, Madam Reporter?

COURT REPORTER: Yes.

MR. CHOUDHRY: What number are we on, for exhibits to the cross-examination for identification?

MS. SHORES: Fourteen, counsel.

MR. CHOUDHRY: Good. Thank you, Ms. Shores.

So we'll mark this as Exhibit 14. And, Madam Reporter, this is the article entitled "Pandemic Planning in Homeless Shelters: A Pilot Study of a Coronavirus Disease 2019 (COVID-19) Testing and Support Program to Mitigate the Risk of COVID-19 Outbreaks in Congregate Settings."

EXHIBIT NO. 14: Article entitled "Pandemic Planning in Homeless Shelters: A Pilot Study of a Coronavirus Disease 2019 (COVID-19) Testing and Support Program to Mitigate the Risk of COVID-19 Outbreaks in Congregate Settings."

BY MR. CHOUDHRY:

318 **Q.** Do you see that title, Dr. Gaetz?

A. I do.

319 **Q.** Do you see the article -- do you see the principal author being Timothy O'Shea?

A. Yes.

320 **Q.** Sorry. Can you read that now?

A. Yes.

321 **Q.** Okay, good. And just give me one second. And I'm taking you now to the "Methods" section of the article. I just want to confirm it's

the same methods. I want to ask you to read -- to confirm that you see here the sentence I've highlighted?

A. Yes, I can see that.

322 **Q.** And you'd agree it says what -- this replicates, to your recollection, the language that was put to you by Ms. Shores --

A. Yes.

323 **Q.** -- regarding the date of testing?

A. Yes.

324 **Q.** So as far as you can tell, does this appear to be the same study that was put to you by Ms. Shores?

A. Yeah, I certainly remember the April 30th as the conclusion and -- yeah, between March 17th to April 30th.

MR. CHOUDHRY: Okay, good. Thank you. Well, Dr. Gaetz, those conclude my questions for you today. Thank you for your time. And I know we've taken longer than we had planned but we're very grateful for your time.

THE DEPONENT: Thank you.

MS. SHORES: Yes, thank you, Dr. Gaetz, thanks for your time and attention to these matters.

THE DEPONENT: Thank you.

--- Whereupon proceedings adjourned at 1:17 p.m.

I HEREBY CERTIFY THE FOREGOING
to be a true and accurate
transcription of my shorthand notes
to the best of my skill and ability.

_____
Dayne Snell, Court Reporter
Computer-Aided Transcription

CURRICULUM VITAE

Ex # 1 m/d/y 08/30/2024 Pg 1 of 80
Exam of Dr. Stephen Gaetz
Heegsma et al v City of Hamilton
Nimigan Mihailovich Reporting Inc.

A) PERSONAL

1. NAME

Stephen Anthony Gaetz
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York University
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2. CURRENT POSITION

Professor, Faculty of Education, York University

President and CEO, Canadian Observatory on Homelessness

Research Director, Making the Shift – Youth Homelessness Social Innovation Lab

Director, Toronto Center of Excellence on Youth Homelessness Prevention at York University (Toronto Centre of Excellence). United Nations Economic Commission for Europe.

3. DEGREES

1990 Ph.D. Anthropology York University, Toronto
Dissertation title: *Community Action and the Provision of Youth Services in Cork, Ireland*

1985 M.A. Anthropology York University, Toronto
Dissertation title: *Youth Expression in the Eighties: A Network Analysis of Punks in Toronto*

1983 B.A. Anthropology (Honours) University of Calgary

4. EMPLOYMENT HISTORY

2014 -	Professor – Faculty of Education, York University
2005 - 2014	Associate Professor - Faculty of Education, York University
2012 - 2013	Associate Dean, Research and Professional Development - Faculty of Education, York University
2007 – 2011	Associate Dean, Research and Professional Development – Faculty of Education, York University
2000 - 2005	Assistant Professor - Faculty of Education, York University
2000 -	Appointment to the Faculty of Graduate Studies, York University
1999 - 2000	Community Development Officer - Community and Neighbourhood Services Department, City of Toronto
1999	Coordinator, Homeless Initiative - Queen West Community Health Centre
1993 - 1999	Health Promoter - Shout Clinic, Toronto, Ontario
1992 - 1993	Lecturer - Department of Anthropology, York University
1990 - 1992	Post-Doctoral Fellow - Department of Anthropology, York University

5. HONOURS AND AWARDS

2020	York Research Chair in Homelessness and Research Impact
2020	York University Research Leader Award
2019	York University Research Leader Award
2017	York University Research Leader Award
2016	Member of the Order of Canada
2016	Dean's Research Award – Faculty of Education
2016	York University Research Leader Award
2015	SSHRC Research Impact – Connection Award
2015	York University Research Leader Award
2013	Faculty of Education Merit Award - $3000
2012	Faculty of Education Merit Award - $2000
2011	Faculty of Education Merit Award - $2000
2010	Faculty of Education Merit Award - $2000
2009	Faculty of Education Merit Award - $2000

2008	Faculty of Education Merit Award - $2000
1990 - 1992	Social Sciences and Humanities Research Council of Canada Postdoctoral Fellowship
1986 - 1989	Social Sciences and Humanities Research Council of Canada Doctoral Fellowship
1986	Ontario Graduate Scholarship (declined)
1985	Ontario Graduate Scholarship

ADVISORY PANELS and COMMITTEES

2018- present	Government of Canada –Reaching Home's Data Strategy Advisory Committee
2017-18	Government of Canada – Advisory Committee on Homelessness
2016-17	Government of Canada – Advisory Committee on Poverty Reduction Strategy
2015	Province of Ontario - Expert Advisory Panel on Homelessness
2013-14	Canadian Mental Health Association – Advisory Committee on Housing First

B SCHOLARLY AND PROFESSIONAL CONTRIBUTIONS

1. SUMMARY OF PUBLICATIONS AND PROFESSIONAL CONTRIBUTIONS

Books: 1
Edited books, special issues of journals: 5
Articles in refereed journals: 42
Chapters in books: 22
Professional Reports: 45 (Peer reviewed: 13)
Conference presentations: 166
Keynote addresses: 31
Invited presentations: 207
Webinars: 18
Book Reviews: 2
Curriculum Materials: 7
Other publications: 8
Blog posts: 32

CITATIONS

	All	Since 2017
Citations	4491	2531
h-index	29	23
i10-index	54	44

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Contract Reports

Schwan, K., French, D., Gaetz, S., Ward, A., Ackerman, J. & Redman, M. (2018) Preventing Youth Homelessness – An International Scan of the Evidence. Wales: Wales Centre for Public Policy; Canadian Observatory on Homelessness & A Way Home Canada

Scott, F., Winland, D. & Stephen Gaetz (2014) *A Path To Home: Supporting Housing Needs for Newcomers Year 1 Evaluation.* Toronto: YMCA.

Gaetz, Stephen (2012*) Summative Evaluation of the Homelessness Partnering Strategy.* Homelessness Partnering Secretariat, Human Resources and Skills Development Canada, May, 2012

Gaetz, Stephen (2011*) Towards a Canadian Definition of Homelessness - A Literature Review.* Homelessness Partnering Secretariat, Human Resources and Skills Development Canada, March, 2011

Gaetz, Stephen (2011) *Plans to End Homelessness in Canada. A Review of the Literature*. Prepared for Eva's Initiatives and Virgin Unite. February, 2011

Gaetz, Stephen (2002). *Street Justice - The Legal and Justice Issues of Homeless Youth in Toronto.* Toronto: Justice for Children and Youth.

Gaetz, Stephen (2002). *Street Youth Agencies and the Legal and Justice Issues of Homeless Youth in Toronto.* Toronto: Justice for Children and Youth

3. PRESENTATIONS and PUBLIC LECTURES

Conference Presentations

Gaetz, Stephen & Melanie Redman (2022) "Housing First for Youth – Emerging Research Results." *Housing First Partners Conference, Seattle.* April 12, 2022

Walter, Heidi & Stephen Gaetz (2022) "Housing First for Youth – Adaptations and Lessons Learned from Canada." *Housing First Partners Conference, Seattle.* April 12, 2022

Gaetz, Stephen (2022) "Homelessness Prevention." *Quebec Homelessness Prevention Policy Collaborative Conference – The Promise of Prevention in Homelessness*. Montreal, Quebec (On Line). February 16, 2022

Gaetz, Stephen & Melanie Redman (2021) "Youth Homelessness Social Innovation Lab – UPDATES." *Upstream Conference, Australia* (On Line). November 19, 2021.

Gaetz, Stephen (2021) "Making the Shift to the Prevention of Youth Homelessness: Opportunities and Challenges for Systems Transformation." *Developing Homelessness Work.* Tampare, Finland. (On Line). November 16, 2021.

Gaetz, Stephen (2021) "Social Innovation in Driving Change." *CAEH Virtual National Conference on Ending Homelessness,* Canada. (On Line). October 26, 2021

Gaetz, Stephen & Walter, Heidi (2021) "Social Innovation in Action: Addressing the Needs of Young People through Housing First for Youth." *The Fourth International Housing First Conference: Knowledge Mobilization of Evidence-Based Housing First practices*. (On Line). October 5, 2021

Gaetz, Stephen (2021) "Housing First for Youth." *Australia. National Youth Homelessness Virtual Conference* (On Line). July 16, 2021

Gaetz, Stephen; Redman, Melanie & Walter, Heidi (2021) "Housing First for Youth – Lessons from Making the Shift." *Housing First Partners Converence* (On Line). April 8, 2021

Gaetz, Stephen (2021) *Research Impact and Homelessness.* Campaigning: A Case Study on Homelessness Advocacy (On Line). February 25, 2021

Gaetz, Stephen (2020) *Covid 19 and Homelessness: What are the implications for Canada?* European Observatory on Homelessness Conference (On Line). Sept 25, 2020

Gaetz, Stephen & Redman, Melanie (2020) *Preventing Youth Homelessness through Duty to Assist*. Atlantic Summer Institute on Healthy and Safe Communities (On Line). August 14, 2020

Gaetz, Stephen (2020) *Covid 19-Lessons from Canada*. More Direct Futures Housing Network (On Line). May 14, 2020

Gaetz, Stephen & Redman, Melanie (2020) *Making the Shift – Youth Homelessness Social*

Innovation Lab. CRISIS UK Homelessness Prevention Conference. March 10, 2020

Gaetz, Stephen (2020) *"YAP – Youth Assessment and Prioritization Tool"* Cardiff, Wales: *Preventing Youth Homelessness 2020*. March 9, 2020.

Gaetz, Stephen (2020) *"THIS is Housing First for Youth"* Cardiff, Wales: *Preventing Youth Homelessness 2020*. March 9, 2020.

Gaetz, Stephen; Kidd, Sean; Malenfant, Jane; Aboud, Cecile & David French (2019) *Without a Home – The National Youth Homelessness Survey - 2019.* Edmonton: National Conference on Ending Homelessness (CAEH). November 5, 2019

Gaetz, Stephen & Redman, Melanie (2019) *Designing the Adaptation of a Duty to Assist in Canada.* Edmonton: National Conference on Ending Homelessness (CAEH). November 4, 2019

Gaetz, Stephen; Redman, Melanie & Sheryl Green (2019) *Making the Shift – A Youth Homelessness Social Innovation Lab.* Edmonton: National Conference on Ending Homelessness (CAEH). November 4, 2019

Gaetz, Stephen (2019) *Implementing Housing First for Youth..* Melbourne Australia. Victorian Homelessness Conference. October 15, 2019

Redman, Melanie & Stephen Gaetz (2019) *Designing the Adaptation of a Duty to Assist in Canada.* European Observatory on Homelessness Research Conference. Helsinborg, Sweden. September 20, 2019

Gaetz, Stephen & Redman, Melanie (2019) *Ending Youth Homelessness.* The Voices of People with Lived Experience. Charlottown, PEI: Atlantic Summer Institute Supportive Environments for Child and Youth Mental Health: Our Shared Responsibility! August 20, 2019

Redman, Melanie & Gaetz, Stephen, (2019) *A Way Home.* Hinkley Island, England: Under One Roof: Homeless Link Annual Conference. July 3, 2019

Gaetz, Stephen (2019) *The Canadian Definition of Youth Homelessness.* Porto, Spain: FEANTSA Policy Conference. May 29, 2019

Gaetz, Stephen & Redman, Melanie (2019) *Ending Youth Homelessness.* Oshawa, ON: Durham Region Homelessness Prevention Conference, March 19, 2019

Gaetz, Stephen (2018) *Realizing the Right of Youth to Housing* Hamilton, Ontario: Canadian Alliance to End Homelessness Conference. November 7, 2018

Gaetz, Stephen (2018) *A Duty to Assist – How we can end youth homelessness in Canada* Hamilton, Ontario: Canadian Alliance to End Homelessness Conference. November 7, 2018

Gaetz, Stephen (2018) *Making Research Matter! The Canadian Observatory on Homelessness.* Hamilton, Ontario: Canadian Alliance to End Homelessness Conference. November 6, 2018

Gaetz, Stephen, Redman, Melanie & Schwan, Kaitlin (2018) *The Roadmap for the Prevention of Youth Homelessness* Hamilton, Ontario: Canadian Alliance to End Homelessness Conference. November 5, 2018

Redman, Melanie & Stephen Gaetz (2018) *Ending Youth Homelessness: Can we do it?* Orillia Ontario: Conference on Youth Homelessness. October 2, 2018

Gaetz, Stephen & Redman, Melanie (2018) *Making the Shift – A Youth Homelessness Social Innovation Lab*. Budapest, Hungary: European Observatory on Homelessness, International Conference on Homelessness. Sept 23, 2018

Redman, Melanie & Stephen Gaetz (2018) *A Way Home: Updates from Canada*. Edinburgh Scotland: National Conference on Ending Youth Homelessness. Sept 18, 2018

Gaetz, Stephen & Redman, Melanie (2018) *A Way Home: Transforming Systems for Change*. Antwerp, Belgium: Launch of A Way Home Europe. Sept 17, 2018

Gaetz, Stephen (2018) *Defining Homelessness.* Sao Paulo Brazil: Housing First conference. August 29, 2018

Gaetz, Stephen (2018) Housing First and *Housing First for Youth .* Sao Paulo Brazil: Housing First conference. August 29, 2018

Gaetz, Stephen & Redman, Melanie (2018) *What the Future Looks Like? A Roadmap for the Prevention of Youth Homelessness.* Happy Valley – Goose Bay, Nfld & Labrador: Social Innovation Summit. June 6, 2018

Redman, Melanie & Gaetz, Stephen (2018) *What the Future Looks Like? A Roadmap for the Prevention of Youth Homelessness.* Windsor: Ontario Municipal Social Services Association. May 27, 2018

Gaetz, Stephen & Redman, Melanie (2018) *Transforming Systems for Change: Lessons from Canada*. New York: National Symposium on Solutions to End Youth Homelessness. April 30, 2018

Redman, Melanie & Stephen Gaetz (2018) *Implementing Housing First for Youth – Key Challenges.* New York: National Symposium on Solutions to End Youth Homelessness. April 30, 2018

Gaetz, Stephen & Redman, Melanie (2018) "THIS is Housing First for Youth". Denver: Housing First Partners Conference. April 10, 2018

Gaetz, Stephen & Dej, Erin (2017) "Homelessness Prevention – From Framework to Action". Winnipeg, Manitoba. Canadian Alliance to End Homelessness Conference, October 26, 2017

Gaetz, Stephen & Schwan, Kaitlin (2017) "Preventing Youth Homelessness- 1o things we can do". Winnipeg, Manitoba. Canadian Alliance to End Homelessness Conference, October 25, 2017

Gaetz, Stephen (2017) "THIS is Housing First for Youth". Winnipeg, Manitoba. Canadian

Alliance to End Homelessness Conference, October 25, 2017

Gaetz, Stephen (2017) "Understanding Youth Homelessness in Canada – The first national survey". Barcelona, Catalonia. European Observatory on Homelessness Conference, September 22, 2017

Gaetz, Stephen (2017) "Understanding Youth Homelessness in Canada – The first national survey". Barcelona, Catalonia. European Observatory on Homelessness Conference, September 22, 2017

Redman, Melanie & Gaetz, Stephen (2017) "Making the Shift – Preventing and Ending Youth Homelessness in Canada". Barcelona, Catalonia. European Observatory on Homelessness Conference, September 22, 2017

Gaetz, Stephen (2017) "Homelessness Prevention and Housing First for Youth". CHRA Congress Halifax, ON. May 4, 2017

Gaetz, Stephen (2016) "Housing First for Youth". *New Directions – National Conference on Homelessness*. Edinburgh Scotland. November 10, 2016

Gaetz, Stephen (2016) "Knowledge Mobilization and Design Thinking". Tackling Homelessness: Developing and Sharing Best Practice. Bristol, UK. November 8, 2016

Gaetz, Stephen (2016) "Homelessness Prevention 101". *Canadian Alliance to End Homelessness conference*. London, Ontario. November 3, 2016

Gaetz, Stephen (2016) "The State of Homelessness in Canada 2016". *Canadian Alliance to End Homelessness conference*. London, Ontario. November 3, 2016

Gaetz, Stephen (2016) "Canadian Definition of Youth Homelessness". *Canadian Alliance to End Homelessness conference*. London, Ontario. November 2, 2016

Gaetz, Stephen; Bill O'Grady & Sean Kidd (2016) "Without a Home: Results of the National Youth Homelessness Survey". *Canadian Alliance to End Homelessness conference*. London, Ontario. November 2, 2016

Redman, Melanie & Gaetz, Stephen (2016) A Way Home – Ending youth homelessness in Canada. OMSSA Service Managers conference. Toronto, Canada. October 27, 2016

Gaetz, Stephen (2016) "Criminalizing Homelessness in Canada: The Impact on Homeless Youth". *International Community Corrections Association*. Toronto, ON October 4, 2016

Gaetz, Stephen (2016) "Transitioning to Housing First – Key Challenges for Service Providers" European Observatory on Homelessness Research Conference. Copenhagen, Denmark. September 23, 2016

Gaetz, Stephen (2016) "Rural Homelessness and Housing First for Youth". *Rural Sociological Society Conference*. Toronto, ON. August 8, 2016

Gaetz, Stephen (2016) "Housing First for Youth – Challenges in Going to Scale" *National Alliance to End Homelessness Conference*. July 26, 2016

Redman, Melanie & Gaetz, Stephen (2016) "*A Way Home". FEANTSA Policy Conference.* Brussels Belgium. June 10, 2016

Gaetz, Stephen & Redman, Melanie (2016) "Housing First for Youth in Europe – A Human Rights Approach" *Rock Trust – Ending Youth Homelessness National Conference.* Edinburgh Scotland. June 6, 2016

Gaetz, Stephen (2016) "Moving from Crisis to Prevention – Reimagining our Response to Youth Homelessness" *Rock Trust – Ending Youth Homelessness National Conference.* Edinburgh Scotland. June 6, 2016

Redman, Melanie & Gaetz, Stephen (2016) "*Coming Together to End Youth Homelessness – A Way Home". Rock Trust – Ending Youth Homelessness National Conference.* Edinburgh Scotland. June 7, 2016

Gaetz, Stephen (2016) "Adolescence, Homelessness and Stigma" *A4YC Conference,* Edmonton AB. May 17, 2016

Gaetz, Stephen (2016) "Tackling 'Wicked Problems' through Collective Impact". *Housing Affordability and Market Based Solutions Conference. University of Calgary*, Calgary AB. February 10, 2016

Gaetz, Stephen (2016) "The Housing System – Can we address affordability?". *Housing Affordability and Market Based Solutions Conference. University of Calgary*, Calgary AB. February 10, 2016

Gaetz, Stephen (2016) Housing First for Youth – The challenges of going to scale" National Alliance to End Homelessness Conference on Family and Youth homelessness. Oakland, CA. Feb 19, 2016

Gaetz, Stephen (2016) "Oh Canada! Lessons on Housing First from the Canadian Response to Homelessness" Second Annual Convening on Unaccompanied Homeless Women. Los Angeles CA. January 21, 2016

Gaetz, Stephen (2016) "Young, Female and Homeless" Second Annual Convening on Unaccompanied Homeless Women. Los Angeles CA. January 21, 2016

Redman, Melanie & Gaetz, Stephen (2015) "A Way Home" *The American Round Table to Abolish Homelessness.* Boston, MA. November 6, 2015

Gaetz, Stephen (2015) "Issues and Challenges in Going to Scale" *The American Round Table to Abolish Homelessness.* Boston, MA. November 6, 2015

Gaetz, Stephen (2015) "Panel: Exploring effective systems responses to homelessness - systems, planning and coordination" *CAEH 2015 – National Conference on Ending Homelessness.* Montreal, Que. October 19, 2015

Gaetz, Stephen (2015) "A Framework for Systems Integration" *CAEH 2015 – National Conference on Ending Homelessness.* Montreal, Que. October 19, 2015

Gaetz, Stephen (2015) "Screening for Housing First" *CAEH 2015 – National Conference on*

Ending Homelessness. Montreal, Que. October 19, 2015

Gaetz, Stephen (2015) "A Framework for Preventing Youth Homelessness" *CAEH 2015 – National Conference on Ending Homelessness.* Montreal, Que. November 2, 2015

Redman, Melanie & Gaetz, Stephen (2015) "A Way Home" *CAEH 2015 – National Conference on Ending Homelessness.* Montreal, Que. November 2, 2015

Gaetz, Stephen (2015) "A Framework for Homelessness Prevention" *Toronto Homelessness Research Symposium.* Toronto, ON. October 19, 2015

Gaetz, Stephen (2015) "Youth Homelessness in Toronto." *Toronto Homelessness Research Symposium.* Toronto, ON. October 19, 2015

Gaetz, Stephen (2015) "Making Research Matter" *Toronto Homelessness Research Symposium.* Toronto, ON. October 19, 2015

Gaetz, Stephen (2015) "Homeless Veterans in Canada: An Emerging Issue." *European Observatory on Homelessness Research Conference.* Dublin, Ireland. September 25, 2015

Gaetz, Stephen (2015) "Criminalizing Homelessness in Canada: What happens when we use policing as a strategic response to youth homelessness?." *International Academy of Law and Mental Health Congress.* Vienna, Austria. July 17, 2015

Gaetz, Stephen (2015) "Oh Canada! Lessons on Housing First from the Canadian Response to Homelessness." *Housing First Day conference,* Utrect NL. July 6th, 2015

Gaetz, Stephen (2015) "A Framework for Housing First for Youth." *Housing First Day conference,* Utrect NL. July 6th, 2015

Redman, Melanie & Gaetz, Stephen (2015) "Building Links for the Prevention of Youth Homelessness." *FEANTSA Conference.* Paris, June 20th, 2015

Gaetz, Stephen & Redman, Melanie (2015) "Youth Homelessness in Canada: Does Challenging Measures that Criminalize Youth Homelessness Work?", *Housing Rights Watch Conference.* Paris, June 18th, 2015

Gaetz, Stephen (2015) "Panel presentation – The Criminalization of Youth Homelessness." *The Legal Needs of Street Youth conference.* London, UK June 17, 2015

Gaetz, Stephen (2015) "Solving Youth Homelessness – Lessons from Canada" Homelessness in a Global Landscape Conference – Institute of Global Homelessness, Chicago, IL., June 2st, 2015

Gaetz, Stephen (2015) "Understanding and measuring homelessness in Canada" Homelessness in a Global Landscape Conference – Institute of Global Homelessness, Chicago, IL., June 1st, 2015

Gaetz, Stephen (2015) "Canadian Point-in-Time Count – Implementation Toolkit" *Government of Canada – Homelessness Partnering Strategy – HPS PiT Count Workshop.* Winnipeg, MN May 1, 2015

Gaetz, Stephen (2015) "From Child Protection to Youth Homelessness: Can we turn off the taps?" *Canadian Housing and Renewal Association National Conference on Housing and Homelessness.* Winnipeg, MN April 30th, 2015

Gaetz, Stephen (2015) "Canadian Point-in-Time Count – Implementation Toolkit" *Government of Canada – Homelessness Partnering Strategy – HPS PiT Count Working Group.* Ottawa, ON April 9, 2015

Gaetz, Stephen (2015) "Solving Youth Homelessness. Lessons from Canada" *Ending Family and Youth Homelessness.* National Alliance to End Homelessness. San Diego, CA. February 19, 2015

Gaetz, Stephen (2014) "Canadian Point-in-Time Count Methodology and Toolkit" National Conference on Ending Homelessness. Vancouver, BC. November 5, 2014.

Gaetz, Stephen (2014) "Can we think about a Housing First strategy for Youth?" National Conference on Ending Homelessness. Vancouver, BC. November 4, 2014.

Gaetz, Stephen (2014) "Thinking about an End to Youth Homelessness" National Conference on Ending Homelessness. Vancouver, BC. November 3, 2014.

Gaetz, Stephen (2014) "Housing First for Youth" National Conference on Ending Homelessness. Vancouver, BC. November 3, 2014.

Gaetz, Stephen (2014) "Young, Female and Homeless" One in Four Convening on Unaccompanied Homeless Women. Harvard, Oct. 24, 2014.

Gaetz, Stephen (2014) "Can Housing First work for youth?". *8th National Conference on Homelessness*. Brisbane Australia, September 12, 2014

Gaetz, Stephen (2014) "Preventing Youth Homelessness - What do we know? What should we do?" *8th National Conference on Homelessness.* Brisbane Australia, September 11, 2014

Gaetz, Stephen (2014) "Oh Canada! Housing first and the evolution of the Canadian response to Homelessness". *8th National Conference on Homelessness.* Brisbane Australia, September 11, 2014

Gaetz, Stephen (2014) "A Framework for Housing First for Youth". *National Alliance to End Homelessness conference*. Washington, DC. July 29, 2014.

Gaetz, Stephen (2014) "Why youth homelessness is different than adult homelessness". *National Alliance to End Homelessness conference*. Washington, DC. July 29, 2014.

Gaetz, Stephen (2014) "Thinking about . . . Youth Homelessness" *Western Next Practices Colloquy*. Lost Angeles, June 18, 2014

Gaetz, Stephen (2014) "A Safe and Decent Place to Live: Understanding youth homelessness in urban and rural areas of Canada". *Youth Housing and Homelessness Conference.* Ottawa, June 23, 2013

Gaetz, Stephen (2014) "Preventing Youth Homelessness" *FEANTSA Youth Homelessness Study Session*. Budapest, Hungary. March 4, 2014.

Gaetz, Stephen (2014) "Research Impact! How research can contribute to ending homelessness." *Housing First Conference*, Kelowna BC. February 27, 2014.

Gaetz, Stephen (2014) "Housing Options for Youth". National Alliance to End Homelessness, Ending Family and Youth Homelessness Conference. New Orleans, LA. Feb 17, 2014.

Gaetz, Stephen. (2014) "Rethinking Our Response to Youth Homelessness" *Ending Youth Homelessness in Red Deer conference*. Red Deer Alberta. January 29, 2014.

Gaetz, Stephen (2013) "Towards a Prevention Framework for Homeless Youth". *FEANTSA Conference on Youth Homelessness.* Prague, Czech Republic. November 9, 2013

Gaetz, Stephen (2013) "Making Research Matter! How Research Can Contribute to Ending Homelessness." *Homelessness Partnering Strategy – National Workshop on Housing First. Ottawa,* ON, November 1, 2013

Gaetz, Stephen (2013) "Research Matters: The Canadian Homelessness Research Network." *National Conference on Ending Homelessness*. Ottawa: October 28th, 2013

Gaetz, Stephen (2013) "The State of Homelessness in Canada, 2013." *National Conference on Ending Homelessness*. Ottawa: October 28th, 2013

Gaetz, Stephen (2013) "A Framework for Preventing Youth Homelessness", *Next Practices*. Boston, USA. October 25th, 2013

Gaetz, Stephen (2013) "Knowledge Mobilization as Design", *York Symposium on the Scholarship of Engagement*. York University, Toronto Canada. October 2, 2013

Gaetz, Stephen (2013) "Adaptation and Implementation Challenges for Housing First", *Housing First. What's Second?* FEANTSA European Research Conference - Berlin, Germany, September 20th, 2013

Gaetz, Stephen (2013) "Family Matters – Youth Homelessness and Family Reconnection". National Alliance to End Homelessness Conference. Washington, DC., July 20th, 2013

Gaetz, Stephen (2013) "Rethinking Models of Prevention, Accommodation and Support for Homeless Youth" *International Homelessness Research Conference*, Philadelphia, Pennsylvania, June 3, 2013

Gaetz, Stephen (2013) "The Real Cost of Homelessness" *Canadian Economics Association conference*, Montreal, May 30, 2013

Gaetz, Stephen (2013) "The Bottom Three Feet of the City: Youth Homelessness and Geographies of Exclusion". *Canadian Anthropology Society meetings*. Victoria, May 10, 2013

Gaetz, Stephen (2013) "Research Impact! Using Research to Support the Work of CABS". *Canadian Housing and Renewal Association – Community Advisory Body Meeting*. Ottawa, May 6, 2013

Gaetz, Stephen (2013) "Reimagining our Response to Youth Homelessness?" *Social Planning Council of Hamilton, Community Meeting.* Hamilton April 24, 2013

Gaetz, Stephen (2013) "The Real Cost of Homelessness" *Northern Housing Conference*, Whitehorse, Yukon. March 25, 2013

Gaetz, Stephen (2013) "A Framework for Preventing Youth Homelessness" *Ending Family and Youth Homelessness*, National Alliance to End Homelessness. Seattle WA, Feb 21, 2013

Gaetz, Stephen (2012) "Supporting Transitions to Adulthood: The Foyer". *Ontario Non-Profit Housing Association Conference*. Toronto. November 17, 2012.

Gaetz, Stephen (2012) "Making Research Matter – Creating impact for Housing and Homelessness Research". *Ontario Non-Profit Housing Association Conference*. Toronto. November 17, 2012.

Gaetz, Stephen (2012) "Homelessness, Social Exclusion and the Risk of Tuberculosis Infection". *Tuberculosis in Canada: Detection, Intervention and Compliance.* Centre for Disease Modelling. Ottawa: November 15, 2012

Gaetz, Stephen (2012) "Stopping the Problem Before it Starts. A Prevention Response to Youth Homelessness" *Pushing the Limits conference*. United Way of Calgary and Area. October 18, 2012

Gaetz, Stephen (2012) "The Possibilities of Connection: Linking schools, community organizations and families in addressing youth homelessness in Australia and the UK" *Pushing the Limits conference*. United Way of Calgary and Area. October 17, 2012

Gaetz, Stephen (2012) "Supporting Transitions to Independence. The Foyer." Woods Homes Provincial Youth Shelter Symposium. Calgary, September 20th, 2012

Gaetz, Stephen (2012). "Do we need a big bridge to cover a small gap since we're all on campus or do we need a small bridge to cover a large gap between research and practice?" *Knowledge Mobilization Forum,* Ottawa. June 17, 2012

Gaetz, Stephen (2012). "Responding to H1N1 in the Context of Homelessness in Canada". *Pan-inFORM – Indigenous Populations Health Protection – IPHP.* York University, May 7, 2012

Gaetz, Stephen (2012). "Thinking about Program Evaluation in the Homelessness Sector", *Homelessness Community Advisory Board Meeting*, St. John's, Nfld. May 4, 2012

Gaetz, Stephen (2012). "Towards a Canadian Definition of Homelessness" *Homelessness Community Advisory Board Meeting*, St. John's, Nfld. May 4, 2012

Gaetz, Stephen (2012). "Reimagining our Response to Youth Homelessness" *Canadian Housing Renewal Association.* St. John's Nfld., May 3, 2012.

Gaetz, Stephen & MacKinnon, Martha (2012) "Educating the Homeless Student. Pedagogical and Legal Issues." *Canadian Association for the Practical Study of Law in Education.* Ottawa, April 30, 2012

Gaetz, Stephen (2012). "Ending Homelessness – The role of data, evidence and knowledge mobilization" *Seven Cities on Housing and Homelessness – Leadership Summit.* Calgary, Alberta. April 16, 2012

Gaetz, Stephen (2012). "Knowledge Transfer and Networking Between Communities of Practice" *Espace public et sans domicile fixe: La Recherche S'Expose.* St. Etienne, France. March 7, 2012

Gaetz, Stephen (2012). "Making the Case for Housing First: What can Research Offer?" *Espace public et sans domicile fixe: La Recherche S'Expose.* St. Etienne, France. March 7, 2012

Gaetz, Stephen (2012). "The Housing Crisis and Homelessness: The Canadian Homeless Hub and Lessons For Ireland" New Housing Poverties in Contemporary Ireland. Cork, Ireland. March 2, 2012

Gaetz, Stephen (2011). "Reimagining our Response to Youth Homelessness: A Canadian and Global Perspective". *CMHC – National Housing Research Committee Meeting.* Ottawa, Nov. 8, 2011

Gaetz, Stephen (2011). (Chair and Session Organizer) "New Directions in Research on Youth Homelessness in Canada" *CMHC – National Housing Research Committee Meeting.* Ottawa, Nov. 8, 2011

Gaetz, Stephen (2011). "Reimagining our Response to Youth Homelessness in Canada". *ONPHA Conference*, Niagara Falls, ON. October 30, 2011

Gaetz, Stephen & O'Grady, Bill (2011). "Can I See Your ID? Policing and the Criminalization of Youth Homelessness in Canada". *Without a Home – Current Issues in Homelessness.* York University,Toronto, October 6, 2011.

Gaetz, Stephen (2011). "Responding to H1N1 in the Context of Homelessness in Canada". *Health Systems Research on H1N1 – Knowledge Exchange Workshop (CIHR)*. Ottawa. September 20, 2011

O'Grady, Bill & Gaetz, Stephen (2011). "Being Served and Protected: Un-housed youth's experiences with the Toronto Police Service". *American Bar Association Meetings*. Toronto, August 5, 2011

Gaetz, Stephen (2011) "Mobilizing Homelessness Research" *2011 Ontario Education Research Symposium.* Toronto. January 27, 2011

Gaetz, Stephen (2010). "Research and Policy". *The Road Home Conference on Homelessness*. Edmonton, Alberta. November 17

Gaetz, Stephen (2010). "Youth, Housing and Homelessness". *The Road Home Conference on Homelessness*. Edmonton, Alberta. November 16

Gaetz, Stephen (2010). "TEDx Presentation - Making Research Matter: Mobilizing Homelessness Research". Ctrl+Alt+Delete TEDx York U. November 4

Gaetz, Stephen (2010). Closing Plenary: "The Engaged Researcher" *l'itinérance. Défis théoriques et méthodologiques. Rethinking Homelessness. Theoretical and Methodological Challenges*. UQAM, Montreal, October 29

Gaetz, Stephen; Waegemakers-Schiff, Jeanette & Schiff, Rebecca (2010). "Pandemic preparedness for homeless persons in various Canadian cities". *l'itinérance. Défis théoriques et méthodologiques. Rethinking Homelessness. Theoretical and Methodological Challenges.* UQAM, Montreal, October 27

Gaetz, Stephen (2010). "Making Research Matter – Mobilizing Research to Help End Homelessness" *Calgary Homeless Foundation Research Conference*. Calgary, October 10, 2010

Gaetz, Stephen (2010). "Safe Streets, livable streets, *whose* streets? The law and order response to youth homelessness in Canada" *The Joe Doherty Seminar. The Changing Urban Frontier and Youth Homelessness* St. Andrews, Scotland. Feb. 10, 2010

Gaetz, Stephen (2009). "A Safe and Decent Place to Live". *Practice and Policy Innovations: Incorporating Socially Marginalized People in Housing and Communities.* Bellagio, Italy. November 5, 2009

Gaetz, Stephen (2009) The Canadian Response to Homelessness – Expensive but is it effective?" Tax Expenditures and Public Policy in Comparative Perspective Conference. Toronto, ON. September 10, 2009

Gaetz, Stephen (2009). "*Creating Agents of Change: Bringing Homelessness into the Classroom".* BC Teachers Federation Leadership Conference,. Vancouver, BC, August 2009

Gaetz, Stephen (2009). *Mobilizing Homelessness Research in Canada*. Growing Home: Housing and Homelessness in Canada. Calgary, February 2009

Gaetz, Stephen (2009). *Canadian Homelessness Research Network: Making Research Matter*. Growing Home: Housing and Homelessness in Canada. Calgary, February 2009

Gaetz, Stephen & Bill O'Grady (2008). *Youth Homelessness and Incarceration*. Raising the Roof - Partners Solving Youth Homelessness. Toronto, Nov. 2008

Gaetz, Stephen (2007). *The Homeless Hub: Canadian Homelessness Research Clearinghouse Project.* Ontario Municipal Social Services Association Annual Meeting. Toronto, Canada October, 2007

Gaetz, Stephen & O'Grady, Bill (2007). *Health among Toronto Street Youth: An Analysis of Immigrant & Non-Immigrant Youth.* ISA Research Committee on Family Studies Health in Families, Healthy Families: Gendered Explorations, Toronto, Canada

Gaetz, Stephen (2006). *Homelessness in Canada.* International Homelessness Seminar held in London, UK

Gaetz, Stephen (2006). *Developing a Clearinghouse of Homelessness Research in Canada.* Workshop: International Comparative Perspectives on Homelessness. 11th International Metropolis Conference. Lisbon, Portugal (October)

Gaetz, Stephen (2005). *Making Research Matter: The Emergence of Research as a Factor in Solving the Homelessness Crisis in Canada.* Breaking New Ground: Innovation in the Public Sector, International Conference, Cork Ireland (September, 2005).

Gaetz, Stephen & O'Grady, Bill (2005). *Diversity and Making Money: Race, Gender and the Economy of Young Homeless Workers in Toronto.* Canadian Conference on Homelessness. Toronto (May)

Naomi Dachner, Valerie Tarasuk, Jinguang Li, Stephen Gaetz & Blake Poland (2005). *Food Insecurity and Nutritional Vulnerability Among Homeless Youth in Toronto.* Canadian Conference on Homelessness. Toronto (May)

Naomi Dachner, Valerie Tarasuk, Stephen Gaetz & Blake Poland (2005). *An Examination of Community Efforts to Help Meet the Food Needs of Homeless People in Toronto.* Canadian Conference on Homelessness. Toronto (May)

Gaetz, Stephen (2004). *An Urban Other: Street Youth and Criminal Victimization in Toronto.* Association of Canadian Studies in Ireland. Cork, Ireland (April).

Gaetz, Stephen (2003). *Street Justice: Alternative Education and Social Inclusion.* Expanding Paradigms: What is Education Anyway?, Graduate Student Conference, York University. Toronto, Ontario.

Gaetz, Stephen & O'Grady, Bill (2002). *Street Youth and Gendered Work*. The Congress of Social Sciences and Humanities conference. Toronto, Ontario.

Gaetz, Stephen (2001). *Starting a Professional Development School*. International Conference on School Effectiveness and Improvement Annual Meeting. Toronto, Ontario.

Gaetz, Stephen & O'Grady, Bill (1999). *"Making a buck" - Income Generating Strategies of Street Youth in Toronto.* American Society of Criminology Annual Meeting. Toronto, Ontario.

Gaetz, Stephen (1999). *Developing Dental Services within a Community Health Centre Context*. Association of Ontario Health Centres Annual Meeting. London, Ontario.

Gaetz, Stephen (1998). *Street Youth and Sexuality*. Guelph Conference and Training Institute on Sexuality. Guelph, Ontario.

Gaetz, Stephen (1996). *Community Development and Lesbian, Gay and Bisexual Youth*. Other Young Lives II Conference. Toronto, Ontario.

Gaetz, Stephen & Travers, Anna (1996). *Are Street Youth a Community? Challenging Notions of Community Development*. Association of Ontario Community Health Centres Conference. Toronto, Ontario.

Gaetz, Stephen (1993). *Planning Community-based Youth Services in Cork, Ireland.* Canadian Association of Anthropology and Sociology. Toronto, Ontario.

Gaetz, Stephen (1991). *Turning Rebellion into Money: an Analysis of the Commodification of Punk Culture.* Critical Anthropology conference. Toronto Ontario.

Gaetz, Stephen (1986). *The Economy of Punks in Toronto*. Canadian Anthropological Association Meetings. Toronto, Ontario.

Gaetz, Stephen (1985). *Punks in Toronto*. North East Anthropology Association Meetings. Buffalo, N.Y.

Keynote Addresses

Gaetz, Stephen (2021) "Impact of Homelessness and Extreme Poverty on Involvement with the Criminal Justice System." *Annual Justice and Treatment Partnership Conference, Toronto (On Line) – December 7, 2021*. (Keynote Address)

Gaetz, Stephen & Redman, Melanie (2021) "Towards the Transformation of Our Response to Youth Homelessness". Australia – National Youth Homelessness Virtual Conference. June 15, 2021. (Keynote Address)

Gaetz, Stephen & Redman, Melanie (2020) "Making the Shift – A Youth Homelessness Social Innovation Lab and the Duty to Assist". London, UK: *Homelessness Prevention Conference | CRISIS*. March 20, 2020. (Keynote Address)

Redman, Melanie & Stephen Gaetz (2020) "Making the Shift – A Youth Homelessness Social Innovation Lab". Cardiff, Wales: *Preventing Youth Homelessness 2020*. March 9, 2020. (Keynote Address)

Gaetz, Stephen & Redman, Melanie (2019) "A Roadmap for the Prevention of Youth Homelessness". Sydney, Australia: *NSW Homelessness, AGM*. October 21, 2019. (Keynote Address)

Gaetz, Stephen (2019) "Lessons from Canada: Progress, Challenges, Next Steps". Melbourne Australia: *Victorian Homelessness Conference*. October 14, 2019. (Keynote Address)

Redman, Melanie & Stephen Gaetz (2019) "Creating Research Impact: Making the Shift, A Youth Homeless Social Innovation Lab". Toronto, York University: *Faculty of Education Launch*. Sept. 4, 2019. (Keynote Address)

Gaetz, Stephen (2018) "Can We End Youth Homelessness in Canada?". Toronto, ON: *The Jackman Lecture: York University*. December 4, 2018. (Keynote Address)

Gaetz, Stephen & Redman, Melanie (2018) "A Way Home: Transforming Systems for Change". Antwerp, Belgium: *Launch of A Way Home Europe*. Sept 17, 2018. (Keynote Address)

Redman, Melanie & Stephen Gaetz (2018) "What the Future Looks Like? A Roadmap for the Prevention of Youth Homelessness". New York: *Point Source Symposium on Solutions to Youth Homelessness*. Thursday, February 22, 2018. (Keynote Address)

Gaetz, Stephen & Redman, Melanie (2018) "What the Future Looks Like? A Roadmap for the Prevention of Youth Homelessness". Ottawa: *Coming Up Together Conference on Youth Homelessness.* Thursday, February 22, 2018. (Keynote Address)

Redman, Melanie & Stephen Gaetz (2018) "What the Future Looks Like? A Roadmap for the Prevention of Youth Homelessness". Toronto: *Homelessness Partnering Strategy / Government of Ontario Homelessness Conference*. January 23, 2018. (Keynote Address)

Gaetz, Stephen (2017) "Preventing and Ending Homelessness" Toronto, Ontario: *ICFHT AGM.* Monday, October 23, 2017. (Keynote Address)

Gaetz, Stephen (2017) "The *SHIFT* to end homelessness". Edmonton, Alberta: *Douglas R.W. Wilson lecture* Thursday, October 19, 2017. (Keynote Address)

Gaetz, Stephen (2015) "A Way Home" *OMSSA Conference on Homelessness Prevention, Toronto, ON.* November 25, 2015. (Keynote Address)

Gaetz, Stephen (2015) "Preventing Youth Homelessness through School-Based Initiatives." *Graduate Student Conference in Education*, York University, Toronto, ON, November 19, 2015. (Keynote Address)

Gaetz, Stephen (2015) "Knowledge Mobilization and Design Thinking: Towards Enhancing the Impact of Homelessness Research". *The North American HIV/AIDS Housing Summit VII.* Washington DC., September 15. (Keynote Address)

Gaetz, Stephen (2015) "Oh Canada! What we have learned, Where we are going …" *Launch of Edmonton Plan to Prevent, Reduce and End Youth Homelessness*. Edmonton, AB., June 10th, 2015. (Keynote Address)

Gaetz, Stephen (2015) "10 things I've learned about Youth Homelessness" *Youth Services Access and Design Forum – Homeward Trust*. Edmonton, AB., June 10th, 2015. (Keynote Address)

Gaetz, Stephen (2015) "Oh Canada! Lessons on Housing First from the Canadian Response to Homelessness" *Housing First: The Solution to Rough Sleeping? Pathway,*

Focus Ireland, City of Dublin. Dublin, Ireland., *June 26th,* 2015. (Keynote Address)

Gaetz, Stephen (2015) "Understanding Youth Homelessness in Canada" *Re-Imagining Youth Homelessness in Ottawa*. Calgary Homeless Foundation Research Symposium, Calgary, AB. April 22nd, 2015. (Keynote Address)

Gaetz, Stephen (2014) "Understanding Youth Homelessness in Canada" *Re-Imagining Youth Homelessness in Ottawa*. Youth Services Bureau, Ottawa. November 17th, 2014

Gaetz, Stephen (2014) "Thinking About Youth Homelessness" *Attacking Rural Homelessness in Lanark County*. Perth, Ontario. October 20, 2014. (Keynote Address)

Gaetz, Stephen (2014) "Oh Canada! Housing first and the evolution of the Canadian response to Homelessness". *8th National Conference on Homelessness.* Brisbane Australia, September 11, 2014. (Keynote Address)

Gaetz, Stephen (2014) Keynote Inaugural lecture of the Star Institute. Li Ka Shing Knowledge Institute, Toronto. On. September 30, 2014. (Keynote Address)

Gaetz, Stephen (2013) "Homelessness in Canada", *International Homelessness Research Conference*, Philadelphia, Pennsylvania, June 3, 2013. (Keynote Address)

Gaetz, Stephen (2013) "Research Impact! How Research Can Contribute to Ending Homelessness". *Southern Alberta Research Symposium*. City of Lethbridge, May 20, 2013

Gaetz, Stephen (2012) "Research Impact! How Research Can Contribute to Ending Homelessness". (Keynote Address) *Calgary Research Symposium*. Calgary Homeless Foundation. November 29, 2012

Gaetz, Stephen (2012) "What if every child had a caring adult in their life?" (Keynote Address) *Pushing the Limits conference*. United Way of Calgary and Area. October 17, 2012 (Keynote Address)

Gaetz, Stephen (2012) "What Works and For Whom? Developing a Framework for Promising Practices". (Keynote Address) *Workshop on Homelessness: Sharing Promising Practices*. Homelessness Partnering Strategy. October 11, 2012. (Keynote Address)

Gaetz, Stephen (2012) "Can We Reimagine our Response to Youth Homelessness?" *Woods Homes Provincial Youth Shelter Symposium.* Calgary, September 20th, 2012. (Keynote Address)

Gaetz, Stephen (2012). "Family Matters: Rethinking the role of family in our response to youth homelessness". Keynote panel. Graduate Students Conference in Education 2012: *Education in a Changing World.* York University. April 27, 2012. (Keynote Address)

Gaetz, Stephen (2010). "The Engaged Researcher: Making Research Matter" (Keynote Address) *Calgary Homeless Foundation Research Symposium*, August, 2010. (Keynote Address)

Gaetz, Stephen (2008). *Making Research Matter: Mobilizing Homelessness Research to End Homelessness.* Calgary Homeless foundation Research Symposium. Calgary, Canada. August, 2008. (Keynote Address)

Invited Public Lectures

Gaetz, Stephen (2022) "Can we end youth homelessness in Canada? " *Office of the President Salon*, York University. February 3, 2022

Gaetz, Stephen (2021) *"UN Sustainable Development Goals: Poverty and Homelessness*." *SDG Action Networking Series,* Government of Canada SDG Unit (ESDC). January 27, 2022,

Gaetz, Stephen (2021) "Building Large Scale Grants". *Vice President of Research and Innovation Event*, York University. December 2, 2021.

Gaetz, Stephen (2021) "PREVENTING Youth Homelessness … Why do it? " *Choices for Youth AGM,* St. John's Nfld. Oct 2, 2021

Gaetz, Stephen (2021) "Knowledge Mobilization and Youth Homelessness Prevention." *LivEx Group Meeting*, York University, Toronto (OnLine). September 3, 2021

Gaetz, Stephen (2021) "What *IS* Youth Homelessness Prevention?" *Innovation York*, York University, Toronto (OnLine). July 7, 2021

Gaetz, Stephen and Redman, Melanie (2021) "Launch of the Toronto Charter Centre on Youth Homelessness Prevention". *York University, Toronto and the United Nations Economic Commission for Europe* (OnLine). June 16, 2021

Gaetz, Stephen and Redman, Melanie (2021) "Making the Shift – Youth Homelessness Social Innovation Lab." *Province of Ontario, Ministry of Housing*, Toronto (OnLine). Tuesday, June 7, 2021

Gaetz, Stephen (2021) *Understanding Research Impact*. Making the Shift Board of Directors, Toronto (OnLine). March 24, 2021

Gaetz, Stephen (2020) *Building Winning Large Scale Grants.* Research Commons Workshop, York University, Toronto (OnLine). December 99, 2020

Gaetz, Stephen (2020) *Covid 19 and Youth Homelessness.* Faculty of Education, York University, Toronto (OnLine). September 19, 2020

Gaetz, Stephen (2020) *Why do research on youth homelessness prevention?.* LivEx Group, York University, Toronto (OnLine). September 19, 2020

Gaetz, Stephen & Redman, Melanie (2020) *Making the Shift, A Youth Homeless Social Innovation Lab. Problematic substance use, Housing and Homelessness.* Ottawa: Health Canada – Elicit Substance and Cannabis Unit. February 6, 2020

Redman, Melanie & Stephen Gaetz (2020) *Making the Shift, A Youth Homeless Social Innovation Lab. Networks of Centres of Excellence.* Ottawa: Health Canada. January 17,

2020

Gaetz, Stephen & Anika Mifsud (2019) *Migration and Homelessness in the Greater Toronto Area.* Toronto: United Way of Greater Toronto. December 9, 2019

Gaetz, Stephen & Redman, Melanie (2019) *Creating Research Impact: Making the Shift, A Youth Homeless Social Innovation Lab.* Toronto: Graduate Program in the Faculty of Education. November 13, 2019

Redman, Melanie & Stephen Gaetz (2019) *Designing the Adaptation of a Duty to Assist in Canada.* Toronto Canada: A Way Home Funders' Table. October 24, 2019

Gaetz, Stephen (2019) *Lessons from Canada: Progress, Challenges, Next Steps.* Melbourne, Australia: Salvation Army, October 17, 2019

Gaetz, Stephen & Redman, Melanie (2019) *Getting Organized through Collective Impact.* Melbourne, Australia: Salvation Army, October 17, 2019

Redman, Melanie & Stephen Gaetz (2019) *Roadmap for the Prevention of Youth Homelessness.* Melbourne, Australia: Salvation Army, October 17, 2019

Gaetz, Stephen & Redman, Melanie (2019) *Upstream: Taking Social Innovation Abroad.* Geelong Australia: Upstream Colloquium. October 16, 2019

Redman, Melanie & Stephen Gaetz (2019) *Creating Research Impact: Making the Shift, A Youth Homelessness Social Innovation Lab. Toronto, Ontario: Meeting with Anna Bailao, Deputy Mayor, City of Toronto.* October 7, 2019

Gaetz, Stephen (2019) *Homelessness in Canada: What We Know, What We Can Do.* Toronto, Ontario: SHAD Lecture, York University. July 16, 2019

Gaetz, Stephen & Redman, Melanie (2019) *The Roadmap for the Prevention of Youth Homelessness* Dublin, Ireland: Focus Ireland. June 26, 2019

Redman, Melanie & Stephen Gaetz (2019) *Understanding Youth Homelessness.* Dublin, Ireland: Trinity College Lecture. June 25, 2019

Gaetz, Stephen (2019) *Understanding Youth Homelessness.* Toronto, Ontario: Bridgeable. May 21, 2019

Gaetz, Stephen & Redman, Melanie (2019) *A Duty to Assist – How We Can End Youth Homelessness.* Toronto, ON: A Way Home Advisory Committee. May 16, 2019

Gaetz, Stephen (2019) *A Duty to Assist – How We Can End Youth Homelessness.* Toronto, ON: National Learning Community on Youth Homelessness Meeting. May 13, 2019

Gaetz, Stephen (2019) *Making the Shift – A Youth Homelessness Social Innovation Lab.* Toronto, ON: National Learning Community on Youth Homelessness Meeting. May 13, 2019

Redman, Melanie & Stephen Gaetz (2019) *A Duty to Assist – How We Can End Youth Homelessness.* Hamilton, ON: Street Youth Planning Collaborative. May 1, 2019

Gaetz, Stephen (2019) *What the Future Looks Like – Preventing and Ending Youth Homelessness in Canada.* Toronto, Ontario: Academy of Lifelong Learning Lecture: University of Toronto February 6, 2019

Gaetz, Stephen & Redman, Melanie (2019) *The Development of Highly Qualified Personnel.* Geneva, Switzerland: United Nations Economic Commission of Europe. February 19, 2019

Redman, Melanie & Stephen Gaetz (2019) *Making the Shift – Towards a UN Charter Centre on Homelessness.* Geneva, Switzerland: United Nations Economic Commission of Europe. February 19, 2019

Gaetz, Stephen & Redman, Melanie (2019) *Canadian Observatory on Homelessness.* Geneva, Switzerland: United Nations Economic Commission of Europe. February 19, 2019

Gaetz, Stephen (2019) *Making the Shift – A Youth Homelessness Social Innovation Lab.* Toronto, Ontario: Social Innovation Seminar, Trillium Fountation. February 6, 2019

Redman, Melanie & Stephen Gaetz (2018) *Making the Shift – A Youth Homelessness Social Innovation Lab.* Ottawa, Ontario: Conference Board of Canada. December 6, 2018

Gaetz, Stephen (2018) *A Duty to Assist – How We Can End Youth Homelessness.* Toronto, ON: Youth Homelessness Funders Table. October 31, 2018

Gaetz, Stephen & Redman, Melanie (2018) *Making the Shift: Youth Homelessness Social Innovation Lab*. Ottawa, Ontario: Government of Canada, Employment and Social Development Canada. October 16, 2018

Redman, Melanie & Stephen Gaetz (2018) "LGBTQ2S Youth and Youth Homelessness. Dublin, Ireland: Focus Ireland meeting. June 16, 2018

Gaetz, Stephen & Redman, Melanie (2018) "The relationship between involvement in Child Welfare and Youth Homelessness". Toronto: Ontario Association of Childrens' Aid Societies. March 7, 2018

Turner, Alina & Gaetz, Stephen (2018) "Building Regina's Plan to Prevent and End Homelessness". Regina: Systems Planning Meeting. February 15, 2018

Gaetz, Stephen (2018) "The Legal and Justice Issues of Youth who Experience Homelessness". Vancouver: American Bar Association Meeting on the Legal Needs of Street Youth. February 1, 2018

Gaetz, Stephen (2018) "A Way Home Canada". Kelowna: Launch of A Way Home Kelowna. January 18, 2018

Gaetz, Stephen (2018) "Housing First for Youth". Kelowna: Launch of A Way Home Kelowna. January 18, 2018

Gaetz, Stephen (2018) "Preventing youth homelessness – Five things we can do". Kelowna: Launch of A Way Home Kelowna. January 18, 2018

Gaetz, Stephen & Redman, Melanie (2017) "THIS is Housing First for Youth" St. John's, Nfld: Choices for Youth Meeting of NL Working Group on Youth Homelessness. December 8, 2017

Redman, Melanie & Gaetz, Stephen (2017) "Making the Shift – Preventing and Ending Homelessness in Canada" Toronto: Province of Ontario Poverty Reduction Strategy. August 18, 2017

Gaetz, Stephen (2017) "Partnerships" Toronto: NCE Planning Day August 15, 2017

Gaetz, Stephen (2017) "Clusters and Themes" Toronto: NCE Planning Day August 14, 2017

Gaetz, Stephen (2017) "Making the Shift Overview" Toronto: NCE Planning Day August 14, 2017

Redman, Melanie & Gaetz, Stephen (2017) "Making the Shift – Preventing and Ending Homelessness in Canada" Toronto: Making the Shift Kick-Off. August 14, 2017

Gaetz, Stephen (2017) "A Framework for Housing First for Youth" Toronto: Making the Shift Training Day. August 13, 2017

Gaetz, Stephen & Redman, Melanie (2017) "Making the Shift" Toronto: Trillium Foundation. July 19, 2017

Gaetz, Stephen & Vasko, Stephanie (2017) "Knowledge Mobilization and Design Thinking" Toronto: REALIZE. July 10, 2017

Redman, Melanie & Gaetz, Stephen (2017) "A Way Home and Collective Impact" Toronto: Trillium Foundation. July 10, 2017

Gaetz, Stephen & Redman, Melanie (2017) "Making the Shift – Preventing and Ending Youth Homelessness in Canada" Dublin: Trinity College. June 27, 2017

Redman, Melanie & Gaetz, Stephen (2017) "Making the Shift – Can we make homelessness prevention a priority?" Dublin: Trinity College. June 27, 2017

Gaetz, Stephen & Redman, Melanie (2017) "Housing First for Youth" Utrecht, Netherlands June 22, 2017

Gaetz, Stephen (2017) "Understanding Youth Homelessness" Budapest, Hungary: FEANTSA Youth Homelessness Study Group. June 12, 2017

Gaetz, Stephen (2017) "Housing First for Youth" Budapest, Hungary: FEANTSA Youth Homelessness Study Group. June 13, 2017

Gaetz, Stephen & Redman, Melanie (2017) "Coming Together to End Youth Homelessness in Peterborough " Peterborough, Ontario. May 22, 2017

Gaetz, Stephen (2017) "Without a Home – The National Youth Homelessness Survey " Toronto, Ontario: National Learning Community on Youth Homelessness. May 10, 2017

Gaetz, Stephen & Redman, Melanie (2017) "Making the Shift Launch – Strategy Session"

Toronto: Catherine Donnelly Foundation. April 21, 2017

Gaetz, Stephen (2017) "Addressing Youth Homelessness in Canada" Toronto: Covenant House AGM. April 19, 2017

Gaetz, Stephen & Redman, Melanie (2017) "Youth Homelessness Social Innovation Lab" Ottawa: Homelessness Partnering Strategy. April 18, 2017

Redman, Melanie & Gaetz, Stephen (2017) "A Way Home Advisory Committee Meeting" Toronto: Catherine Donnelly Foundation. April 6, 2017

Gaetz, Stephen & Redman, Melanie (2017) "Coming Together to End Youth Homelessness in Elgin County " Elgin County. April 3, 2017

Redman, Melanie & Gaetz, Stephen (2017) "Reimagining our Response to Youth Homelessness " Toronto: *Ontario Ministry of Housing*. March 25, 2017

Gaetz, Stephen & Redman, Melanie (2017) "The Canadian Observatory on Homelessness and A Way Home - " Toronto: *Danish Study Tour*. February 16, 2017

Gaetz, Stephen (2017) "Knowledge Mobilization and Design Thinking" Toronto: *Divided City / United City*. February 14, 2017

Gaetz, Stephen & Czech, Wally (2017) "Professional Knowledge Transfer: Housing First for Youth". London, ON. January 22, 2017

Gaetz, Stephen (2017) "Housing First for Youth: Employment Training Program Design Sprint". London, ON. January 18, 2017

Redman, Melanie & Gaetz, Stephen (2016) "Implementing New Community Planning Tools on Youth Homelessness". Homelessness Partnering Strategy/ Ontario Ministry of Housing Conference Toronto, ON. January 11, 2017

Gaetz, Stephen & Redman, Melanie (2016) "A Way Home". Home Depot Canada Foundation, Board Meeting. Toronto, ON. December 13, 2016

Redman, Melanie & Gaetz, Stephen (2016) "Coming Together to End Youth Homelessness in Elgin County". St. Thomas, ON. November 30, 2016

Gaetz, Stephen & Redman, Melanie (2016) "Coming Together to End Youth Homelessness in Renfrew County". Arnprior, ON. November 23, 2016

Gaetz, Stephen (2016) "Homelessness in Canada: Understanding the National Context". Raising the Roof AGM. Toronto, ON. November 24, 2016

Gaetz, Stephen (2016) "Homelessness Prevention 101". *Leo Burnett*. Toronto, Canada. October 31, 2016

Gaetz, Stephen; Tim Richter and Erin Dej (2016) State of Homelessness in Canada release. Ottawa Ontario

Redman, Melanie & Gaetz, Stephen (2016) "Coming Together to End Youth Homelessness in Washington State". Seattle WA. October 12, 2016

Gaetz, Stephen & Redman, Melanie (2016) "Coming Together to End Youth Homelessness in Winnipeg". Winnipeg, MN. October 11, 2016

Redman, Melanie & Gaetz, Stephen (2016) "Coming Together to End Youth Homelessness in LANARK County". *A Way Home Lanark County.* Perth, ON. October 7, 2016

Gaetz, Stephen & Redman, Melanie (2016) "A Way Home". *Catherine Donnelly Foundation – Funders Table*. September 16, 2016

Gaetz, Stephen (2016) "Responding to Youth Homelessness – What We Should Know, What We Should Do". Young Street Mission Board Meeting. Toronto, ON. September 27, 2016

Redman, Melanie & Gaetz, Stephen (2016) "Reimagining our response to youth homelessness" Focus Ireland. Dublin, Ireland June 27

Gaetz, Stephen & Redman, Melanie (2016) "Housing First for Youth in Europe – A Human Rights Approach" Rock Trust. Edinburgh, Scotland. June 6, 2016

Redman, Melanie & Gaetz, Stephen (2016) "A Way Home". *Catherine Donnelly Foundation – Funders Table*. May 4, 2016

Gaetz, Stephen. (2016) "Knowledge Mobilization and Design Thinking." National Learning Community on Youth Homelessness meeting. May 25, 2016

Redman, Melanie & Gaetz, Stephen (2016) *"A Way Home". Downtown Women's Centre.* Los Angeles, CA. April 7, 2016

Gaetz, Stephen (2016) "Knowledge Mobilization and Design Thinking – Making homelessness research matter!" Graduate Seminar. April 5, 2016

Gaetz, Stephen (2016) "Knowledge Mobilization and Design Thinking – Making homelessness research matter!" OISE CEPP Seminar. March 30, 2016

Gaetz, Stephen & Redman, Melanie (2016) "A Way Home". *FEANTSA Youth*. Budapest Hungary. March 14, 2016

Redman, Melanie & Gaetz, Stephen (2016) "Advocacy, Change and Coalition Building". *FEANTSA Youth.* Budapest Hungary. March 14, 2016

Gaetz, Stephen & Redman, Melanie (2016) "Building your coalition through Collective Impact". *FEANTSA Youth.* Budapest Hungary. March 13, 2016

Gaetz, Stephen (2016) A Framework for Homelessness Prevention. FEANTSA. Brussels, Belgium. March 3, 2016

Gaetz, Stephen. (2016) "Knowledge Mobilization and Design Thinking – How to make homelessness research *matter*!." *Rosa Bruno-Jofre Symposium in Education*. Toronto, Ontario, February 25, 2016

Gaetz, Stephen. (2016) "Knowledge Mobilization and Design Thinking – Towards Enhancing the Impact of Research on Policy and Practice." York University, January 20,

2016

Redman, Melanie & Gaetz, Stephen (2016) *A Way Home.* Mental Health Commission Housing First Regional Training meeting Ottawa, ON. December 7, 2015

Gaetz, Stephen (2015) "The Big Picture: Mobilizing PiT Count Results." *HPS Point in Time Count Workshop*. Toronto ON, November 25, 2015

Gaetz, Stephen (2015) "Towards a National Research Agenda." *National Learning Community on Youth Homelessness Conference*, St. John's, NL. November 24, 2015

Gaetz, Stephen (2015) "A Framework for Preventing Youth Homelessness." *National Learning Community on Youth Homelessness Conference*, St. John's, NL. November 24, 2015

Gaetz, Stephen & Redman, Melanie (2015) "A Way Home." *National Learning Community on Youth Homelessness Conference*, St. John's, NL. November 23, 2015

Gaetz, Stephen (2015) "The Big Picture: Mobilizing PiT Count Results." *HPS Point in Time Count Workshop*. Vancouver, BC. November 18, 2015

Redman, Melanie & Gaetz, Stephen (2015) "A Way Home – Supporting Community and Government Planning" *Funders Together meeting*. Toronto, ON September 29th, 2015

Gaetz, Stephen & Redman, Melanie (2015) "From Child Protection to Youth Homelessness: Can we turn off the taps?" *Meeting of Provincial and Territorial Advocates for Youth.* St. John's Nfld. September 13, 2015

Gaetz, Stephen (2015) "Housing Options for Youth." *Yonge Street Mission*. September 9, 2015

Gaetz, Stephen (2015) "Research in Canada: The Canadian Observatory on Homelessness." *Impuls, Netherlands Centre for Social Care Research, Radboud University Medical Centre,* Utrect NL. July 6th, 2015

Gaetz, Stephen & Redman, Melanie (2015) "A prevention-Based Approach to Youth Homelessness" *Trinity College, Dublin.* Dublin, Ireland. June 25th, 2015

Redman, Melanie & Gaetz, Stephen (2015) "Reimagining our Response to Youth Homelessness" *Trinity College, Dublin; Focus Ireland*. Dublin, Ireland. June 24th, 2015

Gaetz, Stephen & Redman, Melanie (2015) "Reimagining our Response to Youth Homelessness" *Raikes Foundation / Campion Foundation meeting*. Seattle WA., June 4th, 2015

Redman, Melanie & Gaetz, Stephen (2015) "A Way Home – Supporting Community and Government Planning" *Raikes Foundation / Campion Foundation meeting*. Seattle WA., June 4th, 2015

Gaetz, Stephen & Redman, Melanie (2015) "Addressing Homelessness through Community Planning" Yellowknife Community Forum. Yellowknife NWT., May 14th, 2015

Gaetz, Stephen (2015) "Reimagining our Response to Youth Homelessness" C*atherine Donnelly Foundation Meeting.* Toronto, ON., May 28th, 2015

Gaetz, Stephen (2015) "Reimagining our Response to Youth Homelessness" *Funders Together Meeting.* Boston, MA. May 6th, 2015

Gaetz, Stephen (2015) "Preventing Youth Homelessness through school-based initiatives" *Working Upstream - Preventing Youth Homelessness through School-Linked Services.* Canadian Observatory on Homelessness Toronto, ON. April 24th, 2015

Gaetz, Stephen (2015) "Oh Canada! Understanding homelessness and the Canadian response" *Toronto Public Library.* Toronto, ON. April 21st, 2015

Gaetz, Stephen (2015) "10 things I've learned about Youth Homelessness" Samuel W. Shaw School. Calgary, AB. April 17th, 2015

Gaetz, Stephen (2015) "Canadian Definition of Homelessness" Ontario Advisory Panel on Homelessness. Toronto, ON. March 15, 2015

Gaetz, Stephen (2015) "Canadian Point-In-Time Count – Methodology and Toolkit" Hamilton Aboriginal Homelessness Symposium. Toronto, ON. March 27, 2015

Gaetz, Stephen (2015) "Canadian Point-In-Time Count – Methodology and Toolkit" COH / Homeless Hub. Toronto, ON. March 24, 2015

Gaetz, Stephen (2015) "Canadian Definition of Homelessness" Ontario Advisory Panel on Homelessness. Toronto, ON. March 15, 2015

Gaetz Stephen (2015) "Taking a Human Rights Approach to Youth Homelessness". *FEANTSA Youth Homelessness Network Meetings.* Strasbourg, France. March 10, 2015

Gaetz, Stephen (2015) "Ending Youth Homelessness" Ministry of Municipal Affairs and Housing, Province of Ontario. Toronto, ON. March 4, 2015.

Gaetz, Stephen (2015) "Understanding Constellations of Activity" Mobilizing Local Capacity meeting. Toronto, ON. March 3, 2015.

Gaetz, Stephen, Pollett, Sheldon (2015) "Coalition to End Youth Homelessness: Coalition Structure" Mobilizing Local Capacity meeting. Toronto, ON. March 3, 2015.

Gaetz, Stephen, Pollett, Sheldon (2015) "The Vision: Coalition to End Youth Homelessness:" Mobilizing Local Capacity meeting. Toronto, ON. March 3, 2015.

Gaetz, Stephen. (2015) "Homelessness in Canada. What do we know, what can we do?" *Toronto Public Library*. Toronto, ON, February 26, 2015.

Gaetz, Stephen (2015) "Oh Canada! Understanding homelessness and the Canadian response." Toronto Public Health. Toronto, ON. February 25, 2015.

Gaetz, Stephen (2015) *"Knowledge Mobilization and Design Thinking: Towards enhancing the impact of research on policy and practice".* Graduate program in Education, February 4th, 2015

Gaetz, Stephen (2015) *Towards an IGH Web Presence",* Institute of Global Homelessness meeting. London, UK. January 27, 2015

Gaetz, Stephen (2015) *"Oh Canada! Lessons from the Canadian Response to Homelessness",* University College Cork, City of Cork, Cork Ireland. January 20, 2015

Gaetz, Stephen (2015) *"Canadian Point in Time Counts – Methodology and Toolkit",* Ottawa Alliance to End Homelessness. Ottawa, ON. January 12, 2015

Gaetz, Stephen (2014) "The State of Homelessness in Canada 2014", *City of Toronto Affordable Housing Office*. Toronto, ON. December 3rd, 2014

Gaetz, Stephen (2014) "Canadian Observatory on Homelessness – Research Agenda", *Newfoundland Housing and Homelessness Network*. St. John's, Nfld. December 5th, 2014

Gaetz, Stephen (2014) "Towards a Strategy to End Youth Homelessness", *Newfoundland Housing and Homelessness Network*. St. John's, Nfld. December 4th, 2014

Gaetz, Stephen (2014) "Youth Homelessness – What do we know? What do we need to do?", *Newfoundland Housing and Homelessness Network*. St. John's, Nfld. December 3rd, 2014

Gaetz, Stephen (2014) "Acuity Assessment and Housing First for communities" *Newfoundland Housing and Homelessness Network*. St. John's, Nfld. December 3rd, 2014

Gaetz, Stephen (2014) "Canadian Point in Time Counts: Methodology and Toolkit" *Newfoundland Housing and Homelessness Network*. St. John's, Nfld. December 3rd, 2014

Gaetz, Stephen (2014) "Leaving Home: Youth Homelessness in York Region" *United Way York Region.* Aurora, ON November 27th, 2014

Gaetz, Stephen (2014) "Housing First in Canada – Is it the solution?" *ACTO National Housing Day Symposium*. Toronto, ON. November 20th, 2014

Gaetz, Stephen (2014) "A Research agenda for Ending Youth Homelessness" *National Learning Community on Youth Homelessness Meeting*. Montreal, Quebec. November 20, 2014.

Gaetz, Stephen (2014) "An End to Youth Homelessness" *Re-Imagining Youth Homelessness in Ottawa*. Youth Services Bureau, Ottawa. November 17th, 2014

Gaetz, Stephen (2014) "A Prevention Framework for Youth Homelessness" *Re-Imagining Youth Homelessness in Ottawa*. Youth Services Bureau, Ottawa. November 17th, 2014

Gaetz, Stephen (2014) "Preventing Youth Homelessness" *Attacking Rural Homelessness in Lanark County*. Perth, Ontario. October 20, 2014

Gaetz, Stephen (2014) "The Real Cost of Homelessness" *Victoria Chamber of Commerce*. Victoria, BC. October 16, 2014

Gaetz, Stephen (2014) "Coming of Age – Addressing Youth Homelessness" *Vancouver Foundation Community Meeting*. Vancouver, BC. October 15, 2014

Gaetz, Stephen (2014) “Housing First, What’s Next?” *Community Legal Clinic of York Region*. October 1, 2014.

Gaetz, Stephen (2014) “Housing First in Canada” *RENT – Training day on Housing First*. September 22, 2014.

Gaetz, Stephen (2014) “The Kids Aren’t Alright: Understanding Youth Homelessness in Winnipeg” *Winnipeg Chamber of Commerce*. Winnipeg, Mn., September 4, 2014

Gaetz, Stephen (2014) “Making A Difference – The role of financial institutions” *Assiniboine Credit Uniion community meeting*. Winnipeg, Mn., September 4, 2014

Gaetz, Stephen (2014) “A Safe and Decent Place to Live - Care, respect and dignity in responding to the needs of homeless youth” *RAY community meeting.* Winnipeg, Mn., September 3, 2014

Gaetz, Stephen (2014) “Youth Homelessness 101: What are the causes and conditions?” *RAY community meeting*. Winnipeg, Mn., September 3, 2014

Gaetz, Stephen (2014) “Getting Ready for Housing First”. *Community meeting,* Fredericton, New Brunswick, June 25, 2014

Gaetz, Stephen (2014) “Understanding Housing First”. *Community meeting,* Fredericton, New Brunswick, June 25, 2014

Gaetz, Stephen (2014) “A Safe and Decent Place to Live: Care, respect and dignity in responding to the needs of homeless youth.” *Harris Centre,* St. John’s Newfoundland. June 16, 2014

Gaetz, Stephen (2014) “Trends in Homelessness in Canada” *Community meeting,* St. John’s Newfoundland.

Gaetz, Stephen (2014) Host: Cafe Scientifique "Ending Homelessness Through Housing First: Lessons Learned from the Toronto Site of the At Home/Chez Soi Project" *MHCC At Home/Chez Soi - Toronto Site* Centre for Social Innovation. Tuesday, April 29th, 2014

Gaetz, Stehen (2014) “State of Homelessness in Canada.” *York Region Human Services Planning Board meeting.* April 15, 2014

Gaetz, Stephen (2014) Host: Panel of key participants. *Mental Health Commission of Canada, official launch of the final report on the At Home/Chez Soi project.* Ottawa: April 8, 2014

Gaetz, Stephen (2014) Panel participant: *The Aging Homeless: Best Practices for End of Life Care* Panel Discussion. Li Ka Shing Knowledge Institute St. Michael's Hospital, Toronto. March 25, 2014

Gaetz, Stephen (2013) “The Role of Research in Addressing Homelessness”. *Ministry of Municipal Affairs and Housing,* Toronto, ON. November 28, 2013.

Gaetz, Stephen (2013) "Reimagining Our Response to Youth Homelessness" *Covenant House*, Toronto, ON, October 27, 2013

Gaetz, Stephen (2013) "Youth Homelessness in York Region. United Way of York Region. Markham, ON. October 25, 2013

Gaetz, Stephen (2013) "Making Research Matter! How Research Can Contribute to Ending Homelessness*", Aboriginal Homelessness Research Network meeting*, Calgary, AL, October 18, 2013

Gaetz, Stephen (2013) "Canadian Homelessness Research Network: Sustaining Complex Partnerships" *SSHRC Partnership Grant Start-up Meeting*, Montreal, Que, October 16, 2013

Gaetz, Stephen (2013) "Making Research Matter! How Research Can Contribute to Ending Homelessness." *Homelessness Partnering Strategy – National Workshop on Housing First*. Ottawa, ON, October 4, 2013

Gaetz, Stephen (2013) "The State of Homelessness in Canada". *Municipality of Kitchener-Waterloo*. Waterloo, ON., Oct. 3, 2013

Gaetz, Stephen (2013) "Ending youth Homelessness – Approaches, Successes and Challenges". *Homeward Trust Community Meeting*, Edmonton. September 6, 2013

Gaetz, Stephen (2013) "The Victimization of Homeless Youth: Crime, Violence and Policing". *Ontario Ministry of Municipal Affairs*. Toronto. February 7, 2013

Gaetz, Stephen (2013) "The Real Cost of Homelessness", *Community Forum*, Uxbridge Ontario. February 6, 2013

Gaetz, Stephen (2013) "Supporting Transitions to Adulthood: The Foyer". *City Seminar*, York University. January 11, 2013

Gaetz, Stephen (2012) "Reimagining Or Response to Youth Homelessness". *United Way, York Region*. Markham. November 26, 2012

Gaetz, Stephen (2012) "The Real Cost of Homelessness: Can We Save Money and Do the Right Thing?" *Canadian Forum on Civil Justice*. November 22, 2012

Gaetz, Stephen (2012) "The Real Cost of Homelessness: Can We Save Money and Do the Right Thing?" *Peel Region*. November 9, 2012

Gaetz, Stephen (2012) "The Canadian Homelessness Research Network". *City of Toronto, Community and Recreation Committee*, September 19th, 2012

Gaetz, Stephen (2012) "What is the meaning of Social Profiling?" *Abused, Neglected, Arrested: Impact of social profiling of people who are homeless.* Hosted by the Wellesley Institute and the Sanctuary. Toronto, September 6, 2012

Gaetz, Stephen; O'Grady, Bill & Buccieri, Kristy (2012). "Can I See Your ID? Policing and the Criminalization of Youth Homelessness in Canada". Office of the Independent Police Review Director (Staff). Toronto, July 12, 2012.

Gaetz, Stephen; O'Grady, Bill & Buccieri, Kristy (2012). "Can I See Your ID? Policing and the Criminalization of Youth Homelessness in Canada". Office of the Independent Police Review Director (Board of Directors). Toronto, June 25, 2012.

Gaetz, Stephen (2012). "Making Research Matter: the Canadian Homelessness Research Network" *Graduate Program in Education Winter Colloquium: Engaged Scholarship – Research Impact on Solutions to Homelessness.* York University, Toronto. Thursday, March 29, 2012

Gaetz, Stephen (2012). "Thinking about knowledge mobilization and engaged research. Lessons from the Canadian Homelessness Research Network" *EDU / LAPS / YorkU Libraries, Research Support Series "Knowledge co-creation and knowledge mobilization"* York University, Toronto, ON. March 20, 2012

Gaetz, Stephen (2012). "Research on Youth Homelessness and Policing". *Hot Spot Youth and Policing Roundtable Meeting.* Toronto, ON. February 27, 2012

Gaetz, Stephen (2011) "Mobilizing Homelessness Research" Toronto: 4th Annual CHRN National Advisory Body meeting. October 8, 2011

Gaetz, Stephen (2011) "Reimagining our Response to Youth Homelessness: A Canadian and Global Perspective". *Greater Victoria Coalition to End Homelessness.* Victoria, BC. July 6, 2011

Gaetz, Stephen & Michaela Hynie (2011) "Understanding Program Evaluation for the Homelessness Sector". Toronto: City of Toronto. May 26, 2011

Gaetz, Stephen (2011) "Family Matters! Homeless youth and Eva's Initiatives "Family Reconnect" Program". Toronto: Eva's Initiatives. April 10, 2011

Gaetz, Stephen (2010) "Homelessness Partnering Secretariat and the Canadian Homelessness Research Network Meeting" Homelessness PAertnering Secretariat, Ottawa, January 18, 2011

Gaetz, Stephen & Bill O'Grady (2010) "Surviving Crime and Violence – Street Youth and Victimization in Toronto" Justice for Children and Youth meeting. Toronto October 23, 2010

Gaetz, Stephen (2010) "Poverty Reduction, Homelessness and Affordable Housing" Province of Ontario Lunch and LearnToronto, June 28, 2010

Gaetz, Stephen (2010) "Responding to Homelessness – Distributed Leadership as a solution?" City of Toronto, Toronto, June 25, 2010

Gaetz, Stephen & Bill O'Grady (2010) "Surviving Crime and Violence" Community town hall. Toronto. June 17, 2010

Gaetz, Stephen (2009) "Thinking about Poverty, Pandemics and Homelessness" Departmental Research Seminar, Department of Anthropology, York University, Toronto, October 15, 2009

Gaetz, Stephen (2008). *Ending Homelessness: Innovation and Research.* SHIFT: Sharing Homelessness Innovation for Toronto. City of Toronto. October 15, 2008

Gaetz, Stephen (2007). *The Homeless Hub – Mobilizing Research on Homelessness.* CMHC National Housing Research Committee. Ottawa, Ontario. October

Gaetz, Stephen (2007). *Homeless Youth.* KM in the AM - Knowledge Mobilization Breakfast. Markham, Ontario. September

Gaetz, Stephen (2005). *Working with Homeless Youth*. Children and Youth "At Risk" Conference, York University.

Gaetz, Stephen (2003). *Street youth, Children's Services and Access to Protection.* Helping Children Who Live in Toxic Situations - Conference sponsored by the American Orthopsychiatric Association and the Sparrow Lake Alliance. Toronto, Ontario. October

Gaetz, Stephen (2003). *Street Justice: Working with Youth who are Homeless.* Building on successes: An agency forum on homelessness - Conference sponsored by the City of Toronto and HRDC Canada. Toronto, Ontario. February

Gaetz, Stephen (2003). *Building Bridges: Street Youth and the Police.* Common Cause: Youth Safety in the City - Conference sponsored by the City of Toronto. Toronto, Ontario. January

Gaetz, Stephen (2002). *Youth Leadership: Including Street youth in the Development of Health Promotion Materials.* Westview Project 10th Anniversary Conference. Toronto, Ontario. September

Gaetz, Stephen (1999). *Planning and Developing Dental Services for Marginalized Populations*. Rexdale Community Health Centre. Toronto, Ontario. September

Gaetz, Stephen (1999). *Working with Street Youth in Toronto.* Eva's Place Annual General Membership Meeting. Toronto, Ontario. May

Gaetz, Stephen (1998). *Developing a Strategy for Street Youth Employment*. Planning in Health Promotion and Population Health Workshop on the Social Services System. University of Toronto.

Gaetz, Stephen (1998). *Thinking about Street Youth and Health Care*. Faculty of Medicine, University of Toronto. April

Gaetz, Stephen (1998). *Working with Street Youth*. Faculty of Social Work, University of Toronto. May

Gaetz, Stephen (1997). *Health Issues of Street Involved Youth*. Canadian Mental Health Association. Toronto, Ontario.

Gaetz, Stephen (1997). *Health Issues of Street Involved Youth.* Hospital for Sick Children. Toronto, Ontario.

Gaetz, Stephen (1996). *Planning a Dental Service for Street Youth*. Central Toronto Dental Hygienist's Society. Toronto, Ontario. November

Gaetz, Stephen (1996). *Planning a Dental Service for Street Youth.* Newmarket: York Region Dental Hygienist Society. Newmarket, Ontario.

Gaetz, Stephen (1996). *Developing Health Promotion Materials with Street Youth*. Planning in Health Promotion and Population Health Workshop, University of Toronto. Toronto, Ontario.

Gaetz, Stephen (1996). *Planning a Dental Service for Street Youth*. Faculty of Dentistry Student's Association. University of Toronto.

Gaetz, Stephen (1995). *Planning a Dental Service for Street Youth*. Durham Dental Hygiene Component Society. Oshawa, Ontario.

Gaetz, Stephen (1995). *Planning a Dental Service for Street Youth.* Halton Peel Dental Hygienist's Society. Mississauga, Ontario.

Gaetz, Stephen (1995). *Planning a Dental Service for Street Youth.* Halton-Peel Dental Nurses and Assistants Association. Mississauga, Ontario.

Gaetz, Stephen (1995). *Oral Health of Street Youth*. Toronto Academy of Dentistry (central). Toronto, Ontario.

Gaetz, Stephen (1995). *Planning a Dental Service for Street Youth*. Toronto North Dental Hygienist's Society. Toronto, Ontario.

Gaetz, Stephen (1995). *Planning a Dental Service for Street Youth.* Central Toronto Dental Hygienist's Society. Toronto, Ontario.

Gaetz, Stephen (1995). *Providing Health Services for Street Youth*. Hospital for Sick Children. Toronto, Ontario.

Gaetz, Stephen (1995). *The Oral Health Needs of Street Youth*. Ontario Dental Association. Toronto, Ontario.

Gaetz, Stephen (1994). *Working with Street Youth*. Series of 6 workshops presented to Metro Toronto Police, 52 Division. Toronto, Ontario.

Gaetz, Stephen (1994) . *Outreach to Straight Male Youth*. Paper presented at the "Get Down to it; Conference on Youth Health Issues", City of Toronto, Department of Public Health. Toronto, Ontario.

Gaetz, Stephen (1994). *Street Youth and Health Care*. East York Department of Public Health. Toronto, Ontario.

Gaetz, Stephen (1992). *Reaching Males through Family Planning Clinics*. East York Department of Public Health. East York, Ontario.

Webinars

Gaetz, S., Redman, M. (2020). *The Role of Research in Youth Homelessness and Prevention: Presentation to the LivEx Network.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/418446312

Redman, M., Gaetz, S., Baab, C. H., Huys, J., Vandergrift, K. (2018). *Putting UN General Comments 21 on Children in Street Situations to Work for Canadian Children and Youth!* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/320579465

Gaetz, S., Redman, M., Schwan, K., & French, D. (2018). *The Roadmap for the Prevention of Youth Homelessness.* Toronto, ON: Canadian Observatory on Homelessness Press. https://www.youtube.com/watch?v=7uKcpIMBygI

Gaetz, S., Turner, A., Elliott, D., & Reilly, J. (2018). *Homeless-Serving System Governance and the HPS Renewal.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/298453641

Gaetz, S., Redman, M., & Ali, N. (2018). *Without a Home - 2nd National Survey on Youth Homelessness.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/269522436

Redman, M., Gaetz, S., Turner, A. (2018). *Systems Planning 101 Webinar - Building Systems Capacity.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/269525431

Gaetz, S., Redman, M. (2018). *THIS is Housing First for Youth: A Program Model Guide Webinar.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/269529941

Gaetz, S., Redman, M., Buchnea, A. (2018). *Getting Ready: Without a Home 2019 Guide for Participating Agencies.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/306444255

Gaetz, S., Redman, M. (2017). *A New Direction: A Framework for Homelessness Prevention Webinar*. Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/218991959

Gaetz, S., Redman, M. (2017). *Introducing new protections services for 16-17 year old youth in Ontario: Impacts and opportunities for youth service providers.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/269533266

Gaetz, S., Redman, M. (2017). *Collective Impact and Youth Homelessness Community Planning.* Toronto, ON: Canadian Observatory on Homelessness Press. https://youtu.be/MMnggSezNmY

Gaetz, S., O'Grady, B., Kidd, S., & Schwan, K. (2016). *Without a Home: The National Youth Homelessness Survey Webinar (Nov 18).* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/269522436

Redman, M., Gaetz, S. (2016). *Launch of a Proposal for Federal Reinvestment in Youth Homelessness (April 13)*. Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/162783375

Gaetz, S., Pollett, S., McMillan, L. (2015). *A Way Home: A New Coalition to Prevent, Reduce and End Youth Homelessness*. Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/143613851

Gaetz, S., Jackson, N., Czech, W., & Turner A . (2015). *Using Point-in-Time Counts to Measure Progress Towards Ending Homelessness Webinar.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/124415829

Gaetz, S., Coffey, M., MacKenzie, D. (2015). *Working Upstream: Preventing Youth Homelessness Through School-Linked Service Models – Part 1.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/130210235

Gaetz, S., Coffey, M., MacKenzie, D. (2015). *Working Upstream: Preventing Youth Homelessness Through School-Linked Service Models – Part 2.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/130438273

Gaetz, S., MacDonald, J., McKitterick, M., Morton, E. (2014). *Webinar: Coming of Age: Reimagining the Response to Youth Homelessness in Canada.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/89446604

Gaetz, S. (2014). Webinar: A Safe and Decent Place to Live: Towards a Housing First Framework for Youth. Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/92675319

Gaetz, S., Doberstein, C., Belanger, Y., MacDonald J., Bellot, C. (2014). *Launch of the Canadian Observatory on Homelessness.* Toronto, ON: Canadian Observatory on Homelessness Press.

Abramovich, A., Tarasuk, V., Dachner, N., & Gaetz, S. (2013). *Book Launch: Youth Homelessness in Canada.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/65264084

Gaetz, S. (2011). *Can I see your ID? Policing and the criminalization of youth homelessness in Toronto.* Toronto, ON: Canadian Observatory on Homelessness Press. https://vimeo.com/31793667

Book Reviews

Gaetz, Stephen (2013) Kristina E. Givson (2011) "Street Kids – Homeless Youth, Outreach and the Policing of New York's Streets." *European Journal of Homelessness* , Volume 7, No.

2, December 2013: 439-443

Gaetz, Stephen (2011) MaryEllen Hombs "Modern Homelessness". European Journal of Homelessness: Volume 5, Issue 2 (December 2011): 241-243

Curriculum Materials

Gaetz, Stephen (2009). "Homelessness Curriculum for Teachers and Students". http://homelesshub.ca/Education/

I directed the development of this resource centre for educators and students interested in exploring the issue of homelessness through a variety of subject areas. Assisted teachers in preparing the following curriculum units: "An Integrated Unit for Elementary School; Exploring Homelessness through the Artist's Hands; Integrating Homelessness Issues into Family / Social Studies; Integrating Homelessness Into Civics Classes; The Study of Homelessness in English and Media Class; Understanding Homelessness Through Drama.

In addition, I also authored supporting resources for teachers and students on the following topics:

- What is Homelessness?
- Who are Homeless People?
- Who are Street Youth?
- Why do Young People Become Homeless?
- Why do Street Youth Panhandle?
- Do Homeless Youth Get Enough to Eat?
- Attitudes about Homelessness

Blog posts

Gaetz, S., Redman, M. (2019). *Announcing the Launch of Making the Shift!* Toronto, ON: Canadian Observatory on Homelessness Press. https://www.homelesshub.ca/blog/announcing-launch-making-shift

Gaetz, S., Redman, M. (2019). *What's the Future of Homelessness Prevention? Adapting the Welsh "Duty to Assist" for Canada.* Toronto, ON: Canadian Observatory on Homelessness Press. https://www.homelesshub.ca/blog/whats-future-homelessness-prevention-adapting-welsh-duty-assist-canada

Gaetz, S., Redman, M. (2019). *Reflections on Reaching Home, the Government of Canada's New Homelessness Strategy.* Toronto, ON: Canadian Observatory on Homelessness Press. homelesshub.ca/blog/reflections-reaching-home-government-canada's-new-homelessness-strategy

French, D., Gaetz, S., & Redman, M. (2019). *Youth continue to be outnumbered! Our response to the Federal Government's National Point-in-Time Count*. Toronto, ON:

Canadian Observatory on Homelessness Press. https://www.homelesshub.ca/blog/youth-continue-be-outnumbered-our-response-federal-government%E2%80%99s-national-point-time-count

Gaetz, S., Redman, M. (2019). *The Making the Shift Lab in Action: 6 Months In.* Toronto, ON: Canadian Observatory on Homelessness Press. https://www.homelesshub.ca/blog/making-shift-lab-action-6-months

Ferguson, C., Gaetz, S., & Redman, M. (2019). Experiments in Paradigm Shifting: How Service Design Can Inform the Duty to Assist Policy. Toronto, ON: Canadian Observatory on Homelessness Press. https://www.homelesshub.ca/blog/experiments-paradigm-shifting-how-service-design-can-inform-duty-assist-policy

Gaetz, S. (2018). *It's time for a change: Report of the Advisory Committee on Homelessness.* Toronto, ON: Canadian Observatory on Homelessness Press. https://www.homelesshub.ca/blog/it%E2%80%99s-time-change-report-advisory-committee-homelessness-0

Gaetz, S., Redman, M. (2018). *Announcing the Launch of Making the Shift!* Toronto, ON: Canadian Observatory on Homelessness Press. https://www.homelesshub.ca/blog/announcing-launch-making-shift

Gaetz, S., Redman, M. (2017). *Towards a Canadian Youth Homelessness Data Dashboard.* Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/towards-canadian-youth-homelessness-data-dashboard

Gaetz, S., Redman, M. (2017). *Announcing the Launch of Making the Shift!* Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/announcing-launch-making-shift

Dej, E., Gaetz, S. (2017). *Looking Forward: Shifting Towards Homelessness Prevention.* Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/looking-forward-shifting-towards-homelessness-prevention

Gaetz, S. (2016). *Let's Talk Housing & Prevention.* Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/lets-talk-housing-prevention

Gaetz, S., Redman, M. (2016). *Towards an Ontario Strategy to End Youth Homelessness.* Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/towards-ontario-strategy-end-youth-homelessness

Gaetz, S. (2016). *OF COURSE, we need a separate definition for youth homelessness*. Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/course-we-need-separate-definition-youth-homelessness

Gaetz, S., Redman , M. (2016). *Opportunity Knocks: A Proposal for Federal Investment to Prevent and End Youth Homelessness.* Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/opportunity-knocks-proposal-federal-investment-prevent-and-end-youth-homelessness

Gaetz, S. (2016). *Why is the harm reduction model so important?* Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/why-harm-reduction-model-so-important

Gaetz, S. (2015). *What is homelessness?* Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/what-homelessness

Gaetz, S. (2015*). Launch: Community Workspace on Homelessness.* Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/launch-community-workspace-homelessness

Gaetz, S. (2015). *Let's do things differently! 'A Way Home' and the promise of ending youth homelessness.* Toronto, ON: Canadian Observatory on Homelessness Press. http://homelesshub.ca/blog/lets-do-things-differently-%E2%80%98-way-home%E2%80%99-and-promise-ending-youth-homelessness

Gaetz, Stephen (2014) Ask the Hub - Are governments supportive of the harm reduction approach? Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Prevention Toronto: Homeless Hub

Gaetz, Stephen (2014) Ask the Hub - Does Housing First "Leave Youth Behind"? Toronto: Homeless Hub

Gaetz, Stephen (2014) Housing First CAN work for young people, but let's make sure we get it right Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Transitional Housing Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Discharge Planning for Hospitals and Mental Health Facilities Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Coordinated Assessment Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Outreach Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Transitions from Child Protection Toronto: Homeless Hub

Gaetz, Stephen (2014) Ask the Hub - Can We End Youth Homelessness? Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Youth Homelessness Toronto: Homeless Hub

Gaetz, Stephen (2014) Ask the Hub - What's new on the Homeless Hub? Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Discharge Planning – Health and Mental Health Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Harm Reduction Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Retooling Emergency Services Toronto: Homeless Hub

Gaetz, Stephen (2014) Solutions: Addressing Legal and Justice Issues Toronto: Homeless Hub

Gaetz, Stephen (2013) The Debate is Over! Housing First Works! Toronto: Homeless Hub

Gaetz, Stephen (2013) Addressing Youth Homelessness: Research Points the Way Toronto: Homeless Hub

Gaetz, Stephen (2013) Things Need to Change Toronto: Homeless Hub

Gaetz, Stephen (2012) Creating Research Impact - How We Make Homelessness Research Matter Toronto: Homeless Hub

Gaetz, Stephen (2012) Foyers give young people a safe and decent place to live, learn and grow Toronto: Homeless Hub

Gaetz, Stephen (2012) Youth Homelessness and Labour Market Integration Toronto: Homeless Hub

Gaetz, Stephen (2012) Canada now has a shared definition of homelessness – but, do we even need one? Toronto: Homeless Hub

Gaetz, Stephen (2012) New Canadian Alliance to End Homelessness will make an impact! Toronto: Homeless Hub

Gaetz, Stephen (2011) The rich get richer and the homeless get fined Toronto: Homeless Hub

Gaetz, Stephen (2011) Solving youth homelessness in Canada Toronto: Homeless Hub

Gaetz, Stephen (2011) Feed the homeless at own risk... Toronto: Homeless Hub

Gaetz, Stephen (2011) Can housing first work if there isn't enough affordable housing? Toronto: Homeless Hub

Gaetz, Stephen (2010) Jail is not a solution for our homelessness problem Toronto: Homeless Hub

Gaetz, Stephen (2010) Does the right to protection from crime and violence apply to all youth ... even homeless youth? Toronto: Homeless Hub

Gaetz, Stephen (2010) Should we give money to panhandlers? Toronto: Homeless Hub

Gaetz, Stephen (2010) The beginnings of a Leadership Academy Toronto: Homeless Hub

5. PROFESSIONAL SERVICES

Conference Organizing Committee

2013 *International Homelessness Research Conference*, Philadelphia, June 3, 2013

2010 *Repenser l'itinérance. Défis théoriques et méthodologiques. Rethinking*

Homelessness. Theoretical and Methodological Challenges. (Organizing Committee) UQAM, Montreal, October 27-30

2004-05 *Canadian Conference on Homelessness: Stories, Research, Solutions* (Chair) York University, 2005.

1995 *Other Young Lives Conference on Lesbian, Gay and Bisexual Youth*, Toronto, February, 1995.

1994 *Get Down to it! Conference on Youth Health Issues,* City of Toronto, Department of Public Health, November, 1994.

Editorial Board:

2006 Guest Editor: Special Issue on Homelessness - *Canadian Review of Social Policy*, 2006, No. 58

2008-09 Editorial Board – Finding Home book project (David Hulchanski, PI)

6. PUBLIC APPEARANCES

Press (newspaper, television and radio) (*selected – stopped tracking in 2015)

2015 "Unstoppable real estate market displaces Beatrice House shelter". Denise Balkissoon. *The Globe and Mail*. June 19, 2015

2015 "Five years of Hamilton police ACTION team: How is it working?" Nicole O'Reilly, *Hamilton Spectator*. May 26, 2015

2015 "Counting the homeless: What's the point of Point-in-Time?" Mark Rendell, *EDGE*, May 21, 2015

2015 "Homeless killings, assaults highlith the perils of life on the streets". John Hembrey, *CBC News*. May 5, 2015

2015 "A national housing strategy: Without one Calgary suffers". James Wilt. *Rabble.ca* April 30, 2015

2015 "Street people susceptible to violent crime" Kathleen Saylors. *Winnipeg Free Press*. April 28, 2015

2015 "From burnings to beatings, homeless people face violence on the streets". Michael Tutton. CTV News. April 26, 2015

2015 "Toronto legal clinic helps homeless fight unpayable 'nuisance' tickets" Toronto legal clinic helps homeless fight unpayable 'nuisance' tickets" Laurie Montsebratten, *Toronto Star*, Mar 9, 2015

2015 "Homelessness – Hardly home free" Debora Van Brenk. London Free Press. February 9th, 2015

2015 "Toronto experts advise Ontario on how to end homelessness" Laurie Montsebratten, *Toronto Star*, February 9, 2015

2015 "Toronto seized under 11th extreme cold alert this winter." Daily Times. Jan 31, 2015

2015 "Suburban homelessness is a problem often neglected in Toronto" , Markus Gee, *The Globe and Mail*, Jan 14, 2015

2015 "Hamilton activists push Liberals to scrap panhandling laws", Teviah Moro, *Hamilton Spectator*, Jan 6, 2015

2014 "Safe Streets Act should be repealed" *CBC Toronto*. December 15, 2014

2014 "Panhandling tickets saddle Toronto's homeless with debt: York professor" *Metro* (Toronto). December 15, 2014

2014 "Michael Bryant urges repeal of law that 'criminalizes homelessness'" *Toronto Star*. Toronto, ON., December 15, 2014

2014 "Repeal 'Rotten' Safe Streets Act, says former Ontario Attorney General" *Canadian Press*. Toronto. December 15, 2014

2014 "Expert optimistic N.L. can reduce youth homelessness" *The Telegram*. St. John's, Nfld. December 4, 2014

2014 "Momentum building for youth homelessness plan in York Region" *Yonge Street*. Toronto, December 3, 2014

2014 "'Housing First' the focus as homelessness experts meet in Ottawa (with video). *Ottawa Citizen*, Ottawa ON. November 17, 2014

2014 "What would it cost to dramatically reduce homelessness? About $46 per Canadian a year". *Ottawa Citizen*, Ottawa ON. October 29, 2014

2014 "Tory's focus on housing welcomed by national homelessness advocate". *York Guardian*, Toronto ON. October 30, 2014

2014 "$46 more per Canadian per year can vastly cut homelessness, new report says", Toronto Star, October 29th, 2014

2014 Tory's focus on housing welcomed by national homelessness advocate". *York Guardian*, Toronto ON. October 30, 2014

2014 "Homelessness groups want each Canadian to contribute Tory's focus on housing welcomed by national homelessness advocate". *York Guardian*, Toronto ON. October 30, 2014

2014 "Report tackles homelessness crisis", Calgary Herald, Oct. 29, 2014

2014 “Solving homelessness could cost you just $46“, Winnipeg Sun, Oct. 30, 2014

2014 “Study: Helping homeless won't break bank” Chronicle Herald, Oct. 30, 2014

2014 “Add $46 a year per Canadian to housing budget, cut homelessness: report”, Hamilton Spectator, Oct. 30, 2014

2014 “'$106 A YEAR' ; Homelessness groups ask Canadians for help” Edmonton Sun, Oct. 30, 2014

2014 “Tory's focus on housing welcomed by national homelessness advocate” York Guardian, Oct. 30, 2014

2014 “Is $46 per Canadian too much to spend?” Daily News Nanaimo, Oct. 30, 2014

2014 “Range of homelessness solutions needed“ Times Colonist Oct. 30, 2014

2014 “Extra $46 per Canadian could help homeless: study” Cape Breton Post, Oct. 30, 2014

2014 “Add $46 a year per Canadian to housing budget, cut homelessness: report “ St. John’s Telegram, Oct. 30, 2014

2014 “Use surplus to aid affordable housing, report says”, Guelph Mercury, Oct. 30, 2014

2014 “Groups want $106 per Canadian to fight homelessness” The Sault Star; Pembroke Observer; The Owen Sound Sun Times; Niagara Falls Review; Northbay Nugget, Belleville intelligencer; Brockville Recorder and Times; Simcoe Reformer; Welland Tribute; Woodstock Sentinel Review; Stratford Beacon; Sudbury Star; Orilla Packet and Times Oct. 30, 2014

2014 “Study: Extra $46 per Canadian could Reduce Homelessness” Blackburn News, Oct. 29, 2014

2014 “Extra $46 per Canadian could help homeless: study “ Caledon Enterprise, Oct. 29, 2014

2014 “Homelessness Report Out Today “ BT Vancouver , Oct. 29, 2014

2014 “Groups want each Canadian to pay $106 a year to reduce homelessness”, Canoe, Oct. 29, 2014

2014 “Thunder Bay homeless shelters operating beyond capacity “ CBC Thunder Bay, Oct. 29, 2014

2014 “Canadian homelessness: $46 a person would help, report says” CBC, Oct. 29,

2014 “Add $46 a year per Canadian to housing budget, cut homelessness: report” City News, Oct. 29, 2014

2014 “Report calls for increased investment in affordable housing”, CTV, N.D.

2014 “Add $46 a year for each Canadian to housing budget, cut homelessness: report“,

CTV Winnipeg, Oct. 29, 2014

2014 "Extra $46 per Canadian could help homeless: study", Durham Region, Oct. 29, 2014

2014 "Add $46 a year per Canadian to housing budget, cut homelessness: report", Edmonton Journal, Oct. 29, 2014

2014 "York research group releases report on homelessness in Canada", Excalibur, Nov. 12, 2014

2014 "Tackling homelessness is everyone's business" *Winnipeg Free Press*. Winnipeg, MN September 5, 2014

2014 "Homelessness is our problem too" *Winnipeg Free Press*. Winnipeg, MN September 30, 2014

2014 "Poverty Reduction Reboot" The Agenda. TVOntario, Sept 22, 2014

2014 "St. John's youth homelessness above national average" The Telegram. St. John's, Nfld, June 17, 2014

2014 "Helping Hidden Lives" The Agenda. TVOntario, Sept 22, 2014

2014 "'Housing First" approach may put homeless youth last, report warns" CTV news, April 21, 2014

2014 "Canada failing homeless youth, report charges" *Toronto Star*. Toronto, ON March 3, 2014

2013 "Canada's Homeless" CBC The National. June 19, 2013

2013 "Homelessness in Canada" CTV National. June 19, 2013

2013 "Canada Homelessness Study: 30,000 on the streets, in shelters on a given night" Toronto Star. June 20, 2013

2013 "Homelessness Affects 200,000 in Canada" Canadian Press story, in newspapers across the country. June 19, 2013

2013 "National report on homelessness says Alberta leads the fight" Calgary Herald June 19, 2013

2013 "Canada's Homeless" CBC Radio (four times, different communities) June 19, 2013

2013 "New Study 'Shatters Myths' of Homelessness in Toronto" Metro Toronto, January 10, 2013. Interviewer, Jessica Smith

2012 "Responding to youth homelessness" Radio Canada (television and radio). Montreal. November 15, 2012. Interviewer, Julie-Anne Lamoureux

2012 News1130 Radio, Vancouver. October 12, 2012. Interviewer, Renee Bernard.

2012 "Cities leading fight against homelessness may surprise you" News1130 Radio Newsletter, Vancouver. October 12, 2012. Interviewer, Renee Bernard.

2012 "Policing Toronto's Panhandlers". Toronto Sun. October 7, 2012. Writer, Simon Kent

2012 "Homelessness, Defined" Novae Res Urbis, October 5, 2012. Interviewer, Jake Tobin Garrett

2012 XFM News, Antigonish NS. October 3, 2012: Interviewer, Brittany Cavanagh

2012 "New Canadian research on costs of homelessness" The American Round Table to Abolish Homelessness. October 4, 2012. Issue XX

2012 CBC Yellowknife. October 3. Interviewer: Mark Winkler

2012 "The Current" – CBC News. September 28, 2012.

2012 Media Mornings, Vancouver's Co-op Radio 100.5 FM. September 27, 2012. Interviewer, Jane Bouey

2012 CBC News, Vancouver. September 27, 2012. Interviewer, Robert Zimmerman

2012 People First Radio, CHHLY, Nanaimo. September 27, 2012. Interviewer, Kevin Midbo

2012 CFAX 1070AM Interview Request, Victoria. September 25, 2012. Interviewer, Sonia Lowe

2012 "Housing homeless cheaper, more effective than status quo: study" Globe and Mail. September 24, 2012. Heather Scoffield, Canadian Press/Globe and Mail

2012 "BC could learn from Alberta how to save on costs of homelessness: expert" Metro Vancouver. September 24, 2012. Interviewer: Kate Webb

2012 Regina Leader-Post. September 24, 2012. Interviewer: David Fraser

2012 AM 800 CKLW, Windsor. September 24, 2012. Interviewer, Rusty Thomson

2012 The Todd Veinotte Show. (Rogers Cable, Atlantic Canada) September 14, 2012. Reporter: Todd Veinotte

2012 As it Happens, (CBC) Toronto, September 14, 2012., Anchor Laura DiBatista

2012 "Critics say new definition of 'homeless' too broad, includes those only 'at risk'." National Post (front page). September 12, 2012. Writer, Tristin Hopper

2012 CBC Morning News, Whitehorse. May, 23, 2012

2011 "Conservatives quietly fund massive homeless housing pilot project – At Home/Chez Soi" Canadian Press. December 26, 2012. Writer, Heather Scoffield.

2011 "Report says homeless youth are unfair police targets. Canadian Press / CTV

News. November 10, 2011. Writer, Heather Scoffield.

2011 "Is the homeless veteran problem set to explode?" The Canadian Press, Nov. 7, 2011. Writer: Heather Scoffield

2011 "Time on the streets not easy for the uninitiated" Toronto Sun. August 20, 2011. Writer, Terry Davidson

2011 "Poll calls for tougher panhandling laws" Canoe News. September 14, 2011. Writer: Jenny Yuen

2010 Metro Morning, Toronto, September 27, 2010, Anchor/Reporters: Matt Gallaway

2005 Canada Now (local) (CBLT-TV), Toronto, 20 May 2005, 06:32PM, Anchor/Reporters: Diana Swain, Christina Birak.

2005 MORNING NORTH (HR1) (CBCS-FM), SUDBURY, 18 May 2005, 06:32AM, Anchor/Reporters: MARKUS SCHWABE, RUTH REID.

2005 Metro Morning, Toronto, 18 May 2005, Anchor/Reporters: Andy Barrie, Martina Fitzgerald

2005 London News (CBCL-FM), 18 May 2005, Anchor/Reporters: Carrie McKee, Jean Carter

2005 Ottawa Morning (CBO-FM), Ottawa, 25 May 2005, 06:21AM, anchor/Reporters: Anthony Germain

1999 Guest on Metro Morning (CBC Radio). Topic: "Street Youth and Making Money".

1999 Guest on TVO Studio 2. Topic: "Safe Streets Act".

1998 Guest on TVO. Parent Connection. Topic: "Squeegee Kids".

1995 Guest on Metro Morning (CBC Radio). Topic: "Street Youth and Oral Health".

* Note: I have not actively kept track of media contacts until this past year

7. FUNDING

Summary:

Research funding received as Principal Investigator: **$46,461,458**
Research funding received as Co-Investigator or Partner: **$6,599,836**
Program Evaluation Contracts: **$1,049,791**
Total: $54,111,085

Research Grants

2022 *The Canadian Observatory on Homelessness (COH) - Mobilizing Partnerships to Prevent and End Homelessness*
SSHRC Partnership Development Grant
Stephen Gaetz (Principal Investigator)
Amount: $2,499,457.

2021 *Making the Shift – Youth Homelessness Demonstration Lab* (extension)
Social Development Partnership Program, Government of Canada
Stephen Gaetz (Co-Principal Investigator); Redman, Melanie, A Way Home Canada (Co-Principal Investigator)
Amount: $3,700,000

2021 *Designing Canada's long-term affordable housing approach*
SSHRC Partnership Development Grant
Stephen Gaetz (Co-Applicant); Abe Oudshoorn, Western University (Principal Investigator)
Amount: $199,114

2021 *Beyond Agency: How does Knowledge Mobilization Advance Social Innovation in Communities?*
SSHRC Insight Development Grant
Stephen Gaetz (Co-Applicant); Jacqueline Sohn, York University (Principal Investigator)
Amount: $50,000

2020 *Enhanced Surveillance for Chronic Disease Program (ESCDP) "Homelessness Counts"*
Public Health Agency of Canada - The Enhanced Surveillance for Chronic Disease
Stephen Gaetz (Co-Applicant); Cheryl Forchuk, Western University (Principal Investigator)
Amount: $995,281

2020 *Making the Shift – Youth Homelessness Demonstration Lab* (extension)

Social Development Partnership Program, Government of Canada
Stephen Gaetz (Co-Principal Investigator); Redman, Melanie, A Way Home Canada (Co-Principal Investigator)
Amount: $3,800,000

2019 *Making the Shift – Youth Homelessness Demonstration Lab* (extension)
Social Development Partnership Program, Government of Canada
Stephen Gaetz (Co-Principal Investigator); Redman, Melanie, A Way Home Canada (Co-Principal Investigator)
Amount: $2,900,000

2019 *Interventions research in homelessness, housing, and health*
Foundation Grant – CIHR
Stephen Gaetz (Partner); Stephen Hwang, University of Toronto (Principal Investigator)
Amount: $3,972,033

2019 *Homelessness; Housing First; Social Service System Coordination*
SSHRC Partnership Development Grant
Stephen Gaetz (Partner); John Graham, UBC - Okanagan (Principal Investigator)
Amount: $192,900

2019 *Working upstream to prevent and end youth homelessness: mapping existing policies and practices to build better educational responses in Canada*
SSHRC Partnership Development Grant
Stephen Gaetz (Partner); Jacqueline Kennelly, Carleton University (Principal Investigator)
Amount: $199,550

2019 *Migration of People Experiencing Homelessness in Greater Toronto*
United Way of Greater Toronto
Stephen Gaetz (Principal Investigator)
Amount: $30,000

2019 *Indigenizing Coordinated Access in Hamilton*
Hamilton Indigenous Community Advisory Body
Stephen Gaetz (Principal Investigator)
Amount: $61,432

2018 *Making the Shift – A Youth Homelessness Solutions Impact Accelerator*
Networks of Centres of Excellence Program – Government of Canada
Stephen Gaetz (Co-lead applicant); Redman, Melanie, A Way Home Canada (Co-lead

applicant)
Amount: $17, 901, 337
#900-2018-202

2017 *Making the Shift – Youth Homelessness Social Innovation Lab*
Social Development Partnership Program, Government of Canada
Stephen Gaetz (Co-Principal Investigator); Redman, Melanie, A Way Home Canada (Co-Principal Investigator)
Amount: $7, 908, 405

2017 *Defining an End to Homelessness*
Homelessness Partnering Strategy, Employment and Social Development, Government of Canada
Stephen Gaetz (Principal Investigator)
Amount: $431,211

2017 *Point in Time Count toolkit and technical support*
Homelessness Partnering Strategy, Employment and Social Development, Government of Canada
Stephen Gaetz (Principal Investigator)
Amount: $126,149

2017 *Youth Homelessness Prevention Framework Consultation*
Home Depot of Canada Foundation
Stephen Gaetz (Principal Investigator)
Amount: $61,732

2016 *National Youth Homelessness Survey*
Home Depot of Canada Foundation
Stephen Gaetz (Principal Investigator)
Amount: $81,000

2016 *Housing First for Youth and Employment – Design Charet*
Home Depot of Canada Foundation
Stephen Gaetz (Principal Investigator)
Amount: $18,500

2016 *Computer simulation modeling to address homelessness*
Social Sciences and Humanities Research Council of Canada
Stephen Gaetz (Co-Investigator); Eric Latimer (McGill: Principal Investigator)
Amount: $196,043

2016 *Enhancing the Influence of Engaged Scholarship*
Social Sciences and Humanities Research Council of Canada
Stephen Gaetz (Co-Investigator); Naomi Nichols (McGill: Principal Investigator)
Amount: $69,933

2015 *Toolkits for Youth Homelessness Employment and Housing Programs*
Home Depot of Canada Foundation
Stephen Gaetz (Principal Investigator)
Amount: $35,000

2015 *Social Sciences and Humanities Research Council (SSHRC) Impact Award – Connection.*
Social Sciences and Humanities Research Council of Canada
Stephen Gaetz (Principal Investigator)
Amount: $50,000
#780-2016-0009

2015 *Point-in-Time Homeless Count Training and Support for Designated Communities of the Homelessness Partnering Strategy*
Community Development and Homelessness Partnering Directorate, Government of Canada
Stephen Gaetz (Principal Investigator)
Amount: $367,576

2014 *Understanding Youth Homelessness: A youth focused Point-in-Time methodology and toolkit*
Laidlaw Foundation
Stephen Gaetz (Principal Investigator)
Amount: $20,000

2014 *Inspiring Local Communities: Toolkits for developing innovative models of housing and support for homeless youth*
The Home Depot Canada Foundation
Stephen Gaetz (Principal Investigator)
Amount: $35,000

2013 *The Canadian Observatory on Homelessness: Creating Policy Impact*
SSHRC Partnership Grant
Stephen Gaetz (Principal Investigator)
Amount: $2,502,967
#895-2012-1012

2013 Transforming Treatment Services and Housing for People with Mental Illness in

Canada: A Systems Approach to Integrated Knowledge Translation
CIHR – Partnerships for Health Systems Improvement
Stephen Gaetz (Co Investigator); Nelson, G., Stergiopolous, V., Goering, P. (Principal Investigators)
Amount: $194,970

2013 *York Symposium on Engaged Scholarship*
SSHRC Connections Grant
Stephen Gaetz (Principal Investigator)
Amount: $31,187

2013 *Housing First Promising Practices Case Studies*
HRDC Homelessness Partnering Strategy
Stephen Gaetz (Principal Investigator)
Amount: $60,000

2012 *Canadian Observatory on Homelessness*
SSHRC Partnership Grant - Letter of Intent
Stephen Gaetz (Principal Investigator)
Amount: $20,000

2012 *Knowledge Mobilization for housing and economic vulnerability*
SSHRC Public Outreach Grant
Stephen Gaetz (Principal Investigator)
Amount: $141,798
#604-2011-0016

2012 *Navigating the Road to Reintegration*
SSHRC Partnership Development Grant
Stephen Gaetz (Co-Investigator); Bill O'Grady (Principle Investigator)
Amount: $198,960

2012 *Developing a Foyer: A Horizontal Pilot Project*
HRDC Homelessness Partnering Strategy
Stephen Gaetz (Principal Investigator)
Amount: $29,640

2011 *Youth Homelessness e-book project*
HRDC Homelessness Partnering Strategy
Stephen Gaetz (Principal Investigator)
Amount: $35,132

2011 *Promising Practices in the Homelessness Sector*

HRDC Homelessness Partnering Strategy
Stephen Gaetz (Principal Investigator) Michaela Hynie, Bernie Pauly, Daphne Winland, Jeannette Waegemakers-Schiff (co-investigators)
Amount: $84,920

2010 *Building Program Evaluation Capacity in the Homelessness Sector*
HRDC Homelessness Partnering Strategy
Stephen Gaetz (Principal Investigator)
Amount: $79,465

2010 *Responding to H1N1 in the Context of Homelessness in Canada*
Canadian Institutes of Health Research
Catalyst Grant: Pandemic Preparedness
Stephen Gaetz (Principal Investigator)
Amount: $100,000

2009 *The provision of charitable food assistance in Canada: forging a more adequate response*
Canadian Institutes of Health Research
Stephen Gaetz, (co-investigator); Valerie Tarasuk, (principal investigator). Blake Poland, A. Hamelin, Alex Ostry, K. Raine, P.L. Williams
Amount: $ 314,521

2009 *Understanding Pandemic Preparedness in the Context of the Canadian Homelessness Crisis*
Canadian Institutes of Health Research
Catalyst Grant: Pandemic Preparedness
Stephen Gaetz (Principal Investigator)
Amount: $100,000

2009 *Ending Homelessness: "What works and for whom?" A Knowledge Mobilization Partnership*
Collaborative Faculty Incentive Grant
York University / University of Victoria
Stephen Gaetz, Bernie Pauly (Principal Investigators)
Amount: $30,000

2008 *Canadian Homelessness Research Network.*
SSHRC Strategic Knowledge Cluster Program
Stephen Gaetz (Principal Investigator)
Amount: $2,097,039
#857-2007-0015

2008 *The Homeless Hub: A Knowledge Mobilization Project*
Homelessness Partnering Strategy
Human Resources & Social Development Canada
Stephen Gaetz (Principal Investigator)
Amount: $90,420

2007 *Canadian Homelessness Knowledge Impact Initiative.*
Housing and Homelessness Branch
Human Resources & Social Development Canada
Stephen Gaetz (Principal Investigator)
Amount: $145,371

2006 *Attending to social vulnerabilities in tuberculosis transmission: A synergistic model of qualitative and quantitative methods.*
SSHRC Research Initiative Grant
Stephen Gaetz (Principal Investigator)
Amount: $40,000

2005 *Institutional Discharge and Homelessness: A Look at Canadian Corrections in the Public and Private Spheres*
National Homelessness Initiative National Research Program
Homelessness and Justice Domain
Stephen Gaetz, Bill O'Grady (Principle Investigators).
Amount: $136,276

2004 *Canadian Conference on Homelessness:*
- National Homelessness Initiative (HRSD): $225,000
- Canada Mortgage and Housing Corporation: $49,000
- National Homelessness Initiative - Ontario Directorate: $45,923
- Ontario Ontario Mental Health Foundation: $25,000
- City of Toronto: $15,000
- Wellesley Central Health Corporation: $15,000

Total amount: $375,923

2004 *A Pilot Study of Local Responses to the Food and Nutrition Needs of Homeless Youth*.
Canadian Institutes of Health Research:
Stephen Gaetz, Blake Poland (co-investigators); Valerie Tarasuk, (principal investigator).
Amount: $98,294

2004 *Literature Review of Research on Homelessness in Canada.*
York Incentive Grant:
Stephen Gaetz (Principal Investigator).

Amount: $5000

2003 *A Study of Community Responses to the Food and Nutrition Needs of Homeless People in Southeast Toronto.*
Wellesley Central Urban Health Grant Initiative:
Stephen Gaetz, Blake Poland (co-investigators); Valerie Tarasuk, (principal investigator)
Amount: $50,000

2003 *Developing a Virtual Clearinghouse of Research on Homelessness*.
Wellesley Central Urban Health Grant Initiative:
Stephen Gaetz, Alice Broughton (Sherbourne Health Centre), Wengari Murkuri (Street Health).
Amount: $15,000

2002 *Food: Nutritional Vulnerability and Social Exclusion among Homeless Youth*. Canadian Institutes of Health Research:
Stephen Gaetz, Blake Poland (co-investigators); Valerie Tarasuk, (PI).
Amount: $227,758

1999 *Community Economic Development and Street Involved Youth*
Homeless Initiative Fund - City of Toronto / HRDC.:
Stephen Gaetz (Principal Investigator).
Amount: $24,000

Program Evaluation Contracts 2016-19
Note that these contracts are with the Canadian Observatory on Homelessness and though in many cases I am listed as Principal Investigator, I may have had limited involvement with the projects.

2019	Penny Lane Evaluation. (Boys and Girls Clubs of Calgary)		$20,340
2019	Program Review of Eva's Family Reconnect & Evaluation of YOUth BelongProject (Eva's)		176,000
2019	ICM Evaluation (Homes First)		$10,666
2019	Development of Survey and Outcome Measuring (Red Door Shelter)		$10,412
2019	Evaluation of Supportive Training, Social Enterprise (Choice for Youth)		$40,000
2019	Evaluation of YES Transitional Housing (Peterborough)		$25,000
2018	Evaluation of LGBTQ Transitional Housing (EGALE)		$80,875

2018	Host Homes evaluation (Raising the Roof)		$49,998
2018	Bridging the Gap – Host Homes Evaluation (Raising the Roof)		$50,000
2018	Evaluation of Youth Services Host Home Program (One Roof Hamilton)		$105,321
2018	Evaluation of A Way Home Toronto (Covenant House)		$35,500
2018	Family Homelessness (City of Toronto)		$38,375
2018	Evaluation of Low Barrier Services (City of Toronto)		$49,575
2017	EPIC Evaluation (City of Toronto)		$57,533
2017	Outcomes Framework (Eva's Initiatives)		$20,540
2017	Evaluation of Grants Program (HDCF)		$19,057
2017	Evaluation of Hire Up (Impakt)		$57,300
2017	CMHA TCM Evaluation (Ottawa Mission)		$42,345
2016	Region of Peel		$90,430
2016	St. John's		$28,274
2016	Training and Technical Assistance Evaluation (Canadian Alliance to End Homelessness)		$42,250

TOTAL REVENUE: $1,049,791

Contract Research

2011 Towards a Canadian Definition of Homelessness
HRDC Homelessness Partnering Initiative
Stephen Gaetz (Principal Investigator).
Amount: $8,000

2011 Plans to End Youth Homelessness in Canada - A Review of the Literature
Eva's Initiatives and Virgin Unite
Stephen Gaetz (Principal Investigator).
Amount: $7,500

2001 *Street Involved Youth and Access to Justice*.
Justice for Children and Youth Foundation:
Stephen Gaetz (Principal Investigator).
Amount: $30,000

1995 *Research on youth values in Toronto.*
Cultural Analysis Group, N.Y, N.Y.
Daphne Winland, Stephen Gaetz (Principal Investigators)
Amount: $2400

1991 *Effectiveness of Refugee Sponsorship Programmes.*
Employment and Immigration Canada
Daphne Winland, Stephen Gaetz (Principal Investigators)
Amount: $5000

Travel/Development Grants

2004 Conference travel support: *Faculty of Education*, ORS (York University): $1,700.00.
Conference paper presentation "*An Urban Other: Street Youth and Criminal Victimization in Toronto.* Association of Canadian Studies in Ireland, Cork, Ireland

2002 Faculty of Education Minor Research and Development Grant: $2500.00.
Stephen Gaetz and Don Dippo (principal investigators). *TL Kennedy Research Project*.

2001 Faculty of Arts International Working Group - International Pilot Projects.$6000.00.
Stephen Gaetz and Penny Van Esterik (principal investigators). *Others in our Midst: Cross-Cultural Practices of Communicating about Cultural Differences.*

2001 SSHRC Small Research Grant: $2500.00.
Broken Promises The Educational Experiences of Homeless Youth in Toronto.

C. TEACHING

1. UNDERGRADUATE PROGRAMME

Courses Taught

2018	ED/EDFE 1101 3.0 Adolescent Development and Health. Course Director (Fall session)
2017	ED/EDFE 1101 3.0 Adolescent Development and Health. Course Director (Fall session)
2016	ED/EDFE 1101 3.0 Adolescent Development and Health. Course Director (Fall session)
2015	ED/EDFE 1101 3.0 Adolescent Development and Health. Course Director (Fall session)
2014	EDUC 3310 3.0 Adolescent Development and Health.
2012	EDUC 3310 3.0 The Adolescent and the Teacher.
2001-2006	EDUC 3310 3.0 The Adolescent and the Teacher (TL Kennedy site).
2001-2006	EDUC 3310 3.0 The Adolescent and the Teacher (Keele site).
2002	EDUC 3310 3.0 The Adolescent and the Teacher (Durham site).
2001-2003	ED/CMYR2400 3.0 Communication and the Education Process (TL Kennedy site).
2001-2003	ED/CMYR2400 3.0 Communication and the Education Process (Keele site).
1996 (winter)	ANTH 4210.03F Other Young Lives: Anthropology and Youth Cultures. York University.
1993-1994	ANTH 2010B.06 Anthropology of Youth Culture. York University.
1992 (fall)	ANTH 2000A.03 Anthropology of Youth Culture. York University.

2. GRADUATE PROGRAMME

2020 EDUC 5935 30. Understanding Youth Homelessness - *Its causes and conditions, and what we can do about it.* Course Director (Summer session)

2019 EDUC 5935 30. Understanding Youth Homelessness - *Its causes and conditions, and what we can do about it.* Course Director (Summer session)

2019 EDUC 5930 3.0 Engaged Scholarship: Bridging the gap between academia, policy and practice through *Knowledge Mobilization*. Course Director (Winter session)

2018 EDUC 5930 3.0 Engaged Scholarship: Bridging the gap between academia, policy and practice through *Knowledge Mobilization*. Course Director (Winter session)

2017 EDUC 5935 3.0. Understanding Youth Homelessness - *Its causes and conditions, and what we can do about it.* Course Director (Summer session)

2016 EDUC 5930 3.0 Engaged Scholarship: Bridging the gap between academia, policy and practice through *Knowledge Mobilization.* Course Director (Winter session)

2016 EDUC 5935 3.0 Understanding Youth Homelessness - *Its causes and conditions, and what we can do about it.* Course Director (Summer session)

2014 EDUC 5930 3.0 Engaged Scholarship: Bridging the gap between academia, policy and practice through *Knowledge Mobilization*.

2011 - 14 EDUC 5435 3.0 Studies of Adolescence and Cultural Experience

2006 EDUC 5435 3.0 Studies of Adolescence and Cultural Experience

2001-2006 EDUC 5430 3.0 Social Deviance, Resistance and Schooling.

2001 EDUC 5120 6.0 Theory and Research in Language, Culture and Teaching.

3. POST-DOCTORAL FELLOWS

Hart Walker (2021 – Present)

Karen Naidoo (2021 – Present)

Emmanuel Banchani (2021 – Present)

Ahmad Bonakdar (2021 – 2022)

Jackie Sohn (2019- present)

Meryl Burato (2018 – 2021)

Anika Mifsud (2018 – 2020)

Rachel Caplan (2018 – 2020)

Erin Dej (2016-2018)

Kaitlin Schwan (2017 – 2020)

Naomi Nichols (2014-2015)

4. GRADUATE SUPERVISION

Doctoral Programme Supervision and Committees

Supervision (Current)

Michael Kenney (2014-21) Faculty of Education

Committee Membership (Current)

Supervision (Completed)

Sabina Mirza (2012-21) *Exploring Schooling and Educational Attainment Through the Experiences of Homeless Youth.* Faculty of Education, York University

Amanda Noble (2012-2018) *Housing First and 'Ending' Youth Homelessness in the Neoliberal Era: A Case Study of the Infinity Project & Calgary's 10-Year Plan to End Homelessness.* Faculty of Education, York University.

Maria Lucia DiPlacito (2010-2015) *Campus Mental Health: Implications For Instructors Supporting Students.* Faculty of Education, York University.

Kristy Buccieri (2007-2012) *Caught Somewhere Between Public and Private: How Patriarchy, Heteronormativity and Neoliberalism Collude to Keep Homeless Youth In and Out of Place.* Faculty of Education, York University.

Committee Membership (Completed)

Jason Webb (2021) Working for Citizenship in the Liminal Space - Social Reproduction in the Emergency Family Shelter System Supervisor: Amber Gazso, Sociology, York University

Dustin Graham (2020) *Reclaiming student voices on school-based, mental health impacts: youth reflections, lived experiences and recommendations for transforming Ontario secondary schools.* Supervisor: Chloe Brushwood-Rose. Faculty of Education, York University.

Kathleen Worton (2018) *Knowledge mobilization for complex community interventions: Examining how peer learning strategies influence local implementation of Housing First.* Supervisor: Geoffrey Nelson. Department of Community Psychology. Wilfred Laurier University. Waterloo Ontario

Rebecca Houwer (2017) Enacting justice-focused sustainabilities through community-engaged learning and action in postsecondary education: The NOISE for Social Change Project. Supervisor: Steve Alsop, Faculty of Education

Lauren Joly (2017) Understanding Romantic Relationships and Resilience Among Street-Involved Youth: A Quantitative and Qualitative Exploration. Supervisor: Jennifer Connolly Clinical-Developmental Psychology, York University

Megan Sandhu (2016) *University-Community Partnerships: An Action-Humanities Approach to Addressing Homelessness.* Supervisor: Markus Reisenleitner. Faculty of Liberal Arts and Professional Studies.York University.

Kaitlin Schwan (2016) *Why Don't We Do Something? The Societal Problematization of "Homelessness" and the Relationship between Discursive Framing and Social Change.* Supervisor, David Hulchanski. Department of Social Work, University of Toronto.

Carrie Anne Marshall (2015) *Occupation, Homelessness, and the Transition to Becoming Housed in Chronically Homeless Persons in a Small Urban Context*. Supervisor: Rosemary Lysaght, Queens University

Michelle Wyndham-West (2014) *Is it worth the shot? Ontario women's negotiations of risk, gender and the Human Papillomavirus (HPV) Vaccine.* Supervisor: Naomi Adelson, Department of Anthropology, York University

Lisa Romano-Dwyer (2012) *"And I can get anyone into Hamlet." Using Humanities-Based Approaches After Expulsion for School Violence: A Hermeneutical Transformation of Safe Schools.* Supervisor: Alison Griffith. Faculty of Education.

Gregory Knoll (2012) *Stages of Change Training for Youth Outreach Workers: Bridging Research, Theory and Practice.* Graduate program in Psychology, York University

Naomi Nichols (2011) *All My Life I've Slipped Through the Cracks" The Social Coordination of "Youth Work". Faculty of Education, York University*

Christopher Smith (2008). *A User's Guide to the City: "Juice Bars', 'Liquid Handcuffs' and the Disorder of Drugs.* Communications Studies, York University

Bronwyn Low (2001). *Spoken Word: Exploring the Language and Poetics of Hip Hop Popular*. Faculty of Education, York University**.**

Dean's Representative

Margaret Jean Mitchell (2002). *Roads, Restlessness and Relationships: An Urban Settlement in Post-Colonial Vanuatu.* Department of Anthropology, York University.

Internal / External Examiner

Lauren Joly (2018) *Understanding Romantic Relationships and Resilience Among Street-Involved Youth: A Quantitative and Qualitative Exploeration.* Graduate Program in Clinical Psychology. Supervisor: Jennifer Connolly

Geoff Sorge (2011) *Cognitive Abilities and Rational Thinking Variables as Predictors of Antisocial/Risky Behaviour*. Faculty of Health, York University.

Jim Steiben (2010) *Neurophysiological Mechanisms of Emotional Regulation for Subtypes of Externalizing Children.* Department of Psychology, York University

Anna Ning (1999). *Embodying the Myth of Healthiness: Conformity, Resistance and Complicity in Narratives of Addiction and Recovery*. Department of Anthropology, York University.

External Examiner

Darren Stonehouse (2021) The Neoliberal Representation of Homelessness and its Alignment with Material Conditions and Lived Experiences in Victoria, Australia. La Trobe University, Melborne, Australia.

Jennifer Bell (2019) Solina Richter, Sarah Stahlke, Department of Nursing, University of Alberta

Heather M. Patterson. (2016) *Attachment Styles, Psychological Functioning, and Resilience Factors among Street-involved Youth: Describing Youth who Access Community Agency Support.* Department of Psychology. Memorial University of Newfoundland

Michelle Wyndham-West (2015) Sarah Benbow (2015) *Mothers Experiencing Homelessness: Social Exclusion, Resistance, and Health.* Nursing, Western University. December, 2015

Erin Dej (2015) Seeking Inclusion in the 'Land of Broken Toys': Negotiating Mental Health Managerialism Among Homeless Men and Women. Department of Criminology, Université d'Ottawa - University of Ottawa

Lorcan Patrick Byrne (2014) *Between Respectability and Disgrace: Schismogenesis & the Regeneration of Inequality, Stigma and Social Exclusion in Limerick.* University College Limerick, Ireland

Felicia Garcia (2013). *Coping and Suicide Amongst 'the Lads': Expectations of masculinity in post-traditional Ireland* . Department of Anthropology. University of Maynooth, Ireland

Abe Oudshoorn (2011) *Client-Provider Relationships in a Community Health Clinic for People Experiencing Homelessness: A Critical Ethnography. Department of Nursing, University of Western Ontario*

Dennis Staunton (2008). *The Occupational Benefits of Getting a University Degree Later in Life as a Mature Student.* Department of Applied Social Studies. University College Cork, Ireland

Masters Programme Supervision and Committees

Supervision (Current)

Sarah O'Connor – Public Policy

Committee Membership (Current)

Arnel Borras – Health

Supervision (Completed)

Cody Samuelson (2021) *From Reaction to Action: The Kelowna Journey Home Systems Approach.* Development Studies, York University.

Rayna Slobodian (2019) *Rich and Poor Divide: How Portreayals of the Poor and Poverty in News Media Perpeduate Stigma and Inequality.* Faculty of Education, York University.

Bahen, Julia (2016) *Ending the Cycle: Incarceration, Reintegration, and Discharge Planning.* Faculty of Environmental Studies, York University

Isaac Coplan (2014) *Youth Homelessness in Ontario – Knowledge Mobilization, Systems*

Integration and Social Media to #EndYouthHomelessness. Faculty of Environmental Studies, York University

Marylou DiPlacito (2009) (M.Ed. Thesis) *A Parent's Journey, An Adolescent's Hardships: The Impacts of Parental Illness on Schooling.* Completed, November, 2009. Faculty of Education, York University

Jodi Barrett (2009). *Vital Links: Connecting Homeless Families with Education.* (M.Ed. Thesis). Completed, September, 2009. Faculty of Education, York University

Fatima Hussein (2008). *The Economic and Social Consequences of Mental Illness with Homelessness as a Demographic Index.* (MA, Thesis). Completed, September, 2008. Critical Disabilities Studies, York University.

Patricia Baird (2007) *The Need for a Harm Reduction Approach to Substance Use in Ontario Schools. Why the Message, 'Just Say No' to Drugs is Ineffective for Youth.* (M.Ed., MRP). Completed, April, 2007. Faculty of Education.

Tally Wolf (2007) *Starred Students at Teva* (M.Ed. Thesis). Completed, March 2007. Faculty of Education.

Ellen Walton (2007) *Sambos, Mandingos, and Gangstas in Toronto's Education System: Exploring Social Relations and the Impact of Identity and Black Masculinity in Schools.* (M.Ed., MRP). Completed, January, 2007. Faculty of Education.

Sharon McCleave (2006) *The Provision of Dental Care for Homeless Youth: Exploring an Educational Model of Service Learning for Dental Students.* (M.Ed. Thesis). Completed, December 2006. Faculty of Education.

Shelly Mediratta (2006) *Identity Abandonment: Trying to make sense of myself and the need for an anti-bias curriculum in Ontario A conceptualization of identity.* (M.Ed. Major Research Paper). Completed, September 2006. Faculty of Education.

Gemma Bose (2006) *Navigating the Educational System for Racial Minority Students and Racial Minority Teachers* (M.Ed. Major Research Paper). Completed, September 2006. Faculty of Education.

Chantal Tremblay (2006) *Leaving High School: On Becoming More Resilient to Verbal Abuse After the Adolescent Years.* (M.Ed: Major Research Paper). Completed, July 2006**.** Faculty of Education.

Jennifer Gee (2005) *Bigger isn't always better: Ideal school size and the Ontario Government's educational funding formula.* (M.Ed. Major Research Paper). Completed, October 2005. Faculty of Education.

Bita Sarabi-Khosravi (2005) *Resistance and second language learning: reflections on possible 'resistant' acts in second language classrooms.* (M.Ed. Major Research Paper). Completed, September 2005. Faculty of Education.

Anne Pohl (2004) (co-supervisor with Celia Haig-Brown) *Opening Respectful Encounters with Inner City, At-Risk Youth in Toronto's Schooling Institutions*. (Thesis). Completed, September, 2004. Faculty of Education.

Maria Melessanakis (2004) *Paradise Envisioned is Seldom a Paradise Realized: The Perspectives of Teacher Candidates on the Impact of Professional Development Schools - A Literature Review and Canadian Case Study.* (Thesis). Completed, May, 2004. Faculty of Education.

Nancy Carvalho (2004). *The Over Representation of Young People with Learning Disabilities in Youth Detention Centres*. (Major Research Paper) Faculty of Education.

Brian Weinstock (2003). *Rethinking Mortadella: Progressing Toward a Critical Multicultural Pedagogy.* (Major Research Paper). Faculty of Education.

Committee Membership (Completed)

Veronica Lockyer (2021) The Violence of Not Being Heard - Rural and Urban Youth, Differing and Similar Oppressive Obstacles. Completed: December 2021. Supervisor: Theresa Holmes. Department of Anthropology, York University.

Meagan La Plante (2017) Rapid Rehousing Practice at a Shelter for Homeless Youth. Supervisor: Girah Bhatt, Royal Rhodes University, Victoria BC

Kathryn Hardill (2016) *That Look That Makes You Not Really Want to Be There: Health Care Experiences of People Who Use Illicit Opioids in Small Urban and Rural Communities - A Critical Social Theory Analysis.* Faculty of Health (Nursing) York University

Mary Choy (2014) *Re-Conceptualizing "Contributing": Homelessness and Unpaid Labour in a Neo-liberal Climate* Completed: November, 2015. Supervisor: Amber Gaszo, Sociology, York University

Tracey Methven (2012) *A Hub School – The Heart of a Community Conceived For and With Stakeholders of Keelesdale-Eglinton West.* (MRP). Completed, September 2012. Supervisor, Don Dippo, Education

Darlene Mooney (2012) *Crown Wards Leaving Care: A Stakeholders' Discussion of their Readiness.* (Thesis). Completed, January 2012. Supervisor, Naomi Norquay, Education

Lauren Joly (2011) *Evaluating Outreach Programs for Street Involved Youth: A Quantitative and Qualitative Review of the Research.* (Thesis) Completed, July, 2011. Supervisor, Jennifer Connolly, Psychology

Sabina Mirza (2010) *South Asian Celebrations in Adolescent and Children's Literature.* (Major Research Paper). Completed, July 2010. Supervisor, Karen Krasny

Suba Jeyaratnam (2010) *A Critical Analysis of the Relationships between Homelessness and Disability among Immigrant Women in Toronto Community Agencies and Shelters.*

(Major Research Paper). Completed, July 2010. Supervisor, Nancy Halifax, Critical Disabilities Studies.

Jennifer J. Logan (2010) *"There's no place like home": A Snapshot of the Settlement Experiences of Newcomer Tibetan Women in Parkdale, Toronto.* Completed, June 2010. Supervisor, Valerie Preston, Geography.

Tina E. Wilson (2009) *In Their Own Best Interests? Textually Mapping Governmentality in the Lives of Young People Without Stable Housing in Canada*. University of Toronto. Adrienne Chambon (Suervisor) Faculty of Social Work, University of Toronto.

Rasulan A. Hoppie (2009) *Moving on up? Black Families' Pursuit of the Suburban Dream and Implications for their Children.* Completed, December 2009. Supervisor, Carl James, Faculty of Education

Yimin Du (2009) *Global Stability of TB Models: Heterogeneous Populations and Resistance.* Completed, December 2009. Supervisor, Jianhong Wu. Graduate Program in Mathematics, York University.

Ilona Abramovich (2008) *Young, Queer and Homeless in Toronto: Where is the Support?* Completed, August 2008. Supervisor, Nancy Halifax. Graduate Program in Critical Disabilities Studies, York University.

Amy Brandon (2007) *The Mis-/Under-Representation of Youth in Canadian Federal Policy and Policy Development.* Completed: February, 2007. Supervisor, Don Dippo, Faculty of Education

Jeewan Chanicka (2006) *The Jihad In Me: A Reflective Journey on the Role of Islamic Epistemology as a Guiding Framework for Student Engagement and Teacher Resistance in a Post September 11th World.* Completed: December, 2006. Supervisor: Carl James, Faculty of Education

Ramon San Vicente (2006) *Old School, New Rules: Redefining Black Males, Hip Hop Culture and Public Schooling*. (Thesis) Completed: December, 2006. Supervisor: Joy Manette, Faculty of Education

Sandra Mayberry (2006) *Constructing and Managing Behaviour in Ontario Schools: An Institutional Ethnographic Study*. (Thesis) Completed: April, 2006. Supervisor: Alison Griffith, Faculty of Education

Maureen Chard (2006) *Constructing and Managing Behaviour in Ontario Schools: An Institutional Ethnographic Study*. (Thesis) Completed: April, 2006. Supervisor: Alison Griffith, Faculty of Education

Katherine Miles (2006) *The Significance of Social Integration Strategies for ESL Students in Mainstream Classrooms*. (MRP). Completed: May 15, 2006. Supervisor: Connie Mayer. Faculty of Education.

Pamela Dogra (2006) *The Way I See It: Stories of Learning and Teaching*. (MRP) Completed: May, 2006. Supervisor: Isabel Killoran. Faculty of Education

Mike Malcolm (2006) *Toronto Schools and the Creation of the Deviant School Profile and Identity: the implications of the social construction of the deviant identity on student success.* (MRP) Completed: April, 2006. Supervisor: Carl James. Faculty of Education

Lisa Varghese (2006) *Finding a "Home": thinking Through the Issues and Complexities of South Asian Adolescent Conduct in Today's Greater Toronto Area* (Thesis) Completed: April, 2006. Supervisor: Carl James. Faculty of Education

Thomas Douglas (2005). *Finding the One (in ten): Early Identification of Teacher Candidates With Maximal Social Justice Education Praxis Potential.* (Thesis) Completed: April, 2005. Supervisor: Patrick Solomon. Faculty of Education

Robert W. Young (2005). *"You Can't Make Me" Punishment and Pedagogy in the Prison Classroom.* (Thesis) Completed: May, 2005. Supervisor: Susan Dion. Faculty of Education

Susan Clarke (2005). *Interpreting the Reggio Emilia approach: Implications for reducing violence and aggression in early childhood.* (Thesis) Completed, February, 2005. Supervisor: Carol Anne Wien. Faculty of Education

James Rhee (2004). *Relationships and Reflection - Two Keys of Teacher Response to Student Behaviour*. (Thesis) Completed, September 2004. Supervisor: Isabel Killoran. Faculty of Education.

Claudia Johnson (2004). *What's Power and Authority Got To Do With It? Making Meaning From Students' Understanding of Student-Teacher Relationships.* (Thesis) Supervisor: Susan Dion. Faculty of Education.

Marisa Panaroni & Sally Rivers (2004). *Transforming novel studies through anti-bias instruction*. (Major Research Paper) Completed, September 2004. Supervisor: Isabel Killoran. Faculty of Education.

Nazreen Motiar (2003). *Use them or lose them: The state of elementary school librarians.* (Major Research Paper) Completed, September 2003. Supervisor: Isabel Killoran. Faculty of Education.

Dean's Representative

Loriann Hottot (2002). *Complexity and Contradiction in the Construction of Femininity*. (Thesis). Supervisor, Alison Griffith. Faculty of Education.

Internal / External Examiner

Kathy Hardill (2016) *"That Look That Makes You Not Really Want to Be There": Health Care Experiences of People Who Use Illicit Opioids In Small Urban and Rural Communities – A Critical Social Theory Analysis.* Faculty of Health (Nursing) York University

Julia Riddell (2014) The Development of Self in Relationships: Youth's Narratives of Change Through a Residential, Wilderness and Family Therapy Intervention. Masters of Arts (Psychology), York University. November, 2014

Bertie Friedlander (2006) Successful Aging - An Analysis of People and Places Dedicated to Learning Programs for Seniors. Masters of Arts (Anthropology) April, 2006

Clifford Agburu (2005) The Dilemma of Alcohol Addiction: A Disability Without Disability Benefits in Ontario. Masters of Arts (Critical Disability Studies), York University.

Andrew Taylor (2005). *Negotiating Harm Reduction: Risk, Bodies and Youth Substance Users.* Masters of Arts (Anthropology), York University.

Caroline McIssac (2003). *Romantic Dissolution and Depressive Problems in Adolescence: A Developmental Analysis.* Masters of Arts (Psychology), York University.

External Examiner

Meagan E. La Plante (2017) Rapid Rehousing Practice at a Shelter for Homeless Youth. Master of Art in Leadership. Royal Rhodes University. Supervisor: Gira Bhatt

Kim Stanford (2002). *The Right (to) Pleasure: A Participatory Foucaultian Exploration of Youth Drug Users' Experience with Harm Reduction.* Masters of Public Health Sciences, Public Health Sciences, University of Toronto.

5. RESEARCH TRAINING through RESEARCH ASSISTANTSHIPS PhD (26); MA (53); Undergraduate (14)

Doctoral Research Assistantships

Afsaneh Bohouli (2013/14)

Christyne Hebert (2013/14)

Kandirra Wilson (2012/13)

Carey Doberstein (2012/13)

Caryl Patrick (2011/12)

Cheryl Athersych (2011/12)

Sabina Mirza (2011/12, 2012/13)

Julia Sinclair-Palm (2011/12, 2012/13)

Jennifer King (2010/11)

Amanda Noble (2011/12, 2012/13, 2013)

Naomi Nichols (2010/11, 2011/12)

Andrew Grimo (2010/11)

Claire Major (2008/09, 2011/12)
Karen Kugelmass (2010/11)
Kristy Buccieri (2008/09, 2009/10, 2010/11, 2011/12, 2012/13)
Jaime Yard (2008/09)

Masters Research Assistantships

Ryan Walters (2013/14)
Fleurie Hunter (2013, 2013/14))
Nick Spohr (2012/13)
Meezan Elgen (2012/13)
Nicki Pariser (2012/13)
Mary Choy (2011/12)
Stefania Jakovlevski (2011/12)
Amanda Dunn (2010/11, 2011/12)
Pulak Bakshi (2010/11, 2011/12)
Jessica Whelan (2010/11, 2011/12)
Christopher Ho (2009/10, 2010/11, 2011/12)
Sabina Mirza (2008/09, 2009/10, 2010/11)
Jesse Newell (2008/09, 2009/10, 2010/11)
Fizza Haider (2008/09, 2009/10)
Vivian Kwouw (2008/09)
Maya Shapiro (2008/09)
Susan Appotive (2007/08)
Isaac Coplan (2013/14)
Kami Chisholm (2013/14)
Jason Bertkin (2012/13)
Sanya Vukas (2012/13)
Andrew Nolan (2012/13)
Michael Gonzales (2012/13, 2013/14)
Allison Leslie Fischer (2011/12)
Jenna Maley (2010/11)
Kirk Hatcher (2010/11)
Tara Patton (2010/11)
Delaney Downer (2009/10, 2010/11)
Janice Fennell (2009/10)
Diwei Wang (2008/09, 2009/10, 2010/11)
Magdalene Garda (2008/09, 2009/10)
Sran Gurgeet (2009/10)
Spy Denhomme-Welch (2008/09)
Shari Grayson (2007/08)

Undergraduate Research Assistantships

Alexander Moldovan (2013/14)
Alicia Campney (2013/14)
Ashley Abbasi (2013/14)
Jesse Donaldson (2013)
Oxana Roudenko (2012)
Monique MacLeod (2012)
Sebastien Wan (2012)
Jesse Thistle (2012)
Gerald Wan (2011, 2012)
Esther Townsend (2011)
Matthew Aaron (2003, 2004, 2005)

D) SERVICE

1. UNIVERSITY SERVICE:

Administrative Roles

2012-2013	Associate Dean, Research and Professional Development – Faculty of Education (six months)
2007-2011	Associate Dean, Research and Professional Development – Faculty of Education (four years) (Note: I have not included committees I sat on in my role as Associate Dean (2007-2011))

Committee Membership

2009-2013	York Centre for Education and Community (Executive Committee and External Advisory Committee)
2008-2013	York Homelessness Research Network
2011-2013	York Institute for Health Research (Executive Committee)
2010-2011	Lifelong Learning, Partnerships & Outreach
2010-2011	York Mental Health Strategy Working Group
2010-2011	York University, Dispute Resolution Committee
2009-2011	GRIP committee
2003-2011	International Advisory Group - RPD – Faculty of Education
2003-2006	Visiting Scholars - Graduate Programme (Chairperson) – Faculty of Education
2003-2004	Awards Committee - Graduate Programme (Chairperson) – Faculty of Education
2003-2011	Coordination and Planning – Faculty of Education
2002-2003	Visiting Scholars - Graduate Programme
2001-2002	Awards Committee - Graduate Programme
2001-2002	Ethics Review Committee – Faculty of Education
2000-2001	Admissions Committee - Graduate Programme – Faculty of Education
2000-2001	Tenure and Promotions Committee – Faculty of Education

Program Development

2008 York Centre for Education and Community – ORU Proposal (successful)

2003-2005 Children at Risk Symposium programme development.

2003-2007 Harm Reduction certificate programme development.

2003-2004 Community-Based Research seminar series programme development.

2003-2005 Canadian Conference on Homelessness.

2. COMMUNITY SERVICE:

Board of Directors - Community Organizations

2014 – 2016 *Raising the Roof*, President

2010 - 2019 *York Region Human Services Planning Board*

2012 – 2018 *Canadian Alliance to End Homelessness*. Board of Directors (Secretary, and Founding Member)

2007 - Present *Raising the Roof.* Board of Directors

2007 - Present *Canadian Housing Renewal Association.* Policy Advisory Committee

2003 - 2007 *Central Toronto Community Health Centres.* President of Board of Directors.

2002 - 2007 *Central Toronto Community Health Centres*. Board Member.

Community Planning Committees

2015-16 Province of Ontario *Provincial Expert Panel on Homelessness*

2002 – 2004 *City of Toronto Mayor's Community Safety Awards Committee.*

1999 *SWYM Consortium.* - Squeegee Initiative.

1998 Toronto *Community and Social Planning Council.* - Squeegee initiative.

1997 – 1998 *Shout Clinic / SETO*

1997 – 1998 Wellesley / St. Michaels Hospital Ambulatory Care Needs Assessment.

1994 *SETO*. Homeless Emergency Access project.

1987-1988 *Togher Community Association*. Cork, Ireland (1987-88).

Court File No. CV-21-00077817-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, ET AL.

Applicants

-and-

CITY OF HAMILTON

Respondent

ACKNOWLEDGMENT OF EXPERT'S DUTY

1. My name is Stephen Gaetz. I live in Colborne, in the Province of Ontario.

2. I have been engaged by or on behalf of the Hamilton Community Legal Clinic to provide evidence in relation to the above-noted court proceeding.

3. I acknowledge that it is my duty to provide evidence in relation to this proceeding as follows:

   (a) to provide opinion evidence that is fair, objective and non-partisan;

   (b) to provide opinion evidence that is related only to matters that are within my area of expertise; and

   (c) to provide such additional assistance as the court may reasonably require, to determine a matter in issue.

4. I acknowledge that the duty referred to above prevails over any obligation which I may owe to any party by whom or on whose behalf I am engaged.

Date June 14, 2022

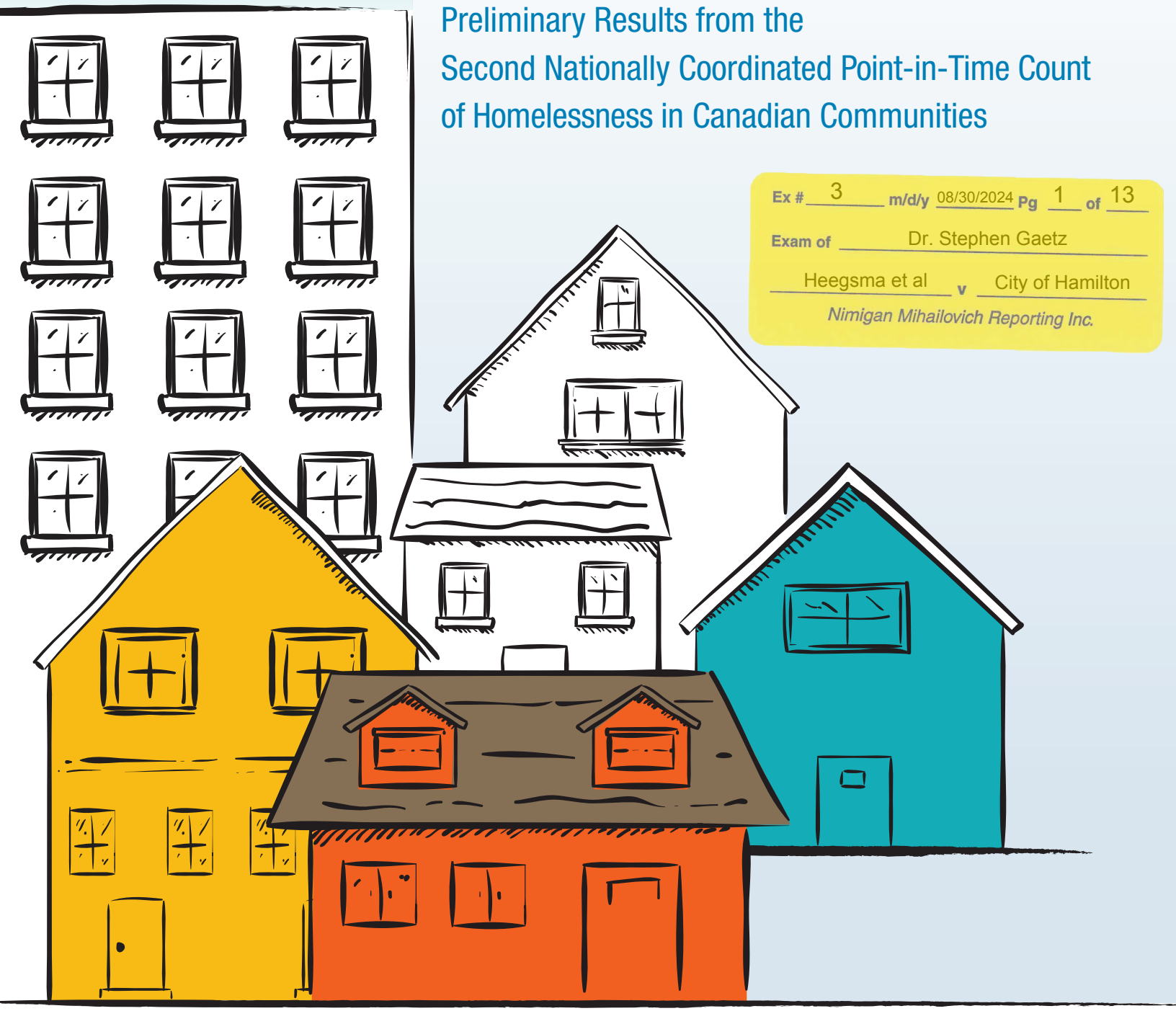
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Signature

Ex # 2 m/d/y 08/30/2024 Pg 1 of 1
Exam of Dr. Stephen Gaetz
Heegsma et al v City of Hamilton
Nimigan Mihailovich Reporting Inc.

2018

EVERYONE COUNTS
HIGHLIGHTS

Preliminary Results from the Second Nationally Coordinated Point-in-Time Count of Homelessness in Canadian Communities



Ex # 3 m/d/y 08/30/2024 Pg 1 of 13
Exam of Dr. Stephen Gaetz
Heegsma et al v City of Hamilton
Nimigan Mihailovich Reporting Inc.

Employment and Social Development Canada
Emploi et Développement social Canada
Canada

Everyone Counts 2018: Highlights – Preliminary Results from the Second Nationally Coordinated Point-in-Time Count of Homelessness in Canadian Communities

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Between March 1 and April 30, 2018, 61 communities participated in **Everyone Counts**, the second nationally coordinated Point-in-Time (PiT) count of homelessness in Canadian Communities. The first count took place in 2016 with 32 participating communities. Everyone Counts 2020 will be the third nationally-coordinated PiT count and is planned for March and April 2020.

The findings highlighted in this report are the result of the enumeration and surveys conducted in the 61 communities in 2018. The results represent a picture of homelessness from a range of communities across Canada, including data from communities in every province and territory, covering major urban centres, suburban communities of various sizes, and more rural and remote communities.

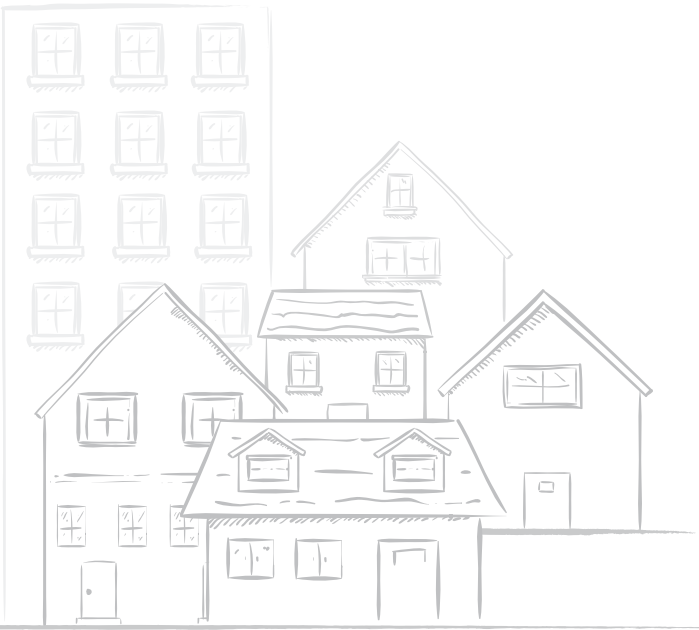
Further results from Everyone Counts 2018 will follow in future reporting, including reasons people cite for their housing loss, sources of income, and deeper analyses on specific populations.

If you have questions about this report, contact the Reaching Home research team: hpsr@hrsdc-rhdcc.gc.ca

Benefits of the Count

Point-in-Time counts provide a unique community-wide view of homelessness that reaches beyond those who are accessing other homelessness services. The survey provides data that can point to services, policies, or programs that can help to prevent and reduce homelessness. This is information that is not captured through administrative data systems.

The counts are particularly helpful to account for people who do not access shelters. Some populations, including Indigenous Peoples, youth and women, are less likely to access shelters and will therefore be underrepresented in administrative data. The PiT Counts offer a means to address this.





Acknowledgements

This report was prepared by Dr. Patrick Hunter, Senior Policy Analyst, Employment and Social Development Canada, and reflects the work by the PiT Count Implementation team at Employment and Social Development Canada, the National PiT Count Working Group and all of the 61 communities that participated in Everyone Counts. Each count was led by a local team, relying on dedicated people working with homelessness serving organizations, municipal staff, emergency services and volunteers who took the time to have conversations with people experiencing homelessness to listen to their stories and understand their needs.

Methodology

PiT Counts provide a one-day snapshot of homelessness in a community, including people experiencing homelessness in shelters, unsheltered locations, and transitional housing. They can also include people experiencing homelessness who are in health or correctional facilities or who are staying with others because they have no access to a permanent residence.

PiT Counts result in an enumeration of homelessness in core locations such as unsheltered locations, shelters and transitional housing. They also include a survey of people experiencing homelessness across the community.

Participating Designated Communities

- Barrie (Simcoe)
- Bathurst
- Belleville
- Brandon
- Brantford
- Calgary
- Charlottetown
- Drummondville
- Dufferin
- Durham (Oshawa)
- Edmonton
- Fredericton
- Gatineau/Outaouais
- Grande Prairie
- Guelph
- Halifax
- Halton Region
- Hamilton
- Iqaluit
- Kamloops
- Kelowna
- Kingston
- Lethbridge
- London
- Medicine Hat
- Metro Vancouver (Conducted in 2017)
- Moncton
- Montréal
- Nanaimo
- Nelson
- Nipissing/North Bay
- Ottawa
- Peel Region
- Peterborough
- Prince Albert
- Prince George
- Québec
- Red Deer
- Regina
- Saguenay/Lac St-Jean
- Saint John
- Saskatoon
- Sault Ste Marie
- Sherbrooke
- St. Catharines/Niagara/ Thorold
- St. John's
- Sudbury
- Summerside
- Sydney/Cape Breton
- Thompson
- Thunder Bay
- Toronto
- Trois-Rivières
- Victoria (Capital Regional District)
- Waterloo Region
- Whitehorse
- Windsor
- Winnipeg
- Wood Buffalo
- Yellowknife
- York

Enumeration and Survey

PiT counts result in an enumeration and survey findings. The enumeration is calculated by a combination of administrative data on occupancy of shelter providers and transitional housing and people who reported or were observed sleeping on the street on a single night. The survey is also done with people experiencing homelessness who are spending the night in shelter, transitional housing, staying with others, in health and corrections institutions, and other places. The results are analyzed to better understand their experience of homelessness.

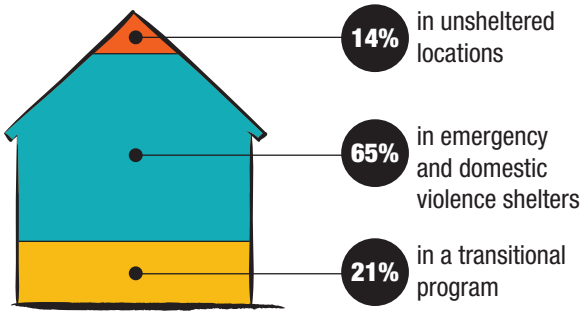
The methodology for Everyone Counts was developed in conjunction with a National PiT Count Working Group, and it includes core methodological standards followed by the 61 communities, including a common set of screening and survey questions. Communities could build on this *core* methodology to address local information needs. More information on the methodology can be found in the Guide to Point-in-Time Counts in Canada.

Enumeration

On a given night, 25,216 people across 61 communities were experiencing absolute homelessness in shelters or unsheltered locations. An additional 6,789 people were in a transitional program. Note, however, that there was some variation across communities as to what constituted a transitional program.

Over the communities that also conducted a count in 2016, there was a 14% increase in the enumeration. In part, this may be due to improvements in the methodology. The first time a community conducts a count there are many lessons learned related to where to look for people experiencing homelessness, how many volunteers are needed, and how to engage people experiencing homelessness. This can result in a more effective PiT Count that reaches, and enumerates, more people.

FIGURE 1 **Overnight Locations**



Survey Results

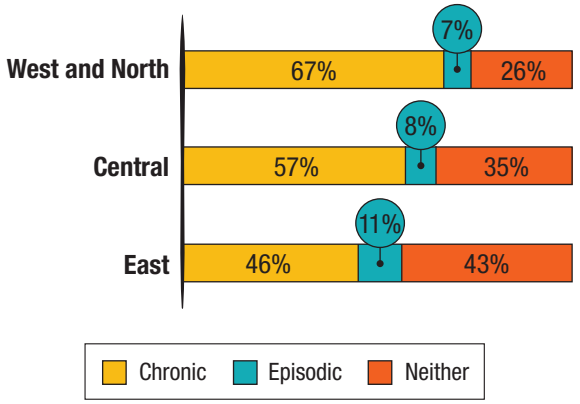
Across the 61 communities, 19,536[1] people were surveyed experiencing homelessness in unsheltered locations, shelters, transitional housing, staying with others, hotels or motels, health or corrections systems, and in unknown locations. The results of each analysis includes all of those who provided a response to each question. The survey questions can be found in the **Guide to Point-in-Time Counts in Canada**.

Chronic and Episodic Homelessness

Survey respondents were asked how long and how many different times they experienced homelessness over the past year. Six or more months of homelessness was considered chronic homelessness, 3 or more episodes lasting less than 6 months of homelessness was considered episodic homelessness.

People experiencing chronic homelessness accounted for 60% of all respondents whereas episodic homelessness accounted for 8% of all respondents. The proportion identified as chronic was typically higher in communities in the West and North (Manitoba, Saskatchewan, Alberta, British Columbia, and the territories) and lower in the East (New Brunswick, Nova Scotia, Prince Edward Island, and Newfoundland).

FIGURE 2 Chronic and Episodic Homelessness Across Regions



[1] The number of people who completed a survey is lower than the number of people enumerated because not everyone completes a survey (see Enumeration and Survey on page 2). In addition, not everyone who is surveyed is enumerated. The enumeration only includes people who are spending the night in shelter, unsheltered locations and in transitional housing which is captured in a consistent way across communities.

Age, Gender Identity and Sexual Identity

The majority (62%) of survey respondents identified as male, 36% identified as female and 2% identified as trans male, trans female, transgender, non-binary, androgynous, gender fluid, two-spirit, genderqueer or gender non-conforming, or provided another response not listed on the survey.[2]

Dependents and unaccompanied youth each comprised 13% of those identified. Adults were the largest group, accounting for nearly half (49%) of those identified. Over 1 in 5 (22%) were older adults and 3% were seniors.

Males and females were equally represented among dependents, but increasingly diverged with age, with males accounting for 56% of youth, 61% of adults, and over 70% of older adults and seniors. Gender diverse responses were most common among youth, accounting for 4% of youth responses.

FIGURE 3 Age and Gender Identity

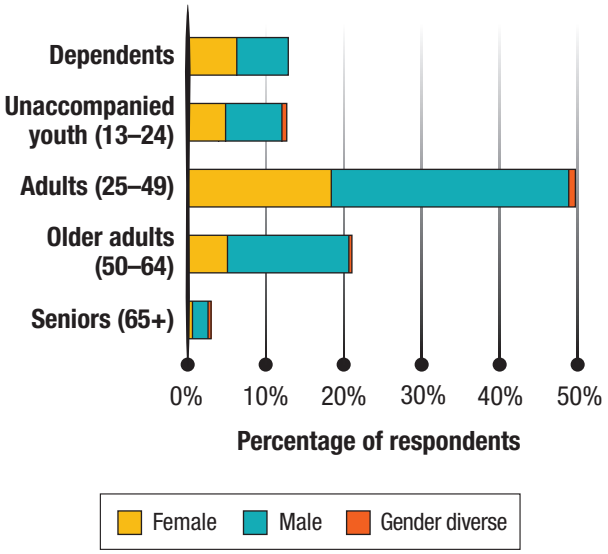
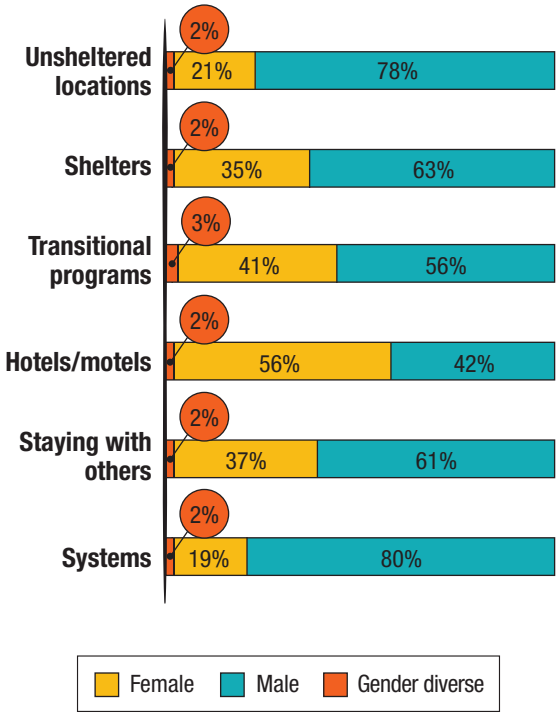


FIGURE 4 Gender and Overnight Location



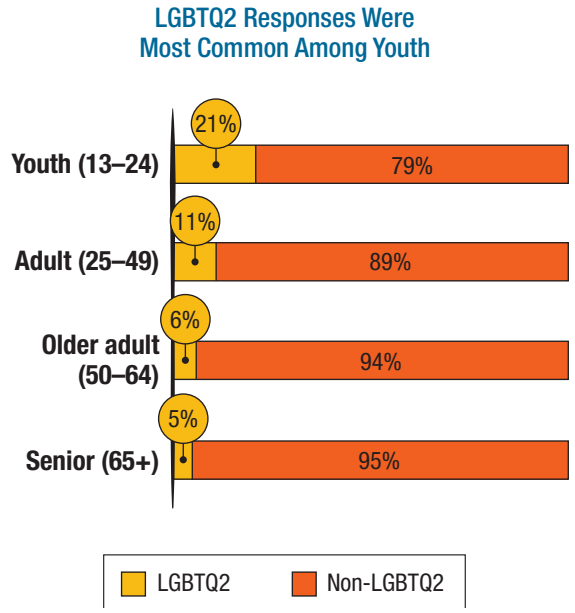
Respondents were asked about their overnight location on the PiT Count night. Those who identified as male represented the majority in most overnight locations with the exception of hotels and motels. This is likely because many communities provide hotel or motel rooms as a response to family homelessness when other facilities are not available, and most families are female-led.

[2] Note that respondents who identified as male and female may include cisgender and transgender people. As a result, this report may undercount the number of people who may identify as gender diverse. Gender for dependents was identified by their parents or guardians.

When respondents were asked about their sexual identity, or orientation, over 20% of youth identified as bisexual, gay, lesbian, asexual, pansexual, two spirit, queer, questioning, or provided another response not listed on the survey. When considered together with gender diverse responses, 21% of youth identified as LGBTQ2.

LGBTQ2 responses were less frequent with age, accounting for 11% of responses from adults, 6% of responses from older adults, and 5% of responses from seniors.

FIGURE 5 LGBTQ2 and Age

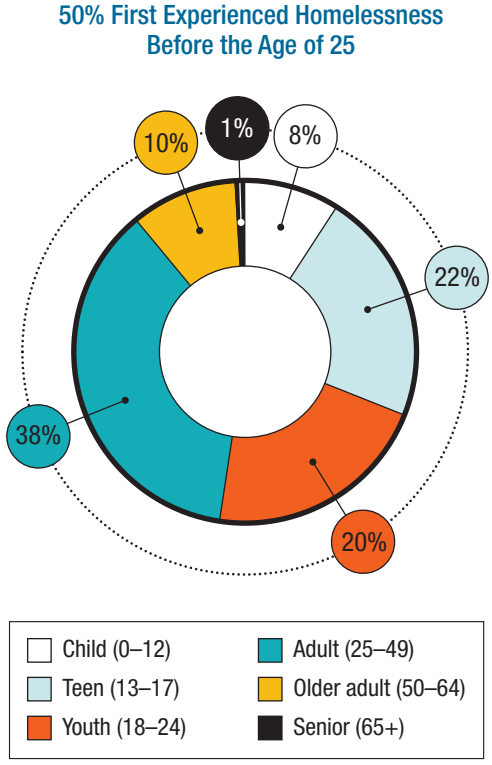


The Experience of Homelessness

One quarter of respondents (25%) had not used a shelter in the past year. Shelter use was less common among people staying with others (53%), but also among those who were in unsheltered locations (41%), transitional housing (47%) and health and corrections systems (41%).

Respondents were asked about the age at which they first experienced homelessness. Approximately 30% of responses were as a child or teen (under 18). A further 20% were youth. First experiences of homelessness under the age 25 were reported by 49% of adults, 26% of older adults, and 17% of seniors.

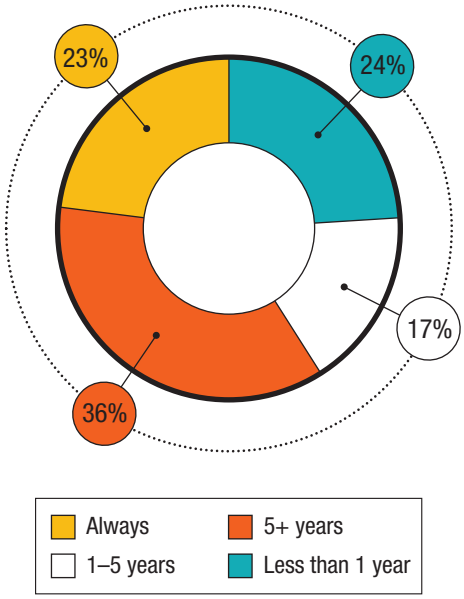
FIGURE 6 Age of First Homelessness Experience



Respondents were asked when they came to the community and where they were previously. Most respondents (59%) have either always been in the community or came more than 5 years ago. Nearly one quarter (24%) came within the past year.

Of those who did report coming to the community, most came from elsewhere within the same province (63%) and over one quarter came from elsewhere in Canada (27%). Fewer came internationally (11%).

FIGURE 7 Time in the Community



Indigenous Identity

Nearly one third (30%) of respondents identified as Indigenous, with the majority identifying as First Nations. In contrast, approximately 5% of the Canadian population identifies as Indigenous in the 2016 census, suggesting an overrepresentation of Indigenous Peoples experiencing homelessness.

This percentage was higher among those who were staying in unsheltered locations (37%) and among those who were staying with others (43%). This suggests that shelter-specific statistics are likely to underestimate the extent of Indigenous homelessness.

FIGURE 8 Indigenous Identity and Gender

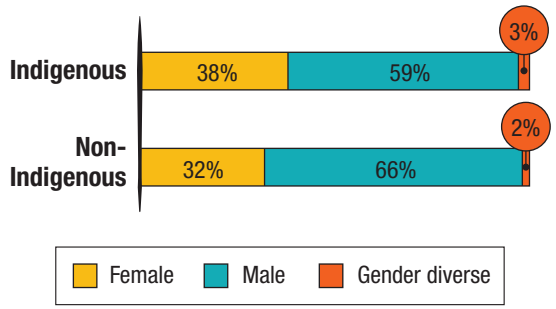
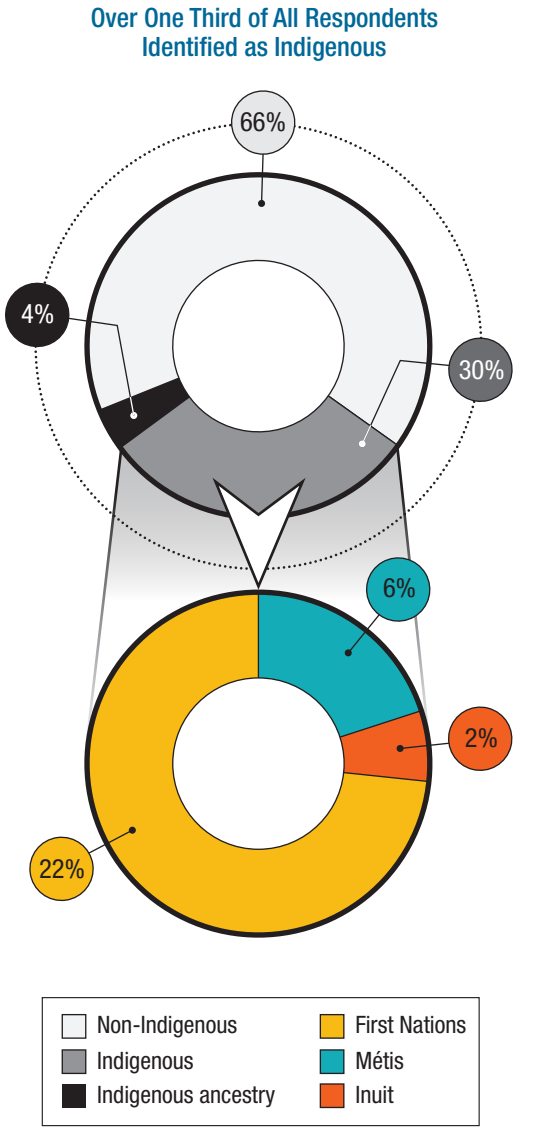


FIGURE 9 Indigenous Identity

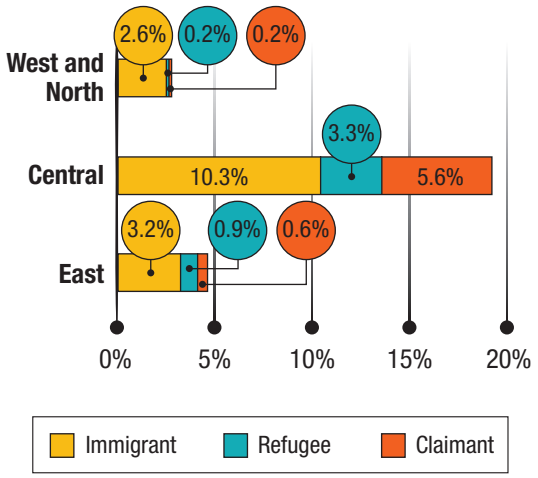


Newcomers to Canada

14% of respondents indicated that they came to Canada as an immigrant, refugee or refugee claimant. These included 8% who indicated that they came as an immigrant, 3% as a refugee and 4% as a refugee claimant. The majority (56%) have been in Canada for 5 or more years, however a significant minority (26%) came within 6 months prior to the count.

In contrast, over 20% of the population in the 2016 census reported that they were, or have been, a permanent resident in Canada[3]. Although this figure does not include current refugees or refugee claimants, it suggests that newcomers to Canada experience lower rates of homelessness than the general population.

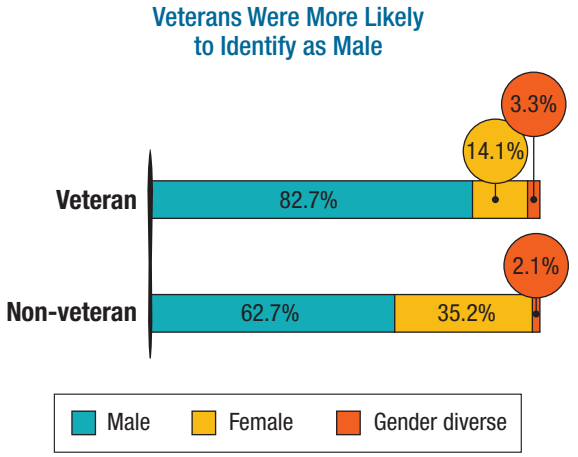
FIGURE 10 Regional differences in the proportion of respondents who came to Canada as newcomers



Veterans

Respondents who identified as veterans of the Canadian Armed Forces accounted for 4.4% of all respondents, and 0.3% identified as veterans of the Royal Canadian Mounted Police. Veterans tended to be older (median age = 48) than non-veterans (median age = 39) and less likely to be female.

FIGURE 11 Veterans and Gender

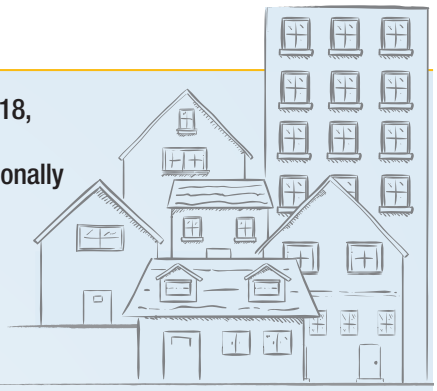


[3] https://www150.statcan.gc.ca/n1/daily-quotidien/171025/dq171025b-eng.htm

EVERYONE COUNTS 2018

Highlights

Between March 1 and April 30, 2018, **61 communities** participated in *Everyone Counts*, the second nationally coordinated Point-in-Time (PiT) count of homelessness in Canadian Communities.



Across the **61 communities**,

32 005

people were identified as experiencing homelessness in:

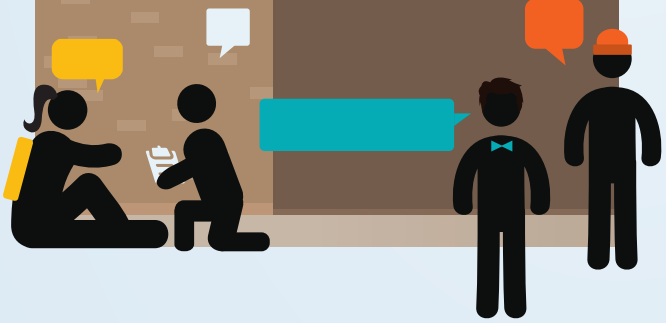
- **14%** unsheltered areas
- **65%** shelters
- **21%** transitional facilities

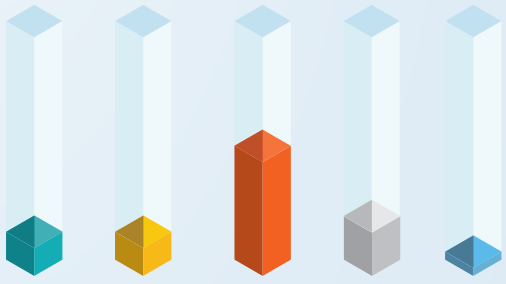
PiT: it's a one-day snapshot of homelessness in each community that contributes to a national picture.

- Women **36%**
- Indigenous identity **30%**
- Veterans **5%**
- LGBTQ2 **11%**

When asked about their experience of homelessness:

- **60%** said that they had been were homeless for 6 months or more in the past year
- **50%** said that they first experienced homelessness before the age of 25





- **13%** Dependents (0-15)
- **13%** Unaccompanied Youth (13-24)
- **49%** Adults (25-49)
- **22%** Older Adults (50-64)
- **3%** Seniors (65+)

REACHING HOME

CANADA'S HOMELESSNESS STRATEGY



For more information, visit Canada.ca/homelessness

The next coordinated PIT Count will be *Everyone Counts 2020*

Employment and Social Development Canada / Emploi et Développement social Canada

Canada

Hamilton



Hamilton's

EMERGENCY SHELTER STANDARDS

September 2023

Ex # 4 m/d/y 08/30/2024 Pg 1 of 75
Exam of Dr. Stephen Gaetz
Heegsma et al v City of Hamilton
Nimigan Mihailovich Reporting Inc.

Hamilton's Emergency Shelter Standards

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1.1 Acknowledgments

The Hamilton Emergency Shelter Standards ("the Standards") were created in collaboration with local Indigenous leaders, people experiencing homelessness, emergency shelter operators, and shelter staff. In addition, the Standards were informed by best practices learned from other municipalities across Canada.
Indigenous Peoples are respected partners and leaders in the work of ending homelessness. The City of Hamilton and shelter operators value the ongoing collaboration with local Indigenous leaders that informs continuous improvement to the homeless-serving sector beyond updating the Standards. This document is representative of the City of Hamilton's commitment to addressing and preventing Indigenous homelessness in ways that are rooted in the spirit and actions of reconciliation.

The City of Hamilton is situated upon the traditional territories of the Erie, Neutral, Huron-Wendat, Haudenosaunee, and Mississaugas. This land is covered by the Dish With One Spoon Wampum Belt Covenant, which was an agreement between the Haudenosaunee and Anishinaabek to share and care for the resources around the Great Lakes. We further acknowledge that this land is covered by the Between the Lakes Purchase, 1792, between the Crown and the Mississaugas of the Credit First Nation.

Today, the City of Hamilton is home to many Indigenous people from across Turtle Island (North America) and we recognize that as part of our commitment to truth and reconciliation, we must do more to learn about the rich history of this land so that we can better understand our roles as residents, neighbours, partners, and caretakers. The City of Hamilton is grateful for the experience, knowledge, and feedback our community partners and people with lived experience contributed throughout the process of developing the Standards.

1.2 Background

The Hamilton Emergency Shelter Standards were designed to support the work happening to end homelessness in our community by providing a transparent framework of consistent shelter services for all individuals and families experiencing homelessness in Hamilton. Building upon the 2008 Emergency Shelter Standards, the updated 2023 Standards provide more comprehensive and detailed information with 24 new sections and 39 enhanced sections. By establishing expectations for minimum operating, service-delivery, and facility standards based on local community input, research, and best practices from the Canadian Shelter Transformation Network and other jurisdictions across Canada, this document is a guide for emergency shelters to continue their individual and collective success in helping individuals resolve their homelessness in order to live safer, healthier lives. This document serves as a tool to support quality, consistency, and transparency in the provision of emergency shelter services in Hamilton.

The Standards apply to Emergency Shelter Operators within the homeless-serving sector of Hamilton. Other services such as Violence Against Women, short-term/transitional housing, and supportive housing programs are all essential components of addressing homelessness, however, these services require distinct service delivery models and standards.

The Standards are not intended to be exhaustive as our homeless-serving sector is continuously adapting to changing circumstances, demands, and challenges. Emergency Shelter Operators will have their own policies and procedures in addition to the expectations laid out in the standards. For issues not covered within the Standards, it is expected that Emergency Shelter Operators will exercise reasonable judgment and/or consult with City of Hamilton staff where necessary.

It is recommended that the Standards be reviewed and updated every four years in order to reflect and adapt to evolving research and needs within the City of Hamilton. The City of Hamilton, Emergency Shelter Operators, and local Indigenous leaders are committed to reconvening as needed to adapt to changing circumstances between the four-year review point.

1.3 Writing the Standards

The Standards were written in collaboration with the community. The City sketched out an initial rough draft of the Standards based on Hamilton's 2008 Standards, a jurisdictional scan of the standards from other municipalities, and best practice documents. Based on this rough draft, the City initiated two parallel consultation processes. A working group made up of emergency shelter operators and Indigenous representatives formed and met weekly to write the Standards. Also, a consultation group was formed between the City and Keeping 6 peer workers to engage people with living experience. People accessing each of the City funded emergency shelters plus three drop-ins were engaged in open-ended small group discussions about the Standards, and what was important to them. The expertise of these two groups, emergency shelter operators and people with living experience, are foundational to the Standards. A first draft was completed and brought to several community groups with expertise related to specific standards. The suggested edits were brought back to the shelter operators' steering committee to draft a final version of the Standards.

1.4 Local Homeless-Serving Sector

The successful ongoing implementation of the Hamilton Emergency Shelter Standards depends on a reciprocal process between the City of Hamilton, emergency shelter operators, and Indigenous community partners. Collaboration to support a coordinated system is essential for improving service integration and effectiveness. Service delivery and positive housing outcomes are enhanced through open and collaborative working relationships. The City of Hamilton, emergency shelter operators, and Indigenous community partners each have important roles to play in supporting each other and the clients we serve.

1.4.1 Role of the City

The City of Hamilton is responsible for coordinating the provision of emergency shelter services within Hamilton through the purchase of services with emergency shelter operators. Funding for emergency shelters is provided through municipal, provincial, and federal funding. Municipal funds are approved by Hamilton's City Council through the annual operating budget process.

The City of Hamilton fulfils the municipal role by:

- Entering into contractual arrangements (purchase of service agreements) with community-based agencies and providers to purchase shelter assistance for people who are homeless, in accordance with the above-mentioned service agreements.
- Acting as the Service Manager for federal and provincial funding by administering and maintaining the shelter system through Funding Agreements with shelters.

- Ensuring that all shelter programs meet the Standards and the contractual obligations as set out in the Subsidy Agreements.
- Coordinating and administrating strategic planning.
- Undertaking an annual review of the funding and service levels.
- Conducting partial reviews as deemed necessary by the City, funders, and/or as requested by the emergency shelter operator.

In addition, the City of Hamilton is accountable to people experiencing homelessness, Indigenous community partners, and emergency shelter operators for:

- Inviting and reviewing the recommendations brought forward by Indigenous community partners, people with lived experience, and emergency shelter operators.
- Aiming to design a system that not only responds to Indigenous homelessness, but also respects, honours and promotes the strength and resiliency of Indigenous peoples.
- Being available for sharing information, resources, etc. that support both client services and developing organizational capacity.
- Leading the development and implementation of a coordinated access system to serve individuals experiencing homelessness more equitably with consistent best practices and service integration across providers.
- Providing support with policy development, research, program development, evaluation, and reviews as needed.
- Reviewing and updating the Standards every four years in partnership and collaboration with emergency shelter operators, Indigenous leaders, and people with lived experience.
- Supporting each emergency shelter operator as a contributing member of the overall service system for the homeless and at-risk population in Hamilton.

1.4.2 Role of Emergency Shelter Operators

As a primary delivery agent of emergency shelter services, each emergency shelter operator will be responsible for ensuring:

- Compliance with the operating agreement between the City of Hamilton and the emergency shelter organization.
- Compliance with the Standards.
- Participation in the Standards review.
- An understanding of their role as a key stakeholder in the emergency shelter service system in Hamilton and the coordinated access system.
- Shelter services respond to the unique needs of Indigenous clients.
- Shelter services understand and respect the needs of other marginalized clients.
- Ensure that all staff have education on the unique needs and experiences of Indigenous clients.

To this end, emergency shelter operators will:

- Ensure full understanding of the requirements of the Standards to implement them.
- Provide input for the regular review of the Standards and other evaluation and improvement projects coordinated by the City of Hamilton (this includes having ready all documentation necessary to support compliance and being prepared to arrange interviews/questionnaires for selected staff, volunteers, clients, and Board members).
- Be available for partial reviews as requested by the City of Hamilton.
- Ask the City of Hamilton to schedule a review if it is deemed an exercise that could be helpful in developing organizational capacity.
- Collaborate with other emergency shelter operators and Indigenous community partners to strengthen client service delivery as a shelter service system.

1.4.3 Role of Indigenous Partners and Community Leaders

Hamilton's homeless-serving system must account for the systemic over-representation of Indigenous peoples experiencing homelessness. Advancing Indigenous partners' autonomy and self-determination, the City of Hamilton is committed to ongoing investments to Indigenous leadership and autonomy. We will work together to develop connections to housing and supports that are culturally appropriate, rooted in the spirit and actions of reconciliation.

As leaders in the City of Hamilton and representatives of the Indigenous community, Indigenous community partners are advancing work related to emergency shelter services through:

- Self-determination and autonomy, identifying local priorities and making investment decisions.
- Leading Indigenous-led research and policy development activities and working in collaboration with the City and shelter providers to support improvements in emergency shelter service delivery.
- Participating in and providing guidance on City-led research and policy development activities.

1.4.4 Role of People with Lived Experience

People with Lived Experience (PWLE) are invaluable to shaping programs, facilities, and policies in the emergency shelter sector. People with living experience know how the system works, they know what their needs are, and experience the system at work on the everyday level. They can bring to light perspectives that may be unknown or unknowable at the staff or senior leadership level.

Updating Hamilton's Emergency Shelter Standards included consulting with PWLE who were currently accessing emergency shelter beds and drop-in programs for people experiencing homelessness. City of Hamilton staff held 12 engagement sessions over the course of four months and met with people accessing the men's, women's, youth, and family sectors as well as Indigenous service providers. People who attended the sessions were compensated for their time and expertise. City staff documented 1,650 suggestions, experiences, and feedback during the engagement process.

Throughout the writing process City staff brought forward feedback from PWLE and integrated responses from PWLE into the updated Standards. Many sections of the Standards were expanded on in ways that reflect suggestions from participants or attempts to address gaps identified by PWLE. The City is grateful to all the people who participated in the engagement sessions for sharing their knowledge, experiences, and ideas.

People with living experience will continue to be invited and supported to take part in the homeless serving sector through:

- A Living Engagement Strategy developed by the City of Hamilton which will promote best practices for engaging PWLE and build formal opportunities for people experiencing homelessness to share their feedback to improve programs and services.
- Client input activities led by emergency shelter operators, such as PWLE advisory committees, satisfaction surveys, etc.

1.5 Guiding Principles

The City of Hamilton and emergency shelter operators are committed to delivering emergency shelter services that uphold the following guiding principles:

- **Accountability:** Emergency shelter operators are held accountable to the standards through multiple mechanisms, including funding contracts, data analysis, the complaints process, and governance tables. Governance tables comprised of representatives from the emergency shelter sector, the local Indigenous community entity, and the City of Hamilton meet regularly to ensure accountability to the Standards and ownership over their development, operationalization, and implementation, especially as it applies to equity policies.

- **Truth and Reconciliation:** Indigenous homelessness is defined as a human condition that describes First Nations, Métis, and Inuit individuals, families or communities lacking stable, permanent, appropriate housing or the immediate prospect, means, or ability to acquire such housing. Services must be committed to supporting Indigenous populations and the commitments outlined in the report on Ontario's Response to the Truth and Reconciliation Committee.
- **Acknowledging the Unique Autonomous Leadership of the Indigenous Community in the Work in Homelessness:** Hamilton's homeless-serving system must account for systemic over-representation of Indigenous persons experiencing homelessness. Indigenous peoples experience homelessness, as well as other forms of social exclusion, at a higher rate than the general population. Specific policy interventions are therefore needed to account for these circumstances. Homelessness amongst Indigenous peoples is a colonial legacy. The interconnectedness of ongoing colonialism, residential schools, intergenerational trauma, and ongoing systematic social and economic marginalization of Indigenous peoples shape our understanding of Indigenous homelessness in Canada. Acknowledging our Indigenous partners' autonomy and self-determination, we will work together to develop connection to housing and supports that are culturally appropriate, rooted in the spirit and actions of reconciliation. Building upon strong relationships between the City of Hamilton and local Indigenous leadership, we aim to design a system that not only responds to Indigenous homelessness, but also respects, honours, and promotes the strength and resiliency of Indigenous peoples.
- **Coordinated Access:** Hamilton's homeless-serving system is made up of a range of community agencies who together offer a continuum of integrated supports to assist people in preventing and ending homelessness. Ending homelessness requires a coordinated approach to reduce gaps in services and improve the process of connecting people to the most appropriate housing supports. The City of Hamilton, Indigenous leaders, and homeless-serving sector partners have developed coordinated access processes to share knowledge of clients experiencing homelessness, establish consistent best practices applied across the sector, and ensure that limited resources are allocated effectively and equitably. Coordinated Access relies on collaborating with other service providers and stakeholders across the homeless-serving sector and with relevant health and community services to connect people to resources that will help them access and retain stable housing.
- **Equitable Access:** Access to appropriate shelter space will never be denied based on citizenship, race, place of origin, ethnic origin, colour, ancestry, disability, age, creed, sex/pregnancy, family status, marital status, sexual orientation, gender identity, gender expression, or economic status.

- **Equity, Diversity, and Inclusion:** While acknowledging strength and resiliency of unique populations, there is also an awareness of unique structural and institutional barriers that each group may experience linked to systemic discrimination and oppression. Services must not be a one-size-fits-all approach and should be able to be effectively adapted to meet the specific needs of the people they serve. An anti-racist, anti-oppression approach and analysis should be applied to the policies, procedures, and services connected to the homeless-serving sector.
- **Harm Reduction:** Hamilton's homeless-serving sector recognizes the complex, intersecting social inequalities which put people experiencing homelessness at high risk of substance use and other activities which may endanger their safety and wellbeing. Partners across the sector work to minimize the harm and risks faced by people experiencing homelessness through a continuum of harm reduction approaches, the minimum of which are referrals to harm reduction supplies, detox, or addiction services.
- **Lived and Living Experiencing Input:** The City of Hamilton and emergency shelter operators will seek to engage people with lived or living experience of homelessness in intervention development, evaluation, and decision-making.
- **Non-Judgment:** A non-judgmental approach is critical to building relationships of openness and trust with program participants that can lead to positive life change. Staff also use a non-judgmental approach to ensure service is provided objectively and consistently to everyone.
- **Respect:** Staff treat program participants with dignity and respect, putting the person at the centre of decision-making and recognizing that an individual's autonomy and self-determination will guide their plan of care. Staff understand that individuals have a right to their choices. Shelters should make every effort to provide an environment that fosters a sense of personal control through providing choice and autonomy and building capacity wherever possible.
- **Strengths-Based and Empowerment Focused:** The homeless-serving sector recognizes that people experiencing homelessness have unique strengths and diverse needs. People experiencing homelessness will be empowered to identify their own goals and provide input into the development of emergency shelter services and policies.

1.6 Key Terms and Definitions

- **2SLGBTQIA+:** An acronym that refers collectively to two-spirited, lesbian, gay, bisexual, transgender, queer, intersex, asexual, and questioning people. While terms and identities evolve and more inclusive acronyms may be introduced elsewhere (e.g. LGBTQQIP2SAA, LBGTQIA), 2SLGBTQIA+ will be used as an all-encompassing term in the Standards.
- **Client:** Any individual who is in receipt of any support services provided by a shelter.
- **Common Intake and Assessment:** A standardized approach to assessing a person's current situation, the acuity of their needs, the services they currently receive/may require in the future, and their preferences for service delivery. It takes into account the background factors that contribute to risk and resilience, changes in acuity, and the role of friends, family, caregivers, community and environmental factors.
- **Discharge:** The process of concluding a client's stay at a shelter. Discharge from shelter may be initiated by the client or staff for a variety of reasons, including finding housing or exceeding the maximum length of stay in shelter.
- **Discrimination:** An action or decision that treats an individual, family, or group negatively and/or denies social participation based on perceived or actual protected human rights grounds: citizenship, race, place of origin, ethnic origin, colour, ancestry, disability, age, creed, sex/pregnancy, family status, marital status, sexual orientation, gender identity, gender expression, receipt of public assistance (in housing) and record of offences (in employment).
- **Emergency Shelter:** An organization that provides shelter to an individual or family experiencing homelessness with or without a referral, with the intention of providing short-term accommodation and support services to move clients into housing.
- **Harm Reduction:** A non-judgmental, non-coercive philosophy and set of practical strategies aimed at improving safety and reducing the adverse health, social, and economic consequences associated with legal and illegal substance use.
- **HMIS**: The Homelessness Management Information System (HMIS) is a system whereby data pertaining to people experiencing homelessness are recorded, stored, retrieved, and processed to improve service coordination and decision-making.

- **HIFIS:** The Homeless Individuals and Families Information System (HIFIS) is a web-enabled database that is used to support coordinated access using real-time information of individuals and families accessing the homeless serving sector. HIFIS is the current primary Homelessness Management Information System (HMIS) used by the City of Hamilton.
- **Homeless:** Academic research on homelessness demonstrates a complex interplay of structural factors, systems failures, and individual circumstances. The Canadian Observatory on Homelessness defines homelessness as "the situation of an individual, family or community without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it." This includes individuals or families who are unsheltered, in emergency shelter, provisionally accommodated and at risk of losing their housing. This working definition of homelessness has been endorsed by the federal government and has been adopted by municipalities across Canada.
- **Housing First:** A service approach that focuses on moving people experiencing homelessness into permanent housing without preconditions and then connecting them to supports and services as needed in order to stabilize their housing.
- **Housing-Focused Shelter:** A housing-focused shelter is unrelenting in its pursuit to make homelessness as brief as possible while returning people to permanent accommodation. From the moment an individual or family pursues shelter, there are efforts to ensure a safe and appropriate exit from shelter. Housing-focused shelter does not operate other programming that can interfere with ensuring stays are short-term with a return to housing rapidly[1].
- **Indigenous:** Persons who identify as having First Nations, Inuit, and/or Métis ancestry.
- **Indigenous Homelessness:** Indigenous Homelessness is a colonial legacy. Indigenous homelessness is a human condition that describes First Nations, Métis, and Inuit individuals, families or communities lacking stable, permanent, appropriate housing, or the immediate prospect, means or ability to acquire such housing. Unlike the common colonialist definition of homelessness, Indigenous homelessness is not defined as lacking a structure of habitation; rather, it is more fully described and understood through a composite lens of Indigenous worldviews. These include: individuals, families and communities isolated from their relationships to land, water, place, family, kin, each other, animals, cultures, languages and identities. Importantly, Indigenous people experiencing these

[1] OrgCode Consulting Inc. in partnership with the Canadian Shelter Transformation Network and Canadian Alliance to End Homelessness. (March 2019). *Housing Focused Shelter*.

kinds of homelessness cannot culturally, spiritually, emotionally, or physically reconnect with their Indigeneity or lost relationships.[2]

- **Medication:** Any prescribed or over the counter medications the client identifies as part of their health care needs.
- **Sector:** Emergency shelters are sub-categorized by the client groups they serve; each of these sub-categories is called a sector. Presently, there are four sectors: single adult men, single adult women, youth, and families. Trans, non-binary, and gender diverse individuals may self-select the shelter environment that feels best able to maintain their safety and well-being.
- **Serious Incidents:** Any occurrence or event that takes place on shelter premises which results in significant negative impact(s) on the health, safety, or well-being of clients and/or staff, such as fire, death, or critical injury.
- **Service Restriction:** Restricting a client's access to one or more shelter services for a length of time due to circumstances, incident(s) or behaviours that jeopardize the safety and well-being of others.
- **Shelter Diversion:** The process of working with clients to explore safe and appropriate accommodations which could be accessed prior to admittance into emergency shelter or the shelter overflow hotel system. Diversion is not saying "no" to sheltering people that have exhausted all their alternate housing options. Rather, diversion works to prevent people from accessing emergency shelter services where other housing options can be explored and, if necessary, supported with services and financial assistance to help them return to permanent housing.
- **Emergency Shelter Operators:** An organization that receives funds from the City to provide emergency shelter services in Hamilton.
- **Support Services:** Any program or service offered on shelter property by a shelter provider or external service provider to help clients meet their goals or needs including, but not limited to a shelter's meal programs, housing services, employment programs, health services, etc.
- **Trauma-Informed Care:** An approach to providing services which acknowledges the impact that trauma and abuse have on the development and behaviour of



2. Client Rights and Responsibilities

2.1. Rights and Responsibilities
2.2. Client Input
2.3. Complaints Process

Intent: This section of the Standards outlines the minimum rights and responsibilities clients can expect while accessing emergency shelters. In addition, this section intends to emphasize how the valuable knowledge of people with lived experience helps shape shelter services, conditions, and decisions related to their experiences.

2.1 Rights and Responsibilities

Standard Statement	Clients accessing emergency shelter will have access to information on their rights and responsibilities while in shelter. Each shelter will have a written policy concerning the rights and responsibilities of clients using the shelter. The policy will be posted in a common area of the shelter and be communicated to clients through various ways such as intake, admission, and meetings. At a minimum, everyone in shelter has the right to: • Be provided with a copy of the client rights and responsibilities at intake (or as soon as possible after admission). • Expect that the standards outlined in this document will be followed. • Be treated in a non-judgmental and respectful way. • Be free from discrimination and harassment. • Be recognized as having unique cultural needs and based on the identified connection (e.g., Indigenous ancestry) be informed of and referred to related community support(s) as requested. • Be provided with access to services in French if required. • Safe, adequate, and nutritious food. Every effort will be taken to meet dietary needs related to religious, cultural, or medical conditions. • Have forms, consent procedures, and policies explained in an accessible way. • Identify their own goals and receive support from staff to achieve them within shelter mandates. • Be given information about services and resources to make informed decisions. • A fair, clear complaints and appeals process without fear of punishment. • Be involved in decisions that affect them. • Have personal information treated confidentially. • Access their personal file if requested. • Provide input and feedback into shelter programs and policies. Clients are responsible for the following:

	• Reviewing and signing a copy of the client rights and responsibilities at intake (or as soon as possible after admission). • Abstain from any form of violence (including physical, verbal, emotional, sexual) and discrimination based on protected grounds. • Follow the rules of the shelter. • Treat shelter staff, volunteers, neighbours, visitors to the shelter, and other shelter residents with respect. • Respect the privacy and confidentiality of other shelter residents. • Respect the private property and belongings of other shelter residents. • Respect the private property and belongings of the shelter. • Work with shelter staff to improve their housing situation within their capacity. Notify the shelter when they will be late for curfew or no longer need to access emergency shelter. • Contribute to maintaining their own space in the shelter whenever possible.
Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • The rights and responsibilities of clients using the shelter which will, at a minimum, include the expectations outlined in Section 2.1: Rights and Responsibilities of the Standards.

2.2 Client Input	
Standard Statement	Clients have unique insight and knowledge which can contribute to continuous quality improvement within emergency shelters. Client input will be sought in all areas of program development, client experience, policy development, and program evaluation in multiple ways, including but not limited to exit interviews, discharge surveys, one-on-one interviews, client surveys, client focus groups, and resident meetings. Emergency shelter operators will promote engagement opportunities and provide accessible methods of participation to all clients, especially those who are members of communities that may have complex barriers to accessing shelter services and taking part in engagement activities. This process will include feedback on harm reduction interventions and supports. On occasion, the City of Hamilton may ask emergency shelter operators for support with seeking input from clients for research, policy development, and program review purposes. Shelters will have a policy and plan regarding client engagement activities and will report activities and outcomes to the City when requested.
Policy	Emergency shelter operators will develop a client input and engagement policy which will, at a minimum, include: • The frequency and format of engagement activities. • How engagement activities will be designed to be accessible for all clients especially members of communities more likely to be marginalized. • How engagement activities will be documented. • How feedback that details experiences of discrimination or harassment will be actioned • How clients will be informed of the impact of their input and any decisions or changes which are a result of client input.

2.3 Complaints Process	
Standard Statement	Clients have the right to participate in a fair and clear complaint and appeal process without fear of reprisal. Each shelter will have a board-approved policy regarding complaints and appeals, including how complaints can be made at the shelter level by clients or community members, how complaints will be investigated and resolved in a timely manner, and any subsequent escalation or appeal processes, including escalating a complaint to the City when all other options have been exhausted, in accordance with the City of Hamilton complaint resolution process. The process will be accessible to all people upon intake, posted within the shelter, and issued upon request. People will be referred to supports throughout this process, if requested. Shelters will allow clients to bring a support person with them throughout the complaint process if requested. If a client does not have support for making a complaint and requests one, shelters will provide information and/or referrals to community resources. Shelter providers will collect and evaluate all complaints and take any necessary corrective action whenever possible.
Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • City of Hamilton complaint resolution process • A complaints policy which will: o Be submitted as an appendix of the contract and updated when changed. o Outline how complaints are received, reviewed, and responded to by the emergency shelter, and escalated within the organization as required. o Include a process for referrals of support to the shelter stayer. o Detail an internal documentation process for tracking and evaluating complaints. o Establish how unresolved complaints will be referred to the manager of Homelessness and Housing Support if resolution is not possible at the level of the emergency shelter, in accordance with the City of Hamilton complaint resolution process.

3



intent:

This section of the standards aims to outline the practices required to support standardized and equitable access to emergency shelter services for all clients. In addition, this section clarifies expectations around how shelters balance operational capacity and maintain safety within the shelter environment, while ensuring that clients have clear information on how emergency shelter facilities can be accessed.

ACCESSING SERVICES

3.1 **Intake and Initial Assessment**

3.2 **Belongings**

3.3 **Daytime Access**

3.4 **Curfew and Overnight Passes**

3.5 **Length of Stay**

3.6 **Capacity Limits**

3.7 **Service Restrictions**

3.1 Intake and Initial Assessment	
Standard Statement	Each shelter will have an intake procedure, which includes a diversion assessment, an assessment of eligibility, and an initial assessment of the person's and dependents' support needs. Clients will be informed of key policies and procedures at intake, including rights and responsibilities, curfew, available supports, service restriction policies, etc. With the appropriate Indigenous training shelter staff will ask whether a person has Indigenous ancestry and if so, will inform client of option for a referral to an Indigenous organization of the person's choice as well as option to not be listed on HIFIS, not complete a VI-SPDAT intake and/or complete the alternative intake process for Indigenous clients. Other referrals may be appropriate at intake including supports for newcomers, health services, or supports based on a person's gender. Each shelter will seek coordinated access consent with clients and complete consent forms in accordance with the data sharing protocol, consent policy, and intake policy. Information will be added to HIFIS following the guidance in the HIFIS User Manual, policies, and training materials. Shelters will document a person's preliminary information including but not limited to legal names, date of birth, dependent details, gender, veteran status, Indigenous ancestry (as voluntarily provided by clients), housing history, contact information, and financial income. In addition to preliminary information, shelters will determine the appropriate length of time to complete the common triage assessment (typically at 15 days of cumulative stay in the shelter system) and assess and document any safety concerns and/or risks as appropriate. A comprehensive, housing-focused plan should be developed with clients within 14 days of admission to shelter. Shelter staff will work with clients to understand their needs by completing common assessment tools as agreed upon with the City. Indigenous clients are not required to participate in the completion of any mainstream assessment tool. These plans may evolve as client circumstances and goals change.

Policy	Emergency shelter operators will adhere to the following policies related to this standard: • *HIFIS Data Sharing Protocol for Hamilton's Homeless Serving System* and applicable data entry guidance. • *Hamilton's Coordinated Access System Process Guide*. • *Hamilton's Homeless Serving System Triage and Assessment Policy*. • *Coordinated Access Case Management Policy.*

3.2 Belongings	
Standard Statement	What people carry with them into the shelter may be their only possessions and should be treated with respect and kept securely. Emergency shelter operators retain the right to limit the type of belongings allowed on-premises based on safety, staffing, and space limitations. Secured storage will be made available for all clients staying in the emergency shelter. Emergency shelter operators will have a policy outlining the limits to storing personal belongings, including length of time belongings will be stored after a client leaves shelter. Policies regarding storage and limitations on specific items will be posted and explained to clients upon intake. At intake and throughout the shelter stay, emergency shelter operators will support clients in maintaining possession of their sacred items and traditional medicines. When a client is discharged and they have left behind their belongings, the items will be securely stored for a minimum of 48 hours. Clients requiring storage for their belongings beyond this length of time should reach out to the shelter to discuss an extension, however emergency shelter operators may not be able to accommodate such requests.
Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • Weapons • Prescribed drugs • Illicit drugs • Drug use equipment

3.3 Daytime Access	
Standard Statement	Emergency shelters provide temporary accommodation while supporting people experiencing homelessness work towards finding housing. Emergency shelters may have common spaces, programs, and services available for clients during the day, however, to address a diverse range of needs, shelter staff will connect clients with other programs and services as appropriate. Access to sleeping quarters and other shelter facilities may be limited at times due to a variety of factors such as staffing levels, resourcing, maintenance, cleaning, and ability to maintain safety in the shelter. At shelters where daytime access is limited, provisions will be in place for people who work overnight shifts or who are ill and need a place to rest (provided they are not in need of medical care). Some emergency shelter operators may require a doctor's note specifying the medical need and timeline for accommodating clients during the day. Clients will have access to hygiene facilities such as toilets, sinks, and showers at all times and in rare instances that access is not possible during daytime hours, emergency shelter operators will provide clients with information on drop-in programs and other services with hygiene facilities that clients can access during daytime hours. In addition, shelters will provide information on recreation and community-based activities that clients could access during the day, for example, use of libraries, recreation centres, seniors programming, connections to programming at non-profit organizations or religious centres of a client's choosing. During Cold Weather or Heat Alerts, it is necessary that all shelters attempt to relax service restrictions and extend daytime access hours wherever possible to minimize risk factors to people experiencing homelessness. When unable to admit a client during a Cold Weather or Heat Alert emergency shelter operators will provide clients with information on drop-in programs and warming and cooling centres.
Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • Accessing beds and common areas during daytime hours, including accommodation guidelines. This policy will be explained to clients at intake and made available to them in writing if requested.

3.4 Curfew and Overnight Passes	
Standard Statement	Emergency shelters may require clients to return to the shelter to access their bed by a certain time. Curfews are a tool for managing safety, reducing interruptions during the night for clients, and managing shelter occupancy. Emergency shelters are intended to support clients without any other options for safe accommodations, therefore emergency shelter operators may require clients to return to access their shelter bed on a nightly basis until they have found housing. Failure to return to shelter may result in a client being discharged from shelter. Each shelter will post their curfew policy, which includes information on extensions and overnight passes. Staff will explain the rules at check-in or at the next available opportunity. In shelters where a nighttime curfew exists, provisions will be in place to accommodate clients who expect to be late for reasons such as work, accessing medical services, family reunion, etc. Emergency shelter operators may grant extensions to curfews or overnight passes to accommodate clients at their discretion. Clients are required to notify shelter staff when they anticipate they will be unable to return by curfew. Due to limited shelter beds within the homeless-serving sector, emergency shelter operators may re-allocate a shelter bed if a client has not been approved for a curfew extension or overnight pass. Whenever possible, shelter staff will provide clients being discharged with information on alternate options when available.
Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • Curfews, which includes information on extensions and overnight passes.

3.5 Length of Stay	
Standard Statement	Emergency shelters are intended to provide temporary shelter, support for meeting basic needs, and housing-focused supports. People experiencing homelessness may face complex circumstances that impact their length of stay in emergency shelter. Emergency shelter operators will use a person-centered approach to determine the length of stay based on each client's unique strengths and support needs. These decisions are to be made using factors which include, but are not limited to: • The safety needs of the client and their dependents. • The level of support needed to exit homelessness successfully. • Availability of affordable, suitable, and adequate housing. • Client's level of engagement toward achieving housing goals. • Upcoming admission to transitional or permanent housing. • The length of time the person has been homeless. A comprehensive, housing-focused plan should be developed within 14 days of admission to shelter. These plans may evolve over time as client circumstances and goals change. Documentation of a stay should include all consecutive days that a client is booked into a shelter from book in to book out.
Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • How maximum lengths of stay will be determined. • *HIFIS Data Sharing Protocol for Hamilton's Homeless Serving System* and applicable data entry guidance.

3.6 Capacity Limits	
Standard Statement	The level of need for emergency shelter varies based on community realities and conditions outside the control of the homeless-serving sector. Unfortunately, shelters may not always be able to accommodate all requests for shelter. Emergency shelter capacity limits adhere to local building code and are designed to maintain safety for clients, staff, and guests. Shelters may exceed their capacity in cases of Cold Weather Alerts, Heat Warnings, or unforeseen emergencies, however, will not exceed capacity if doing so would compromise the safety of other clients, staff, etc. Shelters may need to reduce their capacity in response to health and safety circumstances (e.g. infectious outbreaks). Emergency shelter operators will notify the City when their capacity must be reduced or is at risk of being reduced. At times emergency shelter operators may reach capacity and be unable to provide shelter for all individuals seeking emergency shelter. In these instances, where possible, shelters will assist clients with referrals and transportation to other emergency shelters, drop-in programs, or support services.
Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • Plans for supporting clients when shelter is at capacity, including overflow spaces and referrals to other shelters. • *HIFIS Data Sharing Protocol for Hamilton's Homeless Serving System* and applicable data entry guidance.

3.7 Service Restrictions

Standard Statement	Service restrictions are primarily utilized in situations where other interventions and responses do not resolve behaviours or circumstances that pose significant risk to the safety and well-being of the client, other shelter stayers, staff, shelter property and/or the community. Service restrictions may also be issued due to ongoing behaviours which interfere with shelter operations, illegal activities, court order, significant damage to property, or prolonged refusal to engage with program requirements. Emergency shelter operators must balance the well-being of individual clients against risk of harm to other clients, staff, guests, volunteers, and neighbours, as well as their obligations under the *Occupational Health and Safety Act.* All emergency shelters will follow the City of Hamilton's service restriction policy and appeal process. The service restriction policy provides guidance for emergency shelter operators and staff on best practices and considerations when issuing restrictions, including: • The process for approving, reviewing, documenting, and appealing service restrictions. • Informing clients of the service restriction policy and appeals process at intake, or as soon as is feasible. • How and when clients will be informed of a service restriction, including information on re-accessing shelter services. • How data on service restrictions will be collected and analyzed with homeless-serving sector leadership. • Expectations during cold alerts and heat warnings to relax restrictions where possible. • Using a trauma-informed, anti-racist, anti-oppressive, gender and equity lens, recognizing the systemic barriers faced by women, trans, gender-diverse or non-binary people, and those experiencing intersecting oppressions including, but not limited to, race/ethnicity, substance use, mental health, disability, gender identity, and sexual orientation. This approach will include the following practices: o When an Indigenous person is restricted from emergency shelter, shelter staff will work in partnership with the client's identified Indigenous service provider. If they are not yet connected to one, the shelter will provide a referral at the client's request. o When a youth is restricted from emergency shelter, shelter staff will work with the client to find alternate shelter options through family or emergency shelters in other municipalities.

	o Whenever possible shelter staff will attempt to refer clients to supports (e.g. a referral to another shelter) before discharge or at the request of the client.
Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • *Hamilton's Homeless Serving System Service Restriction Policy.* • *HIFIS Data Sharing Protocol for Hamilton's Homeless Serving System* and applicable data entry guidance.

4



intent:

This section of the standards outlines best practices for delivering basic needs services offered by emergency shelter operators as part of their housing-focused shelter model. In addition, this section emphasizes the importance of Hamilton's coordinated approach and partnerships to meet a broader range of health and social needs.

SERVICES PROVIDED

4.1 **Housing-Focused Supports and Case Management**

4.2 **Basic Needs**

- 4.2.1 **Bedding**
- 4.2.2 **Hygiene**
- 4.2.3 **Laundry**
- 4.2.4 **Clothing**
- 4.2.5 **Nutrition**
- 4.2.6 **Pets**

4.3 **Health Supports and Partnerships**

4.1 Housing-Focused Supports and Case Management	
Standard Statement	Emergency shelter operators are part of a larger network of homeless-serving agencies operating in the context of a housing crisis with limited availability of affordable housing. Emergency shelter operators will maintain a housing-focused approach, following Housing First principles recognizing that stable housing is the primary need shared by all people experiencing homelessness with health and social supports offered in addition as needed to support housing access and retention. Housing-focused sheltering begins at intake, and all emergency shelter operators will offer housing-focused case management to their clients. Case management activities will include: • Reviewing housing expectations and planning how to pursue goals via progressive engagement with housing options. • Supporting clients to access identification, income, and applications for financial benefits and/or subsidized housing to enable their ability to obtain housing. • Sharing information on the Coordinated Access system and how participation facilitates connections to appropriate housing supports. • Assessing client needs using assessment tools and community prioritization criteria. • Addressing barriers to housing through service coordination and referrals to health and social supports. • Shelter staff will work with case managers from housing support programs to ensure that clients receive warm transfers when entering those programs. Clients do not need to demonstrate any preconditions to take part in case management or housing support programs.
Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • *HIFIS Data Sharing Protocol for Hamilton's Homeless Serving System* and applicable data entry guidance. • *Hamilton's Coordinated Access System Process Guide*. • *Hamilton's Homeless Serving System Triage and Assessment Policy*. • *Hamilton's Coordinated Access Case Management Policy.* • *Hamilton's Homeless Serving System Consent and Intake Policy*. • *Hamilton's Coordinated Access Prioritization Policy*.

4.2 Basic Needs	
Standard Statement	Emergency shelters are primarily focused on providing clients experiencing homelessness with temporary accommodation and assistance finding housing. People experiencing homelessness often have few resources to meet the basic necessities of life, such as: meals, hygiene products, laundry services, clothing, etc. **4.2.1 Bedding** Each client will be offered, at minimum, a bed with a mattress, pillow, and necessary bedding. Necessary bedding consists of a minimum of two sheets, a blanket, and pillowcase. A minimum of one shower towel will be provided to each new client upon admission along with bedding/towels. Bedding and towels will be changed weekly, or whenever these articles become soiled. **4.2.2 Hygiene** Emergency shelters will, at a minimum, have a supply of soap, shampoo, shaving products, and menstrual hygiene products for emergency use by clients. Menstrual hygiene products will be made available at all shelters. **4.2.3 Laundry** Shelters with laundry facilities may require that clients launder their own bedding, towels, and clothing. Emergency shelter operators may limit access to laundry facilities if required to maintain peace overnight or if operating laundry machines requires staff supervision. **4.2.4 Clothing** Emergency shelters will help clients obtain basic clothing and footwear for all seasons by using internal resources and/or connecting clients with other community agencies and resources. **4.2.5 Nutrition** Emergency shelters which serve meals to clients will follow the nutritional requirements outlined below. Some emergency shelters provide clients with meal cards or financial support to obtain their own meals and are not required to follow the nutritional standards outlined here. Adult clients will be served three meals and at least one healthy snack per day or provided with resources to access food where units have their own kitchens. Where parents are not providing food for the family unit, children under

	the age of 16 will be offered three meals and two to three healthy snacks per day. Each meal will be of a size, quality, variety, and nutritional value to meet the recommended daily intake based on Canada's Food Guide. A poster stating that shelters cannot guarantee allergen-free food (e.g., peanuts, nuts, eggs, and shellfish) should be posted in the dining area. **4.2.6 Pets** Animal companions may add great value to an individual's emotional well-being and feelings of safety, however most services for people experiencing homelessness are not designed to accommodate pets. Reluctance to give up a pet may cause people to stay in unsafe situations, including sleeping unsheltered. The City of Hamilton and emergency shelter operators will continue to explore ways to design programs which can accommodate pets, however there are significant barriers to adapting existing shelters to safely provide shelter to pets. Emergency shelter operators will support clients with pets through the following practices: • Providing information to pet owners on the community services that accept pets and offer pet-related supports (e.g., pet food, veterinary services, emergency boarding). • Offering support in finding alternative accommodations for their pets and should record what alternative arrangements have been made for the client's pet so that clients can be supported in getting their pet back from emergency accommodations.
Policy	Not applicable

4.3 Health Supports and Partnerships	
Standard Statement	Although the primary focus of emergency shelters is housing, housing-focused sheltering takes a wholistic view of the client as a person with complex and diverse needs. Collaboration within the network of health supports is important to ensure effective and coordinated services. To help clients meet their health needs, emergency shelter operators will: • Offer support with navigating access to physical and mental health services, including providing referrals to health care providers in order to facilitate clients' health needs. • Host health care professionals onsite and continue to connect clients to primary care within the community. • Consider the client's stated health care requirements and any recommendations by a clinician or health care professional when determining whether the client is eligible for service. Clients may have a support person to assist, whether a family member or home and community care. • Work in collaboration with community health care providers to support optimal function and well-being of shelter residents. Emergency shelter operators will assess their ability and resources to meet the needs of residents with complex physical and/or mental health needs. • Ensure that all clients are aware of these potential health supports by informing people at intake and posting information throughout the shelter. Partnerships with health and cultural supports will be informed by the needs of people with living experience.
Policy	Not applicable



5

ADDRESSING INDIGENOUS HOMELESSNESS

5.1 Indigenous Persons



5

ADDRESSING INDIGENOUS HOMELESSNESS

intent:

This section acknowledges the City of Hamilton's distinct commitment to Indigenous Peoples in recognition of their inherent Rights as well as the historic and ongoing social, economic, and political programs in Canada that have led to the disproportionality of Indigenous Peoples experiencing homelessness in Hamilton.

While acknowledging the successes of local Indigenous leadership in addressing and preventing Indigenous homelessness in Hamilton, the homeless-serving sector remains cognizant of historic underinvestment in Indigenous communities as well as systemic discrimination, which requires intentional and sustainable investments specific to redressing the causes and experiences of Indigenous homelessness.

In addition to the recommendations identified in this section and throughout the Standards, the City of Hamilton and emergency shelter operators shall:

- Work in partnership with the Indigenous Community Entity and local Indigenous agencies to address and prevent Indigenous homelessness in ways that advance and grow the autonomy and capacity of urban Indigenous leadership.
- Recognize Indigenous homelessness as distinct throughout development, implementation and review of emergency shelter policies, priorities, and practices.
- Foster more inclusive environments through signage and programs that reflect the causes, experiences, and needs of Indigenous Peoples experiencing homelessness.
- Continually work to ensure Indigenous leadership and experiences are appropriately supported to continue co-developing the City of Hamilton's homelessness response.

5.1 Indigenous Persons	
Standard Statement	Colonialism continues to negatively impact Indigenous individuals, communities, and families in many ways. One consequence of colonialism is that Indigenous peoples experience homelessness, as well as other forms of social exclusion, at a higher rate than the general population. The City of Hamilton and emergency shelter operators work closely with Indigenous leaders and community agencies to respond to the needs of Indigenous clients with culturally appropriate and Indigenous specific supports through the following practices: • Emergency shelter operators will incorporate Indigenous cultural competency training into staff training resources. Having this understanding and perspective can lead to building stronger rapport with clients and a greater understanding of their unique needs when offering services. • Creating welcoming spaces for Indigenous clients through highly visible cultural signage and art posted throughout the shelter to help communicate to Indigenous persons that they are able to share information about their Indigenous ancestry throughout their shelter stay, not just intake, and shelter staff will support with referrals to Indigenous services if requested. • Ongoing Indigenous cultural training will be required for all shelter staff, volunteers, students, leadership, and board of directors. • With the benefit of Indigenous training, staff may be better capable of appropriately inquiring during intake whether a person identifies as having Indigenous ancestry and will inform clients of opportunity to be referred to an Indigenous organization of their choice. • At intake and throughout the shelter stay, emergency shelter operators will support clients in maintaining possession of, and using, their sacred items and traditional medicines. • Shelter staff will inform Indigenous clients that they are not required to use mainstream triage and assessment tools in order to receive. homeless/housing services or be prioritized for housing supports through the Coordinated Access system. An alternative process to the “Common Assessment Tool” developed by the Indigenous Community Entity will be offered as an option to Indigenous clients. Indigenous clients’ names are not required to appear on the By-Name List (BNL) or By-Name-Prioritization-List (BNPL) to be prioritized for service. • Indigenous clients will be made aware of resources and services offered specifically to Indigenous individuals at intake and throughout a person’s stay, both verbally and through signage posted in common areas of the shelter.

	• Recognizing that there is a high number of Missing and Murdered Indigenous Women, girls, 2-Spirit, men, and boys; shelters will have a protocol with Hamilton Police Services (developed in partnership with CHIL, HRIC, and the HPS Indigenous Liaison), which will include relevant procedures to respond to missing Indigenous persons, including their dependents. This protocol will be led by the Indigenous Community Entity, being considerate of the history of policing and the Indigenous community. Ongoing, regular training as recommend by the Indigenous Community Entity will be provided to all shelter staff. The City and emergency shelters commit to continue working with the Indigenous Community Entity to explore how to best deliver culturally safe supports and the resources that are required to make that happen. The City and emergency shelters commit to partnering with the Indigenous Community Entity respond to Indigenous homelessness in ways that respect the Rights of Indigenous Peoples, reflect their unique experiences and needs, and continuing to work in ways that respond to the spirit and intent of Canada's Truth and Reconciliation Commission's Calls to Action.
Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • Supports that will be provided to Indigenous persons and dependents accessing shelter services.

6. Supporting Diverse Communities

6.1. Children
6.2. Youth
6.3. Health and Accessibility
6.4. Substance Use, Harm Reduction and Safer Use
6.5. 2SLGBTQIA+
6.6. Race, Ethnicity, and Immigration Status
6.7. Gender
6.8. Religion
6.9. Owners of Service Animals

Intent: This section emphasizes the importance of understanding the unique needs of our diverse community when developing and delivering emergency shelter policies, programs, and services. Hamilton's homeless serving sector recognizes that people experiencing homelessness are impacted by intersecting aspects of their identities, especially race, gender, age, religion, orientation, substance use, and disability. While acknowledging the strength and resiliency of unique populations, the homeless-serving sector is aware of the differing structural and institutional barriers that are linked to systemic racism, discrimination, and oppression. Understanding and being prepared to meet the unique needs of people experiencing homelessness is essential for helping them find and maintain housing.
In addition to the recommendations outlined in this section and throughout the Standards, the City of Hamilton and emergency shelter operators will:

- Strive to apply an equity lens to all activities to identify and remove barriers and to support best practices in planning, budgeting, delivery and evaluation of programs and services.
- Work in partnership with the Indigenous Community Entity, local Indigenous agency representatives, and other systems to determine emerging best practices for combating discrimination and developing approaches that support the diverse needs of people experiencing homelessness.
- Foster more inclusive environments through signage and programs that welcome the unique populations accessing shelters.
- Recognize that power and privilege are inherent to relationships between shelter staff, management, and clients and use the Standards to ensure clients receive respectful and equitable service.
- Adopt a zero-tolerance approach to racism, sexism, ableism, homophobia, transphobia and discrimination for staff and clients.

6.1 Children	
Standard Statement	Children have their own set of requirements and standards set out by various levels of government to ensure that children are well cared for and that services are designed for their unique needs. Children who experience homelessness are at greater risk of a number of long-term consequences, including chronic homelessness, violence, exploitation, mental health, substance use, dropping out of school and criminality.[3] Where families are being served parents are responsible for meeting the wellbeing, supervision, and basic needs of the children. Parents may reach out to staff for support, guidance, and referrals. Emergency shelter operators will support children through the following activities and practices: • Staff are trained in their obligations under the *Child and Family Services Act* to report any suspected cases of child abuse or neglect. • Staff will actively work with parents/guardians to promote positive parenting techniques and share information on a variety of age appropriate play experiences for children and dependent youth within the shelter or off-site. • Staff will provide information on, and referrals to, available community resources. • Any program plans and/or outlines of planned activities are shared with parents/guardians and conducted with written parental/guardian consent when safe, or appropriate. • Staff will work with parents/guardians and/or school boards to encourage children's regular attendance at school when safe, or appropriate. • Shelter staff are not obligated to provide child minding. In the case where child minding is provided, there will be a policy in place for situations where a parent does not return, which will be explained to parents at intake. • Sleeping arrangements and children's equipment is monitored for age appropriateness and is well-maintained. Cribs, appropriate bedding, car seats, strollers, highchairs, toys, and playpens should reference specifications approved by the Canadian Standards Association (CSA).

[3] Homeless Hub. *About Homelessness: Topics: Child, Youth, and Family Programs*. Canadian Observatory on Homelessness. Retrieved on April 20, 2023 from https://www.homelesshub.ca/about-homelessness/service-provision/child-youth-and-family-programs

Policy	Emergency shelters operators that offer child minding will develop or adhere to the following policies related to this standard: • How child-minding support will be offered, including instances where parents do not return at the agreed upon time.

6.2 Youth	
Standard Statement	Youth presenting to shelter independently have their own unique needs and are at greater risk of a number of long-term consequences, including chronic homelessness, violence, exploitation, mental health, substance use, dropping out of school and criminality.[4] In particular, youth aged 16 to 17 may experience homelessness differently than youth over 18 due to factors such as involvement with child welfare systems, requirements related to attending school, and differences with financial assistance programs. As a result, the homeless serving sector in Hamilton has developed programs to support youth outside of the adult sector when possible. Youth emergency shelter operators will support youth through the following activities and practices: • Youth shelters will work to divert youth from shelter whenever possible. When safe, shelter staff will work with youth to support reconciliation and return to living with their family or guardians. • Youth shelters will not take children under the age of 16. Shelter staff will consult, report, refer and collaborate with Child Welfare agencies if children under the age of 16 come to shelter independently and it has been deemed that they need support and or are at risk of or homelessness. • Staff will be trained on their obligations under the *Child and Family Services Act* and the Duty to Report regulations. • Staff will provide or refer youth to age appropriate recreation activities. • Staff will provide information on, and referrals to, available community resources. • Staff will work with parents/guardians and/or school boards to encourage youth's regular attendance at school when safe, and appropriate.

4 Homeless Hub. *Child, Youth And Family Programs*. Canadian Observatory on Homelessness. Retrieved on April 20, 2023 from https://www.homelesshub.ca/about-homelessness/service-provision/child-youth-and-family-programs

Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • *Hamilton's Homeless Serving System Consent and Intake Policy*.

6.3 Health and Accessibility	
Standard Statement	Those experiencing homelessness often live in conditions that adversely affect their overall mental and physical health. Disability and mental illness are connected to an increased risk of homelessness. Being unhoused makes it difficult to access general health care and mental health services, or follow-up care after receiving treatment or hospitalization, and care is often only accessed through hospital emergency departments. Mortality and morbidity are higher amongst people experiencing homelessness than housed people, as are substance use and mental health issues. Emergency shelter operators and the City of Hamilton work towards creating barrier free environments for people with all types of disability, however many shelters are limited by physical facilities which do not have the capacity for all accessibility features (e.g., elevators). Emergency shelter operators will support client health and disability needs through the following activities and practices: • Prior to intake, shelter staff will assess the health needs of clients and determine if the shelter has the capacity to accommodate the clients' ailments or illnesses, if present. • The shelter operator will ensure staff are able to assist clients in obtaining access to a physician or health care centre and appropriate referrals to essential health care services, when required, including mental health and addictions support services; and obtaining home-care services, or emergency nursing care. • Shelter operators will be conscious of discrimination and racism that clients may have experienced in accessing healthcare services and will work with clients to ensure that they are able to get access to services in a safe and culturally appropriate way. • The shelter will allow such home care services or nursing care to be provided as the shelter can reasonably accommodate (refer to the *Health Insurance Act, R.S.O.* 1990, c.H.6, as amended, and its regulations, for a definition of home care services).

	• Where possible, programs and clinics should be offered on-site; and when not possible, clear referral pathways and connections with the healthcare system should be established. • Shelter staff will respect a client's right to choose to access health services, however if refusing health services results in harm or significant risk of harm to other clients or staff, shelters may be unable to support a client with accessing emergency shelter. In these instances, emergency shelter operators will work with the client to find alternative accommodations whenever possible. • A person with a disability will be supported to receive shelter services unless there are accommodation restrictions such as the need for a level of personal attendant care that cannot be accommodated by shelter staff, etc. Where access to a shelter is limited due to a disability, shelter staff will attempt to find alternative housing, shelter arrangements, or will work with health care providers when admission to hospital is required. • Emergency shelter operators will provide access to safer sex supplies on-site or referrals to community services if unable to provide safer sex supplies. • Emergency shelter operators will provide a minimum of one washroom that is barrier-free, fully accessible and marked as gender neutral. Considerations for service accessibility include: • Providing people who have serious health conditions with the option to remain in the shelter during day. • Materials are made available in large print, in accordance with AODA regulations. • Striving to remove communication barriers through technology and interpreters when possible. • Training for staff on disability accommodations. Shelters will have policies regarding the handling of client medication. Policies should include the following: • For the protection of all clients, medication held by staff will be kept in a secure location such as a locked cabinet in an office. • Clients are fully responsible for taking their own medication; however, some shelters may provide assistance with medication storage and monitoring. • Shelters that choose to provide some assistance with medication will encourage clients to properly self-administer.

	• Where possible and with client consent, staff may consult with a nurse, psychiatrist, physician, or pharmacist to coordinate access to medication or in any situation where they are concerned about the safety of a client taking medication. • Shelters that document medication will maintain a consistent method of documentation. • All sharps will be placed in a regulation sharps container which should be kept in a secure location and out of reach of children. • All expired or unclaimed medications will be returned to a pharmacy for proper disposal.
Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • Handling of client medication.

6.4 Substance Use, Harm Reduction and Safer Use	
Standard Statement	The homeless-serving sector actively works with clients, community partners, and the health care sector to operate emergency shelter services in ways that minimize the harmful effects of substance use rather than ignoring or condemning these activities. A harm reduction philosophy is essential for effectively supporting individuals engaging in substance use; however, to meet the needs of diverse clients in complex journeys with substance use Hamilton's homeless-serving sector offers a broad range of services across the harm reduction continuum, which includes withdrawal management, treatment options, provision of harm reduction supplies, referrals to safe consumption service, and addiction services. Emergency shelter operators reduce the risks associated with substance use through the following best practices and recommendations: • Emergency shelter operators will have a harm reduction policy and harm reduction procedures in place that will make explicit that the shelter operates using a harm reduction approach. The policy and procedures will include, but not be limited to,

	responding to overdose; wellness checks; how harm reduction supplies are distributed, collected, and disposed of. • Harm reduction services and resources should be delivered in combination with other services to reduce stigma and increase accessibility of harm reduction programs. • Emergency shelter operators will have a policy and procedure in place that outlines under which circumstances it is and is not appropriate to contact Child Welfare Services when clients have dependent children. The policy will indicate that substance use alone is not sufficient cause for contacting Child Welfare Services. • During client admission/intake, and periodically throughout a shelter stay, shelter staff will explain what harm reduction services are available at the location and will make explicit that: o The site is a harm reduction positive location o Harm reduction supplies are readily available, onsite or through mobile community services o Naloxone is readily available o Staff are available to help with safety planning and arranging post-drug use safety checks within the scope of their roles. • Ensuring naloxone kits are available at all sites for staff to administer and for client use. All staff will be trained in overdose prevention, recognition, and response, including the administration of naloxone. All clients will be offered an active referral for naloxone kit and training on-site or to a community-based organization. • Posting signage in communal, semi-private and private washrooms and washroom stalls and other visible areas (e.g. hallways, entrances, stairwells, etc.) noting the overdose prevention initiatives available onsite, availability of naloxone and other available harm reduction supplies, and encouraging substance users to let someone know they are using. • Providing safer drug use equipment, and related information on appropriate use (if qualified to do so) or a referral to a community service if the shelter does not provide the requested equipment. • Shelters will monitor the number of suspected overdoses to inform the development of harm reduction strategies and programs. Emergency shelter operators will work with the City and Public Health to share records when appropriate and in accordance with MFIPPA legislation. • Referring clients, when appropriate, to programs that offers addiction supports, detox, harm reduction supplies, training, and related support services.

	• Ensuring that shelter staff have training and access to updated resources on programs and services that support harm reduction for clients and provide referrals as needed (e.g. opioid agonist treatment, supervised consumption sites). • Installing sharps containers are secured against tampering and available throughout a site. Shelter staff will inform clients of the presence of fixed sharps containers and availability of personal sharps containers and how to use them. • Maintaining a regular schedule of monitoring sharps containers and ensuring a contract is in place with a biohazardous waste disposal company to replace them when they are full. • Supporting clients to maintain possession of safer drug use supplies and/or safer sex products. • Emergency shelter operators will comply with their legal obligations, while maintaining the clients' right to privacy and property. • Supporting clients who wish to engage in harm reduction programs by offering public transit fare to attend such programs or related appointments. • Not discharging or impose service restrictions on the basis of substance use alone. • Supporting client-led or community-based harm reduction initiatives (e.g. peer-led programs, safety plans, etc.).
Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • Harm Reduction Policy. • *Hamilton's Homeless Serving System Service Restriction Policy.*

6.5 2SLGBTQIA+	
Standard Statement	Despite significant advances towards 2SLGBTQIA+ equality, homophobia and transphobia are still deeply ingrained in our everyday behaviours, language, and in the policies of many institutions. Due to underreporting of incidents, discrimination against queer and trans individuals remains largely invisible to shelter workers and management, policy makers, and City management, at a time when 2SLGBTQIA+ youth homelessness, in particular, is on the rise.[5]

[5] Homeless Hub. *Solutions: Priority Populations: Lesbian, Gay, Bisexual, Transgender, Transexual, Queer, Questioning and 2-Spiritd (LGBTQ2S)*. Canadian Observatory on Homelessness. Retrieved on

	The risks encountered on the streets and in the shelter system by 2SLGBTQIA+ homeless individuals versus heterosexual and cisgender homeless individuals differ largely due to frequent incidents of homophobic and transphobic violence. Not only are the risks and barriers encountered different, but the needs of 2SLGBTQIA+ individuals differ from those of their heterosexual and cisgender counterparts. Emergency shelter operators will support 2SLGBTQIA+ clients through the following practices: • Staff will provide an atmosphere of dignity and respect for all clients and provide services in a non-judgmental manner. • Establishing clear policies that reflect inclusiveness of 2SLGBTQIA+ individuals to ensure safer spaces for non-binary and gender diverse people in emergency shelters. • Respecting and accepting the self-defined sexual orientation, gender identity, and gender expression of an individual, including their pronouns. • Ensuring that transgender individuals are able to access services in the shelter sector that reflects their gender identity. • A confidentiality strategy that works with clients to ensure that staff do not "out" their gender or orientation. Staff will be aware of what information about a client's gender/orientation/transition experience is not to be disclosed. • Providing clients with options for private access to hygiene facilities to reduce the risk of violence and harassment which 2SLGBTQIA+ persons are at higher risk of experiencing. • Treating hormones that belong to trans clients as any other medication. Clients will be given privacy to self-administer hormones. • Emergency shelter operators are encouraged to seek partnerships with 2SLGBTQIA+-positive health/services providers. Emergency shelter operators will make information on 2SLGBTQIA+-positive health/ services providers available to all clients and facilitate referrals as needed.[6] • Providing and education on 2SLGBTQIA+ issues for staff, volunteers, management, and other residents. • Hiring employees to reflect gender and orientation diversity.

April 20, 2023 from https://www.homelesshub.ca/solutions/priority-populations/lesbian-gay-bisexual-transgender-transsexual-queer-questioning-and-2

[6] Shelter, Support & Housing Administration. (2023). *Toronto Shelter Standards, Version 5*, City of Toronto.

Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • 2SLGBTQIA+ inclusiveness policy.

6.6 Race, Ethnicity, and Immigration Status	
Standard Statement	Black, racialized, newcomer, immigrant, and refugee individuals and families experiencing homelessness often face additional barriers, experiences of discrimination, and challenges when attempting to access services, including emergency shelter. Although the City of Hamilton and emergency shelter operators strive to provide equitable service to everyone experiencing homelessness, systemic racism influences all institutions and levels of government. From microaggressions to overt forms of racism to stereotyping, racism impacts all areas of racialized people's lives culminating in a higher risk of homelessness. Emergency shelters will support racialized and newcomer clients through the following practices: • Where possible and requested, translators will be used to assist with communication. • Emergency shelter operators will not request or collect immigration status information in order to determine service eligibility as part of a shelter's intake or admission process, unless approved by the City of Hamilton. • Providing information on legal and community resources for newcomer clients as needed. • Responding to and addressing complaints of racism or discrimination reported by clients, staff, volunteers, and management. • Communicating to all clients that racism, discrimination, and hate speech are against the law and shelter policy. • Providing ongoing training and education for all staff, volunteers, management, and other residents on anti-racist, including anti-Black racism, and anti-oppression practices and considerations. • Hiring employees to reflect racial diversity. Emergency shelter operators and the City of Hamilton should develop policies and practices that take into consideration the following recommendations for combating racism in the shelter system:

	• Anti-oppression and anti-racism training for all staff, leadership, and board of directors. • Work with Black and racialized community leaders and clients to gather input through engagement activities. • Apply an equity, diversity, and inclusion analysis to current Human Resources policies and practices (hiring, retention, promotion, performance evaluation, and workplace culture initiatives) to support the implementation of processes to address unconscious bias and systemic anti-Black racism, as well as intentional hiring and advancement opportunities for racialized clients and staff. • Support clients with accessing health and mental health supports and services that are culturally responsive when requested and available. • Facilitate and build partnerships with community organizations, racialized and Black community leaders, advocating for the rights of racialized community members and learn from best practices.
Policy	Not applicable

6.7 Gender	
Standard Statement	Gender-based discrimination and violence continues to impact cis and trans women as well as gender diverse individuals, especially during experiences of homelessness. The unique needs of those marginalized due to gender include increased risk of violence, caregiver responsibilities, and pregnancy. Emergency shelter operators support women and gender diverse clients through the following practices: • Accepting gender identity as defined by the individual rather than by the perception of shelter staff and/or other clients. Sometimes this may not correspond with a person's physical appearance. Emergency shelter operators will ask all clients for their gender and pronouns at intake rather than assume and will include a line on intake forms indicating that the shelters welcome trans and gender diverse clients. • Supporting the choices of transgender clients to access designated sleeping areas that will best preserve their safety and dignity. In instances where a transgender client expresses concerns about their safety or dignity, emergency shelter

	operators will accommodate requests for a bed in a gender neutral/private room, if possible. • Providing information on and referrals to reproductive health services. • If a client discloses that they are fleeing gender-based violence or intimate partner violence shelters will provide information on Violence Against Women services and shelters, as well as engage in safety planning if requested. • If possible and available, emergency shelter operators will create safer zones such as semi-private rooms. • Addressing harassment of transgender and gender diverse clients by focusing on the inappropriate behaviour and enforcing rights and responsibilities. • Enforcing policies around confidentiality that do not require transgender individuals to disclose their status. If they do disclose, emergency shelter operators will maintain confidentiality and ask the individual how they would like the topic to be addressed if it is raised. • Having a notification process for when men will be entering private shelter spaces of women, trans, and gender diverse persons. • All shelters will provide menstrual products for clients who menstruate. • A minimum of one washroom that is barrier-free, fully accessible and marked as gender neutral will be provided. Emergency shelter operators will provide options for private bathroom access whenever possible. • Emergency shelter operators will provide staff training on safety planning and resources to connect with a VAW shelter for support for gender based or domestic violence considerations.
Policy	Not applicable

6.8 Religion	
Standard Statement	Emergency shelters serve clients from a wide array of backgrounds, experiences, and religious affiliations. It is important to acknowledge that people experiencing homelessness may have experienced persecution based on their religious affiliations or may have had traumatic experiences stemming from exposure to or involvement with a particular religion or religious organization. To provide a respectful environment for people practicing many different religions emergency shelter operators will ensure that their spaces, staff, and

	clients are welcoming and provide a respectful environment for people affiliated with all religions. Emergency shelter operators support religious diversity through the following practices: • Ensuring that respect for religious differences is maintained through anti-discrimination policies, made clear in written shelter policies and practices, but also posted in visible locations. • Allocating space for religious practice, such as a quiet space or prayer room with a closed door, is important to allow clients to maintain religious observation. • If requested, provide information on local religious communities or congregations that clients can access for support and community building is important for building up local support systems and community connections. • Allowing for flexibility at mealtimes for emergency shelters that provide food to accommodate religious fasting (e.g. during Ramadan). • Not requiring clients to participate in or attend any religious services or activities offered by the shelter.
Policy	Not applicable

6.9 Owners of Service Animals	
Standard Statement	According to the Accessibility for *Ontarians with Disabilities Act* (AODA), clients are permitted to bring service animals into areas that are open to the public unless the animal is excluded by another law. In cases where another law prohibits service animals from entering the premises, emergency shelter operators will provide another way for clients to access services or facilities. Emergency shelter operators will accommodate service animals, however, may refer clients to alternative services if a service animal's behaviour is compromising the safety of staff or clients. Clients must provide documentation from a regulated health professional for their service animal or an identification card from the Ontario Ministry of the Attorney General for people who are blind and use guide dogs. Clients are responsible for managing the behaviour of their service animal, arranging veterinary care, and meeting the basic needs of their service animal.

	If a client requires a service animal, emergency shelter operators should support clients in connecting with appropriate health supports when a service animal designation is needed and advocate for accommodation in housing options for clients with service animals.
Policy	Not applicable

7



intent:

This section details requirements related to the daily operations of emergency shelters, including staff training, facility ratios, and neighbourhood relations.

SHELTER OPERATIONS

7.1 **Training Requirements**

7.2 **Neighbourhood Relationships**

7.3 **Facility Ratios**

7.1 Training Requirements	
Standard Statement	Emergency shelter operators will have a written policy that outlines the orientation procedure and mandatory training for all its new employees, peer workers, volunteers, and Board of Directors members. The training requirements outlined below may change to meet new and emerging needs in the homeless-serving sector. Emergency shelter operators will work with the City to identify and implement new training as required. The minimum mandatory training for shelter staff includes: • Ongoing Indigenous cultural competency and accountability • Shelter Diversion practices • Housing-Focused Case Management Supports • Discharge planning • Serious Incident Guidelines and Reporting • Service Restriction Guidelines and Reporting • Single Facilities Incident Plan (Emergency Contingency Plan) • VI - SPDAT (City to provide training) • HIFIS and/or applicable HMIS and data entry guidance (City to provide training) • Anti-racism, anti-oppression (AROP) • Infection Prevention and Control (IPAC) measures • Standard First Aid/CPR (at least one person per shift is certified in Standard First Aid/ CPR) and health and safety training (in accordance with the Workplace Safety and Insurance Act) • Workplace Hazardous Materials Information System (WHMIS) (for those exposed to hazardous materials in accordance with Regulation 101 under the Workplace Safety and Insurance Act) • Safe Food Handling Certificate (for any staff serving food for over 10 people in accordance with Ontario Food Premised Regulations 562/90) Shelters will also ensure that their volunteers, employees, Board of Directors, or agents, who deal with members of the public, receive training in the following areas: • Suicide intervention; crisis intervention; de-escalation

	• Provision of services to persons with disabilities, in compliance with the *Accessibility for Ontarians with Disabilities Act*, (2005) • Harm reduction education including overdose risk assessment, referral to receive naloxone kits and training for staff and clients • Regular ongoing equity training • Training and education for staff and clients on experiences and issues related to the 2SLGBTQIA+ community • Training for safety planning, or connect with a VAW shelter for support for gender-based or domestic violence • Training on the Hamilton Emergency Shelter Standards
Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • Orientation procedures and mandatory shelter staff training.

7.2 Neighbourhood Relationships	
Standard Statement	The City of Hamilton and emergency shelter operators recognize that emergency shelters operate within and for the Hamilton community, which requires respectful and responsive relationships with properties, businesses, and residents that neighbour shelter facilities. Emergency shelter operators will develop a good neighbour commitment that outlines: • How emergency shelter operators will mitigate and minimize the impacts of shelter activities on neighbouring properties, businesses, and residents. • How to contact the shelter to report incidents or concerns and when to contact police/bylaw for issues outside of shelter scope. • Provide community members with information on the complaints policy.
Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • Complaints policy.

7.3 Facility Ratios	
Standard Statement	Clients accessing emergency shelters are entitled to adequate and appropriate sleeping facilities, washrooms, and bathing facilities. Emergency shelter operators are accountable to the City of Hamilton – Property Standards, zoning requirements, and provincial fire code. Emergency shelter operators will ensure clients have reasonable accommodations to meet their basic needs by: • Ensuring that ratios for amenities follow the Ontario Building Code, emergency safety planning guidelines, and Zoning by-laws as applicable. • Providing a minimum amount of space per person in the sleeping area, in accordance with Ontario Building Code, to decrease the potential spread of illness, to enhance personal security and to decrease altercations resulting from a lack of personal space. • Beds, cribs, and bassinets will be arranged in a manner that: o Facilitates clear walking paths and sightlines for emergency evacuations. o Does not block air vents, windows, doors, plumbing, or access panels. o Does not expose a client to existing or potential danger. To assist clients in meeting their hygiene and sanitary needs, each shelter will provide a minimum of: • One toilet for every 15 clients up to the first 100 clients and one toilet for every 30 clients thereafter (urinals may replace up to half the number of required toilets). • One washbasin for every 15 clients (with liquid soap and paper towels). • One shower for every 20 clients.
Policy	Not applicable

8



intent:

This section details key areas of health and safety concerns which impact the operations of emergency shelters. Information in this section clarifies how emergency shelter operators prepare and respond to serious health and safety concerns in the shelter environment.

HEALTH AND SAFETY

8.1 **Infectious Disease Prevention and Management**

8.2 **Cold Alerts and Heat Warnings**

8.3 **Safety Planning**

8.4 **Serious Incidents**

8.1 Infectious Disease Prevention and Management	
Standard Statement	Emergency shelter operators will follow all directions and standards for infectious disease prevention and management set out by Health Canada and Infection Prevention and Control Canada. In the event of an outbreak or public health risk, emergency shelter operators will follow directions from Hamilton Public Health and the Ministry of Health.
Policy	Not applicable

8.2 Cold Alerts and Heat Warnings	
Standard Statement	When the City's Medical Officer of Health issues a Cold Alert or Heat Warning recreation centres, social service agencies, and the homeless-serving sector respond as they are able to the needs of homeless and vulnerable residents by expanding service hours, easing service limitations/caps, and ensuring locations offer a welcoming space for individuals and families to stay out of the cold. More information on cold alerts and heat warnings can be found online (Cold Alerts: http://hamilton.ca/cold, Heat Warning: http://hamilton.ca/heat).
Policy	Not applicable

8.3. Safety Planning	
Standard Statement	Emergency shelter operators undertake safety planning with clients for a number of reasons. Safety planning is a component of trauma-informed care and may be done at the request of the client when entering shelter and reviewed regularly throughout a shelter stay as needed. Emergency shelter operators and clients will build safety plans together which leverage available resources and reflect shelter limitations related to staffing and physical facilities. In some cases, emergency shelter operators may be able to offer interim safety measures until a more secure arrangement can be made. Safety planning is done in response to a risk assessment and for a variety of reasons including: • Protecting client safety in cases of conflict between residents or from an outside aggressor. • Protecting client safety in known incidents or suspected risk of human trafficking. • Protecting client safety related to harm reduction planning in cases where substance use may be a consideration for clients. • Protecting client safety in cases where suicide risk or self-harm may be a consideration. • Providing trauma-informed care for clients who have experienced abuse, trauma, and/or gender-based violence. • As a means of supporting clients engaging in sex work. • Connecting clients with health or mental health considerations to resources in the community. • Doing community safety planning when a risk may be posed to the surrounding community. • Having a documented approach for how emergency shelter operators and staff will support a client and modify approaches as may be needed to aid in de-escalation. • Maintaining safety at the shelter in accordance with the *Occupational Health and Safety Act.* Safety plans should be time limited and reviewed regularly.
Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • Safety planning.

8.4 Serious Incidents	
Standard Statement	Emergency shelter operators will have a system in place for recording unusual incidents. The recording of the incident should include identifying any residents and staff who were involved in or witnessed the incident in the event of a criminal investigation. An incident report will be completed within 24 hours of all serious incidents involving fire, death, severe assault/accidental injuries and/or attempted suicides requiring medical assistance, and occurrences involving a firearm. One copy of the Serious Incident Report will be forwarded within 24 hours to the City of Hamilton. Shelter providers will make grief and loss support available to staff and clients following a client death or serious incident. Support may include de-briefing, healing circles, one-on-one counselling, and peer-to-peer supports.
Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • Serious incident policy.

9



intent:

Emergency shelter services are shaped by and responsible to numerous external stakeholders. This section clarifies how emergency shelters are held accountable and governed through a combination of internal organizational structures, relevant legislation, and funding agreement requirements.

ACCOUNTABILITY AND GOVERNANCE

9.1 **Program Accountability**

9.2 **Board Requirements**

9.3 **Finance**

9.4 **Relevant Legislation**

9.1 Program Accountability	
Standard Statement	The City of Hamilton and emergency shelter operators work in collaboration to ensure that shelter services are delivered in accordance with the Hamilton Emergency Shelter Standards. Emergency shelter operators and the City of Hamilton are held accountable through the following mechanisms: **Governance and Partnerships:** • The City of Hamilton convenes regularly with emergency shelter operators and Indigenous Community Entity to review emerging issues in the homeless-serving sector, including but not limited to: o Reviewing the size and composition of the emergency shelter sector to determine if adjustments are needed to the number of beds and supports available. o Reporting and reviewing service restriction data on a quarterly basis. o Reviewing best practices and developing partnerships to meet client needs. o Strengthening and growing their relationship with Indigenous Community Entity to support Indigenous clients by exploring how to best deliver culturally safe supports and identifying the resources that would be required to make that happen. o Sharing feedback from PWLE engagement activities regarding system gaps, suggestions, and feedback. **Contract Requirements:** • Funding contracts will be maintained and monitored by the City of Hamilton. Program reviews will be conducted as required by funding contracts or at the request of the City of Hamilton. • Emergency shelter operators will submit information as outlined in funding contracts. **Communicating Policies and Expectations:** • Emergency shelter operators will explain at intake (or as soon as possible) and post the following policies and expectations in a visible area of the shelter: Client rights and responsibilities, curfew policy, policies related to storing personal belongings, service restriction policy, and complaints

	policy. If requested, shelter staff will provide clients with a written copy of any shelter policy. **Information Management:** • Emergency shelter operators will fully participate in Hamilton's Homelessness Management Information System (HMIS), as outlined in Section 10: Information Systems of the standards. • Information management will be assessed in accordance with the applicable policy and guidance as available via HMIS for auditing including but limited to data field completion, user access and activities, attestations, and staff role assignments. System reporting will be assessed in accordance with the applicable policy and guidance as available via HMIS for reporting including but limited to service reach, client demographics, service outcomes, client follow ups, time to service, and service types. **Complaints Policy:** • If a client, advocate, or community member feels that emergency shelter operators are not meeting their obligations as outlined in the Standards, they may follow the process outlined under Section 2.3: Complaints Process. • Complaints which are not resolved by the shelter operator may be escalated to the City of Hamilton as outlined in the complaint resolution process (pending City Council approval September 2023). The City of Hamilton will report back to emergency shelter operators a summary of complaints received after emergency shelter operators complete their internal complaints process. **Applicable Legislation and Bylaws:** • Emergency shelter operators and their Board of Directors are responsible for ensuring that their organization complies with all relevant and applicable federal, provincial, and municipal legislation, including but not limited to those outlined in Section 9.4: Relevant Legislation of the Standards. • Emergency shelter operators will work with the City of Hamilton and Hamilton Public Health to respond as needed to infectious disease situations.
Policy	Not applicable

9.2 Board Requirements	
Standard Statement	Not-for-profit organizations funded to provide emergency shelter services will be governed by a volunteer Board of Directors. At a minimum, the Board of Directors is responsible for: • Ensuring the mandate, mission, values, and strategies of the organization are followed. • Setting agency priorities. • Reviewing and approving policies. • Evaluating services. • Ensuring that the organization meets funder expectations and contract conditions including compliance with the Standards. • Reviewing budgets and expenditures. • Reviewing and approving accounting and reporting procedures. • Selecting and conducting an annual performance review of the Executive Director.
Policy	Not applicable

9.3 Finance	
Standard Statement	On a monthly basis, all shelters will provide program and financial information to the Housing Services Division in a format specified by the City of Hamilton. All annual budget submissions will be submitted, in the specified format, to the City by a date determined by the City of Hamilton. Agencies will invoice the City in accordance with the terms and conditions of the funding agreements. Bookkeeping and financial records will be set up according to generally accepted accounting procedures, adhering to the terms and conditions of the funding agreements, and an annual audit will be conducted by a qualified independent auditor. All financial records will be kept for a minimum of seven years for financial audit purposes.
Policy	Not applicable

9.4 Relevant Legislation	
Standard Statement	Emergency shelter operators and their Board of Directors are responsible for ensuring that their organization complies with all relevant and applicable federal, provincial, and municipal legislation, including but not limited to: **FEDERAL** • Canada Consumer Product Safety Act **PROVINCIAL** • Accessibility for Ontarians with Disabilities Act • Child and Family Services Act • Ontario's Homelessness Prevention Program, including its guidelines • Employment Standards Act • Fire Prevention and Protection Act • French Language Services Act • Health Protection and Promotion Act • Health Insurance Act, R.S.O. 1990 • Municipal Freedom of Information and Protection of Privacy Act • Occupational Health and Safety Act • Ontario Building Code Standards • Ontario Fire Code • Ontario Human Rights Code • Ontario Food Premises Regulation • Personal Health Information Protection Act • Smoke Free Ontario Act • Workplace Safety and Insurance Act **MUNICIPAL** • Property Maintenance By-laws • Property Standards By-laws • Zoning By-laws In the event of any legal conflict between the Hamilton Emergency Shelter Standards and applicable legislation, the legislation shall prevail to the extent of the conflict. Shelter providers and their Board of Directors will consult qualified legal professionals about any and all legal and financial obligations related to their operation as a shelter.

Policy	Not applicable

10



intent:

This section outlines how information about people experiencing homelessness will be recorded, including the process for obtaining consent from clients. Shelter operators and the City of Hamilton are responsible for maintaining records which include sensitive and personal information and as a sector, strive to maintain information in ways that are client centred and reflect best practices for maintaining the privacy and dignity of clients.

INFORMATION SYSTEMS

10.1 **Client Database Information Management Systems**

10.2 **Consent**

10.3 **Confidentiality**

10.4 **Storing Information**

10.1 Client Database Information Management Systems	
Standard Statement	Emergency shelter operators are directed to fully participate with Hamilton's Homelessness Management Information System (HMIS), including participation in HIFIS-related activities, data collection, and reporting cycles. Programs are directed to use HIFIS or any other designated system to collect, manage, and share data at the direction of the City of Hamilton with the consent of the client for the purpose of providing clients with housing supports and helping clients find and maintain a place to live.
Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • *HIFIS Data Sharing Protocol for Hamilton's Homeless Serving System* and applicable data entry guidance. • *Hamilton's Homeless Serving System – HIFIS Confidentiality and User Agreement.* • *Hamilton's Homeless Serving System Consent and Intake Policy*.

10.2 Consent	
Standard Statement	Shelter staff will obtain informed consent from persons and dependents accessing shelter services, prior to consulting with or providing referrals to other service providers. Consent can change over time and shelters may review consent with clients periodically or at client request. Individuals must provide consent to have their personal information stored in the Homelessness Management Information System (HIFIS 4.0 and the By-Name List). All new clients are required to review and sign the Consent to Share Personal Information with Hamilton's Homeless Serving System. In cases of declined consent, no information will be added to HIFIS and the client's name will not appear on the By-Name List. Staff will make every attempt to progressively engage clients to help them understand the benefits of participating in the Coordinated Access system of care and to obtain consent. Progressive engagement to obtain consent should be conducted according to agency practice in a way that is culturally considerate and respects individual autonomy. Consent must be provided in order for a client to be known to the homeless-serving system to be referred to additional supports through Coordinated Access. However, clients who decline consent still have full access to emergency sheltering, outreach, and drop-in services without restriction. The use of declined consent in HIFIS is used in exceptional circumstances and requires City approval. Referrals of Indigenous clients and other clients who do not consent to be added on HIFIS but **do** consent to their information being shared with the City and/or a specific program, can be made through the City of Hamilton based on the Urgent Health and Safety or Missing/Inaccurate Information criteria in the Coordinated Access Prioritization Policy. Indigenous clients are not required, but may choose, to consent to their information being stored in HIFIS and on the By-Name List (BNL). Indigenous clients are not required to complete a VI-SPDAT or SPDAT. This also applies to consent for data storage outside of HIFIS including other databases, tracking sheets, and paper records.
Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • *Hamilton's Homeless Serving System Consent and Intake Policy*.

10.3 Confidentiality	
Standard Statement	Emergency shelter operators have access to detailed and highly sensitive personal information about clients. Protecting the privacy and confidentially of shelter clients and their personal information is of the utmost importance. Each shelter operator and its staff will keep in confidence the personal information of clients to which it has access as part of the *HIFIS Data Sharing Protocol for Hamilton's Homeless Serving System.* All emergency shelter operators will comply with applicable municipal, provincial, and federal legislation relating to the collection, storage, and sharing of client personal information and in so doing will take all reasonable precautions to protect all personal information from any unauthorized use, disclosure, copying, modification, and destruction. Emergency shelter operators will notify clients that personal information collected in HIFIS may be shared with designated parties for the purposes of providing and funding ongoing or future housing supports. Emergency shelter operators will inform clients at intake of the process for requesting access to their personal file and will provide access within a reasonable timeframe of a client request for their file. Emergency shelter operators will develop a confidentiality strategy that works with clients to ensure that staff do not disclose personal information that a client wishes to remain private. Shelter staff will explain the limits of confidentiality to clients at intake, or as soon as possible.
Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • *HIFIS Data Sharing Protocol for Hamilton's Homeless Serving System* and applicable data entry guidance. • Hamilton's Homeless Serving System – *HIFIS Confidentiality and User Agreement.*

10.4 Storing Information	
Standard Statement	As per the *HIFIS Data Sharing Protocol for Hamilton's Homeless Serving System* the HIFIS Community Coordinator (The City of Hamilton) is responsible for the secure storage of all HIFIS data collected from the service providers. The HIFIS Community Coordinator will ensure that the data is backed up daily and stored in a secure location. It should be made clear to clients, through the signing of the Consent to Share Personal and Health Information with the Hamilton's Homeless Serving System, where the client's information will be stored, and which community partners have access to that information. For all new clients who sign the Consent form, staff will scan the signed copy of the consent on a secure scanning device and upload it to HIFIS, delete the electronic copy of the consent, and then retain the physical signed copy of the form in a securely locked cabinet. This also applies to storage methods outside of HIFIS including other databases, tracking sheets, and paper records.
Policy	Emergency shelter operators will develop or adhere to the following policies related to this standard: • Where and how hard copies/files are stored securely, for how long, and who has access to those files. • *Hamilton's Homeless Serving System Consent and Intake Policy* • *HIFIS Data Sharing Protocol for Hamilton's Homeless Serving System*

11

STANDARDS ADMINISTRATION

11.1 **Review History and Approval**

11.2 **Related Documents**

11.1 Review History & Approval			
Revision Number	**Revision and Approval Date**	**Description of Change(s)**	**Process Approval Name & Position**
0	October 2008	Creation of the first Hamilton Emergency Shelter Standards.	City of Hamilton – Housing Services Division
1	July 2023	Creation of the revised Hamilton Emergency Shelter Standards. New Sections created. Major additions to Sections 3, 5 and 6. Updated all existing sections to add clarification on expectations and best practices related to the homeless-serving sector. Endorsed by all sectors including men's, women's, family, youth, and Indigenous community.	Michelle Baird, Director, Housing Services Division
Next Review Date: January 2027			

11.2 Related Documents

The following policies and guides related to Hamilton's homeless serving system referenced in the Standards can be found online: https://www.hamilton.ca/people-programs/housing-shelter/preventing-ending-homelessness/resources-homeless-serving-partners.

- *City of Hamilton complaint resolution process*
- *Hamilton's Coordinated Access Case Management Policy*
- *Hamilton's Coordinated Access Prioritization Policy*
- *Hamilton's Coordinated Access System Process Guide*
- *Hamilton's Homeless Serving System Consent and Intake Policy*
- *Hamilton's Homeless Serving System HIFIS Confidentiality and User Agreement*
- *Hamilton's Homeless Serving System Service Restriction Policy*
- *Hamilton's Homeless Serving System Triage and Assessment Policy*
- *HIFIS Data Sharing Protocol for Hamilton's Homeless Serving System*

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Exam of Dr. Stephen Gaetz
Heegsma et al v City of Hamilton
Nimigan Mihailovich Reporting Inc.

Last Update:
Version 01

Approval Date:

Service Restriction Policy for Emergency Shelters

Policy Statement & Purpose	The service restriction policy outlines a framework to be used by all city-funded emergency shelters to guide decision-making and communication related to restricting a client from one or more shelter service. It is intended to support clear, consistent, and accountable approaches to service restrictions across the homeless-serving system. Service restrictions are at times necessary, however should be viewed as a last resort when all other avenues of resolution have been exhausted. As such, this document also outlines alternate strategies and approaches to avoid a potential restriction.
Scope	This policy applies to the following city-funded emergency shelter programs: • All emergency shelters that serve single adults, youth, and families. This policy applies with limitations to: • The hotel overflow program. City and shelter staff supporting service users staying in the hotel overflow program will adhere to this policy, however hotel staff/owners may discharge clients from hotel at their discretion. In those instances, it may not be possible for the duration guidelines and appeals process to be followed. This policy does not apply to: • Violence Against Women shelters • City funded and non-City funded drop-in programs • Case management programs (ICM, Rapid Rehousing) or transitional housing programs.
Definitions	Client: An individual who is accessing or attempting to access a service provided by one of the included agencies. Sometimes referred to as a service user, guest, or resident. Discharge: The process of concluding a client's stay including the use of HIFIS to release a client's assigned bed. Discharge may be initiated by the client or staff for a variety of reasons, including but not limited to finding housing, no longer meeting eligibility criteria, or service restrictions. Serious Incident: May include, but not limited to, any behavior, possession, or threat, that creates harm to staff, community members, or other clients leading to an incapacity to manage safety within a communal living setting. Service Restriction: An action that limits a client's access to one or more services provided by an emergency shelter for a limited duration of time in response to a specific incident or behavior. A service restriction is NOT to be issued for reasons other than serious incidents or risk of harm to others.

	Turn Away: The process of declining a client access to service due to ineligibility or being over capacity and unable to provide space.
Guiding Principles	Service restrictions should primarily be utilized in situations where there has been, or is a significant risk of, harm to other clients, guests, and/or staff. Service restrictions may also be issued due to ongoing behaviours which interfere with shelter operations, illegal activities, court order, significant damage to property, or prolonged refusal to engage with program requirements. Service restrictions are not to be applied in instances where a client is turned away from shelter due to ineligibility based on demographic factors or medical accommodations beyond the capacity of the agency mandate. Staff and management responsible for issuing and reviewing service restrictions will be mindful of the following guidelines when applying this policy: • The primary focus of agencies should be to avoid service restrictions through alternative person-centered and trauma-informed interventions. • Emergency shelter operators must balance the well-being of individual clients against risk of harm to other clients, staff, guests, volunteers, and neighbours, as well as their obligations under the *Occupational Health and Safety Act.* • Intersectional & Anti-Oppressive Practice: Service restrictions will be considered through a trauma-informed, gender and equity lens; recognizing the systemic barriers faced by women, trans, gender-diverse or non-binary people, and experiencing intersecting oppressions including, but not limited to, race, ethnicity, substance use, mental health, disability, gender identity, religion, and sexual orientation. • Service restrictions are not to be used as a punitive measure. • Weather Alerts / Extreme Weather Events: During a Weather Alert or extreme weather event and under staff discretion, all agencies work to relax restrictions where possible for clients accessing service and for those previously restricted who are seeking service. Decisions will be guided by the prioritization of the health, safety, and wellbeing of all staff, clients, and guests at the location.
Service Restriction Process	Clients will be made aware of the service restriction policy upon admission, intake, or as soon as reasonably possible. The service restriction policy will be posted in each agency for all clients to reference. Staff will follow the steps below when assessing if a service restriction may be necessary: • Confirm that a service restriction is applicable for the situation. Clients who are ineligible for services will **not** be issued a service restriction, rather the reason for ineligibility would be provided to the client and staff would document this in HIFIS as a turn away. • Assess the situation using the service restriction policy guiding principles and values. • Consider if all other avenues of resolution within shelter staff capacity have been exhausted. Review all actions taken to support the client and end the behaviour(s) putting the client at risk of a service restriction. Ensure warnings and attempts to prevent issuing a service restriction have been documented. • Determine if failure to service restrict this client will endanger other clients and staff. • Consider what purpose the service restriction would serve. For example: if a client is attempting to harm a staff member or client, the purpose of the service restriction is to help ensure the safety of staff and other clients. Staff will follow the steps below when issuing a service restriction:

	• When determining the appropriate duration for a service restriction, staff will use the Guideline for Duration (Appendix A) and consider the context surrounding the incident, unique circumstances, and social location of the individual client. • Staff will always make every reasonable effort to secure a space with another system provider. However, the inability to secure an alternate space or the client's refusal to accept a referral to an alternate space does not mean that restrictions won't still be applied. • Staff will inform clients of their right to have a support person with them to attend meetings regarding their service restriction. All clients should be permitted to have a support or an advocate of their choice present during the service restriction and appeals process (when this doesn't present a conflict or safety concern). • When an Indigenous person is being restricted staff will work in partnership with the client's identified Indigenous service provider. If they are not yet connected to one, the agency will provide a referral at the client's request. • Where it is safe and reasonable to do so, staff or management must verbally notify the client that they are being restricted from service(s) at the time of discharge. When requested, service restriction details will also be provided in writing. When it is not safe or reasonable to inform the client at the time of discharge staff will inform the client at the next point of contact. Notice of the service restriction must include: o Specific details of the service restriction (Date, duration, reason, site(s) to which it applies) o The process for re-accessing services after the restriction ends, o Information on how long belongings will be stored and how clients can retrieve their belongings, o A copy of the service restriction policy and guidelines for duration (appendix A), o A copy of the agency's complaints policy should the client wish to appeal the restriction. <u>Agency management, supervisors, or designated senior staff will support staff in applying the service restriction policy by:</u> • Reviewing and approving service restrictions more than 24 hours in length. • Reviewing and determining service restriction durations greater than 1 month. • Reviewing and bring forward any restrictions greater than 3 months in duration or inadvertent system-wide service restrictions to the Manager of Homelessness and Housing Support or Supervisor of Emergency Shelter Services. <u>The City will support operators in applying the service restriction policy by:</u> The City will convene a teleconference with management/leadership to review the circumstances that led to a client being restricted from all locations and potential interventions to support the client with re-engaging in services.
Service Restriction Types	Access to location may be limited or denied in the following ways: • **Postponement Period/Warning:** A brief period in which the client is asked to leave the premises with a view of taking time and space to de-escalate their current behaviour. In such intense situations, the client will be invited to return when they feel better equipped to engage appropriately in the environment. Postponement period/warnings cannot exceed 12 hours in length and will not be issued overnight.

	• **Partial Restriction:** A client who is suspended for a specific time period, from specific activities in the program. Partial restrictions may be part of a harm reduction strategy to keep clients connected to some programs while limiting the risk of harm to others. • Examples: a client with a partial restriction could be denied access to a day program but allowed to stay in the shelter in the evening; or a client may not be permitted to stay in the shelter overnight but is granted limited access to specific programs (e.g. a health clinic; meal program; or a housing worker). • **Full Restriction - Discharge (Level 1-4):** A client is denied all access to a location for a specific length of time greater than 24 hours. • **System-Wide Service Restrictions:** Service restrictions will not be applied across the system pre-emptively, however there may be circumstances where a client's behaviour has resulted in repeated service restrictions from multiple locations, leading to a situation where it is not feasible for the client to be admitted to any of the locations they are eligible for in Hamilton. If all avenues for intervention have been exhausted, then staff will contact the Manager of Homelessness and Housing Support or Supervisor of Emergency Shelter Services. The City will convene a teleconference with management/leadership to review the circumstances that led to a client being restricted from all location and potential interventions to support the client with re-engaging in services.

Documentation	All shelters must maintain records of all service restrictions and these must be documented in the current Homelessness Management Information System (e.g. Homeless Individuals and Families Information System 4.0) as follows:
	• Service Restrictions should be entered into HIFIS by the staff issuing the restriction or their direct supervisor/manager.
	• Any non-overnight restrictions (postponement period/warnings and partial restrictions) will be documented in case notes, including which agency-specific services the client is restricted from (e.g. shelter, food services, all services, etc.).
	• Service Restriction documentation should be completed in accordance with this policy and HIFIS user documentation and training.
	• Staff are required to enter detailed notes about the Service Restriction. These notes should include the following:
	  ○ Reason(s) for the restriction.
	  ○ Alternatives pursued to prevent restriction including details of how staff attempted to avoid service restricting the client (e.g. de-escalation, partial restriction, case management meeting with client, etc.).
	  ○ Date the client was notified of the restriction or attempt to notify client was made.
	  ○ Shelter or other destination to which the client was referred, if applicable.
	  ○ Confirmed authorization by supervisor or manager if the restriction exceeds 24 hours.
	  ○ Details of the three warnings issued leading up to the service restriction being put in place (if it was safe and reasonable to issue warnings).
	  ○ For 60+ day restrictions, details of the review results and extension (as applicable).
	  ○ For appealed restrictions, details on the appeal findings and adjustments made.

	• If the client is being discharged, staff must record that the Reason for Discharge is because they are Service Restricted. • If a shelter has issued a Trespass Order, they must provide the client with a copy of the Trespass Order, including a copy of the Police Occurrence Report (if applicable). Trespass Order number and Police Occurrence Report number should be documented. All staff across the Coordinated Access System will see the Client Alert: *Client Has Active Service Restriction* and will be able to view the Service Provider that issued the restriction and the start and end date. The reason for the restriction will not be visible outside of the issuing shelter.
Appeals Process	Any client who has been restricted from service is entitled to appeal a service restriction and/or request the length of the restriction be reviewed. The client has the right for the appeal to be heard in a timely manner (usually within two days Monday to Friday) with the decision of outcome clearly communicated to the client once a timely decision has been reached. Appeals will be heard by the service manager or designate, and outcomes will immediately be shared with all applicable employees and documentation will be updated as required. Appeals are to be submitted through a shelter's complaints policy process. All agencies will have a written complaints process in accordance with the Hamilton Emergency Shelter Standards. • Exceptions: Hotel staff/owners may discharge clients from hotel at their discretion. If a client disagrees with the decision of the hotel staff/owner, they may request a review of the decision by the Manager of Homelessness and Housing Support or Supervisor of Emergency Shelter Services. When appropriate and possible the Manager of Homelessness and Housing Support or Supervisor of Emergency Shelter Services may direct staff to work with clients to find alternate shelter or hotel options.
Related Documents	• Service Restriction Policy Appendix A: Guidelines for Duration • Hamilton's Homeless-Serving System Consent for the Collection and Sharing of Personal Information • City of Hamilton – Housing Services Complaints Resolution Policy (pending) • City of Hamilton - Hamilton Coordinated Access Process Guidelines, 2022 • City of Hamilton – Case Management Policy, 2023 • City of Hamilton – Housing Services Consent Policy, 2023 • City of Hamilton – Housing Services HIFIS User Manual (pending) • Occupational Health and Safety Act • Ontario Human Rights Code, 1990 • Accessibility for Ontarians with Disabilities Act, 2005
Policy Review	This policy should be reviewed and updated every two years, led by the City of Hamilton Housing Services Division with input from the included partners and Indigenous community entities.

Guidelines for Determining Service Restriction Duration

How to use this guide: Shelter staff will utilize the following guide to determine the appropriate length of time a client will be restricted from services. The categories and recommended lengths in this guide are to be used in complement with the Service Restriction Policy. When issuing a service restriction, staff will use the guiding principles and values from the service restriction policy to consider the context surrounding the incident, unique circumstances, and social location of the individual client. Shelter operators must also take into consideration their obligations under the Occupational Health and Safety Act to provide a safe work environment and will work with staff when determining the duration of service restrictions. With these factors in mind, the length of time a client is restricted may be less than the duration outlined below, however restrictions should not exceed the timeframes in this guide. The circumstances and behaviours which may lead to a service restriction can be complex and evolve quickly between different incidents and risk levels. While staff are expected to follow the duration guidelines outlined below in exceptional circumstances an agency has discretion to implement a restriction that is longer than the recommended guideline, however the rationale for a longer restriction must be documented in HIFIS.

Exceptions:

The hotel overflow program. City and shelter staff supporting the hotel overflow program will attempt to adhere to the guidelines however, hotel management may make decisions related to service restrictions or permanent bans from a hotel that override this guide. In those instances, it may not be possible for the duration guidelines and appeals process to be followed. Whenever possible, staff supporting the hotel overflow program will work with families being restricted from hotel to avoid discharge and find alternate hotel or shelter options. Clients restricted from the hotel overflow program may appeal the decision through the Manager of Homelessness and Housing Support or Supervisor of Emergency Shelter Services.

Court ordered or Trespass Orders. If a client is not permitted to access shelter due to a court order or no trespass order the duration will be based on the length of the court order or no trespass order and therefor may be longer than the duration guideline.

Service Restriction Reasons

Category	Definition
Safety/Security Risk	Behaviours or activities which put the safety and security of other clients, guests, and/or staff at risk, such as: Threatening others Physical violence Deliberate and ongoing harassment of clients or staff
Non-compliance with Agency Rules/Regulations	Failure to follow agency rules or regulations, such as: Name calling/bullying including racism, sexism, or any discriminatory language Refusal to follow health and safety regulations
Illegal Activity	Illegal activities affecting the operations, safety, wellbeing, or property of others, including but not limited to: Violating Ontario Fire Code or Smoke Free Ontario Act (e.g. smoking inside program, tampering with a fire alarm) Arson Selling drugs on property Theft or stealing in the building Deliberate and serious property damage Breaking into locked or prohibited areas of the shelter

Prolonged Refusal to Engage	Refusal to engage with staff as required in the Client Rights and Responsibilities to discuss or work towards housing goals for more than 60 days.
Disruptive Behaviour	Breaching Client Rights and Responsibilities expectations in a manner which significantly interferes with staff's ability to maintain operations. This may include: Being persistently uncooperative and argumentative Interfering with the ability of others to sleep or access services Vandalism/damage to property Refusing to leave when asked
Hotel Admin Restriction	Hotel staff decide to discharge a client due to behaviours which disrupt business operations, negatively affect other customers, failure to comply with hotel rules, or as otherwise deemed necessary by hotel management.
Court Order/No Trespass	A court order or no trespass order which prohibits a client from accessing an emergency shelter site. Issued by a court or Hamilton Police Services.

Type & Duration Guidelines

Type	Description	Recommended Duration	Roles & Responsibilities
Postponement Period / Warning	Repeated breaches of expectations outlined in the Emergency Shelter Standards Client Rights and Responsibilities Name calling/bullying including racism, sexism, or any discriminatory language Violating Ontario Fire Code or Smoke Free Ontario Act (e.g. smoking inside program)	Short postponement e.g. 1 to 12 hours off property Maximum 12 hours and cannot include overnight hours	Approval: Agency staff Issue: Agency staff Documentation: Agency staff (under case notes) Review: N/A
Partial Restriction	A client who is suspended for a specific time period, from specific activities while still being allowed limited access to some programs Partial restrictions may be part of a harm reduction strategy to keep clients connected to some programs while limiting the risk of harm to others	12 or more hours	Approval: Supervisor or above if more than 24 hours in duration Issue: Agency staff Documentation: Agency staff (under case notes) Review: N/A

Level 1 **Discharge**	After 3 documented postponement periods/warnings or partial restrictions <u>First occurrence of:</u> Selling drugs on property Theft or stealing in the building <u>Repeated occurrences of</u>: Being persistently uncooperative and argumentative Violating Ontario Fire Code or Smoke Free Ontario Act (e.g. smoking inside program) Vandalism/damage to property Name calling/bullying including racism, sexism, or any discriminatory language Refusing to leave when asked – may involve police called to escort out	Out of location and off property for 24 hours	Approval: Supervisor or above Issue: Agency staff Documentation: Agency staff Review: Supervisor or above
Level 2 Discharge	Second occurrence of a Level 1 Service Restriction <u>Repeated occurrence of:</u> Selling drugs on property Theft or stealing in the building	Out of location and off property for **up to 4 days** with supervisor review prior to re-entry	Approval: Supervisor or above Issue: Agency staff Documentation: Agency staff Review: Supervisor or above
Level 3 Discharge	Serious incidents which compromise the safety of other clients, staff, and community: Physical violence or immediate threat of violence Arson Breaking into locked areas and resident rooms	Out of location and off property for **up to 60 days** with Supervisor review prior to return	Approval: Supervisor or above Issue: Agency staff Documentation: Agency staff Review: Supervisor or above will conduct review to determine duration of restriction (maximum 1 month without a review)

	Deliberate and ongoing harassment of clients or staff Deliberate and serious property damage.		Review at 1 month and consult with community partners: Supervisor or ED
Level 4 **Discharge**	Long-term service restrictions (over a period of three months) will only be issued in the most serious cases that compromise the safety and security of staff and clients. The Manager of Homelessness and Housing Supports or Supervisor of Emergency Shelter Services must be notified of any long-term service restrictions. Threat of physical harm/ threatening with a weapon Violent behaviour/Physical assault of staff and clients Fire setting/arson	**61 days or greater**, with Supervisor review prior to return	Approval: ED Issue: Supervisor or above Documentation: Agency staff Review: ED will conduct review to determine duration of restriction Review at 3 months and consult with community partners: Supervisor or ED
Court Order/ Trespass Orders	Depending on circumstances, a client may not be permitted to access a location due to court order or a Trespass Order. An order may be initiated by either an individual location or by Hamilton Police Services. In these circumstances, the service restriction due to the order shall be communicated to all affected locations.	Duration will be based on the length of the court order or Trespass Order.	Approval: ED Issue: Supervisor or above Documentation: Agency staff Review: Manager or Director (or delegate)

System-Wide Service Restrictions	Occasionally a client may be restricted from all locations concurrently. In these instances, agency staff will contact the Manager of Homelessness and Housing Support or Supervisor of Emergency Shelter Services. The City will convene a teleconference with agency management to review the circumstances that led to a client being restricted from all locations and potential interventions to support the client with re-engaging in services.	N/A Brought forward to the Manager of Homelessness and Housing Support or Supervisor of Emergency Shelter Services.	Approval: ED Issue: Supervisor or above Documentation: Agency staff Review: Manager or Director (or delegate) from appropriate sector (i.e. men's, women's) via teleconference and the Manager of Homelessness and Housing Support or Supervisor of Emergency Shelter Services.

Pandemic Planning in Homeless Shelters: A pilot study of a COVID-19 testing and support program to mitigate the risk of COVID-19 outbreaks in congregate settings

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Exam of Dr. Stephen Gaetz
Heegsma et al v City of Hamilton
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Abstract:We tested 104 residents and 141 staff for COVID-19 who failed daily symptom screening in homeless shelters in Hamilton, Canada. We detected one resident (1%), seven staff (5%) and one case of secondary spread. Shelter restructuring to allow physical distancing, testing and isolation can decrease outbreaks in shelters.

Keywords: coronavirus, homeless, shelter, surveillance, outbreak

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Introduction:

SARS-CoV-2, the novel coronavirus responsible for causing COVID-19, has particularly affected those in congregate settings such as nursing homes, prisons and homeless shelters (1,2). In Canada, there have been several outbreaks documented in homeless shelters (3,4).

Preventing and minimizing outbreaks in shelter settings using limited resources protects residents and staff within shelters as well as those they may interact with in the broader community. Furthermore, the higher prevalence of comorbidities amongst shelter residents places them at higher risk of severe COVID-19 disease (5). Preventing transmission in this population may have a greater impact on reducing hospital admissions and burden on critical care resources.

The objective of this report is to describe our experience with shelter facility restructuring, daily symptom screening and rapid testing to mitigate the risk of COVID-19 in the homeless shelter setting in Hamilton, Ontario, Canada.

Methods:

The homeless shelter system in the city of Hamilton is operated as a partnership between the municipality and social service agencies. Healthcare within the shelters is provided by the Hamilton Shelter Health Network, a group of physicians (Family Medicine, Internal Medicine and Psychiatry), nurse practitioners, nurses and midwives who are funded through an alternate funding plan by the Provincial Government of Ontario.

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At the start of the pandemic, there were approximately 341 shelter beds across eight shelters in Hamilton. Collaboration between the local public health unit, municipal government, shelter operators and the Shelter Health Network began in March of 2020. The collaboration allowed an increase from 341 to 395 shelter beds spread across the pre-existing shelters, three additional hotel sites and one additional temporary men's shelter. This enabled increased physical spacing between shelter beds and lower density within each shelter. Furthermore, a temporary isolation center (from a repurposed recreation center) was created for COVID-19 positive homeless individuals.

Through a partnership with the Hamilton Regional Laboratory Medicine Program (HRLMP) we were able to access COVID-19 testing with rapid turnaround time. This allowed us to use existing spaces within shelters for short-term isolation while awaiting COVID-19 testing results and to immediately arrange two-week isolation for those who tested positive.

Between March 17 and April 30, 2020, COVID-19 testing was performed on all shelter residents and staff who failed daily screening for potential COVID-19 related symptoms as well as staff and residents identified as close contacts of positive cases. Symptom screening was conducted according to direction given by the local public health unit, and was updated as new information regarding potential symptoms of COVID-19 were uncovered (e.g. anosmia). Nasopharyngeal swabs (NPS) were performed by trained nurses, paramedics and physicians. Between March 19 and April 16, testing was done using a laboratory-developed BD Max Multiplex Real-Time Polymerase Chain Reaction (RT-PCR) for COVID-19 (using 5'-Untranslated region, or 5'-UTR), Influenza A, Influenza B, Respiratory Syncytial Virus (RSV), Metapneumovirus, Parainfluenza 1, Adenovirus and Rhinovirus/Enterovirus. After April 17,

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testing exclusively for COVID-19 was undertaken in order to streamline result times and tests were considered positive if RT-PCR was positive for COVID-19 5'-UTR or Envelope genes.

Residents awaiting results were isolated within their shelter in single room areas. Residents who tested positive for COVID-19 and did not require hospitalization were transferred to our prepared isolation center for further monitoring. Transportation was organized by the City of Hamilton and involved the use of a dedicated transportation vehicle with enhanced infection control measures including a barrier between patient and driver and surgical mask, face shield, gloves and gown for the driver. Isolation continued for a total duration of fourteen days, with the ultimate decision to end isolation made in conjunction with our local public health unit. Nurses performing tests and shelter staff caring for isolated residents wore a disposable gown, surgical mask, face shield and disposable gloves. Staff who tested positive were excluded from work and provided with information related to self-isolation and symptom monitoring. All positive results were reported to the local public health unit for appropriate case management and contact tracing.

For context, the provincial government declared a state of emergency on March 17, limiting public gatherings to 50 people or less, and subsequently closed non-essential businesses on March 23. Gatherings were further limited to five people on March 28. No specific limitations were imposed upon shelter residents during the study period although movement between shelters was discouraged. Universal masking within common areas in the shelter system was initiated on April 18.

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Results:

Between March 19 and April 30, a total of 245 NPS were obtained from 141 staff and 104 residents (Figures 1a and 1b). Of the 88 total tests (59 residents and 29 staff) completed on the multiplex PCR platform prior to April 17, 12 (13.6%) were positive for a viral pathogen. Ten of 59 residents (16.9%) were diagnosed with rhinovirus/enterovirus infection and two of 29 staff (6.8%) were diagnosed with COVID-19 infection. A total of 157 (44 residents and 113 staff) tests performed after April 17 were tested exclusively for COVID-19; of these 1 resident (2.3%) and 5 staff (4.4%) tested positive. Overall during our study period, 1 of 104 residents (1.0%) and 7 of 141 staff (5.0%) were diagnosed with COVID-19 infection, and a total of 17 tests (6.9%) identified a viral pathogen. All positive cases were detected only through the daily symptomatic screening protocol or contact tracing.

Follow up contact tracing and testing revealed no secondary spread linked to the one positive shelter resident. Of the seven staff diagnosed with COVID-19, four were part of a cluster that was cohabiting at the same location distant from the shelter and were presumed to be community acquired. The remaining three staff worked at two separate shelter sites. During the time period of our study, one additional shelter resident was diagnosed with COVID-19 after presentation to a local emergency room (outside of our surveillance protocol).

For comparison, during the study time period, the City of Hamilton reported 422 patients with COVID-19 and a positivity rate of approximately 5-7%. Approximately 10% of the cases

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were in congregate settings (mainly long term care homes). In the province of Ontario, there were 15973 reported COVID-19 infections and 1080 deaths during our study period.

Test turnaround time throughout our study period averaged 14 hours from time of specimen arrival in the lab to time of reported results and 89 per cent of results were reported within 24 hours.

Discussion:

We have thus far been successful in preventing large outbreaks in the shelter setting despite identifying positive cases in both staff and residents. Our results emphasize the importance of taking a proactive, aggressive approach to outbreak mitigation in high risk settings. While there has certainly been some random chance, we postulate that four factors have been particularly important in increasing our chances of success:

1. Increased capacity of shelter space by opening surge shelters and hotel rooms, allowing for more effective physical distancing in congregate shelters;
2. Access to rapid assessment and testing on site when symptomatic residents or staff are identified through active screening;
3. Restructuring of physical spaces to accommodate isolation of residents with confirmed COVID-19 and those awaiting test results; and
4. Rapid turnaround of test results through collaboration with our regional laboratory program allowing triage of individuals into isolation spaces without exceeding available capacity.

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There are several limitations which should be taken into account in interpreting our data. Our testing program provided evaluation of those staff and residents who were identified as symptomatic through active screening within the shelters. We are aware of instances where shelter residents and staff have presented to other settings where testing has been performed, and is not captured in our data. Secondly the test characteristics of a NPS can be influenced by testing technique, and as such the sensitivity of our test in the real world setting of a mobile testing unit has not been clearly established. However, the lack of large scale outbreaks in area shelters suggests that we have not had a large number of false negative tests thus far.

Efforts to mitigate the risk of outbreaks of COVID-19 in high risk congregate settings such as long term care facilities, homeless shelters, and prisons are essential in moving towards the broader goal of managing COVID-19 risk in the general community. Our group has recently initiated a cluster randomized control trial to examine the effectiveness and acceptability of various surveillance testing strategies of asymptomatic individuals within our shelter system in an ongoing effort to enhance our ability to rapidly detect and isolate COVID-19 infected individuals. However, such efforts should be conceptualized as secondary prevention. There is also a pressing need to consider primary prevention - that is, upstream actions to end homelessness.

Our study demonstrates that accessible shelter housing that allows for rapid testing, isolation and physical distance is imperative to outbreak prevention in the shelter setting. The strategy presented here should be considered as part of the COVID-19 pandemic response alongside other homelessness prevention and reduction interventions.

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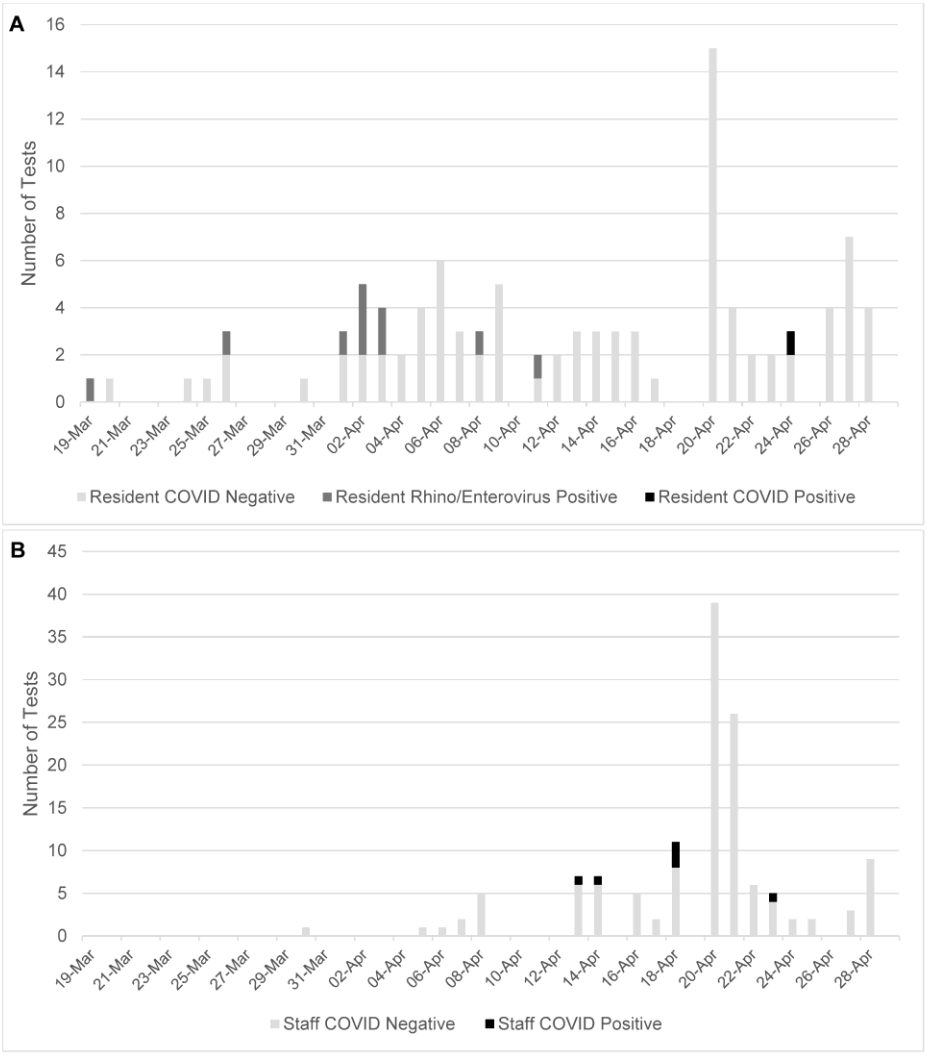
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Figure 1 legend

Number of daily tests and test results in residents (A) and staff (B).

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Figure 1



Number of daily tests and test results in residents (A) and staff (B).

POPULATIONS AT RISK

Homeless People's Perceptions of Welcomeness and Unwelcomeness in Healthcare Encounters

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BACKGROUND: Homeless people face many barriers to obtaining health care, and their attitudes toward seeking health care services may be shaped in part by previous encounters with health care providers.

OBJECTIVE: To examine how homeless persons experienced "welcomeness" and "unwelcomeness" in past encounters with health care providers and to characterize their perceptions of these interactions.

DESIGN: Qualitative content analysis of 17 in-depth interviews.

PARTICIPANTS: Seventeen homeless men and women, aged 29–62 years, residing at 5 shelters in Toronto, Canada.

APPROACH: Interpretive content analysis was performed using iterative stages of inductive coding. Interview transcripts were analyzed using Buber's philosophical conceptualization of ways of relating as "I–It" (the way persons relate to objects) and "I–You" (the way persons relate to dynamic beings).

RESULTS: Most participants perceived their experiences of unwelcomeness as acts of discrimination. Homelessness and low social class were most commonly cited as the perceived basis for discriminatory treatment. Many participants reported intense emotional responses to unwelcoming experiences, which negatively influenced their desire to seek health care in the future. Participants' descriptions of unwelcoming health care encounters were consistent with "I–It" ways of relating in that they felt dehumanized, not listened to, or disempowered. Welcoming experiences were consistent with "I–You" ways of relating, in that patients felt valued as a person, truly listened to, or empowered.

CONCLUSIONS: Homeless people's perceptions of welcomeness and unwelcomeness are an important aspect of their encounters with health care providers. Buber's "I–It" and "I–You" concepts are potentially useful aids to health care providers who wish to understand how welcoming and unwelcoming interactions are fostered.

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INTRODUCTION

Meeting the health care needs of homeless persons is a daunting challenge. An estimated 800,000 Americans are currently homeless, and in Toronto, Canada, more than 5,000 people are homeless on any given night.[1–4] Homeless individuals have a high burden of illness and are at increased risk for premature death,[5–9] but factors such as the daily struggle to meet basic needs, lack of health insurance, mental illness, and addictions can limit homeless people's ability to access health care services appropriately.[1,10,11]

Homeless people's attitudes toward health care services, shaped in part by previous health care encounters, may also affect their propensity to seek care.[12] In this qualitative study, we examine how homeless persons experience interactions with health care providers and specifically explore what it means to these individuals to feel "welcomed" or "unwelcomed" during these encounters. We believed that these concepts might be particularly meaningful to homeless people because of their everyday experiences as a marginalized group.

METHODS

Participants

This study was conducted in Toronto at a convenience sample of 3 men's shelters, 1 women's shelter, and 1 mixed-sex shelter. Potential participants were identified by random selection of bed numbers. Eligibility criteria were age ≥16 years, ability to communicate in English and give written informed consent, and lifetime duration of homelessness ≥1 month. Participants received a payment of $15. The study was approved by the St. Michael's Hospital Research Ethics Board (IRB).

Of 22 individuals approached, 17 consented to participate. Five individuals declined, citing illness (n=2), fatigue (n=2), or dislike of research studies (n=1). Sampling was discontinued after 17 interviews when there were sufficient similarities in the data to identify a common understanding of welcomeness

and unwelcomeness (i.e., theoretical saturation was achieved). Participants included 4 women and 13 men who ranged in age from 29 to 62 years (median 40 years). Lifetime duration of homelessness ranged from 8 months to 14 years (median 3 years).

Data Collection

Each participant completed an audio-taped in-depth semi-structured interview conducted by a single investigator (CKW). An interview guide (available on request) was formulated after literature review and discussion among the research team and revised based on pilot interviews. The interview explored the nature and meaning of welcomeness and unwelcomeness in health care settings. We prompted participants to recount at least 1 health care experience in detail. When needed, probes were used to focus their narratives (e.g., "How did that experience make you feel unwelcome?"). Direct questions concerning the concept of interest were also utilized (e.g., "What does 'welcomeness' mean to you?"). Interviews lasted approximately 1 hour. Audiotapes were transcribed verbatim. To ensure confidentiality, no personal identifiers were recorded. Fictitious names are associated with all quotations in this paper.

Coding and Analysis

We performed interpretative content analysis, which involves identifying, coding, and categorizing patterns in textual data.[13] Codes, which are abbreviated phrases representing underlying concepts or themes, were generated from and applied to the data. Coding began inductively and was iterative (i.e., codes were tested and refined as each transcript was successively analyzed). Line-by-line coding of each transcript was performed by the lead author (CKW) with ongoing input from the other researchers. Discrepancies in interpretation were discussed and resolved during consensus meetings.

During coding, we noted that some participants characterized unwelcoming health care experiences as dehumanizing, using words such as "subhuman" or "dehumanized." For example, 1 participant stated:

> "…she just didn't care. It was like you were a piece of meat."
>
> (Timothy)

These observations led us to consider the philosophical writings of Martin Buber as a potentially relevant framework for understanding these emerging themes. In his seminal work *I and Thou* (1923), Buber described "I–It" as the way a person relates to a thing or object that does not have the power to define its own essence and function.[14] Buber contrasted this with "I–You," the way in which a person relates to a dynamic being who has a say in defining his or her own essence and who should be approached with a degree of openness and receptivity. Buber suggested that rather than relating to others as "I–You," people sometimes relate to other persons in an "I–It" manner, that is, in the same way that they relate to objects.

The language of dehumanization in participants' accounts suggested that "unwelcoming" encounters between participants and health care professionals could be conceptualized as "I–It" relationships, whereas "welcoming" encounters could be conceptualized as "I–You" relationships. To systematically explore this possibility, we generated codes consistent with Buber's definitions of "I–It" and "I–You" relationships and applied them to all transcripts to test their robustness and appropriateness (Table 1). Support for these interpretations is provided using segments of data that most clearly illustrate each analytic point and are representative of the entire dataset.

RESULTS

Experiences of Unwelcomeness

Participants described health care encounters that made them feel unwelcome in a variety of ways. During these episodes, participants often felt that they were being ignored, rushed, brushed aside, or treated rudely. Moreover, 13 of 17 participants perceived their experiences of unwelcomeness as acts of discrimination. Some participants spontaneously and explicitly mentioned a connection between unwelcomeness and discrimination during the course of their interview. For example, when asked to describe any health care experience that stood out for him, 1 participant responded:

> "…on two occasions I had reason to believe that because I'm in a shelter, it's like secondary treatment, not as how we envisage it should be when you go to accident and emergency [an emergency department]."
>
> (Hernando)

For other participants, the connection between unwelcomeness and discrimination was implicit. A participant reported waiting in an emergency department and seeing other patients arrive after him but receive care first. He stated:

> "You know, I mean that's not fair. I mean, I work myself, I pay my taxes and stuff like that. I don't work full time, but I work part time, as a longshoreman. Just like everybody else, I pull my own weight. You know, I just live here [in a shelter] because rent's so high and stuff like that—maybe I can come here and save some money."
>
> (Michael)

This participant felt that he was treated differently because he was homeless, and implicitly attributed this treatment to the stereotyping of homeless people as "freeloaders." Participants identified various characteristics that accounted for what they believed to be discriminatory treatment, most commonly homelessness (n=9) and low social class (n=9). Additional reasons, each mentioned once, were drug addiction, mental illness, race, and age.

For many, perceived discrimination in health care settings was understood as part of a widespread societal pattern of discrimination against homeless persons. Six participants spontaneously related discrimination in health care settings to their general life experiences. For example, 1 participant explained poor treatment in a health care encounter in these terms:

"We are always discriminated against because we are homeless... Walking down the street, people laugh at us. They know you're homeless... wearing not so normal clothes, dirty clothes or something like that."

(Matt)

Another individual explained his experience of unwelcomeness in this way:

"[homeless people] are less welcome in the majority of places...You go to any mall, you dressed the way you are and me, and we sat down on a bench in a mall and was having coffee, within thirty-five minutes a security guard would come over and tell me that I had to leave. They wouldn't say nothing to you."

(Luke)

Many participants reported intense emotional responses when they felt unwelcomed, which frequently led to a strong distrust of health care workers and a desire to avoid health care institutions at almost any cost. As 1 individual stated:

"I get to the point where I don't really, I don't know, trust or like physicians. More and more I see it as almost they would sooner deal with rich people, people with good insurance, and everything else."

(Luke)

Another participant reported:

"I got treated like that the first time over there, and I'm not going to get treated like that, I'm not going through that again. I'd rather sit here and f____n' die on a bench than go over there."

(Michael)

This latter statement was a response to a short interaction with an attendant at a hospital information desk who redirected the individual to the Emergency Department. The participant stated that he perceived unwelcomeness through the attendant's "attitude" and not because of anything the attendant said. Thus, some homeless individuals may impute a great deal of meaning to brief contacts that do not involve any overt verbal discourtesy. A number of participants reported similarly strong negative reactions to subtle experiences of unwelcomeness. Feeling unwelcomed could even affect the desire to care for one's own health:

"If you were welcome, you would feel better, it makes you feel better, it makes you want to get better. If you are not welcome, you don't want to get better. What the f__k, you don't care. I shouldn't get better so I don't care if I get better or not"

(Matt)

Unwelcomeness and Welcomeness as "I–It" and "I–You" Relationships

Participants' descriptions of unwelcoming experiences were often consistent with Buber's characterization of an "I–It" way of relating, in which the patient felt that the health care provider reduced them to an object, was unwilling to know and empathize with them, ignored or failed to listed to them, was preoccupied with their own agenda, and made them feel disempowered (Table 1). In contrast, welcoming experiences were more consistent with an "I–You" way of relating, in which the patient felt that the health care provider valued them as a person, was willing to know and empathize with them, truly listened, acknowledged their needs, and minimized power imbalances (Table 1).

Feelings of dehumanization were frequently evoked by unwelcoming health care encounters, suggesting that participants felt treated as an object and in a manner not recognizing their worth and personhood:

"it makes me subhuman, like that I don't really belong in society,"

(Luke)

In contrast, welcoming health care encounters were often associated with feelings of humanization:

"they made me feel like I was a person, not just some derelict that, you know, shouldn't be breathing."

(Luke)

Accounts of unwelcoming experiences often included descriptions of a closed disposition, also associated with the "I–It" way of relating:

"You [the health care provider] withdraw. You don't really want to know who I am or what I am all about."

(Timothy)

Participants also perceived that health care providers in unwelcoming encounters lacked a desire or ability to empathize:

"like they heard you, but they weren't really concerned as much"

(Irene)

When participants described welcoming experiences, they often perceived the health care provider to have an open intellectual and emotional disposition toward them:

"they're open and receptive and they don't stereotype me..."

(Lisa)

Welcoming experiences enabled genuine sharing and communication. An individual described a welcoming encounter in which he felt invited to disclose his feelings:

"they ask you how you are feeling and you talk about what is wrong with you. Some places are better at doing that."

(Matt)

Unwelcoming experiences with health care providers often involved poor or absent communication, which is characteris-

Table 1. Coding Categories Consistent with "I–It" and "I–You" Encounters, with Specific Examples from Interview Transcripts

"I–It" Encounters			"I–You" Encounters		
Coding category	**Description**	**Examples from transcripts**	**Coding category**	**Description**	**Examples from transcripts**
Identity as object	When an individual feels as though he or she has been reduced to a thing or object	"it makes me subhuman almost, like that I don't really belong in society" (Luke) "…she just didn't care. It was like you were a piece of meat." (Timothy)	Identity as person.	When an individual feels as though he or she has been acknowledged or valued as a person.	"It makes you feel happier inside. It makes you feel wanted." (Matt)
Closed intellect	A closed way of knowing the other. An unwillingness to know the other and/or the use of restrictive concepts to define the other (e.g., stereotypes)	"most of them automatically judge you and stereotype you" (Luke) "…it just seemed like she just wanted to be just, just sit down and wait. Like it seemed to me that she didn't even believe me." (Joe) "they didn't even want to know who in the hell I was." (Timothy)	Open intellect	An open way of knowing the other. A willingness to know the other and the absence of restrictive concepts that define the other (e.g., stereotypes)	"They don't really judge people. They just take all walks of life, whether you're working or not working or where you live." (Irene) "the person likes to get to know you or wants to know about you." (Timothy)
Closed emotions	A closed way of relating to the other. An unwillingness or inability to empathize with the other.	"A lot of the problem is that doctors don't have or won't take the time to actually find out where you are or how things are affecting your life and why." (Luke) "she made me feel like she was sympathetic…but I don't think she was…i don't know, it's just the way I felt" (Matt) "like they heard you, but they weren't really concerned as much" (Irene)	Open emotions	An open way of relating to the other. A willingness and ability to empathize and be receptive toward the emotions of the other.	"To say, you know, I see where you're coming from…" (Irene) [welcomeness is]: "Hi, how are you? How do you feel? Where have you been?" you know? That instead of just "where is the form I sign? Okay, here you go, go". (Pierre)
Closed communi-cation	When an individual feels as if he or she is ignored or not listened to.	"That's it, I don't want to talk to you,' that's the impression I got." (Andre) "They ignore me completely. People only talk to me bad." (Hernando) "They were a bunch of jerks…just because they are running a big hospital they should just take time to personally interact with the individual…you feel like they are snobs and they just don't want to get to know you." (Timothy)	Open communi-cation	When an individual feels as if he or she is truly listened to.	"uh, they ask you how you're doing, sort of thing and if you need any help … What am I looking for, what type of help or?" (Irene) "…with just the tone and the expression of how they talk to you. You know, a lot of times you get them asking how are you doing? Have a bit of a conversation," (Luke)

(*continued on next page*)

Table 1. (continued)

"I–It" Encounters			"I–You" Encounters		
Coding category	**Description**	**Examples from transcripts**	**Coding category**	**Description**	**Examples from transcripts**
Closed agenda	An unwillingness or inability to acknowledge the needs of the other, and preoccupation with one's own agenda (e.g., functional or mechanical relationships)	"...they just gave me like that whole facial look, like, like I'm too busy and all this stuff, like...but that's just how it is though right." (Joe) "they're very business-like I dunno...they want to get on with the next patient... their work day...basically" (Raj) "You serve the customer, get them out of the way, and go to the next one. That's all it basically seemed like, was just an assembly line." (Luke)	Open agenda	A willingness and ability to acknowledge the needs of the other, even at the expense of one's own agenda. (e.g., caring relationships that are not purely functional or mechanical)	"they show that they care, its not just a job... they want to know you as well as a person, if you're okay in general and any other treatments you might need." (Irene) "We see you, you ask for help. We will get you the help you need. And basically didn't abandon me." (Luke)
Power imbalance	When an individual feels disempowered by the other	"...like you're less than the working population." (Christopher) "...like I had no sense of worth." (Matt)	Power equity	When there is a balance of power between individuals encountering one another	"[the doctor] didn't talk down to me like some doctors do...they sometimes have a tendency to do that...I think, maybe doctors just think they're smarter than the public on average" (Christopher) "He knows me, I know him... giving one another pointers, helping, I mean like working together right and not sort of just, just, just dividing ourselves." (Joe)

tic of the "I–It" way of relating. One participant described his frustration when he tried to ask a nurse at an Emergency Department about his expected wait time:

> "She snubbed me when I went up to ask her, you know, how long it's going to be? It will be as long as it takes, was her reply. It's just the way she moved her body, you know. I was sitting there and she was sitting here, and she sort of turned her back on me, and I said, excuse me, and she just looked over and kept pointing over there and kept turning away, so I finally gave up on this one and went back inside and waited."
>
> (Timothy)

Unwelcoming encounters had a purely mechanical, functional, and unidirectional character, another feature of "I–It" relating:

> "Yep, I felt like she was processing a piece of meat…Let's just do this guy out and get him into the waiting room."
>
> (Timothy)

In contrast, participants felt their own agendas were heard and taken seriously during welcoming experiences. This participant described an encounter in which she received assistance with an application for disability benefits:

> "…someone spent an hour on the phone trying to help me get a package together…and that amount of work on, on a case to improve my life circumstances and make an adjustment in me is really commendable."
>
> (Lisa)

Finally, unwelcoming experiences were characterized by power imbalances, consistent with the "I–It" way of relating to persons like things or objects; for example:

> "right then, I felt about that big [gestures to indicate small size]… you feel demeaned…you feel lower class"
>
> (Timothy)

In contrast, a welcoming experience was described in terms of perceived power equity:

> "He makes me feel great. He talks one on one to you, you know, at your level. It doesn't matter whether you are above him or below him. He talks to you at the same level. A lot of people don't do that."
>
> (Timothy)

DISCUSSION

Our findings indicate that perceptions of welcomeness and unwelcomeness are a potentially critical dimension of the homeless people interviewed for this study. Respondents often reported that unwelcoming experiences elicited strong emotional responses and decreased the likelihood they would seek health care in the future. These preliminary findings suggest that the provision of effective care for homeless people may be tied to the ability to create a welcoming environment. Further, many unwelcoming experiences involved nonclinical staff such as receptionists, suggesting that *all* workers who come into contact with patients should be included in future research studies.

Trust has been defined as an "acceptance of a vulnerable situation in which the truster believes that the trustee will act in the truster's best interests."[15] Patient trust is engendered by a health care provider's technical competence, interpersonal interactions, and fiduciary role.[15] Although the experience of feeling welcomed, which arises through interpersonal interactions, likely contributes to the creation of trust,[16] we postulate that welcomeness is not merely a component of trust, but a unique and salient concept in its own right. In this work, we have seen how welcomeness and unwelcomeness are important because they are closely linked to patient perceptions of interactions as humanizing or dehumanizing. Buber's concepts of "I–You" and "I–It" ways of relating provides a useful theoretical framework for examining homeless people's narratives of welcoming and unwelcoming experiences, and offers a new and previously unexplored way of thinking about patient–health professional interactions. Future work exploring the interrelationship between trust, patient satisfaction, and Buber's concepts would be valuable.

Study participants often linked unwelcoming experiences with discrimination, suggesting that stigma is an additional dimension of these interactions. Stigma is "a special kind of relationship between attribute and stereotype" in which an objective attribute (e.g., "homelessness") is linked to a stereotype that is often of a discrediting nature (e.g., "lazy").[17] In social encounters between a nonstigmatized and a stigmatized person, there is a strong tendency for the former to relate to the latter on the basis of these stereotypes. This mode of relating maps clearly onto Buber's "I–It" concept because the stigmatized individual is approached within the preconceived constraints of a stereotype rather than with openness. Prevailing stereotypes of homeless people and homeless individuals' past experiences of discrimination heighten the risk that a homeless patient will feel unwelcome and dehumanized during an encounter.

This study has several limitations. First, our sample of 17 participants, although consistent with qualitative research methods, limits the generalizability of our findings in a statistical sense. Nonetheless, all descriptions of welcoming and unwelcoming experiences included at least some elements of "I–You/I–It" ways of relating, suggesting that our results are likely to be applicable to similar patients in other locations. Second, the rationale for our choice of Buber's "I–You/I–It" conceptualization as an analytic tool may be challenged. Although other theoretical frameworks could have been used, we selected Buber's because it coherently captured important and varied aspects of the nature of patient–physician interactions, which figured prominently in participants' accounts, and because it offered a new and potentially useful understanding of patient–provider interactions. Third, we focused on identifying shared themes in this exploratory study and did not attempt to determine the differential effects of characteristics such as sex, race, or duration of homelessness on experiences of unwelcomeness. Studies of this nature could be the focus of future work. Fourth, study participants often linked their

experiences of unwelcomeness to their homeless state, but such experiences may be shared in common by individuals belonging to a wide range of stigmatized groups or those who frequently use emergency departments as their main source of health care.[18] This is an empirical question that would benefit from additional study. Finally, we sought to understand health care encounters from the perspective of homeless persons and did not aim to critique the objectivity or factual accuracy of their accounts. We worked from the position that participants' accounts accurately described their own honest perceptions and understandings of these interactions. However, homeless people do have a high prevalence of mental illness, substance abuse, and previous traumatic experiences,[19] which may increase their risk of misinterpreting health care providers' verbal and nonverbal cues. Homeless people may also display difficult behaviors that might encourage negative responses from providers. Future studies triangulating the perceptions of both homeless patients and health care providers would address this problem.

In summary, our results indicate that conveying welcomeness was an important aspect of health care for the homeless persons we studied. Whereas this concept is less tangible than other factors that contribute to the accessibility of health care for homeless people, it is no less important. Healthcare providers may find that Buber's "I–You" way of relating provides an easily remembered outline of the characteristics of a welcoming interaction; it encourages health care providers to approach each patient with openness, humility, and receptivity befitting his or her dignity and fullness as a sacred person. Clearly, this goal can only be achieved by recognizing the unique circumstances of each patient rather than through a mechanically applied formula. Such an approach may prove useful in guarding against the tendency to stereotype patients who are members of a stigmatized group.

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Understanding Encampments of People Experiencing Homelessness and Community Responses

Emerging Evidence as of Late 2018

U.S. Department of Housing and Urban Development | Office of Policy Development and Research

Understanding Encampments of People Experiencing Homelessness and Community Responses:

Emerging Evidence as of Late 2018

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Introduction

Cities, suburban communities, and rural areas across the United States have seen in recent years the rise of groups of people experiencing unsheltered homelessness together. The term *encampment* is widely used by journalists and researchers to describe these groups, but other terms include *tent cities, homeless settlements,* and *homeless camps.* Although their existence is not unprecedented, media reports suggest that the number of encampments has increased sharply in recent years (National Law Center on Homelessness and Poverty, 2017).

People experiencing unsheltered homelessness may perceive staying in an encampment as a safer option than staying on their own in an unsheltered location or in an emergency shelter; however, encampments can create both real and perceived challenges for the people who stay in them as well as for neighbors and the broader community. As community leaders seek to develop and deploy a response, they often are called on to balance multiple, sometimes competing priorities and demands from a diverse group of stakeholders, including community residents, business owners, public health and safety officials, and advocates for disadvantaged populations—as well as the people living in the encampments.

This paper documents what is known about homeless encampments as of late 2018, based on a review of the limited literature produced thus far by academic and research institutions and public agencies, supplemented by interviews with key informants. This paper is part of a larger research study sponsored by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, and the U.S. Department of Housing and Urban Development, Office of Policy Development and Research. This study's goal is to contribute to our understanding of homelessness, including the characteristics of homeless encampments and the people who stay in them, as well as local ideas about how to address encampments and their associated costs.

What Are Encampments, and What Do We Need to Know About Them?

The term *encampment* has connotations of both impermanence and continuity. People are staying in temporary structures or enclosed places that are not intended for long-term continuous occupancy on an ongoing basis. Inhabitants may be a core group of people who are known to one another and who move together to different locations when necessary, or they may be a changing group of people who cycle in and out of a single location. The physical structures that make up encampments can take many forms, including tents on pallets and shanties, or lean-to shacks built with scavenged materials. Structures may be simple or complex multiroom compounds. People experiencing homelessness in encampments may also stay in groups of cars or vans or in manmade tunnels and naturally occurring caves.

Community reactions to encampments have taken a variety of forms. Some communities send police to quickly clear ("sweep") encampments, with no attempt to provide services or referrals to help people at the encampment find another place to stay. At the other end of the spectrum, some communities permit ("sanction") encampments formally. Local government or community organizations provide running water and places to prepare food and dispose of waste, as well as healthcare and other services.

The research questions that guided this review are shown in Exhibit 1. In the larger research study, we will attempt to provide information about encampments and the people who are staying in them and to answer these research questions. We sought preliminary information for these questions through a formal examination of the peer-reviewed literature; we also identified and examined non-peer-reviewed reports by academic institutions, public agencies, and other organizations (sometimes called *gray literature*). In addition to conducting literature reviews, we interviewed several key informants who are subject matter experts on encampments. We selected them because they are conducting research on encampments and related topics or they are helping communities devise and implement best practices for dealing with encampments.

Exhibit 1. Research Questions for the Study of Encampments

Understanding Encampments

1. What factors are driving the increase in people living in encampments?
2. What infrastructure or state or local ordinances or other policies impede or promote the establishment of encampments?
3. Who lives in encampments? Are there some subpopulations of people experiencing homelessness who are more likely to form or attach themselves to homeless encampments? Do people staying in the same encampment share certain characteristics? Are there any differences between the unsheltered population living in encampments and those who are unsheltered in other locations?
4. How large are encampments? Do their characteristics vary by size?
5. What types of social structures characterize encampments?
6. Why do people choose to live in encampments? What are the "pull" and "push" factors?

Community Efforts to Address Encampments

7. What steps are communities taking to prevent the establishment of encampments?
8. How are communities responding to encampments? What are the major activities, and which stakeholders are engaged?
9. Can approaches to encampments be categorized—for example, as sanctioning, clearing, or relocating?
10. How do responses to encampments relate to the broader homelessness services system?
11. How do responses to encampments differ across different types of communities?
12. In what ways do these efforts differ from efforts to serve the unsheltered population not living in encampments?

Costs Associated with Encampments

13. What are the direct costs incurred by communities in their efforts to address encampments?
14. How do costs differ depending on different community approaches?
15. How do the costs of managing or addressing encampments compare with the cost of emergency shelter and the cost of permanent supportive housing?
16. What health and safety issues have communities encountered with people staying in encampments?
17. What are the broader societal costs associated with encampments?

We summarize the nascent evidence on encampments in the following two sections. *Understanding Encampments* reviews what we know about why encampments form and what they look like. *Community Responses to Encampments* describes the factors that lead communities to adopt various approaches and what we know so far about their effectiveness. Then we describe the *Limitations of the Current Evidence on Encampments,* including some suggestions for additional research beyond the scope of this study. Finally, Appendix A describes how we conducted the literature review and key informant interviews, Appendix B provides additional details on selected studies that were particularly informative as we completed our review, and Appendix C summarizes selected practitioner resources to assist with addressing encampments.

Understanding Encampments

This section describes what we know as of late 2018 about encampments: why there has been a sudden increase in encampment homelessness in the past few years and how encampments vary in resident characteristics, in social structure, and regionally. As discussed herein, conditions can be harsh, volatile, and unhealthy. Still, people may live in encampments (rather than shelters or in other, unsheltered locations) for a variety of reasons, including factors that lead them to reject other types of shelter and factors that attract them to encampments. Section 3 will cover what we know about emerging community responses to encampments.

Explanations for the Increase in Encampments

Researchers generally agree that increases in homelessness are first and foremost the result of severe shortages of affordable housing, combined with a lack of political will to dedicate sufficient resources to address this problem (Shinn and Khadduri, forthcoming). According to a key informant who is helping communities understand how to deal with encampments, when people are in crisis, their decisions about where to stay represent pragmatic choices among the best available alternatives, based on individual circumstances at a particular moment in time. Encampments form in response to the absence of other, desirable options for shelter.

Within this underlying context, several related factors seem to influence whether people experiencing homelessness form or go to encampments rather than stay in shelters or on their own in unsheltered locations. Primary among those factors are (1) shortcomings in the shelter system, (2) a sense of safety and community within encampments, and (3) a desire for autonomy and privacy. Only one peer-reviewed article (Herring, 2014) mentions the potential for greater access to food and services or other material comforts as reasons that people congregate in encampments rather than stay on their own in unsheltered locations. Key informants and other peer-reviewed articles did not identify this as a primary factor influencing the decisions of people experiencing homelessness.

The Shelter System Falls Short

Shortcomings in the shelter system are consistently identified as a primary factor that "pushes" people to congregate in encampments. Many communities have literal shortages in the capacity of the shelter system to provide beds for everyone experiencing homelessness (Herring and Lutz, 2015; National Coalition for the Homeless, 2016; National Law Center on Homelessness and Poverty, 2014; Speer 2018a). In other communities, shelter beds are available but go unused because of regulations or conditions that are incompatible with potential clients' expectations or needs. Exhibit 2 lists some of the reasons cited in the literature and in key informant interviews why people experiencing homelessness may eschew shelters in favor of encampments. The availability and type of shelter available seem to be key drivers of encampments, as people weigh the disadvantages of staying in a shelter against their tolerance for the difficulties of staying in an unsheltered location (City of San Francisco, 2015; Herring and Lutz, 2015; National Law Center on Homelessness and Poverty, 2014).

Exhibit 2. Shortcomings in the Shelter System

Specific shortcomings in the shelter system that may contribute to increased numbers of people congregating in encampments:

- A supply of shelter beds insufficient to meet the demand; this problem may be exacerbated by limited funding for emergency shelters and by community opposition to creating new or expanded shelter and bridge housing facilities or permanent supportive housing.
- Restrictions in shelters that would result in separation from a partner, family member, or pet.
- Shelter entry/exit times and locations that are inconvenient or incompatible with people's daily routines, including work schedules.
- Concerns about the security of personal belongings; restrictions on the ability to store belongings and difficulty moving belongings in and out of shelters on a daily basis.
- Concerns about personal safety and exposure to germs and disease within shelters.
- Specific barriers to entry, including sobriety requirements and entry fees.
- General perceptions of shelters as "inhospitable," "alienating," "demeaning," and offering little or no support or case management to find permanent housing.

Sense of Safety and Community

People who stay in encampments may see them as offering greater safety and protection from police harassment and aggression (Burness and Brown, 2016), and from assaults or the theft of belongings (Donley and Wright, 2012; Speer, 2017), than if they were unsheltered on their own. This sense of "safety in numbers" may be particularly prevalent in long-standing and highly organized encampments, in which residents have established around-the-clock security patrols and mutually enforced norms and standards for behavior (Lutz, 2015; National Law Center on Homelessness and Poverty, 2014; Sparks, 2017a). In high-cost cities in particular, individuals' decision to congregate in an encampment may be influenced by the behavior of their peers, according to a key informant who is conducting research on encampments. Once a critical mass of people has determined that encampments are a way of dealing with their housing crisis, others may feel emboldened to follow suit. Some cities respond to the presence of an established encampment by providing bathroom facilities and other basic services, making encampments seem to be a reasonable alternative to constant moving, threats of eviction, or shelters.

Desire for Autonomy and Privacy

In contrast to the rules that govern many aspects of shelter stays, staying in an encampment means that people can generally come and go as they please. The ability to exercise autonomy and freedom of movement appears to be a powerful factor that draws some people to encampments (Lutz, 2015; National Law Center on Homelessness and Poverty, 2014; Sparks, 2017a). This independence is sometimes eroded in communities that "normalize" encampments, introducing regulations that restrict residents' activities in the process. When that happens, encampments may in effect become an extension of the same shelter system that people reject in favor of encampments (Herring, 2014; Speer, 2018a).

Access to Illegal Substances

Residents of encampments may or may not be using illegal substances. Nothing in the literature suggests that most or even many encampments are where people congregate primarily to support their drug addiction. That said, in at least one high-profile example, the location of an open-air drug market directly influenced the formation and continued existence of an encampment, according to a key informant studying encampments. In that instance, the availability of a dependable supply of heroin close-by led addicts to stay in encampments in the Kensington area of Philadelphia even though the city had available shelter space.

Variation in Encampments

Researchers and other experts have not yet developed a single, standard set of criteria defining a group of people experiencing unsheltered homelessness as an "encampment." In this review, the definition we used encompasses a wide variety of scenarios—from established settlements that have a well-defined set of mutually agreed-on and enforced rules to loose congregations that have little to no organization or cohesion. In this section, we describe what our literature search and key informant interviews revealed about the variation among encampments in resident characteristics and social structure; we then summarize how encampments may vary in different parts of the United States.

Resident Characteristics, Social Structure, and Motivations of Residents

The literature has little to say about characteristics that distinguish people experiencing unsheltered homelessness in encampments from those who experience unsheltered homelessness on their own. The U.S. Interagency Council on Homelessness is leading an effort to analyze data records for people experiencing homelessness, along with partner organizations including U.S. Department of Housing and Urban Development, the National Alliance to End Homelessness, California Policy Lab (a nonprofit partnership between the Universities of California Los Angeles and Berkeley), and the consulting firm OrgCode. That effort will provide insights into the characteristics and experiences of people experiencing homelessness in unsheltered locations, including whether they are distinctly different from people who experience sheltered homelessness; however, the data will not make it possible to distinguish people in encampments from people in unsheltered locations generally.

Some studies describe variations in the racial and ethnic composition of encampments. For example, one study conducted outside Orlando, Florida, engaged 39 people staying in encampments in focus groups. Nearly three-fourths of participants were men, and most were White—a demographic composition characterized by the local outreach team as generally representative of people experiencing unsheltered homelessness in the area. In contrast, downtown shelters in Orlando had a much larger population of African Americans (Donley and Wright, 2012). Seattle's evaluation of its sanctioned encampments also found fewer people of color in encampments relative to emergency shelters (City of Seattle, 2017). The demographic makeup of people staying in encampments in Oakland, California, seems to include a larger share of people of color, but individual encampments are segregated along racial and ethnic lines (Jones et al., 2015).

The internal organization and motivations of residents significantly vary among encampments. Some encampments have a strong social structure and organization, sometimes with oversight or assistance from local charitable or faith-based organizations. Residents may be required to assume responsibility

for day-to-day operations, including security patrols and other duties (City of Seattle, 2017; Lutz, 2015). Residents may vote in governance decisions, and they may be expected to attend weekly resident meetings in accordance with an encampment-wide code of conduct (Sparks, 2017a). A key informant conducting research on encampments described the social structure established by a group of mothers staying with their children in a recently cleared encampment in Oakland, California. Residents of the encampment prohibited drug use and shared responsibility for childcare. These expectations promote a sense of community and have been credited with helping encampment residents "feel human" and believe that they have something to contribute (Sparks, 2017b).

Other encampments have less cohesion and more informal rules and structure, which may on occasion result in friction and conflict among residents (Sparks, 2017a). Larger encampment "communities" may be less cohesive than smaller groups composed of family members and friends (City of San Francisco, 2015). In addition, the potential for exploitation exists in encampments, according to key informants conducting research on encampments. For example, younger people may offer to provide protection to older residents but then expect some form of compensation in exchange. Encampments formed around access to opioids in Philadelphia seem to have no leadership structure at all; however, according to a key informant conducting research on encampments, rarely do people living in an encampment have a complete lack of interaction with each other. People staying together in encampments tend to look out for one another and have some sense of solidarity.

Motivations of encampment residents may differ, as well. According to key informants who are helping communities develop responses to encampments, some residents of encampments are eager to access services and permanent housing. Others clear out in advance of a sweep, even if the sweep may provide them with access to services. Such variation might occur within one encampment if it is large enough. For example, when more than 700 people were cleared from the Santa Ana River encampment in Orange County, California, some people accepted help and were able to find housing or went to drug treatment centers, whereas others simply left for another encampment. When encampments have formed in areas that provide dependable access to illegal drugs in general and opioids in particular, referrals to housing and services are likely to be met with a mixed reaction, depending on the timing of individual residents' addiction trajectories and the characteristics of the shelters that are an alternative to staying in the encampment.

Regional Differences in Encampments

Cities in the Northeast, where winters can be harsh, are more likely than cities in other parts of the country to have relatively large shelter systems. According to a key informant who is conducting research on homelessness, this difference in the homelessness services system is reflected in the characteristics of people experiencing unsheltered homelessness, including those who stay in encampments. According to her observations, in cities with large numbers of shelter beds, the unsheltered population tends to have high rates of disability and mental health issues, which may create challenges to entering shelters. In contrast, in West Coast cities with limited shelter availability (or where barriers to shelter use are higher), the unsheltered population represents a greater mix of people, including those who do not have behavioral health disabilities but are unable to access shelter for other reasons. They may be recently homeless and unfamiliar with the shelter system, or they could be unwilling or unable to comply with the requirements of relatively high-barrier shelters on the

West Coast, or they may simply be unable to find an available shelter bed. As on the East Coast, many people in West Coast encampments are not able to tolerate or navigate the shelter system because of mental health or substance abuse disorders; however, West Coast encampments are also likely to include people who do not face those challenges.

According to researchers in the San Francisco Bay Area, those who stay in encampments may even have support from family members who visit regularly and bring food and medication or who invite them in to shower and do laundry (Jones et al., 2015). According to key informants who are researching encampments in the West, people who are now staying in encampments in western states could maintain stable housing without supportive services if they had rental assistance or other income support. For those individuals, the lack of access to affordable housing and shortages of shelter beds are the primary factors driving them to experience homelessness in encampments.

The physical nature of encampments often reflects regional differences in the geographic setting, including the natural features and available land. For example, an encampment in Southern California's Coachella Valley consists of a variety of structures detached and spread out across a contiguous area. In Columbus, Ohio, encampments are composed of tightly clustered tents and lean-tos. In San Francisco, people form encampments along the edges of highways and train tracks and under elevated freeways. In Las Vegas, encampments can be found in an underground tunnel system. The location of encampments balances two factors: maximizing convenience (that is, ease of access to the resources people use to address their daily needs) and minimizing visibility (that is, avoiding complaints to the city that could result in the encampment being cleared) (City of San Francisco, 2015).

Regional variation in encampments may also reflect the different ways that cities respond to encampments. Section 3 presents a typology of community responses to encampments and discusses the evidence—at this point, scant—on the effectiveness of those various approaches.

Community Responses to Encampments

Local responses to encampments are evolving in many communities, as stakeholders seek to identify the best strategies to address this growing phenomenon. Approaches vary along many dimensions but can be broken into four basic categories, as described in Exhibit 3. Specific activities range from sending police to quickly clear ("sweep") the encampment—providing little or no support to help people find another place to stay—to formally sanctioning encampments and providing onsite services.

Communities commonly use more than one response at a time to manage encampments, depending on resource availability, the location of encampments, and the characteristics of people congregating in encampments. For example, Las Vegas has created the Courtyard, a one-stop resource center that includes secure space to sleep outside, but it also deploys outreach teams that include law enforcement officers to clear encampments. Jurisdictions within the same region may adopt different strategies to address encampments. According to key informants helping communities to develop responses to encampments, communities may need to use a variety of approaches at the same time to serve populations that have different needs. When those efforts are not well coordinated across departments or neighboring jurisdictions, however, they may act at cross-purposes. For example, a jurisdiction that clears encampments, with little notice and no support, may undermine efforts to build relationships and trust in a neighboring jurisdiction that tacitly approves encampments.

Exhibit 3. Typology of Responses to Encampments

Category	Characteristics
Clearance With Little or No Support	• Notice of pending sweeps provided only a few days in advance, if at all • Belongings stored for a short period of time, if at all • Few or no shelter or service referrals provided • Regulatory or physical barriers to secure the site of the former encampment and keep it from being reoccupied
Clearance With Support	• Notice of pending sweeps provided weeks in advance, often by trained outreach workers who have experience working with people experiencing unsheltered homelessness • Longer term storage of belongings available • Referrals to shelter or services provided by outreach workers, who also accompany the first responders and sanitation crews who clear encampments

Category	Characteristics
Tacit Acceptance	• Encampments allowed to persist regardless of whether laws or ordinances explicitly authorize or prohibit their existence • Longer term storage of belongings available • Basic services or infrastructure provided, in particular to address public health and sanitation concerns (for example, portable toilets, showers, and potable water) • Outreach workers may visit the encampment to provide referrals to permanent housing, shelter, and services
Formal Sanctioning	• Encampments permitted by law or ordinance on public and or privately owned property, usually only in designated locations • May have established rules that govern the size, location, or duration of encampments • May have a public agency or nonprofit organization manage encampments • Infrastructure and public services—which may include laundry and potable water, common spaces for eating and meeting, lockers for storing belongings (including on a longer term basis), meal services and food donations, job training programs, access to mail and voice mail services—provided by the municipality and private or faith-based organizations and volunteers • May provide case management, including assistance applying for transitional or permanent housing and other benefits, appealing denials, and managing funds

Cities also use strategies to prevent encampments from forming. Some communities enact laws prohibiting activities associated with encampments, such as lying down or erecting structures on public space. More than one-third of U.S. cities have adopted camping bans, citing health and safety concerns (National Coalition for the Homeless, 2016). Researchers at the University of Denver identified more than 350 antihomelessness ordinances in Colorado's largest cities (Adcock et al., 2016). Other approaches include physical modifications to the built or natural environment, such as securing vacant lots and buildings to restrict access, clear-cutting brush that could provide cover for encampments, and installing sprinklers in areas where encampments might form (Chamard, 2010; National Law Center on Homelessness and Poverty, 2014). When an encampment is cleared, with or without support, the community may also impose new regulatory or physical barriers to keep the encampment from reemerging in the same location or in other parts of the community.

Factors that Drive Local Responses

Cities respond to encampments for a variety of reasons, and the goals of the interventions may vary—from cleaning up a business area, to helping people access shelter, to helping people obtain permanent housing. Even within the same jurisdiction, different stakeholders may have different definitions of success in dealing with encampments. For example, the transit authority may have a goal of breaking up encampments adjacent to a railroad bed, the department of public health may want to prevent the

spread of disease, the housing department may be working to end homelessness, and community homeless advocates may be focused on avoiding adverse consequences for the encampment population. Those differing views will also influence the strategy, or set of strategies, used by the city to address encampments (Burness and Brown, 2016; Jones et al., 2015) and can make comparing interventions across communities difficult. The factors that were most commonly cited in the literature as influencing cities' approaches to encampments are (1) community and political pressure, (2) resource availability, and (3) fear of litigation.

Community and Political Pressure

According to researchers and key informants who are helping communities devise strategies to address encampments, the "nuisance" factor is the key policy driver. Outreach teams or police usually are deployed only when community residents or other stakeholders complain about an encampment. At that point, interventions need to be visible and quick to demonstrate responsiveness to community concerns and to relieve political pressure (National Law Center on Homelessness and Poverty, 2014). In the absence of sufficient resources to move everyone into permanent housing, communities often employ a clearance strategy, with or without support, that moves people out of sight or farther from central business districts, where their presence can affect economic growth (Speer, 2018b).

Cities typically prioritize efforts in neighborhoods where political pressure is greatest. Not surprising, those neighborhoods often are not the locations with the highest levels of unsheltered homelessness and encampments, according to key informants who are helping communities devise strategies to address encampments. In areas with low visibility, with little or no community pressure, cities may pursue a policy of tacit acceptance—even if encampments exist in violation of a no-camping ordinance (Herring, 2014).

Resource Availability

Concern for community and resident well-being would, ideally, be the primary factor shaping cities' encampment response strategies; however, resource limitations may require city leadership to make trade-offs and choose an approach that works within existing constraints (Herring and Lutz, 2015; Loftus-Farren, 2011; National Law Center on Homelessness and Poverty, 2014). In Philadelphia, for example, according to a key informant conducting research on encampments, recent efforts that could be characterized as clearance with a high level of support were limited to two of four known opioid encampments because the city lacked funding to provide services and shelter for people congregating in all four. Without the ability to provide rent assistance or needed services, the city adopted a policy of tacit acceptance at the remaining two encampments. Cities may also create sanctioned encampments in lieu of providing permanent rent subsidies, or cities may pursue clearance with little or no support if they lack the resources to provide any additional assistance.

Fear of Litigation

Fear of legal challenges influences how cities approach closing encampments. Local jurisdictions want to avoid being taken to court over due process and cruel and unusual punishment challenges, according to a key informant engaged in research on encampments. This concern is likely to grow following the September 2018 ruling of the Ninth Circuit Court of Appeals in *Martin v. City of*

Boise.[1] Courts have found that depriving homeless people of the rights to perform survival activities in public spaces when no alternatives are available violates the 1st, 4th, 5th, 8th, and 14th Amendments to the Constitution (Kieschnick, 2018; National Law Center on Homelessness and Poverty, 2014). In *Martin v. City of Boise*, the court held that "as long as there is no option of sleeping indoors, the government cannot criminalize indigent, homeless people for sleeping outdoors, on public property."

Some legal challenges have resulted in settlements, which generally call for minimum notice before clearance of encampments, requirements for storage of personal belongings, and compensation for people who are swept from encampments and for their attorneys (National Law Center on Homelessness and Poverty, 2017). In January 2018, advocates brought a lawsuit against officials in Orange County, California, following the clearance of a massive encampment along the Santa Ana riverbed. As of October 2018, elements of a preliminary settlement agreement were more expansive and included a commitment to provide proactive outreach and engagement, as well as referrals to services, before evicting people from encampments; development of "standards of care" by the county for homelessness services programs; drawdown of funds already available to support "programs, services, and activities" for people experiencing homelessness; adoption of due process protections; establishment of a method for formally addressing requests for accommodations under the Americans with Disabilities Act; and referrals to collaborative courts[2] to handle citations.[3]

Effectiveness of Various Responses

The effectiveness of responses to encampments may be thought of as creating positive outcomes for the people who stay in encampments, creating positive outcomes for the broader community, or both. At this point, research that attempts to measure any such outcomes in a rigorous way is limited. Findings from anecdotal reports in individual cities are not broadly generalizable or transferable. To begin to address gaps in existing knowledge, the National Alliance to End Homelessness, U.S. Interagency Council on Homelessness, and U.S. Department of Housing and Urban Development are working with state and local partners to develop and test strategies for addressing unsheltered homelessness, including encampments. The Arnold Foundation (2018) is exploring the effectiveness of interventions that first responders can use to address unsheltered homelessness. Those projects are still in the early stages and are complicated, according to a key informant, by the absence of baseline data from which to evaluate the effectiveness of the responses. According to a researcher currently working on encampments, intensive outreach work will be needed to establish study samples, and a

[1] The Ninth Circuit has jurisdiction over nine states in the western United States, including Alaska and Hawaii, as well as the District of Guam and the District of the Northern Mariana Islands.

2 Collaborative courts are an alternative justice model that focuses on treatment and behavior change (rather than sentencing) to help defendants improve their lives. Homeless courts are one type of collaborative court. According to the California Association of Collaborative Courts, these are "special court sessions held in a local shelter or other community site designed for homeless citizens to resolve outstanding misdemeanor criminal warrants." https://www.ca2c.org/types-of-collaborative-justice-courts/

[3] Orange County Catholic Worker et al. v. County of Orange et al., Joint Statement of Settlement Progress (Central District of California, 2018) https://scng-dash.digitalfirstmedia.com/wp-content/uploads/2018/10/oc-homeless-plaintiffs-lawsuit-settlement.pdf.

high level of resources will be required to track people's experiences over time and to measure outcomes, but those efforts will be necessary to develop appropriate policy responses.

Without the availability of strong evidence, cities adopt approaches that seem to be best practices. Local responses also depend on the community's goals and priorities, which may include reducing crime, eliminating health hazards, or improving a business district—and may or may not include housing people experiencing homelessness. In the following sections, we provide descriptive and inferential information on the factors that may determine the effectiveness of responses, including the approach selected, the characteristics of encampment populations, and available resources. We summarize the current state of knowledge for various types of approaches.

Clearance with Little or No Support

Cities that adopt a policy of clearance with little or no support may justify this approach as "tough love" that encourages people in encampments to enter city-operated shelters (Lutz, 2015; National Coalition for the Homeless, 2016). The literature and key informants, however, agree that sweeps of encampments do little to increase shelter usage or otherwise resolve the problem of encampments (National Law Center on Homelessness and Poverty, 2014). Especially in communities with many low-visibility places, people are likely to simply pack up and move on to another location (Junejo, Skinner, and Rankin, 2016) or reestablish the encampment at the former site once the city has cleaned the area.

Clearance with little or no support may actually *reduce* the likelihood that people will seek shelter because it erodes trust and creates an adversarial relationship between people experiencing homelessness and law enforcement or outreach workers. In a survey of encampment residents in Honolulu, 21 percent of respondents said that they were less able or likely to enter shelters after sweeps, and 68 percent said that the sweeps had no effect on whether or not they went to shelters, although those responses seem mostly to be the result of undesirable shelter conditions (Dunson-Strane and Soakai, 2015). Another study conducted in Seattle finds that only one-third of encampment residents "accepted offers of alternative shelter after a sweep" (Junejo, Skinner, and Rankin, 2016: 16). Analyzing interviews with both outreach staff and encampment residents in Oakland, California, Jones and his colleagues hypothesized that continuous sweeps cause people experiencing unsheltered homelessness to "focus on short-term needs and immediate coping strategies," disrupting the level of stability necessary for encampment residents to engage in long-term planning (2015: 82). People forced to relocate during a sweep may have difficulty reconnecting with outreach workers who have been working with them, and any progress made toward moving into housing or accessing services could be lost. Experiences in Honolulu, Seattle, and Oakland suggest that sweeps are disruptive to people who are attempting to stabilize their lives and find a pathway to housing, and they may have lasting traumatic psychological and emotional impacts (Jones et al., 2015; Junejo, Skinner, and Rankin, 2016).

Clearance with Support

The support provided in responses that can be characterized as clearance with support may include extensive outreach in advance of clearance and referrals to existing shelters or housing programs. Communities may also make changes to policies on eligibility and rules for supportive housing or

drug treatment programs. They may create entirely new programs to facilitate entry by people formerly staying in encampments. For example, San Francisco created a new type of shelter, Navigation Centers, to provide shelter-averse people with room and board and access to case management and other services provided by public, nonprofit, and faith-based partners. The low-barrier model waives many of the policies commonly cited as obstacles to shelter: Navigation Centers do not have sobriety requirements, and people may come with their pets and partners, bring their belongings, and stay all day—there are no required entry or exit times. Space in the Navigation Centers is limited, however, and drop-ins are not accepted; instead, access is determined by the city's Homeless Outreach Team (SF HOT) case by case as space becomes available, with a focus on serving the most vulnerable people in San Francisco's encampments. Considerations by the outreach team include the length of time someone has been experiencing homelessness, shelter usage over a 6-month period, and motivation to move to permanent housing (San Francisco Health Network, 2018). Some evidence suggests that people strategically make themselves visible on the street in areas where the SF HOT will be making referrals so that they can gain access to the Navigation Centers, but no evidence indicates that people leave shelters in pursuit of a referral to a Navigation Center (City of San Francisco, 2015).

An evaluation of efforts to clear two encampments in Philadelphia's Kensington neighborhood provides a comprehensive look at another approach to clearance with support. After intensive and continuous outreach to and engagement of people staying in the Kensington encampments, outreach workers offered their clients emergency shelter in low-barrier "respite" and "navigation" centers, with access to case management and drug treatment services. The city also relaxed shelter admission requirements and rules and expectations for residents (Metraux et al., 2019). According to key informants developing policies to address such "drug encampments," enrolling people who are addicted to opioids and other substances into rehabilitation services may be difficult. Efforts to streamline access to drug treatment, however—including waiving requirements for identification and preauthorization and helping people get their documents in order—may ensure that treatment is available to them when they are ready to accept it.

Several key informants reported that communities are beginning to add social workers or community mental health workers to outreach teams. Law enforcement officials often are the only people on call to handle complaints around the clock, and community members may be more likely to call the police than to call a homeless hotline. When outreach teams include trained members, they can offer referrals to services and can begin to establish trust and build relationships with people experiencing homelessness in encampments. Without adequate funding for affordable, bridge, or permanent supportive housing, however, clients may end up back in encampments despite a robust outreach effort.

As of this review, policymakers and practitioners are developing promising practices to support residents of cleared encampments, and researchers are developing descriptive data and hypotheses for testing that approach.

Tacit Acceptance

Some cities tacitly accept encampments, not through sanctioning by law but by a lack of enforcement or by selective enforcement. Cities may tacitly accept homeless encampments to reduce the costs of

enforcing anti-camping ordinances or ordinances that prohibit lying down or sitting down in public places. Homeless people are permitted to congregate in areas that do not generate complaints from local businesses and residents (Herring, 2014). In Fresno, California, for example, police have carried out a more active clearance approach in the higher rent, downtown business districts, but they take a hands-off approach within an abandoned industrial zone (Herring, 2014; Speer, 2018b). In some cases, cities may provide basic services, such as potable water and security, without formally sanctioning the encampment (Loftus-Farren, 2011), and outreach workers charged with helping people resolve unsheltered homelessness may focus on people staying in the tacitly accepted encampments. In addition to having political reservations to sanctioning encampments, city officials may refuse to formally sanction encampments "on the grounds of increased liability, expenditures, and conflicts with health and zoning codes" (Herring, 2014: 298).

The literature we reviewed did not provide any indication of the effectiveness of tacit acceptance of encampments either in helping people resolve the circumstances that made them homeless or in limiting the negative consequences of encampments for the community.

Formal Sanctioning

Some cities formally sanction encampments through a variety of mechanisms: issuing temporary use permits; changing land use and zoning ordinances to permit encampments (which may place limits on the duration and number of people at each site); and creating designated campgrounds that have standards for operations and services to be provided on site. Some sanctioned encampments are managed publicly; others are self-governed but have public and private assistance and oversight.

- ***Publicly managed encampments.*** In some cases, sanctioned encampments are created and operated by the city, sometimes with nongovernmental community partners. Establishment of those encampments often is motivated by a desire to contain people who are unsheltered in a specified area where service delivery can be concentrated and public health risks controlled. For example, in 2017, the City of Las Vegas established the Courtyard Homeless Resource Center, where people can sleep in a secure, open-air, and sheltered courtyard with access to an array of amenities. The Courtyard is funded with public dollars and is currently operated by the city, with medical, employment, and other services provided on site through a variety of partners (City of Las Vegas, 2018).

- ***Safe parking programs*** provide similar structure and access to services for people who are experiencing homelessness and using a car, van, or RV as their primary place of shelter. People staying in their vehicles apply for a permit to safely and legally park overnight in designated lots that typically have some form of security and access to restrooms and other sanitation facilities. These programs are intended to offer transitional assistance for people who are interested in securing permanent housing and, as such, the programs provide access to extensive case management and other social services. Most programs use background checks to screen out sex offenders and recent violent felons, and program participants are required to have their own car insurance and comply with program rules and regulations. Safe parking programs are most common in West Coast cities. Program data from local jurisdictions in California indicate that participants have successfully accessed housing,

although rates of placement vary widely, from 5 percent in Santa Barbara to 65 percent in San Diego (Homelessness Policy Research Institute, 2018).

- ***Self-governed encampments with public and private assistance and oversight.*** Rather than establishing new areas for unsheltered people to congregate, some cities sanction existing encampments. This process typically involves establishing a legal framework for their continued existence and organizing services but allowing the encampment to continue as a self-governed enterprise. In 2011, the Seattle City Council adopted an ordinance to permit transitional encampments as an "accessory use" on land owned or controlled by a religious organization and established health and safety standards for those encampments. A similar ordinance passed in 2015 extended those standards to city-owned or private, nonreligious property. Seattle's Human Services Department selected several nonprofit organizations with experience supporting unsheltered homeless people to provide service-enriched case management, including referrals to diversion programs and shelters, access to legal services and rapid rehousing programs, and employment training and educational referrals at three newly established, permitted encampments (City of Seattle, 2017).

  In a city-sponsored evaluation (City of Seattle, 2017) that attempted to assess the effectiveness of formal sanctioning, Seattle documented a positive response from communities around the new encampments. Data and information about crime levels collected by the Seattle Police Department suggest that crime has not significantly increased in the areas surrounding the encampments since they were established. Authors of the evaluation view the self-managed governance structure positively, as an opportunity for residents to build confidence and leadership skills. Between September 2015 and May 2017, 759 people stayed in Seattle's six permitted encampments, and 16 percent (121 people) transitioned to permanent housing. It is unclear how generalizable these findings are to other communities.

Sanctioned encampments are best understood as an interim solution to address the immediate conditions of people experiencing unsheltered homelessness. Such encampments are not themselves a solution to homelessness, and cities will need to invest in permanent solutions, such as housing that is affordable to extremely low-income people, permanent supportive housing, mental health services, affordable healthcare, and perhaps also supervised drug consumption sites and low-barrier employment opportunities (Junejo, Skinner, and Rankin, 2016; Loftus-Farren, 2011; Parr, 2018). Currently, limited evidence suggests that sanctioned encampments help to reduce homelessness; we also do not know whether certain types of sanctioned encampments are more effective than others.

Limitations of the Current Evidence on Encampments

In this section, we describe limitations in the rigor and scope of the literature considered in preparing this review, as well as challenges to collecting data on the encampment population. We conclude with some recommendations for additional research found in the published literature or made by key informants interviewed as part of this scan of current evidence on encampments.

Scope and Rigor of the Current Literature on Encampments

Research on the nature and causes of homeless encampments is still in the nascent stages, as is evaluation of community responses to encampments. In many ways this is parallel to the state of research on homelessness during the 1980s, when modern homelessness, sheltered and unsheltered, first became apparent and was the focus of news reports and efforts to document and understand the phenomenon. As of late 2018, the research literature on encampments is primarily descriptive, relying on reviews of articles in the news media, along with some ethnographic research and fieldwork that includes interviews with encampment residents, service providers, city staff, and community members. Administrative data are used in only a few cases (Metraux et al., 2019; Speer, 2017). In general, sample sizes are small, with analysis limited to interviews with a small number of community stakeholders or encampment residents.[4] Researchers almost exclusively use convenience samples rather than representative samples of encampment populations. Evaluators have not yet begun to use methods that compare the results of a response to encampments with what would have happened in the absence of the policy or practice.

So far the literature focuses heavily on West Coast cities, especially Fresno and San Francisco, California; Portland, Oregon; and Seattle, Washington. An exception is a descriptive study by the National Law Center on Homelessness and Poverty (2014) that deliberately focuses on East Coast and Southern cities.[5] The ethnographic research reviewed for this paper focuses on people in encampments that are sanctioned, either formally or tacitly. This type of research, which relies on observation of people and conditions within encampments, would be more difficult to carry out in communities that have an encampment clearance policy.

Our scan of the literature identified only one study that begins to develop standards for evaluating the effectiveness of various responses to encampments. Jones and his colleagues (2015) provided standards for three criteria—effectiveness, equity, and implementation feasibility—and use them in connection with resident, service provider, and stakeholder interviews to assess whether alternative approaches would be more effective than a current policy of clearing encampments in Oakland, California (see Appendix B for a description of the study). Some local jurisdictions have started to track housing placements among people who formerly stayed in publicly sanctioned encampments

[4] Research methods and rigor differ little between the peer-reviewed literature and the reports of public agencies and other organizations. Both types of literature rely heavily on media reports and on qualitative interviews.

[5] The cities are Lakewood, New Jersey; New Orleans, Louisiana; Providence, Rhode Island; and St. Petersburg, Florida.

(City of Seattle, 2017; Hunter et al., 2016), but assessing how rigorous and successful those tracking efforts will be is difficult.

Little information is available on the direct and indirect community costs associated with encampments. Some reports provide partial accounts of the costs of various activities associated with local responses to encampments. None attempt a rigorous analysis of the costs of a response type or a comparison with the costs of other interventions for people experiencing homelessness. Adcock and her colleagues (2016) provided a thoughtful methodology for calculating the cost of enforcing ordinances that criminalize homelessness in Denver and the state of Colorado, but that analysis pertains to unsheltered homelessness in general; it is not limited to encampments. Some case studies report expenditures associated with various activities related to encampments (City of Seattle, 2017; Jones et al., 2015). Complicating the documentation of costs, encampment-related expenditures often are spread across multiple agencies and contracts (for example, department of public works for refuse disposal, department of human services for case management), sometimes without a budget category or line item specific to encampments (Junejo, Skinner, and Rankin, 2016).

Challenges to Collecting Data on People in Encampments

Some local jurisdictions have started to collect and report data on the characteristics of people who stay in encampments. The types of information collected include these:

- Basic demographic data, such as gender, age, race, veteran status and discharge type, and first language (City of Seattle, 2017; Metraux et al., 2019)
- Earned income or benefits receipt (City of Seattle, 2017)
- History of domestic violence (City of Seattle, 2017)
- Physical and mental health conditions (City of Seattle, 2017)
- Duration of homelessness (City of Seattle, 2017; Hunter et al., 2016; Metraux et al., 2019)
- Current living conditions (Metraux et al., 2019)
- Where they were staying before the encampment (City of Seattle, 2017; Hunter et al., 2016)
- Potential barriers to entering shelter, such as pets, partners, or a significant number of belongings (Hunter et al., 2016)

That type of data may be collected during the intake process at sanctioned encampments, through outreach to people staying in tacitly accepted encampments, or during the process of encampment clearance. One of the key challenges of any data collection effort associated with encampments is capturing a representative sample of people. As described by a key informant who is conducting research on encampments, people who stay in unsanctioned encampments often strive to keep off the public radar, and they may differ in important ways from the subset of people who are visible for data collection efforts. According to this key informant, outreach workers are generally better received when they make low demands, offer something that people in encampments might want or need, and share demographic characteristics or lived experiences with those in encampments. People who stay

in encampments may be wary of authority figures and are more likely to welcome outreach workers who do not act or present as such. These same considerations may also apply to sanctioned encampments.

Data collection efforts are also hampered by the transient nature of people experiencing unsheltered homelessness and the limited capacity of outreach teams to comprehensively canvas the less visible and less accessible geographies within their communities. Intensive and time-consuming outreach and follow-up efforts are required to collect information about encampment residents over time. Mental illness and substance use can also complicate data collection because the responses of affected individuals to questions may be unreliable.

Suggestions for Additional Research

As part of this review of the current evidence base on encampments, we gathered suggestions from the key informants we interviewed—people who are conducting research on encampments or advising communities on strategies for addressing encampments—for additional research that could advance the field in a variety of ways. Some of the published literature we reviewed also included suggestions for additional research that would support deeper understanding of the nature of encampments and would inform program design going forward. These ideas for additional research include the following:

- ***Understanding the characteristics of people who are living in encampments.*** What are the characteristics of people in encampments, including their immediate past experience? Are they different in meaningful ways from other people experiencing unsheltered homelessness? Are there significant differences in the characteristics of people who live in different types of encampments—for example, in groups of cars or other vehicles compared with encampments of tents or other structures? How long have they lacked stable housing? Where were they living before their stay in the encampment? What were their circumstances that contributed to them staying in an encampment? How often are families with children living in encampments, and how are their characteristics, needs, and vulnerabilities different from those of individual adults? This type of information could help to improve the targeting of efforts to prevent homelessness and stays in encampments.

- ***Understanding the experience of people experiencing unsheltered homelessness in encampments***. How do they spend their days? How long do people stay in encampments, and where do they go when they leave encampments (how often do people continue to experience unsheltered homelessness, how often do they find housing, and how often do they go to shelters or other settings, including treatment programs)? What are their service utilization patterns and the costs of their service use? With a better understanding of the behaviors and needs of people who are living in encampments, practitioners and policymakers can design and implement more effective interventions that meet those needs. Research projects can draw on integrated data systems, real-time surveys, and interviews with people with lived experience. Some of the best early opportunities may be in states and local jurisdictions that already link data systems.

- ***Understanding the relative effect of interventions currently in use.*** Do people who receive extensive outreach and referrals in advance of an encampment clearance fare better than those who stay in formally sanctioned encampments? Do outcomes vary depending on who conducts the outreach? Do sanctioned encampments achieve higher rates of exits from homelessness than do other approaches to ending homelessness for unsheltered people? Do the outcomes of people who formerly stayed in encampments differ over time, depending on the type of assistance they receive?

- ***Exploring racial/ethnic disparities in access to the homeless services system.*** Studies in Oakland, Orlando, and Seattle point to the possibility of racial segregation, and perhaps self-segregation, of encampment populations—and, by inference, of populations using shelters. Research could explore the reasons for these patterns, including possible barriers to entry into shelters or to programs providing permanent housing that affect particular racial/ethnic groups.

- ***Understanding community responses to the presence of encampments.*** What are community members' expectations regarding responses to unsanctioned encampments in their neighborhoods and approaches to resolving them? How are community members' responses shaped by stigma or bias related to race, homelessness, poverty, mental health needs, and substance use? How do community members respond to sanctioned encampments, and are factors present that determine whether sanctioned encampments experience more or less acceptance? What strategies can public and private agencies use to keep community members informed of their approaches to assist people living in encampments?

Conclusion

In recent years, encampments of people experiencing homelessness have become pervasive in communities across the United States. They can be found in busy neighborhoods in large cities, isolated rural areas, and everywhere in between. Encampments may be as small as a cluster of 8 to 10 households next to a highway entrance ramp, or they may encompass multiple structures scattered across several acres of parkland or industrial areas. The encampments that are visible to outside observers take many forms, including tents, lean-to shacks and shanties, and groups of cars or vans; other encampments that are not so visible are hidden in manmade infrastructure or natural features. The motivations and circumstances of people staying in encampments are as varied as their size, shape, and location.

Despite this diversity, at the root of all encampments is a need for greater investment of resources to address severe shortages of affordable housing. Absent this commitment, people experiencing homelessness are forced to find other places to stay, and encampments may be the best alternative among a limited set of options. Articles in the peer-reviewed and gray literature document a consistent set of factors that contribute to people's decisions to stay in encampments rather than in shelters or in other, unsheltered locations. Shortages in the availability of shelter beds, policies that create barriers to entry, and undesirable conditions inside shelters all influence people to seek an alternative place to stay. When shelters cannot fulfill their needs for safety, sense of community, and the freedom to come and go at will, people experiencing homelessness may decide to stay in encampments.

Local jurisdictions are pursuing a variety of strategies to address encampments and the challenges they pose to health, safety, and well-being. The most rudimentary of those approaches is to "sweep" encampments, the primary goal of which is clearing out the people staying in them. Preliminary evidence suggests that this response of clearance without support results in disruption and trauma for inhabitants of the encampments but does little to resolve the problem. Encampments are quickly reestablished in a new location or even back on the recently cleared site. We know little about the effects of other responses that provide support to people in encampments, including responses that allow encampments to persist—through either tacit acceptance or formal sanctioning—and clearance efforts that are accompanied by outreach and referrals to housing and services.

Communities are experimenting with new service approaches to assisting people living in encampments. The Navigation Centers that were first established in San Francisco now are being replicated elsewhere but, so far, not based on strong evidence of their effectiveness. The logic is that removing many of the barriers that cause people to seek alternatives to emergency shelters and including intensive case management to help clients secure permanent housing will prevent encampments from forming and provide a transition to permanent housing for people moved out of encampments. Other cities are relaxing admission requirements for drug treatment programs to expedite entry by people in encampments. Still others are pairing first responders with trained outreach workers who can help make connections to appropriate services. More research will be needed to assess the results of these and other initiatives.

We do not know enough about the characteristics and experiences of people who stay in encampments. Collecting even baseline information can be difficult when many people actively try to escape public notice. Data collection challenges also complicate efforts to understand the costs and effectiveness of public responses to encampments. Practical and political barriers will have to be overcome to arrive at meaningful findings that can inform policymaking and practice.

This review of what we know as of late 2018 about encampments is part of a larger study sponsored by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, and the U.S. Department of Housing and Urban Development, Office of Policy Development and Research that will help increase the body of knowledge. We will use interviews with stakeholders in nine communities and site visits to four communities to collect information on the causes and characteristics of encampments and on community responses to encampments. The site visits to four communities also will attempt to document the public costs of various strategies for addressing encampments.

Appendix A. Methods Used to Conduct the Literature Review and Interviews with Key Informants

Scan of Peer-Reviewed Literature

To identify relevant peer-reviewed literature, we searched EBSCO Discovery Service, which provides a comprehensive search of academic journals and databases, and Google Scholar. Specific search strings and limiters used are listed in Exhibit 4.

Exhibit 4. Search Strings and Limiters

Search string used:

- "homeless encampment" OR "tent city" OR "homeless settlement" OR "homeless camp"

Limiters used:

- Peer-reviewed journals
- Published on or after January 1, 2011
- Published in English

We compiled references and abstracts from all database returns using Zotero software. We then reviewed all abstracts, identifying 43 articles for retrieval and further review. We excluded articles if they focused on encampments serving a non-homeless population, such as refugees or protesters. We also excluded research on homeless encampments in an international context because experiences with encampments and unsheltered homelessness in other countries diverge in important ways from the experience in the United States.

We identified 16 articles from more than 500 returned results that addressed the research questions shown in Exhibit 1 in the introduction. Those 16 articles include several written by the same primary author that draw on a single dataset. Under other circumstances, we might exclude a portion of the similar articles from review; however, given the small body of research on encampments, we opted to consider them all.

Scan of Gray Literature

We searched websites of government agencies, nongovernmental organizations, and academic institutions to supplement the peer-reviewed literature and identify relevant unpublished literature, white papers, presentations, and research briefs. When a website included a search function, we used the search string identified in Exhibit 4 to identify relevant resources. We also scanned relevant website sections for pertinent materials.

We found reports, publications, and conference proceedings on the official websites of the following agencies and organizations: U.S. Department of Justice, National Alliance to End Homelessness, National Coalition for the Homeless, National Law Center on Homelessness and Poverty, Seattle University School of Law, University of Denver Sturm College of Law, and San Francisco Office of

the Controller. We identified 41 documents through this process, 17 of which were determined to be relevant to this project.

We identified additional resources during interviews with key informants and by following references in the peer-reviewed and gray literature.

Interviews with Key Informants

We conducted interviews with key informants to augment information collected during the literature reviews. We identified an initial list of interviewees based on recommendations from the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, and the U.S. Department of Housing and Urban Development, Office of Policy Development and Research staff and from project team members with expertise in homelessness, substance use disorder, and criminal justice. We identified additional individuals by asking at the conclusion of each interview for suggestions of other academics or practitioners who may be studying encampments.

Exhibit 5 lists the key informants we interviewed.

During the interviews, we asked about ongoing research projects focused on the recent growth in unsheltered homelessness and encampments; the characteristics of people in encampments and the factors that lead them to congregate there; and communities' responses, including their costs and effectiveness. We also asked key informants targeted questions about specific research projects or programs, based on our background research.

Exhibit 5. Key Informants

Name	Title	Affiliation	Date Interviewed
Sharon Chamard, PhD	Associate Professor	University of Alaska, Anchorage	November 8, 2018
Dennis Culhane, PhD	Dana and Andrew Stone Professor of Social Policy; Co-Principal Investigator, Actionable Intelligence for Social Policy	University of Pennsylvania	October 16, 2018
Margot Kushel, MD	Professor; Director of the Center for Vulnerable Populations	University of California, San Francisco	October 25, 2018 December 27, 2018
Stephen Metraux, PhD	Associate Professor; Director of the Center for Community Research & Service	University of Delaware	October 26, 2018
Colleen Murphy	Manager, Coordinated Entry System Access	Los Angeles Homeless Services Authority	November 16, 2018
Barbara Poppe	Founder and Principal	Barbara Poppe & Associates LLC	November 2, 2018
Kelly Robson	Chief Social Services Officer	HELP of Southern Nevada	October 29, 2018
Nan Roman	President and CEO	National Alliance to End Homelessness	November 1, 2018

Appendix B. Summaries of Selected Studies

In this appendix, we provide details on the approach, methodology, limitations, and key findings from selected studies in the peer-reviewed and gray literature. These studies were particularly informative as we completed our review.

City of Seattle, Human Services Department. (2017). *Seattle Permitted Encampment Evaluation.* Seattle, WA: City of Seattle.

This internal evaluation assesses the performance of three temporary, permitted encampments in the City of Seattle in 2016: Ballard, Interbay, and Othello. The encampments were created by the city on public land. They are operated by nonprofit partners with oversight from the city's Human Services Department. The authors used HUD's Annual Performance Report, Seattle Police Department data, and stakeholder interviews to inform their analysis, which focuses on (a) determining whether temporary, permitted encampments are an effective homelessness response strategy, and (b) identifying areas where the model works well or could be improved. Data collection challenges include people departing from the encampment before they interact with a case manager, case manager staff turnover, and missing responses (client doesn't know/client refused, data not collected).

The Human Services Department found that several features contributed to the success of the encampments:

- Inhabitants of encampments benefited from being able to stay in one location for a longer period, as they could make progress toward stability goals and build relationships with the community.
- The self-management model used at all three encampments empowered inhabitants and enabled them to build confidence, camaraderie, and leadership skills.
- The provision of structured case management services, including referrals to local shelters and rapid rehousing when appropriate, referrals to employee training and education, domestic violence services, and access to a mobile medical van.

The evaluation concludes that Seattle's sanctioned encampment model is successfully serving people who have been living outside in greenbelts, on the streets, in cars, and in otherwise hazardous situations. The neighboring communities have responded positively, and crime did not increase significantly when a permitted encampment was established.

Donley, A., and J. Wright. 2012. "Safer Outside: A Qualitative Exploration of Homeless People's Resistance to Homeless Shelters," *Journal of Forensic Psychology Practice* 12 (4): 288–306. doi:10.1080/15228932.2012.695645.

This study examines why people experiencing homelessness in Orange County, Florida, stay in encampments instead of available rooms in local shelters. The authors conducted a series of five focus groups with 39 people who lived in the East Orange encampments. All participants were

recruited for the study by the Orlando Homeless outreach team. Each focus group averaged 2 hours in duration and included, on average, eight people from two or three camp sites. The study is limited by the small and localized sample size; in addition, although the study was published in 2012, the focus groups were conducted in February of 2007. The authors do not discuss local preventive or punitive ordinances with regard to encampments in Orange County.

Participants "described their experiences with downtown [Orlando] homeless services and downtown itself in negative terms and said they would not venture back downtown for any conceivable reason, no matter how many services might be available there." Although participants gave many reasons for this decision, the most prevalent themes centered on the undesirable location of shelter facilities, prior negative experiences with shelters, and the sense of companionship, freedom, and safety associated with encampments.

Herring, C., and M. Lutz. 2015. "The Roots and Implications of the USA's Homeless Tent Cities," ***City*** **19 (5): 689–701. doi:10.1080/13604813.2015.1071114.**

Herring and Lutz explain the resurgence of homeless encampments in the United States through comparative case studies of encampments in Fresno, California, and Seattle, Washington. They draw from interviews and field notes completed by both authors between 2009 and 2011, along with the preexisting peer-reviewed and gray literature on encampments. The authors chose to focus on Fresno and Seattle because those cities contain large, persistent camps—including some that are legally recognized and others that are illegal and tacitly accepted.

Herring and Lutz argue that homeless encampments were not rooted in the 2008 recession, nor can they be explained by a general expansion in the homeless population. Using their case studies as supplementary evidence, they conclude that the "crisis of welfare provision in the form of perpetual shelter shortages and repulsive shelter arrangements led homeless people to prefer large encampments and led advocates and city officials to recognize large encampments as legitimate shelter alternatives."

Jones, P., K. Parish, P. Radu, T. Smiley, and J. van der Heyde. 2015. ***Alternatives to Unsanctioned Homeless Encampments.*** **Berkeley, CA: Goldman School of Public Policy, University of California, Berkeley.**

The authors of this report interviewed Oakland, California, encampment residents, service providers, and city stakeholders to understand their needs and concerns. The needs assessment and interviews with Oakland stakeholders revealed that people living in encampments "face serious barriers to both housing and shelter use that makes unsanctioned camps their only viable alternative." Jones and his colleagues then studied best practice examples of two alternatives to Oakland's current approach of clearing encampments: (1) establishing city-sanctioned campgrounds and (2) adopting a Housing First approach. They examined those alternatives in four cities: Nashville, Tennessee; Ontario, California; Portland, Oregon; and Seattle, Washington.

Analyzing the data obtained from interviews in Oakland and the best practices from other cities, the authors assigned a score to each of these approaches (clearance, sanctioned encampments, and Housing First) with respect to three criteria:

- *Effectiveness*, defined as the "degree to which the policy in question addresses the immediate problems associated with homeless encampments, comprehensively and across both the short- and long-term."
- *Equity*, as a measure of the "differential consequences of the policy for different stakeholders or constituents" and that looks at the degree to which an intervention is likely to have disproportionate effects for any particular group.
- *Implementation feasibility*, or a city's capacity to implement each policy according to its original design.

The authors weighted the criteria to reflect stakeholders' stated preferences about the relative importance of each criterion. Effectiveness accounted for 50 percent of the score, equity for 30 percent, and implementation feasibility for 20 percent. Higher scores indicate more preferable alternatives for Oakland.

Jones and his colleagues conclude that Oakland officials could expect a city-sanctioned campground to perform best as measured by effectiveness, equity, and implementation feasibility, followed closely by a Housing First approach. Although the authors found clearing encampments to be the most easily implemented, it scored lowest on effectiveness and equity. Despite efforts to coordinate with outreach services and give sufficient notice to camp residents, the process of clearing camps "prevents residents from complying with important housing or health appointments." In short, the status quo in Oakland as of 2015 "serves as a cyclical disruption for camp residents and creates an additional barrier on their pathway to housing."

Metraux, S., M. Cusack, F. Graham, D. Metzger, and D. Culhane. 2019. *An Evaluation of the City of Philadelphia's Kensington Encampment Resolution Pilot.* Philadelphia, PA: City of Philadelphia.

This report is an independent process evaluation of the City of Philadelphia's Encampment Resolution Pilot (ERP). The ERP is a cross-departmental city initiative that was established to close down two outdoor homeless encampments in May 2018. The ERP process included extensive outreach to and engagement of people staying in the encampments and the establishment of Navigation Centers to provide them with access to housing and drug treatment assistance and intensive case management. The city also took steps to prevent the encampments from re-forming through police monitoring, continued outreach and community involvement efforts, and physical changes to the site.

To evaluate the ERP, Metraux and his colleagues draw on an array of data sources that include city documents and interviews with key stakeholders and persons directly involved with implementing the pilot. In addition, the authors had direct access to planning and operational activities, and they conducted ethnographic observations at the encampments and in the surrounding community. They

used a semi-structured interview guide with a sample of residents at the two encampments targeted by the ERP to elicit open-ended responses in four topic areas: living situation, typical day, background and service use, and perspectives on the encampment closure.

The report uses this information to assess the planning, implementation, and initial outcomes of the ERP and to determine strengths and limitations of the pilot.

National Law Center on Homelessness and Poverty. 2014. *Welcome Home: The Rise of Tent Cities in the United States.* Washington, DC: National Law Center on Homelessness and Poverty.

This report documents the rise of homeless encampments and tent cities across the United States and the legal and policy responses to that growth. The authors reviewed media reports on tent cities published between 2008 and April 2012 as well as existing literature on the subject. They also conducted telephone interviews with experts and service providers. Based on this preliminary research, the authors identified four sites for in-depth case studies: Lakewood, New Jersey; New Orleans, Louisiana; Providence, Rhode Island; and St. Petersburg, Florida. The sites were chosen on the basis of their locations, the size and prominence of the former or current encampments they hosted, and their perceived usefulness for gaining a broader understanding of the causes of and responses to homeless encampments. The authors chose to focus on the East Coast because a report documenting tent cities on the Pacific Coast already existed.

Their media survey found documentation of more than 100 tent communities in 46 states and the District of Columbia. While maintaining that the existence of tent cities itself reflects a severe lack of affordable housing, the report finds that **"**when adequate housing or shelter is not available, forced evictions of tent communities may violate human rights, and may also violate principles of domestic law." The authors argue that tent cities are a result of the absence of other reasonable options. Where alternative housing facilities are insufficient, municipalities should work together with people staying in encampments "in a manner that prioritizes the autonomy and dignity of homeless individuals and allows them to have a voice in the process."

Sparks, T. 2017a. "Citizens Without Property: Informality and Political Agency in a Seattle, Washington Homeless Encampment," *Environment and Planning A: Economy and Space* 49 (1): 86–103. doi:10.1177/0308518X16665360

Sparks, T. 2017b. Neutralizing Homelessness, 2015: Tent Cities and Ten Year Plans. *Urban Geography* 38 (3): 348–356. doi:10.1080/02723638.2016.1247600.

Sparks bases these two articles on his 2006 ethnographic fieldwork, including 6 months living and participating as a resident in Seattle's Tent City 3. In addition to participant observation, during his time in Tent City 3, he conducted 50 in-depth interviews with people staying there.

In "Citizens Without Property," Sparks documents the history of Seattle's encampments and offers an explanation for why people experiencing homelessness often do not to take advantage of social services and shelters, even when they are available. That is, within encampments, people

experiencing homelessness have a venue to "respond, resist, and remake the political landscapes of homelessness" and to "challenge their marginalization and create more habitable and emancipatory spaces." Sparks centers his theory around the social and political structures in Tent City 3, which allow residents to feel responsible, be independent, and participate in camp activities—in contrast to the demeaning treatment received at shelters.

In "Neutralizing Homelessness," Sparks claims that the "medicalization and personalization of homelessness" serves to "stabilize and maintain homelessness in seeming perpetuity"—that is, because of this flawed view of homelessness, people experiencing homelessness are blamed for their situation rather than systems, structures, or societal conditions being blamed. Well-intended service providers accept the narrative of "homeless as pathology" and create an environment that dehumanizes people who might otherwise seek assistance, leading them to stay in encampments, where they can be seen as "normal" people.

Speer, J. 2017. "'It's Not Like your Home': Homeless Encampments, Housing Projects, and the Struggle over Domestic Space" ***Antipode*** **49 (2): 517–35. doi:10.1111/anti.12275.**

Speer, J. 2018a. "The Rise of the Tent Ward: Homeless Camps in the Era of Mass Incarceration," ***Political Geography*** **62: 160–169. doi:10.1016/j.polgeo.2017.11.005.**

Speer, J. 2018b. "Urban Makeovers, Homeless Encampments, and the Aesthetics of Displacement," ***Social & Cultural Geography*** **1–21. doi:10.1080/14649365.2018.1509115.**

In these three articles, Speer builds on interviews and ethnographic fieldwork conducted in Fresno, California, in 2013. Of the 24 people Speer interviewed, 9 were officials involved in homeless management, 8 were homeless, and 7 were local activists. She selected homeless participants from multiple racial/ethnic backgrounds, genders, and ages. The author returned to Fresno in 2016 to volunteer at an activist-led encampment and follow up with former research participants. To supplement fieldwork, Speer also relied on two local media sources and reviewed policy reports, legal documents, and online videos and radio programs depicting homeless activism and evictions. Speer believes Fresno to be an ideal city through which to examine the politics of home in relation to homelessness because of its large-scale encampments and intensive housing subsidy program.

"'It's Not Like Your Home'" focuses on how people staying in encampments define *home*. Participants appreciate the sense of community within encampments and the opportunities to exercise autonomy. Speer demonstrates that, by staying in encampments, "homeless Fresnans were creating a new kind of home in which individuals and families were part of a larger collective tied to each other through relations of mutual care."

"Urban Makeovers" probes the motivations behind Fresno's varying responses to homeless encampments. Drawing on personal interviews, media articles, and statements made by city officials and politicians, Speer claims that in the Fresno political discourse, homeless encampments are framed as "unpleasant objects that must be removed to make way for economic opportunities." Thus, "efforts to reinforce a 'live play work' aesthetic resulted in a politics of displacement and criminalization" as city officials worked to move those in encampments to the margins of town, sanction those marginalized encampments, and make them visually uniform and uncluttered.

"The Rise of the Tent Ward" goes beyond Fresno to look at city-sanctioned and -controlled encampments in King County, Washington; Ontario, California; Portland, Oregon; Reno, Nevada; and St. Petersburg, Florida. Speer terms these encampments as *tent wards* to reflect "how incarceration becomes enmeshed with the provision of care and shelter." She argues that these encampments "are not simply a cost effective form of shelter: they are a new node in a wider network of quasi-carceral spaces that govern homeless mobility" that "undermine structural efforts to address poverty and housing inequality."

Appendix C: Selected Practitioner Resources

In the course of conducting this literature review, the study team identified a number of resources that did not meet our criteria for inclusion in the review but may be informative for local leaders and practitioners who are seeking practical guidance on how to address encampments in their communities. We provide links to these resources below.

United States Interagency Council on Homelessness (USICH)

Following conversations with advocates, housing and services providers, and government officials, USICH prepared a suite of resources intended to help local communities develop an action plan to connect people experiencing homelessness in encampments with permanent housing. Those resources include a paper that discusses the key components of an action plan, a quick guide that provides an introduction to the concepts covered in the paper, and a planning checklist with action steps for each of the key components. Those resources were published in 2015 and are available for download at www.usich.gov/tools-for-action/ending-homelessness-for-people-in-encampments/.

USICH has also prepared a series of case studies of communities that are implementing strategies to address the housing and services needs of people experiencing homelessness in encampments. Published in 2017, the case studies describe lessons learned from the local experience in six communities: Charleston, South Carolina; San Francisco, California; Seattle, Washington; Chicago, Illinois; Philadelphia, Pennsylvania; and Dallas, Texas. Topics covered include the evolution of the city's approach to addressing encampments, key stakeholders and tips for engaging them, and challenges or surprises encountered in the implementation process.

In May 2018, USICH published a brief titled Caution is Needed When Considering "Sanctioned Encampments" or "Safe Zones". The brief urges communities to proceed with caution when considering the establishment of sanctioned encampments and lists key points to consider for those who decide to proceed. The brief concludes with a list of links to additional USICH resources.

Corporation for Supportive Housing (CSH)

CSH has made available for download an extensive set of templates, provider tools, and draft policies for addressing unsheltered homelessness. Although not specific to encampments, many of these resources may be helpful in working with people experiencing unsheltered homelessness in encampments. All resources are available for download at www.csh.org/communityresponse/.

National Alliance to End Homelessness

The National Alliance to End Homelessness publishes presentation notes and slide decks from sessions at its national conferences. Several sessions at recent conferences address encampments, including the following:

- Resolving Encampments: Evaluating Different Approaches (July 2018)
- Sanctioned Encampments: Questions You Should Ask (July 2018)
- Understanding Unsheltered Homelessness: What We Know So Far (July 2018)
- A Growing Unsheltered Population: Addressing Encampments (August 2016)

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EQUAL HOUSING OPPORTUNITY

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SPECIAL SECTION ON COVID-19: COMMENTARY



Homeless encampments: connecting public health and human rights

Ex # 9 m/d/y 08/30/2024 Pg 1 of 4
Exam of Dr. Stephen Gaetz
Heegsma et al v City of Hamilton
Nimigan Mihailovich Reporting Inc.

Nicholas Olson[1] · **Bernadette Pauly**[2]

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Abstract
The COVID-19 pandemic is exacerbating longstanding issues related to homelessness, including lack of affordable housing, unemployment, poverty, wealth inequality, and ongoing impacts of colonization. Homelessness is often accompanied by narratives rooted in individual blame, criminalization, and reinforcement of substance use and mental health-related stigma. Visible homelessness, in the form of encampments, is a manifestation of government policy failures that neglect to uphold the human right to housing, and demonstrate eroding investments in affordable housing, income and systemic supports. Encampments make visible that some in our community lack basic determinants of health such as food, water, sanitation, safety, and the right to self-determination. In order for public health to effectively and equitably promote health and enact commitments to social justice, we argue that public health must adopt a human rights approach to housing and to homeless encampments. Embracing a human rights perspective means public health would advocate first and foremost for adequate housing and other resources rooted in self-determination of encampment residents. In the absence of housing, public health would uphold human rights through the provision of public health resources and prohibition on evictions of encampments until adequate housing is available.

Résumé
La pandémie de COVID-19 exacerbe des problèmes de longue date liés au sans-abrisme, dont le manque de logements abordables, le chômage, la pauvreté, l'inégalité de richesse et les impacts continus de la colonisation. Le sans-abrisme s'accompagne souvent de discours narratifs ancrés dans le blâme personnel, la criminalisation et le renforcement de la stigmatisation de l'usage de substances et des troubles de santé mentale. Le sans-abrisme visible, qui prend la forme des campements, est un constat d'échec des politiques gouvernementales qui négligent de faire respecter le droit fondamental au logement, et il démontre l'érosion des investissements dans les logements abordables, le soutien du revenu et le soutien systémique. Les campements rendent visible le fait qu'il manque à certains membres de la collectivité les déterminants de base de la santé, comme la nourriture, l'eau, les installations sanitaires, la sécurité et le droit à l'autodétermination. Pour que la santé publique fasse efficacement et équitablement la promotion de la santé et pour qu'elle donne suite à ses engagements envers la justice sociale, nous faisons valoir qu'elle doit aborder le logement et les campements de sans-abri selon une approche fondée sur les droits humains. L'adoption d'une perspective axée sur les droits humains signifie que la santé publique doit d'abord et avant tout plaider en faveur de ressources, dont des logements adéquats, ancrées dans l'autodétermination des résidents des campements. En l'absence de logements, la santé publique devrait faire respecter les droits humains par la mise à disposition de ses ressources et par l'interdiction des expulsions des campements jusqu'à ce que des logements adéquats deviennent disponibles.

Keywords Public health · Encampments · Tent cities · Human rights · Housing · Homelessness

Mots-clés Santé publique · campements · villages de tentes · droits de l'homme · logement · sans-abrisme

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The COVID-19 pandemic has resulted in widespread public and private sector restrictions and a global economic crisis that has intensified existing inequities such as lack of affordable housing, unemployment, longstanding poverty and wealth inequality, and the ongoing impacts of colonization. During COVID-19, there has been an increase in

visible homelessness particularly in the form of encampments in urban centres (Lorinc, 2020). The rise of visible homelessness is often paired with troubling public narratives that perpetuate stereotypes, stigma, and discrimination related to crime, substance use, mental health, and poverty, thus intensifying the trauma endured by people experiencing homelessness. Such narratives are often used to justify the displacement of encampments while ignoring that encampment residents lack basic determinants of health and human rights to water, sanitation, food, and shelter. Public health officials are often at the nexus of these controversies and heightened public tensions. In this commentary, we outline the importance and relevance of a human rights approach for informing and bolstering public health responses to homelessness.

Public health is rooted in health equity and social justice, goals (Beauchamp, 1976) that are operationalized in public health standards and competencies (Edwards & Davison, 2008; Public Health Agency of Canada, 2008). Health equity is concerned with the impacts of social conditions on health and promotion of equitable conditions for health with an emphasis on the involvement and engagement of people impacted by inequities (Braveman, 2010). As such, health equity is inextricably linked to human rights including access to adequate housing, food, income, and self-determination as requirements for health justice and enshrined in International Human Rights Covenants (Braveman, 2010; Meier et al., 2018). The 2019 Canadian Housing Strategy Act specifically recognizes that (a) "the right to adequate housing is a fundamental human right affirmed in international law" and (b) "housing is essential to inherent dignity and well-being of the person and to building sustainable and inclusive communities" (Government of Canada, 2019, p. 2). This recognition is echoed in the National Protocol for Homeless Encampments in Canada (National Protocol) outlining the importance of housing as a human right and a human rights approach to homelessness (Farha & Schwan, 2020). Ongoing homelessness and failure to implement these policies is contributing to poor health and premature death for homeless persons (Centre for Equality Rights in Accommodation and National Right to Housing Network, 2021). Recognizing the right to housing and protecting human rights are central to public health commitments to health equity and social justice.

In the absence of housing, COVID-19 guidelines for encampments such as those released by the National Collaborating Centre for Environmental Health (NCCEH) (Yehia, 2020) and the best practices released by the British Columbia (BC) Ministry of Health (BCCDC, 2020) offer public health guidance, but fall short of adopting a human rights approach. This shortcoming raises the risk of these guidelines being co-opted and used to justify stigmatization, displacement, criminalization, and inaction due to a lack of focus on human rights to basic determinants of health (Farha & Schwan, 2020). Without a strong public health and human rights approach, public health can be weaponized in service of societal narratives that problematize homelessness as an individual failing, a disease or crime rather than a structurally produced problem with consequences of trauma and violence.

Dominant discourses surrounding encampments

Encampments are often portrayed publicly through three closely linked narratives—individual deficiencies, mental health and substance use, and criminalization—which often inform governmental, community, and non-profit responses to these sites. Despite the fact that people experiencing homelessness are no more likely to break the law, except for laws that punish people for living outdoors (Rankin, 2019), community opposition to encampments is often based in fears of increasing crime rates and jeopardizing public health and safety (Loftus-Farren, 2011).

For example, court cases, such as *British Columbia v. Adamson BCSC 1245* (2016), have cited "health and safety risks" such as fire hazards, violence, criminal activities, human waste, pests, substance use, and used needles as reasons to call for dismantling of an encampment. When public health is co-opted by narratives of public safety, it denies the varied human rights and public health concerns raised by residents of encampments that often focus on deficiencies in the determinants of health, such as housing, food and sanitation.

The neoliberal notion that encampments exist because of individual shortcomings ignores how encampments are instead sites of public health deficiencies rooted in government policies related to lack of housing, sanitation, food storage, inadequate incomes, and other resources. In May 2020, a BC ministerial order cited public health concerns of COVID-19 transmission, public safety, and increases in crime when forcing residents out of three public spaces in Vancouver and Victoria (Kines, 2020). Although displacement of the three encampments was accompanied by offers of hotel-style spaces, the process ignored rights to self-determination of encampment residents and forced closure of these encampments despite lack of adequate and sufficient spaces to move everyone indoors.

Instead of citing concerns of safety, crime, mental health, and substance use as public health rationale for displacement of encampments, public health officials should recognize encampment residents as rights holders—people with a right to housing, self-determination and basic determinants of health. This would ensure public health responses are rooted in social justice and bolstered by human rights.

Public health and "a human rights approach"

The National Protocol outlines eight principles, including the right to housing and how to uphold human rights in the absence of housing (Farha & Schwan, 2020). These eight principles can be used to squarely orient public health guidelines, such as those identified earlier, to housing as a human right and a public health approach based on protection of human rights and promotion of health equity and social justice.

The first two principles of the National Protocol recognize those who are homeless as holders of human rights, and the priority of appropriate housing as determined by encampment residents themselves as the only adequate, human rights-centred response to encampments (Farha & Schwan, 2020). As such, public health must acknowledge those who are living unsheltered in encampments as having the fundamental right to housing that is contained in human rights law and recognized as an essential basic determinant of health. Principle 2 of the National Protocol states that residents of encampments must be able to participate in decisions that affect their health and well-being as an "exercise of agency, autonomy, and self-determination" (Farha & Schwan, 2020, p. 16). The public health guidelines laid out by the BC Ministry of Health and the NCCEH neglect to foreground self-determination and the involvement of encampment residents as a fundamental requirement of human rights and core principle of health equity. For example, offers of shelter spaces are often refused by people experiencing homelessness because of lack of privacy and safety (Cohen et al., 2019). Further, any decisions surrounding encampment service provision, harm reduction, hygiene and sanitation, and potential relocation should be centred around the perspectives of people living in encampments and acknowledge that "residents are experts in their own lives", including how best to promote and protect health (Farha & Schwan, 2020).

Principles 3, 4, and 5 relate to human rights in the context of evictions and relocations. The BC Ministry of Health and NCCEH public health guidelines acknowledge the increased risk of infectious disease spread and other public health and safety risks that come with displacement of encampments. However, this acknowledgement falls short of a human rights perspective that prohibits forcible evictions "in all circumstances", including but not limited to public health emergencies such as COVID-19 (Farha & Schwan, 2020). Forcible displacement results in a myriad of harms, including trauma and disconnection from services.

The sixth principle of the National Protocol requires governments to "ensure encampments meet basic needs of residents consistent with human rights" (Farha & Schwan, 2020). In the absence of providing adequate housing as determined by encampment residents, a public health and human rights response would ensure access to basic determinants of health such as food, water, sanitation, and garbage disposal. While the BC Ministry of Health and the NCCEH guidelines advocate for the timely provision of such resources, when removed from a rights-based approach these guidelines risk being used for enforcement and displacement when public health standards are not met, instead of protecting rights to basic determinants of health.

Last, principles 7 and 8 speak to the importance of ensuring respect and dignity for all encampment residents with specific attention to Indigenous Peoples. While the BC Ministry of Health refers to human rights and Indigenous rights in their encampment guidelines, the NCCEH guidelines do not mention Indigenous Peoples or Canada's ongoing history of colonization that has deprived Indigenous people of land and resources and led to an overrepresentation of Indigenous people among those who are homeless. Guidelines that neglect to meaningfully frame recommendations from these perspectives risk inadequate public health responses and actions that violate human rights and are complicit in ongoing processes of colonization.

The eight principles of the National Protocol offer examples of how public health responses to encampments can protect public health and uphold human rights, first and foremost through access to adequate housing as defined by encampment residents, and in absence of that, through the provision of public health resources and supports to address basic determinants of health.

Human rights claims and public health assertions

Dominant narratives place the blame for systemic deficiencies onto residents of encampments to rationalize displacement and eviction of encampments. However, encampments are manifestations of government and public health deficiencies, specifically the "failure to successfully implement the right to adequate housing" (Farha & Schwan, 2020) and protect rights to basic determinants of health.

According to the Pan American Health Organization (n.d.), effective public health "requires explicit and concrete efforts to promote and protect human rights and dignity". The BC Ministry of Health and NCCEH guidelines are meant to address public health concerns related to encampments in the context of COVID-19. However, in order to do so effectively, they must pair public health with human rights approaches. While these guidelines include "human rights considerations" and maintain that adequate housing is preferable to people living in encampments, meaningfully taking up a human rights approach would begin by firmly

stating a right to housing and respecting people experiencing homelessness as rights holders in ensuring adequate housing options and basic determinants of health. To enact public health commitments of health equity and social justice, public health guidance regarding homeless encampments should integrate human rights principles as outlined above from the National Protocol.

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Declarations

Ethics approval This article does not contain any studies with human participants or animals performed by any of the authors.

Conflict of interest The authors declare no competing interests.

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PUNISHING HOMELESSNESS

*Sara K. Rankin**

Homelessness is punishing to those who experience it, not just from the inherent and protracted trauma of living exposed on the street, but also due to widespread and pervasive laws that punish people for being homeless. People experiencing homelessness, particularly chronic homelessness, often lack reasonable alternatives to living in public. Yet cities throughout the country are increasingly enacting and enforcing laws that punish the conduct of necessary, life-sustaining activities in public, even when many people have no other option. These laws are frequently challenged in court and often struck down as unconstitutional. But legally sound, cost-effective, and non-punitive alternatives to ending chronic homelessness exist. This article exposes some of the problems with criminalization laws, not only for people experiencing homelessness, but also for the broader community. It discusses how current approaches often make chronic homelessness worse and explains why non-punitive alternatives, especially Housing First and permanent supportive housing, are the most cost-effective means of addressing chronic homelessness. Ultimately, this article urges cities and their constituents to stop punishing homelessness and instead to start solving it.

Keywords: *homeless, constitutional law, human rights, poverty, ordinances, begging, camping, First Amendment, Fourth Amendment, Eighth Amendment, Fourteenth Amendment, stigma, marginalized groups, race, incarceration*

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INTRODUCTION

Is poverty a crime? A quick answer is, of course, yes: poverty is systemically created and punished. Debtors' prisons,[1] mass incarceration,[2] and the structure of the welfare system[3] are just a few examples of systemic designs that produce and reproduce poverty.

The intersectionality of poverty and homelessness suggests its systemic nature. Poverty disproportionately impacts already and otherwise marginalized groups, such as people of color, immigrants, people with mental illness or physical disabilities.[4] For example, consider links between race, poverty, and homelessness. Nationally, white people comprise approximately 74 percent of the population, but only 49 percent of the country's homeless population.[5] By contrast, black Americans represent 13 percent of the general population, but over 40 percent of

1. *Out of Reach 2018*, NAT'L LOW INCOME HOUSING COAL., http://nlihc.org/oor (last visited Sept. 14, 2018); *see, e.g.*, AM. CIVIL LIBERTIES UNION OF WASH. & COLUMBIA LEGAL SERVS., MODERN-DAY DEBTORS' PRISONS: THE WAYS COURT-IMPOSED DEBTS PUNISH PEOPLE FOR BEING POOR (Feb. 2014), https://www.aclu-wa.org/docs/modern-day-debtors-prisons-washington (writing that "[t]he practice of imposing and collecting excessive [legal financial obligations] results in a counterproductive system that punishes people simply for being poor."); AM. CIVIL LIBERTIES UNION, IN FOR A PENNY: THE RISE OF AMERICA'S NEW DEBTORS' PRISON (Oct. 2010), https://www.aclu-wa.org/sites/default/files/media-legacy/attachments/InForAPenny_web.pdf (stating that "day after day, indigent defendants are imprisoned for failing to pay legal debts they can never hope to manage"); ALEXES HARRIS, A POUND OF FLESH: MONETARY SANCTIONS AS PUNISHMENT FOR THE POOR (Russell Sage 2016).

2. *See, e.g.*, MICHELLE ALEXANDER, THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS (2010).

3. Kaaryn Gustafson, *The Criminalization of Poverty*, 99 J. CRIM. L. & CRIMINOLOGY 643 (2009) (examining "the treatment of welfare recipients in the courts, where the poor have been relegated to an inferior status of rights-bearing citizenship, a status on par with parolees and probationers").

4. *See* KAYA LURIE & BREANNE SCHUSTER, SEATTLE UNIV. HOMELESS RIGHTS ADVOC. PROJECT, DISCRIMINATION AT THE MARGINS: THE INTERSECTIONALITY OF HOMELESSNESS & OTHER MARGINALIZED GROUPS 2 (Sara K. Rankin ed., May 2015), https://digitalcommons.law.seattleu.edu/cgi/viewcontent.cgi?article=1002&context=hrap (finding that "marginalized groups disproportionately experience homelessness, including its many burdens—such as laws that criminalize the conduct of necessary, life-sustaining activity in public").

5. JEFFREY OLIVET ET AL., CTR. FOR SOCIAL INNOVATION, SUPPORTING PARTNERSHIPS FOR ANTI-RACIST COMMUNITIES: PHASE 1 STUDY FINDINGS 4 (Mar. 2018), http://center4si.com/wp-content/uploads/2018/03/SPARC-Phase-1-Findings-March-20181.pdf.

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the homeless population.[6] Latinos represent at least 16.9 percent of those experiencing homelessness in the United States.[7] Native American rates of homelessness are also disproportionately high, occurring at rates three to eight times higher than their proportion of the general population.[8] In total, over 68 percent of the nation's homeless population are people of color, even though they represent one-third of the U. S. population overall.[9] Race or, more pointedly, racism and homelessness are inseparable.

Like race and incarceration,[10] homelessness and incarceration are also closely linked, leading some to characterize the United States' penal system as the nation's largest homeless shelter.[11] Homelessness is a risk factor for incarceration: over 15 percent of those in jail were homeless prior to incarceration, a rate of 7.5 to 11.3 times higher than the general adult population.[12] Approximately 25–50 percent of the general homeless population has a criminal history,[13] oftentimes sparked by arrests for non-violent

6. *Id.* at 6.

7. *Id.*

8. *Id.*

9. *Id.* (quantifying racial statistics for homeless populations); *Racial and Ethnic Minority Populations*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN. (Aug. 16, 2018), https://www.samhsa.gov/specific-populations/racial-ethnic-minority (quantifying racial statistics for the national population).

10. *See, e.g.*, ALEXANDER, *supra* note 2.

11. *See, e.g.*, LOÏC WACQUANT, PRISONS OF POVERTY (Univ. of Minn. Press 2009).

12. Sarah Knopf-Amelung, *Incarceration & Homelessness: A Revolving Door of Risk*, 2 IN FOCUS 2, 1 (Nov. 2013), https://www.nhchc.org/wp-content/uploads/2011/09/infocus_incarceration_nov2013.pdf.

13. Stephen Metraux & Dennis P. Culhane, *Recent Incarceration History Among a Sheltered Homeless Population*, 52 CRIME & DELINQ. 3, 507 (2006) (finding that 23.1% of individuals surveyed at adult shelters had a record of incarceration); N. Tejani et al., *Incarceration Histories of Homeless Veterans and Progression Through a National Supported Housing Program*, 50 CMTY. MENTAL HEALTH J. 5, 516 (2013) (finding that 43.4% of individuals who entered a supported housing program for homeless veterans reported a past incarceration history); Martha R. Burt et al., *Homelessness: Programs and the People They Serve, Findings of the National Survey of Homeless Assistance Providers and Clients* (Dec. 1999), http://webarchive.urban.org/UploadedPDF/homelessness.pdf (finding that "54% of currently homeless clients have spent some time incarcerated, compared with 45% of formerly homeless clients"). These records may be generated when poor or homeless people commit crimes of desperation. Randeep Ramesh, *A Fifth of all Homeless People Have Committed a Crime to Get Off the Streets*, GUARDIAN (Dec. 22, 2010), https://www.theguardian.com/society/2010/dec/23/homeless-committing-crimes-for-shelter.

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offenses associated with homelessness, such as camping or begging.[14] And nationwide, approximately 49 percent of homeless adults reported spending five or more days in jail, while 18 percent had been incarcerated in a state or federal prison.[15] Even if inmates were not homeless just before they are arrested or jailed, once they are processed through the criminal justice system, they are more likely to become homeless upon exit.[16]

Key drivers for the criminalization of homelessness are increasingly popular laws and policies that seek to expel visibly poor people from public space. In the broadest sense, the term "visibly poor" and its various iterations "encompass individuals currently experiencing homelessness, but also include individuals experiencing poverty in combination with housing instability, mental illness, or other psychological or socio-economic challenges that deprive them of reasonable alternatives to spending all or the majority of their time in public."[17] In the more specific sense, the term "visibly poor" refers to people experiencing chronic homelessness. Chronic homelessness "is characterized by few spells lasting long periods of time, reflecting a persistent homeless state."[18] In other words, chronic homelessness is the most visible category compared to other homeless populations

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"Since results indicated that the likelihood of committing a nonviolent crime increases as homelessness increases, a strong argument can be made that homelessness encourages nonviolent crime. Rather than thinking of homeless individuals as criminals, it may be more accurate to think of them as people struggling to get by whose engagement in non-violent illegal activities is driven by survival needs." Sean N. Fischer et al., *Homelessness, Mental Illness, and Criminal Activity: Examining Patterns Over Time*, 42 AM. J. CMT. PSYCH. 251, 262 (2008).

14. *See, e.g.*, COALITION ON HOMELESSNESS, PUNISHING THE POOREST: HOW THE CRIMINALIZATION OF HOMELESSNESS PERPETUATES POVERTY IN SAN FRANCISCO 2, http://www.cohsf.org/Punishing.pdf (last visited Sept. 14, 2018) (reporting that 69% of homeless respondents were cited for "quality of life" offenses in the year prior to the study; 90% were unable to pay for their last citation, which results in high fees, an arrest warrant, and driver's license suspension).

15. Burt et al., *supra* note 13.

16. Once burdened with a criminal record, people face extraordinary difficulty finding housing (or employment to pay for housing). Zoe Carpenter, *Think It's Hard Finding a Place to Live? Try Doing So with a Criminal Record*, NATION (Nov. 4, 2015), https://www.thenation.com/article/public-housing-criminal-record/; Pat Hartman, *How to Become Homeless: Have a Criminal Record*, HOUSE THE HOMELESS, INC. (Jan. 31, 2012), http://www.housethehomeless.org/how-to-become-homeless-have-a-criminal-record/.

17. Sara K. Rankin, *The Influence of Exile*, 76 MD. L. REV. 4, 6 (2016) (citing, *e.g.*, JOEL BLAU, THE VISIBLE POOR: HOMELESSNESS IN THE UNITED STATES (1993)).

18. Adam M. Lippert & Barrett A. Lee, *Stress, Coping, and Mental Health Differences Among Homeless People*, 85 SOCIOLOGICAL INQUIRY 3, 345 (2015).

because, unlike most cases of homelessness that are briefly episodic or transitional, people experiencing chronic homelessness are homeless more frequently and for longer periods of time.[19] As a more technical matter, chronic homelessness is defined as sleeping in places not meant for human habitation or staying in emergency shelters for a year or longer—or experiencing at least four such episodes of homelessness in the last three years—and also living with a disabling condition such as a chronic health problem, psychiatric or emotional condition, or physical disability.[20] These co-occurring conditions help to explain the persistence of their homelessness. By virtue of their sustained visibility in public space, chronically homeless people are the primary target of ordinances punishing homelessness.[21] These laws, fueled by the stigma of visible poverty, function to purge chronically homeless people from public space.[22]

19. *Id.* Chronically homeless individuals are also more likely to live unsheltered, compared to homeless populations generally, which are more likely to benefit from rapid rehousing or other transitional housing interventions.

20. The United States Department of Housing and Urban Development (HUD) defines a disabling condition as "a diagnosable substance abuse disorder, a serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions" that "[l]imits an individual's ability to work or perform one or more activities of daily living." U.S. DEP'T OF HOUS. & URBAN DEV. OFFICE OF CMTY. PLANNING & DEV. & OFFICE OF SPECIAL NEEDS ASSISTANCE PROGRAMS, DEFINING CHRONIC HOMELESSNESS: A TECHNICAL GUIDE FOR HUD PROGRAMS (Sept. 2007), https://www.hudexchange.info/resources/documents/DefiningChronicHomeless.pdf. The nexus between chronic homelessness and disabilities is plain in the federal definition: a "chronically homeless individual" is "an individual with a disability who has been continuously homeless for one year or more or has experienced at least four episodes of homelessness in the last three years where the combined length of time homeless in those occasions is at least 12 months." U.S. DEP'T OF HOUS. & URBAN DEV. OFFICE OF CMTY. PLANNING & DEV., THE 2017 ANNUAL HOMELESS ASSESSMENT REPORT (AHAR) TO CONGRESS 2 (Dec. 2017) [hereinafter AHAR 2017], https://www.hudexchange.info/resources/documents/2017-AHAR-Part-1.pdf.

21. Chronic homelessness increases the likelihood of interacting with law enforcement; mental illness commonly associated with chronic homelessness also presents a greater risk of violent outcomes. Mental illness played a role in approximately one quarter of 987 police killings in 2017. Micah Lee & Alice Speri, *Police Broke Into Chelsea Manning's Home with Guns Drawn—In a "Wellness Check"*, THE INTERCEPT (June 5, 2018, 7:13AM), https://theintercept.com/2018/06/05/chelsea-manning-video-twitter-police-mental-health/ (internal citation omitted). The American Civil Liberties Union reports that, in the first eight months of 2018 alone, police shot and killed at least 64 people who were suicidal or had other mental health issues. *Id.*

22. *See generally* Rankin, *supra* note 17.

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Criminalization laws and policies express collective disdain for visible poverty, but many supporters of criminalization are not aware of how such laws actually make homelessness worse. Many are not aware that criminalization, along with other traditional approaches that manage homelessness, are the most expensive and least effective ways to address it. Some are not prepared to accept evidence that non-punitive alternatives, such as permanent supportive housing, are the most cost-effective ways to solve chronic homelessness. They cannot fathom giving housing or help to someone who does not appear worthy.[23] Such resistance to shifting from criminalization to non-punitive alternatives is fueled by fear, stereotypes, and discrimination.[24] But for other supporters of criminalization, they simply do not realize that criminalization is such an urgent problem and that more effective non-punitive alternatives exist.

This article is structured in four parts. Part I of this article lays an important, human-centric context for understanding how homelessness, itself, is punishment. The inherent traumas of homelessness besiege those who experience it. Understanding this context compels more thoughtful legal and policy responses. Part II provides an overview of laws that punish homelessness, gives common examples, and explains how these laws are often constitutionally infirm and make homelessness worse. Part III surveys some reasons why American cities commonly criminalize homelessness, explaining some psychological and sociological motivations, and giving examples of common myths that perpetuate damaging stereotypes and discrimination against people experiencing homelessness. And finally, Part IV examines Housing First and permanent supportive housing, non-punitive alternatives to criminalization, which are proven to be more cost-effective solutions to homelessness.

I. PUNISHING HOMELESSNESS

Being homeless, in and of itself, is punishment. Trauma is both a cause and a consequence of homelessness.[25] Poor physical and mental health, abuse, drug and alcohol abuse, and victimization can contribute to the likelihood

23. *Id.* at 21–22.

24. *Id.*

25. Jennifer Castellow, Bret Kloos, & Greg Townley, *Previous Homelessness as a Risk Factor for Recovery from Serious Mental Illness*, 51 CMTY. MENTAL HEALTH J. 6, 674–84 (2015) (noting "the experience of homelessness is inherently traumatic and thus has the

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that someone will become homeless; however, once a person becomes unsheltered, the likelihood that they will experience such trauma is virtually guaranteed.

Psychiatric disorders affect at least 30 to 40 percent of all people experiencing homelessness.[26] Severe mental illness, present in a significant portion of chronically homeless people, "describes severe and persistent psychiatric disability that generally has a profound impact on a person's behavior, cognition, affect, and social functioning."[27] Common examples include depression, schizophrenia, suicidal ideation, bipolar disorder, and debilitating mood disorders.[28] At least half of chronically homeless people struggle with alcohol and drug abuse or both.[29] By comparison, approximately one fourth of housed people "meet criteria for any mental or drug/alcohol disorder in the past year."[30] Significantly, studies clearly associate these mental and health disorders with "selected stress and coping measures" inherent in dealing with the trauma of homelessness,[31] and these traumas are especially and disproportionately concentrated among those experiencing chronic homelessness.[32]

Homelessness is also acutely associated with other forms of trauma, such as material deprivation, including lack of shelter, food insecurity, and unmet health care needs.[33] Indeed, homelessness makes mental illness worse: "not only are they at risk related to the detection and treatment of the condition, but the exposure to multiple stressors apart from that vulnerability might actually precipitate or exacerbate the manifestation of symptomatology."[34]

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potential to affect the manifestations of mental illness," psychiatric distress, alcohol and drug abuse, and other measures of vulnerability).

26. Lippert & Lee, *supra* note 18, at 344 (citing Barrett A. Lee, Kimberly A. Tyler, & James D. Wright, *The New Homeless Revisited*, 36 ANN. REV. SOC., 501–21 (2010)).

27. Castellow, Kloos, & Townley, *supra* note 25, at 674 n.1.

28. *Id.* at 674; Lippert & Lee, *supra* note 18, at 344 (internal citations omitted).

29. Lippert & Lee, *supra* note 18, at 343.

30. *Id.* (citing Ronald C. Kessler et al., *Prevalence, Severity, and Comorbidity of 12-month DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 ARCHIVES GEN. PSYCHIATRY 617–27 (2005)).

31. *Id.*

32. *Id.* at 345.

33. *Id.* at 347.

34. Castellow, Kloos, & Townley, *supra* note 25, at 675.

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Such resource deprivation naturally contributes to poor physical health indicators, such as malnutrition, hunger, lack of medical care and medicine, and "difficulties following treatment protocols."[35] Common examples of health problems that disproportionately affect people experiencing homelessness include "tuberculosis, HIV\AIDS, heart and lung disease, hypertension, hepatitis, and most other infectious and chronic conditions."[36]

Physical, sexual, or emotional abuse is another common hallmark of homelessness. More than half of people experiencing homelessness "report some kind of victimization while they are homeless, ranging from theft to beatings and sexual assault."[37] In fact, exposure to violence and victimization disproportionately affects people experiencing chronic homelessness who suffer from severe mental illness, with approximately 80 percent "reporting some form of lifetime victimization."[38] Victimization can be direct or can be experienced indirectly or vicariously by exposure to violence on the streets and in the homeless communities around them.[39]

Social isolation is a significant traumatizing factor for people experiencing homelessness. "[T]he loss of one's home and social status can be traumatic and stressful, therefore increasing risk to learned helplessness and social isolation, both of which are prominent contributors to various mental health problems."[40] Even the maintenance of social networks to other people experiencing homelessness, such as homeless encampment communities, can help to fulfill critical basic psychological, emotional, and social needs.[41] The potential traumatizing impacts of social isolation are profound, particularly among chronically homeless people.[42]

II. CRIMINALIZING HOMELESSNESS

The inherent trauma of homelessness is exacerbated by punitive laws and policies that criminalize homelessness. In this context, "criminalization"

35. Lippert & Lee, *supra* note 18, at 347 (internal citations omitted).
36. *Id.*
37. *Id.*
38. *Id.*
39. *Id.* at 348.
40. Castellow, Kloos, & Townley, *supra* note 25, at 675.
41. Lippert & Lee, *supra* note 18, at 348.
42. *Id.*

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refers to laws that prohibit or severely restrict one's ability to engage in necessary life-sustaining activities in public, even when that person has no reasonable alternative.[43] Examples include laws that prohibit sitting, standing, sleeping, receiving food, going to the bathroom, asking for help, or protecting one's self from the elements[44]—all basic behaviors necessary for survival. But most people can engage in these behaviors in some private or relatively private place, such as a home or a business.

For people experiencing chronic homelessness, who lack resort to a private place, surviving in public is fraught with risk. Indeed, chronically homeless people are frequently burdened with civil infractions and criminal charges related to their homelessness.[45] Living in public often triggers criminal charges, such as loitering or trespassing. But living in public also commonly triggers civil infractions: a ticket imposing conditions and requirements, such as an order to show up to court, avoid an area for significant period of time, or pay a fee.[46] These conditions are extremely difficult for chronically homeless individuals, who are not only poor but also burdened with secondary disabling conditions, to meet. When they fail to do so, because of conditions such as sickness, lack of money, lack of transportation, mental illness, or some other common barrier, a civil infraction can mutate into a misdemeanor through failure-to-appear or failure-to-pay provisions.[47] Without an address and without sufficient financial

43. Rankin, *supra* note 17, at 41 (internal citations omitted).

44. *Id.* at 44 (citing, *e.g.*, Nat'l Law Ctr. on Homelessness & Poverty, No Safe Place: the Criminalization of Homelessness in U.S. Cities 18 (2014), https://nlchp.org/documents/No_Safe_Place; Justin Olson & Scott Macdonald, Seattle Univ. Homeless Rights Advocacy Project, Washington's War on the Visibly Poor: A Survey of Criminalizing Ordinances & Their Enforcement (Sara K. Rankin ed., 2015), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2602318; Katherine Beckett & Steve Herbert, Banished: the New Social Control in Urban America (2010)).

45. Christopher Mayer & Jessica Reichert, Ill. Crim. Justice Info. Auth. & Ctr. for Justice Research and Evaluation, the Intersection of Homelessness and the Criminal Justice System 8 (July 9, 2018), http://www.icjia.state.il.us/assets/articles/Homelessness_PDF.pdf ("Disproportionate contact with the criminal justice system is due to a combination of laws that seem to criminalize the state of homelessness, mental illness, victimization, and substance use disorders."). Further, "these disproportionately high rates are driven by homeless individual who commit minor 'survival crimes.'" *Id.* at 7.

46. *See generally* Beckett & Herbert, *supra* note 44.

47. *See, e.g.*, Melissa Hellmann, *For Homeless Seattleites, a Reprieve from the Debilitating Burden of Warrants*, Seattle Weekly (Jan. 10, 2018, 1:30AM), http://www.seattleweekly.

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resources, homeless people are often unaware of or unable to respond to these conditions, resulting in bench warrants and crushing legal financial obligations.[48]

Once individuals are saddled with a misdemeanor or a warrant, they are often rendered ineligible to access shelter, food, services, and other benefits that might support their ability to emerge from homelessness.[49] Even an unpaid civil infraction can generate staggering, insurmountable fees.[50] By criminalizing public survival, such laws actually render chronically homeless people more resistant to recovery and more likely to remain homeless, to become sick, to self-medicate, to be incarcerated, and even to die.[51]

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com/news/for-homeless-seattleites-a-reprieve-from-the-debilitating-burden-of-warrants/ (Seattle Municipal Court staff and public defenders opining that many of the nearly 10,000 outstanding warrants issued to people who lack permanent addresses because they are homeless and often unaware they have been ordered to appear).

48. *See, e.g.*, Columbia Legal Servs., *King County Superior Court Rules in Favor of Seattle Resident Whose Vehicle and Home Were Impounded by City* (Mar. 2, 2018), http://columbialegal.org/king-county-superior-court-rules-favor-seattle-resident-whose-vehicle-and-home-were-impounded-city.

49. *E.g.*, SUZANNE SKINNER, SEATTLE UNIV. HOMELESS RIGHTS ADVOC. PROJECT, SHUT OUT: HOW BARRIERS OFTEN PREVENT MEANINGFUL ACCESS TO EMERGENCY SHELTER (Sara Rankin ed., May 10, 2016), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2776421 (explaining that the conditions and rules of many shelters effectively bar many individuals experiencing homeless from entry to the shelters due to their criminal record, which results from the criminalization of laws that punish individuals for being homelessness); *see generally* Alexandra Natapoff, *Misdemeanors*, 85 S. CAL. L. REV. 1313, 1313 (2012) (writing that "[t]he consequences of these [misdemeanor] convictions are significant: in addition to the stigma of a criminal record, misdemeanants are often heavily fined or incarcerated, and can lose jobs, housing, or education opportunities.").

50. HARRIS, *supra* note 1; *see also* Vianna Davila, *Judge Rules Seattle Homeless Man's Truck is a Home*, SEATTLE TIMES (Mar. 3, 2018), https://www.seattletimes.com/seattle-news/homeless/judge-rules-seattle-homeless-mans-truck-is-a-home/ (ruling that Seattle's impoundment of a vehicle resident's truck violated the state's Homestead Act because he was using it as a home and the city-imposed fees violated constitutional protections against excessive fines).

51. "Exposed on the street, [chronically homeless individuals] suffer from higher rates of poor health, mental illness, and substance abuse when compared to homeless populations generally." SEATTLE UNIV. HOMELESS RIGHTS ADVOCACY PROJECT, *Frequently Asked Questions About Homelessness*, https://law.seattleu.edu/Documents/korematsu/FAQs%20About%20Homelessness.pdf (last visited Sept. 21, 2018) (linking to *Health*, HOMELESS HUB [hereinafter HOMELESS HUB Health], http://www.homelesshub.ca/about-homelessness/topics/health?_ga=2.215176535.155110989.1530558055-210836041 6.1526944142 (last visited Sept. 21, 2018)); and *Homelessness and Housing*, SUBSTANCE ABUSE AND MENTAL

The criminalization of homelessness comes at a significant cost, not just to the lives and liberties of poor men, women, and children, but to society overall. Several studies show it is far more expensive to criminalize poverty and homelessness than it is to pursue non-punitive alternatives such as permanent supportive housing, and mental health and substance abuse treatment.[52] Despite these punishing effects, cities increasingly deploy the strategy of criminalization as a favored response to chronic homelessness.

Criminalization laws take many forms, but are pervasive. Common examples include bans on loitering, loafing, or vagrancy; bans on sitting or lying down in public; begging restrictions; and bans on living in vehicles.[53] The National Law Center on Homelessness and Poverty surveyed hundreds of cities nationwide, and found dramatic spikes in criminalization laws in recent years.[54] For example, over the last decade, city-wide

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HEALTH SERVS. ADMIN. [hereinafter SAMHSA Homelessness and Housing] (Sept. 15, 2017), https://www.samhsa.gov/homelessness-housing.

52. *See, e.g.*, JOSHUA HOWARD & DAVID TRAN, SEATTLE UNIV. HOMELESS RIGHTS ADVOCACY PROJECT, AT WHAT COST: THE MINIMUM COST OF CRIMINALIZING HOMELESSNESS IN SEATTLE AND SPOKANE, at iii (Sara K. Rankin ed., May 2015), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2602530 (examining costs in Seattle and Spokane); GREGORY A. SHINN, RETHINK HOMELESSNESS & IMPACT HOMELESSNESS, THE COST OF LONG-TERM HOMELESSNESS IN CENTRAL FLORIDA: THE CURRENT CRISIS AND THE ECONOMIC IMPACT OF PROVIDING SUSTAINABLE HOUSING SOLUTIONS 8 (2014), https://shnny.org/uploads/Florida-Homelessness-Report-2014.pdf (examining costs in Central Florida); SARAH B. HUNTER ET AL., EVALUATION OF HOUSING FOR HEALTH PERMANENT SUPPORTIVE HOUSING PROGRAM, RAND CORPORATION, at viii (2017), https://www.rand.org/content/dam/rand/pubs/research_reports/RR1600/RR1694/RAND_RR1694.pdf (examining costs in Los Angeles County). In 2016 alone, Los Angeles police arrested 14,000 people experiencing homelessness for everyday activities such as sitting on the sidewalk. *Gale Holland & Christine Zhang, Huge Increase in Arrests of Homeless in L.A.—But Mostly for Minor Offenses*, L.A. TIMES (Feb. 4, 2018, 8:20AM), http://www.latimes.com/local/politics/la-me-homeless-arrests-20180204-story.html. In San Francisco, the City/County Budget analyst's office determined that it cost $20 million in a single year to enforce prohibitions against loitering, panhandling, and so on against people experiencing homelessness. Adam Brinklow, *San Francisco Spends $20 Million on Anti-Homeless Laws: Millions of Dollars Resulted in 125 Arrests in 2015*, CURBED (June 3, 2016, 10:30AM), https://sf.curbed.com/2016/6/3/11852832/homeless-san-francisco.

53. For more information and resources on this topic, see *The Criminalization of Homelessness: Additional Resources*, SEATTLE UNIV. HOMELESS RIGHTS ADVOCACY PROJECT, https://law.seattleu.edu/centers-and-institutes/korematsu-center/initiatives/homeless-rights-advocacy-project/additional-resources (last visited Sept. 14, 2018).

54. NAT'L LAW CTR. ON HOMELESSNESS & POVERTY, HOUSING NOT HANDCUFFS: ENDING THE CRIMINALIZATION OF HOMELESSNESS IN U.S. CITIES 10 [hereinafter NLCHP

bans on camping in public increased by 69 percent; city-wide bans on begging increased by 43 percent; city-wide bans on standing around increased by 88 percent; and bans on sitting or lying down increased by 52 percent.[55] Bans on sleeping in vehicles—the thin tin line that separates a human being from the street—increased by a staggering 143 percent nationwide since 2006.[56]

Statewide studies also suggest the dizzying popularity of criminalization laws.[57] In Washington state, for example, criminalization laws are not only prevalent,[58] but many people spend over 90 days in jail for violating these laws.[59] Moreover, Washington state data suggests that as rates of income disparity rise in any particular city, so does the rate at which that city enforces its criminalization laws.[60] In other words, the greater the gap between the rich and the poor in a particular city, the more punitive that space becomes for the poor people within its boundaries.

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HOUSING NOT HANDCUFFS], https://www.nlchp.org/documents/Housing-Not-Handcuffs (last visited Sept. 27, 2018) (finding that "laws punishing the life-sustaining conduct of homeless people has [*sic*] increased in every measure category since 2006, and in some cases dramatically so.").

55. *Id.* at 10–11.

56. *Id.* at 11.

57. *See, e.g.*, OLSON & MACDONALD, *supra* note 44 (Washington state study); UC BERKELEY SCH. OF LAW POLICY ADVOCACY CLINIC, CALIFORNIA'S NEW VAGRANCY LAWS: THE GROWING ENACTMENT AND ENFORCEMENT OF ANTI-HOMELESS LAWS IN THE GOLDEN STATE (Feb. 12, 2015), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2558944 (California study) RACHEL A. ADCOCK ET AL., UNIV. OF DENVER, STURM COLL. OF LAW, HOMELESS ADVOCACY POLICY PROJECT, TOO HIGH A PRICE: WHAT CRIMINALIZING HOMELESSNESS COSTS COLORADO, https://www.law.du.edu/documents/homeless-advocacy-policy-project/2-16-16-Final-Report.pdf (last visited Sept. 14, 2018) (Colorado study); ALLARD K. LOWENSTEIN, INTERNATIONAL HUMAN RIGHTS CLINIC, YALE L. SCH., "FORCED INTO BREAKING THE LAW": THE CRIMINALIZATION OF HOMELESSNESS IN CONNECTICUT (Nov. 2016), https://law.yale.edu/system/files/area/center/schell/criminalization_of_homelessness_report_for_web_full_report.pdf (Connecticut study).

58. *E.g.*, OLSON & MACDONALD, *supra* note 44, at 3 (surveying criminalizing ordinances in Washington and finding that 78% of surveyed municipalities criminalize sitting or standing in public, 78% of surveyed municipalities criminalize sleeping in public places, and 75% criminalize urination or defecation in public).

59. *E.g.*, *id.* at ii (finding that in Washington, "custody times revealed a high number of individuals spending more than 90 days in jail for violating criminalization ordinances").

60. *E.g.*, *id.* ("As rates of income disparity rise, so does the rate of citations issued for purported violations of criminalization ordinances.").

Although criminalization laws are increasingly popular, they are also commonly and successfully challenged as unconstitutional under various provisions of the federal Constitution, including the First, Fourth, Sixth, Eighth, and Fourteenth Amendments.[61] Recently, favorable results have been reported in 75 percent of cases challenging encampment sweeps or seizure and destruction of homeless people's belongings, 57 percent of cases challenging anti-camping or sleeping laws, and 100 percent of the cases challenging anti-begging laws.[62]

Criminalization laws are often unconstitutional, make homeless people less likely to emerge from homelessness, and waste public resources and taxpayer dollars. Still, cities persist, seeking new ways to skirt constitutional restrictions to achieve the same desired result of pushing homeless people away from public view.[63] A closer look at a few specific examples of criminalization laws reveals not only their common constitutional infirmities, but their punishing impact on already vulnerable people.

A. Punishing Unauthorized Communities

The growing number of unauthorized encampments reflect the reality that many cities lack sufficient emergency shelter and transitional housing. With no safe and legal place to go, many homeless people find community in unauthorized encampments. Encampments can offer several benefits to people experiencing homelessness, such as a sense of safety, security, community, autonomy, stability; they can also lessen health care burdens.[64]

61. *See, e.g.*, Nat'l L. Ctr. on Homelessness & Poverty, Housing Not Handcuffs: A Litigation Manual 11 [hereinafter NLCHP Litigation Manual], https://www.nlchp.org/documents/Housing-Not-Handcuffs-Litigation-Manual (last visited Sept. 14, 2018).

62. *Id.* at 6.

63. Jocelyn Tillisch & Drew Sena, Seattle Univ. Homeless Rights Advocacy Project, Begging for Change: Begging Restrictions Throughout Washington 3 (Sara Rankin & Justin Olson eds., 2018), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3173191 (writing that cities are attempting to circumvent First Amendment jurisprudence by enacting aggressive begging laws that "hinge on subjective perceptions of the person being solicited for help—for example, a person might be guilty of aggressive begging if someone listening to them feels intimidated, regardless of the means and manner of the solicitation." (internal citation omitted)).

64. Evanie Parr, Seattle Univ. Homeless Rights Advocacy Project, it Takes A Village: Practical Guide for Authorized Encampments 4–5 (Sara K. Rankin ed., 2018), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3173224.

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As the population of unsheltered people experiencing homelessness has increased across the country, so have encampments. One national study found a 1,342 percent increase in the number of encampments reported across the country.[65] Encampments have been reported in every state and the District of Columbia.[66] In response to growing encampments, many cities sweep unauthorized homeless encampments.[67] Sacramento County alone closed 1,579 camps in 2016.[68]

Through sweeps, cities disrupt and evict encampment residents without providing a safe and legal alternative place for them to go. Such sweeps often provoke Fourth Amendment challenges.[69] The Fourth Amendment provides: "The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated."[70] Some cases turn on whether tents or other makeshift shelters fall within the Fourth Amendment's prohibition of unreasonable searches of one's "home" or "house."[71] Advocates argue that privacy rights should not apply only to conventional homes with four walls and a lockable door; such constructions could effectively mean that unsheltered people have no Fourth Amendment protections.[72] Courts often agree: although governments may conduct sweeps to clean public areas, seizing and destroying encampment residents' personal property often violates their Fourth Amendment rights to be free from unreasonable searches and seizures.[73]

65. Nat'l Law Ctr. on Homelessness & Poverty, Tent City, Usa: the Growth of America's Homeless Encampments and How Communities are Responding 21 (2017), https://www.nlchp.org/Tent_City_USA_2017.

66. *Id.*

67. Nlchp Housing Not Handcuffs, *supra* note 54, at 8; Olson & Macdonald, *supra* note 44.

68. *Latest Ranger Activity Data, Ranger Activity Reports*, Sacramento County Regional Parks, http://www.regionalparks.saccounty.net/Rangers/Pages/Latest-Ranger-Activity-Data.aspx (last visited Sept. 21, 2018).

69. Nlchp Litigation Manual, *supra* note 61, at 11.

70. U.S. Const. Amend. IV. In addition, the Fourth Amendment provides that "No Warrants shall issue, but upon probable cause, supported by Oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized." *Id.*

71. *See, e.g.*, Evanie Parr, Note, *When a Tent is Your Castle: Constitutional Protection Against Unreasonable Searches of Makeshift Dwellings of Unhoused Persons*, 42 Seattle U. L. Rev. (forthcoming Jan. 2019).

72. *Id.*

73. Nlchp Litigation Manual, *supra* note 61, at 11; *e.g.*, Lavan v. City of Los Angeles, 693 F.3d 1022 (9th Cir. 2012) (finding that Los Angeles violated the Fourth and Fourteenth

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Homeless plaintiffs can also prevail on due process claims under the Fourteenth Amendment when cities fail to follow certain procedures when managing confiscated private property.[74]

But in addition to often being illegal, sweeps frequently inflict real and lasting damage on people experiencing homelessness. Sweeps not only displace homeless people from public space, they also exact significant emotional and psychological tolls on encampment residents.[75] Sweeps often devour and destroy encampment residents' valuable property, such as state identification cards, social security cards, passports, and birth certificates.[76] Personal identification cards are needed to qualify for countless services and are difficult to replace.[77] Items of significant sentimental value such as photos of lost family members, or vital property such as medication, are commonly taken or destroyed.[78]

The loss of these items can be devastating to homeless people. For example, the loss of identification documents can make it difficult, if not impossible, for someone to access employment, gain access to housing, or

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Amendment rights of individuals experiencing homelessness by "seizing and immediately destroying their unabandoned personal possessions, temporarily left on public sidewalks while [the individuals] attended to necessary tasks such as eating, showering, and using the restrooms").

74. *See, e.g.*, Mitchell v. City of Los Angeles, Case No.: 16-cv-01750 SJO (JPR) (C.D. Cal. Apr. 2016).

75. *See, e.g.*, Tai Dunson-Strane & Sarah Soakai, Dep't of Urban & Reg'l Planning Univ. of Hawai'I at Manoa, the Effects of City Sweeps and Sit-Lie Policies on Honolulu's Houseless 25 (June 2015), http://blog.hawaii.edu/durp/files/2015/06/Houseless-Honolulu-Report.small_.pdf.

76. In a 2011 survey by the Law Center of homeless service providers, advocates, and homeless individuals in 26 states, over 75% of respondents reported that sweeps of homeless people in their communities have resulted in the loss of homeless persons' valuables, medications, identification documents, or other personal items. Nat'l Law Ctr. on Homelessness & Poverty, Criminalizing Crisis: the Criminalization of Homelessness in U.S. Cities 21 (Nov. 2011), https://www.nlchp.org/Criminalizing_Crisis. Similarly, a survey of homeless adults at three large homeless encampments in Honolulu, Hawai'i, in February and March of 2015, found that the single largest effect of sweeps in that area was "significant property and economic losses," including loss of property needed to survive in public space. Dunson-Strane & Soakai, *supra* note 75, at 4. Monetary losses can also occur in the form of citations, which were given out to half of encampment residents in one study of Honolulu. *Id.* at 16. For a broader look at the detrimental impact of citations, *see generally* Coalition on Homelessness, *supra* note 14.

77. Dunson-Strane & Soakai, *supra* note 75, at 24–25.

78. *Id.* at 22.

even to exercise their basic right to vote.[79] The loss of warm clothing, protective tents, and medication directly threatens the health of already vulnerable people.[80] Sweeps also create or worsen existing physical and mental health problems for those experiencing chronic homelessness, who are particularly vulnerable to such harms.[81]

Meanwhile, sweeps are ineffective at reducing homelessness. For example, California's state transportation agency eliminated 217 homeless encampments between July 2014 and February 2015, only to have some reopen the very same day.[82] Sweeps are often conducted, as in Seattle, when there are no adequate alternative places to live. Because this exercise merely disperses, rather than reduces, homelessness, new encampments inevitably reappear.[83] Indeed, sweeps can actually worsen the problem of unsheltered homelessness and make it less likely for people to enter or remain in homeless services.[84]

This forced displacement of already vulnerable people, especially in the absence of adequate housing or shelter alternatives, leaves them with no safe and legal place to go. Meanwhile, sweeps can create real harm to encampment residents by disrupting whatever fragile community may have existed, forcing people to constantly move, and sending "a message to people experiencing homelessness that they are not allowed anywhere."[85]

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79. NLCHP HOUSING NOT HANDCUFFS, *supra* note 54.

80. *See, e.g.*, Kincaid v. City of Fresno, 2006 WL 3542732 (E.D. Cal. 2006). In *Kincaid*, a Fresno police officer destroyed the asthma medication and nebulizer machine that a homeless woman, Jeannine Nelson, needed to breathe. *Id.* at *11 (E.D. Cal. 2006). The destruction of this property landed Ms. Nelson in the emergency room, a costly medical intervention, and required her to eventually replace her medications and breathing machine—all at taxpayer expense. *Id.*

81. *See generally* INSTITUTE OF MEDICINE (US) COMMITTEE ON HEALTH CARE FOR HOMELESS PEOPLE, HOMELESSNESS, HEALTH, AND HUMAN NEEDS (1988), https://www.ncbi.nlm.nih.gov/books/NBK218236/.

82. COALITION ON HOMELESSNESS, *supra* note 14, at 27.

83. NLCHP HOUSING NOT HANDCUFFS, *supra* note 54.

84. For example, in a report from the University of Hawaii at Manoa, 21% of homeless people subjected to sweeps reported that they were less able or less likely to seek shelter. DUNSON-STRANE & SOAKAI, *supra* note 75, at 19.

85. SAMIR JUNEJO & SUZANNE SKINNER, SEATTLE UNIV. HOMELESS RIGHTS ADVOCACY PROJECT, NO REST FOR THE WEARY: WHY CITIES SHOULD EMBRACE HOMELESS ENCAMPMENTS 6 (Sara K. Rankin ed., May 11, 2016), https://digitalcommons.law.seattleu.edu/cgi/viewcontent.cgi?article=1006&context=hrap.

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But sweeps also punish the broader community because they do nothing to solve homelessness; instead, they are a costly, rotating door that wastes taxpayer dollars. Certainly sweeps might appease constituents by creating a temporary illusion that homelessness is being solved when it is not. But by failing to ensure a safe and legal place for homeless people to exist, sweeps are an expensive exercise in displacement, generating municipal expenses of millions of dollars by forcing chronically homeless people from one place to another. In 2017, for example, Seattle spent $10 million on homeless sweeps alone.[86] For 2018, Seattle is reported to be doubling the rates of sweeps;[87] accordingly, it is on pace this year to spend $20 million displacing homeless people. If this $20 million were redirected from sweeps to permanent supportive housing, Seattle could end homelessness for approximately 37 percent of its chronically homeless population.[88] But there is no indication that such cities are relenting.[89]

B. Punishing Sleeping, Lying Down, Sitting, or Protecting Oneself from the Elements

Other common criminalization laws ban or severely restrict camping, sleeping, lying down, or sitting in public. Because many cities lack sufficient affordable housing or shelter space, homeless people are often left

86. Chris Daniels, *Seattle Spent $10 Million on Homeless Sweeps in 2017*, K5 NEWS (May 28, 2018, 8:28PM PDT), https://www.king5.com/article/news/local/homeless/seattle-spent-10-million-on-homeless-sweeps-in-2017/281-554503199.

87. Erica C. Barnett, *City Accelerates Homeless Encampment Removals, Doubling Pace in 2018*, THE C IS FOR CRANK (Aug. 21, 2018), https://thecisforcrank.com/2018/08/21/homeless-encampment-removals-accelerated-this-year-doubling-in-pace-since-january/.

88. *See, e.g.*, *Introduction to Housing First/Permanent Supportive Housing*, SEATTLE UNIV. HOMELESS RIGHTS ADVOCACY PROJECT (July 11, 2018), https://law.seattleu.edu/Documents/korematsu/Introduction%20to%20Housing%20First%20and%20Permanent%20Supportive%20Housing.pdf (explaining that, on average, it costs approximately $16,000 to $22,000 to provide permanent supportive housing to each chronically homeless individual). This projection is based on dividing $20 million by the $16K baseline number, suggesting that $20 million could fund approximately 1,250 new units, which would house 37% of the 3,552 chronically homeless people in King County, based on the 2018 point-in-time count.

89. *See, e.g.*, Vianna Davila, *San Francisco is Cracking Down on Tent Camps. Will Seattle do the Same?*, SEATTLE TIMES (Sept. 20, 2018, 6:00AM), https://www.seattletimes.com/seattle-news/homeless/san-francisco-is-cracking-down-on-tent-camps-will-seattle-do-the-same/.

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with no reasonable alternative but to conduct these unavoidable activities in public spaces.

The Ninth Circuit recently addressed the question of whether cities can punish homeless people for such activities in *Martin v. City of Boise*.[90] Given the particular prevalence of homelessness in Western states within the Ninth Circuit,[91] *Martin* has extraordinary implications for the criminalization of homelessness. The plaintiffs, a group of people currently or formerly experiencing homelessness in Boise, Idaho, alleged that the city violated their Eighth Amendment rights[92] by outlawing sleeping or camping in public under its Camping and Disorderly Conduct Ordinances, even when the City failed to offer sufficient shelter.[93] Boise sits within Ada County, where approximately 125 unsheltered individuals live.[94] The City's three shelters offer a total of "354 beds and 92 overflow mats."[95] One shelter "is open to men, women, and children of all faiths"; it has 96 beds, but is routinely full.[96] A second shelter is open to men only, and the third is open exclusively to women and children.[97] The latter two also require adherence to certain religious classes or otherwise impose religious messages on those seeking shelter.[98] The court held that Boise could not "criminalize indigent, homeless people for sleeping outdoors, on public property, on the

90. Martin v. City of Boise, No. 145-35845 (9th Cir. Sept. 4, 2018).

91. States in the Ninth Circuit have been hit especially hard by the increase in unsheltered populations. California, Nevada, Oregon, and Hawaii are the only four states in which more than half of all people experiencing homelessness were staying in unsheltered locations. AHAR 2017, *supra* note 20, at 12. The State of California alone had nearly half of all unsheltered people in the country. *Id.* The State of Washington is also experiencing an unprecedented unsheltered homeless crisis. According to the Washington State Department of Commerce, the number of people experiencing homelessness in Washington State has increased since 2013. *See Why is Homelessness Increasing?*, WASH. DEPT' OF COMMERCE (Jan. 2017), https://www.commerce.wa.gov/wp-content/uploads/2017/01/hau-why-homelessness-increase-2017.pdf.

92. The Eighth Amendment provides: "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." U.S. Const., Amend. VIII. The *Martin* court's analysis of the Eighth Amendment is detailed at pages 28–33. *Martin*, *supra* note 90, at *28–33.

93. *Id.* at *5.

94. *Id.* at *6–7.

95. *Id.* at *9.

96. *Id.* at *7.

97. *Id.* at *8.

98. *Id.* at *9.

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false pretense they had a choice in the matter."[99] The court reasoned that the Eighth Amendment's prohibition against cruel and unusual punishment precluded enforcement of the law prohibiting homeless residents from conducting such activities in public when they have no reasonable alternative but to do so.[100]

Thus, *Martin* stands for the proposition that laws criminalizing homelessness are unconstitutional when (1) a city punishes a homeless person for engaging in necessary, life-sustaining activity in public; (2) that person has no reasonable alternative but to survive in public space; and (3) existing shelters are inadequate in number or are functionally accessible to their homeless population.

Martin also clarifies that determining whether a city provides reasonable alternatives is not a simple mathematical calculation of shelter beds. Instead, that sufficient reasonable alternative shelter must be functionally accessible. In *Martin*, the religious requirements imposed as a condition to accessing many shelter beds created an unacceptable barrier; therefore, those beds were not reasonable alternatives.[101]

Martin is also significant because many shelters throughout the country not only lack capacity, they also impose various barriers to entry that render them functionally inaccessible to many homeless people.[102] For example, a "shortage of emergency shelters leads to overcrowding, which creates unhealthy, unsanitary, and even dangerous conditions in some shelters."[103] A complex system of rules and regulations also commonly creates obstacles to access.[104] Common requirements force families or partners to split up, exclude LGBTQ youth or pet owners, or "refuse admittance to substance abusers and the mentally ill."[105] These common barriers apply to many chronically homeless individuals, excluding them and forcing them to

99. *Id.* at *3.

100. *Id.* at *28–33.

101. *Id.*

102. *See* SKINNER, *supra* note 49.

103. *Id.* at 2.

104. *Id*; *see also* Castellow, Kloos, & Townley, *supra* note 25, at 675 ("[T]he simple act of accessing and utilizing services can be unpredictable and dangerous; the network of resources for people experiencing homelessness is intricate, frustrating, and time-consuming. Shelters, although often essential commodities, can be disruptive and unsafe as multiple individuals from various backgrounds are placed in most quarters with minimal regulation.").

105. SKINNER, *supra* note 49, at 2.

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remain on the street. *Martin* pushes cities to reconsider the punitive, widespread, and cumulative impact of such common barriers to accessing shelter. Several cities are already taking note of *Martin*, proactively declining to enforce existing anti-camping laws.[106]

Still, other cities, like Seattle, suggest that they are not criminalizing homelessness because they do not always charge or cite for violations but instead issue move-along warnings.[107] Such positions miss the point. Not only did the *Martin* case reject similar arguments made by the City of Boise,[108] but move-along warnings are a prevalent form of criminalization that has "detrimental consequences for wide swaths of the homeless population."[109] Such warnings are a form of punishment, conducted under the explicit or implicit threat of criminal prosecution, and thus press against the essential boundaries of the Eighth Amendment—whether it is illegal to be poor, whether having no housing is a crime, or whether resting in public space is against the law.

Moreover, as a policy matter, move-along warnings are highly problematic. Move-along orders "are not recorded or reported in many jurisdictions," amounting to a "virtually invisible practice [that is] common, pervasive, and potent."[110] In terms of punishing homelessness, criminal charges and civil citations may well represent the tip of the proverbial iceberg: below the surface lurks the virtual guarantee of constant exposure to move-along orders and threats of arrest, resulting in forced displacement, social isolation, destruction of property, loss of community, heightened interpersonal conflict, and increased fear of engagement with police.[111]

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106. *See, e.g.*, Maggie Vespa, *Portland Police Will Not Cite Homeless for Sleeping on Streets, Citing Court Ruling*, KGW8 (Sept. 7, 2018), https://www.kgw.com/article/news/local/homeless/portland-police-will-not-cite-homeless-for-sleeping-on-streets-citing-court-ruling/283-591977968.

107. *E.g.*, Vianna Davila, *Federal-Court Ruling on Homeless Camps Won't Affect Seattle, City Attorney Says*, SEATTLE TIMES (Sept. 7, 2018, 5:13PM), https://www.seattletimes.com/seattle-news/homeless/federal-court-ruling-on-homeless-camps-wont-affect-seattle-city-attorney-says/ (quoting Seattle City Attorney Pete Holmes: "Seattle has no blanket citywide policy that criminalizes sleeping outside, therefore we don't expect that this decision will affect the way the City is able to respond to people living outdoors[.]").

108. *Martin*, *supra* note 90, No. 145–35845, *at 18–19.

109. Christopher Herring, Dilara Yarbrough, & Lisa Marie Alatorre, *Pervasive Penalty: How the Criminalization of Homelessness Perpetuates Poverty*, SOC. PROBS. (forthcoming 2019).

110. TILLISCH & SENA, *supra* note 63, at 31.

111. *See, e.g.*, Herring, Yarbrough, & Alatorre, *supra* note 109, at 11 (noting that in San Francisco, "over 80% of homeless complaints are not resolved through citation or arrest, but

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Exacting punishment through move-along warnings is also costly and futile. Aside from the obvious expenses associated with law enforcement time, move-along orders, like the enforcement of criminalization laws generally, do not serve as an effective deterrent.[112] Move-along warnings do not move homeless people indoors. Instead, common responses to such orders are to simply move "down the street, around the corner, or to walk around" and return after police depart.[113] Accordingly, move-along warnings are persistent and pervasive punishments of homelessness.

C. Punishing Requests for Help or Acts of Giving Help

Homeless people are commonly associated with needing help or charity. The First Amendment provides fundamental protection to requests for help and acts of giving it. Among other provisions, the First Amendment protects freedom of speech and religion.[114] In homeless rights advocacy, the First Amendment commonly applies to laws that restrict both begging and food sharing. Peaceful begging is, at its most fundamental level, a request for help.[115] Members of the faith community commonly share food with homeless people as an expression of their faith.[116] Accordingly,

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by police warnings and requests that homeless people stop engaging in activities that violate the law"). For example, recent surveys in San Francisco show that 70% of homeless individuals had been forced to move from public space by law enforcement; over one third experienced such displacement at least once a month, and 20% on a weekly basis. For chronically homeless people, forced displacement through move-along orders was much more common: approximately 90% were forced to move at least once in the past year, and nearly 50% were evicted from public spaces monthly. *Id.* at 12.

112. NLCHP HOUSING NOT HANDCUFFS, *supra* note 54, at 12 ("In addition to being futile, use of 'move along' orders discriminates against homeless people who have not violated any laws, and who are merely present in public.").

113. Herring, Yarbrough, & Alatorre, *supra* note 109, at 22.

114. "Congress shall make no law respecting an establishment of *religion*, or prohibiting the free exercise thereof; or abridging the *freedom of speech*, or of the press; or the right of the people peaceably to assemble, and to petition the government for a redress of grievances." U.S. Const. Amend. I. (emphasis added).

115. TILLISCH & SENA, *supra* note 63.

116. *See generally* Marc-Tizoc González, *Hunger, Poverty, and the Criminalization of Food Sharing in the New Gilded Age*, 23 J. OF GENDER, SOCIAL POLICY & L. 2 (2015); *see also* Joshua Stewart, *After a Hiccup with Permits, a Pacific Beach Church is Back to Feeding the Homeless*, SAN DIEGO UNION-TRIBUNE (June 10, 2017), http://www.sandiegouniontribune.com/news/homelessness/sd-me-church-homeless-20170610-story.html; *City of Philadelphia Sued Over New Regulations that Prevent Religious Groups from*

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laws that prohibit or severely restrict begging or food sharing are often successfully challenged as violating First Amendment rights.

Indeed, since the U.S. Supreme Court's 2015 decision in *Reed v. Town of Gilbert*, courts have uniformly rejected laws restricting begging. *Reed* actually had nothing to do with begging: it involved a city ordinance that provided different restrictions for signs depending on their content.[117] A small church brought a First Amendment challenge, contending that the law discriminated against free speech because church and other non-profit signs were subjected to the highest regulations, while other messages were not.[118] The Court agreed.[119] It held that the law impermissibly discriminated against certain kinds of speech, but not others.[120] In its reasoning, the Supreme Court stressed that the government cannot restrict speech based on its content or single out one form of speech over another based on the perceived worthiness of the speech.[121] The *Reed* decision cleared the way for cases challenging begging restrictions that disfavor even peaceful requests for help, a protected form of free speech.[122]

Many cities have caught on and recast their begging restrictions as so-called "aggressive begging" laws, even though many of these laws can encompass even non-aggressive conduct.[123] Violations can be triggered solely on a witness's subjective perception: If someone witnesses begging and feels fearful or even feels "compelled" to give, such feelings may be

Providing Food for the Homeless in City Parks, AM. CIVIL. LIBERTIES UNION PA (June 5, 2012), https://www.aclupa.org/news/2012/06/05/state-house-committee-passes-bill-to-increase-spying-power-of-government-and-civilians,-says-aclu-of-pa.

117. Specifically, the ordinance differentiated among signs based its content. Reed v. Town of Gilbert, 135 S. Ct. 2218, 2224 (2015). The law provided the greatest flexibility and fewest restrictions for political and ideological signs. The church's signs and some other non-profit, event-related signs could only be six square feet, displayed for no more than fourteen hours, and were limited to four per property. *Id.* at 2225. Other restrictions applied to the other two categories. *Id.* at 2224–25.

118. *Id.* at 2226.

119. *Id.* at 2223.

120. *Id.*

121. *Id.* at 2229 ("Innocent motives do not eliminate the danger of censorship presented by a facially content-based statute, as future government officials may one day wield such statutes to suppressed disfavored speech. That is why the First Amendment expressly targets the operation of the laws—i.e. 'the abridg[ement] of speech'—rather than merely the motives of those who enacted them." (internal citation omitted)).

122. TILLISCH & SENA, *supra* note 63, at 12.

123. *Id.* at 3.

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sufficient to make begging criminal even if the person begging has not engaged in any objectively aggressive conduct.[124] Such reliance on whether a witness "subjectively" feels fear is highly problematic in light of studies proving people tend to feel fear simply when viewing a homeless person, regardless of that person's conduct.[125] Accordingly, homeless rights advocates have recommended that cities repeal begging restrictions and instead rely on existing laws, such as assault, battery, or harassment, to address truly aggressive behavior.[126]

Some cities also seek to punish those who try to help homeless people, including through food-sharing restrictions.[127] "United States cities are enacting ordinances that regulate, under threat of criminal punishment, sharing food with hungry people in public properties, like parks, sidewalks, and streets."[128] Such restrictions not only limit food availability to homeless people, but they also subject individuals or organizations, often faith-based organizations, to fines or criminal charges for sharing food. Perhaps the most infamous instance of a city's enforcement of an anti-food-sharing law was in Fort Lauderdale, Florida, where police arrested a 90-year-old veteran and two pastors attempting to feed homeless neighbors.[129] More recently, California Governor Brown approved Assembly Bill 2178, which reaffirms criminal sanctions against "temporary" feeding operations.[130] Advocates maintain that such food-sharing restrictions are constitutionally or statutorily infirm under judicial precedent and the Religious Land Use

124. *Id.* at 20.

125. Rankin, *supra* note 17, at 6–7.

126. Tillisch & Sena, *supra* note 63, at iv.

127. David L. Abney, *Religion and Housing for the Homeless: Using the First Amendment and the Religious Land Use Act to Convert Religious Faith into Safe, Affordable Housing*, 8 St. Mary's L. Rev. on Minority Issues 1 (2005).

128. González, *supra* note 116, at 47.

129. This event received national media coverage. *See, e.g.*, Peter Holley, *After 90-Year-Old is Arrested Florida Judge Halts Law that Restricts Feeding the Homeless*, Wash. Post (Dec. 3, 2014), https://www.washingtonpost.com/news/post-nation/wp/2014/12/03/after-90-year-old-is-arrested-florida-judge-halts-law-that-restricts-feeding-the-homeless/?utm_term=.03c40f009e2d.

130. Cal. Assembly Bill 2178 (2018) (enacted). For an initial analysis of the AB 2178's predictable negative impacts on hungry people and the religious and political activists who peaceably assemble to publicly share food with them, see Marc-Tizoc González, *California Assembly Bill 2178 Threatens Food Sharing Throughout the State*, Food Sharing Law (Sept. 18, 2018), https://foodsharinglaw.net/2018/09/18/california-assembly-bill-2178-threatens-food-sharing-throughout-the-state/.

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and Institutionalized Persons Act (RLUIPA).[131] Food-sharing restrictions have decreased slightly, perhaps due to recent successful challenges in some high-visibility cases.[132] But at least 6 percent of cities still punish sharing food with people experiencing homelessness.[133]

III. WHY WE CRIMINALIZE HOMELESSNESS

Criminalizing homelessness is often illegal, always expensive, and generally ineffective. If criminalizing homelessness is such a bad idea, why do cities across the country continue to do it? A persistent contributor of the criminalization of homelessness is the power of our instinctive response to visible poverty. Americans are stained by "the influence of exile": deeply ingrained class and status distinctions that can inconspicuously, even unconsciously guide us to create and enforce laws and policies that restrict the visibility of poverty—of poor people—in public space.[134]

Studies suggest that Americans react to evidence of visible poverty with higher rates of negativity than to any other marginalized trait, including traits historically associated with discrimination, such as race or gender.[135] Exposure to evidence of human struggle or desperation commonly provokes fear, annoyance, disgust, or anger from those who witness it.[136] Other researchers explain that disgust of visible poverty expresses "a behavioral immune system," activated by an association of homeless people with "pathogens," a human expression of disease, lack of cleanliness, or disorder.[137] These deeply rooted "physiological mechanisms" compel us to prevent contact with homeless people because we implicitly associate

131. *See, e.g.*, Marc-Tizoc González, *Criminalizing Charity: Can First Amendment Free Exercise of Religion, RFRA, and RLUIPA Protect People who Share Food in Public?*, 7 U.C. IRVINE L. REV. 291, 300, 320–21, 323, 335–37 (2017) (discussing California-based litigation brought by religious food-sharing plaintiffs under RLUIPA).

132. *See, e.g.*, Fort Lauderdale Food Not Bombs v. City of Fort Lauderdale, No. 16–16808 (11th Cir. Aug. 22, 2018).

133. NLCHP HOUSING NOT HANDCUFFS, *supra* note 54, at 10.

134. Rankin, *supra* note 17, at 7.

135. *Id.* at 17.

136. *Id.* at 7.

137. Scott Clifford & Spencer Piston, *Explaining Public Support for Counterproductive Homelessness Policy: The Role of Disgust*, 39 POLIT. BEHAV. 2, 507–509 (2017).

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them with disease, perceiving them as "pathogenic threats" we must avoid through "physical distancing" to avoid potential contamination.[138]

This deeply rooted, often unconscious, stigmatization of visible poverty is expressed in common mythologies about homelessness. For example, a persistent myth is that homelessness is a consequence of bad choices. But the top five causes of homelessness are lack of affordable housing, lack of a living wage, domestic violence, medical bankruptcy, and untreated mental illness.[139] These causes can happen to anyone. Trauma can also play a large role.[140] When coping with mental illness or addiction, maintaining independent housing may not be feasible. Lawyers, doctors, film directors, entrepreneurs, university professors, professional musicians, and many others have experienced homelessness.[141] Anyone can become homeless if they cannot pay for housing and lack other resources or support.

Many causes of homelessness have nothing to do with choice.[142] For example, many homeless women are survivors of domestic abuse.[143] These women lack a support system and may be unable to seek resources. If they depend on their abuser for financial stability, they will face challenges in

138. *Id.* at 507.

139. NAT'L LAW CTR. ON HOMELESSNESS & POVERTY, HOMELESSNESS IN AMERICA: OVERVIEW OF DATA AND CAUSES (Jan. 2015), https://www.nlchp.org/documents/Homeless_Stats_Fact_Sheet.

140. *Trauma*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS, ADMIN., https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/trauma (last visited Sept. 14, 2018) ("Homelessness is traumatic . . . Some such people, particularly women, may have histories of trauma, including sexual, psychological, or physical abuse.").

141. Jens Erik Gould, *Down and Out in L.A.: When the Middle Class Goes Homeless*, TIME (Sept. 2, 2011), http://content.time.com/time/nation/article/0,8599,2090997,00.html (writing that there has been an increase in homeless families that were once "secure members of the middle class," such as movie producers and collections agents); Emily Crane, *California's Hidden Homeless: Teachers, Chefs, Nurses and Other Middle Class Workers Living in Cars in Parking Lots Because of the State's Crazy Property Prices*, DAILY MAIL (Dec. 26, 2017), https://www.dailymail.co.uk/news/article-5212977/Californias-middle-class-homeless-living-parking-lots.html ("Hundreds of people, including nurses and chefs, are sleeping in parking lots in affluent areas like Santa Barbara as they make the most of the only homes they can afford."); *see also* Charles Mudede, *Seattle's New Normal: Homelessness is Now Middle Class*, THE STRANGER (Mar. 23, 2018), https://www.thestranger.com/slog/2018/03/23/25950929/seattles-new-normal-homelessness-is-now-normal.

142. *See* LURIE & SCHUSTER, *supra* note 4.

143. Id. at 14 ("Homelessness has a discriminatory impact on female victims of domestic violence in Washington State. Mirroring the national data, domestic violence is a leading cause of homelessness for women and children statewide." (internal citation omitted)).

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finding the money for a new home, especially if they have been prevented from working by their abuser.[144] Veterans also suffer homelessness disproportionately due to trauma, poverty, lack of support networks, and dismal living conditions in overcrowded or substandard housing.[145]

Some attempt to support such a "homeless by choice" narrative by pointing to statistics showing some unsheltered people decline offers of services or emergency shelter.[146] But many cities lack sufficient shelter, not only due to an insufficient number of beds, but also due to the functional inaccessibility of existing shelter. Some people sleep outside rather than in shelters because they do not fare well in crowded environment, or they fear having to leave pets and belongings outside.[147] In addition, many shelters and homeless housing programs have stringent eligibility criteria and rules that screen out the most vulnerable people.[148] Finally, most shelters are a place to sleep for a few hours, not a place to live. Moreover, offers of services and treatment, without also offering stable housing, are unlikely to benefit someone who must return to the trauma of homelessness after a session of service.

Setting aside the "homeless by choice" narrative, others favor criminalization over investments in positive solutions, such as housing or services,

144. *See, generally Domestic Violence and Homelessness*, AM. CIVIL LIBERTIES UNION, https://www.aclu.org/sites/default/files/pdfs/dvhomelessness032106.pdf (last visited Sept. 25, 2018) ("A lack of alternative housing often leads women to stay in or return to violent relationships. In Minnesota in 2003, for instance, 46% of homeless women reported that they had previously stayed in abusive relationships because they had nowhere to go."). "The intersection of homelessness and domestic violence is complex . . . [A] survivor may be unable to pay rent because of actions taken by an abusive partner to undermine her economic stability and ability to live independently." *Homelessness Prevention and Rapid Re-Housing for Survivors of Domestic Violence*, NAT'L ALLIANCE TO END HOMELESSNESS, http://endhomelessness.org/wp-content/uploads/2011/03/prevention-rapid-rehousing-for-dv-survivors.pdf (last visited Sept. 25, 2018).

145. *Veteran Homelessness Facts*, GREEN DOORS, http://greendoors.org/facts/veteran-homelessness.php (last visited Sept. 14, 2018).

146. *E.g.*, Vernal Coleman & Vianna Davila, *Seattle Officials at Odds on How Many Homeless Get Shelter After Camps Cleared*, SEATTLE TIMES (Nov. 4, 2017), https://www.seattletimes.com/seattle-news/homeless/seattle-officials-at-odds-on-how-many-homeless-get-shelter-after-camps-cleared/ ("79 percent of people offered shelter either declined or ruled 'ineligible' because of their criminal records, lack of identification or other complications.").

147. SKINNER, *supra* note 49, at Part II.

148. *Id.* at 11–14.

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because they believe such investments will serve as a beacon, attracting new homeless people from other locations and overwhelming the host city. This "magnet" myth is closely related to the belief that people experiencing homelessness in any given city are not residents, but outsiders. But the best available evidence suggests otherwise. For example, in Seattle/King County, the vast majority (95%) of the county's homeless population were Washington state residents—83 percent from within King County—before they became homeless.[149] The city of Seattle's Homeless Needs Assessment showed similar results: 49 percent of respondents reported they were living in the city of Seattle when they most recently became homeless; 31 percent reported being originally from Seattle; of the 69 percent of respondents not originally from Seattle, 15 percent reported living in Seattle for a decade or more.[150] These results, which suggest people experiencing homelessness are homegrown, are not uncommon.[151]

149. All Home, Seattle/King County Point-in-Time Count of Persons Experiencing Homelessness 2018, at 30 (2018), http://allhomekc.org/wp-content/uploads/2018/05/FINALDRAFT-COUNTUSIN2018REPORT-5.25.18.pdf.

150. City of Seattle & Asr, 2016 Homeless Needs Assessment 16 (2016), https://assets.documentcloud.org/documents/3480319/City-of-Seattle-Homeless-Needs-Assessment-March.pdf.

151. *E.g.*, Applied Survey Research, San Francisco 2017 Homeless County & Survey Comprehensive Report 22 (2017), http://hsh.sfgov.org/wp-content/uploads/2017/06/2017-SF-Point-in-Time-Count-General-FINAL-6.21.17.pdf (finding that 69% of respondents in the 2017 San Francisco point-in-time (PIT) survey were living in San Francisco at the time they most recently became homeless); Metro Denver Homeless Initiative, 2017 Point-in-Time Report: Seven-County Metro Denver Region at 9 (2017), https://d3n8a8pro7vhmx.cloudfront.net/mdhi/pages/12/attachments/original/1498599733/2017_Metro_Denver_PIT_Final.pdf?1498599733 (finding 32.9% of individuals reported their last permanent residence to be in the City or County of Denver, 37.7% within state, while only 17.2% of individuals reported that their last permanent residence was either out of state or out of country); Bitfocus, Help Hope Home: 2017 Southern Nevada Homeless Census & Survey Comprehensive Report 48 (2017), http://helphopehome.org/wp-content/uploads/2017/07/2017-S-Nevada-Census-and-Survey-for-posting.pdf (finding in the Southern Nevada PIT survey,79% of respondents reported living in Southern Nevada when they most recently become homeless). Contrary indications are not the norm. *See, e.g.*, Amelia Templeton, *How Portland Tried, and Failed, to Provide a Bed for All its Homeless Children*, OPB (Mar. 13, 2018), https://www.opb.org/news/article/portland-oregon-homeless-children-shelter-families/ (reporting Portland's "no turn away" shelter policy attracted 45% of local county residents, but "significant" numbers came from other Oregon counties, and about one-third were from out of state).

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Laziness is another stereotype applied to people experiencing homelessness: many believe that homeless people do not work even though they can. Many homeless people do work (some reports estimate 44% nationally),[152] but still have no reasonable alternative to living in their cars, emergency shelters, or even outside. But it is hard to get or maintain employment without a place to bathe, to prepare meals, or to set an alarm. Getting and keeping a job can be especially challenging. Applying for work can be difficult without a permanent address or regular access to a shower or transportation. Other obstacles such as mental illness, physical disabilities, and even a non-violent criminal history can be a barrier to seeking employment.[153]

Even having a job is no guarantee against homelessness. There is no state in the United States where a minimum wage worker working full time can afford a two-bedroom apartment at fair market rent.[154] For example, currently in Washington State, a resident must work 75 hours a week at minimum wage to afford the rent of a one-bedroom apartment.[155] Accordingly, the price of housing is out of reach for most, especially and including people experiencing chronic homelessness.

Closely related to myths about laziness and unemployment is the misperception that homeless people heavily rely on government assistance, such as disability benefits in Supplemental Security Income (SSI) or welfare benefits in Temporary Assistance to Needy Families (TANF). To the contrary, a relatively small percentage of homeless people receive such

152. *Employment and Homelessness*, NAT'L COAL. FOR THE HOMELESS (July 2009), https://www.nationalhomeless.org/factsheets/employment.html ("As bad as it is for the 44% of homeless people who have jobs and can't escape homelessness, climbing out of homelessness is virtually impossible for those without a job.").

153. OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING & EVALUATION, EMPLOYMENT AND INCOME SUPPORTS FOR HOMELESS PEOPLE: BARRIERS TO WORK FACED BY HOMELESS PEOPLE 3 (Mar. 1, 2007), https://aspe.hhs.gov/report/toward-understanding-homelessness-2007-national-symposium-homelessness-research-employment-and-income-supports-homeless-people/barriers-work-faced-homeless-people (stating that all segments of the homeless population face significant and multiple barriers to employment, including: transportation, educational credentials, mental and physical health, disabilities, substance use disorders, incarceration history, child care, and the digital divide).

154. *See* NAT'L LOW INCOME HOUSING COAL., *supra* note 1.

155. *Out of Reach 2018: Washington*, NAT'L LOW INCOME HOUSING COAL., http://nlihc.org/oor/washington (last visited Sept. 14, 2018).

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assistance.[156] Although over 40 percent of homeless persons are eligible for disability benefits, only 11 percent actually receive them.[157] Most homeless families are eligible for welfare benefits, but only 52 percent receive them.[158] Even when homeless individuals do receive benefits, they rarely receive enough to afford housing. Since 2017, every state's TANF benefits for a family of three are at or far below the poverty line, woefully inadequate to pay a fair market rent.[159]

Another potent stereotype is the association of homeless people with criminality. But a person who is homeless is no more likely to be a criminal than a housed person, with one legal exception: camping ordinances.[160] People who are homeless break that law by being homeless. Criminal records for homeless single adults are overwhelmingly due to misdemeanor offenses related to living outdoors, such as trespass.[161] A person who is homeless is no more likely to perpetrate a violent crime than a housed person,[162] but is much more likely to be the victim of a violent crime, such as murder, assault, rape, and theft.[163] Homeless people are also often the

156. David Long, John Rio, Jeremy Rosen, Employment and Income Supports for Homeless People 6 (2007), https://aspe.hhs.gov/system/files/pdf/180356/report.pdf; *see also* Burt et al., *supra* note 13, at 12 (finding that the "the highest rates of participation [in government benefits] among homeless clients were food stamps (37%) and Medicaid (30%).").

157. Long, Rio, & Rosen, *supra* note 156, at 6 ("In 2000 . . . 39 percent of homeless persons reported mental health problems and 46 percent of homeless persons had chronic physical disabilities, far more than the 11 percent receiving SSI. While not all persons with disabilities are eligible for SSDI or SSI, these disparities suggest that at least some eligible individuals who are homeless are not receiving benefits."); Burt et al., *supra* note 13, at xx ("11 percent receive Supplemental Security Income").

158. Long, Rio, & Rosen, *supra* note 156, at 9.

159. Ife Floyd, *TANF Cash Benefits Have Fallen by More Than 20 Percent in Most States and Continue to Erode*, Ctr. on Budget and Policy Priorities (Oct. 13, 2017), https://www.cbpp.org/research/family-income-support/tanf-cash-benefits-have-fallen-by-more-than-20-percent-in-most-states.

160. Olson & Macdonald, *supra* note 44.

161. Social science studies have found that individuals experiencing homelessness are at risk for engaging in non-violent criminal activity, and that "homeless jail inmates were more likely to have been arrested for nuisance offenses (e.g., camping without a permit, indecent exposure) than domiciled inmates." Fischer, *supra* note 13, at 251.

162. *Myths and Facts of Homelessness in Washington State: Building a New Public Narrative to Combat Criminalization and Advance Real Solutions*, Wash. Low Income Hous. All., https://www.wliha.org/sites/default/files/myths.pdf (last visited Sept. 24, 2018).

163. About half of homeless people (49%) report being victims of violence compared with only 2% of the general U.S. population. Nat'l Coal. for the Homeless,

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victims of hate crimes.[164] The misattribution of heightened criminality to people experiencing homelessness, like many other stereotypes, fuels their criminalization.

IV. ALTERNATIVES TO CRIMINALIZATION

The instinct to criminalize likely is also driven by the misperception that homelessness cannot be solved. But well-established studies show that even chronic homelessness—the most persistent form of homelessness—can be solved.

Although chronically homeless people do not constitute the majority of the overall homeless population,[165] they warrant particular attention for reasons beyond the degree of punishment they bear through criminalization. First, while some other subpopulations are decreasing,[166] many major cities, especially along the West Coast, continue to experience increases in

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VULNERABLE TO HATE: A SURVEY OF HATE CRIMES & VIOLENCE COMMITTED AGAINST HOMELESS PEOPLE IN 2013, at 22 (2014), http://nationalhomeless.org/wp-content/uploads/2014/06/Hate-Crimes-2013-FINAL.pdf. *See* Molly Meinbresse et al., *Exploring the Experiences of Violence Among Individuals who are Homeless Using a Consumer-Led Approach*, 29 VIOLENCE & VICTIMS 1 (2014), http://www.nhchc.org/wp-content/uploads/2014/08/vv-29-1_ptr_a8_122-136.pdf ("The prevalence of violence victimization in the homeless population has been estimated to range from 14% to 21% and approximately one-third report having witnessed a physical attack on another person who was homeless." (internal citations omitted)).

164. NAT'L COAL. FOR THE HOMELESS, NO SAFE STREET: A SURVEY OF VIOLENCE COMMITTED AGAINST HOMELESS PEOPLE IN 2014 & 2015, at 3 (July 13, 2016), http://nationalhomeless.org/category/civil-rights/violence-against-the-homeless/ ("Over the past 17 years, NCH has recorded 1,650 incidents of crimes committed against this unprotected group. In 2014 and 2015, NCH became aware of 192 attacks, 58 of which resulted in death.").

165. In 2017, HUD issued its Annual Homeless Assessment Report (AHAR) to Congress which reported data from a national PIT count of individuals experiencing homelessness. AHAR 2017, *supra* note 20. The 2017 PIT count found that 553,742 individuals were experiencing homelessness, and of that base number, 86,962 were individuals with chronic patterns of homelessness. *Id.* at 1.

166. For example, the 2017 AHAR reported a 5% decrease in the number of unhoused families with children since 2016. AHAR 2017, *supra* note 20, at 1. Additionally, despite a 2% increase in unhoused veterans between 2016 and 2017, "homelessness among veterans dropped 45 percent since 2009." *Id.*

chronic homelessness.[167] So chronic homelessness is increasing in severity and remains at the epicenter of many homelessness crises.

Second, this subpopulation is the most visible. Their sustained visibility not only renders them frequent targets of criminalization laws, but also positions them as a lightning rod for polarized, charged debates around housing and homelessness. Their presence controls the narrative that drives societal perspectives and associated laws and policies.[168] To many homeless rights advocates, if non-punitive interventions can show progress in mitigating chronic homelessness—the so-called "hardest to house"—such progress may help to change the way people think, talk, legislate, and litigate about criminalizing homelessness generally.

Third, in many ways, chronically homeless people are also the most vulnerable. Exposed on the street, they suffer from higher rates of poor health,[169] mental illness, and substance abuse[170] when compared to homeless populations generally. Because chronic homelessness always involves the presence of at least one other significant disabling condition,[171] their pronounced vulnerability contributes to their persistent homelessness. Accordingly, they are the least likely to exit homelessness without intervention.

Fourth, chronic homelessness is the most costly segment. Although they do not constitute a majority within homeless populations overall, chronically homeless individuals generate a disproportionate share of public costs because they are among the highest frequency users of emergency services and hospitalization, as well as police, court, and probation resources, and jail time.[172]

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167. Specifically, "[o]ver half of all states, 28, experienced an increase between 2016 and 2017 in the number of individuals with chronic patterns of homelessness. *California* by far had the largest increase, with 5,996 more chronically homeless individuals in 2017 than in 2016. The next largest increase occurred in *Washington*, with 2,050 more individuals with chronic patterns of homelessness there in 2017." *Id.* at 66 (emphasis added).

168. *See, e.g.*, Robert P. Agans et al., *Public Attitudes Toward the Homeless*, PROCEEDINGS OF THE AMERICAN STATISTICAL ASSOCIATION 5934–46 (2011), https://ww2.amstat.org/sections/srms/Proceedings/y2011/Files/400188.pdf (suggesting public opinions about homelessness drive personal action, such as voting for or against certain related laws and policies).

169. HOMELESS HUB Health, *supra* note 51.

170. SAMHSA Homelessness and Housing, *supra* note 51.

171. *See supra* p. 6 and note 20 (defining "chronic homelessness").

172. *See Ending Chronic Homelessness in 2017*, U.S. INTERAGENCY COUNCIL ON HOMELESSNESS, https://www.usich.gov/resources/uploads/asset_library/Ending_Chronic_

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Fifth and finally, studies consistently show that solving chronic homelessness is achievable through the evidence-based solutions[173] of Housing First[174] and permanent supportive housing (PSH).[175]

A. What is Housing First?

A seminal, widely known theory sets helpful context for understanding Housing First.[176] Regardless of whether someone has studied business, medicine, psychology, or some other discipline, they have likely learned about Maslow's Hierarchy of Needs.[177] Maslow's Hierarchy demonstrates that people must satisfy basic physiological needs—like breathing, eating, drinking, excreting, sleeping, and having stable housing—before they can successfully attend to successively higher-order needs.[178] Since this theory's publication in 1943, it illuminated understanding of human motivation, performance, and capability, immeasurably impacting psychology, psychiatry, health care, business, education, social work, and numerous other fields.

Unfortunately, traditional approaches to homelessness often defy what Maslow's Hierarchy teaches, expecting or requiring people experiencing

Homelessness_in_2017.pdf (last visited Sept. 11, 2018) ("Ending chronic homelessness could reduce avoidable public costs such as avoidable emergency department visits, jail, and shelter costs.").

173. See *Evidence Base*, CTR. FOR EVIDENCE-BASED SOLUTIONS TO HOMELESSNESS, http://www.evidenceonhomelessness.com/evidence-base/ (last visited Sept. 11, 2018).

174. *Fact Sheet: Housing First*, NAT'L ALL. TO END HOMELESSNESS 1, http://endhomelessness.org/wp-content/uploads/2016/04/housing-first-fact-sheet.pdf (last visited Sept. 11, 2018) ("Consumers in a Housing First model access housing faster and are more likely to remain stably housed." (internal citations omitted)).

175. *Chronic Homelessness*, *Ctr. For Evidence-Based Solutions to Homelessness*, http://www.evidenceonhomelessness.com/topic/chronic-homelessness/ (last visited Sept. 11, 2018) ("[Permanent supported housing] can lead to substantial savings and, among the heaviest service users, may even be a cost-neutral investment, with the cost of housing subsidies and services offset by reductions in other spending for public services.").

176. *Deploy Housing First System Wide*, U.S. INTERAGENCY COUNCIL ON HOMELESSNESS (Aug. 15, 2018), https://www.usich.gov/solutions/housing/housing-first/ ("A Housing First system orientation recognizes that people experiencing homelessness—like all people—need the safety and stability of a home in order to best address challenges and pursue opportunities.").

177. A.H. Maslow, *A Theory of Human Motivation*, 50 PSYCH. R. 370–96 (1943).

178. *Id.*

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the trauma of homelessness to accept offers of service or treatment without also offering a stable place to live.[179] Not surprisingly, such traditional approaches are often unsuccessful. Housing First is an exception.

Housing First is a homelessness intervention that prioritizes providing permanent housing to people experiencing homelessness, ending their homelessness and serving as a platform from which they can improve their quality of life. This pragmatic approach reflects the reality that people need basic necessities like food, sleep, and a stable place to live before attending to any secondary issues, such as getting a job, budgeting properly, or attending to substance use issues.[180] It also reflects evidence that allowing residents to exercise choice in housing selection and supportive service participation is key to making them more successful in remaining housed and improving their life.

Housing First does not require people experiencing homelessness to address all of their problems, including behavioral and health problems, or to graduate through a series of services programs before they can access housing. It does not mandate participation in services either before obtaining housing or in order to retain housing. The Housing First approach views housing as the foundation for life improvement and enables access to permanent housing without prerequisites or conditions beyond those of a typical renter. Supportive services are offered to help people with housing stability and individual well-being, but participation is not required: services are proven to be more effective when the recipient chooses to engage. Other approaches make such requirements for a person to obtain and retain housing; these approaches are far less effective.

B. What is Permanent Supportive Housing?

Supportive housing is an evidence-based housing intervention that combines non-time-limited affordable housing assistance with wrap-around

179. *See, e.g.*, Amanda Stafford & Lisa Wood, *Tackling Health Disparities for People who are Homeless? Start with Social Determinants*, 14 INT. J. ENVIRON. RES. PUBLIC HEALTH 12, 1535 (noting the low degree of effectiveness in treating the health needs of people experiencing homelessness then simply sending them back to the conditions that compromise their health).

180. U.S. INTERAGENCY COUNCIL ON HOMELESSNESS, *supra* note 176.

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supportive services for people experiencing homelessness and other people with disabilities.[181] Research shows supportive housing is a cost-effective solution to homelessness, particularly for people experiencing chronic homelessness.[182] Studies consistently show that supportive housing not only resolves homelessness and increases housing stability, but also improves health and lowers public costs by reducing the use of publicly funded crisis services, including shelters, hospitals, psychiatric centers, jails, and prisons.[183]

Together, Housing First and permanent supportive housing programs have demonstrated success in ending homelessness for even the "hardest" to reach.[184] Moreover, once people are housed, they eventually begin to accept services and treatment at higher rates than before, and the impact of those services is far more robust and enduring.[185] Once housed, people can

181. *E.g.*, Kristofor Husted, *A Permanent Home that Allows Drinking Helps Homeless Drink Less*, NPR (Jan. 23, 2012, 11:08AM ET), https://www.npr.org/sections/health-shots/2012/01/19/145477493/a-permanent-home-that-allows-drinking-helps-homeless-drink-less (writing about a supported housing program in Seattle that allowed alcohol consumption found that its participants' consumption of alcohol decreased by about 25% at the end of a two-year study: "the data show that finding homeless people a permanent home first may provide them with the support they need to tackle other health concerns later.").

182. *The Effectiveness of Housing First & Permanent Supportive Housing*, SEATTLE UNIV. HOMELESS RIGHTS ADVOCACY PROJECT (July 25, 2018) [hereinafter HRAP Effectiveness of Housing First & PSH], https://law.seattleu.edu/Documents/korematsu/HRAP-Excerpts-of-Studies-on-Housing-First-Permanent-Supportive-Housing.pdf (providing "a non-exhaustive sampling of studies concerning the Effectiveness of Housing First and Permanent Supportive Housing").

183. *Id.*; *see also* Husted, *supra* note 181.

184. *Id.*

185. *E.g.*, SARAH B. HUNTER ET AL., *EVALUATION OF HOUSING FOR HEALTH*: PERMANENT SUPPORTIVE HOUSING PROGRAM (2017), https://www.rand.org/content/dam/rand/pubs/research_reports/RR1600/RR1694/RAND_RR1694.pdf (finding a 60% reduction in use of public services among PSH participants and a reduction in emergency medical services, illustrating the impact of supporting housing services on stability); M.E. Larimer, D.K. Malone, M.D. Garner, et al., *Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems*, 301 J. OF AMER. MED. ASSOC. 13, 1349–57 (2009) (finding that prior to receiving Housing First intervention, the participants received a median of $4066 in public services per person, but after six months of receiving Housing First intervention, this cost dropped to a median of $1492 per person, illustrating the enduring impact of public services while being in permanent housing).

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more easily and effectively work toward resolving issues such as alcoholism, drug addiction, and mental illness.

Providing permanent supportive housing to individuals with chronic patterns of homelessness is proven to significantly reduce use of expensive acute care services such as emergency shelters, hospital emergency rooms, and detoxification and sobering centers.[186] As a result, permanent supportive housing can lead to substantial savings.[187] Even among the heaviest service users, it may be a cost-neutral investment, with the cost of housing subsidies and services offset by reductions in other spending for public services.

Numerous communities throughout the United States are taking note, taking action, and making significant progress toward ending chronic homelessness.[188] States like Utah[189] and Hawaii,[190] cities such as New Orleans,[191]

186. HRAP Effectiveness of Housing First & PSH, *supra* note 182.

187. NAEH, *Study Data Show that Housing Chronically Homeless People Saves Money, Lives*, NAT'L ALL. TO END HOMELESSNESS: ENDING HOMELESSNESS TODAY (June 30, 2015), https://endhomelessness.org/study-data-show-that-housing-chronically-homeless-people-saves-money-lives/ (including a map of PSH cost studies, the majority of which "show significant savings that completely or nearly offset the cost of housing").

188. David Bornstein, *A Growing Drive to Get Homelessness to Zero*, NY TIMES (June 5, 2018), https://www.nytimes.com/2018/06/05/opinion/homelessness-built-for-zero.html?rref=collection%252Fcolumn%252Ffixes&action=click&contentCollection=opinion&region=stream&module=stream_unit&version=latest&contentPlacement=1&pgtype=collection.

189. Kelly McEvers, *Utah Reduced Chronic Homelessness by 91 Percent; Here's How*, NPR (Dec. 10, 2015, 6:08PM ET), https://www.npr.org/2015/12/10/459100751/utah-reduced-chronic-homelessness-by-91-percent-heres-how (writing that Utah nearly met its goal of ending chronic homelessness in 2015, when the population of chronically homeless people decreased by 91% within the state).

190. Max Dible, *Homeless Ranks Shrink Statewide, Islandwide for Second Straight Year*, WEST HAWAII TODAY (May 8, 2017, 12:05AM), http://www.westhawaiitoday.com/2018/05/08/hawaii-news/homeless-ranks-shrink-statewide-islandwide-for-second-straight-year/ ("This year, Hawaii saw a 9.6 percent decrease in overall homelessness compared with a 9 percent decrease the year before.").

191. Noelle Swan, *In a U.S. First, New Orleans Finds Homes for All Its Homeless Veterans*, CHRISTIAN SCIENCE MONITOR (Jan. 9, 2015), https://www.csmonitor.com/USA/Society/2015/0109/In-a-US-first-New-Orleans-finds-homes-for-all-its-homeless-veterans ("New Orleans [became] the first U.S. city to effectively eliminate veteran homelessness.").

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San Antonio,[192] Detroit,[193] and Tulsa,[194] and countries like Finland,[195] Denmark,[196] and Canada[197] have all made significant progress through such programs. The demonstrated success of such non-punitive alternatives to criminalization underscores the problem with current laws and policies that punish already vulnerable people.

CONCLUSION

Seattle and many other cities throughout the country need to know that our current approach to criminalizing homelessness is an often illegal and always expensive rotating door. It costs far less for cities to invest in non-punitive alternatives that actually solve homelessness, like permanent

192. John Stephens, *A Public-Private Homeless Solution in Texas Might Work for Costa Mesa and O.C.*, Los Angeles Times (Feb. 7, 2018, 12:00PM), http://www.latimes.com/socal/daily-pilot/opinion/tn-dpt-me-commentary-stephens-20180207-story.html (writing that in 2017, San Antonio, Texas, experienced an 80% decrease in numbers of individuals experiencing homeless since 2010).

193. *Detroit's Focus on Supportive Housing Drives Down Homelessness 15 Percent*, Detroit Journalism Cooperative, https://www.detroitjournalism.org/2018/05/09/detroits-focus-on-supportive-housing-drives-down-homelessness-15-percent/ (last visited Sept. 11, 2018) ("The number of people in Detroit experiencing homelessness continued a steady decline in 2017, dropping 15% over the previous year.").

194. Corey Jones, *Built for Zero Tulsa Surpasses 1,000 People Housed in Effort to Stymie Chronic, Veteran Homelessness*, Tulsa World (Apr. 20, 2018), https://www.tulsaworld.com/news/local/built-for-zero-tulsa-surpasses-people-housed-in-effort-to/article_3d648c71-b614-5a7c-a0c1-7a2c2dbdfaf9.html (writing that the Built for Zero Tulsa initiative, a Housing First model, placed 1,000 individuals into permanent housing).

195. Gordon F. Sander, *Finland's Homeless Crisis Nearly Solved. How? By Giving Homes to all who Need*, Christian Science Monitor (Mar. 21, 2018), https://www.csmonitor.com/World/Europe/2018/0321/Finland-s-homeless-crisis-nearly-solved.-How-By-giving-homes-to-all-who-need (writing that "the number of homeless people in Finland has declined from a high of 18,000 30 years ago, to approximately 7,000").

196. *Housing First in Danmark*, Danish Nat'l Ctr. for Soc. Research, https://en.sfi.dk/publications/housing-first-in-danmark-12839/ (last visited Sept. 11, 2018).

197. Vicky Stergiopoulos et al., *Effect of Scattered-Site Housing Using Rent Supplements and Intensive Case Management on Housing Stability Among Homelessness Adults with Mental Illness: A Randomized Trial*, JAMA Network (Mar. 3, 2015), https://jamanetwork.com/journals/jama/fullarticle/2174029 (finding that "scattered-site supportive housing using rent supplements and ICM services led to significantly greater housing stability for homeless adults with mental illness and moderate support needs compared with usual care in 4 cities across Canada over the 24-month follow-up period").

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supportive housing. In Seattle and elsewhere on the West Coast, the rapid rise in homelessness has overwhelmed existing systems,[198] generating crisis responses not capable of actually ending homelessness. Cities throughout America can and should do more to end the criminalization of homelessness and redirect such investments to non-punitive alternatives such as Housing First and permanent supportive housing. The status quo is punishment, broadly borne by us all.

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198. West coast cities may be responsible for most increases in homelessness nationally. *See, e.g.*, Pam Fessler, *Homeless Population Rises, Driven by West Coast Affordable-Housing Crisis*, NPR (Dec. 6, 2017, 12:02AM ET), https://www.npr.org/2017/12/06/568605069/homeless-population-rises-driven-by-west-coast-affordable-housing-crisis ("The increase is almost entirely due to a surge in homelessness in Los Angeles and other cities facing severe shortages of affordable housing, say HUD officials. Many of the cities are on the West Coast, including Seattle, San Diego, and Sacramento, Calif."); Christopher Weber & Geoff Mulvihill, *For the First Time in 7 Years There are More Homeless in US*, WASH. POST (Dec. 6, 2017), https://www.washingtonpost.com/business/us-homeless-count-rises-pushed-by-crisis-on-the-west-coast/2017/12/06/fof8c2de-da42-11e7-a241-084831564 2d0_story.html?utm_term=.634848dc165d ("The nation's homeless population increased this year for the first time since 2010, driven by a surge in the number of people living on the streets in Los Angeles and other West Coast cities."); Jeff Andrews, *West Coast Spike in Homelessness Drives National Increase: Tight West Coast Housing Markets Cause the First Rise in Homelessness in Years*, CURBED (Dec. 7, 2017, 10:30AM ET), https://www.curbed.com/2017/12/7/16743122/west-coast-homelessness-national-increase ("[T]he slight increase in homeless was mostly driven by increases on the West Coast, particularly in tight housing markets like Los Angeles and Seattle.").

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Washington's War on the Visibly Poor:
A Survey of Criminalizing Ordinances & Their Enforcement

Ex # 11 m/d/y 08/30/2024 Pg 1 of 63
Exam of Dr. Stephen Gaetz
Heegsma et al v City of Hamilton
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WASHINGTON'S WAR ON THE VISIBLY POOR:

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EXECUTIVE SUMMARY

Throughout the country, there are laws punishing behaviors that are necessary for survival. For those without shelter, there is no alternative but to conduct these behaviors in public. Camping outdoors, urinating in public, sitting or lying down on sidewalks—these laws target homeless people either in practice or outright. But until now, no one knew how widespread these laws are throughout Washington, or how they are being enforced. This brief answers these questions.

HRAP researchers surveyed the municipal codes of 72 cities across Washington to identify ordinances that essentially criminalize homelessness in each jurisdiction. From this survey, researchers created a chart tracking every ordinance they could find. Seven of the cities were selected as case studies for closer examination of the enforcement and citations of these ordinances. The findings reveal that homeless criminalization exists regardless of where you live. From densely populated urban cities to scattered rural townships, city councils are increasingly passing these laws, often drafting them in a way that raises serious legal and policy concerns about how Washington treats its most vulnerable residents.

This brief shines a spotlight on the problems with these laws: how they are written, how they impact the homeless community, and how easily cities can fall into the trap of vilifying already vulnerable populations in the name of safety and public health. This report shows that the problem of criminalizing homelessness, so often buried in municipal codes, is both widespread and systemic. Key findings of the brief include:

Washington cities increasingly criminalize homelessness by outlawing **necessary, life-sustaining activities**:

- Laws that prohibit or limit sitting or standing in public places (78% of surveyed municipalities)
- Laws that prohibit or limit sleeping in public places (78%)
- Although the majority of cities in Washington (75%) criminalize urination and defecation in public, cities typically fail to provide sufficient access to reasonable alternatives such as 24-hour restrooms and hygiene centers

Whether you live in a small town or a large metropolis, municipalities are **likely to aggressively criminalize homelessness**:

- Since 2000, Washington cities have enacted new ordinances targeting homelessness in 288 new ways, increasing the amount of criminalization by more than 50% compared to prior years
- As population rises, the minimum number of criminalization laws also rises
- At least two-thirds (66%) of cities draft criminalization ordinances in a way that either overlap with other ordinances or contain compound provisions that criminalize multiple, and often unrelated, behaviors; these practices create legal and policy concerns
- Auburn is the city with the highest number of criminalization ordinances (14 ordinances/population 70,000), followed by Spokane (12), Pasco (12), Everett (11), and Bellingham (11)

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- Auburn also criminalizes the broadest range of surveyed activities (13 categories), followed Spokane (12), Puyallup (12), University Place (12), and Pasco (11)
- Seattle has the highest total population (609,000) but was in the median range of criminalization ordinances (7)

Enforcement of criminalization ordinances raises both **legal and policy concerns**, such as inconsistent or selective citation and sentencing practices:

- As rates of income disparity rise, so does the rate of citations issued for purported violations of criminalization ordinances
- Monetary penalties varied between civil infraction fees of $250 or more up to misdemeanor charges as high as $5,000
- Civil infractions can evolve into criminal violations or otherwise result in criminality for homeless defendants; for example, in the likely event that a homeless defendant "fails to respond" or "fails to pay" the fee for the civil infraction
- In 2013, 87% of defendants sentenced to jail time under Seattle's Pedestrian Interference ordinance spent more than 30 days in jail, compared to 42% in 2009
- Seattle cited individuals for "camping in public" at a disproportionately higher rate compared to other ordinances within its jurisdiction (4,117 citations or 71%)
- More warrants were issued for standing, sitting, or sleeping in public places than for any other categories of behavior
- In addition, custody times revealed a high number of individuals spending more than 90 days in jail for violating criminalization ordinances, especially in Seattle (38)

Although a comprehensive list of policy recommendations is beyond the scope of this report, HRAP researchers can make the following **key recommendations** to Washington policymakers:

- Local lawmakers should abandon the policy of imposing sanctions for the conduct of necessary, life-sustaining activity because people experiencing homelessness have no reasonable alternatives but to survive in public
- Civil infractions should never result in criminal penalties if the defendant is unable to pay or whose housing status makes an appearance or payment highly unlikely
- Jurisdictions should stop the practice of writing overlapping and compound ordinances that raise legal and policy concerns
- Policymakers should re-examine and reject laws that discriminatorily impact visibly poor people

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INTRODUCTION

Homelessness leads to a variety of daily hurdles: finding a safe place to sleep, securing shelter from the elements, and obtaining necessary sustenance, to name only a few. Increasingly, cities make overcoming these hurdles more difficult. Cities criminalize "visible poverty" by literally criminalizing evidence of it. Visible poverty refers to the real or perceived state of being poor in public spaces, and social science proves what we intuitively know to be true: bearing witness to visible poverty creates discomfort in passersby.[1] The policy of criminalizing homelessness has been described as "a social control mechanism used to make the blighted human circumstances disappear instead of getting at the root of the concern and addressing it in a meaningful way."[2] In fact, the trend of passing criminalization ordinances on a local level is neither new nor effective[3] at addressing the core problems associated with homelessness—for the homeless individual or for the community at large.[4] Other studies provide compelling data on the increasing criminalization of homelessness;[5] however, to date, no entity has performed a Washington-specific analysis. This brief seeks to remedy that deficit.

Between 2014 and 2015, members of the Seattle University School of Law Homeless Rights Advocacy Project ("HRAP") conducted a survey of 72 municipalities within Washington State (representing 56% of the state population)—the most extensive survey of its kind within the nation.[6] The purpose of this study was to identify ordinances that criminalize homelessness by targeting the conduct of necessary, life-sustaining activities and disproportionately impacting homeless individuals (such as laws that prohibit sitting, sleeping, lying down, panhandling, erecting shelters in public, and more).

HRAP researchers first created a chart with links to every criminalization ordinance throughout the state.[7] Upon completing the chart, researchers initiated public records requests to seven cities that enacted higher numbers of ordinances. These requests sought (1) enforcement data for the identified ordinances during a five year period from January 1, 2009, through December 31, 2013, and (2) demographic data regarding the characteristics of defendants cited

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[1] Sara K. Rankin, *A Homeless Bill of Rights (Revolution)*, 45 SETON HALL L. REV. 383, 390–92 (2015), *available at* http://ssrn.com/abstract=2376488.
[2] Interview with Carla Lee, Deputy Chief of Staff, King County Prosecuting Attorney's Office, SEATTLE UNIVERSITY HOMELESS RIGHTS ADVOCACY PROJECT (Mar. 2, 2015).
[3] Josh Howard & David Tran, Seattle University Homeless Rights Advocacy Project, AT WHAT COST: THE MINIMUM COST OF CRIMINALIZING HOMELESSNESS IN SEATTLE & SPOKANE (Sara Rankin ed., 2015).
[4] *See* Javier Ortiz & Matthew Dick, Seattle University Homeless Rights Advocacy Project, THE WRONG SIDE OF HISTORY: A COMPARISON OF MODERN & HISTORICAL CRIMINALIZATION LAWS (Sara Rankin ed., 2015); *see also* Howard & Tran, *supra* note 3.
[5] *See, e.g.*, THE NATIONAL LAW CENTER ON HOMELESSNESS & POVERTY, FROM WRONGS TO RIGHTS: THE CASE FOR HOMELESS BILL OF RIGHTS LEGISLATION (2014), *available at* http://nlchp.org/documents/Wrongs_to_Rights_HBOR [hereinafter "THE NATIONAL LAW CENTER"]; U.C. Berkeley School of Law Policy Advocacy Clinic, *California's New Vagrancy Laws: The Growing Enactment and Enforcement of Anti-Homeless Laws in the Golden State* (2015).
[6] The survey included every municipality in the 2010 United States Census with populations exceeding 5,000, covering more than 3,700,000 people (56% of the State's population), plus two additional cities based on geographic spread. Omak and Colville, having a population of less than 5,000, were not included in the relevant 2010 Census data but were included in this survey to provide geographic representation.
[7] For a full discussion of the methodologies employed by researchers, please see *infra* Appendix III.

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under these ordinances.[8] Although HRAP researchers encountered several logistical limitations, they obtained a significant amount of data regarding how local cities within Washington State criminalize homeless individuals. Of course, this brief cannot capture all of the laws that may be creatively enforced against the visibly poor. There is an omnipresent need for ongoing research.

This brief is divided into four major parts. Part I reviews key findings and trends with regard to the enactment of ordinances. Part II discusses the results of the public records requests for enforcement data. Part III synthesizes and analyzes the ordinance data analysis with the enforcement data. Finally, Part IV presents recommendations for improving future efforts to collect and analyze homelessness criminalization data in other jurisdictions.

I. WASHINGTON CRIMINALIZATION ORDINANCES

A statewide effort to identify specific criminalization ordinances serves to detail the scope and extent of criminalization throughout the state so that advocates, businesses, service providers, city agencies, and citizens are better educated about the way the homeless are criminalized throughout Washington State. This section provides a summary of core findings regarding a given jurisdiction's propensity to criminalize visible poverty. In particular, this section summarizes: (1) the increasing enactment of criminalizing ordinances over time; (2) the most commonly criminalized behaviors across Washington State; (3) the municipalities with the highest rates of criminalization as measured by the variety of behaviors covered; and (4) the proliferation of overlapping and compound ordinances.

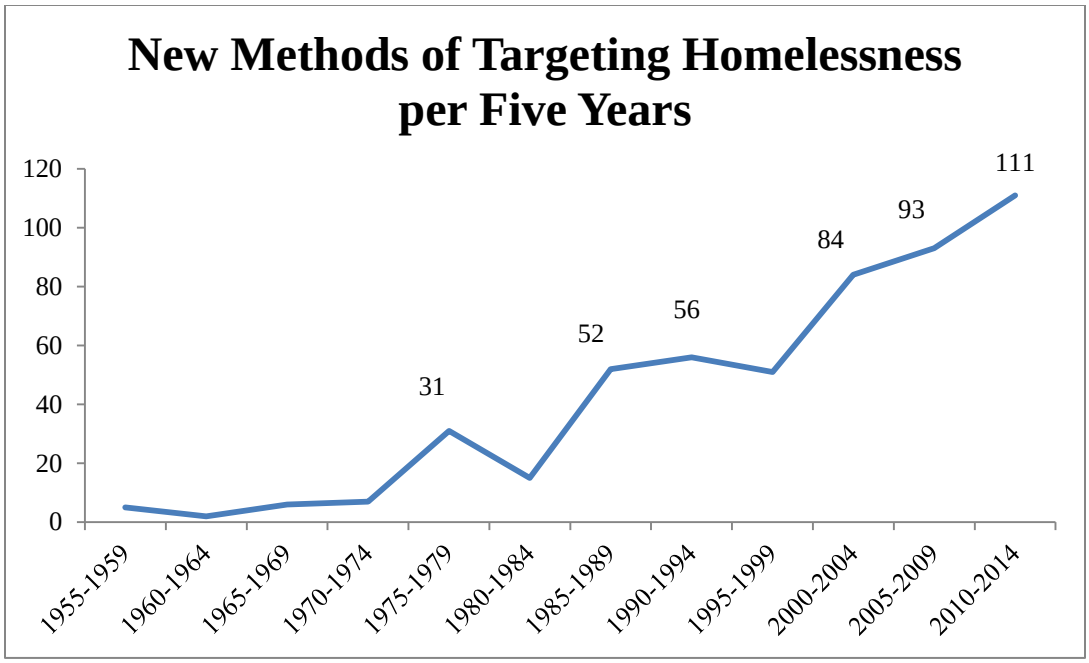
A. Not In Our State: Increasing Statewide Commitment to Criminalization

Criminalization is now local lawmakers' preferred method for addressing the problem of homelessness. Cities are giving themselves new ways to remove homeless people from public spaces, and are doing so at exponentially higher rates. More alarmingly, this trend has intensified in the past fifteen years.

Over half of new criminalization efforts occurred after 2000. This fourteen year span has already eclipsed the previous forty-five years' total enactment numbers, and the numbers are continuing to rise. The graph below shows the number of new avenues cities enacted to criminalize homeless conduct over five-year increments:[9]

[8] *See infra* Appendix I-A (enforcement data request template) and I-B (demographic data request template).
[9] Data based on charting the enactment year of every surveyed ordinance. The entry does not merely chart ordinance enactment, because a single ordinance might result in two new avenues of targeting homeless conduct.

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These Washington specific numbers reinforce evidence from other studies showing that lawmakers are committed to addressing the problem of homelessness through criminalization.[10] However, the graph above does not depict amendments to the original ordinances, which would further reinforce that lawmakers are dedicated to criminalization even after revisiting the issue. In reality, a significant number of pre-2000 ordinances have been reaffirmed or even strengthened by post-2000 amendments.

B. Not On Our Streets: The Focus of Criminalization

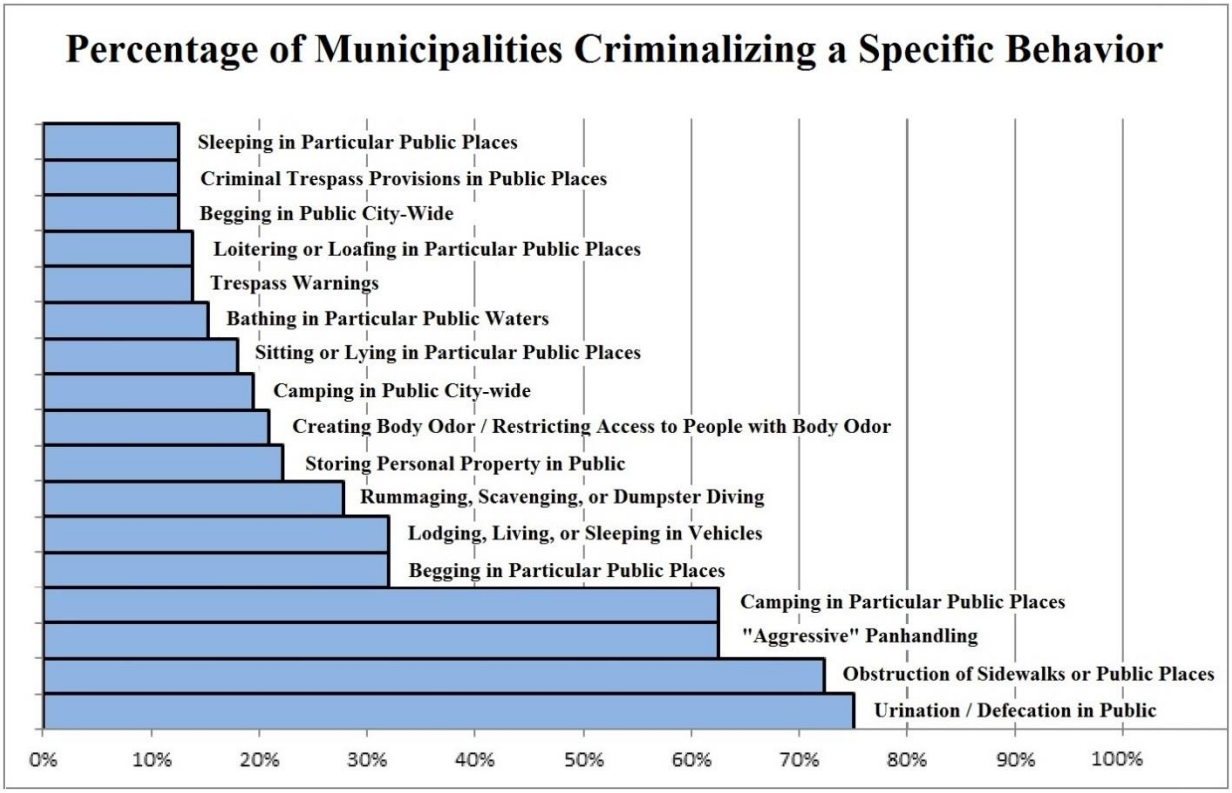
It is not easy for new ordinances to come into being. Homeless criminalization ordinances are written up and proposed to city councilmembers, who then vigorously debate the benefits and drawbacks of each ordinance before voting on its passage. Sometimes, similar ordinances are discussed across the state; other times, certain types of conduct may be a concern only in particular cities, or perhaps even only in other states. In all instances, the passage of ordinances can serve as a window into the priorities of each municipality, as well as illuminate common approaches to homelessness statewide.

In Washington State, the most commonly criminalized behaviors are such benign activities as sitting or standing in public spaces (78%)[11] and sleeping in public spaces (78%).[12] Another frequently targeted behavior is urination or defecation in public (75%). Although the majority of cities in Washington criminalize this activity, studies have shown that cities often fail to provide sufficient access to 24-hour restrooms and hygiene centers.[13] The fourth most

[10] *See* THE NATIONAL LAW CENTER, *supra* note 5; U.C. Berkeley School of Law, *supra* note 5.
[11] This category includes cities with one or more law criminalizing sitting/lying down, obstruction of sidewalks, loitering, or vagrancy.
[12] This category includes cities with one or more laws that criminalize either sleeping or camping in particular public places or in public citywide.
[13] THE NATIONAL LAW CENTER, *supra* note 5.

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frequently prohibited activity is "aggressive" panhandling (63%). These ordinances specifically target visibly poor people and hold them to a higher standard than existing assault or harassment laws, which often prohibit the same type of conduct but are facially neutral. The following graph demonstrates the percentage of Washington cities that prohibit each of the prohibited behaviors surveyed:

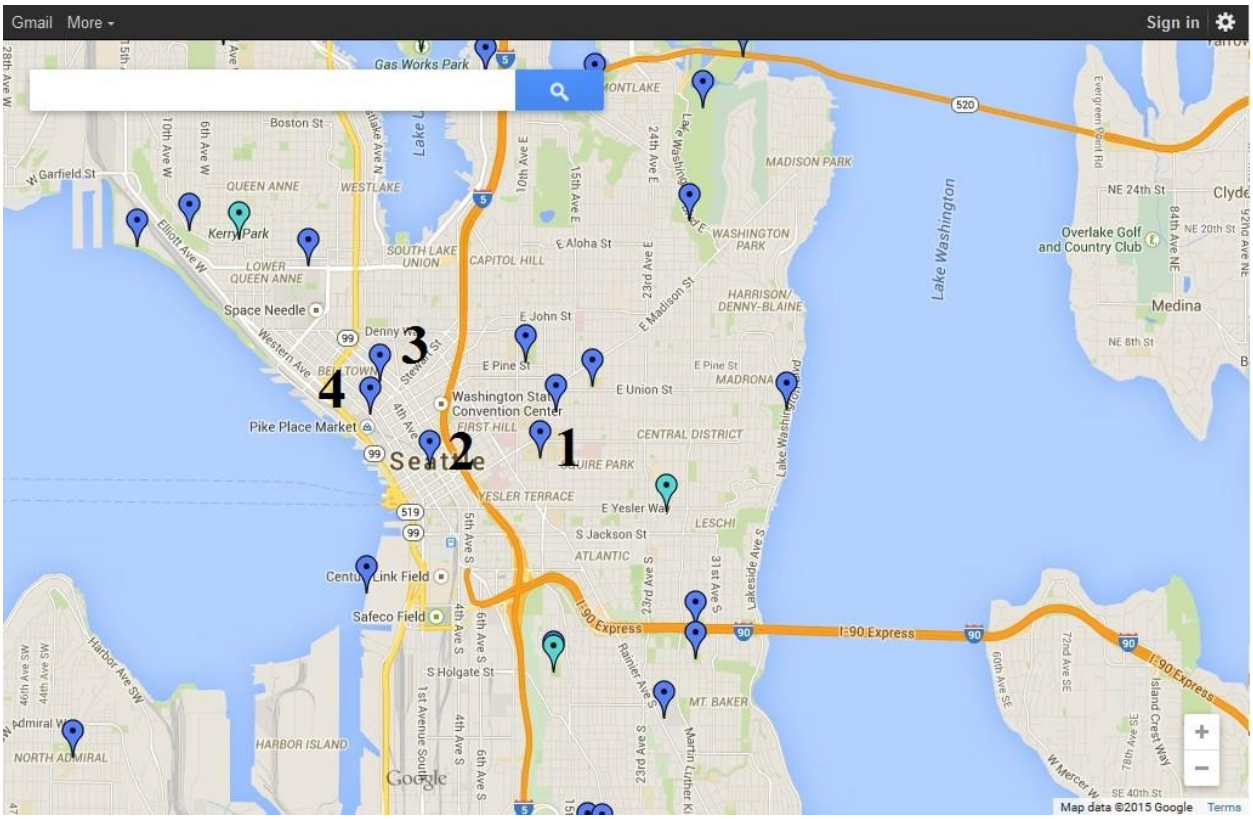


Although some ordinances may appear neutral on their face, in practice, many disproportionately target visibly poor people. For example, 20 cities (28%) prohibit any kind of rummaging or scavenging through trash receptacles. Additionally, 16 cities (22%) criminalize the storage of personal property in public places and 15 cities (21%) criminalize or restrict access to public facilities to those who create body odor. Homeless individuals often have no reasonable alternatives but to violate such ordinances, and housed individuals are far less likely to become offenders.

Laws prohibiting urination and defecation in public are a prime example of the sort of practical, disparate impact on homeless individuals that results from seemingly neutral laws. Although such laws may have legitimate health and sanitation purposes, they are not written with consideration to the availability—or lack thereof—of 24-hour public restrooms and hygiene centers. Indeed, access to public restrooms for unsheltered people is sorely lacking all throughout the country.[14] Looking only at Seattle, a Google search for "24-hour bathrooms" yields the following results:

[14] *Id.*

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So, consider this likely scenario: if an individual living in downtown Seattle needs to use the bathroom late at night, that person might try one of the four numbered bathroom locations. However, numbers 1–3 are not always available to the public; they are for the Seattle University Park (private athletic field), the Seattle Public Library (closed in the evening), and Whole Foods Market (private business location and closed in the evening). Only number 4, the bathroom at Pike Place Market, is both open to the public and available 24-hours per day; functionally, this single location is the only option for a homeless individual in downtown Seattle. Even if an unsheltered man, woman, or child who needed to use the restroom in the middle of the night knew of these options, they would need to contend with getting there. In this way, a facially neutral law—prohibiting public urination or defecation—has a significant, practical, and disproportionate effect on those who truly have no reasonable alternatives.

Like many cities elsewhere in the nation, Washington municipalities are increasingly enacting such nuanced ordinances criminalizing behaviors that purport to fall under health, safety, or general public order.[15] Given increasing criticism of such laws from a legal and policy perspective, Washington policymakers should reconsider this trend.[16]

[15] A complete chart summarizing the range of categorized behavior is available in the separately-published Washington Criminalization Ordinance Data. Scott MacDonald & Justin Olson, Seattle University Homeless Rights Advocacy Project, WASHINGTON CRIMINALIZATION ORDINANCE DATA (Sara Rankin ed., 2015), [hereinafter referred to as ORDINANCE DATA] at Part XII. For a full discussion of municipal responses to constitutional defenses, please see Katherine Beckett and Steve Herbert's influential work. KATHERINE BECKETT & STEVE HERBERT, BANISHED: THE NEW SOCIAL CONTROL IN URBAN AMERICA (2009).

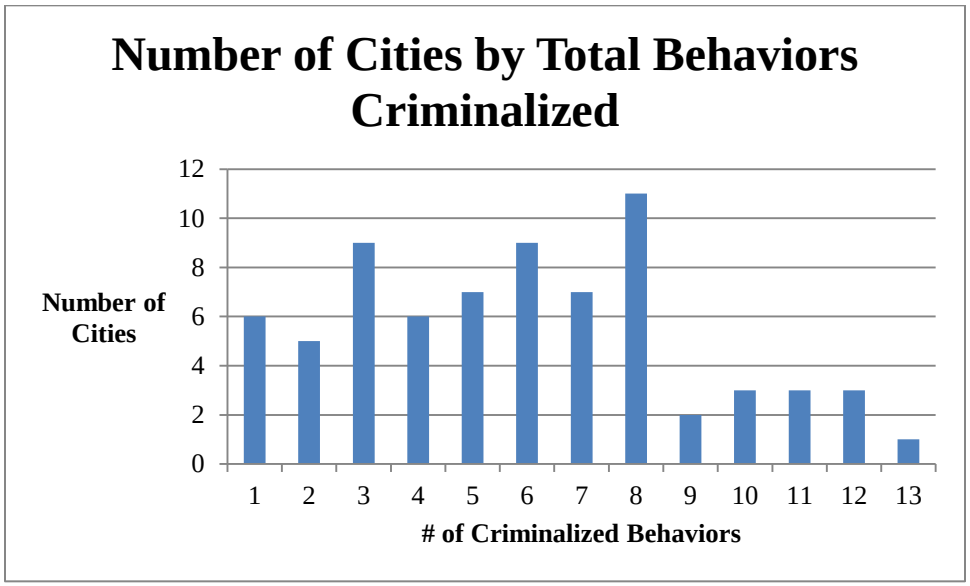
[16] *See* Ortiz & Dick, *supra* note 4.

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C. Not in Our City: Municipalities with the Most Criminalization

Homeless criminalization occurs in cities all throughout Washington. Researchers examined those cities with both the highest total number of ordinances and the greatest variety in behaviors prohibited. The resulting list reflects cities with no apparent commonalities. As a result, homeless individuals have no ability to predict safe harbors in Washington.

Auburn criminalizes 13 behaviors, the most of any surveyed city in Washington. Spokane, Puyallup, and University Place each criminalize 12 different behaviors. Pasco, Arlington, and Vancouver all criminalized 11 behaviors.[17] The graph below provides a visual representation of how many cities criminalize a given number of activities.



For a full summary of cities sorted by categories of behavior criminalized, please see the appendix.[18]

The survey also revealed how many total ordinances a city has enacted that criminalize the conduct of necessary, life-sustaining activities.[19] Generally, the number of enacted ordinances will mirror the number of criminalized behaviors; in other words, a single ordinance will criminalize a single behavior. However, a quirk exists wherever a city enacts either (1) a single ordinance that criminalizes multiple categories of conduct or (2) multiple ordinances that criminalize a single category of conduct.[20] The former situation suggests a city is enacting fewer ordinances than other jurisdictions that are actually criminalizing categories of behavior at the

[17] The least offending municipalities criminalized only one behavior: Pullman, Tukwila, Ellensburg, Mill Creek, West Richland, and Ferndale. Of those six cities, 3 prohibited "camping in particular public places," while the other two prohibited "urination/defecation in public." Beyond those single-ordinance cities, five cities criminalized only two behaviors, and nine cities criminalized three behaviors.
[18] ORDINANCE DATA, *supra* note 15, at Part XIV.
[19] ORDINANCE DATA, *supra* note 15, at Part XV.
[20] Referred to in subsection D as compound ordinances and overlapping ordinances, respectively.

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same rate. The latter situation suggests a city is enacting more ordinances than other jurisdictions that are actually criminalizing categories of behavior at the same rate.

Unsurprisingly, the jurisdiction that criminalizes the broadest range of behavior—Auburn—also has enacted the highest number of criminalization ordinances (14). The next closest are Spokane and Pasco with (12), followed by a slew of municipalities at 11: Puyallup, University Place, Arlington, Bellingham, Everett, and Wenatchee.

D. Legal and Policy Concerns: Overlapping and Compound Ordinances

For purposes of clarity, legislative efficiency, and constitutional due process concerns, each ordinance should deal with a single type of behavior, and each restricted behavior should be addressed by just one ordinance. In synthesizing the survey results, researchers recognized that a majority of municipalities enacted ordinances that did not meet these parameters. Researchers termed these ordinances as either overlapping or compound, and then sought to quantify their presence among the surveyed jurisdictions.

1. *Overlapping Ordinances*

Overlapping occurs when a city criminalizes the same behavior under multiple ordinances**.** Besides the logistical concerns of reviewing duplicative prohibitions, overlapping ordinances create significant concern for homeless individuals and enforcement personnel. On a constitutional level, the discriminatory enforcement of these overlapping ordinances—such as using ordinances with higher penalties against one class of individuals versus others—gives rise to due process and equal protection concerns.

Under the example below, a homeless individual sitting on the sidewalk in Bellingham may be cited under either the Disorderly Conduct ordinance or the Pedestrian Interference ordinance for the exact same conduct.[21]

Bellingham Municipal Code 10.24.010 Disorderly Conduct	**Bellingham Municipal Code 10.24.040 Pedestrian Interference**
A person is guilty of disorderly conduct if he: . . . . C. Intentionally obstructs pedestrian or vehicular traffic without lawful authority; or	A. A person is guilty of pedestrian interference if, in a public place, he or she intentionally: 1. Obstructs pedestrian traffic; or . . . .

Both the risk and the actual presence of constitutional violations could be pervasive throughout Washington. In a sample of seven cities, more than half (4 or 57%) triggered potential legal and policy problems due to the presence of overlapping ordinances with differing

[21] These particular Bellingham ordinances highlight close parallels in language between duplicative ordinances. In this case, the constitutional concerns are lessened because both ordinances carry the same penalty. However, other case studies revealed stronger grounds for concern. *See* Spokane, *infra* Part III.B.3.

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penalties.[22] In fact, available enforcement data from one of these four cities further suggests that city may be enforcing the ordinances in a discriminatory way.[23] Evidence of discriminatory enforcement in such a small sample size is alarming; this sampling reveals the minefield of potential danger to the rights of homeless people throughout the state of Washington and the very real likelihood of cities triggering those mines.

2. *Compound Ordinances*

Conversely, compound ordinances are single ordinances that criminalize multiple categories of behavior. These ordinances create a lack of transparency in the availability of public records. When a person is cited under a compound ordinance, researchers are unable to determine which conduct led to the citation. This "one fell swoop" process of drafting laws frustrates the ability for advocates to examine the true effects of criminalization, shrouding available data from analytical review. Again, pedestrian interference ordinances, such as the example below, are frequently written as compound ordinances.

> **Bellingham Municipal Code 10.24.040 Pedestrian Interference.**
>
> A. A person is guilty of pedestrian interference if, in a public place, he or she intentionally:
>
> 1. Obstructs pedestrian traffic; or
>
> 2. Aggressively begs.
> . . .

Transparency in the law is crucial for the thoughtful advancement of social policy. In preparing this brief, HRAP researchers scoured public municipal codes and submitted numerous requests for public records. The presence of compound ordinances frustrated these efforts by obscuring the picture painted by enactment and enforcement data. Without sufficient transparency, neither advocates nor policymakers can fully understand the true extent of, and purpose behind, criminalization efforts.

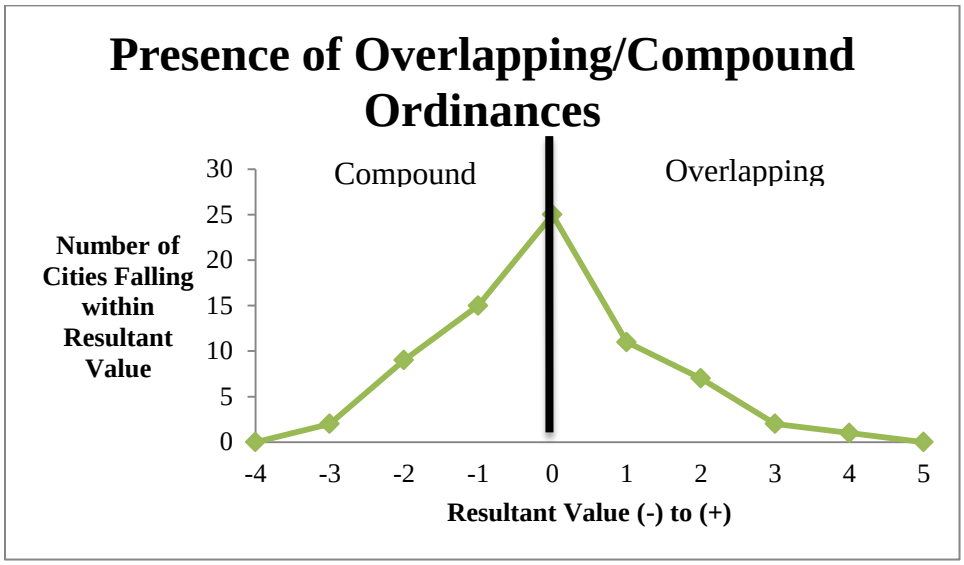
3. *Prevalence in Municipalities*

Having identified the problems associated with overlapping and compound ordinances, researchers created a formula to determine the prevalence of these types of ordinances throughout Washington.[24] The formula provides that cities falling in the negative range have enacted more compound ordinances, while cities in the positive range have enacted more overlapping ordinances.[25] The further away from zero a city is, the higher the number of

[22] These four cities include Pasco, Burien, Vancouver, and Spokane.
[23] This city is Spokane, described in greater detail in Part III.B.3.
[24] The formula researchers created required tallying up the total number of offending ordinances a city has enacted, and then subtracting the number of criminalized categories of behavior. A numerical representation of the formula: (# of ordinances) - (# of behaviors prohibited).
[25] This methodology may not be true in all instances. It is conceivable that a city has enacted both overlapping and compound ordinances that would cancel one another out in the formula. But the formula is a helpful way of

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overlapping or compound ordinances it has enacted. The results of this formula are detailed by the following graph:



The results suggest widespread abuse of overlapping and compound ordinances. The graph indicates that only 25 municipalities mirrored their enacted ordinances to criminalized conduct at a 1:1 ratio, which means that at least 48 cities (66%) have either compound or overlapping ordinances. Furthermore, 26 municipalities (36%) used more overlapping ordinances, while 22 cities (30%) used more compound ordinances.[26] Accordingly, at least two-thirds of surveyed Washington cities contain either transparency issues or constitutional violations, or both.

II. WASHINGTON ENFORCEMENT DATA

After charting the homelessness criminalization ordinances across Washington, researchers sought data regarding the enforcement of those ordinances. This section examines enforcement of homeless criminalization ordinances in the following six cities: Seattle, Bellingham, Spokane, Vancouver, Burien, Auburn, and Pasco.[27]

This section sheds light on how Washington cities are enforcing these ordinances through the police, the city attorney's office, and the judiciary. Police officers across the country face heightened scrutiny as a national debate unfolds regarding their dual roles as peacekeepers and public servants. Meanwhile, the city attorney's office and judiciary struggle with an overwhelming caseload involving defendants who are a far cry from being criminal predators.

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discerning possible scenarios without being forced to manually go through the entire 73 city chart, thus saving these and future researchers valuable time. Furthermore, the cancellation effect would cause these results to be under-inclusive, and is not a flaw that would skew these results to show an effect that in reality is not present.

[26] ORDINANCE DATA, *supra* note 15, at Part XVI.

[27] After cataloguing the first 25 cities, researchers picked the top five with the broadest range of criminalized behaviors. Researchers then added Seattle as the most populous city, and then added Burien as a result of the recently passed "body odor" ordinance. For a more thorough discussion of the enforcement data methodology, see infra Appendix IV.

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Accordingly, the criminalization of homelessness impacts these groups in distinct ways, and each group is an important participant in the policy discussion.

A police officer's perspective of homeless criminalization affects his or her decision whether to issue a citation to a homeless individual in violation of an ordinance. In many cases, a homeless individual may not even know that the conduct—often necessary to their very survival—is considered unlawful and grounds for punishment. At that moment, police officers serve the dual functions of legal enforcer and community advocate. In other situations, police officers may find their hands tied when responding to complaints made by business owners or members of the public.[28]

Similarly, homeless criminalization has caused a shift in public perspective regarding the proper role of courts. A large percentage of homeless defendants suffer from mental health or substance abuse issues.[29] These defendants inevitably violate a criminalization ordinance and, rather than receiving the treatment they need, are brought before the court. As a result, municipal courts are now "held accountable for the failures of the social service system."[30] Even prosecuting attorneys recognize that in some cities "the mental health system is nearly non-existent and the criminal justice system is utilized as a default system."[31]

While all judges "seek to do good,"[32] there are many different avenues to achieve that goal. Some judges tend to give deference to the prosecutor's recommendations, viewing jail as one piece of a rehabilitative program for mental health or substance abuse treatment.[33] Other judges strongly believe that "the purpose of jail is to get predators off the street."[34] Experienced judges are more likely to intervene when they believe that defendants are not truly a danger to society.[35] For example, in Seattle, cases of sleeping in doorways prosecuted as criminal trespass can be dismissed under the city's *de minimis* law.[36] Despite the broad scope of judicial discretion, municipal courts are ill-equipped to fill the void left by underfunded social services programs. The courts are an inadequate means of addressing the problem of homelessness.

This section presents general findings and trends identified from the enforcement data, followed by specific data from each of the seven case study cities. Notably, researchers found

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[28] *See, e.g.*, interview by Bridget Barr and Joseph Ostrowski of Officer Daniel McCormack, Colorado Springs Police Department Homeless Outreach Team, SEATTLE UNIVERSITY HOMELESS RIGHTS ADVOCACY PROJECT (Feb. 20, 2015). Officer McCormack noted that "most of an officer's contacts with homeless individuals are based on calls from the public . . . ."

[29] *See* Kaya Lurie & Breanne Schuster, Seattle University Homeless Rights Advocacy Project, DISCRIMINATION AT THE MARGINS: THE INTERSECTIONALITY OF HOMELESSNESS AND OTHER MARGINALIZED GROUPS (Sara Rankin ed., 2015).

[30] Interview with the Honorable Judith Hightower, Seattle Municipal Court, SEATTLE UNIVERSITY HOMELESS RIGHTS ADVOCACY PROJECT (Mar. 10, 2015).

[31] Interview with Carla Lee, Deputy Chief of Staff, King County Prosecuting Attorney's Office, SEATTLE UNIVERSITY HOMELESS RIGHTS ADVOCACY PROJECT (Mar. 2, 2015).

[32] Interview with the Honorable Judith Hightower, Seattle Municipal Court, SEATTLE UNIVERSITY HOMELESS RIGHTS ADVOCACY PROJECT (Mar. 10, 2015).

[33] *Id.*

[34] *Id.*

[35] *Id.*

[36] *Id.*

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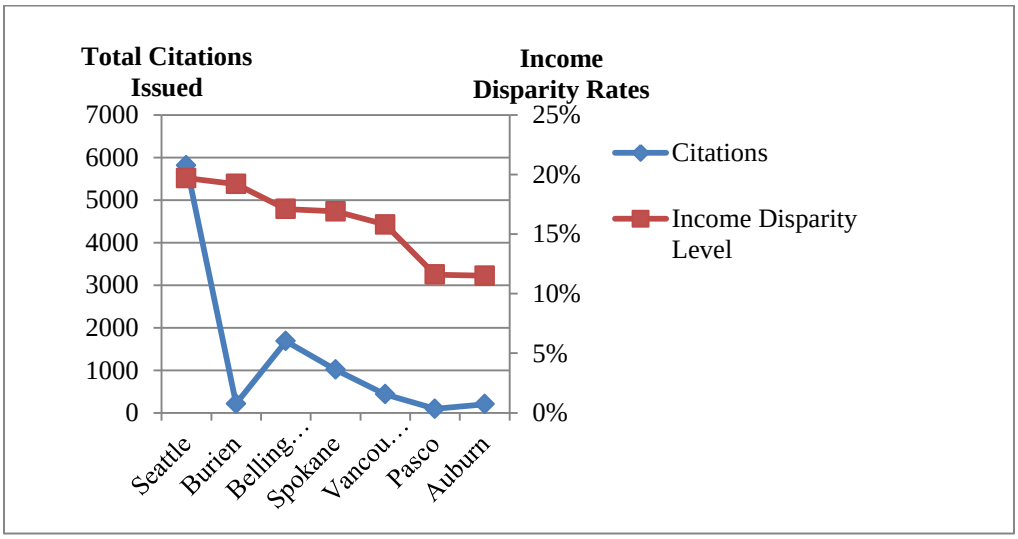
that (1) income disparity predicts ordinance enforcement in nearly all of the case study cities; (2) Washington follows national trends for sit/lie ordinances but also exhibits a greater emphasis on public urination and "aggressive panhandling" ordinances; and (3) distinctions between civil and criminal ordinances allow cities to manipulate the different ways to incarcerate homeless defendants.

A. General Findings and Trends

1. *Predicting Enforcement: The Effects of Income Disparity*

Based on the case study cities, researchers determined that income disparity predicts aggressive enforcement of criminalization ordinances.[37] Income disparity, as used in this section, refers to the percentage of a city's wealth concentrated in the wealthiest 5% compared to the poorest 20%.[38] Visible poverty increases as a city's wealth becomes increasingly inaccessible to the poorest 20%. This increased visibility might trigger efforts to "clean up the streets" by lawmakers and influential business owners.[39]

Of course, numerous political and societal factors also play a role in greater efforts to enforce criminalization ordinances. However, the graph below demonstrates that, with the exception of Burien, a rising income disparity gap (red) is generally matched by rising citation numbers (blue) when cities are compared to one another:



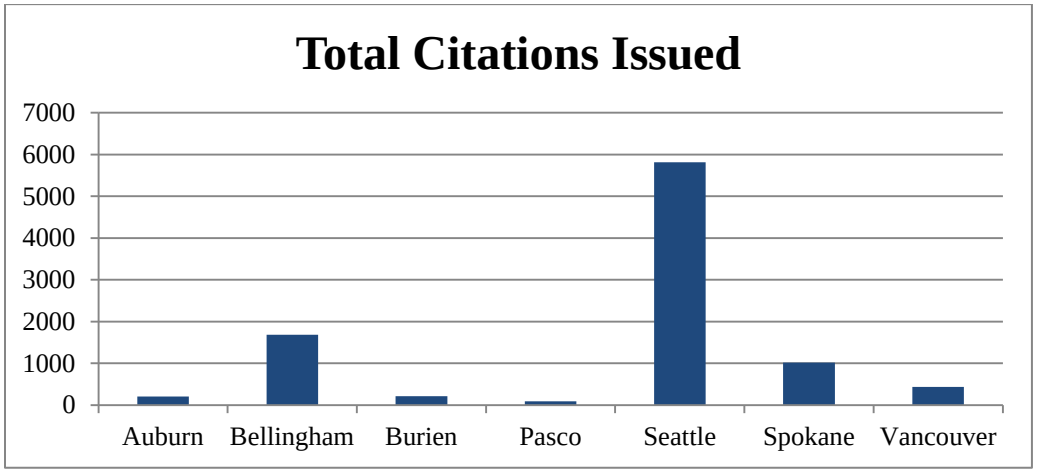
[37] HRAP researchers analyzed other factors such as total population, population density, rates of ordinance enactment. Of course, there are additional factors that may impact either enforcement, such as racial demographics and local economic trends. These factors may be the subject of future research.
[38] Levi Pulkkinen, *Income Inequality: Which Washington City is Worst?*, SEATTLE POST-INTELLIGENCER, (Nov. 7, 2012), http://www.seattlepi.com/local/article/Income-inequality-Which-Washington-city-is-worst-4004464.php#photo-3682135.
[39] *See* Ortiz & Dick, *supra* note 4. Mr. Ortiz and Mr. Dick discuss the "Broken Windows Theory" of visible poverty leading to fears of increased crime.

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2. Comparing Local Enforcement to National Trends

Researchers observed several key similarities between Washington State and national data. Police cited individuals for obstructing sidewalks or public places more than any other behavior; likewise, a national survey reported that 77% of homeless individuals were harassed and cited for sitting or lying down.[40] In addition, cities with higher populations enforced their sit/lie ordinances more than cities with lower populations.[41] Other frequently criminalized behaviors in Washington—such as public urination and aggressive panhandling—may not have been accounted for in national studies that focus on laws prohibiting sitting, standing, and lying down.

In Washington specifically, Seattle led the pack with a total of 5,814 citations issued during the five year period—more than 60% of all citations from all seven case study cities. At this rate, Seattle police issued an average of three citations per day over the five year period. Notably, 70% of Seattle citations were issued under an ordinance criminalizing sleeping in particular public places (detached campers or trailers specifically).[42] On the other hand, Auburn issued relatively few citations (203), despite having a higher total number of ordinances than any other city (14).[43]



3. Civil vs. Criminal: To Jail or Not To Jail

One critical limitation of the data is the distinction between civil and criminal ordinance designations. Specifically, when an ordinance is listed as a civil infraction, the penalties may include fines but not incarceration. Thus, data relating to judicial disposition and incarceration was limited only to those ordinances listed as "criminal." For some cities, this could be a fraction of the ordinances.

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[40] *National Civil Rights Outreach Fact Sheet*, W. Reg'l Advocacy Project (April 5, 2013), *available at* http://wraphome.org/images/stories/pdffolder/NationalCivilRightsFactSheetMarch2013.pdf.
[41] The first, second, and fourth most populous case study cities had the second, first, and third highest number of citations under these ordinances, respectively. ORDINANCE DATA, *supra* note 15, at Part XI.
[42] SMC 11.72.430.
[43] Practicum researchers looked only at municipal codes. Additional enforcement may occur under separate code sources such as administrative codes.

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In addition, designating an ordinance as a civil infraction also creates the potential for due process concerns. An individual cited under a civil ordinance does not have a right to counsel or to a jury trial. If the individual fails to pay the fine, a bench warrant might be issued for their arrest. Some cities, such as Seattle, have specific ordinances triggering misdemeanor penalties when an individual fails to respond to a civil infraction.[44] Alternatively, some ordinances have written in a mechanism to convert to criminal penalties for repeat offenders.[45] Not surprisingly, homeless defendants are unlikely to be able to pay these citations or to make a scheduled court appearance. Thus, an entire category of criminalization data currently lacks sufficient transparency for HRAP to incorporate into this report.

When an individual is ultimately picked up on a bench warrant, the court considers whether they failed to pay the fine without considering whether they committed the underlying infraction. In this case, homeless defendants lose their "day in court" yet may end up in jail all the same. For example, HRAP researchers discovered evidence of a city council using this distinction in an alarming way: removing criminal penalties simply to prevent homeless defendants from prevailing with sympathetic juries.[46] Although in some ways this change seems to de-escalate the criminalization of homelessness, the manipulation of penalties is problematic for two key reasons: (1) as explained earlier, even civil infractions frequently escalate to criminal violations because homeless defendants often cannot pay their fines; and (2) the morphing of a criminal violation into a civil infraction, without explicit provisions to the contrary, strips homeless defendants of their rights to counsel and a jury trial.[47]

The attractiveness and utility of the civil/criminal distinction to cities is reinforced by an exceptional Burien ordinance granting unfettered discretion to move fluidly between each as the city sees fit. Under this law, the city can enforce any regulation as either civil or criminal, even if specific penalties are written into the criminalization ordinances themselves.[48] This boundless discretion represents a grave threat of discriminatory abuse against anyone with whom the city takes issue, especially the homeless.

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[44] SMC 12A.02.085. The City of Seattle informally provided information that suggests a decline in failure to respond cases. In 2008, almost 400 failure to respond cases were brought under this ordinance; in 2009, Seattle pursued over 450 failure to respond cases. But in 2013, the Seattle City Attorney's Office instituted a policy limiting the enforcement of this ordinance to those cases involving numerous civil infractions, and only after "reasonable attempts" had been made to engage the individual in services to resolve the problem. The City further provided information suggesting that the number of cases brought under the ordinance had dropped to just a handful in 2013 and 2014. Such policies, which suggest mindfulness of the disproportionate and unfair impact of failure to respond prosecutions on visibly poor people, are a positive development. Of course, a new administration could easily revoke this policy. A clearer and more permanent solution is to repeal laws that criminalize visible poverty and to enact laws that stop the cycle of criminalization.

[45] For example, Seattle's public urination ordinance (SMC 12A.10.100) provides that "Any person who violates this section and previously has either violated this section or has failed to appear as directed when served with a citation and notice to appear for a violation of this section is guilty of a misdemeanor."

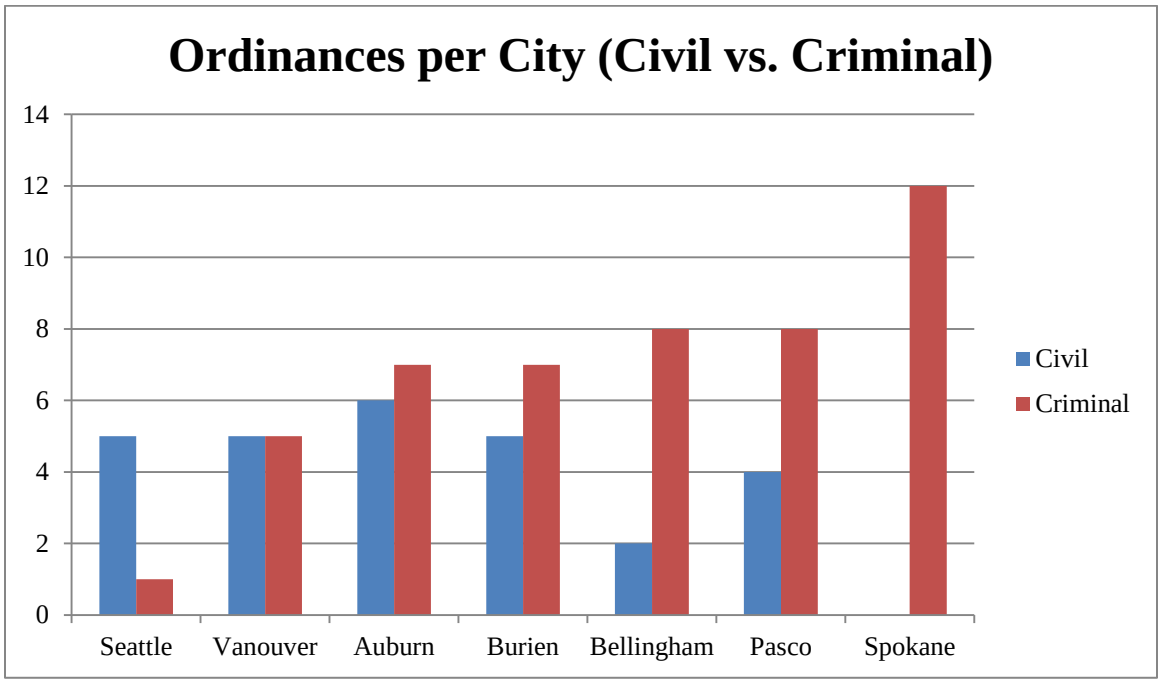
[46] Interview by Bridget Barr and MJ Osman of David Harrison, Partner at Miller & Harrison, LLC, SEATTLE UNIVERSITY HOMELESS RIGHTS ADVOCACY PROJECT. Because homeless defendants were prevailing with sympathetic juries on an anti-camping ordinance using the necessity defense, one city council restructured the ordinance to be civil rather than criminal.

[47] For a more thorough discussion of the "criminal versus civil" distinction, see Howard & Tran, *supra* note 3.

[48] Burien Municipal Code 1.15.080. Of the ordinances listed for Burien, only two failed to have a penalty listed within the ordinance itself.

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A review of the ordinances from the case study cities below reveals that most cities lean toward criminal ordinances. With the exception of Seattle, which had only one criminal ordinance, all of the case study cities had as many or more criminal ordinances than civil. A visual representation of the civil and criminal ordinances for each city is as follows:



B. Under the Microscope: A Case Study of Seven Cities

The case studies below illustrate an important cross-section of available data.[49] These cities present a variety of geographical locations, populations, and income disparity levels. However, they all (in some way or another) present distinct difficulties for homeless individuals whether through variety of ordinances, quantity of citations, or quality of the laws passed.

1. *Seattle*[50]

Population (in 2010):	608,660
Persons Below Poverty Level:	13.2%
Total Housing Units:	308,516
Land Area in Square Miles:	83.94
Total Number of Business Firms:[51]	73,997
Median Household Income:	$63,470



[49] Cities are presented below in the order of most-to-least citations issued.
[50] City-specific facts were obtained from the 2010 United States Census. U.S. Department of Commerce, *State & County QuickFacts*, UNITED STATES CENSUS BUREAU, http://quickfacts.census.gov/qfd/states/53000.html (last visited Mar. 11, 2015). Map data ©2015 Google.
[51] The Census defines a firm as "a business organization or entity consisting of one domestic establishment (location) or more under common ownership or control."

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As the most populous city in the state, Seattle likely has the highest concentration of homeless citizens out of any Washington city. The recent One Night Count revealed at least 3,772 unsheltered individuals living in King County, a 20% increase from 2014.[52] Another estimate ranks Seattle fourth in the country for largest homeless population in metropolitan areas.[53] On March 30, 2015, the city council unanimously passed several ordinances providing regulated homeless encampments and nearly $400,000 in funding for additional shelter beds.[54]

i. Citations

Although Seattle has an average number of criminalization ordinances (6), it issues more citations than any other surveyed city: a total of 5,814 citations during the requested five year period (or an average of three citations per day). Of those, the most frequently cited behavior—by a large margin—was for sleeping/camping in public places (4,117 or 71%).[55] After that, the other behaviors receiving citations were urinating or defecating in public (1,004 or 17%);[56] aggressive panhandling (349 or 6%);[57] sitting or lying in particular public places (250 or 4%);[58] and camping in particular public places (94 or 2%).[59] No citations were reported during the five year period for storing personal property in public.

Citation issuance over time reveals a general downward trend with a couple notable exceptions. In 2010, for reasons as yet unclear to HRAP researchers, citation issuance spiked across the board in every category.[60] Since 2010, there has been a general decrease in citations over the years with the exception of Seattle's "Camper/Trailer Detached" ordinance, which dropped in numbers but has generally remained steady since 2011.[61] Additionally, citations for Pedestrian Interference did not drop until 2012; yet, even through 2013, the total citations remained higher than the number issued in 2009.[62]

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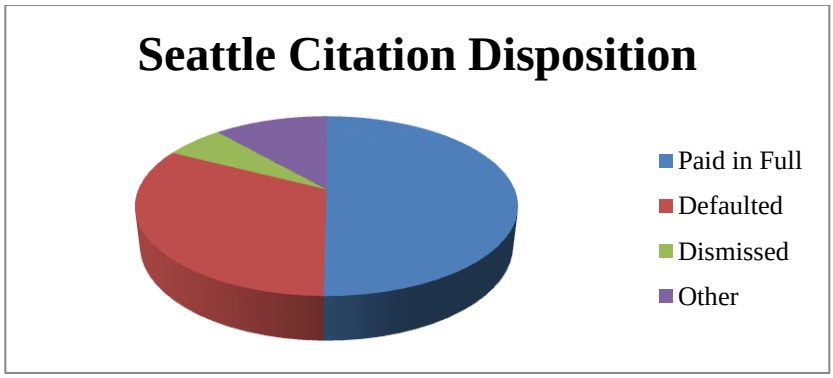
[52] Michael Konopasek, *King Co. Homeless Population up by More Than 20 Percent*, KING 5 NEWS (Feb. 4, 2015), http://www.king5.com/story/news/local/seattle/2015/01/23/king-county-homeless-count/22210763/.
[53] John Ryan, *After 10-Year Plan, Why Does Seattle Have More Homeless Than Ever?*, KUOW.org (Mar. 3, 2015), http://kuow.org/post/after-10-year-plan-why-does-seattle-have-more-homeless-ever.
[54] City of Seattle, *Full Council of 3/30/15*, SEATTLECHANNEL.ORG (Mar. 30, 2015), http://www.seattlechannel.org/mayor-and-council/city-council/full-council?videoid=x53504.
[55] This particular ordinance, SMC 11.72.430, is listed as "Trailer/Camper Detached" and prohibits a trailer or camper from being parked on any street.
[56] SMC 12A.10.100.
[57] SMC 12A.12.015.
[58] SMC 15.48.040.
[59] The ordinance prohibiting aggressive panhandling also prohibits obstruction of sidewalks or public places (SMC 12A.12.015—entitled "Pedestrian Interference"). Accordingly, the 349 citations could be for any combination of those two behaviors.
[60] HRAP hopes to perform additional research on this point in the future.
[61] This ordinance is included because of historical efforts throughout the country to prevent homeless people from sleeping or camping in their vehicles. *See, e.g.*, Ian Lovett, *When Home Has No Place to Park*, THE NEW YORK TIMES (Oct. 3, 2010), *available at* http://www.nytimes.com/2010/10/04/us/04rv.html?_r=1. Other examples of creative criminalization include "scofflaw" ordinances that accelerate vehicle impoundment for unpaid parking tickets (SMC 11.35.010) and Driving While License Suspended ordinances creating a cycle of infractions for being unlicensed (SMC 11.56.320).
[62] For a complete chart of ordinances over time, see ORDINANCE DATA, *supra* note 15, at Part V.

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Seattle had only one instance of overlapping ordinances relating to camping in public. However, the circumstances under each ordinance appeared to be sufficiently distinct. One ordinance deals with camping in parks specifically, while the other ordinance deals with parking campers and trailers on the street.[63]

ii. Case Dispositions

Researchers were particularly interested in the disposition data for citations because of a peculiar discrepancy: although citation disposition data was robust, information relating to consequent fines and penalties was minimal. While a majority of citations were paid in full (2,919), nearly a third of all citations were listed as defaulted (1,881). The consequence of defaulting on a civil infraction is the imposition of an additional fine and referral to an outside collection agency. [64] However, because the collection agency is a private business contracted with the court, HRAP researchers did not have access to data on those fines.



[65]

With regard to Seattle's criminal Pedestrian Interference[66] ordinance, the court reported that additional fines for failing to appear are issued under a particular ordinance, yet no fines had been issued under that law since 2002.[67] The conclusion must be either that the court has consistently declined to enforce monetary penalties for failing to appear, or that data relating to such penalties are simply unavailable through the court's case tracking system.

iii. Sentencing

Under the Pedestrian Interference ordinance, 134 bench warrants were issued and 123 individuals were sentenced to time in custody during the five year period. The complete breakdown is as follows:

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[63] SMC 18.12.250 and 11.72.430, respectively.
[64] The court the court contracts with AllianceOne, a private collections agency. AllianceOne attempts to collect on the debt for 10 years, after which time the debt is "written off by the [c]ourt." A complete copy of the Court's contract with AllianceOne may be found here: http://web6.seattle.gov/FAS/SummitPan/R296/R296.Result.aspx?PoStatus=2&SearchType=2&SearchTerm=allianc e.
[65] Other categories described by the court include: deferred, pending, closed, cancelled, dispositional continuance, failure to appear, no complaint filed, obligations satisfied, pre-trial diversion, suspended sentence.
[66] Pedestrian Interference, SMC 12A.12.015.
[67] SMC 12A.28.070.

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Category	1-2 days	3-7 days	8-14 days	15-30 days	31-60 days	61-90 days	91-365 days
Aggressive Panhandling	9 (7%)	6 (5%)	9 (7%)	12 (10%)	4 (3%)	45 (37%)	38 (31%)

Seattle data suggests sentencing for aggressive panhandling is fairly erratic. Defendants charged with aggressive panhandling risk up to a year in jail. Many factors go into a court's sentencing decision: the circumstances surrounding the infraction, the egregious nature of the offense, the existence of prior warrants, and the defendant's criminal history. For example, Seattle data shows that high jail times were commonly (but not always) imposed when additional violations had been included.[68] On the other hand, a number of aberrations stood out. One defendant spent 365 days in jail for obstructing a public officer and pedestrian interference, while another defendant spent 364 days in jail under only the pedestrian interference ordinance.[69] Future research and investigation could help to clarify potential issues with the factual scenarios found to constitute aggressive panhandling and whether these factual scenarios seem to warrant the imposition of maximum sentences.

"Aggressive panhandling" ordinances, such as Seattle's Pedestrian Interference ordinance, represents a drafting effort to target homeless people specifically. Panhandling by itself is an act protected by the First Amendment.[70] In Seattle, panhandling becomes "aggressive" when the facts suggest an "intent to intimidate" such that a reasonable person would feel "fearful or compelled."[71] This language is in nearly every aggressive panhandling ordinance throughout Washington State—yet cities often have laws already on the books that cover the same type of conduct, laws that are facially neutral and do not target a specific subsect of people. A side-by-side comparison of Seattle's Pedestrian Interference and Harassment ordinances demonstrates this point:

SMC 12A.12.015 – Pedestrian Interference.	SMC 12A.06.040 – Harassment.
A. The following definitions apply in this section: 1. "Aggressively beg" means to beg with the intent to intimidate another person into giving money or goods. 2. "Intimidate" means to engage in conduct which would make a reasonable person fearful or feel compelled.	A. A person is guilty of harassment if: 1. With the intent to annoy or alarm another person he/she repeatedly uses fighting words or obscene language, thereby creating a substantial risk of assault; or 2. Without lawful authority, the person knowingly threatens: . . . . d. Maliciously to do any other act which is intended to substantially harm the person

[68] Search performed by going to www.seattle.gov/courts/ and selecting "Online Services" followed by "Look Up Case." As an example, case number 546485 received a sentence of 365 days but included charges for assault, harassment, and criminal trespass.
[69] Case numbers 551231 and 571215 respectively.
[70] *U.S. v. Kokinda*, 497 U.S. 720, 725 (1990).
[71] SMC 12A.12.015.

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	threatened or another with respect to his or her physical or mental health or safety; and e. The person by words or conduct places the person threatened in reasonable fear that the threat will be carried out. . . . .

The comparison reveals that "aggressive panhandling" is nothing more than harassment in the context of a poor person asking for money. Aggressive panhandling ordinances impose a higher standard of conduct on homeless individuals, simply by virtue of asking for donations. Future research should be performed regarding: (1) how the burdens of proof compare; and (2) how the differing standards applied to the same conduct are reflected in the sentencing outcomes.

With regard to sentencing outcomes for Pedestrian Interference, the Seattle data reveals a startling trend toward imposing greater sentences. In 2009, the duration of jail time sentenced under this ordinance was relatively spread out. The same number of individuals received sentences of between 1–2 days in jail as did individuals sentenced to 31–90 days in jail, and those sentenced to greater than 30 days in jail accounted for 42% of all defendants. But by 2013, no defendant sentenced under this ordinance received less than 15 days in jail and 87% of all defendants were sentenced to more than 30 days in jail.

The below table illustrates this trend of increasing sentences given for pedestrian interference:

CUSTODY TIME	**2009**	**2010**	**2011**	**2012**	**2013**
1-2 days in custody	6	1	1	1	0
3-7 days in custody	3	0	0	3	0
8-14 days in custody	2	4	3	0	0
15-30 days in custody	4	2	0	2	4
31-90 days in custody	6	10	9	8	15
91+ days in custody	5	9	5	3	12

Seattle's homeless population continues to grow, and the city's response influences policymakers, enforcement personnel, city attorneys, and courts throughout the state. For better or for worse, Seattle is at the forefront of homeless policymaking in Washington. The data paints the picture of a house divided: on the one hand trying to de-escalate penalties by designating ordinances as civil infractions, yet on the other hand imposing increasingly severe jail sentences for violations of its remaining criminal ordinance.

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2. *Bellingham*



Population (in 2010):	80,885
Persons Below Poverty Level:	22.6%
Total Housing Units:	36,760
Land Area in Square Miles:	27.08
Total Number of Business Firms:	8,607
Median Household Income:	$40,844

Just 21 miles south of the Canadian border, Bellingham describes itself as "the last major city before the Washington coastline meets the Canadian border."[72] It is also the twelfth most populous city in the state.[73] Out of all six of the case study cities, Bellingham has the second-highest percentage of citizens who fall below the poverty level (after Pasco).[74] Unfortunately, the data received from the city was comparatively minimal.

i. Citations

Bellingham reported a total of 1,682 citations issued during the requested five year period. The majority of citations were issued for obstruction of sidewalks/public places (1,156 or 69%).[75] Bellingham also reported 400 citations for public urination or defecation (25%) and 109 citations for sitting or lying in particular public places (6%).[76] Bellingham reported that no citations had been issued for the remaining eight ordinances identified by HRAP researchers.

Additionally, Bellingham has three overlapping ordinances covering the same type of conduct: obstruction of sidewalks or public places. However, the data did not reveal discriminatory fines or sentencing. All three ordinances are designated as misdemeanors punishable by a fine of up to $1,000 and/or a jail sentence of up to 90 days.

ii. Case Dispositions and Sentencing

Unfortunately, Bellingham did not provide data regarding case dispositions and sentencing for the citations above. A review of the ordinance language revealed monetary penalties ranging from $75 up to $250.[77] Additional fees for failing to appear included a $100 bench warrant fee and a $55 booking fee if the defendant was booked into jail after the issuance

[72] *About Bellingham*, CITY OF BELLINGHAM, http://www.cob.org/visiting/about.aspx (last visited Dec. 4, 2014).
[73] U.S. Department of Commerce, *supra* note 50.
[74] Individuals below poverty level is based on the 2010 Census data.
[75] This number derives from two overlapping ordinances: 1,127 citations under BMC 10.24.010 and 29 citations under BMC 10.24.040.
[76] BMC 10.24.020 and 10.24.070, respectively.
[77] Camping in particular public places ($75); sitting/lying in particular public places ($100); obstruction of sidewalks/public places ($250); nuisances "offending public decency" ($250); urination/defecation in public ($200); and rummaging/scavenging ($200).

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of a warrant. The data from Bellingham did not reveal how often these additional fines were assessed.[78]

3. *Spokane*



Population (in 2010):	208,916
Persons Below Poverty Level:	18.7%
Total Housing Units:	94,291
Land Area in Square Miles:	59.25
Total Number of Business Firms:	18,017
Median Household Income:	$42,274

Located in Eastern Washington, Spokane is one of the last stops before passing over into neighboring Idaho. Nicknamed the "Lilac City," Spokane was originally one of the most productive mining districts in North America before diversifying to include other industries, such as telecommunications and financial services.[79] Spokane is also the second most populous case study city and ties with Pasco as having the second highest number of homeless criminalization ordinances.

i. Citations

Spokane was a particularly challenging case study because of its abundance of compound ordinances—that is, single laws prohibiting multiple types of conduct. Accordingly, Spokane's citation data is presented by ordinance with a notation as to which behaviors each ordinance criminalizes.

Over the requested five year period, Spokane reported a total of 1,015 citations and 759 warrants issued under those citations. Spokane's enforcement followed the state trend, with citations focused on sit/lie and aggressive panhandling ordinances. The specific breakdown is as follows:

Ordinance	Criminalized Behaviors	Total Citations	Total Warrants
10.06.015	Urinating or defecating in public.	72 (7%)	71 (9%)
10.08.030	Body odor; Obstruction of sidewalks/public places.	29 (3%)	17 (2%)
10.08B.040	Camping in particular public places;	100 (10%)	169 (22%)
10.10.025	Sitting/lying in particular public places; Obstruction of sidewalks/public places;	462 (46%)	426 (56%)

[78] Bellingham declined to provide any data with regard how many of the cited individuals were homeless, noting that such information would require "significant research or explanation." Instead, the city referred researchers to the Whatcom County Jail. Practicum researchers require a list of case numbers in order to request information from the jail; however, due to the municipal court's technological limitations, this list of case numbers could not be provided.

[79] *Spokane, WA Metropolitan Statistical Area*, FORBES, http://www.forbes.com/places/wa/spokane/ (last visited Mar. 31, 2015).

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	Aggressive panhandling.		
10.10.026	Sleeping in particular public places; Sitting/lying in particular public places.	21 (2%)	26 (3%)
10.10.040	Camping in particular public places; Begging in particular public places.	291 (29%)	1 (0%)
10.10.100	Urinating or defecating in public.	39 (3%)	49 (6%)
10.19.020	Begging in public city-wide.	1 (0%)	0 (0%)

Peculiarly, Spokane courts issued a higher number of warrants under specific categories than there were total citations. The reason for the discrepancy is currently unclear.[80]

With few exceptions, Spokane's data shows the city's increasing tendency to issue citations, almost across the board. In particular, citations for Pedestrian Interference in the last reported year (2013) were more than double any year prior. As the below chart depicts, citation issuances steadily increased for all but the Nuisance ordinance:

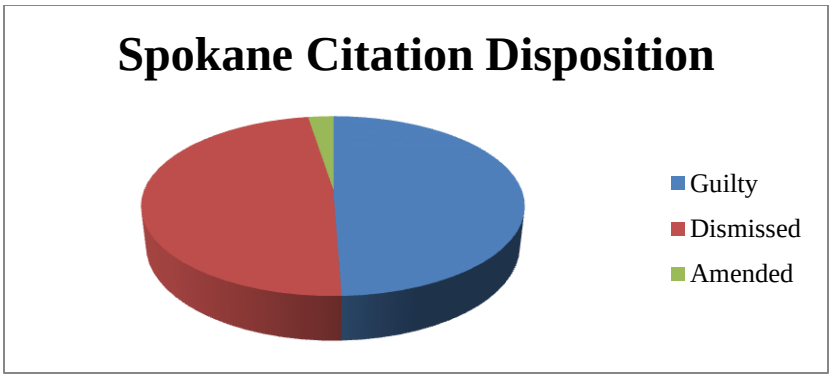
CITATIONS	2009	2010	2011	2012	2013
10.06.015 - Urinating in Public	0	0	1	29	42
10.08.030 – Nuisance	14	13	2	0	0
10.08B.040 - Occupy/Build Transient Shelter	1	4	8	23	64
10.10.025 - Pedestrian Interference	89	83	41	56	193
10.10.026 - Sit/Lie on Sidewalk in Retail Zone	3	1	5	2	10
10.10.040 - Public Park Rules	88	42	75	25	61
10.10.100 - Unlawful Transit Conduct	7	6	10	4	12
10.19.020 – Vagrancy	0	0	0	0	1

ii. Case Dispositions and Sentencing

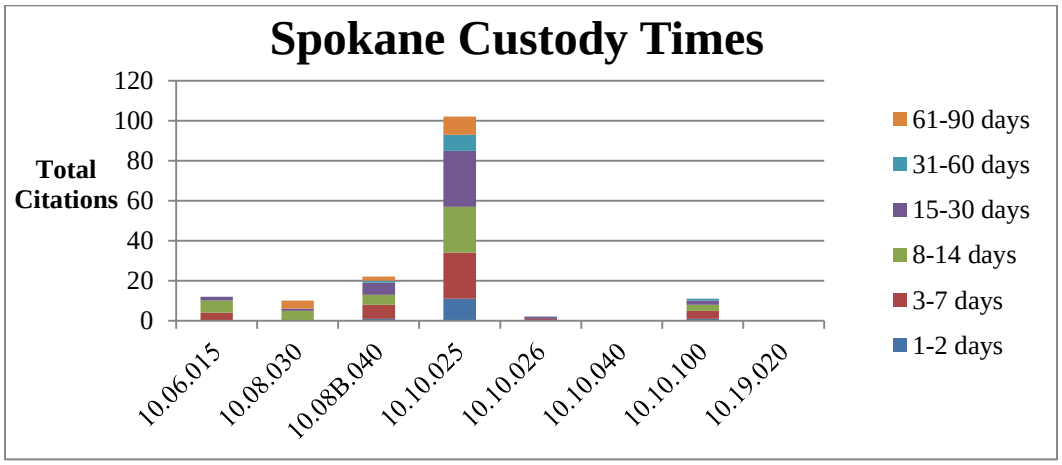
Like Seattle, Spokane provided robust data regarding the disposition of each citation within the five year period. Unlike Seattle, however, citations under each ordinance were adjudicated and dismissed at a roughly equal rate.[81] The following chart depicts the breakdown of citation dispositions:

[80] This issue warrants future study.
[81] For a breakdown of citation dispositions by ordinance, see ORDINANCE DATA, *supra* note 15, at Part VIII.

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Perhaps most striking were Spokane's statistics relating to the duration of time defendants spent in custody. On average, Spokane defendants spent anywhere between 3–30 days in custody for all but two of the ordinances.[82] One ordinance prohibiting a broad range of conduct—sitting/lying in public places, obstructing sidewalks, and aggressive panhandling—led to both the highest number individuals in custody as well as the highest duration of time spent in custody.[83] A visual representation of custody times is as follows:



iii. Overlapping Ordinance Concerns

Spokane's data suggests a potential constitutional issue stemming from enforcement of overlapping ordinances. In general, Spokane's ordinances are punishable as misdemeanors resulting in fines up to $5,000 and jail time of no more than one year.[84] However, for camping in public places, Spokane has multiple ordinances punishing the same behavior yet providing for different penalties.[85] Based on the enforcement data, Spokane police issue citations under the

[82] No defendants spent time in custody for SMC 10.10.040 (begging in particular public places) and SMC 10.19.020 (begging in public city-wide). For complete table of custody times per ordinance, see ORDINANCE DATA, *supra* note 15, at Part VIII.
[83] SMC 10.10.025. As with all custody time data, one inherent limitation is that the sentence imposed may be related to an additional charge brought at the same time as the homeless ordinance violation.
[84] *See* ORDINANCE DATA, *supra* note 15, at Part X for complete table of punishment ranges.
[85] Spokane's ordinances criminalizing camping in public places include SMC 10.08B.040 and SMC 10.10.040.

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criminal ordinance in roughly 25% of cases compared to the alternate ordinance carrying only a civil penalty.

Ordinances Prohibiting Camping in Particular Public Places					
Citation	**Sentence Range**	**Citations Issued**	**Guilty / Committed**	**Dismissed**	**Amended / Other**
10.08B.040	Up to $1,000 and jail up to 90 days	94	20 (21%)	63 (67%)	11 (12%)
10.10.040	Up to $250	291	265 (91%)	20 (7%)	6 (2%)

Not only are the camping ordinances overlapping, but the more criminal ordinance is also compound.[86] That ordinance targets camping in parks specifically but also camping on any street or publicly owned parking lot. Unfortunately, the data is unclear regarding which behavior the total citations account for. The criminal ordinance remains susceptible to discriminatory enforcement; even a single citation under the criminal ordinance for camping in the park would run afoul of constitutional equal protections and established legal principles.

Spokane's story is one of aggressive criminalization. Spokane's municipal code contains numerous instances of overlapping and compound ordinances. Furthermore, citation numbers rose dramatically over the past five years, despite courts dismissing nearly half of all citations. Coinciding with this sharp increase in criminalization, Spokane's code generates equal protection concerns as a result of its public camping and pedestrian interference ordinances. Perhaps more than any other case study city, Spokane's policy on homelessness encapsulates all of the problems inherent to criminalization.



87

[86] SMC 10.08B.040.

[87] All comics prepared by Chris Lee, a local Seattle artist. Although adding some brevity to a serious issue, all comics are based on real news stories involving criminalization ordinances. For this comic, see *Spokane Police Clarify Sit and Lie Ordinance*, 590 KQNT, http://www.590kqnt.com/articles/northwest-news-119088/spokane-police-clarify-sit-and-lie-12810881/ (last visited Mar. 11, 2015).

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4. *Vancouver*



Population (in 2010):	161,791
Persons Below Poverty Level:	16.0%
Total Housing Units:	70,005
Land Area in Square Miles:	46.46
Total Number of Business Firms:	13,642
Median Household Income:	$49,271

Located across the Columbia River from Portland, Oregon, Vancouver is the fourth most populous city in Washington. Vancouver's largest employers are PeaceHealth Southwest Medical Center, followed by Evergreen Public Schools and Vancouver Public Schools.[88] Over the past decade, Vancouver has focused on revitalizing its downtown and waterfront regions, hoping to attract visitors and small businesses alike.[89]

i. Citations

In the requested five year period, Vancouver reported a total of 434 citations. Vancouver police issued the most citations under a compound ordinance that criminalizes both camping in public city-wide and living or sleeping in vehicles (281 or 64%).[90] The next most commonly issued citations were for obstruction of sidewalks/public places (33 or 7%),[91] urinating or defecating in public (91 or 20%),[92] aggressive panhandling (29 or 6%),[93] scavenging (18 or 2%),[94] storing personal belongings in public (9 or 1%),[95] and a provision allowing trespass warnings to be given (1 or less than 1%).[96]

ii. Case Dispositions and Sentencing

According to the City, the vast majority of the citations above reached a plea agreement (345), while only a fraction were contested in court (48).[97] The details of such plea agreements, along with the City's motivations to favor them, are unclear. Regrettably, Vancouver did not provide any additional information regarding the citations or sentencing.

[88] Financial & Management Services, *Comprehensive Annual Financial Report* at 186, CITY OF VANCOUVER, http://www.cityofvancouver.us/sites/default/files/fileattachments/financial_and_management_services/page/1060/cityofvancouver2012cafr.pdf (last visited Mar. 31, 2015).
[89] Community & Economic Development, *Destination Downtown*, CITY OF VANCOUVER, http://www.cityofvancouver.us/ced/page/destination-downtown (last visited Mar. 31, 2015).
[90] V8.22.040.
[91] 29 of these citations derive from a compound ordinance, V7.04.020, which prohibits two types of behavior: obstruction of sidewalks/public places and aggressive panhandling.
[92] V7.10.020.
[93] V7.04.020.
[94] V6.12.216.
[95] V8.22.050.
[96] V15.04.170.
[97] Defined as receiving a guilty verdict or a dismissal. For a complete breakdown of disposition numbers, see ORDINANCE DATA, *supra* note 15, at Part VII.

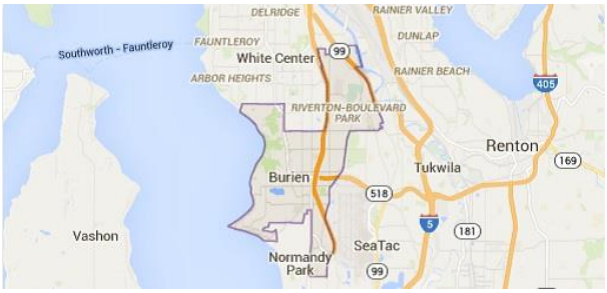
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iii. Overlapping Ordinance Concerns

Vancouver has three overlapping ordinances prohibiting obstruction of sidewalks or public places. The three ordinances are labeled as nuisances, pedestrian interference, and obstruction on a bus or in a bus station.[98] The nuisance ordinance is listed as a civil infraction, yet the pedestrian interference and bus obstruction ordinances are listed as misdemeanors. Vancouver reported no citations under either the nuisance or the bus obstruction ordinance, and only 29 citations under the pedestrian interference ordinance. However, the possibility remains for discriminatory enforcement under the language of these laws.

5. *Burien*

Population (in 2010):	33,313
Persons Below Poverty Level:	17.8%
Total Housing Units:	14,322
Land Area in Square Miles:	7.42
Total Number of Business Firms:	2,998
Median Household Income:	$50,595



Burien has received national attention for recently adopting Chapter 9.125 of its municipal code.[99] The ordinance allows police officers to issue a trespass warning for any conduct that is "dangerous, unsafe, illegal, or unreasonably disruptive to other uses of public property."[100] Such behavior could include using electronic or communicative devices in a manner that is unreasonably disruptive to others, wearing insufficient clothing for the location, or even having body odor that is unreasonably offensive to others.[101] These trespass warnings allow police to banish individuals from an area for up to seven days after the first warning, and then up to a year for any subsequent warnings.[102] The individual receiving the warning need not be charged, tried, or convicted of any crime.[103]

Public response to the new ordinance was overwhelmingly negative. Mike Alben, a pastor for Burien Evangelical Church who invited roughly a dozen homeless citizens to sleep on church property, criticized the treatment of homeless individuals as affording them "little to no dignity."[104] The American Civil Liberties Union sent a letter to the City of Burien urging them to repeal the law for being "counterproductive as a matter of policy and unconstitutional."[105] Burien City Manager Kamuron Gurol responded eight days later in a statement that defended the

[98] 8.20.010 Nuisances Defined; 7.04.020 Pedestrian Interference; and 7.13.040 Unlawful Bus Conduct.
[99] BMC 9.125.020. Full text of the ordinance is available at http://www.codepublishing.com/wa/burien/html/Burien09/Burien09125.html#9.125.
[100] BMC 9.125.020(1).
[101] BMC 9.125.015.
[102] BMC 9.125.020(4).
[103] BMC 9.125.020(3).
[104] KIRO 7 Eyewitness News, *Burien's Trespass Ordinance to Address Disturbances in Public Spaces*, KIROTV.COM (Aug. 23, 2014), http://www.kirotv.com/news/news/buriens-trespass-ordinance-address-disturbances-pu/ng74s/.
[105] Letter from Jennifer Shaw to Lucy Krakowiak and the Burien City Council (Oct. 6, 2014), *available at* https://aclu-wa.org/news/aclu-urges-burien-repeal-unconstitutional-law-targeting-homeless.

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constitutionality of the ordinance and pointed to the guaranteed right of appeal as "an essential feature of the Ordinance."[106] However, (1) the appeals process is available only to individuals receiving a trespass warning for a period longer than seven days; (2) the request for an appeal must be made in writing with a copy of the warning delivered to the City's Legal Department; and (3) a sworn report or declaration from the officer who issued the trespass warning will suffice, without further evidentiary foundation, as prima facie evidence that the individual committed the violation as described.[107] These critical components of Chapter 9.125 limit the ability of homeless individuals to protect themselves from the repercussions of the ordinance.

Since the public backlash, the City of Burien repealed the portion of Chapter 9.125 dealing with body odor; however, the other provisions of the ordinance, including the stringent appeals process requirements, remain unchanged at the time of this writing.[108]

i. Citations

Aside from the controversies surrounding the new Chapter 9.125, Burien's data on existing laws showed a typical approach to enforcement of these ordinances. During the requested five year period, Burien issued a total of 215 citations. Of those, Burien police issued citations for obstruction of sidewalks or public places (151 or 70%) more than any other.[109] Burien reported additional citations for living or sleeping in vehicles (61 or 29%) and aggressive panhandling (3 or 1%).[110] No citations were issued for the remaining six criminalization ordinances and, at the time of this writing, no records yet exist for trespass warnings under Chapter 9.125.[111]

ii. Case Dispositions and Sentencing

Information regarding the disposition of citations was particularly scarce. The court simply noted that the majority of the citations (179 or 83%) were resolved.[112] None of the citations led to the issuance of a warrant, and only two individuals received any sentences of jail time.

Burien's approach to punishment is far more worrisome. Within the criminalization ordinances themselves, punishments range from fines of $50 up to penalties of $250 for each

[106] *Statement from the Burien City Manager Regarding its Trespass Ordinance*, CITY OF BURIEN, http://burienwa.gov/DocumentCenter/View/5174 (last visited Apr. 1, 2015).
[107] BMC 9.125.020(7) and (8).
[108] Kipp Robertson, *Advocates Still Raising Stink Over Burien Law, Say it Targets Homeless*, MYNORTHWEST.COM (Feb. 24, 2015), http://mynorthwest.com/11/2715929/Advocates-still-raising-stink-over-Burien-law-say-it-targets-homeless.
[109] As a note, the City of Burien stated that it does not issue citations for BMC 8.45.020 (obstruction of sidewalks or public places) but instead issues "notices of violation." Because the effect here appears to be the same, and for purposes of consistency, this sub-section will continue to refer to these notices as citations. In addition, Burien referred Practicum researchers to the King County District Court, South Division, which (through an interlocal agreement) handles all of Burien's local ordinance adjudications.
[110] BMC 7.30.110 and 9.80.400.
[111] Additional records may be requested from the Burien Police Department as part of future research.
[112] 151 "notices of violation" were resolved with 10 outstanding. Of the remaining 54 citations, 28 were resolved and 26 were outstanding.

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violation.[113] However, all of these specific penalty provisions are arguably meaningless. Under the general provisions of Burien's municipal code, the city "shall have discretionary authority to enforce a violation as either a civil infraction . . . or as a criminal misdemeanor . . . ."[114] Thus, the city could pursue enforcement of any ordinance as a criminal misdemeanor, and the courts would be empowered to impose a sentence including 90 days in jail and $1,000 in fines.

And of course, the notable punishment outlier remains the new Chapter 9.125. As discussed, this ordinance allows a police officer to banish an individual from a public place without the individual being charged, tried, or convicted of any crime or infraction. Because of how the ordinance is written, Chapter 9.125 could be used to prevent a wide variety of behaviors, including obstruction of sidewalks, bathing in public waters, urinating/defecating in public, and creating a nuisance through body odor. Thus, police officers have the power to both cite individuals for this behavior and banish them from the area. Without more specific data on the enforcement of Chapter 9.125, researchers are unable to determine shed light on how enforcement practices relate to existing legal and policy concerns about Burien's controversial law.

iii. Overlapping Ordinance Concerns

Burien contains numerous overlapping ordinances, covering such categories as obstruction of sidewalks, bathing in public waters, urinating/defecating in public, and creating body odor. While all of these ordinances contain consistent penalties,[115] the general provision above allows for discriminatory enforcement under any or all of them.

Burien has codified expansive measures aimed at removing visible poverty, to the detriment of due process and equal protection. Although Burien's citation numbers are not extraordinary, the mechanisms in place for discriminatory enforcement are staggering. The general punishment provisions allow for limitless discretion in applying civil or criminal penalties for any violation. In addition, the controversial Chapter 9.125 allows police officers to banish an individual from a public place without any due process. The possibilities for discriminatory enforcement placed Burien under heavy scrutiny by the local community and homeless rights advocates statewide.

[113] BMC 10.15.080 and BMC 1.15.120(2), respectively.
[114] BMC 1.15.080(1).
[115] Ordinances for obstruction of sidewalks or public places and urinating in public carried misdemeanor penalties; ordinances dealing with bathing in public waters are classified as Class 1 infractions with a penalty up to $250.

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6. *Auburn*

Population (in 2010):	70,180
Persons Below Poverty Level:	14.9%
Total Housing Units:	27,834
Land Area in Square Miles:	29.62
Total Number of Business Firms:	5,068
Median Household Income:	$39,208



Located between Seattle and Tacoma in the shadow of Mt. Rainier, Auburn boasts a robust outdoor lifestyle. The city has access to the White and Green River trails, three golf courses, and approximately 30 parks of varying sizes.[117] Auburn is also home to the Muckleshoot Indian Tribe. According to census data, only 14.9% of residents are below the poverty level; other data suggests Auburn's poverty rate is greater than 30%.[118] Unfortunately, Auburn has two other notable qualities: it has the highest number of homeless criminalization ordinances out of all 72 surveyed municipalities, and it provided the least amount of information of any case study city.

[116] Comic based on Deborah Horne, *New Ordinance Allows Police to Ban Smelly People from City Buildings*, KIRO 7 (Sept. 15, 2014), http://www.kirotv.com/news/news/new-ordinance-allows-police-ban-smelly-people-city/nhNK8/.
[117] *About Auburn*, CITY OF AUBURN, http://www.auburnwa.gov/about.htm (last visited Dec. 4, 2014).
[118] King County 2010–2014 Consolidated Housing & Development Program, *2009 Needs Assessment* 11 (2009), *available at* www.kingcounty.gov/~/media/socialServices/housing/documents/2010_12_Consol_Plan_Append_A.ashx?la=en.

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i. Citations

Although Auburn has enacted the highest total number of criminalization ordinances, Auburn has the lowest number of citations of the seven case study cities (203 total citations). Of these reported citations, the most frequently cited behavior was obstruction of sidewalks/public places (125 or 62%).[119] The other reported citations were for aggressive panhandling (77 or 38%)[120] and loitering city-wide (1 or less than 1%).[121]

Auburn's municipal code contains numerous overlapping ordinances, covering behaviors such as camping in public places,[122] obstructing pedestrian traffic,[123] and urinating/defecating in public.[124] All of the ordinances under these categories are classified as misdemeanors. Auburn also has overlapping ordinances for scavenging, but these overlapping ordinances also provide for similar penalties between them (civil fines up to $250). [125]

ii. Case Dispositions and Sentencing

Regrettably, Auburn did not provide any information relating to the disposition and sentencing of citations.

7. *Pasco*

Population (in 2010):	59,781
Persons Below Poverty Level:	23.0%
Total Housing Units:	18,782
Land Area in Square Miles:	30.50
Total Number of Business Firms:	3,150
Median Household Income:	$49,220



Pasco is one of three cities making up the Tri-Cities metropolitan region of southeast Washington, along with Kennewick and Richland. The city has experienced rapid residential growth over the past fifteen years, with a 2014 population estimate that is over double the population in 2000.[126] Unfortunately, Pasco also has the highest percentage of people below the poverty level out of all seven case study cities.

i. Citations

Pasco is notable for having the lowest total number of reported citations. During the requested five year period, Pasco issued 93 citations. Of those, Pasco police issued most of the

[119] AMC 9.78.010.
[120] AMC 9.08.010.
[121] AMC 9.50.020.
[122] AMC 9.100.500 and 2.22.210.
[123] AMC 9.08.010, 9.50.020, 9.62.900, 9.78.010, and 9.100.500.
[124] AMC 9.78.010 and 9.100.500.
[125] AMC 8.08.100 and 8.16.031.
[126] *History and Highlights of Pasco*, CITY OF PASCO, http://www.pasco-wa.gov/428/History-and-Highlights-of-Pasco (last visited Mar. 31, 2014).

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citations for urination or defecation in public (54 or 59%). After that, Pascoe reported citations only for loitering in particular public places (32 or 34%), begging in particular public places (6 or 6%), and sitting/lying in particular public places (1 or 1%).[127]

ii. Case Dispositions and Sentencing

Unfortunately, Pasco did not provide any additional information responsive to HRAP researchers' requests.[128]

iii. Overlapping Ordinance Concerns

Pasco has three behaviors criminalized by overlapping ordinances: begging in public,[129] scavenging,[130] and obstruction of sidewalks/public places.[131] Both ordinances for begging in public punished the behavior as a misdemeanor. The two scavenging ordinances contained different penalties, but were associated with different circumstances: it is a misdemeanor to scavenge solid waste from containers in general, yet scavenging at a bus station is merely a civil infraction.[132] Pasco did not report any citations under either scavenging ordinance in the past five years.

Pasco's two obstruction ordinances also provided for different penalties.[133] Under the direct obstruction ordinance, sitting or lying down on the sidewalk is punishable as a misdemeanor. Under the nuisance ordinance, the same behavior is punishable as a civil infraction. Pasco reported one citation issued under the sit/lie ordinance, and no citations under the nuisance ordinance. Although the data did not reveal discriminatory enforcement, the ordinances as written still allow for the possibility.



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[127] The single citation for sitting/lying in public places stems from a compound ordinance that prohibits another type of conduct: sleeping in particular public places. It is unclear which category this particular citation belongs under.
[128] Pasco Municipal Court could not provide additional information outside of its Judicial Information System (JIS) database available for public use in the King County District Court. The system was not user-friendly.
[129] PMC 9.14.020 and 9.44.060.
[130] PMC 6.04.270 and 9.64.120.
[131] PMC 9.44.010 and 9.60.020.
[132] Pasco Municipal Codes 9.64.120 and 6.04.270.
[133] 9.60.20 Nuisances Defined and 9.44.010 Unlawful Street or Sidewalk Interference.
[134] Comic based on Josh Farley, *Bremerton Council Passes Panhandling Ordinance*, KITSAP SUN (Nov. 6, 2014), http://www.kitsapsun.com/news/local-news/panhandling_vote_110714_21089784.

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CONCLUSIONS & RECOMMENDATIONS

Across Washington, cities are embracing criminalization as a solution to the problem of homelessness and visible poverty. The best predictor of ordinance enactment is time. Since 2000, criminalization ordinances have been enacted at a rapidly growing rate without any indication of slowing down. Additionally, income disparity levels predict aggressive enforcement of a city's criminalization ordinances. As the income disparity gap widens, visible poverty increases. The presence of visible poverty may trigger policy efforts to "clean up the streets." Because cities are no likely to abandon enactment efforts and income disparity continues to rise across Washington,[135] the criminalization of homelessness is almost certain to get worse.

This brief does not purport to solve the complex problem of homelessness. Instead, the specific focus of this brief is to examine the scope and extent of the criminalization of homelessness throughout the state of Washington based on available data. This report shows: (1) Washington cities are increasingly criminalizing homelessness; (2) these laws frequently target necessary life-sustaining activities, even though people without shelter have no reasonable alternative but to conduct these activities in public; (3) the enforcement of these laws raises legal and policy concerns, such as inconsistent or selective citation and sentencing practices; (4) the enactment of overlapping and compound ordinances raises constitutional equal protection and due process concerns; (5) the link between income disparity and enforcement of these ordinances should prompt lawmakers to re-consider the societal impact of homeless criminalization; and (6) the limited and inconsistent access to data impedes researchers from demonstrating the full extent of homeless criminalization.

The most obvious way to address the problem of anti-homeless regulations is to repeal laws that criminalize life-sustaining activities or disproportionately target homeless or visibly poor individuals. To paraphrase Chief Justice John Roberts, the way to stop discrimination on the basis of homelessness is to stop discriminating on the basis of homelessness.[136] Cities rely on criminalization to resolve the problems associated with visible poverty. However, criminalization is a broken system that fails to protect the rights and dignities of homeless individuals. Without reliance on criminalization, cities will be compelled to address homelessness directly through systemic social policy changes that respect the inherent humanity of the homeless population.

For the short term, however, there are a number of ways cities can provide both fairer treatment of homeless people and greater transparency for researchers. Local jurisdictions should take care when drafting ordinances to ensure the laws are clear and targeted at truly criminal conduct. To that point, jurisdictions should also avoid writing compound ordinances or

[135] Jennifer Romich, *Poverty, Income Inequality Increase in Washington State*, UWTODAY (Sept. 18, 2014), http://www.washington.edu/news/2014/09/18/poverty-income-inequality-increase-in-washington-state/.
[136] Paraphrased from Chief Justice Roberts's famous line, "[t]he way to stop discrimination on the basis of race is to stop discriminating on the basis of race." *Parents Involved In Community Schools v. Seattle School District No. 1*, 551 U.S. 701 (2007).

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allowing the passage of unnecessary overlapping ordinances. Jurisdictions should also consider whether the conduct is already criminalized through other facially neutral laws. Additionally, cities should endeavor to make their municipal codes easier to navigate and search. And finally, municipal courts in every jurisdiction should be provided with modern technology and software so that basic enforcement and demographic data is easily accessible to the public.

While it may seem a matter of common sense, municipalities should take great care in drafting their ordinances. Some ordinances have ambiguous terms that lead to discriminatory enforcement when left open to interpretation. Additionally, municipalities should include a statement of purpose exempting acts of genuine necessity and survival so that the ordinances are used to punish criminally unlawful conduct. These recommendations would help address the problem of ordinances criminalizing life-sustaining activities while remaining facially neutral. Cities would thus provide much-needed clarity to their municipal codes in ways that better serve their entire populations.

Furthermore, both overlapping and compound ordinances create hurdles for the city and researchers alike. As suggested by the enactment data above, overlapping ordinances allow for officers to apply different punishment schemes to different individuals being cited for the same conduct. This phenomenon opens the door to potential constitutional violations, such as due process and equal protection. Compound ordinances should also be eliminated, though for different reasons. These convoluted ordinances require researchers to effectively guess at the actual conduct an individual was cited for when the case was filed under a single ordinance with several applicable conducts. Without being able to distinguish what conduct led to a citation, it is very difficult for any interested parties to pinpoint what behavior is truly at issue.[137]

Finally, while some municipalities used online municipal code databases very effectively, several others had broken search functions or simply linked to PDF files. Despite the limited resources of municipal governments, maintaining an open and accessible municipal code is crucial. Legal practitioners, pro se defendants, police officers, and city advisors will all benefit from a city code that is easier to navigate. And for interested parties looking into the state of the law, a user-friendly system will lead to better data, and thus more reliable results.[138]

All these recommendations are vital to better understanding and addressing the moral, legal, and economic consequences of persecuting one of the most vulnerable segments of society. Even the most modest improvements suggested in this brief can help illuminate the extent of criminalization throughout Washington. To get at the heart of the problem, however, cities must stop relying on the criminalization of visible poverty as a solution to homelessness.

[137] For instance, if an ordinance criminalizes both begging at intersections and aggressive begging, the citation number will suggest a citation issued for both forms of conduct. This makes it functionally impossible to bolster programs intended to target the at issue conduct, whichever it may be.
[138] For individuals interested in performing similar research in your own state, a discussion of the research process is provided in Appendix V.

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APPENDIX

I-A. Phase I Request Letter

[Month] [Day], [Year]

[Served Entity]
Attn: [Recipient name]
[Title]
[Address 1]
[Address 2]

Via [mail or Email]: [email address if applicable]

RE: Public Records Act Request – Citation Information for [City] Municipal Codes

To Whom It May Concern:

I am requesting that the records described below be made available for inspection, pursuant to the Washington Public Records Act (RCW §42.56 et seq.). In accordance with RCW 42.56.520, you must, within five business days of receipt of this request, respond and let me know the status of the request and how soon you will be able to produce all discoverable records.

I am requesting certain information (see specific questions below) pertaining to citations issued due to violations of the following [City] Municipal Codes:

[Code section 1]
[Code section 2]
[Code section 3]
[Repeat as necessary]

Specifically, I am requesting all relevant records related to the following questions for the time period between January 1, 2009, and December 31, 2013:

1) How many total citations were issued under the city codes specified above?
2) How many citations were issued per each separate city code specified above?
3) How many of the citations were issued to people who are homeless/transient?
4) Of the citations issued to homeless/transient individuals, how many citations were issued per each separate city code specific above?
5) How many of these citations were resolved, or how many are still outstanding?
6) What are the consequent fines that result from any citation issued pursuant to violations of the city codes specified above?
7) How many people spent time in custody as a result of these citations and how much time did they spend in custody?

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8) How many cases led to the issuance of a warrant? How many were brought to the station and/or sent to jail?
9) What are the consequent fines/additional charges that are a result of a failure to appear for these citations?

At this time, please refrain from making copies of any responsive documents. Instead, please contact me to schedule a time for me or my representatives to inspect the documents requested above, at which time we will select those documents we would like copied. You may send any written responses to this request to:

[Supervisor]
[Institution]
[Address 1]
[Address 2]

If any documents are withheld in whole or in part, please specify the reason for withholding such document or any portion thereof. For any document withheld in its entirety, please state the name and date of the document as well as the number of pages within the document. To the extent that portions of the request are specifically exempted from disclosure, please provide all non-exempt portions as allowed for under the Washington Public Records Act. To the extent that any portion of the requested records contain classified information, please redact such information and furnish the requested records.

We very much appreciate your attention to this request. If you would like to contact me with questions or concerns about the requested information please feel free to do so as I am more than happy to clarify in any way I can. Please contact me with any questions at [Supervisor mail] or at [Supervisor phone].

I look forward to hearing from you within five business days. Thank you for your assistance!

Very truly yours,

[Name]
[Title]
[Institution]
[Address 1]
[Address 2]

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I-B. Phase II Request Letter

[Month] [Day], [Year]

[Served Entity]
Attn: [Recipient name]
[Title]
[Address 1]
[Address 2]

Via [mail or Email]: [email address if applicable]

RE: Public Records Act Request – Citation Information for [City] Municipal Codes

To Whom It May Concern:

Thank you for the excellent information you have provided pursuant to our public records request. After reviewing the responsive data, we would like to request additional information pursuant to the Washington Public Records Act (RCW §42.56 et seq.) regarding the [City] Municipal Code citations issued between January 1, 2009, through December 31, 2013, under the following ordinances:

[Code section 1]
[Code section 2]
[Code section 3]
[Repeat as necessary]

Specifically, we are requesting all relevant records related to the following questions:

1) What is the cost per day (on average) to keep an individual in police custody?
2) What is the average "booking cost" associated with the violation of ordinances listed above?

In addition, for the citations of each ordinance listed above:

3) What was the age of each defendant?
4) How many defendants were male and how many were female?
5) What was the ethnicity of each defendant?
6) How many defendants had a physical disability?
7) How many defendants had a mental health disability?
8) How many defendants identified as homosexual, bisexual, or transgender?
9) How many defendants were U.S. citizens?
10) How many defendants were legal immigrants?
11) How many defendants were illegal immigrants?

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12) How many defendants identified as veterans?
13) How many defendants were identified as having substance abuse issues?
14) For the citations involving a disability or substance abuse, how was this determined? (For example, did the officer determine this at arrest, did the defendant identify as having a disability, etc.?)
15) How many defendants were receiving mental health services at the time of the citation?
16) How many defendants retained an attorney?
17) How many defendants retained a public defender?

Please note that this data does not need to be separated by ordinance – total numbers will suffice. If the City of [City] does not track the data related to any of the requests above, please let us know.

At this time, please refrain from making copies of any responsive documents. Instead, please contact me to schedule a time for me or my representatives to inspect the documents requested above, at which time we will select those documents we would like copied. You may send any written responses to this request to:

[Supervisor]
[Institution]
[Address 1]
[Address 2]

If any documents are withheld in whole or in part, please specify the reason for withholding such document or any portion thereof. For any document withheld in its entirety, please state the name and date of the document as well as the number of pages within the document. To the extent that portions of the request are specifically exempted from disclosure, please provide all non-exempt portions as allowed for under the Washington Public Records Act. To the extent that any portion of the requested records contain classified information, please redact such information and furnish the requested records.

We very much appreciate your attention to this request. If you would like to contact me with questions or concerns about the requested information please feel free to do so as I am more than happy to clarify in any way I can. Please contact me with any questions at [Supervisor email] or at [Supervisor phone].

I look forward to hearing from you within five business days. Thank you for your assistance!

Very truly yours,

[Name]
[Title]
[Institution]
[Address 1]
[Address 2]

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II. Examples of Homeless Criminalization Ordinances (By Category of Behavior)

A. Sleeping in public city-wide

A. "Camping" means the use of park land or other publicly owned property for living accommodation purposes including but not limited to any of the following:

1. Sleeping activities;

2. Making preparations to sleep;

3. Laying down of bedding for the purpose of sleeping;

4. Storing personal belongings;

5. Erecting any tent, tarpaulin, shelter, or other structure that would permit one to sleep overnight;

6. Using a motor vehicle for the purposes of sleeping.

Issaquah Municipal Code 9.26.010 Camping, defined.

It is unlawful for any person to engage in camping in any park or playfield owned by the City, or on any sidewalk, street, alley, lane, public right-of-way, or under any bridge or viaduct, or in any other public place to which the general public has access. (Ord. 2261 § 1, 2000).

Issaquah Municipal Code 9.26.030 Camping prohibited.

B. Sleeping in particular public places

It shall be unlawful within the area of the City of Pasco bordered by the railroad tracks on the east, 14th Avenue on the west, Bonneville street on the north and "A" Street on the south, for any person to sit, lay, or sleep on any public right-of-way except for medical emergency, in the furtherance of work or repair to the public right-of-way or of any property or building immediately adjacent thereto or in furtherance of a special permit issued by the City under some other chapter of this code. A violation of this section is a misdemeanor. (Ord. 3491 Sec. 2, 2001; Ord. 2561 Sec. 1, 1985)

Pasco Municipal Code 9.44.030 Sitting, Laying, or Sleeping on Right-of-Way Prohibited

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C. Camping in public city-wide

A. It shall be unlawful for any person to camp, occupy camp facilities for purposes of habitation, or use camp paraphernalia in the following areas, except as otherwise provided by ordinance or as permitted pursuant to Section 8.22.070 of this ordinance:

1. any park;

2. any street; or

3. any publicly owned or maintained parking lot or other publicly owned or maintained area, improved or unimproved.

. . . .

Vancouver Municipal Code 8.22.040 Unlawful camping.

D. Camping in particular public places

No person shall camp in any park area including any park parking lot. [Ord. 475 § 2, 2007]

Burien Municipal Code 7.30.110 Camping.

E. Sitting/lying in particular public places

(1) Prohibition. No person shall sit or lie down upon a public sidewalk, or upon a blanket, chair, stool or other object placed upon a public sidewalk, within the city of Marysville during the hours between 6:00 a.m. and 12:00 midnight.

(2) Exceptions. The prohibition in subsection (1) of this section shall not apply to any person:

(a) Sitting or lying down on a public sidewalk due to a medical emergency;

(b) Who, as a result of a disability, utilizes a wheelchair, walker or similar device to move about the public sidewalk;

(c) Operating or patronizing a commercial establishment conducted on the public sidewalk pursuant to a street use permit; or a person participating in or attending a parade, festival, performance, rally, demonstration, meeting or similar event conducted on the public sidewalk pursuant to a street use or other applicable permit;

(d) Sitting on a chair or bench located on the public sidewalk which is supplied by a public agency or by the abutting private property owner;

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(e) Sitting on a public sidewalk within a bus stop zone while waiting for public or private transportation.

Nothing in any of these exceptions shall be construed to permit any conduct which is prohibited by Chapter 6.37 MMC, Pedestrian Interference.

(3) No person shall be cited under this section unless the person engages in conduct prohibited by this section after having been notified by a law enforcement officer that the conduct violates this section. (Ord. 2157 § 1, 1997).

Marysville Municipal Code 12.22.010 Sitting or lying down on public sidewalks in downtown commercial zones.

F. Lodging, living, or sleeping in vehicles

. . . .
B. It shall be unlawful for any person to occupy a vehicle for the purpose of camping while that vehicle is parked in the following areas, except as otherwise provided by ordinance or as permitted pursuant to Section 8.22.070 of this ordinance:

1. any park;

2. any street; or

3. any publicly owned or maintained parking lot or other publicly owned or maintained area, improved or unimproved.

Vancouver Municipal Code 8.22.040 Unlawful camping.

G. Loitering/loafing/ vagrancy city-wide

A. It is unlawful for any person to loiter, loaf, wander, stand or remain idle either alone and/or in consort with others in a public place in such a manner so as to:

1. Obstruct any public street, public highway, public sidewalk or any other public place or building by hindering or impeding or tending to hinder or impede the free and uninterrupted passage of vehicles, traffic or pedestrians;

2. Commit in or upon any public street, public highway, public sidewalk or any other public place or building any act or thing which is an obstruction or interference to the free and uninterrupted use of property or with any business lawfully conducted by anyone in or upon or facing or fronting on any such public street, public highway, public sidewalk or any other public place or building, all of which prevent the free and uninterrupted ingress, egress and regress, therein, thereon and thereto.

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B. When any person causes or commits any of the conditions enumerated in subsection A of this section, a police officer or any law enforcement officer shall order that person to stop causing or committing such conditions and to move on or disperse. Any person who fails or refuses to obey such orders is guilty of a violation of this chapter. (Ord. 5682 § 1, 2002.)

Auburn Municipal Code 9.50.020 Order to disperse.

H. Loitering/loafing in particular public places

A. It is unlawful to camp in a park except at places set aside for such purpose by the city and so designated by signs.

B. It is unlawful to remain, stay or loiter in a park between the hours of 9:00 p.m. and 6:00 a.m. (Ord. 13-05 § 4, 2013; 1967 code § 8.40.090)

East Wenatchee Municipal Code Section 12.12.090 Camping regulations.

I. Obstruction of sidewalks/public places

A. The following definitions apply in this section:

. . . .

4. "Obstruct pedestrian or vehicular traffic" means to walk, stand, sit, lie, or place an object in such a manner as to block passage by another person or a vehicle, or to require another person or a driver of a vehicle to take evasive action to avoid physical contact. Acts authorized as an exercise of one's constitutional right to picket or to legally protest, and acts authorized by a permit issued pursuant to the Street Use Ordinance, Chapters 15.02 through 15.50 of the Seattle Municipal Code, shall not constitute obstruction of pedestrian or vehicular traffic.

5. "Public place" means an area generally visible to public view and includes alleys, bridges, buildings, driveways, parking lots, parks, plazas, sidewalks and streets open to the general public, including those that serve food or drink or provide entertainment, and the doorways and entrances to buildings or dwellings and the grounds enclosing them.

B. A person is guilty of pedestrian interference if, in a public place, he or she intentionally:

1. Obstructs pedestrian or vehicular traffic; or

2. Aggressively begs.

C. Pedestrian interference is a misdemeanor.

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Seattle Municipal Code 12A.12.015 Pedestrian interference.

J. Closure of particular public places

No Washington Ordinances could be located for this category.

K. Other restrictions on "vagrants"

A. Any person who wanders or prowls in a place, at a time, or in a manner, and under circumstances which manifest an unlawful purpose or which warrant alarm for the safety of persons or property in the vicinity is declared to be a vagrant and is guilty of a misdemeanor.

B. Among the circumstances which may be considered as manifesting an unlawful purpose or warranting alarm for the safety of persons or property, for the purposes of this section, include but are not limited to the following:

1. Flight by a person upon the appearance of a police officer;

2. Refusal of a person to identify himself to a police officer;

3. Attempt by a person to conceal himself or any object from a police officer.

C. No arrest shall be made under this section, nor shall any person be convicted of an offense under this section, unless the police officer first advises such person of his Fifth Amendment constitutional rights and then affords an opportunity for a person suspected of violating this section to dispel any alarm which would otherwise be warranted by requesting such person to identify himself and explain his presence and conduct, unless flight by the suspected violator or other circumstances make it impractical for the police officer to afford such an opportunity.

D. No person shall be convicted of an offense under this section if it appears at trial that the explanation given by the suspected violator was true and, if believed by the police officer at the time, would have dispelled the alarm or suspicion of unlawful purpose. (Ord. 628, 1976)

Monroe Municipal Code 9.08.080 Wandering or prowling under circumstances manifesting unlawful purpose.

L. Explicit provisions allowing for trespass warning to be given (e.g., St. Petersburg, FL)

A. Immediate Expulsion: Any person violating a rule or provision of this Chapter or any federal, state or local law may be ordered by a commissioned peace officer to leave the Transit Center immediately.

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B. Second Expulsion: Any person violating a rule or provision of this Chapter or any federal, state or local law and who has been the subject of a prior expulsion within the immediately preceding three (3) days may be ordered by a commissioned peace officer to leave the Transit Center immediately and will be subject to expulsion for up to seven (7) calendar days.

C. Expulsion Up To One (1) Year: Any person violating a rule or provision of this Chapter or any federal, state or local law and (1) who has been the subject of two prior expulsions within the immediately preceding thirty (30) days, or (2) who has been expelled from the Transit Center three (3) or more times in any 90-day period may be ordered by a commissioned peace officer to leave the Transit Center immediately AND will be subject to expulsion for up to one (1) year.

D. Failure to comply with any expulsion order shall be grounds for prosecution for criminal trespass. (Ord. 5587, 12-13-10; Ord. 5598, 4-25-11)

Renton Municipal Code 6-31-3 Expulsion

M. Enforcement of criminal trespass provisions in public places (e.g., Portland, ME)

A. It is unlawful for any person to:

1. Enter or remain in any park during the period covered by an expulsion notice pursuant to RMC 6-30-2; or

2. Enter, remain in, or be present within the premises of a park during hours that the park is not open to the public.

B. It is not a defense to the crime of trespass in parks:

1. That the underlying expulsion issued pursuant to this chapter is on appeal when the expelled person was apprehended, charged, or tried under this section; nor

2. That the expelled person entered or remained in the park pursuant to a permit that was issued either before or after the date of the expulsion notice.

C. Any person who violates the provisions of this chapter shall be guilty of a misdemeanor and may be punished by a fine in any sum not to exceed one thousand dollars ($1,000) or by imprisonment for a term not to exceed ninety (90) days, or by both such fine and imprisonment. (Ord. 5533, 3-15-10)

Renton Municipal Code 6-30-5 Trespass in Parks - Definition - Penalties

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N. Storing personal property in public places

> Except as permitted by permit pursuant to KCC 8.09.050 or as otherwise provided by ordinance, it shall be unlawful for any person to store personal property, including camp facilities and camp paraphernalia, in any park or other public place.
>
> (Ord. No. 3516, § 1, 7-5-00)
>
> **Kent Municipal Code 8.09.020 Unlawful storage of personal property in public places.**

O. Bathing in particular public waters

> It is unlawful for any person to boat, fish, wade, swim, scuba dive, snorkel, or bathe in any park except in the places and at times designated by the director. (Ord. 6465 § 1, 2013.)
>
> **Auburn Municipal Code 2.22.150 Prohibitions as to boating, fishing, and swimming.**

P. Urination/defecation in public

> A. A person is guilty of urinating in public if he or she intentionally urinates or defecates in a public place, other than a washroom or toilet room, under circumstances where such act could be observed by any member of the public.
>
> B. "Public place" as used in this Section 12A.10.100 has the meaning defined in Section 12A.10.010 A3.
>
> C. Except as provided in subsection D, any person who violates this Section 12A.10.100 shall be guilty of a violation as defined in Section 12A.02.080
>
> D. Any person who violates this section and previously has either violated this section or has failed to appear as directed when served with a citation and notice to appear for a violation of this section is guilty of a misdemeanor.
>
> Ord. 116896 § 1, 1993: Ord. 109674 § 10, 1981: Ord. 108867 § 1, 1980: Ord. 108814 § 9, 1980: Ord. 102843 § 12A.12.140, 1973.
>
> **Seattle Municipal Code 12A.10.100 Urinating in public.**

Q. Creating body odor or restricting access to those with body odor

> . . . .
> (4) Behavior that is "unreasonably disruptive to other users" is behavior that is not constitutionally protected and that unreasonably interferes with others' use and

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enjoyment of publicly owned property. Behavior that is unreasonably disruptive to others includes, but is not limited to, any of the following:

(a) Use of unreasonably hostile or aggressive language or gestures; or

(b) Unreasonably loud vocal expression or unreasonably boisterous physical behavior; or

(c) Using electronic or other communication devices in a manner that is unreasonably disruptive to others; or

(d) Wearing insufficient clothing for the location's use (e.g., no top, no bottom, no shoes); or

(e) Bodily hygiene or scent that is unreasonably offensive to others; or

(f) Unreasonably interfering with the free passage of staff or patrons in or on public property; or

(g) Behavior that is unreasonably inconsistent with the normal use for which the publicly owned property was designed and intended to be used (e.g., bathing, shaving, or washing clothes in a public bathroom or skateboarding in a public parking area or plaza).

(5) Any constitutionally protected action or speech is excluded from the prohibited behavior listed in this section. [Ord. 606 § 1, 2014]

Burien Municipal Code 9.125.015 Definitions [Modified January, 2015]

(1) Officers of the Burien police department shall be empowered to issue a trespass warning to any individual who violates any city ordinance, state statute, or government rule or regulation relating to conduct that is dangerous, unsafe, illegal, or unreasonably disruptive to other users of public property as defined in BMC 9.125.015, while such individual is on or within any city or other publicly owned facility, building, or outdoor area that is open to the general public, as more specifically set forth in BMC 9.125.010(3).

9.125.020 Trespass warnings on city and other property generally open to the public

R. Rummaging/scavenging/dumpster diving

It is unlawful for any person, firm or corporation, other than the city, the city's recycling contractor, or a private disposal company franchised by the city, to scavenge, remove or collect any garbage or refuse after it has been set out by a customer for collection at the curbside or other approved location. (Ord. 2540 § 1, 2004; Ord. 1822 § 7, 1991).

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Marysville Municipal Code 7.08.055 Scavenging prohibited.

S. Begging in public places city-wide

A. Soliciting for Private Needs – Prohibited. No person shall solicit contributions for himself in or upon any public street or public place in the City of Maple Valley.
. . . .

Maple Valley Municipal Code 5.05.080 Charitable solicitations.

T. Begging in particular public places

A. Solicitation Near Designated Locations and Facilities.

1. It is unlawful for any person to solicit another person within fifteen feet of:

a. An automated teller machine;

b. A self-service fuel pump;

c. A public transportation stop; or

d. Any parked vehicle as occupants of such vehicle enter or exit such vehicle.

2. It is unlawful for a person to solicit another person in any public transportation facility or vehicle.

. . . .

Centralia Municipal Code 10.37.050 Place of solicitation.

U. Aggressive" panhandling

A. The following definitions apply in this section:

1. "Aggressively beg" means to beg with the intent to intimidate another person into giving money or goods.

2. "Intimidate" means to engage in conduct which would make a reasonable person fearful or feel compelled.

3. "Beg" means to ask for money or goods as a charity, whether by words, bodily gestures, signs, or other means.
. . . .

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B. A person is guilty of pedestrian interference if, in a public place, he or she intentionally:

1. Obstructs pedestrian or vehicular traffic; or

2. Aggressively begs.

C. Pedestrian interference is a misdemeanor.

Ord. 117104 § 1, 1994: Ord. 116897 § 1, 1993: Ord. 113697 § 1, 1987.

Seattle Municipal Code 12A.12.015 Pedestrian interference.

V. Other begging/panhandling restrictions (i.e. street performers, washing cars/windshields, etc.)

No person shall engage in any solicitation within the limits of the city without having first registered with the city clerk, by name, residence and business address, residence and business telephone number, the purpose of any proposed solicitation, and the name of any other person on behalf of whom any solicitation is to be made, for the purpose of aiding the city officials in referring and resolving complaints, if any. (Ord. 302 § 4, 1977)

Mukilteo Municipal Code 9.54.030 Registration –Required.

W. Food Sharing city-wide or in particular public places (i.e. bans)

No Washington ordinances could be located for this category.

X. Restrictions on food sharing (i.e. permit requirements, etc.)

No Washington ordinances could be located for this category.

Y. Other/miscellaneous restrictions

(1) It is unlawful for any person to do any of the following acts, if a shopping cart has a permanently affixed sign as provided in subsection (2) of this section:
(A) To remove a shopping cart from the parking area of a retail establishment with the intent to deprive the owner of the shopping cart the use of the cart; or
(B) To be in possession of any shopping cart that has been removed from the parking area of a retail establishment with the intent to deprive the owner of the shopping cart the use of the cart.
(2) This section shall apply only when a shopping cart:
(A) Has a sign permanently affixed to it that identifies the owner of the cart or the retailer, or both;
(B) Notifies the public of the procedure to be utilized for authorized removal of the cart from the premises;

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(C) Notifies the public that the unauthorized removal of the cart from the premises or parking area of the retail establishment, or the unauthorized possession of the cart, is unlawful; and
(D) Lists a telephone number or address for returning carts removed from the premises or parking area to the owner or retailer.
(3) Any person who violates any provision of this section is guilty of a misdemeanor.
(Ord. 4153, 2014.)

Pasco Municipal Code 9.34.065 Shopping Cart Theft.

III. Washington Ordinance Chart Methodology

HRAP researchers catalogued every municipal jurisdiction surveyed in the 2010 Census—a total of 72 cities. The total surveyed population represents 53% of Washington State's total population.[139] Two additional cities were included solely for their regional locations in order to capture a geographical representation of the entire state.[140] The resulting chart allowed researchers to spot trends in the enactment of these ordinances.

All catalogued municipalities keep an online database of their municipal codes, but only some of these online databases had an integrated search function. To account for this, HRAP researchers created two separate surveying methods. First, for those databases with search functions, researchers searched for the following keywords: *sleeping*, *sleep*, *camping*, *camp*, *sitting*, *lying*, *lodge*, *vehicle*, *loiter*, *loitering*, *loafing*, *vagrancy*, *obstruction*, *trespass*, *storage*, *bathing*, *urination*, *urinate*, *defecation*, *defecate*, *scavenging*, *begging*, *aggressive*, *panhandling*, *solicitation*, and *food*.[141] The effectiveness of database search functions varied considerably.[142] In some instances, the database did not have a search function, so HRAP researchers resorted to browsing through the code manually.[143] To ensure the reliability of both methods, researchers chose four municipalities with search functions and separately used both the search and browse methods, which ultimately generated the same results.

Upon finding a criminalization ordinance, researchers placed it into a category on the live-links chart. The live-links chart is divided by city and behavioral category, with every cited

[139] 2010 Census data available at http://data.spokesman.com/census/2010/washington/cities/. The Census included only those cities with a population exceeding 10,000. Census Population Districts were not covered by researchers as they are creations of the census bureau and do not function in any way as a municipality.
[140] Omak to cover north-central Washington and Colville to cover the northeast region of Washington.
[141] These terms represent the kinds of conduct most likely targeted in homeless criminalization ordinances.
[142] Unsophisticated search functions would pull codes utilizing only the exact wording searched (for instance, a search for "urinating" would not reveal results for urination, urinate, or urinates). More sophisticated search functions pulled results by identifying the root word and pulling up any iterations of that root in the code. Identifying the sophistication of a given search function required searching for the root word, and then searching for common iterations of that search word, and noting the differences in the results. For those unsophisticated functions, researchers were forced to search both root words and all their possible iterations to ensure proper coverage.
[143] While admittedly more time consuming that using a search function, researchers found it helpful to pay close attention to code sections that commonly harbored criminalizing ordinances. For instance, chapters entitled "Health and Safety" or "Public Peace, Morals, and Welfare" frequently contained ordinances criminalizing obstruction, begging, and other behaviors. The "Park Code" also had anti-camping ordinances in nearly all jurisdictions.

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ordinance hyperlinked directly to the ordinance at issue.[144] In addition to hyperlinking, each ordinance is indexed with at least the chapter and section titles to provide context for readers. Researchers identified the broad category of behavior a certain ordinance prohibited and then placed the ordinance into the chart under the specified category.[145] In several instances, municipalities enacted two or more separate ordinances prohibiting the same category of conduct. In these situations, researchers placed the additional ordinances in subsequent rows under the same column. Similarly, municipalities would occasionally criminalize multiple categories of behavior in a single ordinance. In these cases, the offending ordinance was indexed under each category of prohibited behavior. Researchers included an "other" category to note ordinances that criminalized some behavior that appeared to disproportionality target the homeless population, but that did not fit neatly into a defined category.[146] Before finalizing the live-links chart, researchers jointly reviewed all inputs and approved or denied their inclusion to further ensure reliability.

Scope of Methodology

While the researchers' methodology was effective, it is not without limitations. Primarily, there is no way to ensure 100% coverage of all criminalization ordinances. Any further analysis of the results should note that cities may well have additional ordinances lurking in their codes. Several factors contribute to this fact: (1) database lag time; (2) limited HRAP resources; (3) the potential for cities to creatively manipulate ordinance language to effectuate criminalization without explicitly claiming to do so—or at the least claiming to do so using traditional terminology; and finally (4) the presence of overlapping or compound ordinances.

There is a very real risk that ordinances may have been enacted or amended but not included in online databases. In one instance, researchers became aware of that exact scenario as Arlington passed an ordinance that was not reflected in the online database. Unfortunately, there is little researchers can do to protect against this issue. Occasionally, as was the case in Arlington, an ordinance may become popular due to local media attention; thus, it is worthwhile to stay connected in the local community and to run news searches for potential stories as the catalogue is filled in.

Another issue that presented a limitation was the resources of HRAP researchers. If there were additional researchers on this particular project, the live-links chart likely would have reflected all 275 municipalities. However, researchers observed the beginnings of diminishing returns on their investment as smaller cities tended to have far fewer ordinances than larger cities.

[144] Where direct hyperlinking to the ordinance was unavailable, researchers were forced to link to the municipality's general code page. In very few instances, a municipality elected only to publish the code in PDF format, in which cases the PDF is hyperlinked.

[145] In the event an ordinance used ambiguous language to effectuate a common criminalization, researchers conferred and, based upon the surrounding ordinances and perceived enacting intent, jointly decided whether to include the ordinance. An example would be ordinances criminalizing "offends the senses" which would be included depending on the ordinance's context. If the ordinance targeted businesses or owners of land, then it was excluded. If the ordinance was embedded among other personal conduct regulations, it was generally included.

[146] For instance, several jurisdictions outlawed possession of a shopping cart outside of a shopping center, which is a behavior not explicitly covered by any category in the chart but that researchers still felt was necessary to include.

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In those jurisdictions that allowed researchers to utilize a search function instead of the browsing method, there is a chance that some new and innovative ordinances criminalizing homeless conduct were missed.[147] This concern is partially assuaged by the uniformity of results achieved when researchers independently browsed and searched four municipalities, demonstrating that this issue did not arise once in those four cities. The conclusion is that the problem, while certainly present, appears in relatively rare instances.

IV. Enforcement Data Methodology

On August 6, 2014, HRAP researchers submitted the first round of public records requests to the cities of Auburn, Bellingham, Burien, Pasco, Seattle, Spokane, and Vancouver pursuant to the Washington Public Records Act (RCW §42.56 et seq.).[148] These cities were chosen from the originally surveyed 25 cities[149] because they appeared to criminalize the broadest range of behaviors. Seattle did not fall within this category, but instead was included due to being the largest city in the state. Burien was included a month later primarily because of the passage of Chapter 9.125 of the municipal code: a "trespassing ordinance" that allowed individuals to be banished from public spaces on account of body odor.[150]

HRAP researchers requested the following information from each city regarding the specific criminalization ordinances for that municipality:

1) The **total number of citations** issued under each ordinance for a five year period (January 1, 2009, through December 31, 2013);
2) The total number of citations that were issued to people who are **homeless/transient**, broken down by ordinance;
3) How many of the citations were **resolved** and how many were **outstanding**;
4) The consequent **fines** that result from any citation issued pursuant to the ordinances;
5) The total number of people who spent time in **custody** as a result of the citations;
6) The **duration of time** people spent in custody as a result of the citations;
7) The number of citations that led to the issuance of a **warrant**, and how many people were brought to the station and/or sent to jail pursuant to the warrant;

[147] For instance, researchers found a statute employing the term "protractedly lounge" to effectively criminalize lying down or sleeping. This term was not in our original methodology, but was found because it was embedded in an ordinance that also criminalized camping in public parks.
[148] Occasionally, the cities would refer researchers to the local municipal court or county jail for the data responsive to our requests. New requests were forwarded accordingly.
[149] Researchers initially conducted their study on the top 25 most populous cities in Washington and then subsequently expanded the study to 73. The public records requests were sent after cataloging 25 cities but before expanding to 73.
[150] The ordinance garnered widespread criticism for being both too harsh and too arbitrary. A more thorough discussion of the history surrounding this ordinance may be found in Part III.B.5.

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8) Whether there are consequent fines or additional charges resulting from a **failure to appear** for these citations.

As the data came in, researchers categorized the numbers of citations by the type of prohibited conduct. Doing so allowed researchers to view the data in a way allowing for comparison analysis despite differences in ordinance language between cities. This method functioned well with the exception of Spokane due to the overwhelming number of overlapping ordinances in that jurisdiction.

After receiving the initial data on citations from a particular city, HRAP researchers next sent an additional request seeking a broad range of demographic data.[151] Researchers requested information regarding the cost per day to keep individuals in police custody, as well as the average "booking cost" for citations issued under an identified ordinance. Additionally, researchers asked for data relating to 15 demographic points including ethnicity, gender, and disability.[152]

One crucial piece of data was particularly difficult to obtain: the number of homeless individuals in each municipality. Although the One Night Count provides homeless populations for both Seattle and Auburn, no data could be found for other cities.[153] The One Night Count is useful for advocates to educate the public and raise awareness regarding unsheltered homelessness. In addition, lawmakers can use the count as a comparison from one year to the next. Due to the practical constraints, however, the numbers underrepresent the actual number of homeless individuals in those cities.[154] Notably, the most recent One Night Count did find an increase in the Seattle homeless population by 22% and an increase in Auburn's homeless population by 36%.[155]

V. Researching Your Jurisdiction

While this research is the most expansive to date, the methods used to obtain the data and perform the analysis are not unique to Washington State. This section encourages the replication

[151] *See infra* Appendix I-B.
[152] Complete list of demographic questions include: age, gender, ethnicity, disability (physical or mental health), citizenship, immigration status, veteran status, substance abuse, and identity as homosexual/bisexual/transgender. Researchers also inquired as to whether the defendants were receiving mental health services, had retained an attorney, or had retained a public defender.
[153] The One Night Count sends volunteers out to perform a point-in-time count of homeless individuals in shelters, with transitional housing providers, and on the street. The 2014 findings revealed 2,303 homeless individuals in Seattle and 97 homeless individuals in Auburn. Seattle/King County Coalition on Homelessness, *2014 Street Count Results*, http://www.homelessinfo.org/what_we_do/one_night_count/2014_results.php (last visited Dec. 4, 2014).
[154] For instance, in California, early proponents of the One Night Count faced backlash even from homeless advocacy groups that feared the artificially low numbers would stifle funding and hinder policy advocacy efforts. Faye Fiore, *Down for the Count: Critics of First Census of Homeless Say the Tally Destined to Be Low*, L.A. TIMES (Mar. 18, 1990), *available at* http://articles.latimes.com/1990-03-18/news/hl-768_1_homeless-person. A spokesman for the Sacramento Homeless Organizing Committee estimated that the count was likely to find only 15-20% of the homeless. Frank Clifford, *Census Begins With the Nation's Homeless Count: 15,000 Fan Out For Monumental Overnight Task. Many Meet Difficulties. Incomplete Tally is Expected.*, L.A. TIMES (Mar. 21, 1990), *available at* http://articles.latimes.com/1990-03-21/news/mn-728_1_census-taker.
[155] Konopasek, *supra* note 52.

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of the same or similar studies in jurisdictions across the country. The section is split into two parts: first, a summary of the fundamental methodologies expressed throughout the article and combining them into a single easy to read guide; and second, a guide to expanding research beyond this study.

A. Replicating Research in Your Jurisdiction

Ideally, any research would be done by two or more researchers who can provide constant peer review toward the others' work. The first step in beginning a similar study is to cultivate a catalogue of offending ordinances by city and category.[156] Second, choose which cities you would like to survey.

City selection can be based on population counts, which are then supplemented by other cities to provide geographical representation. The benefit of surveying populous cities is that they have census data. This data can be very useful in assessing trends and can also suggest areas for future research.

Third, having chosen the cities, new researchers should find the municipal code online and employ either the search or browse method to identify offending ordinances depending on the sophistication of the database. Researchers should review the identified ordinances together so that they may agree whether the ordinance disproportionately criminalizes conduct of necessary, life-sustaining activities.[157] As researchers continue to go through the ordinance combing process, they should continually reevaluate the effectiveness of their search terms and vary them accordingly.[158] Cultivating a live-links chart was helpful for quick reference throughout the project and is highly encouraged for other jurisdictions. The final step in the ordinance-gathering process is to make note of overlapping or compound ordinances, which researchers here have identified as problematic.

After identifying offending ordinances, the next step is to gain access to the enforcement data for those ordinances in key jurisdictions.[159] Drawing from the public records request included here in the appendix, researchers should identify the public records officer for each jurisdiction. From this point on, the methods will have to be fluidly changed depending on the jurisdiction. Some jurisdictions will be helpful, while others will throw up cost prohibitive measures that deter the ultimate disclosure of the enforcement data. Researchers should expect to serve requests upon both the cities themselves as well as the municipal courts within the jurisdiction. The exact city agency will vary by municipality, but common agencies were city records offices and offices of the city attorney. Upon receiving, reviewing, and indexing the material germane to the core research questions of the project, analyze the data and draw whatever conclusions stand out.

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[156] For a full discussion of the methodology used to cultivate the ordinance chart, please see Appendix part III.
[157] This peer review process was invaluable. While many ordinances clearly targeted conduct by the visibly poor, several ordinances were more vague or "on the line." While no method will ever be infallible, peer review and consensus allowed researchers to confidently retain only those that truly criminalized homelessness.
[158] It could very well be that the words and phrases employed in a different jurisdiction's criminalization ordinances are completely different from those employed in Washington jurisdictions.
[159] What those key jurisdictions is entirely up to the discretion of researchers who, at this point, are far more knowledgeable about the criminalization patterns in their jurisdiction than any other entity.

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B. Expanding Research in Your Jurisdiction

HRAP researchers were aware of resources available in other jurisdictions that were not available in Washington State, listed below. New researchers should check to see if the following resources do exist and, if they do, utilize them to their fullest. This is not meant to be an exhaustive list, so researchers must think outside the box when generating leads on knowledgeable individuals.

Several jurisdictions have homeless courts, which may provide a wealth of expertise and additional information not available to HRAP researchers. Non-governmental agencies, watchdog, and advocacy groups are generally willing to lend a helping hand to. If new researchers are administering surveys to homeless individuals, these groups become especially useful in connecting researchers to homeless communities. In a different vein, it may be worthwhile to consider qualitative data collection techniques such as interviewing enforcement personnel to get a more complete sense of how municipal ordinances may translate into enforcement. Ultimately, researchers should look to gain any additional information to help them understand the scope, purpose, and prevalence of criminalization ordinances, the assumptions behind them, and the enforcement strategies that follow in their wake.

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MYTHS AND FACTS OF HOMELESSNESS IN WASHINGTON STATE

BUILDING A NEW PUBLIC NARRATIVE TO COMBAT CRIMINALIZATION AND ADVANCE REAL SOLUTIONS

How is homelessness criminalized? The criminalization of homelessness occurs when governments choose to remove visibly homeless people from shared public spaces instead of offering services. It treats life-sustaining activities like sitting, sleeping, and eating as illegal. When community leaders or others talk about ridding the streets of homeless individuals, often they are referring to those who are experiencing chronic homelessness, as they are typically the people who look most visibly poor.

Why is criminalization an ineffective response to chronic homelessness? Criminalization feeds directly into the cycle of chronic homelessness. Individuals are arrested for minor infractions and may spend time in jail, which exacerbates behavioral health issues and results in criminal records, making securing a home and/or a job much harder. Additionally, criminalizing behaviors like sitting or lying effectively create zones of exclusion from public areas. This creates an impossibility of existence, where simply living and being may be criminalized. These policies also perpetuate existing racial disparities and have disparate impacts on other already marginalized groups including LGBTQ people, people with disabilities, and veterans.

MYTH: People choose to be homeless.

FACT: A homeless life is not a comfortable one. Homelessness is dangerous, stressful, and humiliating. Some people who are homeless choose to sleep on the streets rather than in shelters because they are unsettled by shelter conditions and noise. Very few choose the streets over a residence they could call home. Certainly, children do not choose homelessness, nor do victims of domestic violence, which is the leading cause of homelessness among women.

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Exam of Dr. Stephen Gaetz
Heegsma et al v City of Hamilton
Nimigan Mihailovich Reporting Inc.

MYTH: People who are homeless are violent, dangerous, and/or are lawbreakers.

FACT: While a larger number of people experiencing homelessness have substance abuse disorders than the general population, a person who is homeless is no more likely to be a criminal than a housed person, with one legal exception: camping ordinances. But of course people who are homeless break that law merely by being homeless. A person who is homeless is less likely to perpetuate a violent crime than a housed person, and is in fact more likely to be the *victim* of a violent crime, especially if they are a homeless woman, teen, or child.

MYTH: People who are homeless in a community usually came from someplace else, and providing services only encourages more people who are homeless to migrate there.

FACT: It is easy to assume that a rise in visible homelessness in a community means people who are homeless are moving to the area. The truth is conditions in our own communities create and sustain homelessness. Client records from All Home (which coordinates homeless services among King County cities, nonprofits and religious institutions) show that 85–90% of people accessing services in King County became homeless in King County. While some people experiencing homelessness move around to find jobs and housing, many are unable to move because of physical or behavioral health disabilities, because of financial hardships like foreclosure or job loss that may have led to homelessness, or because they simply do not want to leave a community where they have established meaningful roots. People experiencing homelessness who *do* move to new areas do so because they are searching for work, have family nearby or for other reasons not related to services—and are worthy of support regardless.

MYTH: There are plenty of shelters and housing. People become homeless and remain homeless because they refuse to work.

FACT: The National Law Center on Homelessness and Poverty's *No Safe Place* report states: "There are fewer available shelter beds than homeless people in major cities across the nation. In some places, the gap between available space and human need is significant, leaving hundreds or, in some cases, thousands of people with no choice but to struggle for survival in outdoor, public places." In addition, the wages of low-income households continue to decline as rents rise.

In Washington, a worker must now earn at least 2 times the minimum wage to afford a 2-bedroom apartment. Even when low-wage workers can afford to pay for rent, they often cannot save enough to pay move-in costs, which traps them in time-limited transitional housing, or in outright homelessness. Landlords often demand steep deposits and tenant screening reports, while negative credit histories and eviction records bar too many from renting at all. According to the Housing Development Consortium, 21% of Seattle renter households are severely cost-burdened (paying more than 50% of their income in housing costs), and are at significant risk of becoming homeless.

MYTH: It is a waste of public resources to provide homeless services to certain people who don't "deserve" them, such as addicts.

FACT: The construct of the deserving vs. undeserving poor is harmful, and often results in homelessness, drug use and addiction being seen as crimes rather than as conditions in need of treatment. People labeled "undeserving" are in fact usually the most vulnerable among those experiencing homelessness, and most in need of housing and services to escape chronic homelessness and recover. When people have access to housing, treatment services, healthcare, and other support services, they show fast progress establishing healthy, stable lives. It is also less expensive to house a person who is homeless than the taxpayer costs associated with criminalization and emergency service use while living on the street. A Seattle study published in the Journal of the American Medical Association found that the yearly cost to house 95 tenants in a local permanent supportive housing program was 53% less than the yearly cost of services when that same group was homeless. In addition, the group's emergency costs declined by 73% in the two years after the program's launch.

MYTH: Government policies to end homelessness are a waste of time.

FACT: Homelessness is a systemic failure. It is caused by economic and structural conditions like lack of affordable housing, high cost of living, low-wage jobs, lack of access to health care, and mental health treatment & chemical dependency treatment services. Public policy is the leading cause of homelessness. Building more affordable housing, raising the minimum wage, and providing access to health services are just a few of the remedies that require effective public policy and adequate funding.

MYTH: There will always be homelessness. The problem is too big and too complex to solve.

FACT: It is easy to become discouraged about solving homelessness when approaches like criminalization have failed again and again, but homelessness is solvable. We simply must invest fully and consistently in the right solutions. Housing-First is a proven approach to ending chronic homelessness. It prioritizes stable housing as a person's primary need, while also providing services to address behavioral health, addiction, or other issues people may be struggling with. In this model, housing is not a reward for good behavior, it is a necessity to accessing treatment and getting better. Permanent Supportive Housing was developed in Washington state by Downtown Emergency Service Center (DESC), and it's so successful that other states and countries have adopted it, including Utah where they have successfully decreased chronic homelessness by 91%. Advocates are currently working to do the same in Washington by establishing a federally-funded Permanent Supportive Housing Services Benefit through Medicaid to pay for the services delivered in this model of housing.

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ORIGINAL PAPER

Homelessness, Mental Illness, and Criminal Activity: Examining Patterns Over Time

Sean N. Fischer · Marybeth Shinn · Patrick Shrout · Sam Tsemberis

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Exam of Dr. Stephen Gaetz
Heegsma et al v City of Hamilton
Nimigan Mihailovich Reporting Inc.

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Abstract This study examined whether street homelessness, sheltered homelessness, and the severity of psychological symptoms predicted non-violent and violent crime among 207 mentally ill participants who were homeless at baseline. Participants were interviewed at 9 time points over 4 years. Hierarchical linear modeling (HLM) was used to examine whether changes in homelessness status and symptom severity predicted changes in criminal activity over time. Results indicated that homelessness both on the streets and in shelters and psychological symptom severity predicted increases in non-violent crime. Sheltered homelessness and symptom severity predicted increases in violent crime, although street homelessness did not. A separate mediational analysis with 181 participants showed that the relationship between diagnosis of a psychotic disorder and both non-violent and violent criminal activity was partially mediated through the severity of psychotic symptoms. Implications for research and intervention are discussed.

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Introduction

The current study examines the relationship between homelessness, mental illness, and two types of criminal offenses: non-violent and violent crimes. This study builds on the literature by examining how the likelihood of committing a crime changes as individuals cycle between episodes of homelessness and housing and as mental illness symptoms become more and less severe. By estimating effects of housing context and symptom severity on changes in criminal activity within persons across time, it holds constant other personal characteristics which may confound relationships between homelessness, mental illness, and crime in between-person studies.

Non-Violent Criminal Activity

Previous studies have found that homeless individuals are at risk for engaging in non-violent criminal activity (Martell et al. 1995); DeLisi (2000) found that homeless jail inmates were more likely to have been arrested for nuisance offenses (e.g., camping without a permit, indecent exposure) than domiciled inmates. Other researchers showed that homeless individuals are often arrested for crimes resulting from subsistence-related strategies, such as being charged with trespassing or sleeping on a park bench (Fischer 1988; Snow et al. 1989). Snow and Mulcahy (2001) showed that homeless individuals may adopt new subsistence strategies, including illegal strategies such as theft, when previous strategies are blocked (e.g., a new city ordinance restricting panhandling).

Interestingly, no research to the author's knowledge has focused on whether the association between homelessness and non-violent criminal activity is different when individuals are connected to institutional supports such as shelters and drop-in centers. The current study tests whether homeless individuals are less prone to non-violent criminal activity when spending their nights at these types of institutions (referred to as *sheltered homelessness*) than when they are spending their nights in public locations such as the streets or abandoned buildings (referred to as *street homelessness*). Homeless individuals may be less likely to engage in subsistence-driven, non-violent crime if their survival needs are fulfilled by institutional supports.

Surprisingly, little is known about the relationship between mental illness and non-violent crimes. Belcher has suggested that homeless individuals with chronic mental illnesses may be prone to criminal activity because they have difficulty functioning within "'normative' reality" (Belcher 1989, p. 181), or because they lack a structured environment that hinders their use of services or prescribed medication (Belcher 1988). The situation of homelessness, therefore, may aggravate non-violent criminal activity among mentally ill individuals in ways that are different than if they were housed. Specifically, non-violent criminal activity may be similar between domiciled individuals with low and high severity of mental illness symptoms (referred to in this paper as *psychological symptom severity*). However, homeless individuals with high psychological symptom severity may be more likely to engage in non-violent crime than homeless individuals with low symptom severity. The literature provides little evidence for or against this type of interaction.

Violent Criminal Activity

Homeless individuals who have serious mental illnesses may be at risk for arrest for violent crimes (e.g., Richman et al. 1992). In fact, research suggests that people with mental illnesses have a modestly higher rate of committing violent crimes than the general population (for a review, see Mulvey 1994). For example, using data from three large surveys of adult households, Swanson and colleagues found that, controlling for substance abuse, the prevalence of violence among individuals diagnosed with major mental disorders, including schizophrenia and affective disorders, was higher than among individuals without disorders (Swanson et al. 1990). Mulvey (1994) stated that mental illness symptoms may be a better predictor of violence than diagnosis, suggesting that the tendency toward violence may change within individuals as their symptoms become more or less severe. The current study builds on the literature by examining whether the likelihood of committing a violent crime among individuals with serious mental illnesses changes over time as psychological symptom severity changes.

Some researchers have found that the presence of psychotic symptoms in particular may predict violent behavior (for a review, see Bjorkly 2002a, b). For example, Link et al. (1992) found that mentally ill patients were more likely to engage in violent behavior than community controls and that psychotic symptoms accounted for nearly all differences in violent behavior between the two groups. Interestingly, no research to the authors' knowledge has examined the relative importance between the diagnosis of a psychotic disorder and active psychotic symptoms when predicting violent criminal activity. This study tests whether a relationship between diagnosis of a psychotic disorder and criminal activity exists, and if this relationship is fully mediated through the severity of psychotic symptoms. It seems likely that the propensity to commit a violent crime among individuals with a psychotic disorder will change over time as the severity of their symptoms also changes.

Previous research has not provided a clear understanding of the relationship between homelessness and violent criminal activity. Several studies using mentally ill samples suggest that homelessness is significantly associated with violent crime (Martell 1991; Martell et al. 1995). Richman et al. (1992) found that among mentally ill offenders, those individuals who had been homeless at the time of their arrest were more likely to have committed previous violent crimes. Swanson et al. (2002) found that after controlling for self-rated mental health status and history of psychiatric hospitalization, homelessness was independently associated with violent criminal activity. However, other researchers have not been able to replicate this relationship. Snow et al. (1989) found that homeless men were generally no different than the overall male population in committing violent crimes. Arrests were either not statistically different or lower for homeless participants for murder, rape, and aggravated assault, though homeless participants had slightly higher arrest rates for robbery. McNiel et al. (2005) found that homeless inmates were significantly less likely to have been arrested for a violent crime than housed individuals.

Research also has not examined whether interactions between homelessness and mental illness predict increases in violent crime. Belcher (1988) has suggested that some mentally ill individuals may be more prone to criminal behavior in unstructured environments such as homelessness. Although little research directly examines the consequences of an unstructured environment, Katz and Kirkland (1990) found that structure within psychiatric wards may help explain differences in patients' violent behavior. Specifically, patients in wards characterized by unpredictable events and staff–patient encounters exhibited more violent behavior than patients in wards characterized

by clear structure and predictable events. The current study tests whether violent criminal activity is higher among homeless adults than housed adults when symptom severity is high, but similar when symptom severity is low.

Between- Versus Within-Persons Research

Research that suggests positive relationships exist between homelessness, mental illness, and criminal activity has generally used cross-sectional, between-person methods that examine differences between homeless versus housed participants or individuals with static representations of mental illness. Such studies limit causal inference by leaving open the possibility that individuals who are prone to homelessness or severe mental illness symptoms are also prone to criminal activity, but that one does not necessarily encourage the other. Without a longitudinal, within-person design, it remains unclear if the propensity toward criminal activity changes when housing status changes (i.e., individuals move from homelessness into housing or vice versa) or the severity of mental illness symptoms changes.

One example of a study that examined within-person change in a sample of homeless adolescents used retrospective, self-reported criminal activity before and after participants became homeless (McCarthy and Hagan 1991). Findings indicated that participants who were homeless for a year or more were more likely to report engaging in all forms of criminal activity measured in the study than before they became homeless. Although not directly related to criminal activity, other researchers found that among HIV-positive adults, risky behaviors associated with HIV transmission (e.g., needle use, unprotected sex) increased among participants whose housing status worsened between observation periods (e.g., moving from housing to homelessness) and decreased among participants whose housing status improved (Aidala et al. 2005). Unfortunately, comparable research on criminal activity among homeless adults and studies that use prospective designs with multiple time points is scant. In addition, no known study has examined changes in criminal activity as psychological symptom severity fluctuates.

The current study addresses these gaps in the literature. First, its longitudinal design tracks changes within individuals across observation periods to examine how patterns of deviant behavior change as participants experience changes in housing status and severity of psychological symptoms. Second, it examines the relationship between psychiatric diagnosis, psychotic symptoms, and criminal activity. Specifically, this study tests the following within-person hypotheses: (1) Individuals will be more likely to commit a non-violent crime when they are homeless, particularly for offenses that may be related to subsistence strategies (e.g., strategies aimed at meeting basic needs). In addition, street homelessness will have a stronger association with this type of non-violent crime than sheltered homelessness; (2) Individuals will be more likely to commit violent offenses when they experience greater psychological symptom severity. In addition, this study will examine (3) the relationship between symptom severity and non-violent criminal activity, (4) the relationship between street and sheltered homelessness and violent criminal activity, and (5) interactions between symptom severity and both types of homelessness when predicting non-violent and violent criminal activity.

Cross-Level Hypotheses

Cross-level analysis tests relationships between variables at different levels of analysis (see Shinn and Rapkin 2000, for a review). The current study will test the cross-level hypothesis that (6) individuals with a diagnosis of a psychotic disorder will be more likely to commit violent offenses than those with other diagnoses, and this relationship will be mediated by psychotic symptom severity. Diagnosis of a psychotic disorder is represented as a stable, person-level characteristic, whereas psychotic symptom severity is represented as a characteristic that can change within individuals across observation periods. A similar relationship between diagnosis, psychotic symptoms, and non-violent crime (7) will be explored.

Method

Participants

A total of 225 adults participated in the study from which these data are drawn. However, seven participants were not included in any of the analyses in this paper due to incomplete data on the variables of interest. Of the remaining 218 participants, most of the sample ($n = 152$) was literally homeless at the time of recruitment. To be eligible, these participants were required to (1) have spent 15 of the 30 days prior to recruitment on the street or in other public places, (2) have shown a period of housing instability of at least 6 months, and (3) have an Axis I diagnosis of severe mental illness (American Psychiatric Association 2000), such as a psychotic disorder (e.g., schizophrenia) or mood disorder (e.g., major depressive disorder). Other Axis I disorders, such as substance-related disorders or sleep disorders, did not meet this criterion. These participants were recruited mostly through referrals from homeless outreach programs. The remaining participants ($n = 66$) were recruited from two state psychiatric hospitals and were required to meet the same three requirements immediately prior to hospitalization. Baseline

demographic information indicated that the participants were mostly male (78%), non-White (72%), unemployed (89%), and unmarried (88%). The age of participants ranged from 18 to 70 ($M = 41.5$, $SD = 11.9$). The average age for the first time homeless was 29.7 ($SD = 12.9$), the average lifetime homelessness was 6.5 years ($SD = 7.2$), and the average longest period homeless was 3.6 years ($SD = 5.0$), all of which highlight the chronic nature of the sample's homelessness.

Participants were recruited in New York City for a larger study comparing two models of housing services offered to homeless individuals. Specifically, participants were either assigned at the beginning of the study to an experimental "housing first" group in which they received immediate placement into permanent housing with a variety of mostly optional services, or a control group ("treatment as usual" housing) which included housing programs that required psychiatric and substance abuse treatment and sobriety before offering permanent housing (for more information, see: Gulcur et al. 2003; Padgett et al. 2006; Tsemberis et al. 2003, 2004). Group assignment is not relevant to the current study's goals, but it is included in the analyses to control for possible effects.

Procedure

Trained research assistants interviewed participants at the time of recruitment and every 6 months thereafter for 48 months. At each assessment period, data were collected on homelessness, mental illness symptoms, and criminal activity. In addition, because the psychiatric diagnoses required for study entry were assigned by a variety of health care professionals and not with a structured diagnostic instrument, participants were given the Structured Clinical Interview for DSM-IV Axis I Disorders (described later) after the 36-month interview to obtain diagnoses. Interviews generally lasted between 1 and 2 hours and were usually conducted at the research site, although some participants were interviewed at other locations that were more convenient for them. Interviewers read the informed consent statement aloud to participants before asking whether they would like to participate. Participants were paid between $25 and $40 per interview.

Materials

Demographics

Participants' demographic information assessed at baseline included gender, age, marital status, employment status, education, and lifetime history of homelessness. Information on race was also collected during baseline, but missing and unclear responses were replaced with data gathered during the 30-month assessment.

Residential Follow-Back Calendar

This measure assessed the residential history of participants between time points (New Hampshire Dartmouth Psychiatric Research Center 1995). Interviewers began by asking participants where they stayed the night before, how long they had stayed there, where and how long they stayed immediately before that, and so on until they reached the point of the previous interview. Places named by the participants were classified into 34 categories (e.g., street, drop-in center, hospital, own apartment). Of these categories, seven were considered to be literally homeless. These locations were further divided into street homelessness or sheltered homelessness. Locations that were considered street homelessness were: (1) All night theater, subway station, or other indoor public place; (2) subway or bus; (3) abandoned building; (4) car or other private vehicle; (5) on the street or in another outdoor place. Locations that were considered sheltered homelessness were: (1) emergency shelter; (2) drop-in center. Figure 1 shows the sample's mean proportions of time spent homeless at each interview.[1] The residential follow-back calendar has been shown to be a reliable and valid instrument (Tsemberis et al. 2007). Other studies document the method's reliability and validity in other research areas, particularly with substance use (Brown et al. 1998; Ehrman and Robbins 1994; Sobell and Sobell 1992).

Colorado Symptom Index

A modified version of the Colorado Symptom Index (CSI; Ciarolo et al. 1981; Conrad et al. 2001) was used to assess psychological symptom severity at each assessment. The purpose of the CSI is to provide researchers with a short self-report measure of psychological symptoms appropriate for a mentally ill sample, and it includes 15 items that range in severity and type of symptom (e.g., "In the past month, how often have you felt depressed?", "In the past month, how often did you hear voices, or hear or see things that other people didn't think were there?"). Responses range on a five-point scale ranging from zero ("Not at all") to four ("At least every day"). Missing data were replaced with individual participants' average item score within a given observation period. Scores across the 15 items were summed to create a total score. Mean scores ranged from

[1] Certain variables only appear in analyses where a subset of participants was included. For these variables, we report figures and descriptive statistics that include only the relevant subset of participants.

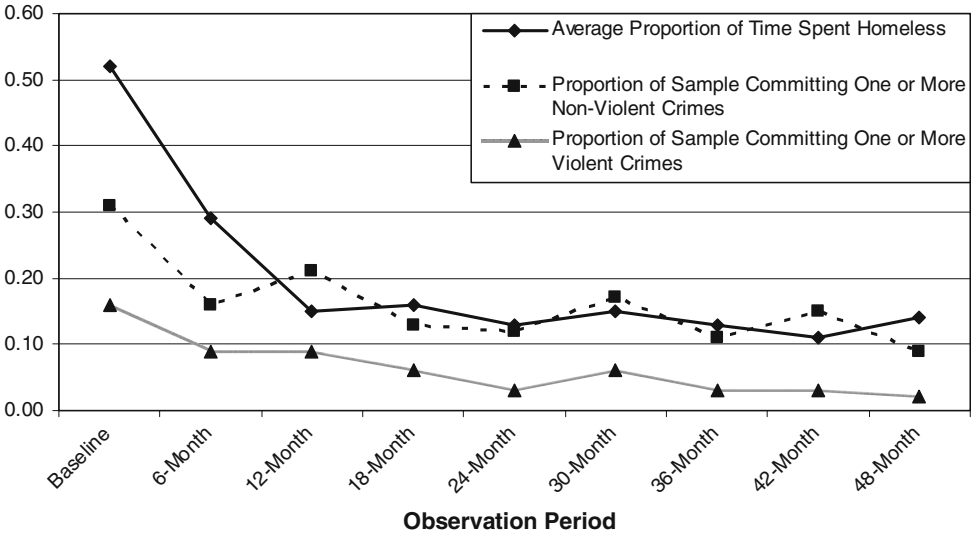


Fig. 1 Average proportion of time spent homeless and the proportions of the sample committing at least one non-violent crime and one violent crime at each time point

14.8 ($SD = 11.2$) to 21.1 ($SD = 14.8$) across the observation periods. Internal consistency reliability was strong, with alphas ranging between .81 and .92. The CSI has also demonstrated acceptable validity in a national sample of homeless individuals of which the current sample is a subset (Conrad et al. 2001). Conrad and colleagues also found strong test-retest reliability within a short 15-day interval, although long-term stability was not tested and may not be as strong. The current study took this possibility into account and modeled the variability across observations.

Structured Clinical Interview for DSM-IV Axis I Disorders, Research Version, Non-Patient Edition (SCID-I/NP)

This instrument assessed the presence of Axis I disorders using the criteria outlined in the American Psychiatric Association's (1994) Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (First et al. 1998). The SCID-I/NP is divided into diagnostic modules that allow the researcher to stop inquiring about a disorder that is clearly not present. The measure consists mostly of closed-ended questions, although open-ended follow-up questions are provided, and interviewers are encouraged to insert their own questions to help make more accurate diagnoses. In addition to assessing all Axis I disorders, the SCID-I/NP also allows the interviewer to assign a principle diagnosis. The instrument has demonstrated good psychometric properties for assessing severe mental illness (Basco et al. 2000; Fennig et al. 1994; Williams et al. 1992).

Criminal Activity Questionnaire

The dependent variables for the analyses were constructed from this measure. Participants were asked 15 questions about their criminal activity in the previous 6 months. The items inquired about a variety of illegal activities (e.g., "During the last six months, have you robbed someone?", "During the last six months, have you hit someone so hard you hurt them?"). After each item, participants were asked to respond, in a yes/no format, whether they had committed the crime(s) mentioned, and then asked whether they were charged for the crime(s). This study focuses only on crimes committed, regardless of whether an arrest was made.

We created two categories of items. The first category consisted of non-violent offenses that we believed could be related to subsistence strategies (i.e., strategies employed by a person to meet basic needs). As noted earlier, homeless individuals employ a variety of subsistence strategies to meet their basic needs, and some of these strategies may be illegal. Non-violent offenses which we did not expect to be related to subsistence strategies, regardless of housing status (e.g., driving a car recklessly or without a license) or which were difficult to classify because of the wording of a particular item ("have you bought, sold, or used illegal drugs?") were excluded from this category. The criminal activities that composed this category included the following, with percentages reflecting the proportion of instances reported for a specific activity out of all criminal instances analyzed in this paper: public disturbances (29.7%; e.g., urinating in a public place, public intoxication), trading sex for money, drugs, goods, or services (12.1%), shoplifting/vandalism (8.6%), burglary/breaking and entering a home or store (5.1%), and writing someone else's name on a check to buy something (1.8%). Various other offenses (15.6%) included in this category were offered by participants in response to the last question, which inquired whether participants committed additional offenses not listed in the previous items. For this question, participants listed offenses such as trespassing, aggressive

panhandling, and turnstile jumping to access the city subway system (the subway system is sometimes used as an alternative form of shelter by homeless individuals in addition to typical transportation needs). Readers should note that shoplifting and vandalism were included in the same item, such that a "Yes" on this particular item could refer to either type of crime. Vandalism would most likely not be related to subsistence strategies, but the item's wording did not allow us to separate participants' responses between these two types of crime. We decided to include this item despite its limitations because we believe that shoplifting could potentially be an important subsistence strategy, as suggested by prior research (e.g., Snow et al. 1989).

The second category consisted of violent crimes and included the following actions: hitting someone so hard that it hurt them (18.3%), robbery (4.6%), rape (0.4%, two instances), and murder, on purpose or accidental (0.4%; two instances). Additional offenses (3.3%) named in the last question included other forms of assault.

For each category, we created a binary variable (non-violent and violent crime, respectively) such that participants received a score of zero if they did not commit a non-violent/violent crime and a score of one if they committed at least one non-violent/violent crime in the previous 6 months. Figure 1 shows the proportions of the sample that committed at least one crime in each category at each time point.

Data Analytic Strategy

Between-person approaches can provide evidence of a relationship between time spent homeless and the probability of committing a crime, but they cannot distinguish the variance that is present between individuals (variance that is accounted for by stable characteristics such as gender) and the variance that is present within individuals (accounted for by time-varying phenomena such as time spent homeless within each observation period). In other words, the relationship between homelessness and criminal activity could be primarily due to a type of person who is simply prone to both (a between-person phenomenon), though the two variables could be causally independent of one another. In this case, the probability of committing a crime would remain unchanged if a particular person moved from homelessness to housing. However, homelessness and criminal activity may share a causal link, such that the probability of committing a crime would change if a particular person moved from homelessness to housing (a within-person phenomenon). Between-persons studies are unable to distinguish between these possibilities. Similar limitations exist when trying to understand the relationship between criminal activity and the severity of psychological symptoms.

To overcome the limitations of a traditional between-person approach, this study employs hierarchical linear modeling (HLM), also known as multilevel modeling (see Raudenbush and Bryk 2002). HLM is specifically geared toward handling nested data and can partition the variance between and within individual participants. We used HLM software, version 6.03 (Raudenbush et al. 2004) for our analyses.

In HLM, a regression equation (known as the level-1 equation) is generated for each participant. For the current study, the level-1 equation estimates the probability that a particular individual committed a crime during a particular 6-month observation period from street homelessness, sheltered homelessness, and CSI score specific to both the person and the observation period. These predictors, which vary from one observation period to the next, are called *time-varying*. The coefficients of the level-1 model (an intercept and slope associated with each level-1 predictor) are in turn predicted in respective level-2 (between-persons) equations using personal characteristics such as gender and age at baseline that are *time-invariant* (i.e., constant across time). In addition to these time-invariant predictors, the level-2 equations also include a person-level random effect component. When the random effect is significantly different across participants, there is strong variation between participants' uniquely generated level-1 intercept or slope coefficients. A nonsignificant result would indicate that the level-1 coefficients are not strongly varying, but there may be subtle variation that could still be explained by including level-2 predictors.

Results

This section examines the extent to which street and sheltered homelessness, psychological symptom severity, and relevant controls predict criminal activity, first for non-violent and then for violent crime. We then test whether psychotic symptoms mediate the relationship between the diagnosis of a psychotic disorder and non-violent and violent criminal activity.

Homelessness, Mental Illness, and Non-Violent Crime

Preliminary Analyses

Due to inadequate data for some participants, 207 participants were included in these analyses. We controlled for several level-2 (person-level) variables. In addition to gender and baseline age, we included lifetime homelessness (defined as years homeless prior to baseline) to account for the possibility that chronically homeless participants may have developed more illegal subsistence-

oriented strategies. We also controlled for recruitment site (psychiatric hospital versus agencies that referred currently homeless individuals) and experimental group assignment.

Due to high positive skew and nonlinear associations with the outcome variables, we dichotomized *street homelessness* and *sheltered homelessness* (1 = street homeless/in shelters at least once during the observation period, 0 = no time street homeless/in shelters). Other dummy coded control variables were *female* (1 = female, 0 = male), *psychiatric hospital* (1 = recruited from a psychiatric hospital upon discharge, 0 = literally homeless at recruitment), and *experimental group* (1 = housing first intervention, 0 = treatment as usual housing). We centered CSI scores, lifetime homelessness, and baseline age at their grand means so that the intercepts represent a person with the average level on these variables. All continuous variables remained unstandardized and retained their original units of variance.

Primary Analyses

To examine the relationship of non-violent crime to homelessness and symptom severity, we began by specifying a within-person (level-1) model without level-2 covariates in which non-violent crime at each time point was predicted from time-varying levels of homelessness and symptom severity (Eq. 1a).

$$\begin{aligned}\text{Non-violent crime} = {} & B_0 + B_1\,(\text{Street homelessness}) \\ & + B_2\,(\text{Sheltered homelessness}) \\ & + B_3\,(\text{CSI}) + r\end{aligned} \tag{1a}$$

To determine whether there was significant variation in the coefficients for the intercept, we added a random effect term (U_0) in the level-2 equation for the intercept (Eq. 1b), but did not add random effects at this step to the equations for the slopes.

$$B_0 = G_{00} + U_0 \tag{1b}$$

$$B_1 = G_{10} \tag{1c}$$

$$B_2 = G_{20} \tag{1d}$$

$$B_3 = G_{30} \tag{1e}$$

Results summarized in Table 1 showed significant positive associations between non-violent crime and street homelessness, sheltered homelessness, and CSI scores. In addition, we tested U_0 and found significant variation in the level-1 intercepts ($\chi^2(206, n = 207) = 396.66$, $p < .001$), indicating that participants' intercept coefficients differed significantly from one another.

Next, we added random effect terms to the original level-2 equations for the slope coefficients (Eqs. 1c, 1d, and 1e). None of the slopes were found to be significantly varying, so these terms were not included in subsequent analyses, leaving only the random effect term predicting the intercept coefficient. Next, we tested level-1 multiplicative interactions between CSI score and street homelessness and sheltered homelessness. Neither the CSI by street homelessness interaction ($B_4 = -0.01$, $OR = 0.99$, SE = 0.01, $p = .47$) nor the CSI by sheltered homelessness interaction ($B_5 = -0.01$, $OR = 0.99$, SE = 0.01, $p = .49$) were significant, so we excluded both from subsequent analyses.

Although these findings indicate main effect relationships for street and sheltered homelessness and symptom severity, subsequent analyses tested whether these relationships held after including relevant controls. We entered between-person control variables into the level-2 equations predicting the level-1 intercept (Eq. 2, building on Eq. 1b) and slopes (not shown, but building on Eqs. 1c, 1d, and 1e in a similar manner).

$$\begin{aligned}B_0 = {} & G_{00} + G_{01}\,(\text{Age}) + G_{02}\,(\text{Female}) \\ & + G_{03}\,(\text{Psychiatric hospital}) \\ & + G_{04}\,(\text{Lifetime homelessness}) \\ & + G_{05}\,(\text{Experimental group}) + U_0\end{aligned} \tag{2}$$

Note that level-2 predictors of the level-1 intercepts act as main effects, and level-2 predictors of the level-1 slopes are essentially level-1 by level-2 interaction terms. These interaction terms test whether the relationship between level-1 variables and non-violent crime depends on personal characteristics such as gender or lifetime homelessness.

We removed predictors of the level-1 slopes (e.g., interaction terms) with significance values above .10 to obtain a final model predicting non-violent crime. After accounting for relevant level-2 variables, the positive main effects for street homelessness, sheltered homelessness, and CSI score were still significant (Table 2). However, the full model differed from the previous one in that the relationship between sheltered homelessness and non-violent crime was stronger for individuals with higher levels of lifetime homelessness. In addition, we found a significant level-2 negative effect for baseline age and a significant level-2 positive effect for psychiatric hospitalization. This model had significant variation in the level-1 intercept ($\chi^2(201, n = 207) = 372.56$, $p < .001$), suggesting that a substantial amount of person-level variance for non-violent criminal activity remained unexplained. Figure 2 depicts the probabilities of committing a non-violent crime within a 6-month period by different levels of symptom severity and whether participants experienced only street homelessness, only sheltered homelessness, both types of homelessness, or no homelessness.

Table 1 Hierarchical linear model with level-1 variables predicting non-violent crime ($n = 207$ participants assessed across nine observations periods)

Level-1 main effects (time-varying level)	*b* (SE)	Odds Ratio (95% CI)
Intercept (average log odds; B_0)	−2.39 (0.13)****	0.09 (0.07–0.12)
Street homelessness (B_1)	1.38 (0.19)****	3.96 (2.73–5.73)
Sheltered homelessness (B_2)	0.53 (0.19)**	1.71 (1.18–2.47)
CSI (B_3)	0.02 (0.01)***	1.02 (1.01–1.04)

** $p < .01$, *** $p < .005$, **** $p < .001$

Colorado Symptom Index (CSI) score is grand-mean centered. Street and sheltered homelessness are binary (1 = at least one night spent in street/sheltered homelessness in a 6-month observation period, 0 = No days spent street/sheltered homeless). All coefficients are unstandardized

Table 2 Hierarchical linear model predicting non-violent crime with level-2 by level-1 interactions ($n = 207$ participants assessed across nine observations periods)

	b (SE)	Odds Ratio (95% CI)
Level-1 main effects (time-varying level)		
Intercept (average log odds; B_0)	−2.69 (0.19)****	0.07 (0.05–0.10)
Street homelessness (B_1)	1.46 (0.20)****	4.30 (2.92–6.33)
Sheltered homelessness (B_2)	0.54 (0.19)**	1.72 (1.19–2.50)
CSI (B_3)	0.02 (0.01)***	1.02 (1.01–1.04)
Level-2 main effects (person level)		
Baseline age (G_{01})	−0.02 (0.01)*	0.98 (0.96–1.00)
Female (G_{02})	0.30 (0.29)	1.34 (0.76–2.39)
Psychiatric hospitalization (G_{03})	0.54 (0.25)*	1.71 (1.05–2.78)
Lifetime homelessness (G_{04})	−0.03 (0.02)	0.97 (0.94–1.01)
Experimental group assignment (G_{05})	0.06 (0.22)	1.06 (0.69–1.65)
Level-2 × Level-1 interaction		
Sheltered homelessness × Lifetime homelessness (G_{21})	0.07 (0.03)**	1.07 (1.02–1.13)

* $p < .05$, ** $p < .01$, *** $p < .005$, **** $p < .001$

Baseline age, lifetime homelessness, and Colorado Symptom Index (CSI) score are grand-mean centered. Binary variables include street and sheltered homelessness (1 = at least one night spent in street/sheltered homelessness in a 6-month observation period, 0 = No days spent street/sheltered homeless), female (1 = female, 0 = male) psychiatric hospitalization (1 = recruited from psychiatric hospital, 0 = recruited from street), experimental group assignment (1 = housing first group, 0 = treatment as usual group). All coefficients are unstandardized

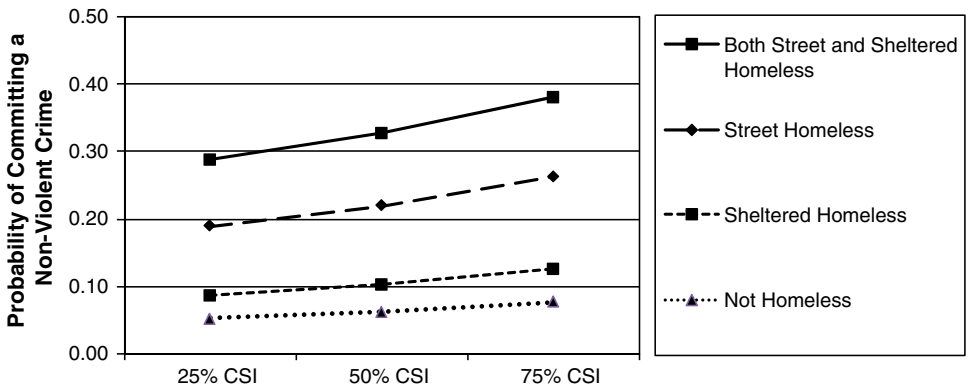


Fig. 2 Probability of committing a non-violent crime within a 6-month period by participants' CSI percentile scores and whether they experienced street homelessness, sheltered homelessness, both types of homelessness, or no homelessness. Corresponding CSI scores are 7.0 (25%), 15.0 (50%), and 25.0 (75%). Values of other variables represent the average participant in the analyses

Violent Crime

Preliminary Analyses

The same participants who were included in the non-violent crime analyses were also present in the violent crime analyses ($n = 207$). These analyses closely parallel the non-violent crime analyses already described. However, because of a nonlinear relationship between CSI scores and violent crime, we divided CSI scores into three distinct categories: "low symptom severity" (CSI scores 0–10), "moderate symptom severity" (over 10–40), and "high symptom severity" (over 40–60). Of all the individual observations, 36.3% were low severity, 58.6% were moderate severity, and 5.1% were high severity. However, of all participants, 69.6% reported low symptom severity, 90.8% reported moderate symptom severity, and 23.2% reported high symptom severity during at least one observation period. Thus, we represented psychological symptom severity in subsequent analyses predicting violent crime as "moderate symptom severity" and "high symptom severity" dummy codes, with "low symptom severity" serving as the reference variable.

Primary Analyses

The initial level-1 model predicting violent crime without level-2 covariates can be seen in Eq. 3.

$$\begin{aligned}\text{Violent crime} = {} & B_0 + B_1\,(\text{Street homelessness}) \\ & + B_2\,(\text{Sheltered homelessness}) \\ & + B_3\,(\text{Moderate symptom severity}) \\ & + B_4\,(\text{High symptom severity}) + r \end{aligned} \quad (3)$$

We added a random effect to test for variation in the intercept coefficients, making the level-2 equations identical to Eqs. 1b–1d, plus two additional equations for moderate symptom severity (B_3) and high symptom severity (B_4) that replaced Eq. 1e. As shown in Table 3, we found a significant, positive effect for high symptom severity and a marginally significant, positive effect for moderate symptom severity on violent crime when compared to low symptom severity. For homelessness, we found significant, positive effects for both street and sheltered homelessness. We also found significant variation in the level-1 intercepts ($\chi^2(206,\ n = 207) = 280.60,\ p < .005$).

Next, random effects were added for the slope coefficients. We did not find significant variation in the slopes, so the effects were removed leaving only the random effect for the intercept coefficient. Next, we tested multiplicative interactions between moderate and high CSI scores and street and sheltered homelessness, creating four interaction terms: moderate symptom severity by street homelessness ($B_5 = -0.11$, $OR = 0.90$, SE $= 0.53$, $p = .84$), high symptom severity by street homelessness ($B_6 = 0.30$, $OR = 1.35$, SE $= 0.70$, $p = .67$), moderate symptom severity by sheltered homelessness ($B_7 = 0.21$, $OR = 1.24$, SE $= 0.61$, $p = .73$), and high symptom severity by sheltered homelessness ($B_8 = -0.26$, $OR = 0.77$, SE $= 0.82$, $p = .75$). As the findings indicate, all four interaction terms were nonsignificant and were removed from the equation prior to subsequent analyses.

Next, we tested whether the positive relationships between violent crime and street homelessness, sheltered homelessness, and symptom severity held after including relevant controls. Predictors were entered into equations predicting the level-2 intercept and slopes. Predictors of the slopes with significance values above .10 were then removed from the analyses to create a final model predicting violent crime (see Table 4). After accounting for relevant level-2 variables, the full model had positive, significant effects for both sheltered homelessness and high symptom severity. However, this model differed from the previous one in that street homelessness no longer significantly predicted violent crime after accounting for the marginally significant moderation of experimental group assignment, such that participants in the experimental group who nonetheless experienced street homelessness

Table 3 Hierarchical linear model with level-1 variables predicting violent crime ($n = 207$ participants assessed across nine observations periods)

Level-1 main effects (time-varying level)	*b* (SE)	Odds Ratio (95% CI)
Intercept (average log odds; B_0)	−3.65 (0.26)****	0.03 (0.02–0.04)
Street homelessness (B_1)	0.48 (0.25)*	1.62 (1.00–2.62)
Sheltered homelessness (B_2)	0.66 (0.25)**	1.93 (1.19–3.12)
Moderate CSI (B_3)	0.52 (0.27)$^+$	1.68 (0.99–2.84)
High CSI (B_4)	2.06 (0.40)****	7.84 (3.57–17.24)

$^+$ $p < .10$, * $p < .05$, ** $p < .01$, **** $p < .001$

All variables are binary: Street and sheltered homelessness (1 = at least one night spent in street/sheltered homelessness in a 6-month observation period, 0 = No days spent street/sheltered homeless); dummy-coded Colorado Symptom Index (CSI) categories: Moderate (score = 10+ to 40) and High (score = 40+ to 60), reference variable is Low CSI (score = 0–10)

Table 4 Hierarchical linear model predicting violent crime with level-2 by level-1 interactions ($n = 207$ participants assessed across nine observations periods)

	b (SE)	Odds Ratio (95% CI)
Level-1 main effects (time-varying level)		
Intercept (average log odds; B_0)	−3.90 (0.31)****	0.02 (0.01–0.04)
Street homelessness (B_1)	0.23 (0.34)	1.27 (0.67–2.40)
Sheltered homelessness (B_2)	0.73 (0.27)**	2.09 (1.23–3.55)
Moderate CSI (B_3)	0.55 (0.25)*	1.74 (1.06–2.85)
High CSI (B_4)	1.68 (0.55)***	4.92 (1.66–14.58)
Level-2 main effects (person level)		
Baseline age (G_{01})	−0.04 (0.01)*	0.97 (0.94–0.99)
Female (G_{02})	−0.48 (0.36)	0.62 (0.31–1.25)
Psychiatric hospitalization (G_{03})	0.79 (0.28)**	2.19 (1.28–3.78)
Lifetime homelessness (G_{04})	−0.03 (0.03)	0.97 (0.92–1.02)
Experimental group assignment (G_{05})	−0.06 (0.30)	0.95 (0.53–1.69)
Level-2 × Level-1 interactions		
Street homelessness × Experimental group assignment (G_{11})	0.82 (0.50)$^+$	2.28 (0.86–6.06)
High CSI × Baseline age (G_{41})	−0.11 (0.04)***	0.90 (0.83–0.97)
High CSI × Psychiatric hospitalization (G_{42})	−1.51 (0.71)*	0.22 (0.06–0.88)

$^+$ $p < .10$, * $p < .05$, ** $p < .01$, *** $p < .005$, **** $p < .001$

Baseline age and lifetime homelessness are grand-mean centered. Binary variables include street and sheltered homelessness (1 = at least one night spent in street/sheltered homelessness in a 6-month observation period, 0 = No days spent street/sheltered homeless), female (1 = female, 0 = male), psychiatric hospitalization (1 = recruited from psychiatric hospital, 0 = recruited from street), experimental group assignment (1 = housing first group, 0 = treatment as usual group), and dummy-coded Colorado Symptom Index (CSI) categories: Moderate (score = 10+ to 40) and High (score = 40+ to 60), reference variable is Low CSI (score = 0–10). All coefficients are unstandardized

were more likely to commit a violent crime. In addition, the effect for moderate symptom severity increased slightly and reached significance. Baseline age and psychiatric hospitalization moderated the relationship between high symptom severity and violent crime. Specifically, participants with high symptom severity were more likely to commit a violent crime if they were younger or were literally homeless at the time of recruitment. We also found a significant level-2 negative main effect for baseline age and a significant level-2 positive main effect for psychiatric hospitalization. The intercepts no longer showed significant variation in this model ($\chi^2(201, n = 207) = 224.58$, $p = .12$). Figure 3 depicts the probabilities of committing a violent crime within a 6-month period by the three levels of symptom severity and whether or not participants experienced sheltered homelessness.

Mediational Analysis: Psychiatric Diagnosis, Psychotic Symptoms, and Criminal Activity

Preliminary Analyses

We wanted to determine whether a diagnosis of a psychotic disorder predicted violent crime, and if so, whether psychotic symptoms mediated this relationship. To obtain an index of psychotic symptoms, we created a variable ranging from 0 (no psychotic symptoms) to 16 (severe psychotic symptoms) by summing four items from the CSI that explicitly measured psychotic symptoms. These items were: "In the past month, how often: (1) have others told you that you acted 'paranoid' or 'suspicious'?" (2) did you hear voices, or hear or see things that other people didn't think were there?" (3) did your [voices]/[things you see/hear] interfere with your doing things?" (4) did you feel suspicious or paranoid?" Although the CSI is generally not treated as multidimensional, Conrad et al. (2001) conducted a psychometric analysis of the instrument using data from a large sample (of which the participants in this study comprised a subset) and found evidence for a secondary factor in addition to a central factor. Our index of psychotic symptoms included the three highest item loadings on this factor and an additional item (#3 above) that was not examined by Conrad et al. because of inconsistent use across sites, but which loaded similarly on the secondary factor in our data.

Except for the 30-month assessment, the index measuring psychotic symptoms had adequate internal consistency, with alphas ranging from .69 to .82. The 30-month assessment was lower, with an alpha of .55. One possible reason for this score was that a significant portion of the sample (38%) completed their 30-month assessment shortly after September 11, 2001 (as noted in Greenwood

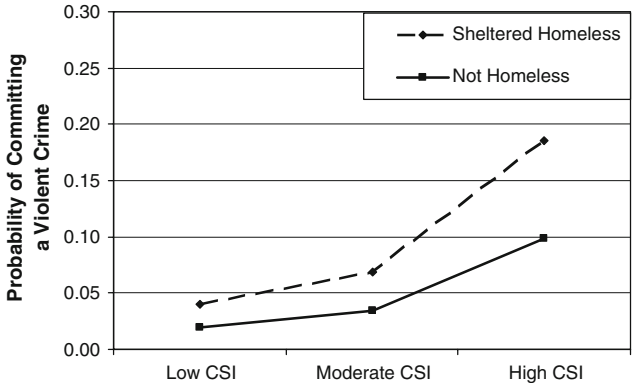


Fig. 3 Probability of committing a violent crime within a 6-month period by participants' CSI score categories and whether they experienced sheltered homelessness or no homelessness. Corresponding scores are 0–10 (Low CSI), above 10–40 (Moderate CSI), and above 40–60 (High CSI). Values of other variables represent the average participant in the analyses except for street homelessness, which is assumed to be zero

et al. 2005). Participants may have had feelings of paranoia or suspiciousness that were not necessarily linked with psychotic symptoms.

Because the SCID was not administered to all participants, 181 participants were included in this analysis. Analyses comparing excluded and non-excluded participants on the level-2 variables indicated the excluded participants were significantly older ($M = 46.2$) than non-excluded participants ($M = 40.5$), $t(216) = 2.66$, $p < .01$. Using HLM to test differences among the level-1 variables, findings indicated that excluded participants were less likely to report non-violent criminal activity (7% vs. 18%; $G_{01} = 1.10$, $t = 2.70$, SE $= 0.41$, $p < .01$).

Primary Analyses

To conduct a mediational analysis within an HLM framework, researchers can follow, with slight adjustment, the three-step plan Baron and Kenny (1986) describe for use with multiple regression. We allowed intercepts to randomly vary in all three steps. In the first step, diagnosis of a psychotic disorder, a level-2, time-invariant variable, marginally predicted violent crime ($G_{01} = 0.63$, $t = 1.77$, SE $= 0.36$, $p < .10$). In the second step, diagnosis significantly predicted psychotic symptoms, a time-varying variable ($G_{01} = 0.77$, $t = 2.14$, SE $= 0.36$, $p < .05$). For the third step, as shown in level-1 equation 4a and level-2 equations 4b and 4c,

$$\text{Violent crime} = B_0 + B_1\,(\text{Psychotic symptoms}) + r \quad (4a)$$

$$B_0 = G_{00} + G_{01}\,(\text{Diagnosis of a psychotic disorder}) + U_0 \quad (4b)$$

$$B_1 = G_{10} \quad (4c)$$

psychotic symptoms significantly predicted violent crime ($B_1 = 0.12$, $t = 3.98$, SE $= 0.03$, $p < .001$), but diagnosis was no longer related to the outcome ($G_{01} = 0.57$, $t = 1.61$, SE $= 0.35$, $p = .11$). We estimated the indirect effect by multiplying the coefficient for diagnosis in the second step by the coefficient for psychotic symptoms in the third step. We estimated the standard error for the indirect effect using the formula from Goodman (1960) as recommended by Krull and Mackinnon (1999) for multilevel mediation with at least 100 level-2 groups. The indirect effect was marginally significant ($B = 0.09$, $z = 1.93$, SE $= 0.05$, $p < .10$). The results suggest that psychotic symptoms partially mediated the relationship between the diagnosis of a psychotic disorder and violent crime.

We conducted a similar analysis to see whether the diagnosis of a psychotic disorder predicted non-violent crime, and if psychotic symptoms mediated this relationship. In the first step, diagnosis of a psychotic disorder significantly predicted non-violent crime ($G_{01} = 0.48$, $t = 1.99$, SE $= 0.24$, $p < .05$). For the second step, diagnosis significantly predicted psychotic symptoms ($G_{01} = 0.75$, $t = 2.08$, SE $= 0.36$, $p < .05$).[2] For the third step, psychotic symptoms significantly predicted non-violent crime ($B_1 = 0.12$, $t = 5.16$, SE $= 0.02$, $p < .001$), but diagnosis no longer significantly predicted non-violent crime ($G_{01} = 0.40$, $t = 1.62$, SE $= 0.25$, $p = .11$). The indirect effect was significant ($B = 0.09$, $z = 1.96$, SE $= 0.04$, $p < .05$). The results suggest that psychotic symptoms partially mediated the relationship between the diagnosis of a psychotic disorder and non-violent crime.

Discussion

The current study examined the relationships between homelessness, psychological symptoms, and criminal activity in a sample of homeless individuals with severe mental illnesses using a within-person design. Findings suggest that the likelihood of an individual committing a crime increased as homelessness and severity of mental illness symptoms increased across observation periods. Certain stable factors such as baseline age and recruitment site also mattered. Separate analyses indicated that psychotic symptoms partially mediated a positive relationship between the diagnosis of a psychotic disorder and non-violent and violent criminal activity.

[2] Although the same participants were included in the meditational analyses for both non-violent and violent crime, the analyses for non-violent crime included slightly fewer observation points (i.e., data specific to a particular person and time point) due to missing data. Therefore, we conducted the second step separately for both outcomes.

Findings supported our hypothesis that both street homelessness and sheltered homelessness would be associated with higher likelihoods of committing non-violent crimes that may be related to subsistence strategies, but that this relationship would be weaker for sheltered homelessness since institutional supports may lower the need for subsistence-driven crimes (e.g., breaking into buildings to find shelter). Since results indicated that the likelihood of committing a non-violent crime increases as homelessness increases, a strong argument can be made that homelessness encourages non-violent crime. Rather than thinking of homeless individuals as criminals, it may be more accurate to think of them as people struggling to get by whose engagement in non-violent illegal activities is driven by survival needs. In addition, we found an interaction between sheltered homelessness and lifetime homelessness such that during periods when participants experienced sheltered homelessness, their likelihood of committing a non-violent crime increased with each year of cumulative lifetime homelessness. A possible explanation for this finding is that individuals with little experience of homelessness use shelters in lieu of illegal subsistence strategies, whereas individuals with longer lifetime experiences of homelessness employ a much broader range of survival strategies that are both legal, such as shelter use, as well as illegal.

We found a different relationship between homelessness and violent crime. There was no main effect of street homelessness, although there was a marginally significant moderation by experimental group assignment. Specifically, the low number of participants who continued to experience homelessness despite being assigned to the housing first program were more likely to commit a violent crime than homeless participants assigned to the treatment as usual group. To understand this finding, it is important to note that the housing first participants were far less likely than the treatment as usual participants to experience homelessness since the former group received immediate access to housing whereas participants in the latter group were required to demonstrate that they were "housing ready" first (Gulcur et al. 2003; Tsemberis et al. 2003, 2004). Those few individuals in the experimental group who nevertheless experienced homelessness may have been characterized by higher levels of social and behavioral instability, which may have been accompanied by a greater propensity toward violent behavior. The most important point, though, is that after taking group assignment into account, street homelessness was not independently related to violent criminal activity.

In contrast, however, we found that sheltered homelessness significantly predicted increases in violent crime. One explanation for this finding could be that temporary shelters increase contact among individuals who already experience high levels of stress and increased violent tendencies from being homeless. Another possibility is that the atmospheres of these settings may unintentionally create stressful and confrontational living conditions that lead to violence, independent of the stress that accompanies homelessness. Again, it is worth noting that the likelihood of committing a violent crime increased within participants as they intermittently experienced sheltered homelessness. In other words, these findings suggest that homeless individuals are not inherently violent, but that some may become violent when exposed to temporary living situations such as shelters. Given these findings, perhaps the best way to prevent violence among homeless individuals is to move them quickly into housing rather than rely on temporary shelters.

We found that psychological symptom severity predicted increases in non-violent and violent criminal activity. For non-violent crime, one explanation is that the most frequently cited type of non-violent criminal offense was public disturbances. Although individuals who admitted to this type of offense could have engaged in a variety of public disturbances (e.g., drinking or urinating in public), participants who experienced higher levels of psychological symptom severity may have reported committing a public disturbance if they expressed these symptoms in a very noticeable way (e.g., talking loudly or experiencing a hallucination in public).

Consistent with prior research, findings suggest that greater symptom severity was associated with an increased likelihood of committing a violent crime. However, the strength of the relationship between high symptom severity and violent crime depended on the participants' age and recruitment location. Specifically, findings suggest that age becomes an even stronger predictor of violent crime among participants with severe psychological symptoms. In addition, participants recruited from the streets were more likely to report violent crime when they experienced high symptom severity. One possible explanation for this finding is the fact that participants recruited from psychiatric hospitals were more likely to stay in psychiatric hospitals during the study, possibly limiting their ability to commit violent crimes.

Interestingly, gender did not significantly predict the likelihood of violent criminal activity. Some researchers who have examined violent behavior between men and women with psychiatric problems have also found non-significant differences or smaller differences than in the general population (e.g., Stueve and Link 1998; Swanson et al. 1999, 2002), whereas other researchers have found that males are more likely to engage in violent behavior or commit a violent crime (Swanson et al. 1990). Hiday and colleagues found no differences between mentally ill men and women in person-directed violence after controlling

for substance abuse (Hiday et al. 1998). In contrast, Fazel and Grann (2006) found that mental illness was a stronger predictor of violence in women than men. Clearly, more research on the role of gender in predicting violent crime in mentally ill populations needs to be done.

We detected no significant interactions between symptom severity and type of homelessness for either outcome. Prior research has found that homeless mentally ill individuals are more likely to commit violent crimes than non-homeless mentally ill individuals. This study suggests that homelessness and mental illness have additive, as opposed to multiplicative, effects.

Certain stable characteristics also by themselves predicted criminal activity. Recruitment from psychiatric hospitals was positively associated with both non-violent and violent crime. Since this finding occurred even after accounting for psychological symptom severity, one possibility is that some participants who were recruited from psychiatric hospitals were initially sent there as a result of breaking the law. Following release from the hospitals, these individuals may have continued their patterns of criminal activity due to factors independent of psychological symptom severity. In addition, consistent with prior research, younger adults were more likely to admit to committing non-violent and violent crimes (e.g., Hirschi and Gottfredson 1983; Steffensmeier et al. 1989).

We found that the diagnosis of a psychotic disorder predicted an increase in the likelihood of non-violent crime and marginally predicted violent crime. We also found evidence that psychotic symptom severity partially mediates both of these relationships. Additional research needs to illuminate what other factors also mediate this relationship. In addition, it is worth noting that the mediational model assumes a causal relationship between diagnosis and symptoms, though symptoms simply could be a better representation of the disorder than diagnosis. However, the results, which separate the associations of within- and between-persons factors, show that even among individuals with a diagnosis of a psychotic disorder, the likelihood of committing a crime fluctuates from observation period to observation period depending on the severity of psychotic symptoms such as hallucinations and feelings of paranoia.

Several limitations to the study exist. One problem is the reliance on self-report data, especially for criminal activity. Underreporting seems likely. Also, although street homelessness was associated with non-violent crime, one cannot say definitively that these crimes were subsistence-driven without knowing their exact nature or the reasons people engaged in them. Based on findings from other research (e.g., Snow et al. 1989), it is likely that at least some of the non-violent crimes were subsistence-driven. However, non-violent criminal activity may also include public disturbances relating to psychological symptoms in this mentally ill sample. Future research should focus on teasing apart these explanations.

In addition, although Conrad et al. (2001) and our own examination of the data found evidence for a secondary "psychotic" scale in the CSI, the four items used to measure psychotic symptoms do not comprise a completely psychometrically distinct subscale. Therefore, it would have been useful to have had a psychometrically strong measure that distinguished psychotic symptoms from other types of symptoms. While the cross-level, mediational analyses suggest that most criminal activity related to the diagnosis of a psychotic disorder is driven more by currently active psychotic symptoms rather than more stable factors associated with the diagnosis, future research must confirm this finding.

Two additional points concerning causal inference warrant consideration. First, although the analytic methods employed in this study lend greater support for a causal relationship than traditional approaches, they have not proven causality. To strengthen causal arguments, future research could gather data on the reasons behind certain types of criminal activity and examine whether they are linked to individuals' environmental context. Researchers could also examine lagged rather than simultaneous relationships between variables in a growth curve framework. However, unless measurement periods correspond reasonably well to the lags in the underlying causal relationships, lagged analyses may not capture causal linkages very well. In the present study, we expect that both cause and effect are likely to occur within a single, 6-month measurement period, so the lags between homelessness and criminal activity should be measured in days or weeks. In addition, future research should examine the role of alcohol and substance abuse, which commonly occurs among individuals in this population (e.g., Fischer and Breakey 1991; North et al. 2004). Given its relationship to homelessness and mental illness, it is possible that substance and alcohol abuse is a "third variable" that might partially account for the relationships found in this study. For example, an individual might engage in criminal activity to obtain and use illegal substances, which also might contribute to an onset of greater symptom severity. It is also possible that substance and alcohol abuse is the first link in a chain that leads to homelessness, which in turn leads to criminal activity. This possibility is plausible among those participants who participated in restrictive housing programs, which often evict clients who do not stay sober.

Future research should build on the strengths of the study. One of the most important strengths, and one that has been largely absent in previous research, is the longitudinal, within-persons design. Understanding how patterns change allows researchers to more directly examine both individual and contextual influences. The study showed a clear association between time-varying, contextual factors

and changes in criminal activity. Therefore, interventions that address criminal activity among homeless individuals should target the context by moving people into permanent housing. In addition, if future research documents that stressful conditions within shelters and other temporary, congregate housing encourage violent criminal activity, then interventions should target these conditions. The relationship between the severity of mental illness symptoms and criminal activity should be addressed by facilitating easier access to adequate health care. This study adds reduction in crime to the many reasons for providing people who are homeless and mentally ill with permanent housing and mental health services.

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Clinical Infectious Diseases

BRIEF REPORT

Pandemic Planning in Homeless Shelters: A Pilot Study of a Coronavirus Disease 2019 (COVID-19) Testing and Support Program to Mitigate the Risk of COVID-19 Outbreaks in Congregate Settings

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We tested 104 residents and 141 staff for coronavirus disease 2019 who failed daily symptom screening in homeless shelters in Hamilton, Canada. We detected 1 resident (1%), 7 staff (5%), and 1 case of secondary spread. Shelter restructuring to allow physical distancing, testing, and isolation can decrease outbreaks in shelters.

Keywords. coronavirus; homeless; shelter; surveillance; outbreak.

Severe acute respiratory syndrome coronavirus 2, the novel coronavirus responsible for causing coronavirus disease 2019 (COVID-19), has particularly affected those in congregate settings, such as nursing homes, prisons, and homeless shelters [1, 2]. In Canada, several outbreaks have been documented in homeless shelters [3, 4].

Preventing and minimizing outbreaks in shelter settings using limited resources protects residents and staff within shelters as well as those who they may interact with in the broader community. Furthermore, the higher prevalence of comorbidities among shelter residents places them at higher risk of severe COVID-19 [5]. Preventing transmission in this population may have a greater impact on reducing hospital admissions and burden on critical care resources.

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Our objective was to describe our experience with shelter facility restructuring, daily symptom screening, and rapid testing to mitigate the risk of COVID-19 in the homeless shelter setting in Hamilton, Ontario, Canada.

METHODS

The homeless shelter system in the city of Hamilton is operated as a partnership between the municipality and social service agencies. Healthcare within the shelters is provided by the Hamilton Shelter Health Network, a group of physicians (family medicine, internal medicine, and psychiatry), nurse practitioners, nurses, and midwives who are funded through an alternate funding plan by the Ontario Provincial Government.

At the start of the pandemic, there were approximately 341 shelter beds across 8 shelters in Hamilton. Collaboration between the local public health unit, municipal government, shelter operators, and the Shelter Health Network began in March 2020. The collaboration allowed an increase from 341 to 395 shelter beds spread across the preexisting shelters, 3 additional hotel sites, and 1 additional temporary men's shelter. This enabled increased physical spacing between shelter beds and lower density within each shelter. Furthermore, a temporary isolation center (from a repurposed recreation center) was created for COVID-19–positive homeless individuals.

Through a partnership with the Hamilton Regional Laboratory Medicine Program, we were able to access COVID-19 testing with rapid turnaround time. This allowed us to use existing spaces within shelters for short-term isolation while awaiting COVID-19 testing results and to immediately arrange 2-week isolation for those who tested positive.

Between 17 March 2020 and 30 April 2020, COVID-19 testing was performed on all shelter residents and staff who failed daily screening for potential COVID-19–related symptoms as well as staff and residents identified as close contacts of positive cases. Symptom screening was conducted according to direction given by the local public health unit and was updated as new information regarding potential symptoms of COVID-19 were uncovered (eg, anosmia). Nasopharyngeal swabs (NPS) were taken by trained nurses, paramedics, and physicians. Between 19 March and 16 April, testing was done using a laboratory-developed BD MAX multiplex real-time polymerase chain reaction (RT-PCR) test for COVID-19 (using 5'-untranslated region, or 5'-UTR), influenza A, influenza B, respiratory syncytial virus, metapneumovirus, parainfluenza 1, adenovirus, and rhinovirus/enterovirus. After 17 April, testing exclusively for COVID-19 was undertaken in order to streamline result times, and tests were considered positive if RT-PCR was positive for COVID-19 5'-UTR or envelope genes.

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Residents awaiting results were isolated within their shelter in single room areas. Residents who tested positive for COVID-19 and did not require hospitalization were transferred to our prepared isolation center for further monitoring. Transportation was organized by the city of Hamilton and involved the use of a dedicated transportation vehicle with enhanced infection control measures, including a barrier between patient and driver and surgical mask, face shield, gloves, and gown for the driver. Isolation continued for 14 days, with the ultimate decision to end isolation made in conjunction with our local public health unit. Nurses performing tests and shelter staff caring for isolated residents wore a disposable gown, surgical mask, face shield, and disposable gloves. Staff who tested positive were excluded from work and provided with information related to self-isolation and symptom monitoring. All positive results were reported to the local public health unit for appropriate case management and contact tracing.

For context, the Ontario Provincial Government declared a state of emergency on 17 March, limiting public gatherings to 50 or fewer people, and subsequently closed nonessential businesses on 23 March. Gatherings were further limited to 5 people on 28 March. No specific limitations were imposed on shelter residents during the study period, although movement between shelters was discouraged. Universal masking within common areas in the shelter system was initiated on 18 April.

RESULTS

Between 19 March and 30 April, 245 NPS were obtained from 141 staff and 104 residents (Figure 1A and 1B). Of the 88 total tests (59 residents and 29 staff) completed on the

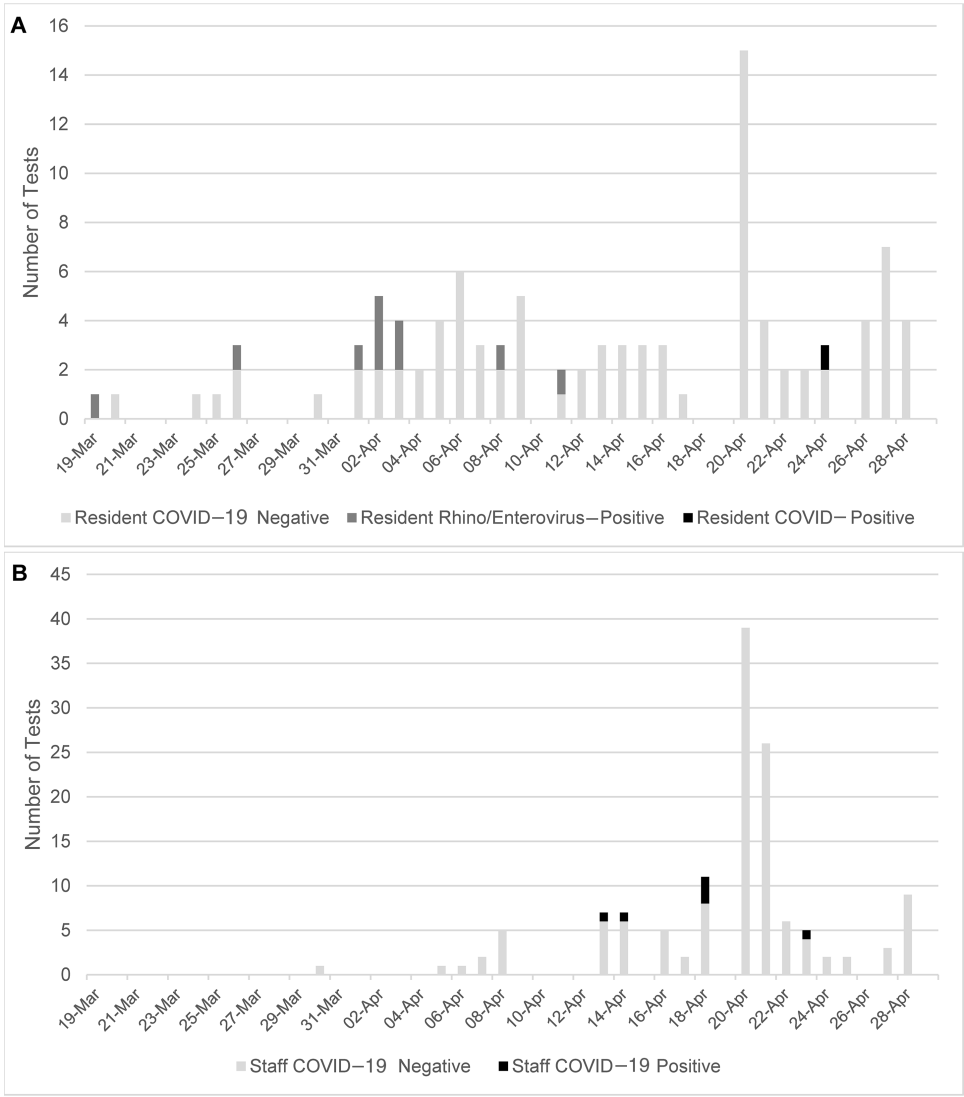


Figure 1. Number of daily tests and test results in residents (*A*) and staff (*B*). Abbreviation: COVID-19, coronavirus 2019.

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multiplex PCR platform prior to 17 April, 12 (13.6%) were positive for a viral pathogen. Ten of 59 residents (16.9%) were diagnosed with rhinovirus/enterovirus infection and 2 of 29 staff (6.8%) were diagnosed with COVID-19. A total of 157 (44 residents and 113 staff) tests performed after 17 April were tested exclusively for COVID-19; of these, 1 resident (2.3%) and 5 staff (4.4%) tested positive. Overall, during our study period, 1 of 104 residents (1.0%) and 7 of 141 staff (5.0%) were diagnosed with COVID-19, and 17 tests (6.9%) identified a viral pathogen. All positive cases were detected only through the daily symptomatic screening protocol or contact tracing.

Follow-up contact tracing and testing revealed no secondary spread linked to the 1 positive shelter resident. Of the 7 staff diagnosed with COVID-19, 4 were part of a cluster that was cohabiting at the same location distant from the shelter and were presumed to be community acquired. The remaining 3 staff worked at 2 separate shelter sites. During the time period of our study, 1 additional shelter resident was diagnosed with COVID-19 after presentation to a local emergency room (outside of our surveillance protocol).

For comparison, during the study period, the city of Hamilton reported 422 patients with COVID-19 and a positivity rate of approximately 5%–7%. Approximately 10% of the cases were in congregate settings (mainly long-term care homes). In the province of Ontario, there were 15 973 reported COVID-19 cases and 1080 deaths during our study period.

Test turnaround time throughout our study period averaged 14 hours from the time of specimen arrival in the laboratory to the time of reported results, and 89%of results were reported within 24 hours.

DISCUSSION

We have thus far been successful in preventing large outbreaks of COVID-19 in the shelter setting despite identifying positive cases in both staff and residents. Our results emphasize the importance of taking a proactive, aggressive approach to outbreak mitigation in high-risk settings. While there has certainly been some random chance, we postulate that the following 4 factors have been particularly important in increasing our chances of success:

- increased capacity of shelter space by opening surge shelters and hotel rooms, allowing for more effective physical distancing in congregate shelters;
- access to rapid assessment and testing on site when symptomatic residents or staff are identified through active screening;
- restructuring of physical spaces to accommodate isolation of residents with confirmed COVID-19 and those awaiting test results; and
- rapid turnaround of test results through collaboration with our regional laboratory program, allowing triage of individuals into isolation spaces without exceeding available capacity.

There are several limitations that should be taken into account in interpreting our data. Our testing program provided evaluation of those staff and residents who were identified as symptomatic through active screening within the shelters. We are aware of instances where shelter residents and staff presented to other settings where testing was performed, and this is not captured in our data. Second, the test characteristics of an NPS can be influenced by testing technique; the sensitivity of our test in the real-world setting of a mobile testing unit has not been clearly established. However, the lack of large-scale outbreaks in area shelters suggests that we have not had a large number of false-negative tests thus far.

Efforts to mitigate the risk of outbreaks of COVID-19 in high-risk congregate settings, such as long-term care facilities, homeless shelters, and prisons, are essential to moving toward the broader goal of managing COVID-19 risk in the general community. Our group recently initiated a cluster, randomized, control trial to examine the effectiveness and acceptability of various surveillance testing strategies of asymptomatic individuals within our shelter system in an ongoing effort to enhance our ability to rapidly detect and isolate COVID-19–infected individuals. However, such efforts should be conceptualized as secondary prevention. There is also a pressing need to consider primary prevention, that is, upstream actions to end homelessness.

Our study demonstrates that accessible shelter housing that allows for rapid testing, isolation, and physical distance is imperative to outbreak prevention in the shelter setting. The strategy presented here should be considered as part of the COVID-19 pandemic response alongside other homelessness prevention and reduction interventions.

Notes

Acknowledgments. The authors thank the Hamilton Regional Laborary Medicine Program, Hamilton Public Health, City of Hamilton, and staff working within the Hamilton Shelter Health Network.

Potential conflicts of interest. The authors: No reported conflicts of interest. All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest.

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TAB 100

Court File No. CV-21-00077817-0000

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, AND SHAWN ARNOLD, ET AL.

Applicants

-and-

CITY OF HAMILTON

Respondent

AFFIDAVIT OF KATE HAYMAN

SWORN FEBRUARY 28, 2023

I, Doctor Kate Hayman, of the City of Toronto in the Province of Ontario, AFFIRM AND STATE:

1. I have personal knowledge with respect to the facts set out below, except where stated otherwise. Where the information is not based on my personal knowledge, it is based upon information provided by others which I believe to be credible and true.

Credentials and Nature of Work

2. A copy of my *Curriculum Vitae* is attached hereto as **Exhibit 'A'.**
3. I am an Emergency Physician.

Expertise in providing health care to unhoused or precariously housed population

4. I have been a physician for 12 years, and an independent practitioner for 7 years.
5. I have been providing health care to the unhoused and/or (precariously housed persons) for 12 years.

   I have been working with the unhoused, precariously housed persons for 12 years; this has been a primary focus of my clinical and academic practice since 2016.
6. Sanctioned encampment sites assist to overcome difficulties associated with providing health care to unhoused persons.

Episodic Themes in Clinic Practice

7. In my experience as an emergency physician, I have daily conversations with patients about where they will stay upon discharge from the hospital. In these conversations, patients who are houseless report that they will not, or prefer not reside in the shelter environment for a number of reasons and the basis of them are often times supported by research as I have outlined below:
   a. Patients report that their belongings have been stolen in shelters, including their prescription medications and identification.
   b. Patients report a fear of violence and sexual violence in shelters. In particular, Cis and trans-women and non-binary patients have reported fear of sexual violence

when staying in congregate settings; the threat of violence and lack of private space can also be triggering for people with a past history of interpersonal violence.

c. Patients report that staying in a congregate shelter setting can also be challenging to their substance use choices, as they have no control over the people who are staying around them. (In contrast to an encampment-type setting, where residents can choose their community members.) For people seeking abstinence or reduced use of drugs, shelters can pose risk of relapse or increased substance use. Patients have also reported that they use stimulants to mitigate safety risks when in shelters or when sleeping unsheltered outside, since it is safer to be awake in the nighttime.

d. Patients who are partnered or have a support network of friends cannot always choose to stay with their partner, as couples' rooms or beds are often not available in Toronto. Particularly for people who use drugs, staying with a partner or support person is imperative to reduce the risk of death by overdose.

e. Pets are often prohibited from shelters; when patients rely on animals for companionship, mental health, and safety this is a major barrier to staying in some shelter spaces.

f. Shelters have wide-ranging harm reduction policies and philosophies. Patients have been evicted from shelter for intoxication, using drugs where they can be seen by staff (which is safer than using alone in a hidden space), and for having drug paraphernalia on their person. The unpredictable nature of these policies and their enforcement (as reported to me by patients) can lead patients to avoid the shelter system entirely.

g. Many people who are houseless have also been in the carceral system and report that the rules in shelters remind them of prior periods of incarceration – they are unwilling to voluntarily re-experience this degree of control and regulation by staff members. A history of prior foster care or incarceration has been found to increase the risk of sleeping in an unsheltered environment.[1]

h. Patients, social workers, and peer support workers in the emergency department often must call the intake line hourly to obtain a shelter space offer. Once an offer is obtained, the space may be in a different part of the city than the patient's support network, pharmacy, outreach team etc. This often leads a patient to give up on trying to find an indoor space to sleep for the night.

These are some of the factors that lead the houseless patients that I see to stay in locations other than shelters. They may choose to instead sleep unsheltered outside, or in an encampment setting when possible.

8. Staying outside without a shelter poses significant risks to health. As an emergency physician, I have personally treated people who have died from hypothermia and overdose while outside, patients who have experienced trauma (including significant head injuries), patients who have been sexually assaulted while sleeping outside, and patients who have experienced heat-and cold-related illnesses such as severe sunburn, heat cramps, and frostbite. Staying in a tent – a structure that is designed to provide privacy and protect one from the elements - helps to reduce some of these risks.

[1] Ann Elizabeth Montgomery et al., "Homelessness, Unsheltered Status, and Risk Factors for Mortality: Findings From the 100 000 Homes Campaign," *Public Health Reports* 131, no. 6 (2016): 765-772.

9. People who are houseless are more likely to receive acute rather than preventive care (in comparison with low-income people who are housed), which increases morbidity and mortality from chronic health conditions. When compared with people staying in shelters, unsheltered people (those who "sleep rough") are also more likely to have skin conditions, poor liver function, and to report recent victimization.[2]
10. Women who are unsheltered ("sleep rough") are at particularly high risk for negative health outcomes, particularly those resulting from interpersonal violence. When compared with women who stay in emergency shelters, unsheltered women report: 3 times greater odds of fair or poor physical health, 12 times greater odds of poor mental health, increased non-injection drug and alcohol use, and increased risk of recent sexual assault. Despite this, they are less likely to have recently utilized health services than women who stay in emergency shelters.[3] Overall, houseless women are also at higher risk for sexual and physical assault than houseless men.[4]
11. People who are houseless (sheltered and unsheltered) are more likely to use substances than people who are housed and are more likely to experience substance-related harms, including fatal overdose. In some populations, death by overdose accounts for 24% of all-cause mortality in people who are houseless. That is, approximately 1 in 4 people who are houseless will die by overdose.[5] When admitted to hospital for substance-related conditions, houseless patients have a longer length of stay in hospital and are more likely

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[4] Suzanne L. Wenzel, Paul Koegel, and Lillian Gelberg, "Antecedents of Physical and Sexual Victimization Among omeless Women: A Comparison to Homeless Men," *American journal of community psychology* 28, no. 3 (2000): 367-390.
[5] Danielle R. Fine et al., "Drug Overdose Mortality Among People Experiencing Homelessness, 2003 to 2018," *JAMA network open* 5, no. 1 (2022): e2142676-e2142676.

to leave the hospital on their own decision than housed patients.[6] Simultaneously, people who are houseless also have challenges engaging in substance-use care: for example, becoming houseless is associated with methadone maintenance therapy discontinuation.[7]

12. In my clinical practice, houselessness – and particularly unsheltered houselessness – poses challenges for patients who are seeking treatment for substance use disorder. Patients report challenges getting to the same pharmacy daily for opioid agonist therapy (i.e., methadone, suboxone) when they must move between shelters or informal accommodations on a regular basis. They also report having medications stolen if they have "carries", for example pharmaceutical-grade hydromorphone (typically prescribed by a physician and dispensed in a daily supply at the pharmacy) to use as a safer alternative to street fentanyl. Patients also have challenges attending regular in-person appointments with their prescriber when they are forced to move frequently and are often unable to attend virtual appointments without a phone, a place to charge the phone, or a private place to discuss their substance use with their provider. Together, these factors mean that people with a very high risk of harms from substance use have the highest number of barriers to treatment. Having a stable place to stay, such as a tent without risk of eviction, may help to decrease some of the harms associated with transiency and decrease barriers to treatment.

[6] Government of Canada, "Substance-Related Poisonings and Homelessness in Canada: A Descriptive Analysis of Hospitalization Data," June 23, 2021, accessed June 8, 2022, https://www.canada.ca/en/health-canada/services/opioids/hospitalizations-substance-related-poisonings-homelessness.html.
[7] Jan Klimas et al., "Factors Associated with Discontinuation of Methadone Maintenance Therapy (MMT) Among Persons Who Use Alcohol in Vancouver, Canada," *Drug and alcohol dependence* 186 (2018): 182-186.

MARCO Encampment Evaluation

13. I endorse the MARCO study attached as exhibit B.[8]

14. The MARCO study on Encampments surveyed 127 and interviewed 23 encampment residents in Toronto in 2021. This study is significant because it provides insight into encampment residents' health status and experiences, as reported by encampment residents themselves. Pertinent findings include:

    a. Encampment residents described finding a community or family of people they respected and could trust in the encampment. They helped to watch over each others' possessions and helped others when they needed it. This stands in contrast to the reports that I have received from patients about the lack of community and trust in the shelter system.

    b. 60% of the people surveyed had tried to find shelter during the pandemic; only 13% were always able to find a shelter bed when needed.

    c. 75% of the people who received and accepted an offer of shelter or housing returned to the encampment, for reasons including: kicked out (29%), did not like restrictions on pets, guests, belongings (16%), location (11%), violence (11%). These results are congruent with firsthand reports that I have received from patients about the challenges with staying in the shelter system.

    d. People staying in encampments reported that they felt their risk of getting COVID-19 was lower than if they had stayed indoors (e.g. in a congregate shelter). Being

[8] Lisa M. Boucher et al., "MARCO Brief Report: Encampment Outreach Evaluation," *MAP Centre for Urban Health Solutions*, *St. Michael's Hospital,* November, 2021, Accessed June 8, 2022, https://maphealth.ca/wp-content/uploads/Encampment-Outreach_MARCO-Nov-2021.pdf.

houseless is a known risk factor for acquiring COVID-19.[9] A recent history of housing instability (when compared with having a stable address) increased the likelihood of being tested for COVID-19 and having a positive test result. In the peak period of the early pandemic, people with housing instability were 20 times more likely to be admitted to hospital for COVID, 10 times more likely to be admitted to an intensive care unit, and 5 times more likely to die.[10] People staying in shelters during the pandemic were subjected to regular asymptomatic testing, daily screening, mandatory masking, and relocation to an isolation shelter if they tested positive for COVID. Sheltered patients reported to me that these measures often felt invasive and punitive, and they were uncertain whether or not they were helping to keep them safe when the physical environment remained crowded.

Advantages and Disadvantages of Living in a Tent/Encampment: Aggregate Themes Amongst this demographic

15. In my experience as an emergency care provider, I have identified the following benefits of living in an encampment versus without:

    a. Improved access to healthcare, including primary and preventive care, substance use treatment, and wound care. People staying in encampments are able to maintain connection to outreach healthcare workers and system navigators, as well as housing services. Harm reduction workers are able to provide supplies (e.g. sterile

[9] Tara Kiran et al., "Association of Homelessness with COVID-19 Positivity among Individuals Visiting a Testing Centre: A Cross-Sectional Study," *Healthcare Policy* 17, no. 3 (2022): 34.
[10] Lucie Richard et al., "Testing, Infection and Complication Rates of COVID-19 Among People with a Recent History of Homelessness in Ontario, Canada: A Retrospective Cohort Study," *Canadian Medical Association Open Access Journal* 9, no. 1 (2021): E1-E9.

needles, sharps containers, clean cookers) to people in the encampment to reduce the risk of blood-borne viral illnesses such as HIV and hepatitis. People are also able to present to the same pharmacy daily to obtain their methadone maintenance therapy, other opioid agonist therapy, or safer opioid supply medications. Staying in an encampment provides people with a (safer) place to store their medications and healthcare supplies.

b. Encampments decrease isolation from community and services. When people know they will be evicted by authorities, they will move further into the margins where they are less visible and more alone to avoid eviction enforcement by the authorities. By moving further into the margins such as to forests, train tracks, abandoned buildings, people place themselves at greater risk of harm because they are alone and disconnected from routine services. This places them at greater risk of interpersonal violence, overdose, and loss of connection to outreach services.

c. Encampments give people a sense of community as opposed to when people are alone and hiding from authorities as they avoid ticketing for sleeping in public. The benefits of this may include increased mental health stabilization, decreased stimulant use (as stimulants are often used to maintain alertness as a safety mechanism), increased chances of being saved during an overdose, and emotional support. Having people available to watch one's possessions also makes it more possible to leave the site to attend healthcare appointments, meet with caseworkers, pick up food or social assistance, and go to the pharmacy.

d. Encampments provide greater privacy when compared with sleeping "rough", for example, on subway grates, in bus stops, or in other partially open public shelters. This provides opportunities for people to change their clothes, remove shoes/boots (which is critical in preventing foot infections and skin breakdown), and is helpful for mental health. This privacy also helps people to get rest and to store their possessions.

e. Encampments reduce sleep deprivation experienced by those without a location or tent, who might wander and stay up at night with nowhere to sleep and fear of violence and theft if they sleep in the open alone.

f. Encampments provide some shelter from cold, rain, and sun. While there are limitations to the shelter provided by tents, they represent a significant improvement in comparison with sleeping outside in an unsheltered environment.

Advantages of living in an encampment versus shelter

16. When people are in crisis, decisions about where to stay are pragmatic choices among best available options, based on circumstances at that time. Encampments represent a lack of other desirable options for housing and shelter and have several distinct advantages:[11]

a. Couples or "survival partners" can remain together. Often there are insufficient shelter options for couples, and they are forced to choose between separating or remaining on the street. Particularly for people with past experiences of trauma,

[11] United States, Department of Housing and Urban Development, *Understanding Encampments of People Experiencing Homelessness and Community Responses: Emerging Evidence as of Late 2018*, by Rebecca Cohen, Will Yetvin & Jill Khadduri (June 2019) at 4.

including traumatic childhood separations from parents and/or siblings, involuntary separation can be very harmful to mental health. Without reliable access to phones, physical separation can lead to complete lack of contact with ones' partner. For people who use drugs, separation from a partner can also increase the risk of overdose (including overdose death).

b. People can remain with their pet, rather than being forced to leave the animal with animal services to obtain shelter. Many people who are houseless have pets as informal emotional support animals (that is, they function to provide significant emotional support but are not formally certified as guide dogs or emotional support animals and are therefore not allowed into shelter). Many shelter spaces will not accommodate animals without formal certification as support animals. People develop strong attachments with their pets that yield psychological benefits. People experiencing houselessness report that pets provide a reason to live, reduce substance use, and increase healthcare seeking.[12] Pet dogs also offer protection and safety when living on the street. Some people who are houseless may have had longer-lasting, more therapeutic bonds with their animal than with family, friends, or partners.[13] Their animals are a major source of support and loss of a pet can be very traumatizing.[14]

[12] Nick Kerman et al., "A Multilevel Intervention Framework for Supporting People Experiencing Homelessness with Pets," *Animals* 10, no. 10 (2020): 1869.
[13] Michelle Cleary et al., "The Homeless and Their Animal Companions: An Integrative Review," *Administration and Policy in Mental Health and Mental Health Services Research* 47, no. 1 (2020): 47-59.; Kerman et al., "A Multilevel Intervention Framework".
[14] Kerman et al, "A Multilevel Intervention Framework. "; Cleary et al., "The Homeless and Their Animal Companions."

c. In comparison with shelter, encampments may provide more continuity of location and ability to plan. As identified in the MARCO study, being "kicked out" (service restricted/evicted) from shelter is common.[15] People who have experienced trauma, have mental health diagnoses, and use drugs may exhibit behaviours that -- despite being secondary to illness and not harmful to co-residents – are not tolerated by shelter staff, leading to frequent service restrictions. People can be service restricted at any time of day or night, and these service restrictions happen without opportunities for advance planning. This is extremely disruptive to healthcare access and planning. For example, I have previously met patients who were evicted from shelter within blocks of their pharmacy, primary care clinic, and the supervised injection site that they usually rely on to reduce overdose risk. The only alternative shelter beds available are often 10-20 kilometres away, making it impossible to maintain connection with their current services. This rapid, unplanned relocation is incredibly destabilizing and can increase the risk of serious harm. Staying in an encampment provides geographic stability without the same risk of unpredicted eviction by staff. These benefits are negated when encampments are moved.

d. Persons attempting to maintain sobriety are at risk of compromising it if they are at a shelter where drug or alcohol use is high.

[15] Boucher et al., "MARCO Brief Report, " 5.

e. Persons attempting to use substances in a safer way may be unable to enter shelter with harm reduction materials such as clean injection or smoking kits.

f. Persons with a history of trauma or abuse may be triggered by a congregate setting of strangers.

Experience attempting to access shelter for my patients

17. In the emergency department, I work with a team of social workers and peer support workers to find shelter for patients on a daily basis. It is extremely common to find that there are no available shelter beds in the city. If a bed is available, it may not be acceptable to the patient for the reasons outlined above. In my setting, patients often get frustrated waiting in the emergency department with no knowledge of when a bed may become available. This leads to them leaving the emergency department to seek informal shelter or sleep outside. When patients leave the emergency department for informal shelter, without a clear idea of where they will be going, it is often impossible to organize follow-up plans. If a patient is going to a house, a pre-specified shelter location, or a known encampment location, we can make referrals to community providers to provide ongoing supports (for example, we can connect with outreach nurses to check in on the patient and support with wound care in an encampment). When there is no clear discharge location and the patient does not have a reliable cell phone, follow-up care is significantly more challenging. Having a place to rest is also helpful for recovery, which is not possible when a patient is wandering on the street immediately after discharge.

Sworn remotely by Kate Hayman at the City of Toronto in the Province of Ontario, before me on February 28, 2023 by "zoom" videoconference in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

Commissioner for Taking Affidavits

Kate Hayman

Bibliography

Boucher Lisa M., Zoe Dodd, Samantha Young, Abeera Shahid, Kimia Khoee, Kris Norris, Melanie Brown, Kahiye Warsame, Linn Holness, Claire Kendall, D. Mergarten, Terry Pariseau, Michelle Firestone, Ahmed M. Bayoumi. "MARCO Brief Report: Encampment Outreach Evaluation." *MAP Centre for Urban Health Solutions*, *St. Michael's Hospital.* November, 2021. Accessed June 8, 2022. https://maphealth.ca/wp-content/uploads/Encampment-Outreach_MARCO-Nov-2021.pdf.

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Methadone Maintenance Therapy (MMT) Among Persons Who Use Alcohol in Vancouver, Canada." *Drug and alcohol dependence* 186 (2018): 182-186.

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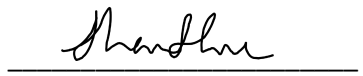
Nyamathi, Adeline M., Barbara Leake, and Lillian Gelberg. "Sheltered Versus Nonsheltered Homeless Women." *Journal of general internal medicine* 15, no. 8 (2000): 565-572.

Richard, Lucie, Richard Booth, Jennifer Rayner, Kristin K. Clemens, Cheryl Forchuk, and Salimah Z. Shariff. "Testing, Infection and Complication Rates of COVID-19 Among People with a Recent History of Homelessness in Ontario, Canada: A Retrospective Cohort Study." *Canadian Medical Association Open Access Journal* 9, no. 1 (2021): E1-E9.

United States, Department of Housing and Urban Development, *Understanding Encampments of People Experiencing Homelessness and Community Responses: Emerging Evidence as of Late 2018*, by Rebecca Cohen, Will Yetvin & Jill Khadduri (June 2019) at 4.

Wenzel, Suzanne L., Paul Koegel, and Lillian Gelberg. "Antecedents of Physical and Sexual Victimization Among omeless Women: A Comparison to Homeless Men." *American journal of community psychology* 28, no. 3 (2000): 367-390.

THIS IS EXHIBIT “A” TO THE
AFFIDAVIT OF KATE HAYMAN
AFFIRMED REMOTELY BEFORE ME AT
THE CITY OF TORONTO DURING A “ZOOM” VIDEOCONFERENCE
IN ACCORDANCE WITH O.REG. 431/20,
ADMINISTERING OATH OR DECLARATION REMOTELY
THIS 28TH DAY OF FEBRUARY, 2023



SHARON CROWE

Commissioner for Taking Affidavits, etc.

Curriculum Vitae

Kate Hayman
Kate.Hayman@uhn.ca
519-860-9866

A. Date Curriculum Vitae is Prepared: 2021 December 2

Only includes Activities from March 2015 to December 2021

B. Biographical Information

Primary Office	University Health Network Department of Medicine Division of Emergency Medicine Toronto, Ontario, Canada
Telephone	519.860.9866
Email	khayman2010@gmail.com

1. EDUCATION

Degrees

2015 Sep - 2017 May	Certificate of Master Teacher, Clinical Teaching, Dept of Medicine, University of Toronto, Toronto, Ontario, Canada
2013 - 2014	MPH, Health in Crisis and Humanitarian Assistance, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland, United States, Supervisor(s): Dr. Shannon Doocy
2006 - 2010	MD, Doctor of Medicine, University of Western Ontario, London, Ontario, Canada
2003 - 2006	BSc, Arts and Sciences – no degree conferred, McGill University, Montreal, Quebec, Canada

Postgraduate, Research and Specialty Training

2013 - 2014	Co-Chief Resident, Division of Emergency Medicine, Department of Medicine, University of Western Ontario, London, Ontario, Canada
2010 - 2015	Emergency Medicine Residency, University of Western Ontario, London, Ontario, Canada

Qualifications, Certifications and Licenses

2015 Jun - present	Fellow, Emergency Medicine, Royal College of Physicians of Canada, Canada

2. EMPLOYMENT

Current Appointments

2016 Nov – present	Assistant Professor, Division of Emergency Medicine, Department of Medicine, University of Toronto, Toronto, Ontario, Canada
2015 Jul - present	Active Staff Physician, Division of Emergency Medicine, Department of Medicine, University Health Network, Toronto, Ontario, Canada
2014 - present	Instructor, Advanced Trauma Life Support, American College of Surgeons, Ontario, Canada

Previous Appointments

CLINICAL

2020 April – 2021 Mar — Co-Medical Director and Physician, COVID Recovery Sites, Inner City Health Associates, Toronto, Ontario, Canada

2018 Nov - 2019 Feb — Medical Activity Manager, MSF Holland, Northeast Syria, Médecins Sans Frontieres, Tal Abyad, Ar Raqqah, Syrian Arab Republic
Provided medical and trauma care and training in emergency department. Didactic and hands-on training focused on management of non-communicable diseases, burns, vaccine-preventable disease and mass casualty triage. Trainees included physicians, nurses, nurse assistants, paramedics and nurse assistant students. Organized and supervised mass casualty training drill for all hospital staff. Set emergency care objectives for 2019 project planning cycle.

2017 Dec - 2017 Dec 30 — Emergency Physician, MSF Holland, Mediterranean Search and Rescue, Médecins Sans Frontieres, Catania, Italy
Provided primary and emergency care to asylum seekers and migrants near Libyan coast. Provided basic life support training for medical and non-medical team members, organized and mass casualty training.

2017 Jun - 2017 Nov — Medical Activity Manager, MSF Holland, Medecins Sans Frontieres, Kirkuk, Kirkuk, Iraq
Provided training, oversight, and team management for national staff. Delivered training in emergency department, assisted in planning and leadership of MSF's medical response to movement of internally displaced persons within Kirkuk District. Performed rapid health assessments in three areas with view to start new medical activities.

3. HONOURS AND CAREER AWARDS

Teaching and Education Awards

LOCAL

Nominated

2020 Mar — **Robert Sheppard Award for Health Equity and Social Justice**, Dept of Medicine, Faculty of Medicine. (Postgraduate MD)
Co-nominated for this award with Drs. Claire Acton and Evelyn Dell for creation of Equity, Diversity, Advocacy and Cultural Safety curriculum for emergency medicine trainees.

4. PROFESSIONAL AFFILIATIONS AND ACTIVITIES

Professional Associations

2018 Jan 1 - present — **Associate**, MSF Canada Association, NA

2013 - present — **Member,** Independent Practitioner Status, Canadian Emergency Ultrasound Society

2009 - present — Canadian Association of Emergency Physicians

Administrative Activities

PROVINCIAL / REGIONAL

Decent Work and Health Network

2015 Jul 1 - present Steering Committee Member, Ontario, Canada.

LOCAL

Emergency Medicine Program, University of Toronto

2019 Mar - present Co-lead: Equity, Diversity, Advocacy and Cultural Safety Curriculum, Faculty of Medicine, Dept of Medicine, Emergency Medicine, Postgraduate MD, Toronto, Ontario, Canada.

Global Health Emergency Medicine, Divisions of Emergency Medicine, University of Toronto, Toronto, Ontario, Canada

2018 Jan - present Health Equity subcommittee - Co-Chair

University Health Network, Toronto, Ontario, Canada

2021 Jan – present Member, Outpatient Care Council

2019 – Mar 2020 Member, Social Needs Steering Committee

University Health Network Emergency Departments, Toronto, Ontario, Canada

2019 Nov - present Co-lead: Health Equity and Disadvantaged Populations

2016 Sep – 2020 Sep UHN Simulation Committee

C. Research Funding

1. GRANTS, CONTRACTS AND CLINICAL TRIALS

PEER-REVIEWED GRANTS

FUNDED

2021 Dec – 2022 Nov **Co-Principal Applicant.** MARCO:POLO Marginalization & COVID-19: Promoting Opportunities for Learning & Outreach. Canadian Institutes of Health Research (CIHR) Operating Grant. Emerging COVID-19 Research Gaps & Priorities - Urban Populations. Principal Applicant: Bayoumi AM. Co-Principal Applicants: Firestone M, Boucher L, Dodd Z, Durbin A, **Hayman K,** Isaacs BJ, Kolla G, Matheson FI, Steer LA, Yakubovich AR, Young SV. Co-Applicants: Beder M, Brothers T, Dobrow M, Du Mont J, Holness L, Huijbregts M, Hwang S, Hynie M, Kendall C, Kenny K, Long C, Maguire J, Nisenbaum R, Shankardass K, Strike C, Walker D. Collaborators: Arcenal M, Delgado R, Heineck K, Lunsky Y, Marcolin A, Pepper V. 313,804 CAD. [Grants].

2018 Jun - present **Co-Investigator**. The State of Advocacy Training in Canada's Family and Emergency Medicine Training Programs. Faculty of Medicine, University of Toronto. Education Development Fund. PI: Hulme, Jennifer. Collaborator(s): Wright, Sarah, Rouleau, Katherine Sherbino, Jonathan, **Hayman, Kate**, Landes, Megan, Sharma, Malika, Pinto, Andrew Atkinson, Kate, Lavelle, Conor, Macdonald, Madeline. 19,800 CAD. [Grants]

2014 - 2019 **Principal Investigator**. Does utilization of an intubation safety checklist improve patient safety during simulated resuscitation scenarios? CAEP 2014 Research Grant Competition.

Collaborator(s): **Hayman K**, Klingel M, Forristal C, Smith N, Ouellette D. 5,000 CAD. [Grants]
Grant to support proposed research project. Study currently ongoing.

2017 Jul - 2018 Oct — **Co-Investigator**. Employment and better employment through relationships project (EMBER): Phase II. Atkinson Foundation. PI: Pinto, Andrew. Collaborator(s): Deena Ladd, **Kate Hayman**, Yogendra Shakya, Lynn Anne Mulrooney, Julia Barnett, Morgan Lay, Linn Holness, Tajnin Islam, Flora Matheson. 126,000 CAD. [Grant supporting both advocacy and research]
Grant funds Decent Work and Health Network, supporting advocacy and research on employment as a social determinant of health.

2017 Jun - 2018 Jun — **Principal Investigator**. Teaching medical students to “go upstream” and advocate on social determinants of health using case-based learning. University of Toronto. Education Development Fund. CFC 107917. Collaborator(s): Andrew Pinto, Malika Sharma, Mei Wen, Tracey Mann, Farooq Khan. 8,000 CAD. [Grants]
Educational innovation targeting second year medical students, with qualitative analysis of findings.

NON-PEER-REVIEWED GRANTS

FUNDED

2019 Jul - present — **Co-Investigator**. Understanding the Experiences of Refugee Claimants in Toronto Emergency Departments: A Qualitative Analysis. University Health Network. Collaborator(s): Siu C, Hulme J, Rao S, Gajaria A. 2,980 CAD. [Grants]
Operational Funding.

2019 Jun - present — **Co-Investigator**. Decent Work: An Antidote for a Healthcare System Under Strain. Atkinson Foundation. Collaborator(s): Jimenez C, Mclaren J, Beckett R, Dhunna S, Sumner A, Ladd D, Begum N. 126,609.87 CAD. [Grants]
Funding for research and advocacy activities.

2019 Mar - present — **Principal Investigator**. Understanding the Experiences of Refugee Claimants in Toronto Emergency Departments: A Qualitative Analysis. Medical Student Education Research Grant. Compassionate Care Stream. Collaborator(s): Rao, Sampreeth
Hulme, Jennifer
Siu, Colin. 5,000 CAD. [Grants]

2018 Jun - present — **Principal Investigator**. Advocacy Writing as Resident Education. Faculty of Medicine, University of Toronto, Matched by UHN Emergency Medicine. Medical Humanities Education Grant. Collaborator(s): Hulme, Jennifer
Lavelle, Conor
Bigham, Blair. 6,000 CAD. [Grants]

2018 Jul - 2019 Dec — **Co-Investigator**. The Gender Pay Gap Among ER Physicians in Canada: An Exploratory Study within the GTA. Centre for Industrial Relations and Human Resources, University of Toronto. SSHRC Institutional Grant. PI: Pohler, Dionne. Collaborator(s): **Hayman, Kate**; Landes, Megan. 823.76 CAD. [Grants]

D. Publications

1. PEER-REVIEWED PUBLICATIONS

Journal Articles

1. Formosa E, Kishimoto V, Orchanian-Cheff A, **Hayman K**. Interventions to address homelessness in the emergency department: A systematic review. Canadian Journal of Emergency Medicine. 2021; 23: 111–122. **Senior Author.**

2. Forristal C, **Hayman K**, Farooki N, Smith N, Mal S, Columbus M, Van Aarsen K, McLeod S, Ouellette D. Does utilization of an intubation safety checklist reduce dangerous omissions during simulated resuscitation scenarios: A multi-center randomized controlled trial. Canadian Journal of Emergency Medicine. 2020; 23(1):45-53. **Co-Principal Author.**

3. McLaren J, **Hayman K**, Sheikh H. CAEP Position Statement on Sick Notes for Minor Illness. Canadian Journal of Emergency Medicine. 2020;22(4):475–476. **Coauthor or Collaborator**.

4. **Hayman K**, Wen M, Khan F, Mann T, Pinto A, Ng SL. Missing the target? Teaching undergraduate students to “go upstream” and advocate on social determinants of health. Canadian Medical Education Journal. 2019 Nov 1. In Press. **Principal Author**.

5. Riggan MA, **Hayman K**, Chen BC, Hoffman RS. Phenobarbital for acute alcohol withdrawal: a prospective randomized double-blind placebo-controlled study. J Emerg Med. 2016 Jun;50(6):895-6. **Coauthor or Collaborator**.

6. Sharma D, **Hayman K**, Stewart B, Dominguez L, Trelles M, Saqeb S, Kasonga C, Hani T, Mupenda J, Naseer A, Wong E, Kushner A. Surgery for conditions of infectious etiology in resource-limited countries affected by crisis: the Medicins Sans Frontieres Operations Centre Brussels Experience. Surgical Infections. 2015 Dec;16(6):721-7. **Coauthor or Collaborator**.

7. Sharma D, **Hayman K**, Stewart B, Dominguez L, Trelles M, Saqeb S, Kasonga C, Hani T, Mupenda J, Naseer A, Wong E, Kushner A. Care of surgical infections by Medicins Sans Frontieres Operations Centre Brussels in 2008-14. Lancet. 2015 Apr;387:Suppl 2:S31. **Coauthor or Collaborator**.

Online Resources

1. Alia Dharmasi, Soojin Yi, **Kate Hayman**. Suspected COVID=19. Baylis, Jared, editor(s). (Canada): EMSimcases; 2020 Feb 18. Available from: https://emsimcases.com/?s=covid. **Coauthor or Collaborator**.

2. **Kate Hayman**, Dawn Lim. Iron overdose in a pregnant patient. Caners, Kyla, editor(s). (Canada): EMSimcases; 2018 Feb 13. Available from: https://emsimcases.com/2018/02/13/iron-overdose-in-a-pregnant-patient/. **Co-Principal Author**.

3. Anne Rucchetto, **Kate Hayman**. Fighting the Flu with Labour Laws: The Case for Paid Sick Days. (Canada): healthydebate.ca; 2017 Feb 15. Available from: http://healthydebate.ca/opinions/paid-sick-leave. **Co-Principal Author**.

2. NON-PEER-REVIEWED PUBLICATIONS

Editorials

1. Danyaal Raza, **Kate Hayman**. How labour policy in both Canada and the US affects the spread of coronavirus. Macleans Magazine. 2020 Mar 13. Available from: https://www.macleans.ca/opinion/how-labour-policy-in-both-canada-and-the-u-s-affects-the-spread-of-coronavirus/. **Coauthor or Collaborator**.

Newspaper Articles

1. Jesse McLaren, **Kate Hayman**, Carolina Jimenez. From flu to coronavirus: bring back paid sick days. Toronto Star (Opinion). 2020 Feb 5. Available from: https://www.thestar.com/opinion/contributors/2020/02/05/from-flu-to-coronavirus-bring-back-paid-sick-days.html. **Coauthor or Collaborator**.

2. Mclaren, Jesse & **Hayman, Kate**. Wake hike, paid sick days part of hallway medicine cure. Toronto Star (Opinion). 2018 Aug 21. Available from: https://www.thestar.com/opinion/contributors/2018/08/21/wage-hike-paid-sick-days-part-of-hallway-medicine-cure.html. **Coauthor or Collaborator**.

3. Mclaren, Jesse & **Hayman, Kate**. Tim Horton's response undermines health. Toronto Star. 2018 Jan 19;Opinion. Available from: https://www.thestar.com/opinion/contributors/2018/01/19/tim-hortons-response-undermines-health.html. **Coauthor or Collaborator**.

Online Resources

1. **Hayman K**, Loubani T. Thromboembolic disease" Global Health Emergency Medicine Teaching Module. (Canada); 2016. Available from: http://ghem.ca/module-category/medical-emergencies/. **Principal Author**.

2. Zbar A, Fitzgerald-Husek A, **Hayman K**. Health and Homelessness Reference Guide for Healthcare Providers. (Canada); 2016. Available from: healthandhomelessness.weebly.com. **Coauthor or Collaborator**.

E. Presentations and Special Lectures

1. INTERNATIONAL

Invited Lectures and Presentations

2018 Sep 27 **Invited Speaker**. Physician Advocacy: Decent Work and Health Network. Gary Bloch. Toronto, Ontario, Canada. Presenter(s): **Kate Hayman**. Presented to Min-Iren, delegation of Japanese Physicians who participated in an exchange on social policy change toward equity, health, and peace.

2. NATIONAL

Invited Lectures and Presentations

2021 Nov 30 Invited Lecture. COVID, Homelessness, and the Overdose Crisis: Lessons learned for the ED. Emergency Department Administration Conference, Canada. Presenter: **Hayman, K**

2021 Jun 21 Invited Lecture. "COVID, Homelessness, and the Overdose Crisis: Interventions for Overlapping Pandemics". Canadian Association of Emergency Physicians Conference. Canada. Presenter: **Hayman, K.**

2021 May 21 Panelist. Trauma-informed care in the emergency department. Canadian Association of Emergency Physicians National Grand Rounds Series. Canada. Presenters: **Hayman K,** Bromberg R, Sampsel K, Liu J.

Presented Abstracts

2015 Jun **Moderator**. Can paramedics safely transport patients with ST-segment elevation myocardial infarction (STEMI) directly to a PCI capable centre? Canadian Association of Emergency Physicians Conference. Canada. Presenter(s): **Hayman K**, McLeod SL, Dukelow A, Lewell M. Poster presentation.

Media Appearances

2017 May 10 **Interviewee**. Paid Sick Leave and Personal Emergency Leave. Interviewer: Mike Crawley. CBC News. Ontario, Canada. Available from: http://www.cbc.ca/news/canada/toronto/good-life-fitness-personal-trainers-sick-pay-work-ontario-1.4106196.

3. PROVINCIAL / REGIONAL

Invited Lectures and Presentations

2019 Mar 14 **Invited Lecturer**. Advocacy writing in medical education. Erin Cameron. Thunder Bay, Ontario, Canada. Presenter(s): **Kate Hayman**. Invited to discuss Advocacy writing as a tool for operationalizing the health advocate role. Will discuss research findings with medical students and residents with faculty at the Northern School of Medicine.

Media Appearances

2020 Feb 27 **Invited Speaker**. The cost and benefit of Paid Sick Days. Interviewer: Steve Paikin. The Agenda, TVOntario. Ontario, Canada.

2020 Feb 13 **Invited guest**. Paid Sick Days. Interviewer: Rita Celli. Ontario Today, CBC. Ontario, Canada. Invited expert on the health impacts of paid sick days. Available from: https://www.cbc.ca/listen/live-radio/1-45-ontario-today/clip/15760727-doctors-say-covid19-underlines-the-need-to-bring-back-paid-sick-days.

2017 May 24 Paid Sick Days for all Ontarians. Interviewer: Matt Galloway. Metro Morning, CBC. Toronto, Ontario, Canada. Presenter(s): **Kate Hayman**. Described negative health impact of current legislation that does not ensure paid sick leave for all Ontarians.

4. LOCAL

Invited Lectures and Presentations

2018 Oct 18 **Facilitator**. Meeting the needs of emergency department patients experiencing poverty: A panel discussion. University Health Network. Toronto, Ontario, Canada. Presenter(s): **Kate Hayman**, Nicole Furey, Kai Wong, invited members of Toronto Lived Experience Advisory Group. Facilitated panel discussion about the experiences of patients utilizing our emergency departments, with view to improving care for marginalized populations.

2017 Apr 12 **Invited Speaker**. Decent Work and Health Network. St. Joseph's Family Medicine Residents. Toronto, Ontario, Canada. Presenter(s): **Kate Hayman**, Tracey Mann. Presented on Decent Work and Health Network, followed by facilitated discussion about work as a social determinant of health.

F. Teaching and Design

1. INNOVATIONS AND DEVELOPMENT IN TEACHING AND EDUCATION

2019 Jan - present Equity, diversity, advocacy and cultural safety curriculum co-lead, Postgraduate MD, Faculty of Medicine, Dept of Medicine, Emergency Medicine
Developing equity, diversity, advocacy and cultural safety curriculum for emergency medicine residents in Royal College Training stream. Curriculum will be 8 hours of in-class time over 2 years.
Planned dissemination of curriculum development and assessment at national level.

2014 - 2015 Resident Journal Club, Postgraduate MD, Faculty of Medicine, Dept of Medicine, Emergency Medicine
Initiated resident journal club for emergency medicine training program, to fill perceived gaps in critical appraisal skills for emergency trainees.

G. Research Supervision

1. PRIMARY OR CO-SUPERVISION

Undergraduate Education

2018 Sep - 2019 Apr **Primary Supervisor**. B. Sc. Vanessa Kishimoto. Supervisee Position: Human Biology Research Student (Undergraduate Year 4), Supervisee Institution: University of Toronto. *Determining Evidence Base & KT Opportunities for Health Equity in the ED*. Supervisor(s): Kate Hayman, Jennifer Hulme.

Graduate Education

2018 May - 2018 Sep **Co-Supervisor**. Master of Public Health. Kai Wong, Public Health Sciences. Supervisee Position: Public Health Practicum Student - Health Promotion, Supervisee Institution: Dalla Lana School of Public Health. *Non-thesis Project*. Supervisor(s): Kate Hayman, Jennifer Hulme.

Undergraduate MD

2019 Feb - present **Primary Supervisor**. Year 2. Sampreeth Rao. Supervisee Position: Medical Student, Year 2, Supervisee Institution: University of Toronto. *Understanding the experience of refugees in Toronto's emergency departments*, *Non-thesis Project*. Supervisor(s): Kate Hayman, Jennifer Hulme. Collaborator(s): Colin Siu.

2018 Jun - 2020 **Primary Supervisor**. Year 2. Evan Formosa. Supervisee Position: Medical Student, Year 2, Supervisee Institution: New York Medical College. *Emergency department interventions for homeless patients: A systematic review*, *Non-thesis Project*. Awards: Medical Student Summer Research Fellowship ($1000). Collaborator(s): Patricia Hoyek, Vanessa Kishimoto.

Postgraduate MD

2018 Jul - present **Primary Supervisor**. Core Program. Colin Siu. Supervisee Position: Emergency Medicine Resident, Supervisee Institution: University of Toronto. *Understanding the experience of refugees in Toronto's emergency departments*. Supervisor(s): Kate Hayman, Jennifer Hulme. Collaborator(s): Sampreeth Rao.

2014 Jul - 2019 **Primary Supervisor**. Core Program. Chantal Forristal, Medical Science. Supervisee Position: Emergency Medicine Resident, Supervisee Institution: University of Western Ontario. *Does utilization of an intubation safety checklist reduce dangerous omissions during simulated resuscitation scenarios?*. Supervisor(s): Kate Hayman, David Ouellette. Collaborator(s): Sameer Mal, Norma Smith, Shelley McLeod.

THIS IS EXHIBIT “B” TO THE
AFFIDAVIT OF KATE HAYMAN
AFFIRMED REMOTELY BEFORE ME AT
THE CITY OF TORONTO DURING A “ZOOM” VIDEOCONFERENCE
IN ACCORDANCE WITH O.REG. 431/20,
ADMINISTERING OATH OR DECLARATION REMOTELY
THIS 28TH DAY OF FEBRUARY, 2023



SHARON CROWE

Commissioner for Taking Affidavits, etc.

Encampment Outreach Evaluation

November 2021

MAP Centre for Urban Health Solutions

UNITY HEALTH TORONTO

UNIVERSITY OF TORONTO

About the MARCO Study

The MARCO project is evaluating how local efforts responding to the COVID-19 pandemic serve people experiencing marginalization, and how these interventions can be improved. Changes in society to control the pandemic have affected everyone, but they place a particularly heavy burden on people who are marginalized.

We evaluated programs that support many communities who may be experiencing marginalization during COVID-19, including people experiencing homelessness, people with developmental disabilities, people who use drugs, and women who are experiencing violence. The MARCO Community Committee and Steering Committee chose the programs. The programs include:

- COVID-19 Isolation and Recovery Sites (CIRS)
- Encampment Outreach
- Substance Use Service (SUS) at the COVID-19 Isolation and Recovery Site
- Toronto Developmental Service Alliance's Sector Pandemic Planning Initiative (SPPI)
- Violence Against Women (VAW) Services

About this Report

This report is a brief summary of one of the MARCO Evaluations. This report highlights the key findings of the Encampment Outreach evaluation. The final, full length report will be released in December 2021.

The views contained in this report do not necessarily express the views of any MARCO community partner, funding agencies, MAP, St. Michael's Hospital, Unity Health Toronto, the University of Toronto, or any other organization with which MARCO authors or project team members may be affiliated.

Suggested Citation

Boucher LM, Dodd Z, Young S, Shahid A, Khoee K, and Norris K (Co-lead authors), Brown M, Warsame K, Holness L, Kendall C, Mergarten D, Pariseau T, Firestone M, Bayoumi AM. MARCO Encampment Outreach Evaluation Brief Report. Toronto, Ontario: MAP Centre for Urban Health Solutions, St. Michael's Hospital. November, 2021. Available from https://maphealth.ca/wp-content/uploads/Encampment-Outreach_MARCO-Nov-2021.pdf

Acknowledgements

MARCO gratefully acknowledges funding from: the Temerty Foundation and the University of Toronto through the Toronto COVID-19 Action Initiative; the University of Toronto's Faculty of Medicine Equity, Diversity, and Inclusion fund; and the St. Michael's Hospital Foundation.

We also wish to thank all individuals who participated in this evaluation for sharing their important perspectives, as well as all members of the larger MARCO study team and other community groups that assisted our evaluation.

Land Acknowledgement

We wish to acknowledge the sacred land on which MAP and Unity Health Toronto operate. It has been a site of human activity for 15,000 years. This land is the territory of the Huron-Wendat and Petun First Nations, the Seneca, and most recently, the Mississaugas of the Credit First Nation. The territory was the subject of the Dish With One Spoon Wampum Belt Covenant, an agreement between the Iroquois Confederacy and Confederacy of the Ojibwe and allied nations to peaceably share and care for the resources around the Great Lakes. Today, the meeting place of Toronto is still the home of many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work in the community, on this territory. We are also mindful of broken covenants and the need to strive to make right with all our relations.

Website: maphealth.ca/marco Email: marco@unityhealth.to

What we did and what we learned

What was evaluated?

Even before the COVID-19 pandemic, some people experiencing homelessness lived in encampments under bridges, in parks and ravines around Toronto. Since the pandemic started, a growing number of people have been staying in encampments, which have become more visible.

New outreach groups formed and existing agencies and organizations working with people experiencing homelessness adapted to reach out to encampment residents and provide alternatives to services that were closed or limited due to COVID-19. Outreach groups included community-based organizations, volunteer groups, and city services.

We studied encampment outreach in Toronto during the pandemic to understand how these supports met the needs of encampment residents. The questions we focused on were:

- Did supports meet people's most important needs? Which needs were left unmet?
- What outreach supports and shelter or housing options were offered to people?
- In what ways did these supports affect people's lives, both positive and negative?

Our evaluation included several steps:

1. We met with key community members and groups to plan the study.
2. We conducted 127 surveys and 23 interviews with encampment residents at six encampments in Toronto between March and June 2021.
3. We looked for patterns from the surveys and common themes in the interviews.

We also conducted 16 interviews with encampment outreach workers and volunteers. We will share findings from these interviews in a future report.

Who did we talk to?

38% of people we surveyed identified as female, and one in four identified as 2SLGBTQ+. A large number were from racialized groups, including 26% Indigenous, 16% Black, and 11% other racialized identities. People were between 21 and 64 years of age.

The people who answered our survey listed over 30 different encampments they had stayed in during the pandemic. Many had stayed in more than one encampment, and 39% were no longer staying in an encampment at the time they were surveyed.

What were the key findings?

Encampment Living:

- The month prior to the pandemic, people stayed in many locations, including 17% in an encampment, 29% elsewhere on the street, 20% in a rented place, 16% with family or friends, and 13% in a shelter.
- Half of the people surveyed reported that they moved to an encampment for reasons related to the pandemic. People also said they moved to encampments because they

People experiencing homelessness have a firm understanding of their own needs and should be listened to. Until we collaborate with people living outside to create more permanent housing options that meet their needs, encampments will continue to exist.

---

were not able to find housing, did not know where else to go, knew people in encampments, felt that shelters were not safe or secure, or wanted more freedom than shelters provided. Many people moved back and forth between encampments and other spaces, like shelters, shelter hotels, and respites.

- Many people described finding a community or family in the encampments among people they respected and could trust. Residents often supported each other and worked together on daily tasks, including watching each other's personal possessions, sharing food or other items, and helping people when they needed assistance. These relationships led people to visit residents in encampments after they had moved on to other shelter or housing.

Outreach Supports:

- Overall, encampment residents greatly appreciated the support they received from community-based and volunteer outreach groups.
- 69% of encampment residents said that outreach supports met their basic survival needs, like food and drink, shelter supplies and warmth, and harm reduction supplies.
- Many encampment residents valued the ways in which community-based outreach workers and volunteers provided supports:
  - Workers and volunteers were often present in the encampments. Most residents felt they could count on workers and volunteers when they needed them.
  - Workers and volunteers were flexible and respected residents' points of view. Many residents said workers and volunteers asked for their input and adapted supports to best respond to their needs.
  - Workers and volunteers provided social support through a kind and compassionate approach. This helped to meet some residents' social and mental health needs.
- Residents indicated that certain outreach workers or groups were less caring and more judgemental. Residents found this approach upsetting and not helpful. Some noted that it was harder to trust workers when they acted like security, such as recording what residents were doing or telling them what to do.
- Some residents interacted with city outreach workers when they were getting shelter offers and reported feeling rushed or forced into decisions by threat of eviction.
- The greatest unmet need that residents identified was permanent housing.
- Some residents said they got everything they needed at the encampments, but others said they did not have good access to hygiene, technology, and mental health supports.

Shelter and Housing Offers:

- 60% of people surveyed tried to find a shelter bed or shelter hotel room during the

pandemic at least once, and only 13% of them were able to find one every time. Of those who tried, 68% were told that no shelter was available.

- 55% of people were offered a shelter or housing option by city staff at least once. Of those who received offers, 77% were offered a bed in a shelter hotel and only 4% were offered permanent housing.
- 75% of people who accepted an offer of shelter or housing returned to live in an encampment. The most common reasons they left the shelter or housing were:
  - 29% were kicked out
  - 16% did not like the restrictions, such as no pets, no guests, or a limit on the belongings they could bring
  - 11% felt the shelter or housing was too far away from where they wanted to be
  - 11% were worried about violence
  - Some people reported more than one reason
- Other reasons people gave for leaving or not accepting temporary shelter options included COVID-19 outbreaks, a lack of privacy, overdose risk and friends' deaths in these settings, disrespectful treatment by staff, not having their health needs met, and being tired of waiting for permanent options.

COVID-19 Risk in Encampments:

- 80% of people surveyed had been tested for COVID-19 and 13% of them reported testing positive.
- Encampment outreach workers and volunteers provided COVID-19 supplies, such as masks and hand sanitizer, to residents. Many residents reported distancing from others, washing or sanitizing hands, wearing masks, and not sharing drinks, food, or drug use equipment.
- Many encampment residents felt their risk of getting COVID-19 was greater in indoor living settings with many people in the same space, like shelters or respites. This is compared to encampments, where residents expressed they felt safer being outdoors.

What are the recommendations moving forward?

1. Organizations should be helped to expand or maintain their outreach services and hand out survival supplies to meet encampment residents' basic needs.

2. Encampment outreach supports should be responsive, flexible, and adapt to what encampment residents need. Supports should be offered frequently and consistently.

3. Encampment outreach and shelter or housing services should support people to build and maintain their community connections.

4. Conditions in temporary shelter settings should be improved. Encampment residents should not be pressured into leaving encampments or entering shelter or housing that does not meet their needs, especially considering the risks of getting COVID-19 or overdosing in shelter spaces.

5. The city government should put a priority on providing encampment residents and other people experiencing homelessness with permanent housing. Permanent housing should respect people's dignity and meet their needs.

6. Encampment residents should be included in decisions about encampments, shelters, and housing.

Affiliations

Bruyère Research Institute: Lisa Boucher, Claire Kendall

Canadian Mental Health Association: Terry Pariseau

South Riverdale Community Health Centre: Zoë Dodd

The Neighbourhood Group: Melanie Brown

Unity Health Toronto: Ahmed Bayoumi, Zoë Dodd, Michelle Firestone, Kris Norris, Linn Holness, Kimia Khoee, Kahiye Warsame, Samantha Young

University of Toronto: Ahmed Bayoumi, Michelle Firestone, Samantha Young

University of Ottawa: Lisa Boucher, Claire Kendall, Abeera Shahid

TAB 101

Court File No. CV-21-00077817-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, ET AL.

Applicants

-and-

CITY OF HAMILTON

Respondent

ACKNOWLEDGMENT OF EXPERT'S DUTY

1. My name is Kate Hayman. I live at Toronto, in the Province of Ontario.

2. I have been engaged by or on behalf of the Hamilton Community Legal Clinic to provide evidence in relation to the above-noted court proceeding.

3. I acknowledge that it is my duty to provide evidence in relation to this proceeding as follows:

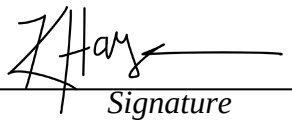
   (a) to provide opinion evidence that is fair, objective and non-partisan;

   (b) to provide opinion evidence that is related only to matters that are within my area of expertise; and

   (c) to provide such additional assistance as the court may reasonably require, to determine a matter in issue.

4. I acknowledge that the duty referred to above prevails over any obligation which I may owe to any party by whom or on whose behalf I am engaged.

Date June 13, 2022



Signature

TAB 102

Court File No. CV-21-77187

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLEN GNATUK, TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD

Applicants

- and -

CITY OF HAMILTON

Respondent

CROSS-EXAMINATION OF DR. KATE HAYMAN,
on behalf of the Applicants,
on her affidavit dated February 28, 2023,
held via Zoom Videoconference hosted by
the offices of Nimigan Mihailovich Reporting Inc.,
Hamilton, Ontario, on Friday, August 16, 2024,
at 10:04 a.m. EDT

APPEARANCES:

Sujit Choudhry Sharon Crowe Curtis Sell Michelle Sutherland Nnonyechi Okenwa	for the Applicants
Bevin Shores Jordan Diacur Vivian Caldas	for the Respondent
Jojo Johnson	Articling Student

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LIST OF UNDERTAKINGS, REFUSALS, & UNDER ADVISEMENTS

Undertakings (U/T) found at pages:
6

Refusals (REF) found at pages:
NONE

Under Advisements (U/A) found at pages:
NONE

LIST OF EXHIBITS

NO.	DESCRIPTION	PAGE
A	"Canadian Medical Education Journal" article titled "What knowledge is needed? Teaching undergraduate medical students to 'go upstream' and advocate on social determinants of health"	10
B	Screen captures of tweets from the account @Hayman_Kate	12
C	"Antecedents of Physical and Sexual Victimization Among Homeless Women: A Comparison to Homeless Men," from the "American Journal of Community Psychology"	30
D	Study entitled "Understanding Encampments of People Experiencing Homelessness and Community Responses, Emerging Evidence as of Late 2018."	37

Zoom Videoconference

--- Upon commencing on Friday, August 16, 2024, at 10:04 a.m. EDT

AFFIRMED: DR. KATE HAYMAN

CROSS-EXAMINATION BY MS. SHORES:

1 **Q.** Good morning, Dr. Hayman. As I introduced off record, my name is Bevin Shores. My pronouns are she and her. I'm a lawyer for the respondent, the City of Hamilton, in this matter and we're here for a cross-examination on your affidavit sworn February 28, 2023.

Before we get into the cross-examination, I'd like to confirm: Where are you participating in this Zoom examination from?

A. I am currently in Toronto, Ontario, at my home.

2 **Q.** Okay. And are you alone in the room?

A. I am.

3 **Q.** All right. And if there are any interruptions or difficulties with your connection, please just let us know; okay?

A. Okay.

MR. CHOUDHRY: Counsel, if I could -- Ms. Shores, I've just also -- I've advised all

5

of our witnesses that they are allowed to have a paper copy of their affidavit and exhibits with them that they can reference.

In fact, Dr. Hayman, could you show that to Ms. Shores?

But she has no other notes; okay? So those are just her exhibits and affidavit.

MS. SHORES: All right. Thank you, Counsel.

4 **Q.** So Mr. Choudhry anticipated my next question. So you're to have no assistance in giving your answers, and if you are referring to any materials in giving your answers, just be aware that we need to state what you're referring to. It needs to be made an exhibit, and then we'll need to explain how it informs your evidence. Is that understood?

A. Yes, it is.

5 **Q.** All right. You've been affirmed to tell the truth today?

A. Yes.

6 **Q.** What do you understand your role is in this litigation?

A. So I understand that my role is to provide expert witness based on my

6

experience as an emergency physician where I treat many people experiencing houselessness.

7 **Q.** Now, I don't believe you've been qualified to give evidence as an expert witness in a court in Ontario yet; is that correct?

A. That is correct.

8 **Q.** And your affidavit sworn February 28, 2023, does not have a Rules of Civil Procedure Form 53 appended to it?

A. I would just defer to counsel for clarification on that point.

9 **Q.** Have you signed a Rules of Civil Procedure Form 53, Acknowledgement of Expert's Duty?

--- (Reporter interjection.)

--- (Off-the-record discussion.)

U/T MR. CHOUDHRY: Ms. Shores, I'm advised that Form 53s have been signed by the expert witnesses, and I apologize if those haven't been served on the City.

So what I can do is provide an undertaking to you to provide those forthwith, and my cocounsel is looking into that right now.

MS. SHORES: Noted.

7

10 **Q.** Dr. Hayman, at the time you wrote your report for -- I'm sorry. At the time that you swore your affidavit, what instructions had been provided to you with respect to your evidence in this proceeding?

A. So I was instructed to provide evidence based on my expertise as an emergency physician and an academic emergency physician who also does research in this area.

11 **Q.** And what specific issues or questions were you instructed to address?

A. I was instructed to provide evidence about my understanding about the health issues that people face when experiencing houselessness, particularly nuanced understanding about health issues related to unsheltered homelessness where people stay without a tent; in my clinical experience, some of the benefits, potentially, of staying in an encampment; and some of the reasons why people stay in encampments, such as access to shelter, or reasons why they choose to stay in encampment versus shelter based on clinical encounters that I've had.

12 **Q.** And any factual assumptions that your opinions are based on are set out in the

8

body of your affidavit?

A. That is correct.

13 **Q.** And any documents you relied on in forming your opinion -- I noted there are several footnotes and there's one report appended as an exhibit. Those are the documents that you relied on in forming your opinion?

A. That's correct.

14 **Q.** You didn't conduct any research of your own in the formation of your opinion?

A. No, I did not.

15 **Q.** I'd like to take you to your CV, which is appended as Exhibit A. I'm going to put that up on the screen. You can either refer to the version on the screen or the version in front of you.

Are you able to see that?

A. I am, yes.

16 **Q.** I'm going to take you to Section D of your CV, called "Publications," item number 4. You list a journal article, and you identify yourself as a principal author. And the title of the article is "Missing the target? Teaching undergraduate students to 'go upstream'

9

and advocate on social determinants of health."

You agree that's one of your publications?

A. I do.

17 **Q.** You were the principal author of that article?

A. That's correct.

18 **Q.** Now, I have obtained what I believe is a copy of the article, and I've placed it on the screen here.

Do you recognize this document?

A. I do.

19 **Q.** Okay. And you'll agree with me that it is the "Canadian Medical Education Journal" article titled "What knowledge is needed? Teaching undergraduate medical students to 'go upstream' and advocate on social determinants of health"?

A. Yes.

20 **Q.** Okay. So this is the article referenced at item 4 under "Publications" on your CV?

A. Yes.

MS. SHORES: Okay. Let's just mark this for identification as Exhibit A, please.

10

EXHIBIT NO. A: "Canadian Medical Education Journal" article titled "What knowledge is needed? Teaching undergraduate medical students to 'go upstream' and advocate on social determinants of health"

MS. SHORES:

21 **Q.** Now, if I can take you, Dr. Hayman, to page 2 of the document, but I think the first part of the body of the article, under the heading "Background," it's written here:

"Upon completion of training, Canadians expect our physicians to respond to community needs and advocate for change both within and beyond the immediate clinical environment." (As read.)

You agree that's -- you agree with that statement?

A. Yes, I do.

22 **Q.** That's a statement in the journal article that you wrote?

A. That is correct.

23 **Q.** And, again, at page number of the article e60, under the subheading

11

"Discussion," the third paragraph, it's stated, and I quote again:

"Canadian medical students should graduate capable of communicating with the public and stakeholders -- for example, through op-eds and deputations -- and capable of identifying appropriate stakeholders at varied levels of government." (As read.)

Do you agree with that statement?

A. I do.

24 **Q.** And that's a statement in the article that you wrote?

A. That is correct.

25 **Q.** You're a member of the group Health Providers Against Poverty?

A. I am not currently an active member of that group. I have been a member of that group in the past.

26 **Q.** When did you cease your involvement, or your active involvement with that group?

A. I would have to look back on personal records to clarify, but I have not

12

attended any meetings in the last two or more years.

27 **Q.** Now, I looked up that group and I understand, based on their website, they self-describe as a group of health providers working to eliminate poverty and reduce health inequities in Canada. You agree that's an accurate description of the group?

A. I do.

28 **Q.** You use the social media platform named X, formerly Twitter?

A. I do.

29 **Q.** Your handle is @Hayman_Kate?

A. That's correct.

30 **Q.** Now, I'm going to place up on the screen some screen captures of tweets made by the account @Hayman_Kate.

For the record, I'll identify this as not a complete list of all tweets by the account @Hayman_Kate. These are only a few that I'd like to draw your attention to, and I'm going to mark this for identification as Exhibit B.

EXHIBIT NO. B: Screen captures of tweets from the account @Hayman_Kate

13

MS. SHORES:

31 **Q.** So let's identify these. The first one at the very top -- are you able to read what's on the screen?

A. Yeah. So this is a tweet from August of 2020 that says:

"Join me in a national campaign to end homelessness in Canada, once and for all."

32 **Q.** And there's a website address, RecoveryForAll.ca?

A. That's correct.

33 **Q.** And I looked it up. Recovery for All is an initiative by the Canadian Alliance to End Homelessness?

A. That sounds correct. I would have to look back at the tweet to confirm exactly. It was three years ago.

34 **Q.** That's fair.

You wrote that tweet?

A. I did.

35 **Q.** And you wrote that to encourage people to take action to end homelessness?

A. That is correct.

36 **Q.** The next capture of a tweet is

14

dated March 30, 2021, and it states:

"As a doctor and neighbour, I am very distressed about upcoming encampment evictions. Evictions are not about protecting health." (As read.)

And then there's three bullet points beneath it:

"The weather is getting warmer, i.e. safer; COVID outbreaks in shelters are very bad; forced relocation is harmful to mental and physical well-being." (As read.)

And then there's a graphic underneath that reads:

"I support my neighbours in tents. No encampment evictions."

You wrote that tweet?

A. I did.

37 **Q.** And you included that graphic?

A. I did.

38 **Q.** And you wrote that to encourage people to take action to end homelessness? Or, I'm sorry, you wrote that to encourage people to oppose encampment evictions?

A. I wrote that to share my perspective as a physician about the ongoing

15

encampment evictions in my neighbourhood.

39 **Q.** And to share your viewpoint that you oppose encampment evictions?

A. That is correct.

40 **Q.** There's another tweet dated May 27, 2021, which reads:

"In the past year, I've spoken with hundreds of people experiencing homelessness, and the vast majority express a strong preference for hotel settings. Toronto, I hope we can do better and ensure that people are offered housing rather than a return to congregate settings." (As read.)

And that's in response to a tweet by someone named Kelly Doran, according to her Twitter name, stating:

"NYC planning moves of people experiencing homelessness from hotels back to congregate shelters." (As read.)

So I understand you did not write the tweet with the name Kelly Doran, but the previous statement, you wrote that?

16

A. That is correct.

41 **Q.** Okay. And you wrote that to encourage people, Torontonians in particular, to support hotels for people experiencing homelessness as opposed to shelters?

A. I wrote that tweet to share my expertise. At that time, I was providing care to many people who were transitioning between situations in my role as the medical director of a COVID recovery and isolation site, and I wanted to share that perspective and bring to light that some of these hotel shelters were closing and people were being returned to congregate settings.

42 **Q.** Okay. And the final tweet that I'll take you to is one dated June 26, 2023, and it reads:

"Toronto, get out and vote --" with three exclamation points. "As an emergency doctor who sees many people experiencing homelessness, I voted for @OliviaChow. She is the candidate most likely to improve access to housing and emergency shelter. I want to work and live in a city

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where everyone is safe and housed."
(As read.)
And underneath, there's a picture. It appears to be you with a baby. So is that you?
A. That is me.
43 Q. And you wrote that tweet?
A. I did write that tweet.
44 Q. Okay. And you wrote that to encourage people to vote for a candidate who you believe is most likely to improve access to housing and emergency shelter?
A. That's correct.
45 Q. Okay. So you'd agree you're an advocate for people experiencing homelessness?
A. Yes, I would agree.
46 Q. And your involvement in this case is part of that work advocating for people experiencing homelessness?
A. Yes. I am involved in this case because I think the housing situation is important, and I think that I have something to offer in terms of my clinical expertise in this area as well.
47 Q. I'm going to return to your CV, going back to the first page. So again for

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the record, we're now at Exhibit A to your affidavit, not Exhibit A to this examination.
Your primary office is at University Health Network in Toronto?
A. That's correct.
48 Q. You're an emergency medicine physician?
A. That's correct.
49 Q. You don't practise in Hamilton?
A. That is correct.
50 Q. And unless I misread your CV, I don't believe you've ever practised in Hamilton?
A. That's correct.
51 Q. I'll take you now to your affidavit. I'll start with paragraph 5. You've written:
"I have been providing health care to the unhoused and/or precariously housed persons for 12 years. I have been working with the unhoused, precariously housed persons for 12 years. This has been a primary focus of my clinical and academic practice since 2013."

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(As read.)
I'm going to ask you some general questions informed by that experience.
Do you agree that some needs are higher priority than others? So, for example, I'm going to give you a complete hypothetical. Someone who can't breathe and who also hasn't eaten in 24 hours, their need for air would take precedence over their need for food. Do you agree?
A. Yeah. I believe you're referring, sort of in general, to the concept of triage in emergency medicine, and I do agree with the principle of triaging needs.
52 Q. Okay. I wasn't going to use the word "triage" because I was a little concerned I'd use it improperly. You're the expert, not me.
Okay. So I'll put a couple of other examples to you. So if that same patient who couldn't breathe, hadn't eaten in 24 hours was also feeling socially isolated, once you got them breathing again, their need for food would be the first thing to address, in priority to their feelings of social isolation?
A. So I would have a challenging

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time answering that question without seeing the patient in front of me and understanding a lot of the nuance of their situation in terms of, you know, once I've addressed the emergent threat to their life and they can become a participant actively in the decision-making and in the conversation, their perspective on what is the most important thing to them right now also becomes tremendously valuable.
So it would be hard for me as a physician to really determine what is most critical to them once the emergency threat to life has been addressed. I hope that makes sense.
53 Q. That does. Thank you.
And let's zero in a little bit further. And, again, we're speaking entirely hypothetically, and I realize there are limits to that.
If someone presents who doesn't have shelter, you'd agree that the need to provide them with shelter will take precedence over other needs that aren't as high priority?
A. Again, a lot of that decision-making really has to do with the conversation with the patient to determine what is

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their most urgent need in this moment, and many of the patients who I see have multiple, significant pressing needs that are simultaneous, and they are consistently trying to rebalance that prioritization.

I understand my job as a physician to share my medical expertise with them and to jointly make decisions about what is best for their health, based in large part on their understanding of what is best for their health.

54 **Q.** And so the need for shelter may change depending on the circumstances -- or, I'm sorry, the relative need for shelter may change depending on the circumstances of the individual or even the surrounding circumstances; right?

A. Yeah. I would say that's correct.

55 **Q.** Okay. So, for example, if it's very nice out, if it's very mild, it's not precipitating, it might be more important to attend to one of their other competing needs?

A. It may be. It would also depend on the experiences of that person and how they're prioritizing the competing needs in their

22

life at that time.

56 **Q.** Okay. And, certainly, people don't need to have a roof over their heads every single minute of every single day in order to have their survival needs met?

A. For most people, that would be true. It would depend on the health needs, again, of that individual. For example, if they had multiple disabilities, if they were on antibiotics that potentially could cause harm with significant sun exposure, there would be specific, unique clinical circumstances to each individual that would help determine how critical their need for shelter was in that moment.

57 **Q.** I'm going to take you to paragraph 7, subparagraph (c) of your affidavit, and you've written here:

"Patients report that staying in a congregate shelter setting can also be challenging to their substance use choices, as they have no control over the people who are staying around them." (As read.)

And then you go on to note parenthetically:

"In contrast to an encampment-style

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setting, where residents can choose their community members." (As read.)

You made that statement?

A. I did.

58 **Q.** And you'd agree with me that encampment residents can't entirely control their community members; right?

A. I would agree that it depends on the circumstances and the situation in an encampment. I have met people who have stayed in encampments that are relatively small communities where they may have a larger degree of control over their community members than in a congregate shelter or another shelter setting where the operator of the shelter is the primary decision-maker in who stays in that facility.

59 **Q.** And, certainly, there are circumstances where someone might be living encamped and someone comes up that they don't want to be around, and their choices are just to deal with it or move?

A. I think that that is possible. I can't speak to that circumstance in my expertise as an emergency physician necessarily, though.

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60 **Q.** Okay. Staying with paragraph 7(c), going to the second sentence, you also note:

"For people seeking abstinence or reduced use of drugs, shelters can pose risk of relapse or increased substance use." (As read.)

So if I understand correctly, you're flagging that shelters are bad for people trying to maintain sobriety because they'll be around drug use?

A. So shelters, as I believe I have outlined elsewhere in my affidavit, have a wide-ranging tolerance to harm reduction principles and to drug use in this space. In Toronto, where I practise, when people are matched to a shelter, they typically have no choice. So when they get a bed, they get a bed at that shelter.

It may be a shelter that has relatively little drug use, or it may be a shelter where there is a lot of active drug use. If someone has chosen to abstain from drugs and they're matched to a shelter option where there is a high amount of drug use and there is a very harm-reduction-positive philosophy, they have told me that they feel that threatens their sobriety.

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61 **Q.** Okay. And to be clear, you don't have any practice experience with the shelters in the city of Hamilton?

A. I do not have practice experience with the shelters in the city of Hamilton. However, I think many of these themes that patients have expressed to me are likely similar in Toronto.

For example, I trained in London and in other parts of the Greater Toronto and Hamilton Area. I don't anticipate that some of these issues that clients have expressed would be markedly different between Toronto and Hamilton.

62 **Q.** In the last sentence of subparagraph 7(c), it's written here:

"Patients have also reported that they use stimulants to mitigate safety risks when in shelters or when sleeping unsheltered outside, since it is safer to be awake in the nighttime." (As read.)

You'd agree with me that there are also safety risks when sleeping in a tent?

A. There may be safety risks when sleeping in a tent.

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Patients have described to me that they feel safer sleeping in a tent than they do sleeping, for example, in an alleyway in the dark, where I have had women tell me they feel absolutely unsafe and use stimulants to ensure that they are not left sleeping in an alleyway after dark where they feel at risk of sexual assault, for example, and I have had patients tell me that sleeping in a tent, in their opinion, helps to mitigate those risks.

63 **Q.** Okay. I want to talk a little bit more about your understanding of safety risks, or your opinion on safety risks. You'd agree with me that a tent won't do much to prevent someone with bad intentions from accessing the person inside?

A. I don't think I can opine on that. Access to a tent -- I think there are many circumstances that could change access or not. I would say I think the visibility in a tent is quite different than visibility in an alleyway, for example.

64 **Q.** You'd agree with me that when it's cold outside, hypothermia and frostbite are still a risk for a person in a tent?

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A. So in my expertise as an emergency physician, one of the critical factors in hypothermia is wet weather. So many people -- I have seen someone previously who died from hypothermia when it was approximately 10 degrees outside and raining.

What a tent does is it protects people from getting wet, when it's a functional tent. So it may not prevent hypothermia in extremes of temperature, but it can help to mitigate that risk significantly and critically by providing protection from wind and from rain, which increase the rate of a body cooling.

65 **Q.** And you referenced extremes of temperature. Those temperature extremes would also pose a risk of frostbite, potentially, to a person, notwithstanding that they're in a tent?

A. That is possible. I have not personally treated anyone who sustained frostbite injuries while staying in a tent in my practice as an emergency physician.

66 **Q.** You agree that thefts can happen in encampments?

A. That deaths can happen?

67 **Q.** Theft.

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A. Theft.

I -- it's not something that patients have reported to me. I would agree that hypothetically that could occur, yes.

68 **Q.** People can bring weapons into encampments?

A. Again, that is not in my expertise as an emergency physician.

69 **Q.** People exhibiting violent behaviour can go to encampments?

A. I -- again, people's behaviour, it's not -- I don't police encampments. So I can't comment specifically on that or not.

70 **Q.** Okay. So you don't know?

A. It's not in my clinical expertise.

71 **Q.** People can bring drugs into encampments?

A. Yes.

72 **Q.** People consume drugs in encampments?

A. Yes.

73 **Q.** Discarded drug paraphernalia can be left in encampments?

A. I have not personally

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witnessed that, nor have I heard reports of that in the area where I live and work. Theoretically, that could be possible, but it is not something that I have any firsthand experience of.

74 **Q.** And I take it you have no knowledge of the frequency of discarded drug paraphernalia surrounding encampments in the city of Hamilton?

A. I do not.

75 **Q.** Paragraph 10 of your affidavit, I'll next refer you to. The last sentence, you state:

"Overall, houseless women are also at higher risk for sexual and physical assault than houseless men." (As read.)

And there's Footnote 4. Footnote 4 corresponds to the study titled "Antecedents of Physical and Sexual Victimization Among Homeless Women: A Comparison to Homeless Men," authored by Wenzel, Koegel and Gelberg in the "American Journal of Community Psychology." That's a source you cite for that statement?

A. That's correct.

76 **Q.** I'm going to go next to that

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study. I'm placing it up on the screen. So I've pulled what I believe is the study you're referring to.

This is a document called "Antecedents of Physical and Sexual Victimization Among Homeless Women: A Comparison to Homeless Men," published in the "American Journal of Community Psychology," Volume 28, Number 3, from the year 2000. Is that the study you were citing?

A. I believe so, although in full transparency I wrote this affidavit more than 18 months ago. So I don't recognize it from sight, but it --

77 **Q.** That's fair enough. I'm going to take you to some particular paragraphs, and if that jogs your memory, let me know.

So let's mark this for identification as Exhibit C.

EXHIBIT NO. C: "Antecedents of Physical and Sexual Victimization Among Homeless Women: A Comparison to Homeless Men," from the "American Journal of Community Psychology"

MS. SHORES:

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78 **Q.** I'm going to direct you to -- I believe it's journal page 379. At the very bottom under the heading title "Discussion," the authors of this study write:

"Descriptive analyses do not support previous findings that homeless women experience higher rates of victimization than homeless men --"

and then it continues two pages down

"-- e.g., Geissler et al., 1995; however, more homeless women than men in this study experienced sexual violence." (As read.)

Now -- oh, I'm sorry. They continue on. I should read the rest of the paragraph:

"In interpreting these findings, it is important to note that, unlike other studies that found higher rates of violence among homeless women than men, we utilized a very recent prevalence of victimization. A more expansive time window and thus a greater representation of experiences may have yielded a

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different picture." (As read.)

So the authors have qualified this statement, but you'll agree with me that they're identifying that their descriptive analyses in the study did not support previous findings that homeless women experience higher rates of victimization than homeless men, other than sexual violence; right?

A. I would have to go back and read the paper in more detail to definitively confirm that. But from what you've shown, that -- that seems to be an accurate understanding of the text that you've shown.

79 **Q.** Okay. And you'll also agree that this study, if you remember, does not distinguish the risk of victimization as between women who live in encampments versus some other form of shelter, be it temporary or no shelter?

A. I would have to review the paper in more detail to see if the authors differentiated on that point.

80 **Q.** Okay. Well, to tie it back to the statement in paragraph 10 of your affidavit, you certainly weren't relying on this study to make a proposition that sexual or physical assault risk for women changes based on whether they're in

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an encampment or not?

A. I was not relying on that paper to make a statement about whether they are in an encampment or not. That is correct.

81 Q. At paragraph 13 of your affidavit under the heading "MARCO Encampment Evaluation," you write:

"I endorse the MARCO study attached as Exhibit B."

I'm going to take you to that MARCO report. So going to Exhibit B of your affidavit -- and, again, for the record, this is Exhibit B to the Affidavit of Kate Hayman, not Exhibit B to this examination.

The document is entitled "MARCO Brief Report, Encampment Outreach Evaluation, November 2021." Do you recognize that?

A. I do.

82 Q. Okay. So going to the very first page past the title, under the heading "About the MARCO Study" at the top, it states:

"The MARCO project is evaluating how local efforts responding to the COVID-19 pandemic serve people experiencing marginalization and

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how these interventions can be improved." (As read.)

So you agree that this study was performed in the context of the COVID-19 pandemic?

A. That is correct.

83 Q. And under the heading a little further down, the heading titled "About This Report," the authors write:

"This report is a brief summary of one of the MARCO evaluations. This report highlights the key findings of the encampment outreach evaluation. The final, full-length report will be released in December 2021." (As read.)

The final, full-length report isn't discussed in your opinion; correct?

A. It is not discussed, no.

84 Q. Okay. You were not a participant in the preparation of the MARCO study; correct?

A. I was a participant in the preparation of the MARCO study specifically on the COVID-19 isolation and recovery sites and the substance-use services. I was not a participant

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in this component of the MARCO study on encampments.

85 Q. Now, I'll take you to page 3 of the MARCO brief report. At the bottom of the first column, the authors write:

"Our evaluation included several steps:

"1. We met with key community members and groups to plan the study.

"2. We conducted 127 surveys and 23 interviews with encampment residents at six encampments in Toronto between March and June 2021.

"3. We looked for patterns from the surveys and common themes in the interviews." (As read.)

So this study, from what the authors say, is a summary of surveys that report the self-reported experiences and preferences of unhoused people?

A. As well as the people who were supporting them, yes.

86 Q. Okay. Well, I do want to take you to the next paragraph, then, because the

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authors write:

"We also conducted 16 interviews with encampment outreach workers and volunteers. We will share findings from these interviews in a future report." (As read.)

So I take it from that statement that those findings actually aren't included in this brief summary; correct?

A. That is my understanding.

87 Q. So just on the topic of the experiences of people living in encampments, I want to refer you to another source that you've cited, in fairness to you, elsewhere in your affidavit.

So in your affidavit at Footnote 11, which is a footnote to paragraph 16, you cite the United States Department of Housing and Urban Development, "Understanding Encampments of People Experiencing Homelessness and Community Responses, Emerging Evidence as of Late 2018."

I'm going to take you to that study. So I place this up on the screen here, a document titled "Understanding Encampments of People Experiencing Homelessness and Community

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Responses, Emerging Evidence as of Late 2018." You'll agree that's the study cited in your affidavit?

A. To the best of my recollection, yes.

MS. SHORES: Okay. I'm going to mark that as Exhibit D for identification to your examination.

EXHIBIT NO. D: Study entitled "Understanding Encampments of People Experiencing Homelessness and Community Responses, Emerging Evidence as of Late 2018."

MS. SHORES:

88 **Q.** Now, I'm going to take you to page, I believe, 19 of the report. So page 19, and, just to orient you, the passage I'll direct you to is under a heading that begins on the preceding page called "Challenges to Collecting Data on People in Encampments." The last paragraph under that heading states:

"Data collection efforts are also hampered by the transient nature of people experiencing unsheltered homelessness and the limited

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capacity of outreach teams to comprehensively canvass the less visible and less accessible geographies within their communities. Intensive and time-consuming outreach and follow-up efforts are required to collect information about encampment residents over time. Mental illness and substance use can also complicate data collection because the responses of affected individuals to questions may be unreliable." (As read.)

Do you agree that that's a limitation on survey data?

A. Sorry, what specifically are you referring to? That mental illness and substance use can complicate data collection?

89 **Q.** Yes.

A. So I would -- I would state that, generally, in my experience as an evaluator, people tend to respond to survey data during a period of the day when they are awake, and not intoxicated, enough to engage with the researcher.

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I would agree with the general limitations that they have outlined here in terms of some of the difficulties about doing research with people experiencing unsheltered houselessness and also stay in encampments.

90 **Q.** And that potential challenge to the reliability of the data collection isn't referenced in the MARCO brief report; correct?

A. That is correct. I would say the MARCO brief report really sought to understand, I believe as you said, the experiences of -- firsthand experiences of people who were staying in encampments.

And, again in my understanding, in terms of methodology, people tend to engage with this work during periods of relative sobriety, not during periods of intoxication or when they would be highly unreliable.

91 **Q.** So let's just talk briefly about some of the results of the surveys conducted in preparation of this MARCO brief report. I'm directing you to page 5 of the report. The second -- I'm sorry, the second full bullet point down, it reads:

"75 percent of people who accepted

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an offer of shelter or housing returned to live in an encampment. The most common reasons they left the shelter or housing were:

"29 percent were kicked out;

"16 percent did not like the restrictions, such as no pets, no guests, or a limit on the belongings they could bring;

"11 percent felt the shelter or housing was too far away from where they wanted to be;

"11 percent were worried about violence;

"Some reported more than one reason." (As read.)

This brief report doesn't indicate the particular questions the participants were asked; correct?

A. That's correct.

92 **Q.** Okay. And if we look at the bullet point "29 percent were kicked out," there's no indication that the authors of this study made any efforts to validate the accuracy of these claims, that they were, in fact, kicked out of shelter; correct?

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A. That is correct. I would like to differentiate, though. If someone understands that they've been service-restricted from a shelter, the details of that service restriction, in my experience caring for them in the emergency department, are often not as relevant.

If someone understands that they cannot return to a shelter, whether that is, in fact, the shelter policy or the person's understanding, in my experience, they tend not to return to that shelter.

So I think the individual's understanding about if they've been kicked out or the terms of their service restriction, in my experience, is more influential to their behaviour than sometimes what those specific details may be.

And I say that as an emergency physician who has often called shelters to try to understand the specific details when I'm trying to understand if someone can return or not. So I think the person's firsthand understanding of the situation may be more relevant to the specific -- on the shelter end in their decision-making about where they can stay.

93 **Q.** I'm going to take you back to

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paragraph 16 of your affidavit. So paragraph 16, on page 10, reads at the very beginning:

> "When people are in crisis, decisions about where to stay are pragmatic choices among best available options, based on circumstances at that time. Encampments represent a lack of other desirable options for housing and shelter and have several distinct advantages," colon. (As read.)

And then you go on to list things in a number of paragraphs. But for that passage that I just read, there's a footnote, again, Footnote 11, being the "Understanding Encampments" study that we previously identified as Exhibit D. So that's the source that you're citing for that statement?

A. That source would have informed a component of that statement, and some of that statement is also based on my expert opinion in talking to patients in terms of how they make pragmatic choices.

94 **Q.** Okay. So let's be really clear about that. So Footnote 11 refers to, it

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says at the very end, "at 4." That's page 4 of the "Understanding Encampments" study?

A. I would have to go back and refer to it again.

95 **Q.** Okay. Let's go to page 4. So, again, we're at page 4 of Exhibit D to this examination, and if we read the first paragraph under the heading "Explanations for the Increase in Encampments," the second sentence:

> "According to a key informant who is helping communities understand how to deal with encampments, when people are in crisis, their decisions about where to stay represent pragmatic choices among the best available alternatives, based on individual circumstances at a particular moment in time. Encampments form in response to the absence of other, desirable options for shelter." (As read.)

So if we go back to your statement, what the study at Exhibit D doesn't say is that encampments offer several distinct advantages. You'd agree?

A. Again, I would have to go

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back -- I would have to go back to reference the study.

96 **Q.** Okay. All right. Well, let's do that. Let's take a little bit more time to go into that study. So I'm going to return to paragraph 4 again of Exhibits D. This is the "Understanding Encampments" study. In the second paragraph under "Explanations for the Increase in Encampments," the authors write:

> "Within this underlying context, several related factors seem to influence whether people experiencing homelessness form or go to encampments rather than stay in shelters or on their own in unsheltered locations. Primary among those factors are (1) shortcomings in the shelter system, (2) a sense of safety and community within encampments, and (3) a desire for autonomy and privacy." (As read.)

So this is summarizing, you'll agree, factors that seem to influence whether people experiencing homelessness form or go to encampments rather than

stay in shelters or unsheltered locations; correct?

A. That is summarizing some of the factors.

97 **Q.** Okay. But to put a finer point on it, the authors of the study aren't offering a conclusion that encampments are better than shelter or unsheltered locations for those reasons?

A. No, they are not concluding that encampments are necessarily better for all people for those reasons.

98 **Q.** I'm going to take you back to your affidavit, paragraph 16, and some of the distinct advantages that are identified at paragraph 16. Subparagraph (a), you reference couples or survival partners.

You'd agree with me that if there's abuse between a couple, separating them might actually aid the person experiencing the abuse to get help?

A. So what I'm describing are the best available options that people are making when in crisis. So when I'm referring to couples or survival partners remaining together, I'm

referring to couples who are choosing to remain together.

And just to elaborate on that, if I can go to my affidavit, these are people with past experiences of trauma, including traumatic childhood separations from parents and/or siblings where involuntary separation can be very harmful to mental health. I am not referring in this paragraph in any way to people who are fleeing an abusive relationship.

These are people who are choosing to remain with their partner out of a volitional choice that they've made, which is a very different circumstance and is often a circumstance that cannot be accommodated in a shelter system where I work.

99 **Q.** You'd agree that in an abusive relationship, "volitional choice" is certainly a loaded term, and what someone may feel is an option to them in the circumstances may not represent the full expression of their volition?

A. As an emergency physician, I can support someone in making the best available choice, including, in the Canadian context, in an abusive relationship. But what I'm referring to

here are the tremendous benefits that someone has when they stay with an intimate partner or a partner by choice.

I've referred to a survival partner. So, for example, that may be someone who stays with them to ensure that they don't die of a drug overdose or stays with them to provide some degree of safety and security from other people in the context where they're living.

That's critically important to someone's well-being, and it is not my position, legally or medically, to separate someone from their survival partner if that is the decision that they make.

100 **Q.** And with respect to specifically acting as prevention for someone overdosing and fulfilling that role as a survival partner, you'd agree that that can also be done by someone with harm reduction training if they're present; correct?

A. That's correct. But I have no experience in the shelter system, in any location, including in a highly medicalized location of the recovery and isolation site, where a harm reduction worker could be present 24 hours a day,

seven days a week to support someone in reducing the risk of overdose.

That is possible when a coupled relationship or when two survival partners can remain together, or very near possible. The degree of support and supervision for overdose prevention that can be obtainable from a community member or partner as opposed to a harm reduction worker is fundamentally different.

101 **Q.** And you don't have any knowledge of the availability of trained harm reduction workers at the shelters in the city of Hamilton?

A. In the city of Hamilton, I do not. But it would be -- it would be very, very surprising to me, based on my in-depth knowledge of the shelters in Toronto, if there was a facility where harm reduction workers were available to supervise someone 24 hours a day, seven days a week with the same degree of supervision that is available from a couple or a survival partner.

102 **Q.** At subparagraph (b) at 16, you state:

"People can remain with their pet,

rather than being forced to leave the animal with animal services to obtain shelter." (As read.)

Now, just on the topic of pets, you'd agree that pets, as opposed to service animals, they don't have any sort of specialized training; correct?

A. That is correct.

103 **Q.** It's even possible that pets can be aggressive?

A. That is correct.

104 **Q.** And it's possible that someone could bring an aggressive pet into an encampment?

A. That is correct.

105 **Q.** And there's nothing stopping an aggressive animal from harming another person or another animal in an encampment?

A. That is correct, although I would say aggression, in my understanding, tends to be situationally related, and many people I have met who are experiencing homelessness who have an animal that can at times demonstrate aggression often does that to protect the person that it is accompanying.

106 **Q.** Now, you'd also agree with me that if a person or their pet or their service

animal was attacked by an aggressive animal, that would be traumatizing to that person?

A. That's possible, yes.

107 **Q.** Now, at subparagraph (c) of paragraph 16, second sentence, you state:

"As identified in the MARCO study, being 'kicked out' -- service-restricted/evicted -- from shelter is common." (As read.)

And then you go on to state:

"People who have experienced trauma, have mental health diagnoses, and use drugs may exhibit behaviours that, despite being secondary to illness and not harmful to co-residents, are not tolerated by shelter staff, leading to frequent service restrictions." (As read.)

Certainly, your evidence is not that the only reason for service restriction is behaviours that are not harmful to co-residents?

A. That is correct. That is not the only reason, but I can give you one example. Someone may respond to a lot of stimuli by yelling

very loudly. Very loud yelling is not necessarily causing physical harm to the people around them but may be intolerable in a shelter situation.

That is a common reason that I've seen for conflict resulting between shelter staff and the client, and people have been evicted for reasons such as yelling, swearing, talking in a loud voice, which is not causing physical harm to the other people in the situation.

108 **Q.** You'd agree with me that yelling and talking in a loud voice might be disturbing to other people trying to rest in a shelter; correct?

A. It could be, depending on the physical layout of the space.

109 **Q.** And you don't have any knowledge that, in the city of Hamilton, an immediate service restriction -- in other words, meaning someone is kicked out of the shelter -- results from one occasion of raising their voice, swearing or yelling?

A. I do not have knowledge of that happening specifically in Hamilton. However, I do not have any reason to believe that the behaviours of the shelter staff and the behaviours

of the shelter residents would be markedly different in the Toronto context than in the Hamilton context.

And I do have extensive experience meeting people who have been kicked out of shelter, particularly late at night, for what they report as behavioural concerns such as yelling.

110 **Q.** But, again, you don't have any experience with City of Hamilton shelters. You're drawing a conclusion based on your experience in the city of Toronto?

A. I do not work in the city of Hamilton. I do not have direct experience with the City of Hamilton shelters. That is correct.

111 **Q.** And you haven't reviewed any policies for City of Hamilton shelters with respect to service restrictions and when and how they may be imposed?

A. That's correct. I have not.

112 **Q.** Bear with me one moment.

At paragraph 16(f) of your affidavit, you state:

"Persons with a history of trauma or abuse may be triggered by a congregate setting of strangers."

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(As read.)
But you'd agree that encampments may also involve contact with strangers?
A. They may. But, again, people in encampments may have control over how many people are in the environment based on how big the encampment is, and there is a different level of control over who is staying in the immediate vicinity around you, compared within a shelter setting where the people controlling where people are sleeping and who can come into and out of the building is in the control of the shelter staff rather than the residents in that community.
113 **Q.** You'd agree that it's possible that someone could potentially encounter someone who has caused their trauma in the past if they're in an encampment?
A. That is possible. It is also possible in a shelter setting.
114 **Q.** At paragraph 17, you state at the second sentence:
"It's extremely common to find that there are no available shelter beds in the city."
I just want to be clear. The city you're referring to is the city of Toronto?

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A. That is correct.
115 **Q.** Not Hamilton?
A. That's correct. I don't call a central intake or call shelters of Hamilton. So I cannot speak to that point.
116 **Q.** And further down in that paragraph -- let me find my spot. About halfway down -- I'll highlight it on the screen here, just so you can see the sentence I'm referring to:
"When patients leave the emergency department for informal shelter, without a clear idea of where they will be going, it is often impossible to organize follow-up plans." (As read.)
I ask you, though: Is it not possible to refer them to some sort of outpatient care or community health provider that they can attend?
A. So, in my experience, it can often be very hard for someone who doesn't have a regular place where they stay, be it an encampment or a shelter or a home, to attend a community clinic. Part of the reason for that is they may end up in a part of town that is quite far from that clinic.

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If they don't have access to charge a device, or they don't have a device, it can be very hard to keep track of time sometimes, and it can be hard to attend a regularly scheduled appointment if you are engaged, for example, in active substance use or if you have significant mental health challenges, which many people in this population do.
In my experience, it is often more helpful to connect people with drop-in care or care where, for example, a street outreach team comes to them at a time that is often more convenient to them than a lot of what happens in our medical system, where appointments may be very early in the morning, they often involve a lot of waiting, may be at a location that is not possible, may involve transportation that is not possible.
Many of those limitations make it much preferable, for example, to have a street outreach team visit a patient, a client, in a known encampment location where we know they can be found, where the client feels safe, where they feel in control of the situation and they don't have to face a lot of the limitations of attending

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follow-up care in our health-care system.
117 **Q.** Thank you, Dr. Hayman.
I have no further questions for you, other than just confirming: You understood all of my questions today?
A. I have.
MS. SHORES: Thank you.
MR. CHOUDHRY: Ms. Shores, I'm going to propose that, since I'm with my cocounsel, we'd like to confer before we decide the scope of redirect. So I propose that we take a bit of a break.
Dr. Hayman, you're under oath and so you can't communicate with us, as you know, or with anyone else while you're still in this examination. Can you confirm you understand that?
THE WITNESS: I do.
MR. CHOUDHRY: Thank you very much.
So, Ms. Shores, if you could just give Ms. Crowe and I about ten minutes or so, just to confer?
MS. SHORES: Of course.
MR. CHOUDHRY: And, Dr. Hayman, you're free to use the washroom, to get a coffee, to do whatever you need to do, but just please

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don't be talking with anyone else. That's very important.

THE WITNESS: Noted. Thank you.

MR. CHOUDHRY: Ms. Shores, anything else before we let Dr. Hayman have a break?

MS. SHORES: No.

MR. CHOUDHRY: Okay, good. Thank you very much.

--- Recess taken at 10:59 a.m.

--- Upon resuming at 11:08 a.m.

REEXAMINATION BY MR. CHOUDHRY:

118 **Q.** Dr. Hayman, my name is Sujit Choudhry. It's nice to see you again. We just have a few questions on redirect, and it's about survey methods and the value of survey methods and survey-methods-based research in peer-reviewed medical research.

I know Ms. Shores asked you a number of questions about survey methods and their limitations. So I have a couple of brief follow-up questions. I know we're not engaged -- it's not a workshop on survey methods, but it's relevant, I think, and so I'd like to just ask you a couple of questions.

And, again, as with Ms. Shores, I

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can speak a bit quickly, I'm afraid. So if you want me to repeat a question or slow down, you should just tell me; okay?

A. Okay.

119 **Q.** So, Dr. Hayman, are you able to explain the use of patient surveys in contemporary medical research generally?

A. So I think the indications for patient surveys could be broad. But in general, asking a patient for their firsthand experience gives additional perspective on the patient's understanding of their health condition or their social situation, as well as their understanding of their mental and physical health.

Patient surveys often differ from other parts of the medical literature, which might be based on, for example, quantitative data about health statistics, in that they oftentimes, not always, seek to gather a more in-depth understanding of the person's lived experience.

120 **Q.** How widely used are they in contemporary medical research?

A. I would say very widely used in terms of papers that I read.

121 **Q.** Okay. So are they used just

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in research about the houseless, or are they used in other areas of medical research as well?

A. No, they're used broadly.

122 **Q.** Right. And so in your experience as an academic clinician, is their use in research about the houseless any different than their use in other areas of medical research?

MS. SHORES: Sorry, hang on one second. Counsel, how did you describe the expertise of Dr. Hayman?

MR. CHOUDHRY: She's an academic at -- she's a professor at the University of Toronto.

MS. SHORES: I'm going to note for the record that, again, because Dr. Hayman has not been admitted as an expert with any particular expertise, there may be some positions about the scope or effect of her next answer.

But go ahead and answer, Dr. Hayman. I'm not objecting. I'm just noting the position on the record.

THE WITNESS: I apologize. Could you repeat the question for me?

MR. CHOUDHRY:

123 **Q.** The question is, Dr. Hayman, based on your expertise, how do you compare the

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use of survey methods in the research that you've described in your affidavit around the houseless and medical research using certain methods with respect to other patient populations?

A. So in my understanding, many of the limitations and benefits of surveying this population is similar to the general population.

MR. CHOUDHRY: Okay. Thank you.

Those conclude my questions, Ms. Shores and Dr. Hayman. Thank you.

MS. SHORES: Off record.

--- Whereupon the proceedings adjourned at 11:12 a.m.

* * * * * * * *

This is to hereby certify that the foregoing is a true and accurate transcript of DR. KATE HAYMAN to the best of my skill and ability.



_____

Kristy Fulton

Court Reporter

NIMIGAN MIHAILOVICH REPORTING INC.

Ex # A mday 8/16/2024 Pg 1 of 5
Exam of Dr. Kate Hayman
Heegsma et al v City of Hamilton
Nimigan Mihailovich Reporting Inc.

Canadian Medical Education Journal 2020 11(1)

Canadian Medical Education Journal

Brief Report

What knowledge is needed? Teaching undergraduate medical students to "go upstream" and advocate on social determinants of health

Quelles sont les connaissances requises ? Enseigner aux étudiants de premier cycle en médecine à aller « en amont » et à se porter à la défense des déterminants sociaux de la santé

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Abstract

Background: We rarely teach medical students the skills required to engage in policy change to address the structural factors that underpin the social determinants of health, which are driven by the unequal distribution of power and resources in society. Acquiring the knowledge and skills to influence policy can empower students to *act on* healthcare inequities rather than simply be aware of them.

Methods: Using Metzl and Hansen's structural competency framework, we designed and piloted an intervention for medical students. Participants attended a workshop, presented to a hypothetical political stakeholder, and wrote an opinion editorial piece. Students participated in a focus group that was audio-recorded and transcribed. We coded and analyzed presentations, editorials, and transcripts to develop a thematic analysis.

Correspondence: Kate Hayman, email: khayman2010@gmail.com

Results: Nine students participated in the workshop. They chose structural interventions and presented potential solutions to structural barriers in written and oral outputs. Students identified a lack of knowledge about health and political systems as a potential barrier to future advocacy work.

Conclusion: Medical trainees require training in specific advocacy skills such as oral and written communication, however this alone may be insufficient. As future advocates, trainees must also acquire a specific skill set and associated knowledge about health systems and policy to navigate the systems in which they will practice.

Résumé

Contexte : Nous enseignons rarement aux étudiants en médecine les habiletés nécessaires pour participer aux changements de politique afin d'aborder les facteurs structurels sous-jacents aux déterminants sociaux de la santé, et la distribution inégale du pouvoir et des ressources dans la société. L'acquisition de connaissances et d'habiletés aptes à influencer les politiques peut encourager les étudiants à *s'engager* pour contrer les inégalités en matière de soins de santé plutôt que d'en être simplement conscients.

Méthodes : À l'aide du cadre de compétence structurelle de Metzl et Hansen, nous avons conçu et piloté une intervention pour les étudiants en médecine. Les participants ont assisté à un atelier présenté à un décideur politique simulé pour l'occasion, à la suite duquel il sont rédigé un article d'opinion. Les étudiants ont participé à un groupe de discussion qui a été enregistré et transcrite. Nous avons codifié et analysé les présentations, les articles d'opinion, et les transcriptions pour développer une analyse thématique.

Résultats : Neuf étudiants ont participé à l'atelier. Ils ont choisi des interventions structurelles et présenté des solutions potentielles aux obstacles structurels dans leurs épreuves écrites ou orales. Les étudiants ont indiqué que le manque de connaissances sur le système de santé et le système politique représente un obstacle potentiel au futur travail de défenseur.

Conclusion : Les stagiaires en médecine ont besoin de formation spécifique sur les habiletés de communication orale et écrite pour se porter à la défense des patients; cependant, cette formation à elle seule peut s'avérer insuffisante. En tant que futurs promoteur de la santé, les stagiaires doivent également acquérir des habiletés spécifiques et des connaissances associées aux systèmes et aux politiques de santé pour naviguer à travers les systèmes dans lequel ils exerceront leur pratique.

Background

Upon completion of training, Canadians expect our physicians to respond to community needs and advocate for change both within and beyond the immediate clinical environment.[1] Effective advocacy requires knowledge in addition to the traditional medical repertoire including skills that must be taught and practiced.[2] However, we rarely teach students the knowledge and skills necessary to engage in policy change that would improve the social determinants of health (SDOH) of patients.[3] When we teach the SDOH as content to be learned, rather than inequitable conditions to remediate, educators risk perpetuating the inequities they may seek to change.[3] Acquiring the knowledge and skills to advocate and influence policy might prepare students to *act on* healthcare inequities in an informed manner, rather than simply *to know* them.[4,5]

Prior studies have described curricular interventions designed to teach advocacy skills such as editorial writing[6] and writing letters to the editor.[7] However, researchers did not examine the content or the quality of the written pieces. Also, the topics that students chose (e.g. pool safety, choking hazards, vaccine refusal) suggested that their understanding of advocacy was focused on (individual) behavior change rather than addressing the structural determinants or resolving inequities.[7,8] Other efforts to teach advocacy, such as Political Action Days, teach students how to influence elected officials around concerns of the profession (e.g. medical student debt). These sometimes do not focus on addressing health inequities.[9]

Based on the current gaps in advocacy education—an identified basis of knowledge and skill, and a lack of attention to systemic and structural factors—we chose to develop an educational initiative based on

Metzl and Hansen's Structural Competency paradigm. This initiative includes five intersecting knowledge and skill-sets, including recognizing the structures that shape clinical interactions, developing an extra-clinical language of structure, rearticulating "cultural" formulations in structural terms, observing and imagining structural interventions, and developing structural humility.[10] This framework has been utilized by educators in pre-health curriculum,[11] pre-clinical education,[12] and as a checklist by clinical trainees.[13] Within this framework, we developed and piloted a brief curricular intervention to allow medical students to practice advocacy.

Methods

Our study protocol received approval from the University Health Network Research Ethics Board (17-5068). Our goal was to recruit a convenience sample of second year (pre-clinical) medical students at the University of Toronto (Toronto, Canada) to participate. We obtained written consent from each participant prior to participation in the study. Using Metzl and Hansen's structural competency framework, we designed and piloted a three-hour workshop designed to equip attendees with skills in advocacy and policy change.[10] The workshop utilized case-based learning, using the example of local advocacy by physicians to address precarious employment. We asked students to identify a topic and target for advocacy. Students received two assignments: to participate in a group deputation to a hypothetical policymaker about their topic, and individually to write an opinion editorial. After the workshop, we invited students and facilitators to participate in semi-structured focus groups and provide feedback on the experience of the workshop. We recorded all deputations and focus groups and transcribed them verbatim.

Our analysis focused on understanding how the intervention influenced students, exploring the outputs of the assignments using the lens of structural competency, and to identify opportunities for improvement. Two research assistants coded all transcripts of the deputations and focus groups, and the written assignments, using Microsoft Word (Version 16.22, Microsoft 2019). The five components of Metzl and Hansen's structural competency paradigm informed our initial coding framework.[14] Additional codes emerged as two research assistants analyzed the transcripts, and the entire study team identified key themes through consensus.[14]

Results

We recruited nine medical students to participate in the workshop on policy-level advocacy in October 2017. Eight students completed at least one of the assignments and five students completed both the assignments. Seven of the nine participating students had previous advocacy experience, and all participants identified as women. We will present our findings according to what students chose to do, how the elements of structural competency per Metzl and Hansen were demonstrated (or not) through their assignments, and the students' feedback on the educational experience.

What students chose to do

In groups, students performed deputations targeting varied stakeholders. Students required some guidance as to who precisely would be the best target, i.e. would actually have authority over the policy that needed to be changed. One group targeted a municipal Community Development and Recreation Committee seeking improved data collection for deaths among homeless persons. A second group targeted Members of Provincial Parliament seeking expansion of public health insurance to uninsured students. A third group targeted a committee of the federal government regarding national Pharmacare. Opinion-editorial topics included addressing homelessness, improving refugee health, the relationship between opioid misuse and poverty, and addressing domestic violence.

How structural competency manifested in students' work

Students produced outputs with appropriately referenced facts about the SDOH paired with narratives that emphasized the importance of the issue. For example, in an opinion editorial about the opioid crisis, the writer identified a higher minimum wage and access to subsidized post-secondary training as structural factors that might have helped prevent one patient's addiction to opiate medications. The students presented evidence with structural humility, for example, during a deputation a student stated: "*We are not experts in policy or*

public health, nor have we personally experienced homelessness, but as medical students, we have already observed how gaps in healthcare provision lead to bad outcomes for homeless individuals." Students were able to imagine how interventions could address structural causes of ill health and presented potential solutions to barriers that would be faced in both the written and oral outputs.

Students' feedback on the educational initiative

Students valued the aspects of the workshop that focused on building skills in oral and written communication. These aspects differentiated the intervention from existing curriculum. One student stated "*We're often just vaguely taught that advocacy is a CanMEDS role for example, so my expectation was how to actually […] develop that skill, which the session did a good job of doing."*

Learning the "logistics" of advocacy work, such as how to identify the right stakeholders to engage with and how to approach them, emerged as key to advocacy on SDOH. For example, a participant reflected that *"what could be improved was looking at the logistical sense of advocacy and being aware of the administrative steps."* Students lacked knowledge on how to depute and how to take an op-ed from an idea through to publication. After the exercise, one student stated: "*How do you even go to a deputation, where do you go, who do you get involved with…"* Another student reflected "*will I ever be able to do this, because I don't know where to start?"*

Discussion

In developing this intervention, we focused on applying a structural competency framework as a theory-based guide to advocacy education – one that could provide a foundation of both knowledge and skill – and selected assignments/assessments that could test whether students were able to transfer this knowledge and skill to a relevant structural advocacy situation. We asked students to produce an advocacy output (i.e. a deputation and an opinion-editorial) with some guidance about how to structure these outputs. Student did target structural advocacy as opposed to individual, so this shows some improvement upon prior interventions; students also demonstrated elements of structural competency, lending support to Metzl and Hansen's framework. However, students lacked some requisite knowledge and were left with a sense of still not knowing what to do.

Our study findings and limitations lead us to important discussion points about the underlying knowledge required as part of advocacy training. Most of our students had previous advocacy experience and already demonstrated an understanding of structural determinants of health; hence our findings may not be generalizable to all medical students. Our participants all identify as women and are at a similar early point in their training, which might also limit the generalizability of findings. We assumed that medical students had an understanding of the organization of the health system, including political, economic, and social structures that impact the social determinants of health. We also assumed that students would be able to identify the targets of advocacy, including government committees, policymakers, the public or community stakeholders. These assumptions related to underlying knowledge that would be required to engage most effectively with advocacy. Metzl and Hansen's framework provides a theory about advocacy, but a foundation of knowledge is required for specific acts of advocacy. Future work would need to identify such knowledge and – while perhaps unrealistic to teach all such knowledge within medical school – provide students with paths to acquire such knowledge before engaging in advocacy.

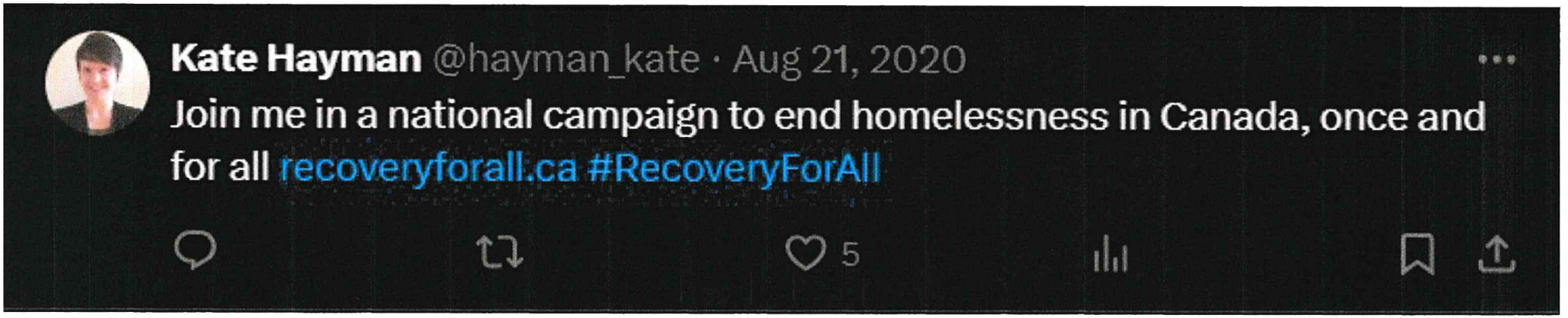
Canadian medical students should graduate capable of communicating with the public and stakeholders (for example, through op-eds and deputations), and capable of identifying appropriate stakeholders at varied levels of government.[1] However, the structures governing the health system and social determinants of health in Canada are complex and often confusing to health practitioners. In a study by Kuper et. al. on the non-bioscientific knowledge required for medical training, participants suggested that medical learners should be taught about public policy, policy change, and legislative process[15] Increased educational experiences that include skill-development in navigating and acting on the political and social structures affecting the social determinants of health would need to be integrated with requisite knowledge. For example, Lucey's proposed addition of social, economic and behavioural sciences as basic sciences required for the development of expertise.[16]

Conclusion

The next generation of physician advocates require knowledge from many disciplines, fields, and sources, including biomedical, social, personal, and practical. The Metzl and Hansen structural competency framework provides a useful guide for advocacy education focused on advocacy skills. However, given research that demonstrates the importance of basic knowledge in supporting ongoing learning and practice within dynamic systems, we suggest additional attention to the basic knowledge required to engage in specific advocacy efforts.[17] Advocacy skills training may be required to ensure that medical students can address structural factors perpetuating inequities. Nevertheless, skills training alone is likely insufficient for Canadian medical students to fully embody the role of physician-advocate. Instead, we should teach these practical skills in integration with relevant underlying knowledge about health systems, health policy, and the SDOH.

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Kate Hayman @hayman_kate · Aug 21, 2020

Join me in a national campaign to end homelessness in Canada, once and for all recoveryforall.ca #RecoveryForAll

5

Ex # B m/d/y 8/16/2024 Pg 1 of 4

Exam of Dr. Kate Hayman

Heegsma et al v City of Hamilton

Nimigan Mihailovich Reporting Inc.



Kate Hayman @hayman_kate · Mar 30, 2021

As a doctor & neighbour, I am very distressed about upcoming encampment evictions.

Evictions are NOT about protecting health:

- The weather is getting warmer (i.e. SAFER)
- COVID outbreaks in shelters are very bad
- Forced relocation is harmful to mental & physical wellbeing



1 3 18



Kate Hayman @hayman_kate · May 27, 2021

In the past year, I've spoken with hundreds of people experiencing homelessness, and the vast majority express a strong preference for hotel settings.

Toronto, I hope we can do better and ensure that people are offered housing rather than a return to congregate settings.

> 
> **Kelly Doran MD MHS** @KellyMDoran · May 27, 2021
> NYC planning moves of people experiencing homelessness from hotels back to congregate shelters. Reporting by @mirelaiverac @WNYC wnyc.org/story/city-pre...

1 4



Kate Hayman @hayman_kate · Jun 26, 2023

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Toronto, get out & vote!!!
As an emergency doctor who sees many people experiencing homelessness, I voted for @oliviachow — she is the candidate most likely to improve access to housing & emergency shelter. I want to work & live in a city where everyone is safe & housed.



27 41 318 14K

American Journal of Community Psychology, Vol. 28, No. 3, 2000

Ex # C m/d/y 8/16/2024 Pg 1 of 24
Exam of Dr. Kate Hayman
Heegsma et al v City of Hamilton
Nimigan Mihailovich Reporting Inc.

Antecedents of Physical and Sexual Victimization Among Homeless Women: A Comparison to Homeless Men[1]

Suzanne L. Wenzel,*,†,[2] Paul Koegel,* and Lillian Gelberg†

**RAND Corporation, †University of California, Los Angeles*

Homeless women experience extensive health risks including physical and sexual victimization. Few studies that have gathered information on homeless persons have reported results separately for women or have compared them directly with men. Research that both investigates antecedents of victimization among homeless women and compares them to those for men is necessary to determine whether prevention efforts must be different for each group. We investigated potential antecedents of recent (past 30 days) physical and sexual victimization in a probability sample of 394 homeless women and compared findings to those for 1159 homeless men. As hypothesized, mental disorder, substance dependence, and engaging in economic survival strategies significantly predicted victimization among homeless women. With few dissimilarities, these characteristics also predicted victimization among homeless men. Although differences in the needs and experiences of homeless women and men must be recognized, both women and men require assistance to establish and maintain safe residences, treatment of any substance use and mental disorder, and alternatives to economic survival strategies that place them at risk for victimization.

KEY WORDS: homeless women; homeless men; violence; victimization.

[1]We thank Barbara Leake, Ph.D., for advice on statistical analyses for this paper. Funding for this study was provided by the Southern California Injury Prevention Research Center through a grant from the Centers for Disease Control, by the National Institute of Mental Health (1 R01 MH64121) (to Dr. Koegel), and by the Robert Wood Johnson Generalist Physician Faculty Scholar Program (to Dr. Gelberg).

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Homeless women are among the most highly impoverished members of our society (e.g., Bassuk, 1993; Benda & Dattalo, 1990) and experience extensive and severe health risks including physical and sexual violence (Breton & Bunston, 1992; Gelberg, 1996; Ugarizza & Fallon, 1994). A number of studies have found that homeless women experience higher rates of victimization than their housed counterparts (Bassuk, 1993; Bassuk, Weinreb, Buckner, Salomon, & Bassuk, 1996; Bassuk & Rosenberg, 1988; D'Ercole & Struening, 1990; Milburn & D'Ercole, 1991; Padgett & Struening, 1992), although this finding is not uniform across studies and depends on definition, time frame, and measurement of victimization and characteristics of the nonhomeless comparison samples (Bassuk *et al.,* 1996, 1997; Browne & Bassuk, 1997; Goodman, 1991). Homeless women have been found at greater risk than homeless men of both sexual and physical assault (Geissler, Bormann, Kwiatkowski, Braucht, & Reichardt, 1995; North & Smith, 1993; Padgett & Struening, 1992).

Studies have examined the prevalence, characteristics, and risk factors of victimization among women in the general population, but survey research with a focus on homeless women is sparse (Bassuk *et al.,* 1997; Bassuk, Melnick, & Browne, 1998; Benda & Dattalo, 1990; North & Smith, 1993; Robertson & Winkleby, 1996). Thus, there is very limited understanding of the risk factors for violence among profoundly impoverished (homeless) women. Further, although limited research has shown that homeless women deserve consideration as a group distinct from homeless men (Bassuk, 1993; Benda & Dattalo, 1990; Geissler *et al.,* 1995; Koegel, Sullivan, Burnam, Morton, & Wenzel, 1999; North & Smith, 1993), few studies of homeless persons have reported results separately for women or have compared them with men (North & Smith, 1993). Research that investigates risk factors for victimization among homeless women and also compares them to those for men is necessary to determine whether prevention efforts must be different for each gender (Davidson, 1996). To our knowledge, no previous study has utilized sizable probability samples of homeless women and men to investigate comprehensively the factors that may place women at risk of assault *and* compare risk factors for women to those for men.

Antecedents of Physical and Sexual Victimization

Different theories have been proposed to explain victimization risk in the general population. The structural-choice model (Miethe & Meier, 1990), a synthesis of key concepts underlying several popular theories of victimization risk, may provide a suitable framework for understanding physical and sexual victimization among homeless women as well as men.

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The model stresses both the macrolevel (''structural'') processes that contribute to a criminal opportunity structure and the micro-level (''choice'') factors that promote the selection of targets for victimization. ''Structural'' features are proximity to high-crime areas and exposure to offenders; ''choice'' factors are the potential ''value'' of a crime target to an offender and level of guardianship. This model accommodates interpersonal dynamics affecting selection of victimization targets in a sociospatial context (Miethe & Meier, 1990).

Common measures of *proximity* are place of residence and perceived safety of one's neighborhood (Lynch, 1987; Miethe & Meyer, 1990). Proximity to higher-crime areas has been an important predictor of victimization (Rodgers & Roberts, 1995), and certainly, living situation is of special relevance for homeless persons. It is reasonable that those who spend more time in exposed locations (i.e., outdoors) would be at higher risk than those who spend their nights in shelters or similar protected facilities. Many subsistence services for homeless persons are located in higher-crime areas. Studies have not yet systematically explored the relationship of homeless persons' specific living environments to victimization (North, Smith, & Spitznagel, 1994).

Exposure to criminal opportunities represents accessibility to victimization and includes engaging in risky activities, visiting risky places, and nonhousehold primary activity (Lynch, 1987; Miethe & Meier, 1990; Sampson & Lauritsen, 1990). Homeless persons may be exposed to situations and engage in behaviors that place them at risk (e.g., panhandling and selling items on the street such as food stamps, drugs, and sexual favors) (Baumohl & Miller, 1984; Whitbeck & Simons, 1993).

Although not mentioned by Miethe and Meier (1990), problems with alcohol or illicit drugs also deserve consideration since they may increase exposure to criminality (Alexander, 1996; Bennet, 1995; Sampson & Lauritsen, 1990) and may increase one's level of vulnerability. Substance problems are significant risk factors for victimization, particularly sexual victimization (Burnam *et al.,* 1988). Among homeless persons, several studies have found relationships between substance use and victimization (Gelberg & Linn, 1988; Padgett & Struening, 1992; Stein & Gelberg, 1995).

One element of *choice* is ''target attractiveness'' (Miethe & Meier, 1990), of special relevance in financially motivated crimes such as robbery. Major indicators have been social class rank and amount of cash carried in public (Miethe & Meier, 1990). Homelessness represents a rather consistently impoverished condition, although the amount of cash carried by individual homeless persons may vary somewhat. It is not clear whether such variation would increase the risk of physical and sexual assault among homeless persons in the absence of economic motivation.

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Physical or social guardianship, the second component of choice, has previously been defined as whether persons over the age of 16 (such as a spouse) live with one and whether one owns a dog, has a burglar alarm, or has a friend living in the neighborhood (Miethe & Meier, 1990). A number of these definitions may have limited applicability to women generally and, especially, to persons in nonresidential situations. For women, the company of men does not necessarily offer protection from assault (Breton & Bunston, 1992; Browne & Bassuk, 1997; Fisher, Hovell, Hofstetter, & Hough, 1995). For homeless persons, living environments may confer risk instead of protection and thus it may be more appropriate to explore the level of *supportiveness* of social relationships, where support may reduce risk of victimization (Dutton, Hohnecker, Halle, & Burghardt, 1994), rather than simple proximity of other persons.

Personal vulnerability factors should be considered to enhance the applicability of the Miethe and Meier model to women and homeless persons: childhood abuse, mental illness, and physical health limitations. Childhood physical and sexual abuse have been associated with adult physical and sexual victimization in general population studies (Gidycz, Hanson, & Layman, 1995; Malinosky-Rummell & Hansen, 1993; Moeller, Bachmann, & Moeller, 1993; Nash, Hulsey, Sexton, Harralson, & Lambert, 1993). Studies of homeless women have yielded similar associations (Browne & Bassuk, 1997; Simons & Whitbeck, 1991). Like substance abuse, mental illness has a striking prevalence in the homeless population (Breakey, Fischer, & Kramer, 1989; Koegel, Burnam, & Farr, 1988) and is a robust risk factor for victimization (Burnam *et al.,* 1988; Goodman, Dutton, & Harris, 1995) since it may critically interfere with vigilance and self-protective behavior. Homeless persons are often burdened with poor physical health (Gelberg, 1996). Although serious health consequences may result from violence, impaired physical health and mobility may diminish the capacity for vigilance and self-defense in a hazardous environment.

The Meithe and Meier model and previous research suggest a number of possible predictors of victimization. We hypothesize that homeless women who engage in risky survival strategies such as panhandling and selling items on the street will be more likely to experience victimization than homeless women who do not. We also predict that homeless women who experience substance dependence will have a greater occurrence of recent physical or sexual victimization than homeless women who do not. Given the limited research highlighting the needs of homeless women as distinct from men and that separate violence prevention strategies are advocated for women, we asked whether the predictors of victimization for homeless women would be different from those for men.

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METHOD

Participants and Procedures

Research participants were 394 homeless women and 1159 homeless men ages 18 through 77 who were interviewed as part of RAND's Course of Homelessness (COH) Study (Koegel & Burnam, 1991). The COH Study, funded by the National Institute of Mental Health, selected the 1563 homeless persons from shelters, soupkitchens, and streets in the Westside and downtown Skid Row areas of Los Angeles County, the two areas of the County having the greatest concentrations of homeless persons, using probability sampling techniques.

Data collection took place in a stratified random sample of blocks in the Westside and downtown areas and in 77 shelters and meal programs (Koegel, Burnam, & Morton, 1996). Only three sites serving homeless persons refused to participate. The homeless women and men completed structured, 1.5- to 2-hr face-to-face interviews. Eighty-nine percent of the 5342 people approached for eligibility screening interviews and 88% of those invited to participate in the study after screening agreed to do so. In the COH Study, a homeless person was defined as one who had spent at least 1 night in the past 30 days in either (a) a setting that was defined as a temporary shelter or not designed to be a shelter, excluding those doubled up with family or friends, or (b) a program for homeless people that defined stays as temporary (Koegel *et al.,* 1996).

Sample Design

The sampling plan utilized elements of the ''service-setting'' (Burnam & Koegel, 1988) and the ''blitz'' sampling approaches (Rossi, Fisher, & Willis, 1986). To obtain a representative sample of homeless persons in each of the two COH study sites, three nested sampling strata were defined (persons who use shelter beds, who use soup lines but not shelter beds, and who use neither). Within the bed and meal strata, respondents were sampled in proportion to the number of homeless persons served by a facility in a 30-day period. Persons who used neither beds nor soup lines were randomly sampled while they slept outside at night [(Rossi *et al.,* 1986); see Koegel *et al.* (1996) for a more detailed discussion of the sampling plan]. Women, who comprise 17% of homeless persons in the Westside and Skid Row areas, were oversampled to represent 26% of the total COH Study sample.

Weights were calculated for all respondents to take advantage of the

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probability sampling techniques used to obtain a representative sample of homeless persons. The weight variable is based on the reciprocal of an estimated probability of selecting each homeless person into the COH Study sample [see Koegel *et al.,* (1996) for a more detailed discussion]. Probabilities were estimated based on two stochastic models that make assumptions about homeless persons' patterns of migration through shelters, soupkitchens, and streets. One model assumes that homeless persons visit the same facilities and street locations over time, and the other assumes that homeless persons make random decisions regarding visits to available facilities and street locations. The weight variable in this study is an average of these two models normed for the male and female subsamples individually.

Variable Definition

We define recent physical or sexual victimization, our dependent variable, as any self-reported physical assault or attack within the past 30 days or any self-reported sexual assault or attack within the past 30 days. A single, dichotomous variable was created for this purpose from two ''yes/no'' questions from the COH Study: (1) ''Within the past 30 days, have you been physically assaulted or attacked, not including sexual assault?'' and (2) ''Have you been sexually assaulted within the last 30 days?'' These questions were developed for a study of Skid Row homeless adults in the 1980s (Koegel *et al.,* 1988), but it must be noted that behavioral descriptions are now the standard rather than direct questions about rape and assault. Requiring persons to label experiences as assault is less likely to reveal victimization than behavioral indices that simply describe experiences (Finkelhor, 1994a, b; National Research Council, 1996; Peters, Wyatt, & Finkelhor, 1986).

Proximity variables examined as potential antecedents of victimization are area of city where interviewed (Westside versus Downtown Skid Row) and a usual sleeping place outdoors (i.e., street or other outdoor place) during the past 30 nights as opposed to any other place. The downtown Skid Row area is generally thought to be more dangerous than the Westside, especially for homeless women. We contrasted outdoor locations with others to reflect our expectation that outdoor sleeping locations would be associated with the most danger for women (North *et al.,* 1994).

Variables representing exposure to criminal opportunities are engaging in survival strategies during the past 30 days and a recent (i.e., 6-month) diagnosis of substance dependence. Engaging in survival strategies was defined as receiving any income during the past 30 days from panhandling;

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recycling cans or other used items that can be returned for cash; or selling items on the street such as food stamps, vouchers, bus passes, drugs, or sexual favors. Recent diagnoses of alcohol and drug dependence were obtained through the Diagnostic Interview Schedule (DIS), Version III-R (Robins, Heltzer, Croughan, & Ratcliff, 1981), a structured instrument that permits trained lay interviewers to collect data that are then used to make diagnoses using a scoring algorithm. DIS diagnoses are based on American Psychiatric Association criteria (Diagnostic and Statistical Manual; DSM-III-R). We created combination variables from these diagnostic variables to indicate whether one had a diagnosis of alcohol dependence only, a diagnosis of other drug dependence only, or diagnoses of both alcohol and other drug dependence.

To assess choice, we used the total self-reported income from jobs, benefits, and family and friends during the past 30 days (target attractiveness); whether one was currently married or living as married; and level of social support (guardianship). Income was not normally distributed, thus we created an ordinal variable for regressions that represented four levels of income. Social support was an average index of perceived support available from partners, family, friends, and social service providers derived from 5-point Likert scale items from Sherbourne and Stewart (1991).

Personal vulnerability factors include childhood abuse, serious mental illness, and physical health limitations. A dichotomous variable was created for childhood abuse from two ''yes/no'' questions asking whether, during the ages of 6 to 18, any adult members of their household physically assaulted them (i.e., hit them so hard it left bruises or required medical care) or sexually assaulted them (i.e., masturbated in front of them, touched them in sexual way, forced the child to touch the adult in a sexual way, or had sex with them) (Koegel *et al.,* 1988). DIS diagnoses were also obtained for serious mental illness (i.e., schizophrenia, depression, and mania) based on American Psychiatric Association criteria (DSM-III-R) (Koegel *et al.,* 1999). Three dichotomous items from the RAND Physical Functional Status Scale (Stewart & Kamberg, 1992) assessed respondents' physical health limitations (inability to walk one block; bend, lift, or stoop; or walk uphill or climb stairs) that lasted over 3 months. We developed one dichotomous item to assess whether any of the three limitations was present for more than 3 months.

Analyses

The Pearson chi-square test and Student's *t* test examined relationships between recent victimization and the potential predictors from the struc-

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tural-choice model. We screened three demographic variables for possible inclusion in subsequent multivariate analyses: age, educational level (achieved at least high school or GED level versus did not), and ethnic group (Black non-Hispanic, White non-Hispanic, Hispanic, Asian, and Native American). Only ethnicity was associated with victimization and was retained for multivariate analyses. Preliminary analyses for each gender supported a simplified categorization of Black or White non-Hispanic versus Hispanic or other ethnic group. Variable intercorrelations were examined for evidence of multicollinearity before multivariate analysis. No coefficients exceeded .60; thus, we excluded no variables due to high intercorrelations.

Separate logistic regression equations for men and women using the SAS LOGISTIC procedure (SAS Institute, Inc., 1990) assessed the contribution of all potential antecedents simultaneously (with the exception of statistically insignificant demographic variables) to recent adult victimization. Where findings indicated differences in predictors between men and women, we created variables to represent all possible combinations of gender with predictors that appeared different by gender in their relationship to victimization. To test gender differences, each combination variable, along with other potential predictors from the separate models for men and women, was assessed in an additional regression equation with the full sample of men plus women. Except for sample sizes, all results reported here are based on weighted analyses. We considered test results significant at $p < .05$.

RESULTS

Sample Description

Women. The women were 35 years old on average (SD = 10.0 years); most (57%) were Black non-Hispanic, almost a tenth were Hispanic, and 12% were Asian, Native American, or members of another non-Anglo ethnic group. Twenty-three percent reported being either physically or sexually victimized in the 30 days before their interview; 18% had been physically victimized, 9% had been sexually victimized, and 2% had been sexually but not physically victimized.

Previous studies have found that homeless women with children in their care and those without differ, particularly in that women with children have fewer mental and substance problems (Burt & Cohen, 1989; Robertson, 1991; Smith & North, 1994). This deserves acknowledgment, although we do not treat parenthood as a variable in the structural-choice model.

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Over three-fourths (78%) of the women had had children (excluding those by adoption). Over a third (35%) of all women had children living with them during the past year who were either children of their own or children for whom they acted as a parent, and 43% of those (or 15% of all women) had such children living with them at time of interview. Women with children at interview were younger than women without children, had a higher past-month income, and were less likely to have been physically or sexually victimized, to be living outdoors, to have recent alcohol dependence, and to have engaged in survival strategies.

Men. The men were 37 years old on average (SD = 10.0 years); 54% were Black non-Hispanic, 18% were Hispanic, and 5% were Asian, Native American, or members of another non-Anglo ethnic group. Physical victimization occurred in 20% and sexual victimization occurred in only 1% of the men in the past 30 days prior to the interview; 21% reported either physical or sexual victimization. None reported being only sexually victimized. Many (58%) had fathered children. Fifteen percent had children living with them during the past year; of those, only 2% had children living with them at the time of the interview.

Bivariate Analyses

Women. As shown in Table I, White non-Hispanic and Black non-Hispanic women appeared to be at less risk of victimization. Women whose usual sleeping place was outdoors during the past month were more likely to experience physical or sexual victimization. Drug dependence alone and experiencing both drug and alcohol dependence were associated with greater victimization risk. Women who received income in the past month from survival strategies were more likely to have been victimized, as were women with a higher level of income from jobs, benefits, and friends or family. Personal vulnerability factors of schizophrenia, mania, and physical health limitations were also more likely among victimized than nonvictimized women.

Men. As shown in Table II, homeless men who experienced victimization were more likely to be Hispanic or of other non-Black, non-White ethnicity. Victimized men were also more likely to have usually slept outdoors. Alcohol dependence alone was associated with a greater likelihood of victimization, but drug dependence alone and dependence on both alcohol and other drugs were unrelated to victimization. Income from survival strategies and the personal vulnerability factors of depression, schizophrenia, mania, and physical health limitations also contributed to victimization risk.

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Table I. Characteristics of Homeless Women in the Baseline Sample of the RAND Course of Homelessness Study, by Recent (Past 30 Days) Physical or Sexual Victimization Status

Variable	Physical or Sexual Victimization (N = 70)	Neither Type of Victimization (N = 324)	Total (N = 394)[a]	Test[b]	p
Demographics					
Age (mean)[c]	33.6	35.4	35.0	−1.5	.142
Ethnic group				7.4	.006
White, non-Hisp. or Black, non-Hisp.	69.3	82.5	79.5		
Versus Hispanic or Other	30.7	17.5	20.5		
At least high school education	71.4	66.0	67.2	0.8	.350
Proximity					
Interviewed Downtown (vs. Westside)	63.1	56.8	58.2	1.1	.283
Usual sleeping place outdoors past month	41.4	24.6	28.4	9.5	.002
Exposure					
Drug dependence only[d] (6-month diagnosis)	12.8	6.2	7.7	4.2	.041
Alcohol dependence only (6-month diagnosis)	20.3	14.3	15.7	1.9	.168
Both drug and alcohol dependence	24.3	7.9	11.7	18.0	.001
Any income from survival strategies past month	59.2	29.2	36.0	26.2	.001
Target attractiveness					
Total income past month[e]				10.1	.018
<$101	29.6	35.5	34.2		
$101–$250	4.5	15.5	13.1		
$251–$500	25.6	23.6	24.1		
>$500	40.2	25.4	28.6		
Married or living as married	29.8	28.3	28.6	0.1	.793
Target attractiveness					
Social support (mean)[c]	2.5	2.7	2.6 (.94)	−1.6	.105
Personal vulnerability					
Major depression (6-month diagnosis)	24.7	16.8	18.6	2.8	.095
Schizophrenia (6-month diagnosis)	13.4	2.3	4.8	18.3	.001
Mania (6-month diagnosis)	12.3	3.0	5.1	12.3	.001
Physical health limitation	37.3	24.5	27.4	5.5	.019
Childhood physical or sexual abuse	40.3	30.2	32.4	3.1	.080

[a]Column values are percentages unless noted otherwise; all results are based on weighted analyses except that sample sizes are unweighted.
[b]Pearson chi-square test values unless noted otherwise. Degrees of freedom = 1; except total income df = 3, age df = 1,392, and social support df = 1,392.
[c]t test.
[d]Two and one-half percent of women were diagnosed with recent marijuana dependence, 4% with recent heroin dependence, <1% with recent amphetamine dependence, and <1% with recent opiate, hallucinogen, or PCP dependence.
[e]Treated as an ordinal variable in regressions.

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Table II. Characteristics of Homeless Men in the Baseline Sample of the RAND Course of Homelessness Study, by Recent (Past 30 Days) Physical or Sexual Victimization Status

Variable	Physical or Sexual Victimization (N = 206)	Neither Type of Victimization (N = 953)	Total (N = 1159)[a]	Test[b]	p
Demographics					
Age (mean)[c]	37.0	37.2	37.2	−0.3	.793
Ethnic group				8.5	.003
White, non-Hisp. or Black, non-Hisp.	69.4	78.4	76.6		
Versus Hispanic or Other	30.6	21.6	23.4		
At least high school education	68.4	70.8	70.4	0.5	.477
Proximity					
Interviewed Downtown (vs. Westside)	69.1	73.3	72.5	1.6	.199
Usual sleeping place outdoors past month	46.8	31.4	34.5	19.8	.001
Exposure					
Drug dependence only[d] (6-month diagnosis)	12.2	13.3	13.1	0.2	.678
Alcohol dependence only (6-month diagnosis)	36.1	19.8	23.1	28.0	.001
Both drug and alcohol dependence	14.4	17.8	17.1	1.5	.221
Any income from survival strategies past month	62.9	51.3	53.6	9.5	.002
Target attractiveness					
Total income past month[e]				5.5	.140
<$101	31.0	33.1	32.7		
$101–$250	20.6	25.9	24.9		
$251–$500	24.2	23.0	23.3		
>$500	24.1	17.9	19.1		
Married or living as married	5.1	6.2	6.0	0.4	.555
Target attractiveness					
Social support (mean)	2.40	2.52	2.5 (1.0)	−1.8	.077
Personal vulnerability					
Major depression (6-month diagnosis)	27.4	12.7	15.7	30.7	.001
Schizophrenia (6-month diagnosis)	10.1	4.5	5.7	10.8	.001
Mania (6-month diagnosis)	7.4	3.2	4.1	5.5	.003
Physical health limitation	27.1	17.9	19.7	9.4	.002
Childhood physical or sexual abuse	15.6	15.8	15.7	0.1	.947

[a]Column values are percentages unless noted otherwise; all results are based on weighted analyses except sample sizes are unweighted.
[b]Pearson chi-square test values unless noted otherwise; degrees of freedom = 1, except total income df = 3, age df = 1,1157, and social support df = 1,1130.
[c]t test.
[d]Six percent of men had diagnoses of recent marijuana dependence, 4% heroin dependence, 2% amphetamine dependence, and 1% opiate, hallucinogen, or PCP dependence.
[e]Treated as an ordinal variable in regressions.

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Multivariate Analyses

Women. In the regression for homeless women, the odds of being victimized during the previous month were significantly greater among Hispanic and other non-Black and non-White women (OR = 2.97, 95% CI = 1.34–6.61, p = .008). Women who were dependent only on drugs other than alcohol (OR = 4.20, 95% CI = 1.30–13.55, p = .016), who were dependent on both alcohol and other drugs (OR = 6.02, 95% CI = 2.24–16.22, p = .0004), who received income from survival strategies (OR = 3.93, 95% CI = 1.85–8.36, p = .0004), and who earned a greater amount of income from legitimate sources (OR = 1.61, 95% CI = 1.19–2.17, p = .002) were also more likely to have been victimized. A usual living place outdoors and dependence on alcohol achieved trend status (respectively, OR = 1.90, 95% CI = .91–4.06, p = .089, and OR = 2.37, 95% CI = .98–5.70, p = .055). Mania and physical health limitations were also associated with victimization (respectively, OR = 4.61, 95% CI = 1.11–19.15, p = .036, and OR = 2.11, 95% CI = 1.01–4.38, p = .046); however, confidence intervals were broad for mania and schizophrenia, suggesting too few cases to support stable estimates. Depression did not predict victimization.

Men. As for the women, the odds of being victimized during the previous month were significantly greater among Hispanic and other non-Black and non-White men (OR = 1.70, 95% CI = 1.15–2.51, p = .007). Unlike the women, the proximity variables of interview site and usual living place were significantly associated with victimization. Men who were living in downtown Skid Row areas at time of interview were more likely to have been victimized (OR = .59, 95% CI = .40–.89, p = .011), as were men whose usual living place during the previous 30 days was outdoors (OR = 1.85, 95% CI = 1.31–2.62, p = .0005). Men who were dependent only on alcohol were more likely to have been victimized (OR = 2.07, 95% CI = 1.40–3.07, p = .0003), as were men who received income from survival strategies in the past month (OR = 1.70, 95% CI = 1.20–2.43, p = .003). Schizophrenia and mania were not associated with victimization, although the odds of being victimized were significantly greater for men with diagnoses of depression (OR = 2.23, 95% CI = 1.42–3.50, p = .0005).

Total Sample. Based on results of regression analyses performed for women and men separately, we combined gender with site of interview, drug dependence only, dependence on both alcohol and other drugs, depression, mania, and physical health limitations. For example, in addition to the variables analyzed as predictors in the separate regressions for men and women, three variables were entered into a regression model to test for differences between men and women in depression as an antecedent of

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victimization: no depression, gender is male; depression, gender is female; and depression, gender is male. We tested the six sets of combination variables in six separate models.

Combination variables were significant in two of the six regressions. These were dependence on both alcohol and other drugs with gender and site of interview with gender. Combinations of gender with drug dependence only, depression, mania, and physical health limitations were not statistically significant. In Table III are results for the regression model that tested combinations of gender and dependence on both alcohol and other drugs. We abstract below the significant findings for the regression examining the combination of interview site and gender. Except for the different sets of combination variables tested in each model, findings for other predictors were the same across models.

As in the separate samples of men and women, Hispanic and other non-Black and non-White ethnic status was associated with a higher probability of being victimized during the previous 30 days in the total sample. The odds of being victimized were also greater for persons who were interviewed Downtown rather than in the Westside areas of Los Angeles, a finding driven by the male sample and that represents a true difference in importance of site between males and females. In a regression assessing the combination of interview site and gender in relationship to victimization, the odds of being victimized were significantly decreased among men who were interviewed in locations on Los Angeles' Westside (OR = .44, 95% CI = .248–.781, p = .005).

As shown in Table III, having a usual sleeping place outdoors during the past month was associated with victimization during the past month, and a diagnosis of alcohol dependence also increased the odds of victimization. The combination of female gender and both drug and alcohol dependence was significant, indicating that having diagnoses of both alcohol and drug dependence is important for women but not for men. Receiving income from survival strategies and receiving a greater amount of income from legitimate sources in the past month were both associated with victimization. Major depression significantly predicted victimization, but there was no difference between men and women when depression was examined in combination with gender. The odds of being victimized were higher among those with diagnoses of schizophrenia.

DISCUSSION

Descriptive analyses do not support previous findings that homeless women experience higher rates of victimization than homeless men (e.g.,

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Table III. Antecedents of Recent (Past 30 Days) Physical or Sexual Victimization for Women and Men in the Baseline Sample of the RAND Course of Homelessness Study[a]

Variable	Parameter Estimate	SE	Odds Ratio	95% Confidence Interval	*p*
Hispanic, or other non-Black, non-White	.64	.17	1.90	1.36–2.67	.001
Interviewed Downtown (vs. Westside)	−.42	.17	.66	.47–.92	.016
Usual sleeping place outdoors past month	.62	.16	1.86	1.37–2.52	.001
Drug dependence (6-month diagnosis)	.22	.24	1.25	.78–2.00	.357
Alcohol dependence (6-month diagnosis)	.74	.18	2.09	1.48–2.96	.001
Neither drug nor alcohol dependence, male gender	−.11	.24	.90	.56–1.44	.659
Both drug and alcohol dependence,	1.47	.50	4.34	1.63–11.56	.003
Both drug and alcohol dependence, male gender	−.43	.33	.65	.34–1.24	.191
Any income from survival strategies past month	.63	.16	1.87	1.37–2.55	.001
Total income past month	.16	.07	1.17	1.03–1.34	.016
Married or living as married	.20	.27	1.22	.72–2.06	.465
Social support	−.12	.08	.89	.76–1.04	.131
Major depression (6-month diagnosis)	.62	.20	1.87	1.26–2.77	.002
Schizophrenia (6-month diagnosis)	.65	.30	1.91	1.05–3.47	.034
Mania (6-month diagnosis)	.26	.36	1.29	.64–2.61	.471
Physical health limitation	.27	.18	1.31	.93–1.87	.127
Childhood physical or sexual abuse	−.24	.20	.79	.53–1.16	.786

[a]Results of model using combination of gender and dependence on both alcohol and other drugs.

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Geissler *et al.,* 1995); however, more homeless women than men in this study experienced sexual violence. In interpreting these findings, it is important to note that, unlike other studies that found higher rates of violence among homeless women than men (e.g., Geissler *et al.,* 1995), we utilized a very recent prevalence of victimization. A more expansive time window and thus a greater representation of experiences may have yielded a different picture.

Analyses largely supported our hypotheses that personal vulnerability factors and exposure to criminal opportunities would be antecedents of recent victimization for the homeless women. Multivariate analyses revealed a higher rate of recent victimization among women with diagnoses of mania, of drug dependence only, and of both alcohol and drug dependence and among women who engaged in economic survival strategies. These findings suggest that exposure and personal vulnerability are important, unique antecedents of victimization among homeless women that deserve the attention of researchers and providers alike. Exposure and personal vulnerability were also important antecedents of victimization for the men, although the definitions of these model factors appeared to differ in some cases for men and women based on the separate regressions. Analyses using the total sample of men and women and incorporating tests of differences via gender-based combination variables, however, revealed more similarities than differences in antecedents. These similarities highlight a sense of urgency regarding the victimization of homeless women as well as men.

Depression and schizophrenia were significant predictors of victimization for the total sample of women and men. Although it is important to acknowledge that depression may *result* from adult and childhood assault (Beitchman *et al.,* 1992; Koss, 1990; Miller, Downs, & Testa, 1993), mental illness is also a well-established risk factor (e.g., Burnam *et al.,* 1988; North *et al.,* 1994). Depression may have a direct impact on victimization risk by reducing the level of vigilance in hazardous environments or by causing an appearance of greater vulnerability to perpetrators. Homeless women and men with mental health disturbances need special consideration to be protected from victimization. In future research, analytic models must accommodate personal vulnerability factors, and the nature of the linkage between psychiatric disorder and victimization requires clarification so that prevention efforts can be more specifically targeted.

As hypothesized for the women, substance dependence predicted victimization. Comorbid diagnoses of alcohol and drug dependence emerged as an important risk factor among women in analyses for the total sample, and alcohol dependence was important in understanding victimization for both men and women. Substance disorder has been consistently associated with victimization in general population studies (Fagan & Chin, 1990;

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Goldstein, 1985; Miller, 1990). Prior research found relationships between homeless women's substance problems and their victimization (e.g., North *et al.,* 1994; Padgett & Struening, 1992) but did not examine them in comprehensive predictive models with other potential risk factors or make distinctions in types of substance disorder (such as alcohol dependence alone or accompanying drug dependence). Researchers focusing on the needs of women have observed that few studies have examined the context of violence in the lives of homeless or durg-addicted women (Goodman *et al.,* 1995; National Research Council, 1996). What seems clear is that there is a close association between substance disorder and victimization that is extremely complicated and poorly understood (Gardner & Resnick, 1996). In accordance with the macro-level or structural features of the Meithe and Meier (1990) model, individuals with these disorders may be more likely to frequent environments that carry a high risk of assault. Acquisition and consumption of alcohol and drugs among homeless persons may occur in locales where there is little formal or informal social control and that may have high rates of interpersonal violence (Collins, 1990).

The complexity of the relationship between substance dependence and victimization is accentuated in that the likelihood of victimization with diagnoses of both alcohol and drug dependence was notable for women but not apparent for men. Within the framework of the Meithe and Meier (1990) model, this result suggests that homeless women with diagnoses of alcohol as well as other drug use disorders frequent particularly dangerous environments and are thus particularly prone to assault. Although future studies must shed light on this difference between women and men, previous arguments that homeless people with substance disorders must receive the benefit of accessible and effective treatment is still highly relevant (Koegel *et al.,* 1999; Wenzel, Koegel, & Gelberg, 1996).

Equally complex and deserving of more investigation is the finding that Hispanics, Asians, and Native Americans were more likely to have experienced victimization than White and Black non-Hispanics. This finding is perhaps most safely interpreted as a marker for other socioeconomic and cultural considerations not assessed in this study, since other research has determined that abuse is more related to social class, income and education than to race or ethnicity per se (Lindholm & Willey, 1986; O'Keefe, 1994).

Supporting the relevance of exposure to criminal activity is the hypothesis that women who received income in the past month through panhandling, recycling, or selling items on the street were more likely to have been victimized during that period of time. There are few opportunities for such impoverished individuals to support themselves through legitimate means (Simons & Whitbeck, 1991; Whitbeck & Simons, 1990, 1993), so

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survival techniques are quite common (Baumohl & Miller, 1984). In accordance with the macro-level, structural features of the Miethe and Meier (1990) model, these risky activities likely bring both women and men into contact with high-risk environments and with people who would directly exploit or otherwise harm them. This finding indicates the need for alternative economic support strategies that would ideally result in exits from homelessness.

Job training for better employment and education may be important in reducing reliance on survival strategies, but alone it is insufficient since a greater amount of income from legitimate sources also predicted victimization. It is reasonable that a homeless individual with money may be an attractive target to would-be assailants; it is unreasonable to expect that a homeless recipient of job training would accumulate enough assets in a timely fashion to establish a secure residence and protection from assault. Physical protection appears crucial since the hypothesis that victimization would be more likely among women living outdoors was confirmed, and since the finding also extended to the men (Coston & Finckenauer, 1993; North *et al.,* 1994; Whitbeck & Simons, 1993). Safer living conditions must be provided for homeless women and men to reduce risk of victimization (Gelberg, 1996; Jahiel, 1992; Padgett & Struening, 1992). In this study, men enjoyed more safety on Los Angeles' westside, an area that is considered less dangerous than Downtown's Skid Row. While this particular finding for the men may not generalize well to other areas of the nation, it emphasizes the relevance of the physical environment and exposure to criminal activity.

Limitations

This study has advanced the knowledge of risk factors for both homeless women and men, but there are caveats that point to areas for additional research. The cross-sectional nature of this work prohibits statements about causality and resolution of temporal ordering of variables. Longitudinal research with a more in-depth examination of assaultive experiences and their possible precursors over an extended period of time is necessary to clarify the specific linkages between victimization and the possible antecedents, although even a more sophisticated correlational study does not support causal statements. Future research must also explore whether risk factors differ for different kinds of victimization experiences. One of the greatest contributions of the present study may be in stimulating more hypothesis-testing and longitudinal research designs to delve further into this complicated issue.

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This study took advantage of data collected to understand the course of homelessness, and thus the variables may not represent the full range of factors needed to understand victimization risk. Also, as noted earlier, behavioral indicators of assault are preferred over questions using the label of assault. The use of single-question "yes/no" items may suppress estimates of physical and sexual abuse (Browne & Bassuk, 1997), and typically the more questions used to measure the experience of abuse, the higher the prevalence rate of abuse (Finkelhor, 1994a, b).

Although there were many similarities across homeless women and men, we have no information on whether women and men operationalized assault differently. Victims may use a number of coping strategies to deal with an abusive event, including denying abuse and reconstructing the meaning of the event and perceiving it as not abusive (Koss, 1990). Of additional concern is that a woman may not define forced coitus as sexual assault if the act was perpetrated by her partner (National Research Council, 1996), and substance-abusing women may see their physically or sexually abusive experiences as normal (Woodhouse, 1992). Qualitative research is needed to understand more thoroughly the context of violence in homeless women's lives, how they interpret violent acts, and how violence impacts them (Goodman *et al.,* 1995). Results and their implications may be more relevant to physical rather than sexual victimization given that most of the recent victimization experiences for women involved physical abuse and no men reported sexual abuse alone. Research including larger samples of sexually victimized homeless persons would aid in understanding how distinct the risk factors are for physical versus sexual assault.

CONCLUSIONS

The findings provide valuable initial insight into the violence prevention needs of homeless women and men and suggest directions for further research and intervention. While there are strong similarities among men and women in antecedents, efforts to prevent violence should recognize that the context of violence may still be very different for men and women (Benda & Dattalo, 1990; North & Smith, 1993). For example, a woman is much more likely than a man to be victimized by a person known to her than by a stranger (National Research Council, 1996). The field of substance abuse treatment research alone has demonstrated that women have multiple challenges and service needs that set them apart from men (Beckman & Amaro, 1986; Brown, 1992; Hawk, 1994; Kline & Strickler, 1993; Reed, 1987).

Homeless women and men require comprehensive assistance in estab-

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lishing and maintaining safe and permanent residences, many require assessment and ongoing intervention to deal with mental and substance use disorder, *and* they need appropriate educational and training opportunities to protect them from victimization and support exits from homelessness. The importance of structural characteristics reinforces Garske's (1996) caution that ''macro-level'' solutions to victimization must go beyond an exclusive focus on individual level factors. The need for such encompassing solutions also highlights that *prevention* of victimization requires more than eliminating the negative; *promotion* of comprehensive intervention strategies is required (Pransky, 1991). Compassion is an obvious reason to adopt such comprehensive recommendations, but there are also costly implications for a society that chooses to ignore the health-related needs of homeless and other impoverished persons.

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Understanding Encampments of People Experiencing Homelessness and Community Responses

Emerging Evidence as of Late 2018

U.S. Department of Housing and Urban Development | Office of Policy Development and Research

Understanding Encampments of People Experiencing Homelessness and Community Responses:

Emerging Evidence as of Late 2018

January 7, 2019

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Introduction

Cities, suburban communities, and rural areas across the United States have seen in recent years the rise of groups of people experiencing unsheltered homelessness together. The term *encampment* is widely used by journalists and researchers to describe these groups, but other terms include *tent cities, homeless settlements,* and *homeless camps.* Although their existence is not unprecedented, media reports suggest that the number of encampments has increased sharply in recent years (National Law Center on Homelessness and Poverty, 2017).

People experiencing unsheltered homelessness may perceive staying in an encampment as a safer option than staying on their own in an unsheltered location or in an emergency shelter; however, encampments can create both real and perceived challenges for the people who stay in them as well as for neighbors and the broader community. As community leaders seek to develop and deploy a response, they often are called on to balance multiple, sometimes competing priorities and demands from a diverse group of stakeholders, including community residents, business owners, public health and safety officials, and advocates for disadvantaged populations—as well as the people living in the encampments.

This paper documents what is known about homeless encampments as of late 2018, based on a review of the limited literature produced thus far by academic and research institutions and public agencies, supplemented by interviews with key informants. This paper is part of a larger research study sponsored by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, and the U.S. Department of Housing and Urban Development, Office of Policy Development and Research. This study's goal is to contribute to our understanding of homelessness, including the characteristics of homeless encampments and the people who stay in them, as well as local ideas about how to address encampments and their associated costs.

What Are Encampments, and What Do We Need to Know About Them?

The term *encampment* has connotations of both impermanence and continuity. People are staying in temporary structures or enclosed places that are not intended for long-term continuous occupancy on an ongoing basis. Inhabitants may be a core group of people who are known to one another and who move together to different locations when necessary, or they may be a changing group of people who cycle in and out of a single location. The physical structures that make up encampments can take many forms, including tents on pallets and shanties, or lean-to shacks built with scavenged materials. Structures may be simple or complex multiroom compounds. People experiencing homelessness in encampments may also stay in groups of cars or vans or in manmade tunnels and naturally occurring caves.

Community reactions to encampments have taken a variety of forms. Some communities send police to quickly clear ("sweep") encampments, with no attempt to provide services or referrals to help people at the encampment find another place to stay. At the other end of the spectrum, some communities permit ("sanction") encampments formally. Local government or community organizations provide running water and places to prepare food and dispose of waste, as well as healthcare and other services.

The research questions that guided this review are shown in Exhibit 1. In the larger research study, we will attempt to provide information about encampments and the people who are staying in them and to answer these research questions. We sought preliminary information for these questions through a formal examination of the peer-reviewed literature; we also identified and examined non-peer-reviewed reports by academic institutions, public agencies, and other organizations (sometimes called *gray literature*). In addition to conducting literature reviews, we interviewed several key informants who are subject matter experts on encampments. We selected them because they are conducting research on encampments and related topics or they are helping communities devise and implement best practices for dealing with encampments.

Exhibit 1. Research Questions for the Study of Encampments

Understanding Encampments

1. What factors are driving the increase in people living in encampments?
2. What infrastructure or state or local ordinances or other policies impede or promote the establishment of encampments?
3. Who lives in encampments? Are there some subpopulations of people experiencing homelessness who are more likely to form or attach themselves to homeless encampments? Do people staying in the same encampment share certain characteristics? Are there any differences between the unsheltered population living in encampments and those who are unsheltered in other locations?
4. How large are encampments? Do their characteristics vary by size?
5. What types of social structures characterize encampments?
6. Why do people choose to live in encampments? What are the "pull" and "push" factors?

Community Efforts to Address Encampments

7. What steps are communities taking to prevent the establishment of encampments?
8. How are communities responding to encampments? What are the major activities, and which stakeholders are engaged?
9. Can approaches to encampments be categorized—for example, as sanctioning, clearing, or relocating?
10. How do responses to encampments relate to the broader homelessness services system?
11. How do responses to encampments differ across different types of communities?
12. In what ways do these efforts differ from efforts to serve the unsheltered population not living in encampments?

Costs Associated with Encampments

13. What are the direct costs incurred by communities in their efforts to address encampments?
14. How do costs differ depending on different community approaches?
15. How do the costs of managing or addressing encampments compare with the cost of emergency shelter and the cost of permanent supportive housing?
16. What health and safety issues have communities encountered with people staying in encampments?
17. What are the broader societal costs associated with encampments?

We summarize the nascent evidence on encampments in the following two sections. *Understanding Encampments* reviews what we know about why encampments form and what they look like. *Community Responses to Encampments* describes the factors that lead communities to adopt various approaches and what we know so far about their effectiveness. Then we describe the *Limitations of the Current Evidence on Encampments,* including some suggestions for additional research beyond the scope of this study. Finally, Appendix A describes how we conducted the literature review and key informant interviews, Appendix B provides additional details on selected studies that were particularly informative as we completed our review, and Appendix C summarizes selected practitioner resources to assist with addressing encampments.

Understanding Encampments

This section describes what we know as of late 2018 about encampments: why there has been a sudden increase in encampment homelessness in the past few years and how encampments vary in resident characteristics, in social structure, and regionally. As discussed herein, conditions can be harsh, volatile, and unhealthy. Still, people may live in encampments (rather than shelters or in other, unsheltered locations) for a variety of reasons, including factors that lead them to reject other types of shelter and factors that attract them to encampments. Section 3 will cover what we know about emerging community responses to encampments.

Explanations for the Increase in Encampments

Researchers generally agree that increases in homelessness are first and foremost the result of severe shortages of affordable housing, combined with a lack of political will to dedicate sufficient resources to address this problem (Shinn and Khadduri, forthcoming). According to a key informant who is helping communities understand how to deal with encampments, when people are in crisis, their decisions about where to stay represent pragmatic choices among the best available alternatives, based on individual circumstances at a particular moment in time. Encampments form in response to the absence of other, desirable options for shelter.

Within this underlying context, several related factors seem to influence whether people experiencing homelessness form or go to encampments rather than stay in shelters or on their own in unsheltered locations. Primary among those factors are (1) shortcomings in the shelter system, (2) a sense of safety and community within encampments, and (3) a desire for autonomy and privacy. Only one peer-reviewed article (Herring, 2014) mentions the potential for greater access to food and services or other material comforts as reasons that people congregate in encampments rather than stay on their own in unsheltered locations. Key informants and other peer-reviewed articles did not identify this as a primary factor influencing the decisions of people experiencing homelessness.

The Shelter System Falls Short

Shortcomings in the shelter system are consistently identified as a primary factor that "pushes" people to congregate in encampments. Many communities have literal shortages in the capacity of the shelter system to provide beds for everyone experiencing homelessness (Herring and Lutz, 2015; National Coalition for the Homeless, 2016; National Law Center on Homelessness and Poverty, 2014; Speer 2018a). In other communities, shelter beds are available but go unused because of regulations or conditions that are incompatible with potential clients' expectations or needs. Exhibit 2 lists some of the reasons cited in the literature and in key informant interviews why people experiencing homelessness may eschew shelters in favor of encampments. The availability and type of shelter available seem to be key drivers of encampments, as people weigh the disadvantages of staying in a shelter against their tolerance for the difficulties of staying in an unsheltered location (City of San Francisco, 2015; Herring and Lutz, 2015; National Law Center on Homelessness and Poverty, 2014).

Exhibit 2. Shortcomings in the Shelter System

Specific shortcomings in the shelter system that may contribute to increased numbers of people congregating in encampments:

- A supply of shelter beds insufficient to meet the demand; this problem may be exacerbated by limited funding for emergency shelters and by community opposition to creating new or expanded shelter and bridge housing facilities or permanent supportive housing.
- Restrictions in shelters that would result in separation from a partner, family member, or pet.
- Shelter entry/exit times and locations that are inconvenient or incompatible with people's daily routines, including work schedules.
- Concerns about the security of personal belongings; restrictions on the ability to store belongings and difficulty moving belongings in and out of shelters on a daily basis.
- Concerns about personal safety and exposure to germs and disease within shelters.
- Specific barriers to entry, including sobriety requirements and entry fees.
- General perceptions of shelters as "inhospitable," "alienating," "demeaning," and offering little or no support or case management to find permanent housing.

Sense of Safety and Community

People who stay in encampments may see them as offering greater safety and protection from police harassment and aggression (Burness and Brown, 2016), and from assaults or the theft of belongings (Donley and Wright, 2012; Speer, 2017), than if they were unsheltered on their own. This sense of "safety in numbers" may be particularly prevalent in long-standing and highly organized encampments, in which residents have established around-the-clock security patrols and mutually enforced norms and standards for behavior (Lutz, 2015; National Law Center on Homelessness and Poverty, 2014; Sparks, 2017a). In high-cost cities in particular, individuals' decision to congregate in an encampment may be influenced by the behavior of their peers, according to a key informant who is conducting research on encampments. Once a critical mass of people has determined that encampments are a way of dealing with their housing crisis, others may feel emboldened to follow suit. Some cities respond to the presence of an established encampment by providing bathroom facilities and other basic services, making encampments seem to be a reasonable alternative to constant moving, threats of eviction, or shelters.

Desire for Autonomy and Privacy

In contrast to the rules that govern many aspects of shelter stays, staying in an encampment means that people can generally come and go as they please. The ability to exercise autonomy and freedom of movement appears to be a powerful factor that draws some people to encampments (Lutz, 2015; National Law Center on Homelessness and Poverty, 2014; Sparks, 2017a). This independence is sometimes eroded in communities that "normalize" encampments, introducing regulations that restrict residents' activities in the process. When that happens, encampments may in effect become an extension of the same shelter system that people reject in favor of encampments (Herring, 2014; Speer, 2018a).

Access to Illegal Substances

Residents of encampments may or may not be using illegal substances. Nothing in the literature suggests that most or even many encampments are where people congregate primarily to support their drug addiction. That said, in at least one high-profile example, the location of an open-air drug market directly influenced the formation and continued existence of an encampment, according to a key informant studying encampments. In that instance, the availability of a dependable supply of heroin close-by led addicts to stay in encampments in the Kensington area of Philadelphia even though the city had available shelter space.

Variation in Encampments

Researchers and other experts have not yet developed a single, standard set of criteria defining a group of people experiencing unsheltered homelessness as an "encampment." In this review, the definition we used encompasses a wide variety of scenarios—from established settlements that have a well-defined set of mutually agreed-on and enforced rules to loose congregations that have little to no organization or cohesion. In this section, we describe what our literature search and key informant interviews revealed about the variation among encampments in resident characteristics and social structure; we then summarize how encampments may vary in different parts of the United States.

Resident Characteristics, Social Structure, and Motivations of Residents

The literature has little to say about characteristics that distinguish people experiencing unsheltered homelessness in encampments from those who experience unsheltered homelessness on their own. The U.S. Interagency Council on Homelessness is leading an effort to analyze data records for people experiencing homelessness, along with partner organizations including U.S. Department of Housing and Urban Development, the National Alliance to End Homelessness, California Policy Lab (a nonprofit partnership between the Universities of California Los Angeles and Berkeley), and the consulting firm OrgCode. That effort will provide insights into the characteristics and experiences of people experiencing homelessness in unsheltered locations, including whether they are distinctly different from people who experience sheltered homelessness; however, the data will not make it possible to distinguish people in encampments from people in unsheltered locations generally.

Some studies describe variations in the racial and ethnic composition of encampments. For example, one study conducted outside Orlando, Florida, engaged 39 people staying in encampments in focus groups. Nearly three-fourths of participants were men, and most were White—a demographic composition characterized by the local outreach team as generally representative of people experiencing unsheltered homelessness in the area. In contrast, downtown shelters in Orlando had a much larger population of African Americans (Donley and Wright, 2012). Seattle's evaluation of its sanctioned encampments also found fewer people of color in encampments relative to emergency shelters (City of Seattle, 2017). The demographic makeup of people staying in encampments in Oakland, California, seems to include a larger share of people of color, but individual encampments are segregated along racial and ethnic lines (Jones et al., 2015).

The internal organization and motivations of residents significantly vary among encampments. Some encampments have a strong social structure and organization, sometimes with oversight or assistance from local charitable or faith-based organizations. Residents may be required to assume responsibility

for day-to-day operations, including security patrols and other duties (City of Seattle, 2017; Lutz, 2015). Residents may vote in governance decisions, and they may be expected to attend weekly resident meetings in accordance with an encampment-wide code of conduct (Sparks, 2017a). A key informant conducting research on encampments described the social structure established by a group of mothers staying with their children in a recently cleared encampment in Oakland, California. Residents of the encampment prohibited drug use and shared responsibility for childcare. These expectations promote a sense of community and have been credited with helping encampment residents "feel human" and believe that they have something to contribute (Sparks, 2017b).

Other encampments have less cohesion and more informal rules and structure, which may on occasion result in friction and conflict among residents (Sparks, 2017a). Larger encampment "communities" may be less cohesive than smaller groups composed of family members and friends (City of San Francisco, 2015). In addition, the potential for exploitation exists in encampments, according to key informants conducting research on encampments. For example, younger people may offer to provide protection to older residents but then expect some form of compensation in exchange. Encampments formed around access to opioids in Philadelphia seem to have no leadership structure at all; however, according to a key informant conducting research on encampments, rarely do people living in an encampment have a complete lack of interaction with each other. People staying together in encampments tend to look out for one another and have some sense of solidarity.

Motivations of encampment residents may differ, as well. According to key informants who are helping communities develop responses to encampments, some residents of encampments are eager to access services and permanent housing. Others clear out in advance of a sweep, even if the sweep may provide them with access to services. Such variation might occur within one encampment if it is large enough. For example, when more than 700 people were cleared from the Santa Ana River encampment in Orange County, California, some people accepted help and were able to find housing or went to drug treatment centers, whereas others simply left for another encampment. When encampments have formed in areas that provide dependable access to illegal drugs in general and opioids in particular, referrals to housing and services are likely to be met with a mixed reaction, depending on the timing of individual residents' addiction trajectories and the characteristics of the shelters that are an alternative to staying in the encampment.

Regional Differences in Encampments

Cities in the Northeast, where winters can be harsh, are more likely than cities in other parts of the country to have relatively large shelter systems. According to a key informant who is conducting research on homelessness, this difference in the homelessness services system is reflected in the characteristics of people experiencing unsheltered homelessness, including those who stay in encampments. According to her observations, in cities with large numbers of shelter beds, the unsheltered population tends to have high rates of disability and mental health issues, which may create challenges to entering shelters. In contrast, in West Coast cities with limited shelter availability (or where barriers to shelter use are higher), the unsheltered population represents a greater mix of people, including those who do not have behavioral health disabilities but are unable to access shelter for other reasons. They may be recently homeless and unfamiliar with the shelter system, or they could be unwilling or unable to comply with the requirements of relatively high-barrier shelters on the

West Coast, or they may simply be unable to find an available shelter bed. As on the East Coast, many people in West Coast encampments are not able to tolerate or navigate the shelter system because of mental health or substance abuse disorders; however, West Coast encampments are also likely to include people who do not face those challenges.

According to researchers in the San Francisco Bay Area, those who stay in encampments may even have support from family members who visit regularly and bring food and medication or who invite them in to shower and do laundry (Jones et al., 2015). According to key informants who are researching encampments in the West, people who are now staying in encampments in western states could maintain stable housing without supportive services if they had rental assistance or other income support. For those individuals, the lack of access to affordable housing and shortages of shelter beds are the primary factors driving them to experience homelessness in encampments.

The physical nature of encampments often reflects regional differences in the geographic setting, including the natural features and available land. For example, an encampment in Southern California's Coachella Valley consists of a variety of structures detached and spread out across a contiguous area. In Columbus, Ohio, encampments are composed of tightly clustered tents and lean-tos. In San Francisco, people form encampments along the edges of highways and train tracks and under elevated freeways. In Las Vegas, encampments can be found in an underground tunnel system. The location of encampments balances two factors: maximizing convenience (that is, ease of access to the resources people use to address their daily needs) and minimizing visibility (that is, avoiding complaints to the city that could result in the encampment being cleared) (City of San Francisco, 2015).

Regional variation in encampments may also reflect the different ways that cities respond to encampments. Section 3 presents a typology of community responses to encampments and discusses the evidence—at this point, scant—on the effectiveness of those various approaches.

Community Responses to Encampments

Local responses to encampments are evolving in many communities, as stakeholders seek to identify the best strategies to address this growing phenomenon. Approaches vary along many dimensions but can be broken into four basic categories, as described in Exhibit 3. Specific activities range from sending police to quickly clear ("sweep") the encampment—providing little or no support to help people find another place to stay—to formally sanctioning encampments and providing onsite services.

Communities commonly use more than one response at a time to manage encampments, depending on resource availability, the location of encampments, and the characteristics of people congregating in encampments. For example, Las Vegas has created the Courtyard, a one-stop resource center that includes secure space to sleep outside, but it also deploys outreach teams that include law enforcement officers to clear encampments. Jurisdictions within the same region may adopt different strategies to address encampments. According to key informants helping communities to develop responses to encampments, communities may need to use a variety of approaches at the same time to serve populations that have different needs. When those efforts are not well coordinated across departments or neighboring jurisdictions, however, they may act at cross-purposes. For example, a jurisdiction that clears encampments, with little notice and no support, may undermine efforts to build relationships and trust in a neighboring jurisdiction that tacitly approves encampments.

Exhibit 3. Typology of Responses to Encampments

Category	Characteristics
Clearance With Little or No Support	• Notice of pending sweeps provided only a few days in advance, if at all • Belongings stored for a short period of time, if at all • Few or no shelter or service referrals provided • Regulatory or physical barriers to secure the site of the former encampment and keep it from being reoccupied
Clearance With Support	• Notice of pending sweeps provided weeks in advance, often by trained outreach workers who have experience working with people experiencing unsheltered homelessness • Longer term storage of belongings available • Referrals to shelter or services provided by outreach workers, who also accompany the first responders and sanitation crews who clear encampments

Category	Characteristics
Tacit Acceptance	• Encampments allowed to persist regardless of whether laws or ordinances explicitly authorize or prohibit their existence • Longer term storage of belongings available • Basic services or infrastructure provided, in particular to address public health and sanitation concerns (for example, portable toilets, showers, and potable water) • Outreach workers may visit the encampment to provide referrals to permanent housing, shelter, and services
Formal Sanctioning	• Encampments permitted by law or ordinance on public and or privately owned property, usually only in designated locations • May have established rules that govern the size, location, or duration of encampments • May have a public agency or nonprofit organization manage encampments • Infrastructure and public services—which may include laundry and potable water, common spaces for eating and meeting, lockers for storing belongings (including on a longer term basis), meal services and food donations, job training programs, access to mail and voice mail services—provided by the municipality and private or faith-based organizations and volunteers • May provide case management, including assistance applying for transitional or permanent housing and other benefits, appealing denials, and managing funds

Cities also use strategies to prevent encampments from forming. Some communities enact laws prohibiting activities associated with encampments, such as lying down or erecting structures on public space. More than one-third of U.S. cities have adopted camping bans, citing health and safety concerns (National Coalition for the Homeless, 2016). Researchers at the University of Denver identified more than 350 antihomelessness ordinances in Colorado's largest cities (Adcock et al., 2016). Other approaches include physical modifications to the built or natural environment, such as securing vacant lots and buildings to restrict access, clear-cutting brush that could provide cover for encampments, and installing sprinklers in areas where encampments might form (Chamard, 2010; National Law Center on Homelessness and Poverty, 2014). When an encampment is cleared, with or without support, the community may also impose new regulatory or physical barriers to keep the encampment from reemerging in the same location or in other parts of the community.

Factors that Drive Local Responses

Cities respond to encampments for a variety of reasons, and the goals of the interventions may vary—from cleaning up a business area, to helping people access shelter, to helping people obtain permanent housing. Even within the same jurisdiction, different stakeholders may have different definitions of success in dealing with encampments. For example, the transit authority may have a goal of breaking up encampments adjacent to a railroad bed, the department of public health may want to prevent the

spread of disease, the housing department may be working to end homelessness, and community homeless advocates may be focused on avoiding adverse consequences for the encampment population. Those differing views will also influence the strategy, or set of strategies, used by the city to address encampments (Burness and Brown, 2016; Jones et al., 2015) and can make comparing interventions across communities difficult. The factors that were most commonly cited in the literature as influencing cities' approaches to encampments are (1) community and political pressure, (2) resource availability, and (3) fear of litigation.

Community and Political Pressure

According to researchers and key informants who are helping communities devise strategies to address encampments, the "nuisance" factor is the key policy driver. Outreach teams or police usually are deployed only when community residents or other stakeholders complain about an encampment. At that point, interventions need to be visible and quick to demonstrate responsiveness to community concerns and to relieve political pressure (National Law Center on Homelessness and Poverty, 2014). In the absence of sufficient resources to move everyone into permanent housing, communities often employ a clearance strategy, with or without support, that moves people out of sight or farther from central business districts, where their presence can affect economic growth (Speer, 2018b).

Cities typically prioritize efforts in neighborhoods where political pressure is greatest. Not surprising, those neighborhoods often are not the locations with the highest levels of unsheltered homelessness and encampments, according to key informants who are helping communities devise strategies to address encampments. In areas with low visibility, with little or no community pressure, cities may pursue a policy of tacit acceptance—even if encampments exist in violation of a no-camping ordinance (Herring, 2014).

Resource Availability

Concern for community and resident well-being would, ideally, be the primary factor shaping cities' encampment response strategies; however, resource limitations may require city leadership to make trade-offs and choose an approach that works within existing constraints (Herring and Lutz, 2015; Loftus-Farren, 2011; National Law Center on Homelessness and Poverty, 2014). In Philadelphia, for example, according to a key informant conducting research on encampments, recent efforts that could be characterized as clearance with a high level of support were limited to two of four known opioid encampments because the city lacked funding to provide services and shelter for people congregating in all four. Without the ability to provide rent assistance or needed services, the city adopted a policy of tacit acceptance at the remaining two encampments. Cities may also create sanctioned encampments in lieu of providing permanent rent subsidies, or cities may pursue clearance with little or no support if they lack the resources to provide any additional assistance.

Fear of Litigation

Fear of legal challenges influences how cities approach closing encampments. Local jurisdictions want to avoid being taken to court over due process and cruel and unusual punishment challenges, according to a key informant engaged in research on encampments. This concern is likely to grow following the September 2018 ruling of the Ninth Circuit Court of Appeals in *Martin v. City of*

Boise.[1] Courts have found that depriving homeless people of the rights to perform survival activities in public spaces when no alternatives are available violates the 1st, 4th, 5th, 8th, and 14th Amendments to the Constitution (Kieschnick, 2018; National Law Center on Homelessness and Poverty, 2014). In *Martin v. City of Boise*, the court held that "as long as there is no option of sleeping indoors, the government cannot criminalize indigent, homeless people for sleeping outdoors, on public property."

Some legal challenges have resulted in settlements, which generally call for minimum notice before clearance of encampments, requirements for storage of personal belongings, and compensation for people who are swept from encampments and for their attorneys (National Law Center on Homelessness and Poverty, 2017). In January 2018, advocates brought a lawsuit against officials in Orange County, California, following the clearance of a massive encampment along the Santa Ana riverbed. As of October 2018, elements of a preliminary settlement agreement were more expansive and included a commitment to provide proactive outreach and engagement, as well as referrals to services, before evicting people from encampments; development of "standards of care" by the county for homelessness services programs; drawdown of funds already available to support "programs, services, and activities" for people experiencing homelessness; adoption of due process protections; establishment of a method for formally addressing requests for accommodations under the Americans with Disabilities Act; and referrals to collaborative courts[2] to handle citations.[3]

Effectiveness of Various Responses

The effectiveness of responses to encampments may be thought of as creating positive outcomes for the people who stay in encampments, creating positive outcomes for the broader community, or both. At this point, research that attempts to measure any such outcomes in a rigorous way is limited. Findings from anecdotal reports in individual cities are not broadly generalizable or transferable. To begin to address gaps in existing knowledge, the National Alliance to End Homelessness, U.S. Interagency Council on Homelessness, and U.S. Department of Housing and Urban Development are working with state and local partners to develop and test strategies for addressing unsheltered homelessness, including encampments. The Arnold Foundation (2018) is exploring the effectiveness of interventions that first responders can use to address unsheltered homelessness. Those projects are still in the early stages and are complicated, according to a key informant, by the absence of baseline data from which to evaluate the effectiveness of the responses. According to a researcher currently working on encampments, intensive outreach work will be needed to establish study samples, and a

[1] The Ninth Circuit has jurisdiction over nine states in the western United States, including Alaska and Hawaii, as well as the District of Guam and the District of the Northern Mariana Islands.

2 Collaborative courts are an alternative justice model that focuses on treatment and behavior change (rather than sentencing) to help defendants improve their lives. Homeless courts are one type of collaborative court. According to the California Association of Collaborative Courts, these are "special court sessions held in a local shelter or other community site designed for homeless citizens to resolve outstanding misdemeanor criminal warrants." https://www.ca2c.org/types-of-collaborative-justice-courts/

[3] Orange County Catholic Worker et al. v. County of Orange et al., Joint Statement of Settlement Progress (Central District of California, 2018) https://scng-dash.digitalfirstmedia.com/wp-content/uploads/2018/10/oc-homeless-plaintiffs-lawsuit-settlement.pdf.

high level of resources will be required to track people's experiences over time and to measure outcomes, but those efforts will be necessary to develop appropriate policy responses.

Without the availability of strong evidence, cities adopt approaches that seem to be best practices. Local responses also depend on the community's goals and priorities, which may include reducing crime, eliminating health hazards, or improving a business district—and may or may not include housing people experiencing homelessness. In the following sections, we provide descriptive and inferential information on the factors that may determine the effectiveness of responses, including the approach selected, the characteristics of encampment populations, and available resources. We summarize the current state of knowledge for various types of approaches.

Clearance with Little or No Support

Cities that adopt a policy of clearance with little or no support may justify this approach as "tough love" that encourages people in encampments to enter city-operated shelters (Lutz, 2015; National Coalition for the Homeless, 2016). The literature and key informants, however, agree that sweeps of encampments do little to increase shelter usage or otherwise resolve the problem of encampments (National Law Center on Homelessness and Poverty, 2014). Especially in communities with many low-visibility places, people are likely to simply pack up and move on to another location (Junejo, Skinner, and Rankin, 2016) or reestablish the encampment at the former site once the city has cleaned the area.

Clearance with little or no support may actually *reduce* the likelihood that people will seek shelter because it erodes trust and creates an adversarial relationship between people experiencing homelessness and law enforcement or outreach workers. In a survey of encampment residents in Honolulu, 21 percent of respondents said that they were less able or likely to enter shelters after sweeps, and 68 percent said that the sweeps had no effect on whether or not they went to shelters, although those responses seem mostly to be the result of undesirable shelter conditions (Dunson-Strane and Soakai, 2015). Another study conducted in Seattle finds that only one-third of encampment residents "accepted offers of alternative shelter after a sweep" (Junejo, Skinner, and Rankin, 2016: 16). Analyzing interviews with both outreach staff and encampment residents in Oakland, California, Jones and his colleagues hypothesized that continuous sweeps cause people experiencing unsheltered homelessness to "focus on short-term needs and immediate coping strategies," disrupting the level of stability necessary for encampment residents to engage in long-term planning (2015: 82). People forced to relocate during a sweep may have difficulty reconnecting with outreach workers who have been working with them, and any progress made toward moving into housing or accessing services could be lost. Experiences in Honolulu, Seattle, and Oakland suggest that sweeps are disruptive to people who are attempting to stabilize their lives and find a pathway to housing, and they may have lasting traumatic psychological and emotional impacts (Jones et al., 2015; Junejo, Skinner, and Rankin, 2016).

Clearance with Support

The support provided in responses that can be characterized as clearance with support may include extensive outreach in advance of clearance and referrals to existing shelters or housing programs. Communities may also make changes to policies on eligibility and rules for supportive housing or

drug treatment programs. They may create entirely new programs to facilitate entry by people formerly staying in encampments. For example, San Francisco created a new type of shelter, Navigation Centers, to provide shelter-averse people with room and board and access to case management and other services provided by public, nonprofit, and faith-based partners. The low-barrier model waives many of the policies commonly cited as obstacles to shelter: Navigation Centers do not have sobriety requirements, and people may come with their pets and partners, bring their belongings, and stay all day—there are no required entry or exit times. Space in the Navigation Centers is limited, however, and drop-ins are not accepted; instead, access is determined by the city's Homeless Outreach Team (SF HOT) case by case as space becomes available, with a focus on serving the most vulnerable people in San Francisco's encampments. Considerations by the outreach team include the length of time someone has been experiencing homelessness, shelter usage over a 6-month period, and motivation to move to permanent housing (San Francisco Health Network, 2018). Some evidence suggests that people strategically make themselves visible on the street in areas where the SF HOT will be making referrals so that they can gain access to the Navigation Centers, but no evidence indicates that people leave shelters in pursuit of a referral to a Navigation Center (City of San Francisco, 2015).

An evaluation of efforts to clear two encampments in Philadelphia's Kensington neighborhood provides a comprehensive look at another approach to clearance with support. After intensive and continuous outreach to and engagement of people staying in the Kensington encampments, outreach workers offered their clients emergency shelter in low-barrier "respite" and "navigation" centers, with access to case management and drug treatment services. The city also relaxed shelter admission requirements and rules and expectations for residents (Metraux et al., 2019). According to key informants developing policies to address such "drug encampments," enrolling people who are addicted to opioids and other substances into rehabilitation services may be difficult. Efforts to streamline access to drug treatment, however—including waiving requirements for identification and preauthorization and helping people get their documents in order—may ensure that treatment is available to them when they are ready to accept it.

Several key informants reported that communities are beginning to add social workers or community mental health workers to outreach teams. Law enforcement officials often are the only people on call to handle complaints around the clock, and community members may be more likely to call the police than to call a homeless hotline. When outreach teams include trained members, they can offer referrals to services and can begin to establish trust and build relationships with people experiencing homelessness in encampments. Without adequate funding for affordable, bridge, or permanent supportive housing, however, clients may end up back in encampments despite a robust outreach effort.

As of this review, policymakers and practitioners are developing promising practices to support residents of cleared encampments, and researchers are developing descriptive data and hypotheses for testing that approach.

Tacit Acceptance

Some cities tacitly accept encampments, not through sanctioning by law but by a lack of enforcement or by selective enforcement. Cities may tacitly accept homeless encampments to reduce the costs of

enforcing anti-camping ordinances or ordinances that prohibit lying down or sitting down in public places. Homeless people are permitted to congregate in areas that do not generate complaints from local businesses and residents (Herring, 2014). In Fresno, California, for example, police have carried out a more active clearance approach in the higher rent, downtown business districts, but they take a hands-off approach within an abandoned industrial zone (Herring, 2014; Speer, 2018b). In some cases, cities may provide basic services, such as potable water and security, without formally sanctioning the encampment (Loftus-Farren, 2011), and outreach workers charged with helping people resolve unsheltered homelessness may focus on people staying in the tacitly accepted encampments. In addition to having political reservations to sanctioning encampments, city officials may refuse to formally sanction encampments "on the grounds of increased liability, expenditures, and conflicts with health and zoning codes" (Herring, 2014: 298).

The literature we reviewed did not provide any indication of the effectiveness of tacit acceptance of encampments either in helping people resolve the circumstances that made them homeless or in limiting the negative consequences of encampments for the community.

Formal Sanctioning

Some cities formally sanction encampments through a variety of mechanisms: issuing temporary use permits; changing land use and zoning ordinances to permit encampments (which may place limits on the duration and number of people at each site); and creating designated campgrounds that have standards for operations and services to be provided on site. Some sanctioned encampments are managed publicly; others are self-governed but have public and private assistance and oversight.

- ***Publicly managed encampments.*** In some cases, sanctioned encampments are created and operated by the city, sometimes with nongovernmental community partners. Establishment of those encampments often is motivated by a desire to contain people who are unsheltered in a specified area where service delivery can be concentrated and public health risks controlled. For example, in 2017, the City of Las Vegas established the Courtyard Homeless Resource Center, where people can sleep in a secure, open-air, and sheltered courtyard with access to an array of amenities. The Courtyard is funded with public dollars and is currently operated by the city, with medical, employment, and other services provided on site through a variety of partners (City of Las Vegas, 2018).

- ***Safe parking programs*** provide similar structure and access to services for people who are experiencing homelessness and using a car, van, or RV as their primary place of shelter. People staying in their vehicles apply for a permit to safely and legally park overnight in designated lots that typically have some form of security and access to restrooms and other sanitation facilities. These programs are intended to offer transitional assistance for people who are interested in securing permanent housing and, as such, the programs provide access to extensive case management and other social services. Most programs use background checks to screen out sex offenders and recent violent felons, and program participants are required to have their own car insurance and comply with program rules and regulations. Safe parking programs are most common in West Coast cities. Program data from local jurisdictions in California indicate that participants have successfully accessed housing,

although rates of placement vary widely, from 5 percent in Santa Barbara to 65 percent in San Diego (Homelessness Policy Research Institute, 2018).

- ***Self-governed encampments with public and private assistance and oversight.*** Rather than establishing new areas for unsheltered people to congregate, some cities sanction existing encampments. This process typically involves establishing a legal framework for their continued existence and organizing services but allowing the encampment to continue as a self-governed enterprise. In 2011, the Seattle City Council adopted an ordinance to permit transitional encampments as an "accessory use" on land owned or controlled by a religious organization and established health and safety standards for those encampments. A similar ordinance passed in 2015 extended those standards to city-owned or private, nonreligious property. Seattle's Human Services Department selected several nonprofit organizations with experience supporting unsheltered homeless people to provide service-enriched case management, including referrals to diversion programs and shelters, access to legal services and rapid rehousing programs, and employment training and educational referrals at three newly established, permitted encampments (City of Seattle, 2017).

  In a city-sponsored evaluation (City of Seattle, 2017) that attempted to assess the effectiveness of formal sanctioning, Seattle documented a positive response from communities around the new encampments. Data and information about crime levels collected by the Seattle Police Department suggest that crime has not significantly increased in the areas surrounding the encampments since they were established. Authors of the evaluation view the self-managed governance structure positively, as an opportunity for residents to build confidence and leadership skills. Between September 2015 and May 2017, 759 people stayed in Seattle's six permitted encampments, and 16 percent (121 people) transitioned to permanent housing. It is unclear how generalizable these findings are to other communities.

Sanctioned encampments are best understood as an interim solution to address the immediate conditions of people experiencing unsheltered homelessness. Such encampments are not themselves a solution to homelessness, and cities will need to invest in permanent solutions, such as housing that is affordable to extremely low-income people, permanent supportive housing, mental health services, affordable healthcare, and perhaps also supervised drug consumption sites and low-barrier employment opportunities (Junejo, Skinner, and Rankin, 2016; Loftus-Farren, 2011; Parr, 2018). Currently, limited evidence suggests that sanctioned encampments help to reduce homelessness; we also do not know whether certain types of sanctioned encampments are more effective than others.

Limitations of the Current Evidence on Encampments

In this section, we describe limitations in the rigor and scope of the literature considered in preparing this review, as well as challenges to collecting data on the encampment population. We conclude with some recommendations for additional research found in the published literature or made by key informants interviewed as part of this scan of current evidence on encampments.

Scope and Rigor of the Current Literature on Encampments

Research on the nature and causes of homeless encampments is still in the nascent stages, as is evaluation of community responses to encampments. In many ways this is parallel to the state of research on homelessness during the 1980s, when modern homelessness, sheltered and unsheltered, first became apparent and was the focus of news reports and efforts to document and understand the phenomenon. As of late 2018, the research literature on encampments is primarily descriptive, relying on reviews of articles in the news media, along with some ethnographic research and fieldwork that includes interviews with encampment residents, service providers, city staff, and community members. Administrative data are used in only a few cases (Metraux et al., 2019; Speer, 2017). In general, sample sizes are small, with analysis limited to interviews with a small number of community stakeholders or encampment residents.[4] Researchers almost exclusively use convenience samples rather than representative samples of encampment populations. Evaluators have not yet begun to use methods that compare the results of a response to encampments with what would have happened in the absence of the policy or practice.

So far the literature focuses heavily on West Coast cities, especially Fresno and San Francisco, California; Portland, Oregon; and Seattle, Washington. An exception is a descriptive study by the National Law Center on Homelessness and Poverty (2014) that deliberately focuses on East Coast and Southern cities.[5] The ethnographic research reviewed for this paper focuses on people in encampments that are sanctioned, either formally or tacitly. This type of research, which relies on observation of people and conditions within encampments, would be more difficult to carry out in communities that have an encampment clearance policy.

Our scan of the literature identified only one study that begins to develop standards for evaluating the effectiveness of various responses to encampments. Jones and his colleagues (2015) provided standards for three criteria—effectiveness, equity, and implementation feasibility—and use them in connection with resident, service provider, and stakeholder interviews to assess whether alternative approaches would be more effective than a current policy of clearing encampments in Oakland, California (see Appendix B for a description of the study). Some local jurisdictions have started to track housing placements among people who formerly stayed in publicly sanctioned encampments

[4] Research methods and rigor differ little between the peer-reviewed literature and the reports of public agencies and other organizations. Both types of literature rely heavily on media reports and on qualitative interviews.

[5] The cities are Lakewood, New Jersey; New Orleans, Louisiana; Providence, Rhode Island; and St. Petersburg, Florida.

(City of Seattle, 2017; Hunter et al., 2016), but assessing how rigorous and successful those tracking efforts will be is difficult.

Little information is available on the direct and indirect community costs associated with encampments. Some reports provide partial accounts of the costs of various activities associated with local responses to encampments. None attempt a rigorous analysis of the costs of a response type or a comparison with the costs of other interventions for people experiencing homelessness. Adcock and her colleagues (2016) provided a thoughtful methodology for calculating the cost of enforcing ordinances that criminalize homelessness in Denver and the state of Colorado, but that analysis pertains to unsheltered homelessness in general; it is not limited to encampments. Some case studies report expenditures associated with various activities related to encampments (City of Seattle, 2017; Jones et al., 2015). Complicating the documentation of costs, encampment-related expenditures often are spread across multiple agencies and contracts (for example, department of public works for refuse disposal, department of human services for case management), sometimes without a budget category or line item specific to encampments (Junejo, Skinner, and Rankin, 2016).

Challenges to Collecting Data on People in Encampments

Some local jurisdictions have started to collect and report data on the characteristics of people who stay in encampments. The types of information collected include these:

- Basic demographic data, such as gender, age, race, veteran status and discharge type, and first language (City of Seattle, 2017; Metraux et al., 2019)
- Earned income or benefits receipt (City of Seattle, 2017)
- History of domestic violence (City of Seattle, 2017)
- Physical and mental health conditions (City of Seattle, 2017)
- Duration of homelessness (City of Seattle, 2017; Hunter et al., 2016; Metraux et al., 2019)
- Current living conditions (Metraux et al., 2019)
- Where they were staying before the encampment (City of Seattle, 2017; Hunter et al., 2016)
- Potential barriers to entering shelter, such as pets, partners, or a significant number of belongings (Hunter et al., 2016)

That type of data may be collected during the intake process at sanctioned encampments, through outreach to people staying in tacitly accepted encampments, or during the process of encampment clearance. One of the key challenges of any data collection effort associated with encampments is capturing a representative sample of people. As described by a key informant who is conducting research on encampments, people who stay in unsanctioned encampments often strive to keep off the public radar, and they may differ in important ways from the subset of people who are visible for data collection efforts. According to this key informant, outreach workers are generally better received when they make low demands, offer something that people in encampments might want or need, and share demographic characteristics or lived experiences with those in encampments. People who stay

in encampments may be wary of authority figures and are more likely to welcome outreach workers who do not act or present as such. These same considerations may also apply to sanctioned encampments.

Data collection efforts are also hampered by the transient nature of people experiencing unsheltered homelessness and the limited capacity of outreach teams to comprehensively canvas the less visible and less accessible geographies within their communities. Intensive and time-consuming outreach and follow-up efforts are required to collect information about encampment residents over time. Mental illness and substance use can also complicate data collection because the responses of affected individuals to questions may be unreliable.

Suggestions for Additional Research

As part of this review of the current evidence base on encampments, we gathered suggestions from the key informants we interviewed—people who are conducting research on encampments or advising communities on strategies for addressing encampments—for additional research that could advance the field in a variety of ways. Some of the published literature we reviewed also included suggestions for additional research that would support deeper understanding of the nature of encampments and would inform program design going forward. These ideas for additional research include the following:

- ***Understanding the characteristics of people who are living in encampments.*** What are the characteristics of people in encampments, including their immediate past experience? Are they different in meaningful ways from other people experiencing unsheltered homelessness? Are there significant differences in the characteristics of people who live in different types of encampments—for example, in groups of cars or other vehicles compared with encampments of tents or other structures? How long have they lacked stable housing? Where were they living before their stay in the encampment? What were their circumstances that contributed to them staying in an encampment? How often are families with children living in encampments, and how are their characteristics, needs, and vulnerabilities different from those of individual adults? This type of information could help to improve the targeting of efforts to prevent homelessness and stays in encampments.

- ***Understanding the experience of people experiencing unsheltered homelessness in encampments***. How do they spend their days? How long do people stay in encampments, and where do they go when they leave encampments (how often do people continue to experience unsheltered homelessness, how often do they find housing, and how often do they go to shelters or other settings, including treatment programs)? What are their service utilization patterns and the costs of their service use? With a better understanding of the behaviors and needs of people who are living in encampments, practitioners and policymakers can design and implement more effective interventions that meet those needs. Research projects can draw on integrated data systems, real-time surveys, and interviews with people with lived experience. Some of the best early opportunities may be in states and local jurisdictions that already link data systems.

- ***Understanding the relative effect of interventions currently in use.*** Do people who receive extensive outreach and referrals in advance of an encampment clearance fare better than those who stay in formally sanctioned encampments? Do outcomes vary depending on who conducts the outreach? Do sanctioned encampments achieve higher rates of exits from homelessness than do other approaches to ending homelessness for unsheltered people? Do the outcomes of people who formerly stayed in encampments differ over time, depending on the type of assistance they receive?

- ***Exploring racial/ethnic disparities in access to the homeless services system.*** Studies in Oakland, Orlando, and Seattle point to the possibility of racial segregation, and perhaps self-segregation, of encampment populations—and, by inference, of populations using shelters. Research could explore the reasons for these patterns, including possible barriers to entry into shelters or to programs providing permanent housing that affect particular racial/ethnic groups.

- ***Understanding community responses to the presence of encampments.*** What are community members' expectations regarding responses to unsanctioned encampments in their neighborhoods and approaches to resolving them? How are community members' responses shaped by stigma or bias related to race, homelessness, poverty, mental health needs, and substance use? How do community members respond to sanctioned encampments, and are factors present that determine whether sanctioned encampments experience more or less acceptance? What strategies can public and private agencies use to keep community members informed of their approaches to assist people living in encampments?

Conclusion

In recent years, encampments of people experiencing homelessness have become pervasive in communities across the United States. They can be found in busy neighborhoods in large cities, isolated rural areas, and everywhere in between. Encampments may be as small as a cluster of 8 to 10 households next to a highway entrance ramp, or they may encompass multiple structures scattered across several acres of parkland or industrial areas. The encampments that are visible to outside observers take many forms, including tents, lean-to shacks and shanties, and groups of cars or vans; other encampments that are not so visible are hidden in manmade infrastructure or natural features. The motivations and circumstances of people staying in encampments are as varied as their size, shape, and location.

Despite this diversity, at the root of all encampments is a need for greater investment of resources to address severe shortages of affordable housing. Absent this commitment, people experiencing homelessness are forced to find other places to stay, and encampments may be the best alternative among a limited set of options. Articles in the peer-reviewed and gray literature document a consistent set of factors that contribute to people's decisions to stay in encampments rather than in shelters or in other, unsheltered locations. Shortages in the availability of shelter beds, policies that create barriers to entry, and undesirable conditions inside shelters all influence people to seek an alternative place to stay. When shelters cannot fulfill their needs for safety, sense of community, and the freedom to come and go at will, people experiencing homelessness may decide to stay in encampments.

Local jurisdictions are pursuing a variety of strategies to address encampments and the challenges they pose to health, safety, and well-being. The most rudimentary of those approaches is to "sweep" encampments, the primary goal of which is clearing out the people staying in them. Preliminary evidence suggests that this response of clearance without support results in disruption and trauma for inhabitants of the encampments but does little to resolve the problem. Encampments are quickly reestablished in a new location or even back on the recently cleared site. We know little about the effects of other responses that provide support to people in encampments, including responses that allow encampments to persist—through either tacit acceptance or formal sanctioning—and clearance efforts that are accompanied by outreach and referrals to housing and services.

Communities are experimenting with new service approaches to assisting people living in encampments. The Navigation Centers that were first established in San Francisco now are being replicated elsewhere but, so far, not based on strong evidence of their effectiveness. The logic is that removing many of the barriers that cause people to seek alternatives to emergency shelters and including intensive case management to help clients secure permanent housing will prevent encampments from forming and provide a transition to permanent housing for people moved out of encampments. Other cities are relaxing admission requirements for drug treatment programs to expedite entry by people in encampments. Still others are pairing first responders with trained outreach workers who can help make connections to appropriate services. More research will be needed to assess the results of these and other initiatives.

We do not know enough about the characteristics and experiences of people who stay in encampments. Collecting even baseline information can be difficult when many people actively try to escape public notice. Data collection challenges also complicate efforts to understand the costs and effectiveness of public responses to encampments. Practical and political barriers will have to be overcome to arrive at meaningful findings that can inform policymaking and practice.

This review of what we know as of late 2018 about encampments is part of a larger study sponsored by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, and the U.S. Department of Housing and Urban Development, Office of Policy Development and Research that will help increase the body of knowledge. We will use interviews with stakeholders in nine communities and site visits to four communities to collect information on the causes and characteristics of encampments and on community responses to encampments. The site visits to four communities also will attempt to document the public costs of various strategies for addressing encampments.

Appendix A. Methods Used to Conduct the Literature Review and Interviews with Key Informants

Scan of Peer-Reviewed Literature

To identify relevant peer-reviewed literature, we searched EBSCO Discovery Service, which provides a comprehensive search of academic journals and databases, and Google Scholar. Specific search strings and limiters used are listed in Exhibit 4.

Exhibit 4. Search Strings and Limiters

Search string used:

- "homeless encampment" OR "tent city" OR "homeless settlement" OR "homeless camp"

Limiters used:

- Peer-reviewed journals
- Published on or after January 1, 2011
- Published in English

We compiled references and abstracts from all database returns using Zotero software. We then reviewed all abstracts, identifying 43 articles for retrieval and further review. We excluded articles if they focused on encampments serving a non-homeless population, such as refugees or protesters. We also excluded research on homeless encampments in an international context because experiences with encampments and unsheltered homelessness in other countries diverge in important ways from the experience in the United States.

We identified 16 articles from more than 500 returned results that addressed the research questions shown in Exhibit 1 in the introduction. Those 16 articles include several written by the same primary author that draw on a single dataset. Under other circumstances, we might exclude a portion of the similar articles from review; however, given the small body of research on encampments, we opted to consider them all.

Scan of Gray Literature

We searched websites of government agencies, nongovernmental organizations, and academic institutions to supplement the peer-reviewed literature and identify relevant unpublished literature, white papers, presentations, and research briefs. When a website included a search function, we used the search string identified in Exhibit 4 to identify relevant resources. We also scanned relevant website sections for pertinent materials.

We found reports, publications, and conference proceedings on the official websites of the following agencies and organizations: U.S. Department of Justice, National Alliance to End Homelessness, National Coalition for the Homeless, National Law Center on Homelessness and Poverty, Seattle University School of Law, University of Denver Sturm College of Law, and San Francisco Office of

the Controller. We identified 41 documents through this process, 17 of which were determined to be relevant to this project.

We identified additional resources during interviews with key informants and by following references in the peer-reviewed and gray literature.

Interviews with Key Informants

We conducted interviews with key informants to augment information collected during the literature reviews. We identified an initial list of interviewees based on recommendations from the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, and the U.S. Department of Housing and Urban Development, Office of Policy Development and Research staff and from project team members with expertise in homelessness, substance use disorder, and criminal justice. We identified additional individuals by asking at the conclusion of each interview for suggestions of other academics or practitioners who may be studying encampments.

Exhibit 5 lists the key informants we interviewed.

During the interviews, we asked about ongoing research projects focused on the recent growth in unsheltered homelessness and encampments; the characteristics of people in encampments and the factors that lead them to congregate there; and communities' responses, including their costs and effectiveness. We also asked key informants targeted questions about specific research projects or programs, based on our background research.

Exhibit 5. Key Informants

Name	Title	Affiliation	Date Interviewed
Sharon Chamard, PhD	Associate Professor	University of Alaska, Anchorage	November 8, 2018
Dennis Culhane, PhD	Dana and Andrew Stone Professor of Social Policy; Co-Principal Investigator, Actionable Intelligence for Social Policy	University of Pennsylvania	October 16, 2018
Margot Kushel, MD	Professor; Director of the Center for Vulnerable Populations	University of California, San Francisco	October 25, 2018 December 27, 2018
Stephen Metraux, PhD	Associate Professor; Director of the Center for Community Research & Service	University of Delaware	October 26, 2018
Colleen Murphy	Manager, Coordinated Entry System Access	Los Angeles Homeless Services Authority	November 16, 2018
Barbara Poppe	Founder and Principal	Barbara Poppe & Associates LLC	November 2, 2018
Kelly Robson	Chief Social Services Officer	HELP of Southern Nevada	October 29, 2018
Nan Roman	President and CEO	National Alliance to End Homelessness	November 1, 2018

Appendix B. Summaries of Selected Studies

In this appendix, we provide details on the approach, methodology, limitations, and key findings from selected studies in the peer-reviewed and gray literature. These studies were particularly informative as we completed our review.

City of Seattle, Human Services Department. (2017). *Seattle Permitted Encampment Evaluation.* Seattle, WA: City of Seattle.

This internal evaluation assesses the performance of three temporary, permitted encampments in the City of Seattle in 2016: Ballard, Interbay, and Othello. The encampments were created by the city on public land. They are operated by nonprofit partners with oversight from the city's Human Services Department. The authors used HUD's Annual Performance Report, Seattle Police Department data, and stakeholder interviews to inform their analysis, which focuses on (a) determining whether temporary, permitted encampments are an effective homelessness response strategy, and (b) identifying areas where the model works well or could be improved. Data collection challenges include people departing from the encampment before they interact with a case manager, case manager staff turnover, and missing responses (client doesn't know/client refused, data not collected).

The Human Services Department found that several features contributed to the success of the encampments:

- Inhabitants of encampments benefited from being able to stay in one location for a longer period, as they could make progress toward stability goals and build relationships with the community.
- The self-management model used at all three encampments empowered inhabitants and enabled them to build confidence, camaraderie, and leadership skills.
- The provision of structured case management services, including referrals to local shelters and rapid rehousing when appropriate, referrals to employee training and education, domestic violence services, and access to a mobile medical van.

The evaluation concludes that Seattle's sanctioned encampment model is successfully serving people who have been living outside in greenbelts, on the streets, in cars, and in otherwise hazardous situations. The neighboring communities have responded positively, and crime did not increase significantly when a permitted encampment was established.

Donley, A., and J. Wright. 2012. "Safer Outside: A Qualitative Exploration of Homeless People's Resistance to Homeless Shelters," *Journal of Forensic Psychology Practice* 12 (4): 288–306. doi:10.1080/15228932.2012.695645.

This study examines why people experiencing homelessness in Orange County, Florida, stay in encampments instead of available rooms in local shelters. The authors conducted a series of five focus groups with 39 people who lived in the East Orange encampments. All participants were

recruited for the study by the Orlando Homeless outreach team. Each focus group averaged 2 hours in duration and included, on average, eight people from two or three camp sites. The study is limited by the small and localized sample size; in addition, although the study was published in 2012, the focus groups were conducted in February of 2007. The authors do not discuss local preventive or punitive ordinances with regard to encampments in Orange County.

Participants "described their experiences with downtown [Orlando] homeless services and downtown itself in negative terms and said they would not venture back downtown for any conceivable reason, no matter how many services might be available there." Although participants gave many reasons for this decision, the most prevalent themes centered on the undesirable location of shelter facilities, prior negative experiences with shelters, and the sense of companionship, freedom, and safety associated with encampments.

Herring, C., and M. Lutz. 2015. "The Roots and Implications of the USA's Homeless Tent Cities," ***City*** **19 (5): 689–701. doi:10.1080/13604813.2015.1071114.**

Herring and Lutz explain the resurgence of homeless encampments in the United States through comparative case studies of encampments in Fresno, California, and Seattle, Washington. They draw from interviews and field notes completed by both authors between 2009 and 2011, along with the preexisting peer-reviewed and gray literature on encampments. The authors chose to focus on Fresno and Seattle because those cities contain large, persistent camps—including some that are legally recognized and others that are illegal and tacitly accepted.

Herring and Lutz argue that homeless encampments were not rooted in the 2008 recession, nor can they be explained by a general expansion in the homeless population. Using their case studies as supplementary evidence, they conclude that the "crisis of welfare provision in the form of perpetual shelter shortages and repulsive shelter arrangements led homeless people to prefer large encampments and led advocates and city officials to recognize large encampments as legitimate shelter alternatives."

Jones, P., K. Parish, P. Radu, T. Smiley, and J. van der Heyde. 2015. ***Alternatives to Unsanctioned Homeless Encampments.*** **Berkeley, CA: Goldman School of Public Policy, University of California, Berkeley.**

The authors of this report interviewed Oakland, California, encampment residents, service providers, and city stakeholders to understand their needs and concerns. The needs assessment and interviews with Oakland stakeholders revealed that people living in encampments "face serious barriers to both housing and shelter use that makes unsanctioned camps their only viable alternative." Jones and his colleagues then studied best practice examples of two alternatives to Oakland's current approach of clearing encampments: (1) establishing city-sanctioned campgrounds and (2) adopting a Housing First approach. They examined those alternatives in four cities: Nashville, Tennessee; Ontario, California; Portland, Oregon; and Seattle, Washington.

Analyzing the data obtained from interviews in Oakland and the best practices from other cities, the authors assigned a score to each of these approaches (clearance, sanctioned encampments, and Housing First) with respect to three criteria:

- *Effectiveness*, defined as the "degree to which the policy in question addresses the immediate problems associated with homeless encampments, comprehensively and across both the short- and long-term."
- *Equity*, as a measure of the "differential consequences of the policy for different stakeholders or constituents" and that looks at the degree to which an intervention is likely to have disproportionate effects for any particular group.
- *Implementation feasibility*, or a city's capacity to implement each policy according to its original design.

The authors weighted the criteria to reflect stakeholders' stated preferences about the relative importance of each criterion. Effectiveness accounted for 50 percent of the score, equity for 30 percent, and implementation feasibility for 20 percent. Higher scores indicate more preferable alternatives for Oakland.

Jones and his colleagues conclude that Oakland officials could expect a city-sanctioned campground to perform best as measured by effectiveness, equity, and implementation feasibility, followed closely by a Housing First approach. Although the authors found clearing encampments to be the most easily implemented, it scored lowest on effectiveness and equity. Despite efforts to coordinate with outreach services and give sufficient notice to camp residents, the process of clearing camps "prevents residents from complying with important housing or health appointments." In short, the status quo in Oakland as of 2015 "serves as a cyclical disruption for camp residents and creates an additional barrier on their pathway to housing."

Metraux, S., M. Cusack, F. Graham, D. Metzger, and D. Culhane. 2019. *An Evaluation of the City of Philadelphia's Kensington Encampment Resolution Pilot.* Philadelphia, PA: City of Philadelphia.

This report is an independent process evaluation of the City of Philadelphia's Encampment Resolution Pilot (ERP). The ERP is a cross-departmental city initiative that was established to close down two outdoor homeless encampments in May 2018. The ERP process included extensive outreach to and engagement of people staying in the encampments and the establishment of Navigation Centers to provide them with access to housing and drug treatment assistance and intensive case management. The city also took steps to prevent the encampments from re-forming through police monitoring, continued outreach and community involvement efforts, and physical changes to the site.

To evaluate the ERP, Metraux and his colleagues draw on an array of data sources that include city documents and interviews with key stakeholders and persons directly involved with implementing the pilot. In addition, the authors had direct access to planning and operational activities, and they conducted ethnographic observations at the encampments and in the surrounding community. They

used a semi-structured interview guide with a sample of residents at the two encampments targeted by the ERP to elicit open-ended responses in four topic areas: living situation, typical day, background and service use, and perspectives on the encampment closure.

The report uses this information to assess the planning, implementation, and initial outcomes of the ERP and to determine strengths and limitations of the pilot.

National Law Center on Homelessness and Poverty. 2014. *Welcome Home: The Rise of Tent Cities in the United States.* Washington, DC: National Law Center on Homelessness and Poverty.

This report documents the rise of homeless encampments and tent cities across the United States and the legal and policy responses to that growth. The authors reviewed media reports on tent cities published between 2008 and April 2012 as well as existing literature on the subject. They also conducted telephone interviews with experts and service providers. Based on this preliminary research, the authors identified four sites for in-depth case studies: Lakewood, New Jersey; New Orleans, Louisiana; Providence, Rhode Island; and St. Petersburg, Florida. The sites were chosen on the basis of their locations, the size and prominence of the former or current encampments they hosted, and their perceived usefulness for gaining a broader understanding of the causes of and responses to homeless encampments. The authors chose to focus on the East Coast because a report documenting tent cities on the Pacific Coast already existed.

Their media survey found documentation of more than 100 tent communities in 46 states and the District of Columbia. While maintaining that the existence of tent cities itself reflects a severe lack of affordable housing, the report finds that **"**when adequate housing or shelter is not available, forced evictions of tent communities may violate human rights, and may also violate principles of domestic law." The authors argue that tent cities are a result of the absence of other reasonable options. Where alternative housing facilities are insufficient, municipalities should work together with people staying in encampments "in a manner that prioritizes the autonomy and dignity of homeless individuals and allows them to have a voice in the process."

Sparks, T. 2017a. "Citizens Without Property: Informality and Political Agency in a Seattle, Washington Homeless Encampment," *Environment and Planning A: Economy and Space* 49 (1): 86–103. doi:10.1177/0308518X16665360

Sparks, T. 2017b. Neutralizing Homelessness, 2015: Tent Cities and Ten Year Plans. *Urban Geography* 38 (3): 348–356. doi:10.1080/02723638.2016.1247600.

Sparks bases these two articles on his 2006 ethnographic fieldwork, including 6 months living and participating as a resident in Seattle's Tent City 3. In addition to participant observation, during his time in Tent City 3, he conducted 50 in-depth interviews with people staying there.

In "Citizens Without Property," Sparks documents the history of Seattle's encampments and offers an explanation for why people experiencing homelessness often do not to take advantage of social services and shelters, even when they are available. That is, within encampments, people

experiencing homelessness have a venue to "respond, resist, and remake the political landscapes of homelessness" and to "challenge their marginalization and create more habitable and emancipatory spaces." Sparks centers his theory around the social and political structures in Tent City 3, which allow residents to feel responsible, be independent, and participate in camp activities—in contrast to the demeaning treatment received at shelters.

In "Neutralizing Homelessness," Sparks claims that the "medicalization and personalization of homelessness" serves to "stabilize and maintain homelessness in seeming perpetuity"—that is, because of this flawed view of homelessness, people experiencing homelessness are blamed for their situation rather than systems, structures, or societal conditions being blamed. Well-intended service providers accept the narrative of "homeless as pathology" and create an environment that dehumanizes people who might otherwise seek assistance, leading them to stay in encampments, where they can be seen as "normal" people.

Speer, J. 2017. "'It's Not Like your Home': Homeless Encampments, Housing Projects, and the Struggle over Domestic Space" ***Antipode*** **49 (2): 517–35. doi:10.1111/anti.12275.**

Speer, J. 2018a. "The Rise of the Tent Ward: Homeless Camps in the Era of Mass Incarceration," ***Political Geography*** **62: 160–169. doi:10.1016/j.polgeo.2017.11.005.**

Speer, J. 2018b. "Urban Makeovers, Homeless Encampments, and the Aesthetics of Displacement," ***Social & Cultural Geography*** **1–21. doi:10.1080/14649365.2018.1509115.**

In these three articles, Speer builds on interviews and ethnographic fieldwork conducted in Fresno, California, in 2013. Of the 24 people Speer interviewed, 9 were officials involved in homeless management, 8 were homeless, and 7 were local activists. She selected homeless participants from multiple racial/ethnic backgrounds, genders, and ages. The author returned to Fresno in 2016 to volunteer at an activist-led encampment and follow up with former research participants. To supplement fieldwork, Speer also relied on two local media sources and reviewed policy reports, legal documents, and online videos and radio programs depicting homeless activism and evictions. Speer believes Fresno to be an ideal city through which to examine the politics of home in relation to homelessness because of its large-scale encampments and intensive housing subsidy program.

"'It's Not Like Your Home'" focuses on how people staying in encampments define *home*. Participants appreciate the sense of community within encampments and the opportunities to exercise autonomy. Speer demonstrates that, by staying in encampments, "homeless Fresnans were creating a new kind of home in which individuals and families were part of a larger collective tied to each other through relations of mutual care."

"Urban Makeovers" probes the motivations behind Fresno's varying responses to homeless encampments. Drawing on personal interviews, media articles, and statements made by city officials and politicians, Speer claims that in the Fresno political discourse, homeless encampments are framed as "unpleasant objects that must be removed to make way for economic opportunities." Thus, "efforts to reinforce a 'live play work' aesthetic resulted in a politics of displacement and criminalization" as city officials worked to move those in encampments to the margins of town, sanction those marginalized encampments, and make them visually uniform and uncluttered.

"The Rise of the Tent Ward" goes beyond Fresno to look at city-sanctioned and -controlled encampments in King County, Washington; Ontario, California; Portland, Oregon; Reno, Nevada; and St. Petersburg, Florida. Speer terms these encampments as *tent wards* to reflect "how incarceration becomes enmeshed with the provision of care and shelter." She argues that these encampments "are not simply a cost effective form of shelter: they are a new node in a wider network of quasi-carceral spaces that govern homeless mobility" that "undermine structural efforts to address poverty and housing inequality."

Appendix C: Selected Practitioner Resources

In the course of conducting this literature review, the study team identified a number of resources that did not meet our criteria for inclusion in the review but may be informative for local leaders and practitioners who are seeking practical guidance on how to address encampments in their communities. We provide links to these resources below.

United States Interagency Council on Homelessness (USICH)

Following conversations with advocates, housing and services providers, and government officials, USICH prepared a suite of resources intended to help local communities develop an action plan to connect people experiencing homelessness in encampments with permanent housing. Those resources include a paper that discusses the key components of an action plan, a quick guide that provides an introduction to the concepts covered in the paper, and a planning checklist with action steps for each of the key components. Those resources were published in 2015 and are available for download at www.usich.gov/tools-for-action/ending-homelessness-for-people-in-encampments/.

USICH has also prepared a series of case studies of communities that are implementing strategies to address the housing and services needs of people experiencing homelessness in encampments. Published in 2017, the case studies describe lessons learned from the local experience in six communities: Charleston, South Carolina; San Francisco, California; Seattle, Washington; Chicago, Illinois; Philadelphia, Pennsylvania; and Dallas, Texas. Topics covered include the evolution of the city's approach to addressing encampments, key stakeholders and tips for engaging them, and challenges or surprises encountered in the implementation process.

In May 2018, USICH published a brief titled Caution is Needed When Considering "Sanctioned Encampments" or "Safe Zones". The brief urges communities to proceed with caution when considering the establishment of sanctioned encampments and lists key points to consider for those who decide to proceed. The brief concludes with a list of links to additional USICH resources.

Corporation for Supportive Housing (CSH)

CSH has made available for download an extensive set of templates, provider tools, and draft policies for addressing unsheltered homelessness. Although not specific to encampments, many of these resources may be helpful in working with people experiencing unsheltered homelessness in encampments. All resources are available for download at www.csh.org/communityresponse/.

National Alliance to End Homelessness

The National Alliance to End Homelessness publishes presentation notes and slide decks from sessions at its national conferences. Several sessions at recent conferences address encampments, including the following:

- Resolving Encampments: Evaluating Different Approaches (July 2018)
- Sanctioned Encampments: Questions You Should Ask (July 2018)
- Understanding Unsheltered Homelessness: What We Know So Far (July 2018)
- A Growing Unsheltered Population: Addressing Encampments (August 2016)

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U.S. Department of Housing and Urban Development
Office of Policy Development and Research
Washington, DC 20410-6000

677

EQUAL HOUSING OPPORTUNITY

June 2019

TAB 103

Court File No. CV-21-00077817-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, ET AL.

Applicants

-and-

CITY OF HAMILTON

Respondent

AFFIDAVIT OF STEPHEN HWANG

SWORN FEBRUARY 27, 2023

I, Dr. Stephen W. Hwang, physician, Toronto, Ontario, MAKE OATH AND SAY AS FOLLOWS:

1. I have personal knowledge with respect to the facts set out below, except where stated otherwise. Where the information is not based on my personal knowledge, it is based upon information provided by others which I believe to be credible and true.

2. I am a specialist in general internal medicine with training in public health and epidemiology. My primary research interests are homelessness and health, access to health care for homeless persons, and housing as a determinant of population health. I currently hold the following positions:

   Professor, Department of Medicine, Faculty of Medicine, University of Toronto

   Professor (cross-appointed), School of Public Health Sciences, University of Toronto

Professor (cross-appointed), Department of Health Policy, Management, and Evaluation, University of Toronto

Senior Adjunct Scientist, Populations and Public Health Program, Institute for Clinical Evaluative Sciences, Toronto

Director, MAP Centre for Urban Health Solutions, Unity Health Toronto, Toronto

Staff Physician, Division of General Internal Medicine, St. Michael's Hospital

3. A copy of my Curriculum Vitae is attached to this my Affidavit as Exhibit "A".

4. I have been asked by the Hamilton Community Legal Clinic to provide an expert opinion in this matter regarding the health implications of being homeless and living on the streets with no shelter. Specifically, I was asked to opine on the increased health risks faced by homeless people, the health implications of lack of sleep for homeless people, and the health implications on homeless people who sleep outside and are prohibited from erecting even the most rudimentary forms of shelter from the elements (e.g. tent, tarpaulin, cardboard barriers) and evicted from that shelter. My opinion is thus focused on addressing these specific issues.

5. In my opinion, homelessness has major health implications. I have attached two academic articles that I have written which summarize these issues "Homelessness and Health," *Canadian Medical Association Journal*, 2001(Exhibit "B") and "Homeless People," from the *Handbook of Urban Health, 2*005, (Exhibit "C") and adopt these articles as part of my opinion in this case. People who become homeless often have physical and mental health problems which worsen over the period that they are homeless. This deterioration

in health is related to numerous factors, including a lack of stable housing, an adverse social environment, the near impossibility of maintaining health-promoting behaviours in the face of homelessness, and barriers to accessing appropriate health care. The state of being homeless also has direct adverse effects on health through an increased exposure to infectious and communicable diseases (e.g., tuberculosis and insect infestations such as bed bugs and scabies) and an increased risk of violence and victimization while living in shelters and on the street. For those living outside, exposure to the elements can lead to a number of serious and potentially life-threatening conditions. Homeless people are at risk for severe sunburn and heatstroke during the summer months. During cold weather, frostbite and hypothermia are major problems.

6. Homeless people often suffer from sleep deprivation due to an inadequate number of hours of sleep, as well as disturbed or fragmented sleep. For homeless people sleeping outside, sleep fragmentation is often related to external stimuli, such as bright lights, loud noises, and intentional efforts by other people to awaken or disturb them. A large body of research evidence has shown that inadequate sleep has numerous adverse health effects, including an increased risk of diabetes, cardiovascular disease, obesity, depression, and injuries, as well as the more commonly recognized problems of impaired alertness, attention, and concentration.

7. If homeless people who sleep outside are prohibited from erecting even the most rudimentary forms of shelter from the elements (e.g. tent, tarpaulin, or cardboard

barriers), this would have clear and direct adverse impacts on their health. First, a lack of protection from wind and rain would increase the wind chill effect, which would greatly increase the risk of hypothermia. As has been documented in the research literature, homeless people are at particularly high risk of death from hypothermia, and half of all such deaths occur when the air temperature is above freezing ("Accidental hypothermia and death from cold in urban areas," *International Journal of Biometeorology,* 1991). The wind chill effect plays a key role in such deaths. Second, prolonged exposure to cold and dampness increases the risk of skin breakdown and skin infections, particularly in the feet. In homeless people, exposure of the feet to wet and cold conditions can lead to immersion foot or trench foot, a serious condition that was first described among soldiers serving in the trenches during World War I. Third, recent research has shown that exposure to the cold increases the risk of developing respiratory tract infections, which are a major health problem among people experiencing homelessness. Fourth, a lack of shelter from the sun would greatly increase homeless people's risk of severe sunburn and heatstroke during the summer months. Fifth, the lack of a tent or other structure to provide even a minimal degree of protection from the elements, light, and noise would result in even more disturbed and fragmented sleep, with the adverse health effects detailed above.

8. In summary, if homeless people who sleep outside are prohibited from erecting any form of shelter such as a tent, tarpaulin, or cardboard box, it is absolutely clear that this would

have a substantial and potentially severe adverse effect on their health, and would likely increase their risk of death.

Sworn remotely by Stephen Hwang at the City of Toronto in the Province of Ontario, before me on February 27, 2023 in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

Commissioner for Taking Affidavits

Stephen Hwang

Stephen Hwang

THIS IS EXHIBIT “A” TO THE
AFFIDAVIT OF STEPHEN HWANG
AFFIRMED REMOTELY BEFORE ME AT
THE CITY OF TORONTO DURING A “ZOOM” VIDEOCONFERENCE
IN ACCORDANCE WITH O.REG. 431/20,
ADMINISTERING OATH OR DECLARATION REMOTELY
THIS 27TH DAY OF FEBRUARY, 2023



SHARON CROWE

Commissioner for Taking Affidavits, etc.

Curriculum Vitae

Stephen W. Hwang
MD, MPH, FRCPC

A. Date Curriculum Vitae is Prepared: 2022 April 22

B. Biographical Information

Primary Office	St. Michael's Hospital MAP Centre for Urban Health Solutions 30 Bond Street Toronto, Ontario, Canada M5B 1W8
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1. EDUCATION

Degrees

1994 - 1996	Master of Public Health, Clinical Effectiveness, Harvard School of Public Health, Boston, Massachusetts, United States
1984 - 1988	MD, Medicine, Johns Hopkins University School of Medicine, Baltimore, Maryland, United States
1980 - 1984	BA, Biochemistry (magna cum laude), Harvard University, Cambridge, Massachusetts, United States

Postgraduate, Research and Specialty Training

1991 - 1992	Chief Medical Resident, Toronto Western Hospital/Toronto General Hospital, Department of Medicine, University of Toronto, Toronto, Ontario, Canada
1988 - 1991	Internal Medicine Residency, Department of Medicine, University of Toronto, Toronto, Ontario, Canada

Qualifications, Certifications and Licenses

2003 - present	Fellow, American College of Physicians, Philadephia, Pennsylvania, License / Membership #: 46674
1992 - present	General Licence, College of Physicians and Surgeons of Ontario, Toronto, Ontario, License / Membership #: 60001
1992 - present	Fellow, Royal College of Physicians of Canada, Ottawa, Ontario, License / Membership #: 432499

2. EMPLOYMENT

Current Appointments

2017 Jan - present	Full Member, School of Graduate Studies, University of Toronto, Toronto, Ontario, Canada
2015 Jul - present	Director, MAP Centre for Urban Health Solutions, St. Michael's Hospital, Toronto, Ontario, Canada
2014 Jul - present	Professor, Department of Medicine, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada
2014 Jul - present	Professor (cross appointment), Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada
2014 Jul - present	Professor (cross appointment), Dalla Lana School of Public Health, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada
2008 Sep - present	Research Scientist, Li Ka Shing Knowledge Institute, St. Michael's Hospital, Toronto, Ontario, Canada
2008 Mar - present	Adjunct Senior Scientist, Primary Care and Population Health Program, Institute for Clinical Evaluative Sciences, Toronto, Ontario, Canada
1996 Sep - present	Staff Physician, Division of General Internal Medicine, Department of Medicine, St. Michael's Hospital, Toronto, Ontario, Canada

Previous Appointments

HOSPITAL

2001 - 2005	Acting Director, Clinical Epidemiology Unit, St. Michael's Hospital, Toronto, Ontario, Canada
1996 Sep - 2008 Sep	Population Health Epidemiologist, Inner City Health Program, St. Michael's Hospital, Toronto, Ontario, Canada
1992 - 1996	Staff Physician, Division of General Internal Medicine, Boston City Hospital, Boston, Massachusetts, United States

UNIVERSITY

2005 Nov - 2016 Jun	Director, Division of General Internal Medicine, Department of Medicine, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada
2005 Jul - 2016 Dec	Associate Member, School of Graduate Studies, University of Toronto, Toronto, Ontario, Canada

UNIVERSITY - CROSS APPOINTMENT

2005 - 2014 May	Associate Professor (cross-appointment), Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada
2005 - 2014 May	Associate Professor (cross-appointment), Dalla Lana School of Public Health, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada
2001 - 2005	Assistant Professor (cross-appointment), Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada
1998 - 2005	Assistant Professor (cross-appointment), Public Health Sciences, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada

UNIVERSITY - RANK

2008 - 2014	Associate Professor, Medicine, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada
1998 - 2005	Assistant Professor, Medicine, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada
1996 - 1998	Lecturer, Medicine, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada

1995 - 1996	Clinical Assistant Professor, Medicine, School of Medicine, Boston University, Boston, Massachusetts, United States
1992 - 1995	Clinical Instructor, Medicine, School of Medicine, Boston University, Boston, Massachusetts, United States

OTHER

2020 May - 2020 Jul	Medical Co-Director, COVID Recovery Sites, Inner City Health Associates, Toronto, Ontario, Canada *Medical co-director of hotel sites for people experiencing homelessness who are recovering from COVID-19*

3. HONOURS AND CAREER AWARDS

Distinctions and Research Awards

INTERNATIONAL

Received

2016 Jul	**2016 Robert Carr Award**, Research team member, International Council of AIDS Service Organizations (ICASO). (Research Award) *This award recognizes a research project conducted by a community-academic partnership that has led to evidence-based programs and/or influenced policies in the field of HIV to guide a human rights-based response. The award was presented to the Positive Spaces Healthy Places Study at the 21st International AIDS Conference in Durban, South Africa, July 2016.*

NATIONAL

Received

2014 - present	**Fellow**, Canadian Academy of Health Sciences, Canada. (Distinction) *Fellows of the Academy are elected on the basis of their demonstrated leadership, creativity, distinctive competencies and commitment to advance academic health sciences. Membership is considered one of the highest honours for members of the Canadian health sciences community and carries with it a covenant to serve the Academy and Canadian society.*
2015	**CSIM Dr. David Sackett Senior Investigator Award**, Canadian Society of Internal Medicine, Canada. (Research Award) *This award recognizes excellence in research by a senior Canadian general internist. The award is intended to increase awareness of high quality research by general internists in Canada and to foster such research. Total Amount: 2,500*
2014	**Chinese Canadian Legend Award**, Asian Business Network Association, Canada. (Distinction) *The Chinese Canadian Legend Award recognizes Chinese Canadians who have accomplished outstanding achievements in their lives and made valuable contributions to the world community.*
2002	**CSIM Young Investigator Award**, Canadian Society of Internal Medicine, Canada. (Research Award) *This award is presented annually to an outstanding Canadian investigator in the field of general internal medicine who is within the first five years of his or her research career. Total Amount: 2,500*

LOCAL

Received

2020 Nov	**2020 Complete Physician Award**, St. Michael's Hospital, Toronto, Ontario, Canada. (Distinction) *This annual award recognizes one physician at St. Michael's Hospital that best exemplifies an ongoing commitment to and role modeling of the CanMEDS Roles.*
2020 - 2024	**2020 President's Impact Award**, University of Toronto, Toronto, Ontario, Canada. (Distinction) *This award recognizes and celebrates University of Toronto faculty members whose research has led to significant impact beyond academia. Total Amount: 50,000 CAD*
2016 Dec	**Spirit of Philanthropy Award**, St. Michael's Hospital Foundation. (Distinction) *This award recognizes an individual who has been an outstanding hospital fundraising partner over the past year.*
2013	**Dr. Vincent J. Hughes Physician Humanitarian Award**, St. Michael's Hospital Medical Staff Association. (Distinction) *This award is presented annually to a physician member of St. Michael's Hospital who has demonstrated outstanding compassion, respect for human dignity and caring of patients of all ages, races and economic status.*
2008	**Community-Based Research Award of Merit.**, Centre for Urban Health Initiatives and the Wellesley Institute, Toronto, Ontario, Canada. (Research Award) *The award recognizes principal investigators who have demonstrated exemplary participation in the field of Community Based Research.*

Teaching and Education Awards

LOCAL

Received

2021	**Department of Medicine Outstanding Postgraduate Teacher Award**, Dept of Medicine, Faculty of Medicine, St. Michael's Hospital, University of Toronto. (Postgraduate MD) *This award recognizes faculty for their dedication, enthusiasm and teaching excellence.*
2018	**Robert Sheppard Award for Health Equity and Social Justice**, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada *This award recognizes outstanding contributions of faculty members involved in the development and/or implementation of activities, programs or research related to social justice and health equity in faculty development or postgraduate medical education.*
2014	**FitzGerald Academy Master Teacher Award**, Dept of Medicine, Faculty of Medicine, University of Toronto *This award is presented annually by the FitzGerald Academy, Faculty of Medicine, in recognition of passion, enthusiasm, and sustained excellence in the teaching and support of undergraduate medical students.*
2001	**Outstanding Teacher Award in Postgraduate Medical Education**, Dept of Medicine, Faculty of Medicine, St. Michael's Hospital, Toronto, Ontario. (Postgraduate MD)
1998	**Outstanding Teacher Award in Postgraduate Medical Education**, Dept of Medicine, Faculty of Medicine, St. Michael's Hospital, Toronto, Ontario. (Postgraduate MD)
1997	**Outstanding Teacher Award in Postgraduate Medical Education**, Dept of Medicine, Faculty of Medicine, St. Michael's Hospital, Toronto, Ontario. (Postgraduate MD)

4. PROFESSIONAL AFFILIATIONS AND ACTIVITIES

Professional Associations

2010 Oct - present	**Member of Council and Executive Committee**, Canadian Society of Internal Medicine
2003 - present	**Member**, International Society for Urban Health
2002 - present	**Member**, Canadian Society of Internal Medicine
2001 - present	**Member**, Christian Medical and Dental Society of Canada
1998 - present	**Member**, National Health Care for the Homeless Council
1992 - present	**Member**, Society of General Internal Medicine
2015 Oct - 2017 Oct	**President**, Canadian Society of Internal Medicine
2014 Oct - 2015 Oct	**President-Elect**, Canadian Society of Internal Medicine
2010 Oct - 2014 Oct	**Secretary-Treasurer**, Canadian Society of Internal Medicine
2006 - 2016	**Member**, Association of Chiefs and Leaders of General Internal Medicine (ACLGIM)
2004 - 2006	**Member, Executive Committee**, International Society for Urban Health
2003 - 2009	**Chair, Communications Committee**, International Society for Urban Health

Administrative Activities

INTERNATIONAL

International Society for Urban Health

2006 Jan - 2006 Oct	**Member**, Scientific Committee, 5th International Conference on Urban Health, Amsterdam, Netherlands.
2005 Jan - 2005 Oct	**Member**, Community Engagement Subcommittee, 4th International Conference on Urban Health, Toronto, Ontario, Canada.
2005 Jan - 2005 Oct	**Member**, Conference Steering Committee, 4th International Conference on Urban Health, Toronto, Ontario, Canada.
2004 Jan - 2004 Oct	**Member**, Scientific Committee, 3rd International Conference on Urban Health, Boston, Massachusetts, United States.
2003 Jan - 2003 Oct	**Member**, Scientific Committee, 2nd International Conference on Urban Health, New York City, New York, United States.
2001 Dec - 2002 Oct	**Co-Chair**, Scientific Committee, 1st International Conference on Inner City Health, Toronto, Ontario, Canada.

National Academies of Sciences, Engineering, and Medicine

2016 Aug - 2018 Jul	**Member**, Housing, Health, and Homelessness Committee, Washington, District of Columbia, United States.

National Health Care for the Homeless Council (NHCHC)

2009 Sep - present	**Member**, Research Committee, United States.

North American Housing and HIV/AIDS Research Summit.

2010 Mar - 2010 Jun	**Member**, Planning Committee for Pre-Summit Learning Institute on “Examining Structural HIV Interventions: Methodological Challenges”, Toronto, Ontario, Canada.

Society of General Internal Medicine

2014 Sep - 2015 Feb	**Member**, 2015 Eisenberg Award Selection Committee, United States.

2013 Jun - 2018 May	**Member**, SGIM Research Committee, United States.
2006 Jul - 2007 Mar	**Chair**, 2007 Annual Meeting Workshop Review Committee, Health Disparities/Unique Populations, Toronto, Ontario, Canada.
2006 Jan - 2006 Mar	**Member**, 2006 Annual Meeting Workshop Review Committee, Health Disparities/Unique Populations, United States.
2005 Jan - 2005 Mar	**Member**, 2005 Annual Meeting Workshop Review Committee, Health Disparities/Unique Populations, United States.
2004 Jan - 2004 Mar	**Member**, 2004 Annual Meeting Workshop Review Committee, Health Disparities/Unique Populations, United States.
2003 Jan - 2003 Mar	**Member**, 2003 Annual Meeting Workshop Review Committee, Health Disparities/Unique Populations, United States.

University of Pennsylvania

2012 Jul - 2013 Jun	**Member**, Conference Organizing Committee, International Homelessness Research Conference, June 2013, Philadelphia, Pennsylvania, United States.

NATIONAL

Canadian Conference on Homelessness

2004 Jul - 2005 May	**Member**, Steering Committee, Toronto, Ontario, Canada.

Canadian Housing and Renewal Association

2003 Jan - 2003 Oct	**Member**, Organizing Committee, National Symposium on Health and Housing, Calgary, Alberta, Canada.

Canadian Observatory on Homelessness (successor to the Canadian Homelessness Research Network)

2009 Jul - 2019	**Member**, National Advisory Board, Toronto, Ontario, Canada.

Canadian Society of Hospital Medicine

2008 Jan - 2009 Sep	**Member**, Organizing Committee, 7th Annual Canadian Society of Hospital Medicine Conference, Toronto, Ontario, Canada.

Canadian Society of Internal Medicine

2013 Oct - 2014 Oct	**Member**, 2014 Annual Meeting Committee, Calgary, Alberta, Canada.
2012 Oct - 2013 Oct	**Chair**, 2013 Annual Meeting Committee, Toronto, Ontario, Canada.
2011 Oct - 2012 Oct	**Member**, 2012 Annual Meeting Committee, Quebec City, Quebec, Canada.

Government of Canada

2005 Sep - 2006 Jun	**Member**, Minister's Advisory Board, Canadian Housing Framework, Ottawa, Ontario, Canada.

The Salvation Army

2013 Jul - 2014 Dec	**Member**, National Advisory Board, Task Team on Homelessness, Canada.

PROVINCIAL / REGIONAL

Ministry of Municipal Affairs and Housing

2015 Jan - 2015 Oct	**Member**, Expert Panel on Homelessness, Ontario, Canada.

University of Calgary

2017 Oct **External Reviewer**, External Review of the Division of General Internal Medicine, University of Calgary, Ottawa, Ontario, Canada.

University of Ottawa

2010 Nov - 2010 Dec **External Reviewer**, External Review of the Division of General Internal Medicine, University of Ottawa, Ottawa, Ontario, Canada.

LOCAL

Department of Health Policy, Management and Evaluation, University of Toronto

2001 Jul - 2006 Jun **Member**, Executive Committee, Clinical Epidemiology and Health Care Research Program

Department of Medicine, University of Toronto

2006 Apr - 2016 Jun **Co-Chair**, On-Site Review Committee for the Core Internal Medicine Training Program, Faculty of Medicine, Dept of Medicine

2005 Nov - 2016 Jun **Member**, Core Internal Medicine Program Committee, Faculty of Medicine, Dept of Medicine

2005 Nov - 2016 Jun **Member**, Executive Committee, Department Division Directors

2004 Sep - 2005 Oct **Member**, Selection Committee, Director of the Division of General Internal Medicine

1998 Jul - 2005 Jun **Member**, Internal Medicine PGY1 Selection Committee, Faculty of Medicine, Dept of Medicine

Division of General Internal Medicine, University of Toronto

2006 Jul - 2016 Jun **Member**, General Internal Medicine PGY4-5 Selection Committee, Faculty of Medicine, Dept of Medicine, General Internal Medicine

2006 Jan - 2016 Jun **Chair**, University of Toronto Division of General Internal Medicine Executive Committee, Toronto, Ontario, Canada.

Good Shepherd Ministries

2020 Oct - present **Vice Chair**, Board of Directors, Toronto, Ontario, Canada.

2019 Oct - present **Member**, Board of Directors, Toronto, Ontario, Canada.

Member, Board of Directors, Toronto, Ontario, Canada.

Inner City Family Health Team (ICFHT)

2015 Jan - 2019 Oct **President**, Board of Directors, Toronto, Ontario, Canada.

2013 Oct - 2015 Jan **Member**, Board of Directors, Toronto, Ontario, Canada.

2011 Jul - 2013 Oct **Chair**, Board of Directors, Toronto, Ontario, Canada.

Inner City Health Associates (ICHA)

2011 Jul - 2014 Sep **Chair**, Board of Directors, Toronto, Ontario, Canada.

St. Michael's Hospital

2011 Jan - 2013 **Member**, St. Michael's Hospital Research Advisory Committee, Toronto, Ontario, Canada.

2011 Jan - 2011 Dec **Chair**, Li Ka Shing Knowledge Institute, Internal Scan Working Group on Knowledge Translation/Policy Research/Disadvantaged Populations, Toronto, Ontario, Canada.

2010 Nov - 2017 Dec **Member**, Li Ka Shing Knowledge Institute Reappointments Committee

2009 Apr - 2009 Jun	**Member**, Search Committee for Physician-in-Chief, St. Michael's Hospital
2009 Feb - 2009 Apr	**Member**, Five-Year Review Committee for Dr. Patricia O'Campo, Ricard Chair of Inner City Health and Director, Centre for Research on Inner City Health, St. Michael's Hospital
2000 Jul - 2003 Jun	**Member**, Postgraduate Medical Education Committee, St. Michael's Hospital, Faculty of Medicine, Dept of Medicine
2000 Jul - 2003 Jun	**Coordinator**, Postgraduate Education, Division of General Internal Medicine, St. Michael's Hospital
1997 - 2001	**Member**, Research Operations Committee, St. Michael's Hospital
1996 Jan - 2009 Jun	**Member**, Homeless and Underhoused Community Advisory Panel, St. Michael's Hospital

Street Health Community Nursing Foundation

2006 Jan - 2009 Jun	**Member**, Street Health Survey - Community Advisory Committee, Toronto, Ontario, Canada.

The Hospital for Sick Children

2009 May - 2009 Jun	**Member**, External Review Committee, Division of Paediatric Medicine

Unity Health Toronto

2019 Jan - present	Research Ethics Board, Toronto, Ontario, Canada.

University of Toronto

2013 Dec - 2014 Jun	**Member**, Review and Search Committee, Chair, Division of General Surgery, Toronto, Ontario, Canada.

Peer Review Activities

EDITORIAL BOARDS

Editorial Board Member

2009 May - 2012 Apr	Society of General Internal Medicine, Journal of General Internal Medicine

GRANT REVIEWS

External Grant Reviewer

2009	Ontario HIV Treatment Network (OHTN), Community Based Research Capacity Building Fund, Number of Reviews: 1
2009	Winnipeg Health Sciences Centre Foundation, Number of Reviews: 1
2008	Michael Smith Health Research Foundation, British Columbia, Number of Reviews: 1
2005	Ontario HIV Treatment Network (OHTN), Number of Reviews: 1
2004	Canadian Foundation for AIDS Research (CANFAR), Number of Reviews: 1
2004	Ontario Ministry of Health and Long Term Care, Health Research Personnel Development Program, Number of Reviews: 1
2002 - 2004	The Physicians' Services Incorporated Foundation, Ontario, Number of Reviews: 2
2001 - 2007	Michael Smith Health Research Foundation, British Columbia, Number of Reviews: 4

Reviewer

2014	Guy's and St. Thomas' Charity, United Kingdom, Number of Reviews: 1
2013	United States Department of Veterans Affairs, Cooperative Studies Program (CSP) Letter of Intent (LOI), Number of Reviews: 1
2010	United States Department of Veterans Affairs, Health Services Research and Development

	Service, Special Research Proposal Review Panel on Ending Homelessness Among Veterans. Number of Reviews: 1
2004 - 2007	Canadian Institutes of Health Research, Health Research Salary A Peer Review Committee (New Investigator Awards), Number of Reviews: 120
2003 - 2004	Canadian Institutes of Health Research, Health Disparities Initiative Peer Review Committee, Number of Reviews: 40

MANUSCRIPT REVIEWS

Reviewer

2021	American Journal of Public Health, Number of Reviews: 1
2021	Annals of Internal Medicine, Number of Reviews: 1
2021	Journal of General Internal Medicine, Number of Reviews: 1
2020	American Heart Association (AHA) Statements, Number of Reviews: 1
2020	Annals of Internal Medicine, Number of Reviews: 1
2020	British Journal of Psychiatry, Number of Reviews: 1
2020	Health Services Research, Number of Reviews: 1
2020	New England Journal of Medicine, Number of Reviews: 1
2019	AIDS Care, Number of Reviews: 1
2019	Annals of Internal Medicine, Number of Reviews: 1
2019	Canadian Journal of Public Health, Number of Reviews: 1
2019	Health & Social Care in the Community, Number of Reviews: 1
2019	Health Services Research, Number of Reviews: 1
2019	Social Psychiatry and Psychiatric Epidemiology, Number of Reviews: 1
2018	Health & Social Care in the Community, Number of Reviews: 1
2016	Health Services Research, Number of Reviews: 1
2015	Journal of General Internal Medicine, Number of Reviews: 1
2015	Journal of Urban Health, Number of Reviews: 1
2014	American Journal of Public Health, Number of Reviews: 1
2014	BMC Health Services Research, Number of Reviews: 1
2014	Journal of Neurotrauma, Number of Reviews: 1
2013	Canadian Medical Association Journal, Number of Reviews: 2
2013	Trials, Number of Reviews: 1
2012	Journal of Urban Health, Number of Reviews: 2
2011	Annals of Internal Medicine, Number of Reviews: 1
2011	BMC Research Notes, Number of Reviews: 1
2011	Journal of General Internal Medicine, Number of Reviews: 1
2010	Canadian Journal of Urban Research, Number of Reviews: 1
2010	Journal of General Internal Medicine, Number of Reviews: 1
2009	JAMA, Number of Reviews: 1
2008	International Journal of Epidemiology, Number of Reviews: 1
2008	JAMA, Number of Reviews: 1
2008	Journal of Urban Health, Number of Reviews: 1
2008	Medical & Veterinary Entomology, Number of Reviews: 1
2008	Milbank Quarterly, Number of Reviews: 1
2007	JAMA, Number of Reviews: 2
2007	Journal of Hospital Medicine, Number of Reviews: 1

2007	Open Medicine, Number of Reviews: 1
2007	Seminars in Medical Practice, Number of Reviews: 1
2006	BMC Health Services Research, Number of Reviews: 1
2006	Emerging Infectious Diseases, Number of Reviews: 1
2005 - 2007	American Journal of Public Health, Number of Reviews: 2
2005 - 2007	Canadian Journal of Public Health, Number of Reviews: 2
2003 - 2006	JAMA, Number of Reviews: 4
2003 - 2006	Journal of General Internal Medicine, Number of Reviews: 3
2003	The Lancet, Number of Reviews: 1
2002 - 2006	Canadian Medical Association Journal, Number of Reviews: 6
2002	International Journal for Quality in Health Care, Number of Reviews: 1
2001 - 2007	Journal of Urban Health, Number of Reviews: 4
2001	Lancet Infectious Disease, Number of Reviews: 1
2000 - 2001	Acta Psychiatrica Scandinavica, Number of Reviews: 4
1999 - 2006	Annals of Internal Medicine, Number of Reviews: 8
1999	Journal of Health Care for the Poor and Underserved, Number of Reviews: 1

External Scientific Report Reviewer

2007	Canadian Institute for Health Information, Canadian Population Health Initiative, Number of Reviews: 1

SCIENTIFIC ABSTRACT REVIEWS

Member

2012 Oct - 2013 Jan	Society of General Internal Medicine 2013 Annual Meeting, Health Disparities & Vulnerable Populations Abstract Review Committee

Chair

2013 Oct - 2014 Jan	Society of General Internal Medicine 2014 Annual Meeting, Health Disparities & Vulnerable Populations Abstract Review Committee

Conference Abstract Reviewer

2008	7th International Conference on Urban Health, Vancouver 2008, Number of Reviews: 38

C. Academic Profile

1. RESEARCH STATEMENTS

Description of Research Program.
My research program focuses on the connections between homelessness, housing, and health. Our objectives are to develop, evaluate, and scale up interventions to improve the health and well-being of people who are homeless or unstably housed, and interventions to end homelessness itself.

D. Research Funding

1. GRANTS, CONTRACTS AND CLINICAL TRIALS

PEER-REVIEWED GRANTS

FUNDED

2022 Feb - 2024 Jan — **Co-Investigator**. Health equity during the pandemic recovery period: Updated knowledge syntheses, policy tracking and health outcome monitoring. Canadian Institutes of Health Research (CIHR). Operating Grant:Addressing the Wider Health Impacts of COVID. PI: Persaud, Navindra. Collaborator(s): Co-Principal Applicants: Adams O, Lofters A. Co-Applicants: **Hwang S**, Pinto A, Sayani A. 184,134 CAD. [Grants]

2022 - 2027 — **Co-Investigator**. The Canadian Observatory on Homelessness - Mobilizing Partnerships to Prevent and End Homelessness. Social Sciences and Humanities Research Council of Canada (SSHRC). Partnership Grant. PI: Gaetz, Stephen. [Grants]

2022 - 2023 — **Co-Investigator**. Social isolation, loneliness and causes of early death among adults with histories of homelessness who transitioned into urban supportive housing in Toronto. Social Sciences and Humanities Research Council of Canada (SSHRC). Insight Grant. PI: Lachaud, James. Collaborator(s): **Hwang SW**, Jenkinson J, Mejia-Lancheros C, O'Campo P, Woodhall-Melnik J, Perri M, Stergiopoulos V. [Grants]

2021 Dec - 2022 Nov — **Co-Investigator**. MARCO:POLO Marginalization & COVID-19: Promoting Opportunities for Learning & Outreach. Canadian Institutes of Health Research (CIHR). Operating Grant:Emerging COVID-19 Research Gaps & Priorities. PI: Bayoumi, Ahmed. Collaborator(s): Co-Principal Applicants: Firestone M, Boucher L, Dodd Z, Durbin A, Hayman K, Isaacs BJ, Kolla G, Matheson FI, Steer LA, Yakubovich AR, Young SV. Co-Applicants: Beder M, Brothers T, Dobrow M, Du Mont J, Holness L, Huijbregts M, **Hwang S**, Hynie M, Kendall C, Kenny K, Long C, Maguire J, Nisenbaum R, Shankardass K, Strike C, Walker D. Collaborators: Arcenal M, Delgado R, Heineck K, Lunsky Y, Marcolin A, Pepper V. 313,804 CAD. [Grants]

2021 Dec - 2022 Nov — **Co-Investigator**. The Surgical EQUITY initiative: Establishing equitable access to surgery following the pandemic. Canadian Institutes of Health Research (CIHR). Operating Grant:Emerging COVID-19 Research Gaps & Priorities. PI: Gomez Jaramillo, David. Collaborator(s): Co-PIs: Chan T, Sankar A. Co-Investigators: Baxter N, **Hwang S**, Irish J, Sarhangian V, Simpson A, Stukel T, Urbach D, Wijeysundera D, de Mestral C. 220,596 CAD. [Grants]

2021 Jul - 2023 Jun — **Co-Investigator**. Service Bans among People Experiencing Homelessness: A Timeline Mapping Study of Antecedents and Consequences. Social Sciences and Humanities Research Council of Canada (SSHRC). Insight Development Grant. PI: Kidd, Sean. Collaborator(s): **Hwang S**, Kozloff N, Marshall CA, Noble A, Stergiopoulos V, Kerman N, Polillo A. 74,885 CAD. [Grants]

2021 Jun - 2022 May — **Principal Applicant**. A Qualitative Exploration of Vaccine Uptake and Hesitancy Among People Experiencing Homelessness in Toronto. Canadian Institutes of Health Research (CIHR). Operating Grant:Emerging COVID-19 Research Gaps & Priorities. PI: **Hwang, Stephen**. Collaborator(s): Jenkinson J, Kiran T, Orkin A, Thulien N. 100,258 CAD. [Grants]

2021 Feb - 2022 Mar — **Co-Investigator**. Co-building Equity-Mobilizing Partnerships in Community (EMPaCT) to

increase impact through equitable patient-oriented partnerships in research, policy and practice. Ontario Strategy for Patient Oriented Research (SPOR) SUPPORT Unit. EMPOWER Award. PI: Sayani, Ambreen and Maybee, Alies. Collaborator(s): Lofters A, Shaw J, **Hwang S**, Bloch G, Parsons J, Gordon D, Chandra S, Corrado AM, Manthorne J, Nicholson E. 25,000 CAD. [Grants]

2020 Sep - 2021 Aug — **Principal Applicant**. The COVENANT Study: COVID-19 Cohort Study of People Experiencing Homelessness in Toronto. Canadian Institutes of Health Research (CIHR). Operating Grant: COVID-19 Rapid Research Funding Opportunity. VR5-173211. PI: **Hwang, Stephen**. Collaborator(s): Nisenbaum N, McGeer A, Mishra S, Ostrowski M, deVilla E, Dhalla I, Gingras A, Gommerman J, Jamal A, Kiran T, Lachaud J, Lee R, Mejia Lancheros C, Mubareka S, Baral S, Chris A, Agarwal A. 1,901,698 CAD. [Grants]

2020 Jul - 2024 Jun — **Co-Investigator**. Canadian Housing Evidence Collaborative (CHEC). Canada Mortgage and Housing Corporation (CMHC) / Social Sciences and Humanities Research Council (SSHRC). CMHC-SSHRC Housing Partnership Development Grant. PI: Dunn, James R. Collaborator(s): 41 Co-investigators. 1,135,000. [Grants]

2020 Jul - 2022 Jun — **Co-Investigator**. Differential Cognitive Contributions to Functional Ability and Quality of Life in Homeless Adults. Social Sciences and Humanities Research Council of Canada (SSHRC). Insight Development Grant. PI: Gicas, Kristina. Collaborator(s): Stergiopoulos V, **Hwang S**. 65,188 CAD. [Grants]

2020 Jun - 2021 May — **Co-Investigator**. The COVID-19 Hospital Analytics Laboratory: Improving the Clinical, Organizational, and System Response to COVID-19. Canadian Institutes of Health Research (CIHR). Operating Grant: COVID-19 Rapid Research Funding Opportunity. PI: Verma A (Nominated PI). Collaborator(s): Greenberg A, Chan T, Cheung A, Ghassemi M, Herridge M, Mamdani M, Razak F, Rosella L (Co-PI); Ahmed A. Appleton A, Azzam K, Bell C, Chignell M, Clifford P, Cram P, Daneman N, Desveaux L, Dhalla I, Diamant A, Edelstein B, Fralick M,Gill S, Grimshaw J, Hadfield G, Hawker G, Hussein H, **Hwang SW**, Ivers N, Jensen L, Kandel C, Kapral M, Kwan J, Lapointe-Shaw L, Leis J, Liu J, Lubbers S, MacFadden D, MacMillan T, Manuel D, Marville-Williams C, Mishra S, Muller M, Ng V, et.al. (Co-I). 2,010,000 CAD. [Grants]

2020 May - 2023 May — **Co-Investigator**. Improving access to lung cancer screening in the underserved, and building capacity for future cancer patient oriented research in Canada. Canadian Institutes of Health Research (CIHR). Patient-Oriented Research Grant. PI: Sayani, Ambreen. Collaborator(s): Lofters A, **Hwang S**, Bloch G, Parsons J, Manthorne J, Nicholson E. 22,500 CAD. [Grants]

2020 May - 2021 Apr — **Co-Investigator**. The Effects of the COVID-19 Pandemic Response for People who are Marginalized. University of Toronto, Toronto COVID-19 Action Imitative. PI: Bayoumi, Ahmed M. Collaborator(s): Caudarella A, Du Mont J, Durbin A, Firestone M, Holness L, **Hwang S**, Maguire J, Mason R, Matheson F, Nisenbaum R, O'Campo P, Persaud N, Strike C, Werb D, Kolla G, Long C, Young S, Beder M, Dell E, Vozzolo B, Brillinger C, Davis S, Klaiman M, Schlosser L, Younie K, Raybourne R, Sheth P, Steer L, Hewitt T, Heineck K, Lunsky Y, Ibrahim S, John J, Thompson C, Kenny K, Brothers T, Dodd Z, Kendall C, Mawani F, Yakubovich A. 250,000 CAD. [Grants]

2020 May - 2020 Nov — **Co-Investigator**. Pandemic-Proof: Synthesizing Real-World Knowledge of Promising Mental Health and Substance Use Practices for Young People Who Are Experiencing or Have Experienced Homelessness. Canadian Institutes of Health Research (CIHR). Operating Grant: Knowledge Synthesis: COVID-19-Mental Health. PI: Thulien N, Noble A. Collaborator(s): **Hwang S**, Kidd S. 49,548 CAD. [Grants]

2019 Sep - 2021 Sep **Co-Investigator**. Phenobarbital for the management of severe acute alcohol withdrawal syndrome: The PHENOMANAL Trial. St. Michael's Hospital. Department of Medicine Priorities Fund. PI: Burns, Karen E.A. Collaborator(s): Filewod N, **Hwang S**, Ailon J, Caudarella A, Lamba W, Gray S, Klaiman M. 50,000. [Grants]

2019 Apr - 2027 Mar **Principal Investigator**. Interventions Research in Homelessness, Housing, and Health. Canadian Institutes of Health Research (CIHR). Foundation Grant. Collaborator(s): Aubry T, Dunn J, Fabreau G, Gaetz S, Heineck K, Isaranuwatchai W, Nisenbaum R, Palepu A, Raine L, Richter T, Stergiopoulos V, Thulien N, Watson K. 3,972,033 CAD. [Grants]

2019 Apr - 2020 Mar **Co-Investigator**. Housing for All Canadians. Social Sciences and Humanities Research Council of Canada (SSHRC). Partnership Development Grant. PI: Dunn, James. Collaborator(s): Harris R, Gabel C, Dion M, Baker-Collins S, Fudge Schormans A, Van Der Linden C, Woodhall J, **Hwang S**, Riva M, Evans J, Collins D, Moos M, Amborski D, Baker E, Leishman C, Suttor G, Gurstein P, Smith M, Pomeroy S, Smetanin P, Barata P, Dewling G, Johnson P, Nord P, Rolfe S. 80,000 CAD. [Grants]

2018 Oct - 2019 Sep **Co-Investigator**. Women, Victimization, and Homelessness: Towards a conceptual model to advance trauma- and violence-informed research, policy and practice. Canadian Institutes for Health Research (CIHR). Project Grant. PI: Frankish, James and Abbott, Janet. Collaborator(s): Eiboff F, **Hwang S**, Krausz R, Martin R, Nicholls T, O'Campo P, Strehlau V, Torchalla I. 68,850. [Grants]

2017 Oct - 2020 Sep **Principal Investigator**. Improving Support Systems and Health Outcomes for People Experiencing Homelessness. Ontario Ministry of Health and Long-Term Care. Health System Research Fund. Collaborator(s): Vicky Stergiopoulos. 2,087,998 CAD. [Grants]

2017 Jul - 2018 Nov **Principal Investigator**. Evaluation Services for the Ontario Basic Income Pilot. Ministry of Community and Social Services. Collaborator(s): **Hwang S**, Dunn J (Co-Lead) O'Campo P, Gabel C, Downey B, Pinto A, Tarride J, Lewchuk W (Co-Principal Investigators) Jüni P, Glazier R, Persaud N, Tarasuk V, Kurdyak P, Coulombe S, Oreopoulos P, Kroft K, Forget E, Sweetman A, Myers K, Aratangy T, Shankardass K, Upshur R, Smith B, Rosella L, Bayoumi AM, Isanaranuwatchi W, Zuberi D, Fudge-Schormans A, Boyle M, Siddiqi A, King M (Co-Investigators). 2,460,000 CAD. [Grants]

2017 Mar - 2021 Mar **Co-Investigator**. CLEAN Meds RCT: Carefully seLected and Easily Accessible at No charge Medications. Canadian Institutes of Health Research (CIHR). SPOR Innovative Clinical Trial Multi-Year Grant. PI: Persaud, Nav. Collaborator(s): Mitchell C, Laupacis A, Nicholas A, Boozary A, Glazier R, Gomes T, **Hwang S**, Jüni P, Law M, Mamdani M, Manns B, Martin D, Morgan S, Oh P, Pinto A, Shah B, Sullivan F, Thorpe K, Tu K. 1,065,001 CAD. [Grants]

2017 Mar - 2021 Mar **Co-Investigator**. Betting on housing: Women, problem gambling and homelessness. Social Sciences and Humanities Research Council of Canada (SSHRC). Insight Grants. 435-2017-0716. PI: Matheson, Flora. Collaborator(s): Woodhall-Melnik J, Guilcher SJT, **Hwang SW**, Hahmann TE. 252,387 CAD. [Grants]

2016 Apr - 2019 Mar **Co-Investigator**. Optimizing Support and Service Delivery for Problem Gambling Among People Living with Complex Needs. Ontario Ministry of Health and Long-Term Care. Health System Research Fund. PI: Matheson, Flora & Guilcher, Sara. Collaborator(s): **Stephen Hwang**, Nigel Turner, Chris McKillop, Stuart Watt, Wayne Skinner. 749,185. [Grants]

2016 Jan - 2019 Dec **Co-Investigator**. CLEAN Meds RCT: The impact of providing carefully selected essential medications at no charge to primary care patients. Ontario Strategy for Patient-Oriented Research (SPOR) Support Unit. Targeted IMPACT Award. PI: Persaud, Nav & Shah, B. Collaborator(s): J Abelson, M Bedard, S Booker, A Boozary, M Evans, R Glazier, T Gomes,

S Hwang, S Ikura, A Laupacis, M Law, M Mamdani, B Manns, D Martin, S Morgan, D Morisette, P Oh, A Pinto, F Sullivan, K Thorpe, K Tu. 1,000,000. [Grants]

2015 Oct - 2017 Sep **Co-Investigator**. Elucidating the health care utilization of people who experience detention or incarceration in provincial facilities in Ontario: a population-based study. Physicians Services Inc. Health Research Grant. PI: Kouyoumdjian, Fiona. 77,000. [Grants]

2015 Jul - 2022 Jun **Co-Investigator**. Improving Mental Health Care for High Risk and Disadvantaged Populations: Evidence to Inform Policy and Practice. Canadian Institutes for Health Research (CIHR). Foundation Scheme. PI: Stergiopoulos V. Collaborator(s): **Hwang S**, Goering P, Bowlby A, Chodos H. 1,427,647. [Grants]

2015 May - 2016 Apr **Co-Principal Investigator**. Understanding the health impact of extreme temperatures on homeless populations with a view to enhancing Toronto's extreme weather plans and responses: Developing a research proposal. University of Toronto Dalla Lana School of Public Health, The Wellesley Institute, and Toronto Public Health. Healthier Cities and Communities Hub Seed Grant. PI: Bassil, Kate. Collaborator(s): **SW Hwang**, S Gower, A Wainberg, M Kim. 9,861. [Grants]

2015 Apr - 2017 Mar **Co-Investigator**. Effects of the Regent Park Housing Redevelopment on Mental Health: Medium-Term Effects of a Population Health Intervention. Canadian Institutes of Health Research (CIHR). Population Health Intervention Research. PI: Dunn, James. Collaborator(s): Co-Investigators: **S. Hwang**, M. Janus, F. Matheson, R Moineddin, C. Muntaner, P. O'Campo. 198,878. [Grants]

2015 Jan - 2015 Dec **Co-Investigator**. Understanding the Landscape of Youth Mental Health: Engaging Youth in an Interactive World Café. Canadian Institutes of Health Research (CIHR). Planning and Dissemination Grant. PI: Woodhall-Melnik, Julia. Collaborator(s): Co-Principal Investigator: F.I. Matheson. Co-Investigators: S. Guilcer, P. Ferentzey, W. Skinner, **S. Hwang**, N. Turner. 12,500. [Grants]

2015 Jan - 2015 Dec **Co-Investigator**. Defining Gender-Specific Health Research Priorities for Youth Facing Homelessness. Canadian Institutes of Health Research (CIHR). Planning and Dissemination Grant. PI: Matheson, Flora. Collaborator(s): Co-Principal Investigator: J. Woodhall-Melnik. Co-Investigators: S. Guilcer, P. Ferentzey, W. Skinner, **S.W. Hwang**, N. Turner. 10,000. [Grants]

2014 Oct - 2019 Sep **Co-Investigator**. Examining the interplay between victimization, justice involvement and housing among homeless mentally ill men and women: A longitudinal study. Canadian Institutes of Health Research (CIHR). Open Operating Grant. PI: Nicholls, Tonia. Collaborator(s): A.G. Crocker, **S.W. Hwang**, R.M. Krausz, E.A. Latimer, L. Roy, J. Somers. 774,958. [Grants]

2014 Jul - 2018 Jun **Co-Investigator**. Does subsidized housing improve mental health? GTA West Housing and Health Study Renewal. Canadian Institutes of Health Research (CIHR). Open Operating Grant. PI: Dunn, James. Collaborator(s): P. O'Campo, C. Muntaner, R. Moineddin, **S. Hwang**, F. Matheson, M. Janus. 995,877. [Grants]

2014 Jul - 2015 Jun **Co-Investigator**. Defining priorities and creating a network for prisoner health research in Canada. Canadian Institutes of Health Research (CIHR). Planning Grant. PI: Kouyoumdjian, Fiona. Collaborator(s): G. Brown, **S. Hwang**, L. Kiefer, F. Matheson, D. Silva. 24,890. [Grants]

2013 Oct - 2018 Sep **Co-Principal Investigator**. A Randomized Controlled Trial of Housing First for Homeless People with Mental Illness: Long-term Outcomes. Canadian Institutes of Health Research

(CIHR). Operating Grant. MOP-130405. PI: **Hwang, Stephen**,O'Campo P, Stergiopoulos V. Collaborator(s): A. Bayoumi, P. Goering, R. Nisenbaum, S. Tsemberis. 1,984,383. [Grants]

2013 Oct - 2017 Sep **Co-Investigator**. Our Health Counts Toronto: Developing a Population Based Urban Aboriginal Cohort to Assess and Enhance Individual, Family, and Community Health and Wellbeing. Canadian Institutes for Health Research (CIHR). Operating Grant. PI: Smylie, Janet. Collaborator(s): SE Booth, C Bourgeois, SH Wolfe, B Allan, M Firestone, P Fleiszer, D Gesink, RH Glazier, HA Howard, **SW Hwang**, R Nisenbaum, PJ O'Campo, M Snyder. 992,183. [Grants]

2013 May - 2014 Jul **Co-Investigator**. Problem Gambling and Housing Instability. Ontario Problem Gambling Research Centre. Standard Research Awards. PI: Matheson, Flora. Collaborator(s): **S.W. Hwang**, P. Ferentzy, W.J. Skinner. 101,346. [Grants]

2013 Mar - 2014 Feb **Co-Investigator**. Does subsidized housing improve mental health and healthy child development? GTA West Housing and Health Study Renewal. Canadian Institutes of Health Research (CIHR). Operating Grant - Population Health Interventions. PI: Dunn, James. Collaborator(s): **S. Hwang**, M. Janus, F. Matheson, R. Moineddin, C. Muntaner, P. O'Campo. 100,000. [Grants]

2012 Jul - 2019 Jun **Co-Investigator**. Canadian Observatory on Homelessness: Creating Policy Impact. Social Sciences and Humanities Research Council of Canada (SSHRC). Partnership Grant. PI: Gaetz, Stephen. Collaborator(s): T Aubry, S Baker Collins, Y Belanger, C Bellot, CJ Charette, J Distasio, MP Eberle, C Forchuk, P Goering, JR Graham, R Hurtubise, **SW Hwang**, JM Karabanow, KA Kovacs Burns, DS McCormack, PM Menzies, J Mosher, WL O'Grady, B Pauly, VA Preston, S Shapson, AI Tanasescu Turner, WE Thurston, JL Waegemakers Schiff. 2,500,000. [Grants]

2012 Apr - 2015 Mar **Co-Investigator**. The effectiveness of a brief intervention on improving health outcomes for homeless people with unmet health needs. Canadian Institutes of Health Research (CIHR). Partnerships for Health System Improvement. PI: Stergiopoulos, Vicky. Collaborator(s): D. Wasylenki, J. Durbin, **S. Hwang**, R. Nisenbaum, P. O'Campo, J. Tepper. 343,000. [Grants]

2012 Apr - 2015 Mar **Co-Investigator**. Increasing Access to Mental Health Services for Street-Involved Youth: The Effectiveness of a Theory-based Multicomponent Resilience and Motivational Intervention. Canadian Institutes of Health Research (CIHR). Partnerships for Health System Improvement. PI: McCay, Elizabeth. Collaborator(s): C. Howes, B. Ferguson, J. Henderson, W. Horton, J. Hughes, **S. Hwang**, J. Karabanow, S. Kidd, J. Langley, B. MacLaurin, I. Manion, S. Quesnel, E. Saewyc, E. Santa Mina, J. Schwind, A. Aiello, K. Ginsburg, D. Soenen. 217,140. [Grants]

2012 Apr - 2014 Mar **Co-Investigator**. Picturing foster care: A photo voice evaluation of three different fostering models and their implications for perinatal care provision. Canadian Institutes of Health Research (CIHR). Operating Grant. PI: Parsons, Janet. Collaborator(s): K. Boydell, **S. Hwang**, P. O'Campo, A. Scott, S. Sridharan. 257,496. [Grants]

2012 Apr - 2014 Mar **Principal Investigator**. Advancing the Health and Housing in Transition (HHiT) Study: An extended four-year follow-up of the health of homeless and vulnerably housed adults in three Canadian cities. Canadian Institutes of Health Research (CIHR). Operating Grant. MOP-86765. Collaborator(s): T. Aubry, S. Farrell, A. Palepu, J. Dunn, J. Hoch, A. Hubley, J. Hulchanski, F. Klodawsky, R. Nisenbaum. 1,111,930. [Grants]

2012 Mar - 2014 Feb **Principal Investigator**. Population Health Interventions to End Homelessness. Canadian Institutes of Health Research (CIHR). Operating Grant: Population Health Intervention Research. GIR-120511. Collaborator(s): T. Aubry, C. Benoit, J. Dunn, S. Farrell, J. Hoch, A.

Hubley, J. Hulchanski, F. Klodawsky, B. MacLaurin, A. Palepu, M. Shapcott, V. Stergiopoulos, C. Worthington. 200,000. [Grants]

2011 Oct - 2012 Sep **Co-Investigator**. Clarifying the link between traumatic brain injury and homelessness: a planning workshop. Canadian Institutes of Health Research (CIHR). Meetings, Planning and Dissemination Grant: Planning Grant. PI: Topolovec-Vranic, Jane. Collaborator(s): Angela Colantonio, Michael Cusimano, **Stephen Hwang**, Pia Kontos, M. Donna Ouchterlony, Vicky Stergiopoulos. 24,837. [Grants]

2011 Jul - 2012 Jun **Co-Investigator**. Meeting, Planning, and Dissemination Grant: A Resilience and Strengths-based Intervention to Promote Engagement, Positive Development and Reduce Risk in Street-involved Youth. Canadian Institutes of Health Research (CIHR). PI: McCay, Elizabeth. Collaborator(s): C. Howes, M. McDonald, S. Quesnel, K. Ginsburg, T. Guimond, S. Kidd, J. Hughes, **S. Hwang**, J. Karabanow, J. Langley, B. MacLaurin, E. Saewyc, E. Santa Mina, J. Scwind, A. Aiello. 24,800. [Grants]

2010 Nov - 2011 Mar **Principal Investigator**. Development Grant for the preparation of a CIHR Programmatic Grant Proposal “Population Health Interventions to Reduce Homelessness and Improve Health”. Canadian Institutes for Health Research (CIHR). Collaborator(s): Tim Aubry, Susan Farrell, Anita Hubley, Fran Klodawsky, Anita Palepu, Catherine Worthington (Co-Investigators). 15,000. [Grants]

2010 Apr - 2011 Mar **Co-Investigator**. Responding to H1N1 in the Context of Homelessness in Canada. Canadian Institutes of Health Research (CIHR). Operating Grant: Health Systems Research on H1N1. PI: Gaetz, Stephen. Collaborator(s): Syed Ali, John Graham, Roch Hurtubise, **Stephen Hwang**, Roger Keil, Janet Mosher, Bernadette Pauly, Jeannette Waegemakers-Schiff, Jianhong Wu. 99,975. [Grants]

2010 Jan - 2014 Dec **Co-Investigator**. CIHR Team in Traumatic Brain Injury and Violence. Canadian Institutes of Health Research (CIHR). Team Grant: Strategic Teams in Applied Injury Research. TIR-103946. PI: Cusimano, Michael. Collaborator(s): Jane Topolovec-Vranic, Carolyn Snider, Charles Tator, **Stephen Hwang**, et al. 2,000,000. [Grants]

2010 Jan - 2012 Dec **Co-Investigator**. Enhancement of Transitional Housing Programmes for Street-involved Youth through the Application of Dialectical Behaviour Therapy to Strengthen Resilience. Canadian Institutes of Health Research (CIHR) & the Mental Health Commission of Canada (MHCC). Partnerships for Health System Improvement (PHSI). PI: McCay, Elizabeth. Collaborator(s): Carol Howes, Madelyn McDonald, Heather Beanlands, Linda Cooper, Jean Hughes, **Stephen Hwang**, Jeff Karabanow, John Langley, Bruce MacLaurin, Shelley McMain, Susan Quesnel, Souraya Sidani, Catherine Worthington (co-investigators & decision maker partners). 329,792. [Grants]

2009 Aug - 2010 Jun **Co-Investigator**. Understanding Pandemic Preparedness in the Context of the Canadian Homelessness Crisis. Canadian Institutes of Health Research (CIHR). CIHR Catalyst Grant: Pandemic Preparedness. PI: Gaetz, Stephen. Collaborator(s): Syed Ali, John Graham, Roch Hurtubise, **Stephen Hwang**, Roger Keil, Janet Mosher, Bernadette Pauly, Jeannette Waegemakers-Schiff, Jianhong Wu. 100,000. [Grants]

2009 Jul - 2012 Jun **Co-Investigator**. Positive Spaces, Healthy Places - Phase IV: Monitoring and Evaluation to Understand the Health Effects of Housing Status in HIV/AIDS. Canadian Institutes of Health Research (CIHR). PI: Rourke, Sean. Collaborator(s): Saara Greene, Ruthanne Tucker, Jean Bacon, Steve Byers, **Stephen Hwang**, Jay Koornstra, Frank McGee, LaVerne Monette, Michael Sobota. 300,000. [Grants]

2009 Apr - 2015 Mar **Co-Investigator**. The CIHR ACHIEVE Research Partnership: Action for Health Equity

Interventions Training Grant. Canadian Institutes of Health Research (CIHR). Strategic Training Initiative in Health Research. TGF-96566. PI: O' Campo, Patricia. Collaborator(s): Kelly Murphy (co-PI), Ahmed M Bayoumi, James Dunn, Patrick Fafard, Sarah Flicker, Richard Glazier, Jeffrey Hoch, **Stephen Hwang**, Kamran Kahn, James Lvery, Rosane Nisenbaum, Sean B Rourke, Janet K Smylie, Sanjeev Sridharan, Robb Travers, Alan Walks, Blair Whaeaton. 1,790,000. [Grants]

2009 Apr - 2013 Mar — **Co-Principal Investigator**. The "At Home" Research Demonstration Project in Mental Health and Homelessness --Toronto Site. Mental Health Commission of Canada / Health Canada. PI: **Stephen Hwang**, Vicky Stergiopoulos, Pat O'Campo. Collaborator(s): Sanjeev Sridharan, James Dunn, Ahmed Bayoumi, Kelly Murphy. 22,246,216. [Grants]
This project is a multi-site randomized controlled trial of Housing First and mental health support services for persons experiencing homelessness and mental illness. I am co-PI for the Toronto site, which has recruited a total of 550 study participants (300 to receive intervention and 250 to receive "treatment as usual"). Total funding for the Toronto site is $22.2 million over 4 years ($18.6 million for service delivery and $3.6 million for research and evaluation). This project has already had a major policy impact at the national level: (http://www.vancouversun.com/news/Ottawa+commits+five+more+years+funding+affordable+housing/8133648/story.html).

2009 Jan - 2009 Dec — **Co-Investigator**. A retrospective longitudinal cohort study comparing health services utilization and health outcomes between patients admitted to an urban tertiary care centre's family practice inpatient ward, either under their own family doctor or a previously unknown family doctor. British Columbia College of Family Physicians. PI: Chuck Wen. Collaborator(s): Garey Mazowita and **Stephen W. Hwang** (co-investigators). 7,600. [Grants]

2009 Jan - 2009 Dec — **Co-Investigator**. Alleviating disparities in oral health: Responding to the information needs of key decision makers. Canadian Institutes of Health Research (CIHR). DOH-87105. PI: David Locker, Carlos Quinonez. Collaborator(s): Peter Cooney, Raisa Deber, Paul Grootendorst, **Stephen Hwang**, Jeffrey Racine, S. Suri (Co-Investigators). 109,900. [Grants]

2008 Dec - 2012 Jun — **Co-Investigator**. Effects of the Regent Park Housing Redevelopment on Mental Health and Healthy Child Development. Canadian Institutes of Health Research (CIHR). PI: James Dunn. Collaborator(s): **Stephen Hwang**, Patricia O'Campo (co-investigators). 251,000. [Grants]

2008 Jul - 2015 Jun — **Co-Investigator**. Strategic Knowledge Clusters Grant: Canadian Homelessness Research Network. Social Sciences and Humanities Research Council (SSHRC). PI: Stephen Gaetz. Collaborator(s): Céline Bellot, C. James Frankish, Janet Mosher, J. David Hulchanski, Jeff Karabanow, Roch Hurtubise, **Stephen Hwang**, Tim Aubry, Uzoamaka Anucha, William O'Grady (Co-applicants); Anita Palepu, Isolde Daiski, Roger Keil, Shirley Roy, Valerie Preston (Collaborators). 2,100,000. [Grants]

2008 Apr - 2013 Mar — **Co-Investigator**. Effects of Social Housing on Adult and Child Mental Health: A Prospective Study in the GTA West. Canadian Institutes of Health Research (CIHR). PI: James Dunn. Collaborator(s): **Stephen Hwang**, Magdalena Janus, Flora Matheson, Rahim Moineddin, Carles Muntaner, Patricia O'Campo (Co-Investigators). 1,119,795. [Grants]

2008 Apr - 2012 Mar — **Principal Investigator**. The Health and Housing in Transition (HHiT) Study: A Longitudinal Study of the Health of Homeless and Vulnerably Housed Adults in Vancouver, Toronto, and Ottawa. Canadian Institutes of Health Research (CIHR). CIHR MOP-86765. Collaborator(s): Tim Aubry, Susan Farrell, Anita Palepu (Co-Principal Investigators); James Dunn, Jeff Hoch, Anita Hubley, J. David Hulchanski, Fran Klodawsky, Rosane Nisenbaum (Co-Investigators). 1,602,472. [Grants]

2008 Jan - 2009 Mar **Co-Principal Investigator**. A Developmental Community-Based Research Study to Investigate Factors Leading to Pregnancy and HIV Risk among Female Street Youth in Toronto. Ontario HIV Treatment Network (The) (OHTN). PI: Allison Scott & **Stephen Hwang**. Collaborator(s): Beth Hayhoe, Janet Parsons, Catherine Worthington (Co-investigators). 23,880. [Grants]

2007 Oct - 2009 Sep **Co-Investigator**. Collaborative mental health care for the homeless: Effectiveness and cost-effectiveness of two shelter-based models. Canadian Institutes of Health Research (CIHR). CIHR PHE-85210. PI: Vicky Stergiopoulos. Collaborator(s): Carolyn Dewa, Katherine Rouleau, Donald Wasylenki (Co-Principal Investigators); Jeffrey Hoch, **Stephen Hwang**, Rosane Nisenbaum (Co-Investigators). 98,224. [Grants]

2007 Jul - 2008 May **Principal Investigator**. A Survey of Domiciliary Hostel Program Residents in Ontario. Ontario Mental Health Foundation. 149,250. [Grants]

2006 Dec - 2007 Dec **Co-Investigator**. Homelessness and Diversity Issues in Canada: Dissemination Grant in support of the preparation of an edited volume entitled “Finding Home: Policy Options for Addressing Homelessness in Canada”. Social Sciences and Humanities Research Council (SSHRC). PI: J. David Hulchanski. Collaborator(s): **Stephen Hwang**, Sylvia Novac (Co-Investigators). 50,000. [Grants]

2006 Jun - 2006 Nov **Principal Investigator**. Development Grant to assist in the preparation of a full proposal entitled “CIHR Team Grant in Homelessness, Housing, and Health”. Canadian Institutes for Health Research (CIHR). CIHR CTL-80871. Collaborator(s): Tim Aubry, James Dunn, Jeff Hoch, Anita Hubley, David Hulchanski, Bruce MacLaurin, Anita Palepu, Marie Robert, Élise Roy, Jeffrey Turnbull, Catherine Worthington (Co-Investigators). 10,000. [Grants]

2006 Apr - 2011 Mar **Principal Investigator**. Interdisciplinary Capacity Enhancement Grant in Homelessness, Housing, and Health. Canadian Institutes of Health Research (CIHR). CIHR HOA-80066. Collaborator(s): Tim Aubry, James Dunn, Jeff Hoch, Anita Hubley, David Hulchanski, Bruce MacLaurin, Anita Palepu, Marie Robert, Élise Roy, Jeffrey Turnbull, Catherine Worthington (Co-Investigators). 820,000. [Grants]

2006 Apr - 2009 Mar **Collaborator**. Hospice and Homelessness in Canada. Social Sciences and Humanities Research Council (SSHRC). PI: Manal Guirguis-Younger. Collaborator(s): Frances Legault, Tim Aubry (Co-Investigators); **Stephen Hwang**, Jeff Turnbull, Vivien Runnels (Collaborators). 85,845. [Grants]

2006 Apr - 2007 Feb **Principal Investigator**. The Effects of Supportive Housing on the Health Status and Service Utilization of Homeless and Hard-to-House Adults. The Wellesley Institute. Collaborator(s): Tim Aubry, Jim Dunn, Jeff Hoch (Co-Investigators); Joseph Taylor, Marcella Fresolone (Collaborators). 40,000. [Grants]

2005 Jul - 2006 Jun **Co-Investigator**. Access to Primary Care for the Homeless: A Synthesis of Research Evidence on Effective Practices. Canadian Institutes for Health Research (CIHR). PI: Samuel Shortt. Collaborator(s): **Stephen Hwang**, Heather Stuart (Co-Investigators). 64,900. [Grants]

2005 Jul - 2005 Nov **Principal Investigator**. Development Grant to assist in the preparation of a full proposal entitled “CIHR Interdisciplinary Capacity Enhancement Grant in Homelessness, Housing, and Health”. Canadian Institutes for Health Research (CIHR). CIHR HDD-77939. Collaborator(s): Tim Aubry, James Dunn, Jeff Hoch, Anita Hubley, David Hulchanski, Bruce MacLaurin, Anita Palepu, Marie Robert, Élise Roy, Jeffrey Turnbull, Catherine Worthington (Co-Investigators). 5,000. [Grants]

2005 Jun - 2007 May **Co-Principal Investigator**. Attitudes of Medical Trainees Towards Homeless Persons

Presenting for Care in the Emergency Department. The Physicians' Services Incorporated (PSI) Foundation. PI: Julie Spence and **Stephen Hwang**. Collaborator(s): Glen Bandiera (Co-Investigator). 94,000. [Grants]

2005 Jun - 2006 Mar — **Principal Investigator**. Development Grant to assist in the preparation of a full proposal entitled "CIHR Team Grant in Homelessness, Housing, and Health". Canadian Institutes for Health Research (CIHR). CIHR CTL-77144. Collaborator(s): Tim Aubry, James Dunn, Jeff Hoch, Anita Hubley, David Hulchanski, Bruce MacLaurin, Anita Palepu, Marie Robert, Élise Roy, Jeffrey Turnbull, Catherine Worthington (Co-Investigators). 10,000. [Grants]

2005 Apr - 2008 Mar — **Co-Investigator**. A prospective study to explore the impact of housing support and homelessness on the health outcomes of people living with HIV/AIDS in Ontario. Canadian Institutes for Health Research (CIHR). CIHR CBR-75568. PI: Ruthann Tucker and Saara Greene. Collaborator(s): Steve Byers, James Dunn, Dale Guenter, **Stephen Hwang**, Jay Koornstra, LaVerne Monette, Lea Narciso, Sean Rourke, Michael Sobota (Co-Investigators). 300,000. [Grants]

2004 Jul - 2005 Jun — **Co-Investigator**. Nature and Extent of Inappropriate Living Environments for Adults with Moderate to Severe Acquired Brain Injury. Ontario Neurotrauma Foundation. PI: Angela Colantonio. Collaborator(s): Peter Coyte, **Stephen Hwang**, Audrey LaPorte, Bruce Christensen, Bonnie Kirsh, Charissa Levy, Teresa Chiu, Diana Clarke, Carolyn Abramowitz (Co-Investigators). 150,000. [Grants]

2004 Jul - 2005 Jun — **Co-Investigator**. Development of a quality of life instrument for homeless persons and street youth. Canadian Institutes for Health Research (CIHR). PI: Anita Palepu and Anita Hubley. Collaborator(s): Tim Aubry, Ahmed Bayoumi, **Stephen Hwang**, Elise Roy (Co-Investigators). 60,160. [Grants]

2004 Mar - 2005 Aug — **Co-Principal Investigator**. The Effect of the Ontario Severe Acute Respiratory Syndrome (SARS) Outbreak on Population Mortality. Canadian Institutes for Health Research (CIHR). CIHR SAR-67802. PI: **Stephen Hwang** and Chaim Bell. Collaborator(s): Angela Cheung, Rahim Moineddin (Co-Investigators). 51,593. [Grants]

2003 Sep - 2006 Sep — **Principal Investigator**. Health Care Utilization among Homeless People. Agency for Healthcare Research and Quality (AHRQ). 1 RO1 HS014129-01. Collaborator(s): Wendy Levinson, Don Redelmeier, John Paul Szalai, George Tolomiczenko (Co-Investigators). 667,788 USD. [Grants]

2003 Jul - 2009 Jun — **Co-Investigator**. An Integrated Training Program in Health and Social Science Research to Improve the Health of Marginalized Populations. Canadian Institutes of Health Research (CIHR). CIHR STO-64598. PI: Wendy Levinson, Andreas Laupacis, Joan Eakin. Collaborator(s): Richard Glazier, **Stephen Hwang**, Alex Jadad, Prabhat Jha, Donald Redelmeier, Harvey Skinner, Donald Wasylenki (Co-Investigators). 1,350,000. [Grants]

2003 Jul - 2007 Jun — **Co-Investigator**. Health services utilization in a concentrated urban setting: A population-based analysis of trends over time. Canadian Institutes for Health Research (CIHR). CIHR MOP-15693. PI: Richard Glazier. Collaborator(s): Mohammad Agha, Elizabeth Badley, **Stephen Hwang**, Flora Matheson, Rahim Moineddin, Leah Steele (Co-Investigators). 630,092. [Grants]

2003 Jul - 2004 Jun — **Principal Investigator**. REACH3: Research Alliance for Canadian Homelessness, Housing, and Health. Canadian Institutes for Health Research (CIHR). CIHR HDP-63062. Collaborator(s): Tim Aubry, James Dunn, Anita Palepu, Élise Roy, Alan Shiell, Jeffrey Turnbull (Co-Investigators). 100,000. [Grants]

2003 Mar - 2006 Mar **Principal Investigator**. Health Care Utilization among Homeless People. Canadian Institutes for Health Research (CIHR). CIHR MOP-62736. Collaborator(s): Wendy Levinson, Don Redelmeier, John Paul Szalai, George Tolomiczenko (Co-investigators). 261,328. [Grants]

2002 Jul - 2003 Jun **Co-Investigator**. Housing as a Socio-economic Determinant of Health: A needs, gaps, and opportunities assessment for research. Canadian Institutes for Health Research (CIHR), Institute of Population and Public Health. CIHR NGO-54119. PI: James Dunn. Collaborator(s): Michael Hayes, David Hulchanski, **Stephen Hwang**, Louise Potvin (Co-Investigators). 97,900. [Grants]

2001 Feb - 2003 Mar **Principal Investigator**. A Community-Based Program to Promote Cervical Cancer and Breast Cancer Screening in Homeless Women. Ontario Women's Health Council. Collaborator(s): Angela Cheung, Eva Mocarski (Co-Investigators). 622,650. [Grants]

1999 Jul - 2003 Jun **Co-Investigator**. Trends in Health Services Utilization in a Concentrated Urban Setting, 1991-2003. Medical Research Council of Canada. MRC MT-15693. PI: Richard Glazier. Collaborator(s): Robin Badgley, Elizabeth Badley, Marsha Cohen, **Stephen Hwang**, Dianne Patychuk (Co-Investigators). 158,140. [Grants]

1999 Jul - 2000 Jun **Co-Investigator**. Changes in the Demographic Composition and Health Status of Immigrant Populations in Toronto's Inner City: Time Trend Analysis and Innovative Mapping. Joint Centre of Excellence for Research on Immigration and Settlement – Toronto (CERIS). PI: Richard Glazier. Collaborator(s): Carl Amrhein, Marsha Cohen, Elizabeth Badley, Robin Badgley, **Stephen Hwang**, Byron Moldofsky, Rob Wright, David Buckeridge, Nita Chaudhry (Co-Investigators). 40,000. [Grants]

1998 Jul - 2001 Jun **Co-Investigator**. Effects of Restructuring the Health System on Equity and Access for a Vulnerable Inner City Population: A Time Trend Analysis 1991-2001. National Health Research and Development Program. PI: Richard Glazier. Collaborator(s): Robin Badgley, Elizabeth Badley, Marsha Cohen, Vivek Goel, **Stephen Hwang**, Michael Mendelson (Co-Investigators). 149,892. [Grants]

1998 Jul - 2001 Jun **Co-Investigator**. The Health Effects of Reductions in Welfare Payments and Hospital Closures on Immigrant Populations in Southeast Toronto: A Ten Year Time Trend Analysis. Joint Centre of Excellence for Research on Immigration and Settlement - Toronto. PI: Richard Glazier. Collaborator(s): Marsha Cohen, Elizabeth Badley, Robin Badgley, Vivek Goel, **Stephen Hwang**, Michael Mendelson (Co-Investigators). 45,000. [Grants]

1998 Jul - 2000 Jun **Principal Investigator**. Determinants of Health Status in Inner City Rooming House Residents. The Connaught Foundation and the University of Toronto. Collaborator(s): George Tolomiczenko, J. David Hulchanski (Co-Investigators). 45,000. [Grants]

1997 Jul - 1999 Jun **Principal Investigator**. Health Status and Health Care Utilization in Patients Leaving the Hospital Against Medical Advice. The Physicians' Services Incorporated Foundation. Collaborator(s): Jianli Li (Co-Investigator). 16,000. [Grants]

NON-PEER-REVIEWED GRANTS

FUNDED

2012 Jan - 2013 Dec **Principal Investigator**. Probiotics for the Prevention of Clostridium difficile Infection in Hospitalized Patients. University of Toronto, Department of Medicine. Strategic Planning Innovation Fund. Collaborator(s): Valerie Palda, Susy Hota, Irfan Dhalla, David Klein, Dante Morra, Muhammad Mamdani, Kevin Thorpe, Catharine Chambers. 74,784. [Grants]

2003 Jul - 2003 Dec	**Co-Investigator**. Health, mental health, and addiction treatment needs of people who are homeless in Toronto. City of Toronto, Supporting Community Partnership Initiative (SCPI). PI: Paula Goering. Collaborator(s): Jennifer Pyke, **Stephen Hwang**, Sheryl Lindsay, George Tolomiczenko, Donald Wasylenki (Co-Investigators). 90,000. [Grants]
2002 Jul - 2003 Jun	**Co-Principal Investigator**. Models and Practices in Service Integration and Coordination for Women who are Homeless or at Risk of Homelessness. Ontario Women's Health Council. PI: **Stephen Hwang**. Collaborator(s): Deborah Hierlihy (Co-Principal Investigator). 94,969. [Grants]
2002 Jul - 2003 Jun	**Co-Investigator**. The Multidimensional Impacts of Adequate Housing: Factors that Affect Housing Stability, Service Use, and Community Integration. City of Toronto, Supporting Communities Partnership Initiative (SCPI). PI: J. David Hulchanski. Collaborator(s): **Stephen Hwang**, Lynn McDonald, Sylvia Novac, George Tolomiczenko, Valerie Tarasuk (Co-Investigators). 64,953. [Grants]
2002 Jul - 2002 Dec	**Co-Principal Investigator**. First International Conference on Inner City Health. Canadian Institutes for Health Research (CIHR). PI: **Stephen Hwang**. Collaborator(s): Ahmed Bayoumi (Co-Principal Investigator). 50,000. [Grants]
1998 Jul - 1999 Jun	**Co-Principal Investigator**. Housing and Population Health. Canada Mortgage and Housing Corporation. PI: **Stephen Hwang**. Collaborator(s): Esme Fuller-Thompson, J. David Hulchanski (Co-Principal Investigators). 45,800. [Grants]
1997 Jul - 1999 Jun	**Principal Investigator**. Mortality in a Cohort of Homeless Adults in Toronto. University of Toronto Faculty of Medicine, Dean's Fund. 10,000. [Grants]
1995 Jul - 1996 Jun	**Principal Investigator**. Risk Factors for Death in Homeless Adults in Boston. Boston University School of Medicine, Health Services Research Program. 6,500 USD. [Grants]

2. SALARY SUPPORT AND OTHER FUNDING

Personal Salary Support

2013 Jan - present	Chair in Homelessness, Housing and Health. St. Michael's Hospital and the University of Toronto. Toronto, Ontario, Canada.
2003 Mar - 2008 Feb	New Investigator Award. Canadian Institutes of Health Research. 275,000. Ottawa, Ontario, Canada.
1998 Jul - 2003 Jun	Career Scientist Award, Health Research Personnel Development Program. Ontario Ministry of Health and Long Term Care. 298,750. Toronto, Ontario, Canada.
1996 Sep - 2013 Jan	Population Health Epidemiologist. St. Michael's Hospital. Toronto, Ontario, Canada.
1994 Jul - 1996 Jun	Health Services Research Fellowship. Agency for Health Care Policy Research (AHCPR) and the Harvard School of Public Health. 90,000. Boston, Massachusetts, United States.

Trainee Salary Support

2021 Jun - 2023 Jun	CIHR Fellowship - Research & Knowledge Translation on Urban Housing and Health. Trainee Name: Jesse Jenkinson. Canadian Institutes of Health Research. 90,000. Toronto, Ontario, Canada.
2020 Apr - 2022 Mar	CIHR Fellowship - Research & Knowledge Translation on Urban Housing and Health. Trainee Name: James Lachaud. Canadian Institutes of Health Research. 90,000. Toronto, Ontario, Canada.
2013 Jul - 2016 Jun	CIHR Fellowship. Trainee Name: Fiona Kouyoumdjian, MD, PhD. Canadian Institutes of Health Research. 165,000. Ottawa, Ontario, Canada.
2012 Aug - 2017 Jul	National Institute on Drug Abuse (NIDA) Mentored Patient-Oriented Research Career Development Award (K23). Trainee Name: Travis Baggett, MD, MPH. National Institutes of Health. 840,000 USD. Bethesda, Maryland, United States.
2008 Sep - 2010 Aug	Graduate Studentship Award. Trainee Name: Allison Scott, MSc. Ontario HIV Treatment Network (OHTN). 44,000. Toronto, Ontario, Canada.
2006 Jul - 2008 Jun	CIHR Strategic Training Initiative in Health Research (STIHR) Fellowship. Trainee Name: Allison Scott, MSc. Canadian Institutes of Health Research. 50,000. Toronto, Ontario, Canada.

E. Publications

1. MOST SIGNIFICANT PUBLICATIONS

1. Stergiopoulos V, **Hwang SW**, Gozdzik A, Nisenbaum R, Latimer E, Rabouin D, Adair CE, Bourque J, Connelly J, Frankish J, Katz LY, Mason K, Misir V, O'Brien K, Sareen J, Schütz CG, Singer A, Streiner DL, Vasiliadis H-M, Goering PN, for the At Home/Chez Soi Investigators. Effect of Scattered-Site Housing Using Rent Supplements and Intensive Case Management on Housing Stability among Homeless Adults with Mental Illness: A Randomized Trial. JAMA. 2015 Mar;313(9):905-915. Impact Factor 30. **Co-Principal Author**.

   This paper reports the main outcomes of the At Home/Chez Soi Study, a randomized trial of the Housing First model for people with mental illness who are experiencing homelessness. This study is helping to change how society addresses the problem of homelessness. The study has had a substantial impact on federal and provincial programs and policies to end chronic homelessness (http://www.esdc.gc.ca/eng/communities/homelessness/housing_first/index.shtml), and it is the impetus for a MaRS proposal for a Housing First Social Impact Bond (http://www.marsdd.com/mars-library/housing-first-social-impact-bond-feasibility-study/).

2. **Hwang SW**, Burns T. Health Interventions for People who are Homeless. The Lancet. 2014 Oct;384(9953):1541-1547. Impact Factor 39.1. **Principal Author**.

   This review article was published by The Lancet as one of two featured papers on the theme of homelessness.

3. Olah ME, Gaisano G, **Hwang SW**. The Effect of Socioeconomic Status on Access to Primary Care: An Audit Study. Canadian Medical Association Journal. 2013 Apr;185(6):E256-E262. Impact Factor 9 (Trainee publication, Michelle Olah & Greg Gaisano - medical students). **Senior Responsible Author**.

   This study demonstrated that discrimination against patients of low socioeconomic status occurs within Canada's universal health insurance system. Standardized callers presenting with high socioeconomic status received preferential access to primary care over those presenting with low socioeconomic status. This study informed and stimulated the ongoing debate about physicians engaging in "cherry-picking" of patients, a contentious issue that has been a topic of concern for provincial medical regulatory authorities across Canada. This study received widespread media attention because it has important implications for the general public, policy makers, and health care providers.

   Examples of major media coverage:
   Toronto Star:
   http://www.thestar.com/life/health_wellness/2013/02/25/are_ontario_family_doctors_more_likely_to_take_on_wealthier_patients.html
   Canada AM: http://www.ctvnews.ca/health/are-family-doctors-more-likely-to-take-on-wealthy-patients-1.1170958
   The Globe and Mail: http://www.theglobeandmail.com/life/health-and-fitness/health-navigator/some-doctors-offices-play-favourites-study-finds/article9023268/
   Los Angeles Times: http://www.latimes.com/health/boostershots/la-sci-sn-rich-favored-over-poor-in-canada-healthcare-20130225,0,7927898.story
   Reuters: http://www.reuters.com/article/2013/03/07/us-canada-wealth-treatment-idUSBRE92613A20130307

   Editorials on this study:
   Toronto Star:
   http://www.thestar.com/opinion/editorials/2013/02/26/a_toronto_bias_study_shows_doctors_prefer_bankers_to_welfare_recipients_editorial.html
   Ottawa Citizen: http://www.ottawacitizen.com/opinion/editorials/Canada+tier+health+care/8025398/story.html
   Vancouver Sun:
   http://www.vancouversun.com/opinion/editorials/Editorial+rich+better+health+care/8031955/story.html

   Other media coverage included: As It Happens (CBC Radio), News 1130 radio, Huffington Post Canada, Ottawa Citizen, Edmonton Journal, Vancouver Province, Vancouver Sun, Calgary Herald, Saskatoon Star-Phoenix, PostMedia News, Regina Leader-Post, MSN.ca, CP24, CITY-TV, citynews.ca, CTVnews.ca, CBC.ca, Yahoo.ca, Yahoo.com, 680 News, The Medical Post.com, Medical Xpress, medicalnewstoday.com. medilexicon.com, Estevan (Sask.) Mercury, The (PEI) Guardian, Global Saskatoon, Global Edmonton, News Talk CKOM (Saskatoon), The Loop (Sympatico), therapeuticsdaily.com, Sun-Sentinel (Florida), Canada.com, Science Codex, Oye! Times, TopNews United States, News-Medical.net.

   Total media coverage: 207 items (138 Canadian, 53 United States, and 16 International).

4. **Hwang SW**, Weaver J, Aubry T, Hoch JS. Hospital Costs and Length of Stay among Homeless Patients Admitted to Medical, Surgical, and Psychiatric Services. Medical Care. 2011 Apr;49(4):350-354. Impact Factor 4.3 (Trainee publication, James Weaver). **Principal Author**.

   This paper was the first to study hospital costs among homeless people in Canada. Our research demonstrated that after adjustment for age, gender, and resource intensity weight, homeless patient admissions cost $2,559 more than housed patient admissions. For patients on medical and surgical services, much of this difference was explained by more alternate level of care days spent in the hospital, during which patients did not require the level of services provided in an acute care facility. Media coverage included: The Globe and Mail, CBC Metro Morning, Toronto Sun, CTV News.

5. **Hwang SW**, Ueng JJM, Chiu S, Kiss A, Tolomiczenko G, Cowan L, Levinson W, Redelmeier DA. Universal health insurance and health care access for homeless people. American Journal of Public Health. 2010 Aug;100:1454-1461. Impact Factor 4.2 (Trainee publication, Joanna Ueng - medical student). **Principal Author**.

   This study was the first to examine unmet need for care among homeless people within a system of universal health insurance. Our findings are of particular relevance in light of recent health care reforms that will result in the expansion of health insurance coverage to include homeless people in the United States. Media coverage included: Toronto Sun, PostMedia News (Montreal Gazette, Vancouver Sun, Windsor Star, Edmonton Journal), Science Daily.com, CBC Radio Toronto (Here and Now), and Newstalk 1010 Toronto with John Tory.

6. **Hwang SW**, Wilkins R, Tjepkema M, O'Campo PJ, Dunn JR. Mortality among residents of shelters, rooming houses, and hotels in Canada: An 11-year follow-up study. BMJ. 2009 Oct;339:b4036. Impact Factor 12.8. **Co-Principal Author**.

   This large national cohort study, the first of its kind, demonstrated that homeless and marginally- housed persons living in shelters, rooming houses, and hotels have much higher mortality and shorter life expectancy than expected on the basis of low income alone. This study highlighted the fact that people who are vulnerably housed suffer from many of the same threats to health as people who are homeless. This research provided important support for the concept of housing as a determinant of health.

7. **Hwang SW**, Colantonio A, Chiu S, Tolomiczenko G, Kiss A, Cowan L, Redelmeier DA, Levinson W. The Effect of Traumatic Brain Injury on the Health of Homeless People. Canadian Medical Association Journal. 2008 Oct;179(8):779-784. Impact Factor 7.1. **Principal Author**.

   This study was the first to demonstrate the high prevalence of traumatic brain injury among homeless individuals and the strong association between history of traumatic brain injury and poor health in this population. This paper has sparked research efforts on this topic in Canada, the United States, and Europe.

2. PEER-REVIEWED PUBLICATIONS

Journal Articles

1. Jenkinson J, **Hwang SW**, Strike C, Di Ruggiero E. "We don't have a good system for people who don't have a home and don't need a hospital": Contextualizing the Hospital Discharge Process for People Experiencing Homelessness in Toronto, Canada. Social Science and Medicine - Qualitative Research in Health. 2022 Dec;2:100056 (Trainee publication, Jesse Jenkinson (PhD student)). **Coauthor or Collaborator**.

2. Kiran T, Hodwitz K, Parsons J, Juando-Prats C, Rosenthal E, Craig-Neil A, **Hwang SW**, Lockwood J, Das P. Challenges faced by people experiencing homelessness and their providers during COVID-19: a qualitative study. CMAJ Open. 2022 Apr. In Press. **Coauthor or Collaborator**.

3. Wiens K, Rosella LC, Kurdyak P, Chen S, Aubry T, Stergiopoulos V, **Hwang SW**. Using healthcare encounter data to identify high-cost users among adults with a history of homelessness: a validation study. Journal of Social Distress and Homelessness. 2022 Apr. In Press (Trainee publication, Kathryn Wiens (PhD student)). **Senior Responsible Author**.

4. Sayani A, Manthorne J, Nicholson E, Bloch G, Parsons JA, **Hwang SW**, Amenu B, Freedman H, Rathbone M, Jeji T, Wathen N, Browne AJ, Varcoe C, Lofters A. Toward Equity-Oriented Cancer Care: A Strategy for Patient-Oriented Research (SPOR) protocol to promote equitable access to lung cancer screening. Research Involvement and Engagement. 2022 Apr;8(1):11. **Coauthor or Collaborator**.

5. Liu M, Richard L, Campitelli MA, Nisenbaum R, Dhalla IA, Wadhera RK, Shariff SZ, **Hwang SW**. Hospitalizations During the COVID-19 Pandemic Among Recently Homeless Individuals: A Retrospective Population-Based Matched Cohort Study. Journal of General Internal Medicine (JGIM). 2022 Apr. [Epub ahead of print]. Impact Factor 5.1. **Senior Responsible Author**.

6. Liu M, Koh KA, **Hwang SW**, Wadhera RK. Mental Health and Substance Use Among Homeless Adolescents in the United States. JAMA. 2022 Mar. In Press. Impact Factor 56.3. **Coauthor or Collaborator**.

7. Ecker J, Brown M, Aubry T, Francombe Pridham K, **Hwang SW**. Coordinated access and coordinated entry system processes in the housing and homelessness sector: A critical commentary on current practices. Housing Policy Debate. 2022 Mar. In Press. Impact Factor 2.3. **Senior Responsible Author**.

8. Shariff SZ, Richard L, **Hwang SW**, Kwong JC, Forchuk C, Dosani N, Booth R. COVID-19 vaccine coverage and factors associated with vaccine uptake among 23 247 adults with a recent history of homelessness in Ontario, Canada: a population-based cohort study. The Lancet Public Health. 2022 Mar. Impact Factor 21.6. **Coauthor or Collaborator**.

9. Czechowski K, Sylvestre J, Gogosis E, Agha A, Kerman N, Polillo A, Palepu A, **Hwang SW**. Cycles of Instability: Proximal and Distal Influences on Residential Instability Among People with Histories of Homelessness in Three Canadian Cities. Journal of Community Psychology. 2022 Mar. [Epub ahead of print]. Impact Factor 2.2. **Coauthor or Collaborator**.

10. Liu M, Richard L, Campitelli MA, Nisenbaum R, Dosani N, Dhalla IA, Wadhera RK, Shariff SZ, **Hwang SW**. Drug Overdoses During the COVID-19 Pandemic Among Recently Homeless Individuals. Addiction. 2022 Feb. [Epub ahead of print]. Impact Factor 6.5 (Trainee publication, Michael Liu (graduate student)). **Senior Responsible Author**.

11. Luong L, Beder M, Nisenbaum R, Orkin A, Wong J, Damba C, Emond R, Lena S, Loutfy M, Wright V, Bruce-Barrett C, Cheung W, Cheung K, Williams V, Vanmeurs M, Boozary A, Manning H, Hester J, **Hwang SW**. Prevalence of SARS-CoV-2 infection among people experiencing homelessness in Toronto during the first wave of the COVID-19 pandemic. Canadian Journal of Public Health. 2022 Feb;113(1):117-125. Impact Factor 2.4. **Senior Responsible Author**.

12. Kiran T, Craig-Neil A, Das P, Lockwood J, Wang R, Nathanielsz N, **Hwang SW**. Association of Homelessness with COVID-19 Positivity among Individuals Visiting a Testing Centre. Healthcare Policy. 2022 Feb;17(3):34-41. **Coauthor or Collaborator**.

13. Jenkinson J, Strike C, **Hwang SW**, Di Ruggiero E. Legal, geographic and organizational contexts that shape knowledge sharing in the hospital discharge process for people experiencing homelessness in Canada. Health and Social Care in the Community. 2022 Feb;30(2):e377–e387. Impact Factor 2.8 (Trainee publication, Jesse Jenkinson (PhD student)). **Coauthor or Collaborator**.

14. Mejia-Lancheros C, Lachaud J, Aubry T, Wiens K, O'Campo P, Stergiopoulos V, **Hwang SW**. Multi-trajectory group profiles of well-being and associated predictors among adults experiencing homelessness and mental illness: Findings from the At Home/Chez Soi study, Toronto site. Social Psychiatry and Psychiatric Epidemiology. 2022 Jan;57(1):67-81. Impact Factor 3.3 (Trainee publication, Cilia Mejia-Lancheros (postdoctoral fellow)). **Senior Responsible Author**.

15. Reid N, Mason J, Kurdyak P, Nisenbaum R, de Oliveira C, **Hwang S**, Stergiopoulos V. Evaluating the Impact of a Critical Time Intervention Adaptation on Health Care Utilization among Homeless Adults with Mental Health Needs in a Large Urban Center. Canadian Journal of Psychiatry. 2022 Jan;67(1):57-66. Impact Factor 3.3. **Coauthor or Collaborator**.

16. Filewod N, **Hwang S**, Turner CJ, Rizvi L, Gray S, Klaiman M, Buell D, Ailon J, Caudarella A, Ginocchio GF, Santos M, Sandhu G, Dewhurst N, Sequeira K, Burns KEA. Phenobarbital for the Management of Severe Acute Alcohol Withdrawal (PHENOMANAL): A Pilot Randomized Controlled Trial. Pilot and Feasibility Studies. 2022 Jan;8(1):14. Impact Factor 0.9. **Coauthor or Collaborator**.

17. Vogel M, Choi F, Westenberg JN, Cabanis M, Nikoo N, Nikoo M, **Hwang SW**, Somers J, Schütz CG, Krausz MR. Chronic pain among individuals experiencing homelessness and its interdependence with substance use and mental illness. International Journal of Environmental Research and Public Health. 2021 Dec;19(1):5. Impact Factor 3.3. **Coauthor or Collaborator**.

18. Gadermann AM, Hubley AM, Russell LB, Thomson KC, Norena M, Rossa-Roccor V, **Hwang SW**, Aubry T, Karim ME, Farrell S, Palepu A. Understanding subjective quality of life in homeless and vulnerably housed individuals: The role of housing, health, substance use, and social support. Social Science & Medicine - Mental Health. 2021 Dec;1:Article 100021. **Coauthor or Collaborator**.

19. Persaud N, Woods H, Workentin A, Adekoya I, Dunn J, **Hwang S**, Maguire J, Pinto A, O'Campo P, Rourke SB, Werb D. Recommendations for equitable Covid-19 pandemic recovery in Canada. Canadian Medical Association Journal (CMAJ). 2021 Dec;193:E1878-88. Impact Factor 8.3. **Coauthor or Collaborator**.

20. Persaud N, Thorpe KE, Bedard M, **Hwang SW**, Pinto AD, Juni P, da Costa B, for the DISTANSE COVID-19 (Direct Income SupporT and Advice Negating Spread of Epidemic COVID-19: a randomized controlled trial) study team. Cash transfer during the COVID-19 pandemic: a multicentre, randomized controlled trial. Family Medicine and Community Health. 2021 Dec;9:e001452. **Coauthor or Collaborator**.

21. Durbin A, Nisenbaum R, Wang R, **Hwang SW**, Kozloff N, Stergiopoulos V. Recovery Education for adults experiencing homelessness: A longitudinal outcome evaluation. Frontiers in Psychiatry. 2021 Nov;12:763396. Impact Factor 4.1. **Coauthor or Collaborator**.

22. Liu M, Luong L, Lachaud J, Edalati H, Reeves A, **Hwang SW**. Adverse Childhood Experiences Among Adults Experiencing Homelessness: A Systematic Review and Meta-Analysis. The Lancet Public Health. 2021 Nov;693(11):e836-e847. Impact Factor 21.6. **Senior Responsible Author**.

23. Paudyal V, Racine M, **Hwang SW**. COVID-19 vaccination amongst homeless persons : practices and lessons from UK, Canada and the US. Public Health. 2021 Oct;199:e2-e3. Impact Factor 2.4. **Coauthor or Collaborator**.

24. Liauw SSL, Luong L, Liu S, Atcha M, Kwok Y, Nisenbaum R, Fam N, **Hwang SW**, Cheema AN. Clinical Presentation and Outcome of Patients Experiencing Homelessness with ST-Elevation Myocardial Infarction. Canadian Journal of Cardiology. 2021 Oct;37(10):1555-1561. Impact Factor 5.2 (Trainee publication, Samantha Liauw (cardiology resident)). **Coauthor or Collaborator**.

25. Liu M, Mejia-Lancheros C, Lachaud J, Latimer E, Aubry T, Somers J, Distasio J, Stergiopoulos V, **Hwang SW**. Overall and Gender-Specific Associations Between Dimensions of Adverse Childhood Experiences and Mental Health Outcomes among Homeless Adults. Canadian Journal of Psychiatry. 2021 Oct;66(10):906–917. Impact Factor 3.3 (Trainee publication, Michael Liu (graduate student)). **Senior Responsible Author**.

26. Tweed EJ, Thomson RM, Lewer D, Sumpter C, Kirolos A, Southworth PM, Purba AK, Aldridge RW, Hayward A, Story A, **Hwang SW**, Katikireddi SV. Health of people experiencing co-occurring homelessness, imprisonment, substance use, sex work, and/or severe mental illness in high-income countries: a systematic review and meta-analysis. Journal of Epidemiology & Community Health. 2021 Oct;75(10):1010-1018. Impact Factor 3.3. **Coauthor or Collaborator**.

27. Nasmith TE, Gadermann A, Jaworski D, Norena M, To MJ, **Hwang SW**, Palepu A. Clinically significant substance use and residential stability among homeless or vulnerably housed persons in Canada: a longitudinal cohort study. Journal of Public Health. 2021 Sep;43(3):532-540. Impact Factor 1.8. **Coauthor or Collaborator**.

28. Campbell D, Campbell RB, McBrien KA, Booth GL, **Hwang SW**. The use of community-based participatory research approaches to meaningfully engage those with lived experience of diabetes and homelessness. BMJ Open Diabetes Research & Care. 2021 Aug;9:e002154. Impact Factor 3.1 (Trainee publication, David Campbell (postdoctoral fellow)). **Coauthor or Collaborator**.

29. Sayal AP, Popovic MM, Mustafa M, **Hwang SW**, Lichter M. The Attitudes of Canadian Ophthalmology Residents and Pre-Clerkship Medical Students at an Ontario Medical School Towards Homeless Individuals: A Cross-Sectional Study. Ophthalmic Epidemiology. 2021 Aug;28(4):330-336. Impact Factor 1.5. **Coauthor or Collaborator**.

30. Jenkinson J, Strike C, **Hwang SW**, Di Ruggiero E. Nowhere to go: exploring the social and economic influences on discharging people experiencing homelessness to appropriate destinations in Toronto, Canada. Canadian Journal of Public Health. 2021 Aug. Impact Factor 1.6. **Coauthor or Collaborator**.

31. Reid N, Nisenbaum R, **Hwang SW**, Durbin A, Kozloff N, Wang R, Stergiopoulos V. The Impact of Financial Incentives on Service Engagement Among Adults Experiencing Homelessness and Mental Illness: A Pragmatic Trial Protocol. Frontiers in Psychiatry. 2021 Aug;12:1316. Impact Factor 4.1. **Coauthor or Collaborator**.

32. Sayani A, Maybee A, Manthorne J, Nicholson E, Bloch G, Parsons J, **Hwang SW**, Lofters A. Building equitable patient partnerships during COVID19: Challenges and key considerations for research and policy. Healthcare Policy. 2021 Aug;17(1):17-24. Impact Factor 0.9. **Coauthor or Collaborator**.

33. Thulien N, Wang A, Wang R, **Hwang SW**. Tackling exclusion: A pilot mixed method quasi-experimental identity capital intervention for young people exiting homelessness. PLOS ONE. 2021 Aug;16(8):e0256288. Impact Factor 3.2. **Coauthor or Collaborator**.

34. Lachaud J, Mejia-Lancheros C, Durbin A, Nisenbaum R, Wang R, O'Campo P, Stergiopoulos V, **Hwang SW**. The Effect of a Housing First Intervention on Acute Health Care Utilization among Homeless Adults with Mental Illness: Long-term Outcomes of the At Home/Chez-Soi Randomized Pragmatic Trial. Journal of Urban Health. 2021 Aug;98(4):505-515. Impact Factor 2.3 (Trainee publication, James Lachaud (postdoctoral fellow)). **Senior Responsible Author**.

35. Campbell RB, Larsen M, DiGiandomenico A, Davidson MA, Booth GL, **Hwang SW**, McBrien KA, Campbell DJT. The challenges of managing diabetes while homeless: a qualitative study using photovoice methodology. Canadian Medical Association Journal (CMAJ). 2021 Jul;193(27):E1034-E1041. Impact Factor 8.3 (Trainee publication, David Campbell (postdoctoral fellow)). **Coauthor or Collaborator**.

36. Mejia-Lancheros C, Lachaud J, To MJ, Lee P, Nisenbaum R, O'Campo P, Stergiopoulos V, **Hwang SW**. The Long-Term Effects of a Housing First Intervention on Primary Care and Non-Primary Care Physician Visits Among Homeless Adults with Mental Illness: A 7-Year RCT Follow-Up. Journal of Primary Care & Community Health. 2021 Jul;12:1-11. Impact Factor 2.1 (Trainee publication, Cilia Mejia-Lancheros (postdoctoral fellow)). **Senior Responsible Author**.

37. Grewal EK, Campbell RB, Booth GL, McBrien KA, **Hwang SW**, O'Campo P, Campbell DJT. Using concept mapping to prioritize barriers to diabetes care and self-management for those who experience homelessness. International Journal for Equity in Health. 2021 Jul;20:158. Impact Factor 2.5. **Coauthor or Collaborator**.

38. Wang A, Francombe Pridham K, Nisenbaum R, Pedersen C, Brown R, **Hwang SW**. Factors Associated with Readmission Among General Internal Medicine Patients Experiencing Homelessness. Journal of General Internal Medicine (JGIM). 2021 Jul;36(7):1944-1950. Impact Factor 5.1. **Senior Responsible Author**.

39. Pinto AD, Perri M, Pedersen C, Aratangy T, Hapsari AP, **Hwang SW**. Exploring different methods to evaluate the impact of Basic Income interventions: a systematic review. International Journal for Equity in Health. 2021 Jun;20:142. Impact Factor 2.5. **Coauthor or Collaborator**.

40. Wiens K, Rosella LC, Kurdyak P, Chen S, Aubry T, Stergiopoulos V, **Hwang SW**. Factors associated with higher healthcare costs in a cohort of homeless adults with a mental illness and a general cohort of adults with a history of homelessness. BMC Health Services Research. 2021 Jun;21:555. Impact Factor 2 (Trainee publication, Kathryn Wiens (PhD student)). **Senior Responsible Author**.

41. Persaud N, Bedard M, Boozary A, Glazier RH, Gomes T, **Hwang SW**, Juni P, Law MR, Mamdani M, Manns B, Martin D, Morgan SG, Oh P, Pinto AD, Shah BR, Sullivan F, Umali N, Thorpe KE, Tu K, Laupacis A, for the CLEAN Meds (Carefully seLected and Easily Accessible at No Charge Medications) study team. Adherence at 2 years with distribution of essential medicines at no charge: The CLEAN Meds randomized clinical trial. PLOS Medicine. 2021 May;18(5):e1003590. Impact Factor 10.5. **Coauthor or Collaborator**.

42. Sayani A, Vahabi M, O'Brien MA, Liu G, **Hwang S**, Selby P, Nicholson E, Giuliani M, Eng L, Lofters A. Advancing Health Equity in Cancer Care: The Lived Experiences of Poverty and Access to Lung Cancer Screening. PLOS ONE. 2021 May;16(5):e0251264. Impact Factor 2.7. **Coauthor or Collaborator**.

43. Loftus EI, Lachaud J, **Hwang SW**, Mejia-Lancheros C. Food Insecurity and Mental Health Outcomes among Homeless Adults: A Scoping Review. Public Health Nutrition. 2021 May;24(7):1766-1777. Impact Factor 2.5 (Trainee publication, Elizabeth Loftus (undergraduate student), Cilia Mejia-Lancheros (postdoctoral fellow)). **Coauthor or Collaborator**.

44. Lachaud J, Mejia-Lancheros C, Wang R, Liu M, Nisenbaum R, Stergiopoulos V, **Hwang SW**, O'Campo P. Severe Psychopathology and Substance Use Disorder Modify the Association between Housing Trajectories and Food Security among Homeless Adults. Frontiers in Nutrition. 2021 May;8:Article 608811. Impact Factor 3.3 (Trainee publication, James Lachaud (postdoctoral fellow)). **Coauthor or Collaborator**.

45. Luong L, Lachaud J, Kouyoumdjian FG, **Hwang SW**, Mejia-Lancheros C. The Impact of a Housing First intervention and health-related risk factors on incarceration among people with experiences of homelessness and mental illness in Canada. Canadian Journal of Public Health. 2021 Apr;112(2):270-279. Impact Factor 1.6 (Trainee publication, Linh Luong (MPH practicum student)). **Coauthor or Collaborator**.

46. Wiens K, Nisenbaum R, Sucha E, Aubry T, Duhoux A, Farrell S, Gadermann A, Palepu A, **Hwang SW**. Does housing improve health care utilization and costs? A longitudinal analysis of health administrative data linked to a cohort of individuals who experience homelessness. Medical Care. 2021 Apr;59:S110–S116. Impact Factor 3.2 (Trainee publication, Kathryn Wiens (PhD student)). **Senior Responsible Author**.

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12. **Hwang SW**. Discharge Against Medical Advice. AHRQ WebM&M, 2005. An online publication of the U.S. Agency for Healthcare Research and Quality. Available at: http://webmm.ahrq.gov. **Principal Author**.

13. **Hwang SW**. Mental illness and mortality among homeless people. Acta Psychiatrica Scandinavica. February 2001;103:81-2. Impact Factor 2.1. **Principal Author**.

Letters to Editor

1. Goligher EC, Del Sorbo L, Cheung AM, Alibhai SMH, Liao L, Easson A, Halpern J, Ely EW, Sulmasy DP, **Hwang SW**. Why conscientious objection merits respect. Canadian Medical Association Journal (CMAJ). 2016 Aug;188(11):822-823. Available from: http://www.cmaj.ca/content/187/18/1339.full/reply#cmaj_el_731617. **Coauthor or Collaborator**.

2. Stergiopoulos V, **Hwang SW**, Gozdzik A. Effect of Scattered-Site Housing Using Rent Supplements and Intensive Case Management on Housing Stability among Homeless Adults with Mental Illness -- Reply. JAMA. 2015 May;313(24):2493-4. **Co-Principal Author**.

3. **Hwang SW**. Dealing with alcoholism. Canadian Medical Association Journal. August 2006; 175(5):502-3. **Principal Author**.

Clinical Care Guidelines

1. Lemsky C, Jenkins D, King B, Synovec C, Caughlin J, Gelberg L, **Hwang S**, Lepore SW, Tatlock T. Adapting your practice: Recommendations for the care of patients who are homeless or unstably housed living with the effects of traumatic brain injury. Nashville (United States): Health Care for the Homeless Council, Inc.; 2018 Oct. Available from: https://nhchc.org/clinical-practice/adapted-clinical-guidelines/tbi/. **Coauthor or Collaborator**.

Non-Fiction

1. **Hwang SW**. Discharge Day. Canadian Medical Association Journal. April 2006; 174(8):1138-9. Impact Factor 5.9. **Principal Author**.

Reports

1. Adamo A, Klodawsky F, Aubry T, **Hwang SW**. Ending homelessness in Canada: A study of 10-year plans in 4 Canadian cities. 2016 Oct. Toronto: Research Alliance for Canadian Homelessness, Housing, and Health (REACH3). October 2016. **Senior Responsible Author**.

2. Wismer B, Amann T, Diaz R, Eisen D, Elder N, Ho C, **Hwang S**, Johnston M, Joslyn M, Kertesz S, Kushel M, Preston C, Solotoroff R, Thompson L, Silva F, Smith S, Zevin B, Meinbresse M, Post P (Ed.). Adapting Your Practice: Recommendations for the Care of Homeless Adults with Chronic Nonmalignant Pain. Nashville, TN: Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc., 2011. Available at: http://www.nhchc.org/clinicalresources/ChronicPainManagement.pdf. **Coauthor or Collaborator**.

3. Holton E, Gogosis E, **Hwang S**. Housing vulnerability and health: Canada's hidden emergency. Toronto: Research Alliance for Canadian Homelessness, Housing, and Health (REACH3), November 2010. **Senior Responsible Author**.

4. **Hwang S**, Chiu S, Wilkins E. A Survey of Domiciliary Hostel Program Tenants in Ontario. Report for the Ontario Mental Health Foundation. January 2009. **Principal Author**.

5. Khandor E, Mason K. The Street Health Report 2007. Toronto: Street Health, 2007. Full report available at: www.streethealth.ca. "Street Health Stories" film available at: http://www.youtube.com/watch?v=-omQ5rr3GUk. **Acknowledged in Publication (Not Author)**.

6. **Hwang SW**, Martin RE, Tolomiczenko GS, Hulchanski JD. The Relationship Between Housing Conditions and Health Status of Rooming House Residents in Toronto. Centre for Urban and Community Studies, Research Bulletin #26. Toronto: Centre for Urban and Community Studies, 2004. **Principal Author**.

7. Goering P, Pyke J, Bullock H, Hoch J, **Hwang S**, Lindsay S, Tolomiczenko G, Wasylenki D. Health, Mental Health and Addiction Treatment Needs of People Using Emergency Shelters in Toronto. Prepared for: City of Toronto, Community and Neighbourhood Services, Shelter, Housing and Support Division, 2004. **Coauthor or Collaborator**.

8. Hierlihy D, **Hwang SW**, Whitzman C, Hamilton A. Models and Practices in Service Integration and Coordination for Women who are Homeless or At-Risk of Homelessness: An Inventory of Initiatives. Toronto: Ontario Women's Health Council, 2004. **Coauthor or Collaborator**.

9. Frankish CJ, **Hwang SW**, Quantz D. The Relations Between Homelessness & Health in Canada: Research Lessons and Priorities. Ottawa: Canadian Institutes of Health Research, 2003. **Coauthor or Collaborator**.

10. **Hwang SW**, Martin R, Tolomiczenko G, Hulchanski D. Rooming house residents: Challenging the stereotypes. Centre for Urban and Community Studies, Research Bulletin #16. Toronto: Centre for Urban and Community Studies, 2003. **Principal Author**.

11. **Hwang SW**, Fuller-Thomson E, Hulchanski JD, Bryant T, Habib Y, Regoeczi W. Housing and Population Health: A Review of the Literature. Ottawa: Canada Mortgage and Housing Corporation, 1999. **Principal Author**.

12. **Hwang SW**, Fuller-Thomson E, Hulchanski JD, Bryant T, Habib Y, Regoeczi W. The Housing/Health Relationship: Research, Policy and Program Implications. Ottawa: Canada Mortgage and Housing Corporation, 1999. **Principal Author**.

4. SUBMITTED PUBLICATIONS

Journal Articles

1. Wiens K, Bai L, **Hwang SW**, Booth GL, Ronksley PE, Austin PC, Spackman E, Campbell DJT. Long-term association between homelessness and mortality among people with diabetes. The Lancet Diabetes & Endocrinology. 2022 Apr. **Coauthor or Collaborator**.

2. Richard L, Nisenbaum R, Liu M, McGeer A, Mishra S, Gingras A, Gommerman JL, Sniderman R, Pedersen C, Spandier O, Jenkinson J, Baral S, Mejia Lancheros C, Agarwal A, Jamal AJ, Ostrowski M, Dhalla I, Stewart S, Gabriel M, Brown M, Hester J, **Hwang SW**. COVENANT, the COVID-19 Cohort Study of People Experiencing Homelessness in Toronto, Canada: A study protocol. BMJ Open. 2022 Apr. **Senior Responsible Author**.

3. Thulien NS, Akdikmen A, Amiri A, **Hwang SW**, Kozloff N, Roglich J, Wang A, Nisenbaum R. Effect of Portable Rent Subsidies and Mentorship on Socioeconomic Inclusion for Young People Exiting Homelessness: A Community-Based Pilot Randomized Clinical Trial. JAMA Open. 2022 Apr. **Coauthor or Collaborator**.

4. Kerman N, Wang R, Aubry T, Distasio J, Gaetz S, **Hwang SW**, Latimer E, O'Grady B, Schwan K, Somers JM, Stergiopoulos V, Kidd SA. Shelter Bans among People Experiencing Homelessness: An Exploratory Study of Predictors in Two Large Canadian Datasets. Journal of Urban Health. 2022 Mar. **Coauthor or Collaborator**.

5. Campbell D, Yaphe H, Campbell R, Mancini N, Grewal E, Tibebu T, Saunders- Smith T, **Hwang SW**. The development of a conceptual framework for providing tailored diabetes care for individuals experiencing homelessness: A qualitative study. Diabetes Research and Clinical Practice. 2022 Mar. **Coauthor or Collaborator**.

6. Wiens K, Rosella LC, Kurdyak P, Chen S, Aubry T, Stergiopoulos V, **Hwang SW**. Determinants of health care utilization: Comparing a cohort of homeless adults with mental illness to a general cohort of adults with a history of homelessness. Health Services Insights. 2022 Mar (Trainee publication, Kathryn Wiens (PhD student)). **Senior Responsible Author**.

7. Firestone F, Zewge-Abubaker N, Salmon C, McKnight C, **Hwang SW**. Using Concept Mapping to Define Indigenous Housing First in Hamilton, Ontario. Health Promotion Practice. 2022 Feb. **Coauthor or Collaborator**.

8. Liauw S, Mejia-Lancheros C, Lachaud J, O'Campo P, Stergiopoulos V, **Hwang SW**. Effect of a housing intervention on major cardiovascular events among homeless adults with mental illness. Journal of Social Distress and Homelessness. 2022 Jan (Trainee publication, Samantha Liauw (cardiology resident)). **Senior Responsible Author**.

9. Mejia-Lancheros C, Alfayumi-Zeadna S, Lachaud J, O'Campo P, Gogosis E, Da Silva G, Stergiopoulos V, **Hwang SW**, Thulien N. Differential impacts of COVID-19 and associated responses on the health, social well-being and food security of users of supportive social and health programs during the COVID-19 pandemic: A qualitative study. Health & Social Care in the Community. 2022 Jan. **Coauthor or Collaborator**.

10. Mejia-Lancheros C, Lachaud J, Gogosis E, Thulien N, Stergioupoulos V, Da Silva G, Nisenbaum R, O'Campo P, **Hwang SW**. Providing Housing First services for an undeserved population during the COVID-19 pandemic: A qualitative study. PLOS ONE. 2021 Aug (Trainee publication, Cilia Mejia-Lancheros (postdoctoral fellow)). **Senior Responsible Author**.

F. Presentations and Special Lectures

1. INTERNATIONAL

Invited Lectures and Presentations

2022 Apr 5 **Invited Speaker**. A Pilot Intervention Program: From Shelter Hotels to Stable Housing. Harvard T.H. Chan School of Public Health, Initiative on Health and Homelessness, Research & Practice Seminar Series. Boston, Massachusetts, United States. Presenter(s): **Hwang SW**.

2020 Feb 19 **Distinguished Speaker**. Creating Urban Health Solutions: Promises and Perils. University of Colorado, Department of Family Medicine, Levitt Distinguished Speaker Series. Denver, Colorado, United States. Presenter(s): **Hwang SW**.

2015 Apr 23 **Invited Speaker**. Pragmatic and Patient-Centered: Clinical Trials Done Differently. Society of General Internal Medicine (SGIM) 38th Annual Meeting / Patient-Centered Outcomes Research Institute (PCORI). Toronto, Ontario, Canada. Presenter(s): Chuang CH, **Hwang SW**, Jacobs E, Gapka S, Bild D, Kraschnewski JL.

2015 Apr 22 **Invited Speaker**. Defining the Role and Value of GIM -- The Canadian Experience. Association of Chiefs and Leaders of General Internal Medicine (ACLGIM) Management and Leadership Institute. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2014 Dec 5 **Invited Speaker**. High-Cost Medicaid Users Supportive Housing Think Tank. Supportive Housing Network of New York (SHNNY). New York City, New York, United States. Presenter(s): **Hwang SW**.

2014 Mar 5 **Keynote Speaker**. 2nd International Symposium on Homelessness, Social Exclusion, and Health Inequalities. Faculty for Homeless and Inclusion Health. London, United Kingdom. Presenter(s): **Hwang SW**. Epidemiology of Homelessness and Exclusion.

2012 Oct 24 **Invited Speaker**. Caring for Homeless Patients: Why Research Does (and Doesn't) Help. Boston University School of Medicine/Boston Medical Center - Section of General Internal Medicine Grand Rounds. Boston, Massachusetts, United States. Presenter(s): **Hwang SW**.

2012 Oct 24 **Invited Speaker**. The At Home Study: An RCT of Housing First for Homeless People with Mental Illness. Massachusetts General Hospital - General Internal Medicine Rounds. Boston, Massachusetts, United States. Presenter(s): **Hwang SW**.

2012 Oct 23 **Invited Speaker**. Research on Homelessness, Housing, and Health in Toronto, Canada. Boston Health Care for the Homeless Program (BHCHP) Grand Rounds. Boston, Massachusetts, United States. Presenter(s): **Hwang SW**.

2010 Jun 2 **Invited Speaker**. Examining Structural HIV Interventions: Methodological Challenges. North American Housing and HIV/AIDS Research Summit V. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2008 Feb 4 **Invited Speaker**. Traumatic Brain Injury and Homelessness. The 2nd Annual Camillus House Institute of

Homeless Studies Symposium: Applying Research to End Homelessness. Miami, Florida, United States. Presenter(s): **Hwang SW**.

2007 Oct 18 **Invited Speaker**. Traumatic Brain Injury and Homelessness. Columbia University Mailman School of Public Health, Center for Homelessness Prevention Studies, Grand Rounds. New York City, New York, United States. Presenter(s): **Hwang SW**.

2007 Oct 11 **Invited Speaker**. Quality of Life in Non-mainstream Populations. 2007 Annual Meeting of the International Society for Quality of Life Research (ISOQOL). Toronto, Ontario, Canada. Presenter(s): **Hwang SW**, Hubley A, Smylie J.

2007 Jun 14 **Invited Speaker**. Pandemic readiness planning and homelessness. 2007 National Health Care for the Homeless Conference. Washington, District of Columbia, United States. Presenter(s): **Hwang SW**.

2006 Oct 21 **Co-author**. Impact of Housing Status and Perceived Quality of Housing Environment on Health Related Quality of Life in HIV/AIDS. National Housing and HIV/AIDS Research Summit II. Baltimore, Maryland, United States. Presenter(s): Tucker R, Greene S, Rourke SB, Guenter D, Monette L, Narciso L, Koornstra J, Byers S, Sobota M, Dunn J, **Hwang SW**. Oral presentation by M. Sobota and J. Koornsta.

2006 Mar 9 **Invited Speaker**. National and International Perspectives on Homelessness and Health. Canadian Institutes of Health Research (CIHR), Reducing Health Disparities Research and Policy Symposium. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2005 Oct 26 **Invited Speaker**. How to Understand and Conduct Research on Homelessness: A Practical Guide. 4th International Conference on Urban Health. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**, Svoboda T. Pre-Conference Workshop.

2005 Jun 29 **Invited Speaker**. Homeless and Mentally Ill: Quality of Life. Seminar on “Psychiatric Epidemiology: Searching for Causes”. 2005 Joint Meeting of the Society for Epidemiologic Research and the Canadian Society for Epidemiology and Biostatistics (SER/CSEB). Toronto, Ontario, Canada. Presenter(s): **Hwang SW**. Seminar Presentation.

2003 Sep 21 **Invited Speaker**. Homelessness and Health. Canadian Institutes of Health Research (CIHR), International Think Tank on Reducing Health Disparities and Promoting Equity for Vulnerable Populations. Ottawa, Ontario, Canada. Presenter(s): **Hwang SW**.

2002 Oct 6 **Chair**. Closing Remarks. 1st International Conference on Inner City Health. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**, Bayoumi A.

1996 Apr **Speaker**. Mortality Rates Among Homeless Adults in Boston. Harvard School of Public Health, Clinical Epidemiology Research Rounds. Boston, Massachusetts, United States. Presenter(s): **Hwang SW**.

Presented Abstracts

2021 Dec **Co-author**. What can be done to improve diabetes care for the homeless? A comprehensive international scoping review of interventions. International Diabetes Federation Congress [Virtual Meeting]. Presenter(s): Campbell D, Grewal E, Tibebu T, Gonzalez P, Campbell R, **Hwang S**, McBrien K, Booth G.

2021 Nov **Co-author**. Placeless and Powerless: Experiences of patients who are homelessness and healthcare workers caring for them during COVID-19. 2021 North American Primary Care Research Group (NAPCRG) Annual Meeting. United States. Presenter(s): Hodwitz K, Juando-Prats C, Parsons J, Rosenthal E, Das P, Lockwood J, Snider C, **Hwang S**, Kiran T.

2021 Oct **Presenter**. Beyond Housing: Enhancing coordination and supports to complement case management in Housing First. Fourth International Housing First Conference. Canada. Presenter(s): **Hwang S**, Francombe Pridham K, Ecker J.

2021 Feb **Co-author**. Cognitive and functional trajectories in homeless adults: 6-year outcomes from the At Home/Chez Soi study. 49th Annual Meeting of the International Neuropsychological Society. United States. Presenter(s): Gicas KM., Mejia-Lancheros C, Wang R., **Hwang S**, Stergiopoulos V. Poster

presentation [virtual conference].

2019 Nov **Co-author**. How does context shape the process of discharging people experiencing homelessness from acute care hospitals? American Public Health Association (APHA) 2019 Annual Meeting and Expo. Philadelphia, Pennsylvania, United States. Presenter(s): Jenkinson J, **Hwang SW**, Strike C, Di Ruggiero E. Oral presentation. (Trainee Presentation).

2019 Sep **Co-author**. Beyond a Home: Facilitating Socioeconomic Inclusion for Young People Transitioning Out of Homelessness. 14th European Research Conference on Homelessness. Helsingborg, Skåne län [SE-12], Sweden. Presenter(s): Naomi Thulien, **Stephen Hwang**, Andrea Wang. (Trainee Presentation).

2019 Jun **Co-author**. Mental illness, homelessness, and victimization: Results from the National At Home/Chez Soi Study and perspectives of people with lived experience (Symposium). International Association of Forensic Mental Health Services. Montreal, Quebec, Canada. Presenter(s): Nicholls TL, Eiboff F, Wang R, O'Campo P, **Hwang SW**, Frankish CJ. (Trainee Presentation).

2019 Jun **Co-author**. The effect of housing status on health care utilization and costs among homeless and vulnerably housed persons in Ontario. Symposium on Findings from a Longitudinal Study of the Health of Adults Who Are Homeless or Vulnerably Housed in Three Canadian Cities. Society for Community Research and Action - 2019 Biennial Conference. Chicago, Illinois, United States. Presenter(s): **Stephen Hwang**, Kathryn Wiens, Rosane Nisenbaum, Ewa Sucha, Tim Aubry, Arnaud Duhoux, Susan Farrell, Anne Gadermann, Anita Palepu. (Trainee Presentation).

2018 Aug **Co-author**. Perceptions of Housing Transitions Among People with Histories of Unstable Housing in Ottawa, Canada. American Psychological Association (APA) 2018 Convention. San Francisco, California, United States. Presenter(s): Konrad Czechowski, John Sylvestre, Fran Klodawsky, **Stephen Hwang**.

2018 Jun **Co-author**. Criminal justice-involvement, recovery and victimization among homeless mentally ill individuals: Findings from the Canadian At Home/Chez Soi study. International Association of Forensic Mental Health Services. Antwerp, Antwerpen, Belgium. Presenter(s): Eiboff F, Nicholls TL, Wang R, Frankish CJ, **Hwang SW**. (Trainee Presentation).

2018 Mar **Co-author**. High prevalence and severity of intimate partner violence among women who are homeless with mental illness. American Psychology-Law Society (AP-LS) 2018 Annual Conference. Memphis, Tennessee, United States. Presenter(s): Eiboff F, Nicholls TL, Wang R, Krausz M, Frankish CJ, **Hwang SW**. (Trainee Presentation).

2017 Nov 6 **Co-author**. Understanding the health impacts of weather on people experiencing homelessness: Using research to inform healthy public policy. American Public Health Association (APHA) 2017 Annual Meeting and Expo. Atlanta, Georgia, United States. Presenter(s): Bassil K, Wainberg A, Coleman PC, Gower S, Keirstead H, Kim M, **Hwang S**, Gogosis E. Oral presentation.

2017 Sep 1 **Co-author**. A comparison of intimate partner victimization among homeless women and men with mental illness. Symposium: Criminal justice involvement and victimization among homeless individuals with mental illnesses. The Royal Australian & New Zealand College of Psychiatrists (RANZCP) Faculty of Forensic Psychiatry 2017 Conference. Vancouver, British Columbia, Canada. Presenter(s): Eiboff F, Nicholls TL, Wang R, Moniruzzaman A, **Hwang SW**, Frankish CJ, Krausz M.

2015 Nov 2 **Senior author.**. Emergency Department Visits for Cold-related Injuries among Homeless Adults: A 5-Year Cohort Study in Toronto, Canada. 143rd Annual Meeting of the American Public Health Association (APHA). Chicago, Illinois, United States. Presenter(s): Zhang P, Gower S, Bassil K, Kiss A, Katic M, **Hwang S**. Poster presentation.

2015 Nov 1 **Co-author**. High prevalence of overweight and obesity among homeless individuals with mental illness in Toronto, Canada. 143rd Annual Meeting of the American Public Health Association (APHA). Chicago, Illinois, United States. Presenter(s): Kaufman-Shriqui V, Gozdzik A, Misir V, Molnar A, **Hwang SW**. Oral presentation.

2015 Sep 25 **Co-author**. Homeless youth transitions to independent housing in Canada: Preliminary findings. European Research Conference on Families, Housing and Homelessness. Dublin, Ireland. Presenter(s):

Thulien N, Gastaldo D, **Hwang S**, McCay E. (Trainee Presentation).

2015 Jun 25 **Co-author**. Health and housing in transition: A qualitative study. 2015 Biennial Conference of the Society for Community Research and Action. Lowell, Massachusetts, United States. Presenter(s): Polillo A, Sylvestre J, Aubry T, Klodawsky F, **Hwang SW**. Poster presentation. (Trainee Presentation).

2015 Apr 25 **Presenter**. Canadian Healthcare 101: Answers to all of the questions you are embarrassed to ask. 38th Annual Meeting of the Society of General Internal Medicine (SGIM). Toronto, Ontario, Canada. Presenter(s): Cram P, Bell C, Cavalcanti R, Dhalla I, **Hwang S**. Workshop. (Trainee Presentation).

2013 Nov 4 **Presenter**. Housing First with Intensive Case Management: 12 Month Outcomes of the At Home/Chez Soi Randomized Trial. 141st Annual Meeting of the American Public Health Association (APHA). Boston, Massachusetts, United States. Presenter(s): **Hwang SW**. Oral presentation.

2013 Oct 9 **Co-author**. Critical Illness in Homeless Persons: A Systematic Review of the Literature. 26th Annual Congress of the European Society of Intensive Care Medicine (ESICM). Paris, Paris, France. Presenter(s): Chant C, Smith O, Wang A, **Hwang S**, Friedrich JO, Burns KEA, Dos Santos CC. Poster presentation.

2013 Jun 3 **Co-author**. Development and Initial Validation of the Observer-rated Housing Quality Scale (OHQS) in a multi-site trial of Housing First. 2013 International Homelessness Research Conference, University of Pennsylvania & VA National Center on Homelessness Among Veterans. Philadelphia, Pennsylvania, United States. Presenter(s): Adair CE, Kopp B, Lavoie J, Distasio J, **Hwang S**, Watson A, Veldhuizen S, Chislett K, Voronka J, Ahmad M, Ahmed N, Goering P. Poster presentation.

2013 Jun 3 **Presenter**. At Home: A Randomized Controlled Trial of Housing First and Intensive Case Management for Homeless People with Mental Illness. 2013 International Homelessness Research Conference, University of Pennsylvania & VA National Center on Homelessness Among Veterans. Philadelphia, Pennsylvania, United States. Presenter(s): **Hwang SW**. Oral presentation.

2013 May 21 **Co-author**. Homelessness and Critical Care: A Systematic Review of the Literature. 2013 American Thoracic Society International Conference. Philadelphia, Pennsylvania, United States. Presenter(s): Chant C, Smith O, Wang A, **Hwang S**, Friedrich JO, Burns KEA, Dos Santos CC. Poster presentation.

2013 Mar 14 **Presenter**. At Home: A Randomized Controlled Trial of Housing First for Homeless People with Mental Illness. 2013 National Health Care for the Homeless Conference. Washington, District of Columbia, United States. Presenter(s): **Hwang SW**, Stergiopoulos V. Oral presentation (Workshop).

2012 Oct **Co-author**. Examining response shift and true change in self-reported physical and mental health status in homeless and vulnerably housed individuals. International Society for Quality of Life Research Conference. Budapest, Budapest, Hungary. Presenter(s): Gadermann AM, Sawatzky R, Palepu A, Hubley AM, Zumbo BD, Aubry T, **Hwang SW**. Oral presentation.

2011 Nov 3 **Co-author**. Implementing and Evaluating Dialectical Behaviour Therapy in Urban Street Youth: Addressing the Need for Mental Health Intervention. 10th International Conference on Urban Health. Belo Horizonte, Brazil. Presenter(s): McCay B, **Hwang SW**, et al. Poster presentation.

2011 May 10 **Senior Author**. Drowning risk of immigrants versus non-immigrants in the province of Ontario: A cross-sectional retrospective study. World Conference on Drowning Prevention 2011. Danang, Viet Nam. Presenter(s): Gallinger Z, Fralick M, Nisenbaum R, **Hwang SW**. Oral Presentation. (Trainee Presentation).

2010 Oct 28 **Co-author**. Housing Satisfaction is Associated with Better Physical and Mental Health-related Quality of Life among Persons Living with HIV. 9th International Conference on Urban Health. New York City, New York, United States. Presenter(s): Rourke SB, Bekele T, Tucker R, Sobota M, Monette L, Koornstra J, Byers S, **Hwang SW**, Dunn J, Guenter D, Watson J, Ahluwalia A, Bacon J, the Positive Spaces, Healthy Places Team. Oral presentation.

2010 Oct 28 **Presenter**. Health Care Utilization among Homeless Adults in Toronto, Canada. 9th International Conference on Urban Health. New York City, New York, United States. Presenter(s): **Hwang SW**, Chiu S,

Chambers C, Tolomiczenko G, Kiss A, Cowan L, Redelmeier D, Levinson W. Oral presentation.

2010 Oct 28 **Principal Author**. Homeless People in the Hospital: Why Do They Cost More? 9th International Conference on Urban Health. New York City, New York, United States. Presenter(s): **Hwang SW**, Weaver J, Aubry T, Hoch J. Oral presentation. (Trainee Presentation).

2010 Oct 27 **Co-author**. Defining a Typology of Homelessness for Single Adults Based on Shelter Utilization Patterns in Three Canadian Cities. 9th International Conference on Urban Health. New York City, New York, United States. Presenter(s): Aubry TD, **Hwang SW**, Farrell S, Calhoun M. Oral presentation. (Trainee Presentation).

2010 Jul 19 **Co-author**. Upstream determinants of health and housing are major contributors to health-related quality of life in HIV infection. XVIII International AIDS Conference. Vienna, Austria. Presenter(s): Rourke S, Bekele T, Tucker R, Greene S, Monette L, Koornstra J, Sobota M, Byers S, Watson J, Bacon J, Ahluwalia A, Hambly K, **Hwang S**, Guenter D, Dunn J, Hamilton M, Truax J, Hintzen DB, White P, Kayitesi M, Desbiens M, De Blois S, Cubillos M, The Positive Spaces, Healthy Places Team. Poster presentation.

2009 Feb 26 **Co-author**. Epidemiology of tuberculosis among the homeless: Toronto 1998-2007. 13th International Union Against Tuberculosis and Lung Disease (IUATLD) North America Region Conference. Vancouver, British Columbia, Canada. Presenter(s): Khan K, Rea E, McDermaid C, Stuart R, Gardam M, Yang J, **Hwang S**. Poster presentation.

2008 Oct 31 **Presenter**. Changes in health status, quality of life, and alcohol and drug use among homeless and vulnerably housed adults applying to a supportive housing program. 7th International Conference on Urban Health. Vancouver, British Columbia, Canada. Presenter(s): **Hwang SW**. Oral presentation.

2008 Oct 30 **Presenter**. Access to primary care among homeless people within a system of universal health insurance. 7th International Conference on Urban Health. Vancouver, British Columbia, Canada. Presenter(s): **Hwang SW**. Poster presentation.

2008 Oct 29 **Presenter**. Homelessness and immigration in Toronto: A comparison of the health of homeless recent immigrants, non-recent immigrants, and Canadian-born individuals. 7th International Conference on Urban Health. Vancouver, British Columbia, Canada. Presenter(s): **Hwang SW**. Oral presentation.

2008 Oct 29 **Presenter**. The research alliance for Canadian homelessness, housing, and health (REACH3). 7th International Conference on Urban Health. Vancouver, British Columbia, Canada. Presenter(s): **Hwang SW**, Cowan L. Oral presentation.

2008 Oct 28 **Presenter**. Homelessness and immigration in Toronto: A comparison of the health of homeless recent immigrants, non-recent immigrants, and Canadian-born individuals. 136th Annual Meeting of the American Public Health Association (APHA). San Diego, California, United States. Presenter(s): Chiu S, **Hwang SW**. Oral presentation.

2008 Aug 6 **Co-author**. Housing status/stability and key determinants of health affect health outcomes in people living with HIV/AIDS: Moving Research into Action. XVII International AIDS Conference. Mexico City, Mexico. Presenter(s): Tucker R, Greene S, Sobota M, Koornstra J, Monette L, Guenter D, Byers S, Dunn J, **Hwang S**, Bernstine N, Shubert G, Bacon J, Rourke SB. Poster presentation.

2007 Nov 7 **Presenter**. Traumatic brain injury among homeless persons. 135th Annual Meeting of the American Public Health Association. Washington, District of Columbia, United States. Presenter(s): **Hwang SW**, Colantonio A, Chiu S, Tolomiczenko G, Kiss A, Cowan L, Redelmeier D, Levinson W. Poster presentation.

2007 Nov 2 **Presenter**. Traumatic brain injury among homeless persons. 6th International Conference on Urban Health. Baltimore, Maryland, United States. Presenter(s): **Hwang SW**, Colantonio A, Chiu S, Tolomiczenko G, Kiss A, Cowan L, Redelmeier D, Levinson W. Poster presentation.

2007 Jul 25 **Co-author**. Significant Housing, Economic and Social Challenges for People with HIV Who are Living with and Caring for Their Children: Results from the Canadian Positive Spaces, Healthy Places Study. NIMH Annual International Research Conference on the Role of Families in Preventing and Adapting to HIV/AIDS. San Francisco, California, United States. Presenter(s): Greene S, Tucker R, Rourke SB,

Guenter D, Monette L, Narciso L, Koornstra J, Byers S, Sobota M, Dunn J, **Hwang SW**.

2006 Aug 13 **Co-author**. Building Community-Based Research Capacity through Exploring the Impact of Housing Status on People Living with HIV/AIDS in Ontario. XVI International AIDS Conference. Toronto, Ontario, Canada. Presenter(s): Tucker R, Greene S, Rourke SB, Guenter D, Monette L, Narciso L, Koornstra J, Byers S, Sobota M, Dunn J, **Hwang SW**. Oral presentation.

2006 Jun 8 **Presenter**. Access to Health Care for Homeless People with Serious Health Conditions in Toronto, Canada. 2006 National Health Care for the Homeless Conference. Portland, Oregon, United States. Presenter(s): **Hwang SW**, Chiu S, Khandor E, Mason K, Cowan L, Tolomiczenko G, Kiss A, Katic M, Redelmeier D, Levinson W. Poster presentation.

2005 Oct 26 **Presenter**. Access to Health Care for Homeless People with Serious Health Conditions in Toronto, Canada. 4th International Conference on Urban Health. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**, Chiu S, Khandor E, Mason K, Cowan L, Tolomiczenko G, Kiss A, Katic M, Redelmeier D, Levinson W. Oral presentation.

2004 Oct **Presenter**. Bedbugs redux: Cimex lectularius infestations in homeless shelters and other locations in Toronto. 3rd International Conference on Urban Health. Boston, Massachusetts, United States. Presenter(s): **Hwang SW**, Svoboda TJ, De Jong IJ, Kabasele KJ, Moukas E. Poster presentation.

2004 Oct **Presenter**. Use of meal programs and shelters by homeless people in Toronto. 3rd International Conference on Urban Health. Boston, Massachusetts, United States. Presenter(s): **Hwang SW**, Chiu S, Kiss A, Katic M, Tolomiczenko G, Levinson W, Redelmeier D, Szalai JP, Cowan L. Poster presentation.

2004 Oct **Co-author**. Predictors of satisfaction with primary care and improving homeless men's access to primary care: A randomized controlled trial (preliminary results). 3rd International Conference on Urban Health. Boston, Massachusetts, United States. Presenter(s): Svoboda T, Bloch G, Knowles H, **Hwang S**, Glazier R, Kelly M, Chow K, Jones K, Tynan AM. Poster presentation.

2004 May 13 **Presenter**. General Internists: Shaping the Future of Homeless Health Care. 27th Annual Meeting of the Society of General Internal Medicine. Chicago, Illinois, United States. Presenter(s): Kertesz SG, Gordon A, Bharel M, Buchanan D, **Hwang S**, Jain S, Kehoe L, Kushel M, McCary J, O'Connell JJ, O'Toole TP. Pre-Course Presentation.

2003 Oct 15 **Presenter**. Risk factors for cardiovascular disease among homeless people in Toronto. 2nd International Conference on Urban Health. New York City, New York, United States. Presenter(s): Lee TC, Hanlon J, Ben-David J, Booth G, Cantor W, **Hwang SW**. Poster presentation.

2003 Sep 20 **Co-author**. Do graphic illustrations improve patients' comprehension of medication labels? Society of Teachers of Family Medicine Conference, Research Forum. Atlanta, Georgia, United States. Presenter(s): Tram C, Knarr N, **Hwang SW**. Oral presentation.

2002 Oct 3 **Co-author**. The Annex Harm Reduction Program: Rates of adherence and hepatotoxicity among homeless alcohol dependent men receiving directly observed prophylactic therapy (DOPT) during a tuberculosis outbreak. 1st International Conference on Inner City Health. Toronto, Ontario, Canada. Presenter(s): Svoboda T, **Hwang SW**, Chien K, Ross J. Poster preseentation.

2002 Oct 3 **Co-author**. Do shelters for the homeless in Toronto provide appropriate menus for those with diabetes? 1st International Conference on Inner City Health. Toronto, Ontario, Canada. Presenter(s): Ross N, Chislett D, **Hwang S**, Whitham D, Hanning R, Miller K, Darling P. Poster preseentation.

2002 Sep **Co-author**. Dietary folate deficiency suppresses mammary tumorigenesis in a chemical carcinogen rat model of breast cancer. Era of Hope 2002 Department of Defense Breast Cancer Research Program Meeting. Orlando, Florida, United States. Presenter(s): Kotsopoulos J, Sohn K-J, Martin R, Renlund R, **Hwang S**, Medline A, Kim YI. Oral presentation.

2002 Jun **Co-author**. Perceptions of emergency services among homeless people. 2nd International Conference of the International Society for Equity in Health. Toronto, Ontario, Canada. Presenter(s): Zakrison TL, Hamel PA, **Hwang SW**. Poster presentation.

2002 Apr **Co-author**. Effects of dietary folate on the initiation and promotion phases of MNU-induced mammary tumorigenesis in rats. 2002 Annual Meeting of the American Association for Cancer Research. San Francisco, California, United States. Presenter(s): Kotsopoulos J, Sohn K-J, Martin R, Renlund R, **Hwang S**, Medline A, Kim YI. Oral presentation.

2001 May **Co-author**. Effects of dietary folate on colorectal carcinogenesis in a genetically-predisposed murine model of ulcerative colitis-associated colon cancer. 2001 Digestive Disease Week. Atlanta, Georgia, United States. Presenter(s): Carrier J, Medline A, Sohn KJ, **Hwang SW**, Kim YI. Poster presentation. Award for poster of distinction.

1999 Apr **Presenter**. Mortality Among Homeless Men in Toronto. 22nd Annual Meeting of the Society of General Internal Medicine. San Francisco, California, United States. Presenter(s): **Hwang SW**. Poster presentation.

1997 May **Presenter**. Risk Factors for Death in Homeless Adults in Boston. 20th Annual Meeting of the Society of General Internal Medicine. Washington, District of Columbia, United States. Presenter(s): **Hwang SW**, Lebow JM, Bierer MF, O'Connell JJ, Orav EJ, Brennan TA. Poster presentation.

Presented and Published Abstracts

2015 Oct 22 **Co-author**. Minimal impact of response shift for SF-12 mental and physical health status in the homeless and vulnerably housed: An item-level multi-group analysis. International Society for Quality of Life Research (ISOQOL) 22nd Annual Conference. Vancouver, British Columbia, Canada. Presenter(s): Gadermann AM, Sawatzky R, Palepu A, Hubley AM, Zumbo BD, Aubry T, **Hwang SW**. Oral presentation.

Publication Details:
Minimal impact of response shift for SF-12 mental and physical health status in the homeless and vulnerably housed: An item-level multi-group analysis. **Coauthor or Collaborator**.

2015 Apr 22 **Senior author**. The effect of advance directive completion on hospital care among homeless persons: A prospective cohort study. 38th Annual Meeting of the Society of General Internal Medicine (SGIM). Toronto, Ontario, Canada. Presenter(s): Leung AK, To M, Luong L, Syavash-Vahabi Z, Song J, **Hwang SW**. Poster presentation. (Trainee Presentation)

Publication Details:
The effect of advance directive completion on hospital care among homeless persons: A prospective cohort study. Journal of General Internal Medicine. April 2015:30,(2) S268.

2014 Jun 8 **Co-author**. Concurrent validity of the EQ-5D-3L in homeless adults with mental illness. 15th Biennial European Meeting of the Society for Medical Decision Making (SMDM). Antwerp, Antwerpen, Belgium. Presenter(s): Bayoumi AM, Pinto AD, O'Campo P, Stergiopoulos V, **Hwang S**. Oral presentation.

Publication Details:
Concurrent validity of the EQ-5D-3L in homeless adults with mental illness. Medical Decision Making. October 2014, 34(7) p.E7.

2014 Apr 24 An Advance Directive Intervention for Chronically Homeless People: Acceptability, Factors Associated with Completion, and Treatment Preferences. 37th Annual Meeting of the Society of General Internal Medicine (SGIM). San Diego, California, United States. Presenter(s): Leung AK, Nayyar D, Sachdeva M, Song J, **Hwang SW**. Poster presentation. (Trainee Presentation)

Publication Details:
An Advance Directive Intervention for Chronically Homeless People: Acceptability, Factors Associated with Completion, and Treatment Preferences. Journal of General Internal Medicine. April 2014:29,(1)S17.

2014 Apr **Senior author**. Advance directive intervention for chronically homeless people: Acceptability, factors associated with completion, and treatment preferences.

Publication Details:
Leung A, Nayyar D, Sachdeva M, Song J, **Hwang S**. Advance directive intervention for chronically homeless people: Acceptability, factors associated with completion, and treatment preferences. Journal of General Internal Medicine. 2014 Apr. April 2014;29(S1):S17-18. **Senior Responsible Author**.

2013 Jun Health status, health care utilization, and legal incidents following traumatic brain injury in homeless and vulnerably housed adults in three Canadian cities.

Publication Details:
To M, O'Brien K, Palepu A, Hubley AM, Farrell S, Aubry T, Gogosis E, Muckle W, **Hwang S**. Health status, health care utilization, and legal incidents following traumatic brain injury in homeless and vulnerably housed adults in three Canadian cities. Journal of General Internal Medicine. 2013 Jun. June 2013;28(S1):S85. **Senior Responsible Author**.

2013 Jun Unmet health needs among homeless and vulnerably housed adults in three Canadian cities.

Publication Details:
Argintaru N, Chambers C, Gogosis E, Farrell S, Palepu A, Klodawsky F, **Hwang S**. Unmet health needs among homeless and vulnerably housed adults in three Canadian cities. Journal of General Internal Medicine. 2013 Jun. June 2013;28(S1):S231-232. **Senior Responsible Author**.

2013 May Homelessness And Critical Care: A Systematic Review Of The Literature.

Publication Details:
Chant C, Smith O, Wang A, **Hwang S**, Friedrich JO, Burns KEA, Dos Santos CC. Homelessness And Critical Care: A Systematic Review Of The Literature. American Journal of Respiratory and Critical Care Medicine. 2013 May. 187;2013:A4419. **Coauthor or Collaborator**.

2011 May Mortality and Causes of Death Among Homeless Adults in Boston.

Publication Details:
Baggett TP, Rigotti NA, Stringfellow E, **Hwang S**, Orav EJ, O'Connell JJ. Mortality and Causes of Death Among Homeless Adults in Boston. Journal of General Internal Medicine. May 2011;26(S1):S234. **Coauthor or Collaborator**.

2011 May Is "appearing chronically ill" a sign of poor health?

Publication Details:
Hwang SW, Rawal S, Atia M, Nisenbaum R, Pare DE, Joordens S. Is "appearing chronically ill" a sign of poor health? Journal of General Internal Medicine. May 2011;26(S1):S94. **Principal Author**.

2009 May Differences in social and health determinants between First Nations and Non-First Nations Aboriginal people living with HIV/AIDS in Ontario: The Positive Spaces, Healthy Places Study.

Publication Details:
Monette L, Rourke SB, Tucker R, Greene S, Sobota M, Koornstra J, Byers S, Guenter D, **Hwang SW**, Dunn J, Ahluwalia A, Bekele T, Johnston C, Bacon J. Differences in social and health determinants between First Nations and Non-First Nations Aboriginal people living with HIV/AIDS in Ontario: The Positive Spaces, Healthy Places Study. Journal of Urban Health. May 2009:86(3):324. **Coauthor or Collaborator**.

2009 May Direct and indirect effect of social support on health-related quality of life among people living with HIV/AIDS in Ontario: The Positive Spaces, Healthy Places Study.

Publication Details:
Bekele T, Rourke SB, Tucker R, Greene S, Sobota M, Koornstra J, Monette L, Byers S, Ahluwalia A, **Hwang SW**, Dunn J, J Bacon. Direct and indirect effect of social support on health-related quality of life among people living with HIV/AIDS in Ontario: The Positive Spaces, Healthy Places Study. Journal of Urban Health. May 2009:86(3):326. **Coauthor or Collaborator**.

2009 May Disparities in health outcomes and social determinants of health between Aboriginal and Caucasian people living with HIV/AIDS in Ontario.

Publication Details:
Monette L, Rourke SB, Tucker R, Greene S, Sobota M, Koornstra J, Byers S, Guenter D, **Hwang SW**, Dunn J, Ahluwalia A, Bekele T, Johnston C, J Bacon. Disparities in health outcomes and social determinants of health between Aboriginal and Caucasian people living with HIV/AIDS in Ontario. Journal of Urban Health. May 2009:86(3):327. **Coauthor or Collaborator**.

2009 May Mental health and addiction issues and health service needs of people living with HIV/AIDS in Ontario: The Positive Spaces, Healthy Places Study.

Publication Details:
Rourke SB, Tucker R, Greene S, Sobota M, Koornstra J, Monette L, Byers S, Guenter D, **Hwang SW**, Dunn J, Ahluwalia A, Bacon J. Mental health and addiction issues and health service needs of people living with HIV/AIDS in Ontario: The Positive Spaces, Healthy Places Study. Journal of Urban Health. May 2009:86(3):446. **Coauthor or Collaborator**.

2009 May Homelessness and immigration in Toronto: A comparison of the health of homeless recent immigrants, non-recent immigrants, and Canadian born individuals.

Publication Details:
Hwang SW, Chiu A, Tolomiczenko C, Kiss A, Cowan L, Redelmeier D, Levinson W. Homelessness and immigration in Toronto: A comparison of the health of homeless recent immigrants, non-recent immigrants, and Canadian born individuals. Journal of Urban Health. May 2009:86(3):350. **Principal Author**.

2009 May Changes in health status, quality of life, and alcohol and drug use among homeless and vulnerably housed adults applying to a supportive housing program.

Publication Details:
Hwang SW, Gogosis E, Aubry T, Dunn J, Hoch J, Taylor J, Fresolone M, Kiss A. Changes in health status, quality of life, and alcohol and drug use among homeless and vulnerably housed adults applying to a supportive housing program. Journal of Urban Health. May 2009:86(3):365. **Principal Author**.

2009 May Access to primary care among homeless people within a system of universal health insurance.

Publication Details:
Hwang SW, Chiu S, Ueng J, Tolomiczenko C, Kiss A, Cowan L, Levinson W, Redelmeier D. Access to primary care among homeless people within a system of universal health insurance. Journal of Urban Health. May 2009:86(3):435. **Principal Author**.

2008 Apr 9 **Co-author**. Value of a longitudinal clinic experience: A survey of resident perceptions at a large Canadian internal medicine program. 31st Annual Meeting of the Society of General Internal Medicine. Pittsburgh, Pennsylvania, United States. Presenter(s): Locke KA, Tzanetos K, Imrie K, **Hwang SW**.

Publication Details:
Value of a longitudinal clinic experience: A survey of resident perceptions at a large Canadian internal medicine program. Journal of General Internal Medicine. March 2008; 23, (S2) p. 437.

2008 Apr 9 **Co-author**. Priced out of the safety net? Declining access to health care among Birmingham's homeless, 1995-2005. 31st Annual Meeting of the Society of General Internal Medicine. Pittsburgh, Pennsylvania, United States. Presenter(s): Kertesz SG, **Hwang SW**, Ritchey FJ, LaGory M.

Publication Details:
Priced out of the safety net? Declining access to health care among Birmingham's homeless, 1995-2005. Journal of General Internal Medicine. March 2008; 23, (S2) p. 379.

2008 Mar Value of a longitudinal clinic experience: A survey of resident perceptions at a large Canadian internal

medicine program.

Publication Details:
Locke KA, Tzanetos K, Imrie K, **Hwang SW**. Value of a longitudinal clinic experience: A survey of resident perceptions at a large Canadian internal medicine program. Journal of General Internal Medicine. March 2008;23(S2):437. **Coauthor or Collaborator**.

2008 Mar Priced out of the safety net? Declining access to health care among Birmingham's homeless, 1995-2005.

Publication Details:
Kertesz SG, **Hwang SW**, Ritchey FJ, LaGory M. Priced out of the safety net? Declining access to health care among Birmingham's homeless, 1995-2005. Journal of General Internal Medicine. March 2008;23(S2):379-380. **Coauthor or Collaborator**.

2006 Apr 27 **Presenter**. Population Mortality during the SARS Outbreak in Toronto. 29th Annual Meeting of the Society of General Internal Medicine. Los Angeles, California, United States. Presenter(s): **Hwang SW**, Cheung AM, Bell CM, Moineddin R. Poster presentation.

Publication Details:
Population Mortality during the SARS Outbreak in Toronto. Journal of General Internal Medicine. April 2006; 21, (S4) p. 104.

2006 Apr Population Mortality during the SARS Outbreak in Toronto.

Publication Details:
Hwang SW, Cheung AM, Moineddin R, Bell CM. Population Mortality during the SARS Outbreak in Toronto. Journal of General Internal Medicine. April 2006;21(Supplement 4):104. **Principal Author**.

2005 Dec Access to Health Care for Homeless People with Serious Health Conditions in Toronto, Canada.

Publication Details:
Hwang SW, Chiu S, Khandor E, Mason K, Cowan L, Tolomiczenko G, Kiss A, Katic M, Redelmeier D, Levinson W. Access to Health Care for Homeless People with Serious Health Conditions in Toronto, Canada. Journal of Urban Health. December 2005;82(Supplement 5):v28. **Principal Author**.

2005 Jun Use of meal programs and shelters by homeless people in Toronto.

Publication Details:
Hwang SW, Chiu S, Kiss A, Katic M, Tolomiczenko G, Levinson W, Redelmeier D, Szalai JP, Cowan L. Use of meal programs and shelters by homeless people in Toronto. Journal of Urban Health. June 2005;82(Supplement 2):ii46. **Principal Author**.

2005 Jun Bedbugs redux: Cimex lectularius infestations in homeless shelters and other locations in Toronto.

Publication Details:
Hwang SW, Svoboda TJ, De Jong IJ, Kabasele KJ, Moukas E. Bedbugs redux: Cimex lectularius infestations in homeless shelters and other locations in Toronto. Journal of Urban Health. June 2005;82(Supplement 2):ii46. **Principal Author**.

2005 Jun Predictors of satisfaction with primary care and improving homeless men's access to primary care: A randomized controlled trial (preliminary results).

Publication Details:
Svoboda T, Bloch G, Knowles H, **Hwang S**, Glazier R, Kelly M, Chow K, Jones K, Tynan AM. Predictors of satisfaction with primary care and improving homeless men's access to primary care: A randomized controlled trial (preliminary results). Journal of Urban Health. June 2005;82(Supplement 2):ii47-ii48. **Coauthor or Collaborator**.

2003 Oct Risk factors for cardiovascular disease among homeless people in Toronto.

Publication Details:
Lee TC, Hanlon J, Ben-David J, Booth G, Cantor W, **Hwang SW**. Risk factors for cardiovascular disease among homeless people in Toronto. Journal of Urban Health. October 2003;80(Supplement 2):ii69. **Senior Responsible Author**.

2003 Apr Mortality among homeless women.

Publication Details:
Cheung AM, **Hwang SW**. Mortality among homeless women. Journal of General Internal Medicine. April 2003;18(Supplement 1):170. **Senior Responsible Author**.

2003 Apr Homeless people's interactions with and trust in paramedics and police in Toronto.

Publication Details:
Hwang SW, Zakrison TL, Hamel PA. Homeless people's interactions with and trust in paramedics and police in Toronto. Journal of General Internal Medicine. April 2003;18(Supplement 1):176. **Principal Author**.

2002 Dec The Annex Harm Reduction Program: Rates of adherence and hepatotoxicity among homeless alcohol dependent men receiving directly observed prophylactic therapy (DOPT) during a tuberculosis outbreak.

Publication Details:
Svoboda T, **Hwang S**, Chien K, Ross J. The Annex Harm Reduction Program: Rates of adherence and hepatotoxicity among homeless alcohol dependent men receiving directly observed prophylactic therapy (DOPT) during a tuberculosis outbreak. Journal of Urban Health. December 2002 (Supplement 1);79:S150-S151. **Coauthor or Collaborator**.

2002 Dec Do shelters for the homeless in Toronto provide appropriate menus for those with diabetes?

Publication Details:
Ross N, Chislett D, **Hwang S**, Whitham D, Hanning R, Miller K, Darling P. Do shelters for the homeless in Toronto provide appropriate menus for those with diabetes? Journal of Urban Health. December 2002 (Supplement 1);79:S147-S148. **Coauthor or Collaborator**.

2002 Effects of dietary folate on the initiation and promotion phases of MNU-induced mammary tumorigenesis in rats.

Publication Details:
Kotsopoulos J, Sohn K-J, Martin R, Renlund R, **Hwang S**, Medline A, Kim Y-I. Effects of dietary folate on the initiation and promotion phases of MNU-induced mammary tumorigenesis in rats. Proceedings of the American Association for Cancer Research 2002;. 43: Abstract #2539. **Coauthor or Collaborator**.

2001 Jun 1 The Impact of Leaving Hospital Against Medical Advice.

Publication Details:
Hwang SW, Li J. The Impact of Leaving Hospital Against Medical Advice. American Journal of Epidemiology. June 1, 2001;153(11):S221. **Principal Author**.

2001 Jun 1 The Relationship Between Income Level and Alcohol-Related Hospitalization Rates in an Urban Area.

Publication Details:
Hwang SW, Glazier RH. The Relationship Between Income Level and Alcohol-Related Hospitalization Rates in an Urban Area. American Journal of Epidemiology. June 1, 2001;153(11):S242. **Principal Author**.

2001 Jun **Presenter**. The Relationship Between Income Level and Alcohol-Related Hospitalization Rates in an Urban Area. 2001 Congress of Epidemiology. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**, Glazier RH. Joint Meeting of the American College of Epidemiology, the American Public Health

Association Epidemiology Section, the Canadian Society for Epidemiology and Biostatistics, and the Society for Epidemiologic Research. Poster presentation.

Publication Details:
The Relationship Between Income Level and Alcohol-Related Hospitalization Rates in an Urban Area. American Journal of Epidemiology. 153,(11), p. S242.

2001 May Effects of dietary folate on colorectal carcinogenesis in a genetically-predisposed murine model of ulcerative colitis-associated colon cancer.

Publication Details:
Carrier J, Medline A, Sohn KJ, **Hwang SW**, Kim YI. Effects of dietary folate on colorectal carcinogenesis in a genetically-predisposed murine model of ulcerative colitis-associated colon cancer. Gastroenterology. May 2001;120(supp 1):A2279. **Coauthor or Collaborator**.

2001 Apr What happens to patients who leave against medical advice?

Publication Details:
Hwang SW, Li J. What happens to patients who leave against medical advice? Journal of General Internal Medicine. April 2001;16(S1):140. **Principal Author**.

2001 Reductions in welfare payments and avoidable hospital admissions in a Canadian inner city.

Publication Details:
Glazier RH, Badley EM, Agha MM, Creatore MI; Inner City Toronto Time Trends Working Group. Reductions in welfare payments and avoidable hospital admissions in a Canadian inner city. American Journal of Epidemiology. 2001; 153(11):S1017. **Member of Research Group**.

2000 Apr Income levels and alcohol-related hospital admission rates.

Publication Details:
Hwang SW, Glazier RH. Income levels and alcohol-related hospital admission rates. Journal of General Internal Medicine. April 2000;15(S1):73. **Principal Author**.

2000 Apr Risk of death during periods of homeless shelter use.

Publication Details:
Hwang SW. Risk of death during periods of homeless shelter use. Journal of General Internal Medicine. April 2000;15(S1):73. **Principal Author**.

1999 Aug Barriers to appropriate diabetes management among homeless persons in Toronto.

Publication Details:
Bugeja AL, **Hwang SW**. Barriers to appropriate diabetes management among homeless persons in Toronto. Clinical and Investigative Medicine. August 1999; 22(S4):S10. **Senior Responsible Author**.

1999 Apr Mortality among homeless men in Toronto.

Publication Details:
Hwang SW. Mortality among homeless men in Toronto. Journal of General Internal Medicine. April 1999;14(S2):42. **Principal Author**.

1998 Aug Patients with serious injury from stairway falls.

Publication Details:
Ragg M, Steinhart B, **Hwang SW**. Patients with serious injury from stairway falls. Clinical and Investigative Medicine. August 1998;21(S4):S32. **Senior Responsible Author**.

1997 Apr Risk factors for death in homeless adults in Boston.

Publication Details:
Hwang SW, Lebow JM, Bierer MF, O'Connell JJ, Orav EJ, Brennan TA. Risk factors for death in homeless adults in Boston. Journal of General Internal Medicine. April 1997;12(S1):121. **Principal Author**.

1996 Apr Causes of mortality in a cohort of homeless adults in Boston.

Publication Details:
Hwang SW, Lebow JM, O'Connell JJ, Orav EJ, Brennan TA. Causes of mortality in a cohort of homeless adults in Boston. Journal of General Internal Medicine. April 1996;11(S1):144. **Principal Author**.

1996 Apr Medicaid expenditures in a homeless population admitted to a recuperative care facility.

Publication Details:
Lebow J, **Hwang S**, O'Connell JJ, Krause D, DeCourcey M. Medicaid expenditures in a homeless population admitted to a recuperative care facility. Journal of General Internal Medicine. April 1996;11(S1):145. **Coauthor or Collaborator**.

Media Appearances

2020 Feb 6 **Quoted Source**. Traumatic Brain Injury in Homeless People Is Underrecognized. Interviewer: Susan Fitzgerald. Neurology Today, American Academy of Neurology. United States. https://journals.lww.com/neurotodayonline/Fulltext/2020/02060/Traumatic_Brain_Injury_in_Homeless_People_Is.4.aspx.

2015 May 15 **Quoted Source**. Panhandling. Interviewer: Trey Kay. Us & Them Podcast, West Virginia Public Broadcasting. West Virginia, United States. http://usandthempodcast.com/podcast/to-give-or-not-to-give/.

2013 Sep 25 **Quoted Source**. The Portland Mercury. Portland, Oregon, United States. Presenter(s): Joe Streckert. The Millionaire Panhandler. http://www.portlandmercury.com/portland/the-millionaire-panhandler/Content?oid=10627133.

2010 Dec 20 **Quoted Source**. A Plan to Make Homelessness History. The New York Times. New York City, New York, United States. Presenter(s): David Bornstein. The New York Times. http://opinionator.blogs.nytimes.com/2010/12/20/a-plan-to-make-homelessness-history/.

2009 May **Personal Profile**. At Home with the Homeless. Stephen Hwang '88 has dedicated his career to serving society's most desperate and difficult. Johns Hopkins University School of Medicine. Baltimore, Maryland, United States. Presenter(s): Kurt Kleiner. Hopkins Medicine. Spring/Summer 2009.

2005 Nov 16 **Personal Profile**. Interventions to Improve the Health of the Homeless. A Backwards Glance: Interviews with public health and healthcare leaders coping with infectious disease challenges to the marginalized. Medical Advocates (medadvocates.org). United States.

2. NATIONAL

Invited Lectures and Presentations

2022 Jan 25 **Presenter**. The COVENANT Study: COVID-19 Cohort Study of People Experiencing Homelessness in Toronto. CanCOVID Speaker Series. Canada. Presenter(s): **Stephen Hwang**.

2019 May 28 **Keynote Speaker**. Challenges in homelessness research: What data will make a difference? Data That Makes a Difference: 4th Annual Canadian Homelessness Data Sharing Initiative Conference, Calgary Homeless Foundation and University of Calgary School of Public Policy. Calgary, Alberta, Canada. Presenter(s): **Stephen Hwang**.

2017 May 6 **Invited Speaker**. Healthcare among the Marginalized. Christian Medical and Dental Society 2017 National Conference. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**, Etzkorn W, Rajah J, Zung P.

2016 Sep 24 **Invited Speaker**. "Homeless but not Hopeless:" A Panel Discussion on Homelessness. Young Presidents' Organization (YPO) 2016 Canadian Conference. Toronto, Ontario, Canada. Presenter(s): Barata P, **Hwang SW**, Stergiopoulos V, Gadon S.

2015 Oct 15 **Keynote Speaker**. The Beauty and Boundaries of Research. Canadian Society of Internal Medicine 2015 Annual Conference, Dr. David Sackett Senior Investigator Award Presentation. Charlottetown, Prince Edward Island, Canada. Presenter(s): **Hwang SW**.

2015 Oct 15 **Invited Speaker**. Five Top Papers in General Internal Medicine. Canadian Society of Internal Medicine 2015 Annual Conference. Charlottetown, Prince Edward Island, Canada. Presenter(s): **Hwang SW**.

2014 Oct 3 **Invited Speaker**. Seeing the Big Picture: Acting on the Social Determinants of Health. Canadian Society of Internal Medicine 2014 Annual Conference, ACP/AM Edwards Lecture. Calgary, Alberta, Canada. Presenter(s): **Hwang SW**.

2014 Jun 6 **Invited Speaker**. Science Panel: Livable Cities. Canadian Science Writers Association 2014 Annual Conference. Toronto, Ontario, Canada. Presenter(s): Murphy J, **Hwang SW**, Roorda M, Cowen D.

2014 May 15 **Invited Speaker**. Caring for Vulnerable and Marginalized Populations in Toronto. The Commonwealth Fund and the Canadian Foundation for Healthcare Improvement (CFHI). Harkness Fellowships in Health Care Policy and Practice. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2014 May 15 **Invited Speaker**. The Bridging of Research and Policy by At Home/Chez Soi (AH/CS): A multi-site trial of Housing First for persons with a mental illness who are homeless. Canadian Association of Health Services and Policy Research (CAHSPR) 2014 Conference. Toronto, Ontario, Canada. Presenter(s): **Hwang S**, Goering P, More F.

2013 Oct 17 **Invited Speaker**. Poverty, Homelessness, and Health: Why Housing Matters. Canadian Mental Health Association (CMHA) National Conference 2013. Addressing the Social Determinants of Mental Health and Addictions. Ottawa, Ontario, Canada. Presenter(s): **Hwang SW**.

2011 Oct 6 **Invited Speaker**. Health care utilization among people who are homeless. Canadian Homelessness Research Network. Without a Home: Research symposium on contemporary issues in Canadian homelessness. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2010 Nov 15 **Invited Speaker**. The Health and Housing in Transition Study: Understanding the trajectories of homeless and vulnerably housed adults. National Housing Research Committee (NHRC) Homelessness Working Group. Ottawa, Ontario, Canada. Presenter(s): **Hwang SW**.

2010 Jun 14 **Invited Speaker**. Beyond Barriers: Photographs from the Frontlines of Health (Exhibit at the Centenary Conference of the Canadian Public Health Association). AstraZeneca Canada/Frontline Health. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2009 Dec 1 **Invited Speaker**. Life expectancy of the homeless. Canadian Housing and Renewal Association. Ontario, Canada. Presenter(s): **SW Hwang**.

2009 Nov 29 **Invited Speaker**. What Causes Homelessness? Myths and Realities. Mental Health Commission of Canada. Into the Light: Transforming Mental Health in Canada. Vancouver, British Columbia, Canada. Presenter(s): **SW Hwang**.

2009 May 27 **Invited Speaker**. One Size Doesn't Fit All: Primary Care Access for Vulnerable Populations. Canadian Institutes of Health Research - Institute of Gender and Health and Institute of Health Services and Policy Research. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**, Grace SL, Travers A.

2009 Apr 24 **Invited Speaker**. Aging among People Experiencing Homelessness. 2009 Annual Meeting of the Canadian Geriatric Society. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**. (Continuing Education).

2009 Feb 18 **Invited Speaker**. Unmet needs for health care among homeless people within a universal health

insurance system. Finding Home: The 2nd National Conference on Housing and Homelessness. Calgary, Alberta, Canada. Presenter(s): **Hwang SW**.

2009 Feb 18 **Invited Speaker**. REACH3: The Research Alliance for Canadian Homelessness, Housing, and Health. Finding Home: The 2nd National Conference on Housing and Homelessness. Calgary, Alberta, Canada. Presenter(s): **Hwang SW**. Khandor E. Klodawky F. Worthington C. MacLaurin B. Aubry T.

2008 Jun 2 **Invited Speaker**. Drug Use among Homeless People: Data from a Representative Sample in Toronto. Health Canada, Drug Strategy and Controlled Substances Programme, Office of Research and Surveillance. Ottawa, Ontario, Canada. Presenter(s): **Hwang SW**.

2008 May 27 **Invited Speaker**. Mental Health and Homelessness Workshop. Canadian Population Health Initiative, Canadian Institute for Health Information (CIHI). Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2008 May 13 **Invited Speaker**. Research on Homelessness, Housing, and Health. Health Council of Canada. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2006 Nov 2 **Invited Speaker**. Health Care Delivery in the Shelter Setting. Human Resources and Social Development Canada (HRSDC), Housing and Homelessness Branch, Meeting of Large Multi-Service Shelters. Montreal, Quebec, Canada. Presenter(s): **Hwang SW**.

2006 Mar 30 **Invited Speaker**. Homelessness and Health. Street Level Conference 2006: Truthtellers and Peacemakers. Sponsored by the Evangelical Fellowship of Canada. Ottawa, Ontario, Canada. Presenter(s): **Hwang SW**.

2005 May 20 **Invited Speaker**. Risk Factors and Behaviors Among Homeless Persons: Mortality Among Homeless Women. Canadian Conference on Homelessness. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**. Plenary address.

2005 May 19 **Invited Speaker**. Translating Research on Homelessness into Policy and Action. Canadian Conference on Homelessness. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**. Plenary address.

2005 May 19 **Presenter**. Bedbugs infestations in homeless shelters and other locations in Toronto. Canadian Conference on Homelessness. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**, Svoboda TJ, De Jong IJ, Kabasele KJ, Gogosis E. Poster presentation.

2005 May 19 **Presenter**. Use of meal programs and shelters by homeless people in Toronto. Canadian Conference on Homelessness. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**, Chiu S, Kiss A, Katic M, Tolomiczenko G, Levinson W, Redelmeier D, Szalai JP, Cowan L. Poster presentation.

2004 May 5 **Invited Speaker**. Canadian Policy Briefing. Commonwealth Fund International Program in Health Care Policy (Harkness Fellowships) and the Canadian Health Services Research Foundation. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2004 Mar 22 **Invited Speaker**. Policy Forum on Health Disparities. Health Canada, Canadian Institutes for Health Research (CIHR), and the Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security. Ottawa, Ontario, Canada. Presenter(s): **Hwang SW**.

2003 Nov 18 **Invited Speaker**. Homelessness and Health: What is the Role of Housing? Canada Mortgage and Housing Corporation (CMHC), National Housing Research Committee (NHRC) Working Group on Homelessness. Ottawa, Ontario, Canada. Presenter(s): **Hwang SW**.

2003 Oct 3 **Invited Speaker**. Homelessness: Implications for Housing and Health. Canadian Housing and Renewal Association (CHRA), National Symposium on Health and Housing. Calgary, Alberta, Canada. Presenter(s): **Hwang SW**.

2003 Jun 18 **Invited Speaker**. Consultation Workshop on the National Research Agenda of the National Homelessness Initiative. National Secretariat on Homelessness (Human Resources Development Canada). Ottawa, Ontario, Canada. Presenter(s): **Hwang SW**.

2002 Nov 4 **Invited Speaker**. Overview of Research on Homelessness and Health. Canadian Institutes of Health Research (CIHR) and the National Secretariat on Homelessness (NSH), Community-Research Think Tank on Health and Homelessness. Ottawa, Ontario, Canada. Presenter(s): **Hwang SW**.

2002 Oct 18 **Invited Speaker**. Inner City Health and the Heart of General Internal Medicine. 2002 National Conference of the Canadian Society of Internal Medicine. Halifax, Nova Scotia, Canada. Presenter(s): **Hwang SW**. Keynote Address.

2002 Mar **Invited Speaker**. National Roundtable on Homelessness. National Secretariat on Homelessness (Human Resources Development Canada). Ottawa, Ontario, Canada. Presenter(s): **Hwang SW**.

2000 Aug **Invited Speaker**. Expert Panel on Gaps in Research on Homelessness. National Secretariat on Homelessness (Human Resources Development Canada). Ottawa, Ontario, Canada. Presenter(s): **Hwang SW**.

1997 Mar **Invited Speaker**. The Role of the Chief Medical Resident: Leadership. 6th Annual Canadian Chief Medical Resident's Conference. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**. (Continuing Education).

Presented Abstracts

2021 Jun 24 **Co-author**. : The Attitudes of Canadian Ophthalmology Residents and Pre-Clerkship Medical Students at an Ontario Medical School Towards Homeless Individuals. Canadian Ophthalmological Society (COS) 2021 Annual Conference. Canada. Presenter(s): Sayal AP, Popovic MM, Mustafa M, **Hwang SW**, Lichter M.

2021 May 19 **Co-author**. Diabetes self-management and homelessness: Using concept mapping to understand and prioritize challenges. 2021 Annual CAHSPR Conference. Canada. Presenter(s): Grewal E, Campbell R, Booth G, McBrien K, **Hwang S**, O'Campo, P, Campbell D.

2020 Oct 28 **Co-author**. Identifying Challenges and Solutions to Providing Diabetes Care for the Homeless. Diabetes Canada/CSEM Professional Conference, Virtual Conference. Oct 28-30, 2020. Canada. Presenter(s): Mancini N, Campbell R, Yaphe H, Tibebu T, Grewal E, Saunders-Smith T, **Hwang S**, McBrien K, Booth G, Campbell D.

2020 Oct 28 **Co-author**. Approaches to Enabling Care for People with Diabetes Experiencing Homelessness. Diabetes Canada/CSEM Professional Conference, Virtual Conference. Oct 28-30, 2020. Canada. Presenter(s): Yaphe H, Campbell R, Mancini N, Grewal E, Tibebu T, Saunders-Smith T, Booth G, McBrien K, **Hwang S**, Campbell D.

2020 Oct 28 **Co-author**. Patient-level Barriers to Diabetes Management Among those with Housing Instability. Diabetes Canada/CSEM Professional Conference, Virtual Conference. Oct 28-30, 2020. Canada. Presenter(s): Campbell R, Saunders-Smith T, Tibebu T, Grewal E, Yaphe H, Mancini N, **Hwang S**, McBrien K, Booth G, Campbell D.

2020 Oct 28 **Co-author**. Diabetes Management and Homelessness: Understanding Barriers Using Concept Mapping. Diabetes Canada/CSEM Professional Conference, Virtual Conference. Oct 28-30, 2020. Canada. Presenter(s): Campbell R, Saunders-Smith T, Tibebu T, Grewal E, Yaphe H, Mancini N, **Hwang S**, McBrien K, Booth G, Campbell D.

2020 Oct 21 **Co-author**. Baseline characteristics and clinical outcomes of homeless adults presenting to an inner city STEMI network hospital. Canadian Cardiovascular Congress (CCC). Canada. Presenter(s): Liauw S et al. (Trainee Presentation).

2020 May **Co-author**. Giving a voice to the voiceless: Use of an arts-based approach to understand the challenges of managing diabetes while homeless . 2020 Canadian Association for Health Services and Policy Research (CAHSPR) Conference. Saskatoon, Saskatchewan, Canada. Presenter(s): David Campbell et al. Oral presentation. (Trainee Presentation).

2020 May **Co-author**. Diabetes self-management and homelessness: Using concept mapping to understand and prioritize challenges. 2020 Canadian Association for Health Services and Policy Research (CAHSPR) Conference. Saskatoon, Saskatchewan, Canada. Presenter(s): David Campbell et al. Oral presentation. (Trainee Presentation).

2020 May **Co-author**. Community-based Participatory Research and Knowledge Translation: Lessons from a Toronto-based client group. 2020 Canadian Association for Health Services and Policy Research (CAHSPR) Conference. Saskatoon, Saskatchewan, Canada. Presenter(s): David Campbell et al. Oral presentation. (Trainee Presentation).

2020 Mar **Co-author**. Outcomes of ST-Segment Elevation Myocardial Infarction in a Canadian Homeless Population. ACC Rockies Conference. Banff, Alberta, Canada. Presenter(s): Liauw S, Luong L, Atcha M, Liu S, Fam N, Cheema A, **Hwang S**. Poster presentation. (Trainee Presentation).

2019 Nov 4 **Presenter**. Beyond the Advisory: Lessons Learned from a Research Community Expert Group. Canadian Alliance to End Homelessness - 2019 National Conference on Ending Homelessness. Edmonton, Alberta, Canada. Presenter(s): Zewge-Abubaker N, **Hwang S**.

2019 May **Co-author**. Characterizing program models for diabetes management among those experiencing homelessness. 2019 Canadian Association for Health Services and Policy Research (CAHSPR) Conference. Halifax, Nova Scotia, Canada. Presenter(s): David Campbell, Kerry McBrien, **Stephen Hwang**, Gillian Booth. Oral presentation. (Trainee Presentation).

2019 May **Co-author**. Findings from a scoping review on self-management of problem gambling. 2019 Canadian Association for Health Services and Policy Research (CAHSPR) Conference. Halifax, Nova Scotia, Canada. Presenter(s): Flora Matheson, Sarah Hamilton-Wright, David Kryszajtys, Jessica Wiese, Lauren Cadel, Carolyn Ziegler, **Stephen Hwang**, Sara Guilcher. Poster presentation. (Trainee Presentation).

2019 May **Co-author**. Validity of Health Administrative Data in Identifying Individuals Experiencing Homelessness. 4th Annual Canadian Homelessness Data Sharing Initiative - Data That Makes a Difference, Calgary Homeless Foundation and University of Calgary School of Public Policy. Calgary, Alberta, Canada. Presenter(s): Salimah Shariff, Lucie Richard, **Stephen Hwang**, Cheryl Forchuk, Rosane Nisenbaum, Kristin Clemens, Kathryn Wiens, Richard Booth, Mahmoud Azimaee.

2018 Nov 6 **Co-author**. Impact of Housing First Interventions on Housing and Well-being Outcomes Among Homeless Individuals with Mental Health Issues in Toronto. Canadian Alliance to End Homelessness - 2018 National Conference on Ending Homelessness. Hamilton, Ontario, Canada. Presenter(s): Mejia-Lancheros C, Lachaud J.

2018 Nov 6 **Co-author**. Beyond a Demonstration Project: Evaluating and Supporting Housing First in a Real-World Context. Canadian Alliance to End Homelessness - 2018 National Conference on Ending Homelessness. Hamilton, Ontario, Canada. Presenter(s): Granat S, Dunn J.

2018 Nov 6 **Co-author**. The Tools of Housing First: Evaluating a Client Needs Assessment. Canadian Alliance to End Homelessness - 2018 National Conference on Ending Homelessness. Hamilton, Ontario, Canada. Presenter(s): Raine L, **Hwang SW**.

2018 Nov 6 **Co-author**. Capturing an Indigenous Approach to Housing First. Canadian Alliance to End Homelessness - 2018 National Conference on Ending Homelessness. Hamilton, Ontario, Canada. Presenter(s): Francombe-Pridham K, Passmore D.

2018 Oct 12 **Co-author**. Ted Giles Clinical Vignettes: “An Unusual Cause of Involuntary Movements”. Canadian Society of Internal Medicine 2018 Annual Meeting. Banff, Alberta, Canada. Presenter(s): Prakash V, **Hwang SW**. (Trainee Presentation).

2016 Nov 3 **Co-author**. The Effect of the At Home/Chez Soi Housing First program on Database-Documented Health Care Utilization among Homeless Adults with Mental Illness. Canadian Alliance to End Homelessness - 2016 National Conference on Ending Homelessness. London, Ontario, Canada. Presenter(s): Gozdzik A, **Hwang SW**.

2016 Jun 15 **Co-author**. Extreme Cold Weather Alerts in Toronto: An Emerging Public Health Issue. Poster presentation. Public Health 2016 - Annual Conference of the Canadian Public Health Association. Toronto, Ontario, Canada. Presenter(s): Coleman P, Bassil K, Ansara D, Gower S, Kim M, Wainberg A, Zhang P, **Hwang S**, Benny R, Campbell M, Shapiro H.

2015 Oct 1 **Co-author**. Assessing the Effectiveness of a Brief Case Management Program for Frequent Users of Hospital Emergency Departments. Workshop. 65th Annual Conference of the Canadian Psychiatric Association. Vancouver, British Columbia, Canada. Presenter(s): Stergiopoulos V, Wasylenki D, Leszcz M, O'Campo P, Kurdyak P, Voore P, **Hwang SW**, Guimond T, Alsharafi Z, Gozdzik A.

2015 Sep 30 **Co-author**. Does Housing First Decrease Suicidal Behavior Among Homeless Adults with Mental Health Disorders? Oral Presentation. Canadian Academy of Psychiatric Epidemiology 2015 Annual Scientific Symposium. Vancouver, British Columbia, Canada. Presenter(s): Roos L, Distasio J, Katz L, Bourque J, Bolton JM, Bolton SL, Wong J, Chateau D, Somers J, **Hwang S**, Frankish JC, Sareen J, for the At Home Chez Soi Team.

2015 Jun 5 **Co-author**. Understanding the lived experiences of housing transitions for homeless and vulnerably housed individuals: A qualitative study. 76th Annual Convention of the Canadian Psychological Association. Ottawa, Ontario, Canada. Presenter(s): Polillo A, Sylvestre J, Aubry T, Klodawsky F, **Hwang SW**. Poster presentation. (Trainee Presentation).

2015 May 29 **Senior Author**. End-of-life & Palliative Care Interventions for Homeless People: A Systematic Review (poster presentation; winner of Best Poster Presentation Award). Canadian Society of Palliative Care Physicians, 11th Advanced Learning of Palliative Medicine Conference. Calgary, Alberta, Canada. Presenter(s): Sumalinog R, Harrington K, Dosani N, **Hwang SW**. (Trainee Presentation).

2014 Nov 4 **Senior Author**. Measuring progress towards ending homelessness. Canadian Alliance to End Homelessness - National Conference on Ending Homelessness. Vancouver, British Columbia, Canada. Presenter(s): Adamo A. Panel presentation.

2014 Sep 11 **Presenter**. Being a psychiatrist practicing evidence-based Housing First approaches with homeless people with severe mental illness. Canadian Psychiatric Association 64th Annual Conference. Toronto, Ontario, Canada. Presenter(s): Lesage A, Farmer O, Musgrave I, Stergiopoulos V, **Hwang S**.

2014 May **Co-author**. Hospital Readmissions among Homeless Patients in Toronto. 2014 Canadian Association for Health Services and Policy Research (CAHSPR) Conference. Toronto, Ontario, Canada. Presenter(s): Saab D, Katic M, Dhalla I, Nisenbaum R, **Hwang SW**. Poster presentation. (Trainee Presentation).

2014 Apr 30 **Co-author**. Hospital Readmissions among Homeless Patients in Toronto. Canadian Housing Renewal Association (CHRA) 46th National Congress on Housing and Homelessness. Edmonton, Alberta, Canada. Presenter(s): Saab D, Katic M, Dhalla I, Nisenbaum R, **Hwang SW**. Emerging Professional Research Colloquium. (Trainee Presentation).

2013 Oct 30 **Senior Author**. Conducting a medical chart review in a homeless mentally ill population: Lessons from the Toronto site of the At Home Study. Canadian Alliance to End Homelessness - National Conference on Ending Homelessness. Ottawa, Ontario, Canada. Presenter(s): Dosani N, Young S, Whisler A, **Hwang S**. Oral presentation. (Trainee Presentation).

2013 Oct 29 **Co-author**. Identifying the Patterns of Shelter Stays of Families in Three Canadian Cities of Different Sizes. Canadian Alliance to End Homelessness - National Conference on Ending Homelessness. Ottawa, Ontario, Canada. Presenter(s): Aubry T, Farrell S, **Hwang SW**, Calhoun M. Oral presentation. (Trainee Presentation).

2013 Apr 12 **Co-author**. Impact of comprehensive harm reduction services on access to and engagement with care at a residential palliative and supportive care program for people living with HIV/AIDS: A qualitative study. 22nd Annual Canadian Conference on HIV/AIDS Research (CAHR 2013). Vancouver, British Columbia, Canada. Presenter(s): Dilley L, McNeil R, Guirguis-Younger M, **Hwang SW**, Small W. Oral presentation.

2013 Apr 12 **Co-author**. Impact of Food Insecurity and Housing on Health Outcomes among People Living with HIV from 2006-2009: Longitudinal Findings from Positive Spaces, Healthy Places Cohort Study. 22nd Annual

Canadian Conference on HIV/AIDS Research (CAHR 2013). Vancouver, British Columbia, Canada. Presenter(s): Choi S, Globerman JM, Fielden S, Bekele T, Koornstra JJ, Hambly K, Greene S, Sobota M, Watson J, Walker G, O'Brien Teengs D, Tucker R, **Hwang SW**, Rourke SB, and the Positive Spaces, Healthy Places Team. Poster presentation.

2012 Nov 26 **Co-author**. Rates and characteristics of traumatic brain injury among homeless civilian men. 3rd Annual Military and Veteran Health Research Forum, Canadian Institute for Military and Veteran Health Research. Kingston, Ontario, Canada. Presenter(s): Topolovec-Vranic J, Ennis N, Johnson P, Michalak A, Masanic C, Ouchterlony D, Distin K, Stergiopolous V, **Hwang S**, Kontos P, Colantonio A, Cusmano M. Poster presentation.

2012 Oct 18 **Co-author**. Aging with HIV: Basic Needs and Health Status. 41st Annual Meeting, Canadian Association on Gerontology. Vancouver, British Columbia, Canada. Presenter(s): Sok P, Rourke SB, Tucker R, Greene S, Sobota M, Koornstra J, Byers S, **Hwang S**, Watson J, Bekele T, for the Positive Spaces, Healthy Places Team. Poster presentation. Winner of the Canadian Association on Gerontology Divisional Poster Award for Social Sciences. (Trainee Presentation).

2012 Jun 12 **Senior Author**. Discrimination on the Basis of Socioeconomic Status in Access to Primary Care. 4th Canadian National Medical Student Research Symposium, University of Manitoba. Winnipeg, Manitoba, Canada. Presenter(s): Olah M, Gaisano G, **Hwang SW**. (Trainee Presentation).

2011 Oct 15 **Presenter**. Discrimination in Access to Primary Care on the Basis of Socioeconomic Status: A Randomized Controlled Audit Study. 2011 Annual Meeting of the Canadian Society of Internal Medicine. Halifax, Nova Scotia, Canada. Presenter(s): **Hwang SW**, Gaisano G, Olah M. Oral presentation.

2011 Apr 14 **Co-author**. Housing affordability and sense of community belonging predict health-related quality of life among people with HIV in Ontario: Results from the Positive Spaces, Healthy Places study. 20th Annual Canadian Conference on HIV/AIDS Research (CAHR 2011). Toronto, Ontario, Canada. Presenter(s): Rourke ST, Bekele T, Tucker R, Greene S, Monette L, Koornstra J, Sobota M, Byers S, Watson J, Bacon J, Hambly K, **Hwang S**, Guenter D, Dunn J, Hamilton M, Truax J, Hintzen DB, White P, Kayitesi M, Desbiens M, De Blois S, Cubillos M, and The Positive Spaces, Healthy Places Team. Poster presentation.

2009 Apr 24 **Co-author**. Housing Instability Over Time is Associated with Worse Health Outcomes in People Living with HIV in Ontario: The Positive Spaces, Healthy Places Study. 18th Annual Canadian Conference on HIV/AIDS Research. Vancouver, British Columbia, Canada. Presenter(s): Koornstra J, Tucker R, Greene S, Sobota M, Monette L, Guenter D, Byers S, Dunn J, **Hwang SW**, Rourke SB. Poster presentation.

2009 Apr 24 **Co-author**. Examining Food Insecurity and its Associated Factors in People Living with HIV in Ontario: The Positive Spaces, Healthy Places Study. 18th Annual Canadian Conference on HIV/AIDS Research. Vancouver, British Columbia, Canada. Presenter(s): Koornstra J, Tucker R, Greene S, Sobota M, Monette L, Guenter D, Byers S, Dunn J, **Hwang SW**, Rourke SB. Oral presentation.

2009 Apr 24 **Co-author**. Determinants of health amongst people living with HIV/AIDS in Ontario with and without HCV co-infection: The Positive Spaces, Healthy Places Study. 18th Annual Canadian Conference on HIV/AIDS Research. Vancouver, British Columbia, Canada. Presenter(s): Koornstra J, Tucker R, Greene S, Sobota M, Monette L, Guenter D, Byers S, Dunn J, **Hwang SW**, Rourke SB. Poster presentation.

2009 Apr 24 **Co-author**. Social support has direct and indirect effects on health-related quality of life among people living with HIV/AIDS in Ontario: The Positive Spaces, Healthy Places Study. 18th Annual Canadian Conference on HIV/AIDS Research. Vancouver, British Columbia, Canada. Presenter(s): Tsegaye, Koornstra J, Tucker R, Greene S, Sobota M, Monette L, Guenter D, Byers S, Dunn J, **Hwang SW**, Rourke SB. Poster presentation.

2009 Feb 18 **Principal Author**. Chronic pain among homeless people. Finding Home: The 2nd National Conference on Housing and Homelessness. Calgary, Alberta, Canada. Presenter(s): Wilkins E. **Hwang SW**. (Trainee Presentation).

2008 Jun 7 **Co-Author**. Impact of a Homeless Curriculum on the Attitudes of Medical Trainees Towards Homeless Persons who Present for Care in the Emergency Department. 2008 Annual Meeting of the Canadian Association of Emergency Physicians (CAEP). Ottawa, Ontario, Canada. Presenter(s): Spence JM,

Bandiera G, Taback N, Balu-Kakkar P, **Hwang S**.

2008 Apr 26 **Co-author**. Positive Spaces, Healthy Places: Health Outcomes at 6 Months. 17th Annual Canadian Conference on HIV/AIDS Research. Montreal, Quebec, Canada. Presenter(s): Tucker R, Greene S, Sobota M, Koornstra J, Monette L, Guenter D, Byers S, Dunn J, **Hwang SW**, Rourke SB. Oral presentation.

2008 Apr 26 **Co-author**. Positive Spaces, Healthy Places: Regional Analyses to Put Research into Action. 17th Annual Canadian Conference on HIV/AIDS Research. Montreal, Quebec, Canada. Presenter(s): Koornstra J, Tucker R, Greene S, Sobota M, Monette L, Guenter D, Byers S, Dunn J, **Hwang SW**, Rourke SB. Oral presentation.

2007 Apr 26 **Co-author**. Increasing Participation of Community Members at Research Conferences: Evidence from the International Conference on Urban Health, 2005 and the OHTN Research Conference, 2006. 16th Annual Canadian Conference on HIV/AIDS Research. Toronto, Ontario, Canada. Presenter(s): McKay C, Travers R, Meagher A, Wilson MG, O'Campo P, **Hwang SW**, Cowan L, Parris UJ, Globerman J, Rourke SB. Poster presentation.

2006 May 25 **Co-author**. Whose Capacity Are We Building Through HIV/AIDS Community-Based Research? 15th Annual Canadian Conference on HIV/AIDS Research. Québec City, Quebec, Canada. Presenter(s): Tucker R, Greene S, Rourke SB, Guenter D, Monette L, Narciso L, Koornstra J, Byers S, Sobota M, Dunn J, **Hwang SW**. Poster presentation.

2005 May 19 **Presenter**. REACH3: Research Alliance for Canadian Homelessness, Housing, and Health. Canadian Conference on Homelessness. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**, Aubry T, Dunn J, Palepu A, Roy E, Shiell A, Turnbull J. Poster presentation.

2005 May 19 **Presenter**. Group A Streptococcal Carriage Among Residents of an Urban Homeless Shelter. Canadian Conference on Homelessness. Toronto, Ontario, Canada. Presenter(s): Bargh GJM, Hoch J, Speechley M, Willey B, McGeer A, **Hwang SW**. Poster presentation.

2005 May 19 **Presenter**. Dyspepsia in Homeless Adults. Canadian Conference on Homelessness. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**, Wong SY, Bargh GJ. Poster presentation.

2000 Sep **Co-author**. Prevalence of Helicobacter pylori infection among homeless people in Toronto. 69th Annual meeting of the Royal College of Physicians and Surgeons of Canada, Canadian Association of Teachers of Community Health / National Specialty Society in Community Medicine. Edmonton, Alberta, Canada. Presenter(s): Wong S, **Hwang SW**. Oral presentation.

1999 Sep **Co-author**. Barriers to appropriate diabetes management among homeless persons in Toronto. 68th Annual meeting of the Royal College of Physicians and Surgeons of Canada, Canadian Association of Teachers of Community Health / National Specialty Society in Community Medicine. Montreal, Quebec, Canada. Presenter(s): Bugeja A, **Hwang SW**. Oral presentation.

1998 Sep **Co-author**. Access to Prescription Medications among Homeless Men in Toronto. 67th Annual meeting of the Royal College of Physicians and Surgeons of Canada, Canadian Association of Teachers of Community Health / National Specialty Society in Community Medicine. Toronto, Ontario, Canada. Presenter(s): Gottlieb J, **Hwang SW**. Oral presentation.

Presented and Published Abstracts

2017 Nov 8 **Co-author**. Access to primary care for persons recently released from prison: An audit study. Family Medicine Forum 2017 Family Medicine Innovations in Research and Education Day. Montreal, Quebec, Canada. Presenter(s): Fahmy N.

Publication Details:
N Fahmy, FG Kouyoumdjian, J Berkowitz, S Fahmy, CM Neves, **SW Hwang**, RE Martin. Access to primary care for persons recently released from prison: An audit study. Canadian Family Physician. **Coauthor or Collaborator**.

2007 Apr 26 **Co-author**. The Effects of Housing Status on Health-Related Outcomes in People living with HIV: A Systematic Review of the Literature. 16th Annual Canadian Conference on HIV/AIDS Research. Toronto, Ontario, Canada. Presenter(s): Leaver CA, Bargh G, Dunn JR, **Hwang SW**. Poster presentation.

Publication Details:
The Effects of Housing Status on Health-Related Outcomes in People living with HIV: A Systematic Review of the Literature. AIDS & Behavior. 11(S2): 85-100.

2001 Socioeconomic barriers to ambulatory mental health services despite universal health care in a Canadian inner-city setting.

Publication Details:
Steele LS, Glazier RH, Agha M, Lin E, Cohen MM; Inner City Toronto Time Trends Working Group. Socioeconomic barriers to ambulatory mental health services despite universal health care in a Canadian inner-city setting. American Journal of Epidemiology. 2001;153(11):S856. **Member of Research Group**.

2000 Aug Prevalence of Helicobacter pylori infection among homeless people in Toronto.

Publication Details:
Wong S, **Hwang SW**. Prevalence of Helicobacter pylori infection among homeless people in Toronto. Clinical and Investigative Medicine. August 2000; 23(S4):S7. **Senior Responsible Author**.

1998 Aug Access to prescription medications among homeless men in Toronto.

Publication Details:
Gottlieb J, **Hwang SW**. Access to prescription medications among homeless men in Toronto. Clinical and Investigative Medicine. August 1998;21(S4):S23. **Senior Responsible Author**.

Media Appearances

2020 Dec 10 **News Article**. Toronto researchers to study COVID-19 among people experiencing homelessness. Interviewer: Muriel Draaisma. CBC. Canada. Available from: https://www.cbc.ca/news/canada/toronto/researchers-covid-19-homelessness-people-problem-toronto-federal-task-force-1.5835321.

2019 Jan 2 **Quoted Source**. Oshawa addiction clinic takes a stab at opioid crisis with acupuncture treatment. Interviewer: Marcus Gee. The Globe and Mail. Canada. Available from: https://www.theglobeandmail.com/canada/article-acupuncture-treatments-used-to-aid-drug-users-on-road-to-recovery/.

2018 Jun 1 **Quoted Source**. 'Be An Angel' project offers a little taste of humanity for most vulnerable patients. Interviewer: Michael Swan. Catholic Register. Ontario, Canada. Available from: https://www.catholicregister.org/item/27459-be-an-angel-project-offers-a-little-taste-of-humanity-for-most-vulnerable-patients?platform=hootsuite.

2017 Feb 28 **Quoted Source**. Bringing homeless deaths to light. Interviewer: Webster P. CMAJ News. Ontario, Canada. Available from: http://cmajnews.com/2017/02/28/bringing-homeless-deaths-to-light-109-5399/.

2015 Jul 5 **Opinion / Commentary**. Doctor pushes the boundaries of health-care: Goar. The Toronto Star. Toronto, Ontario, Canada. Available from: http://www.thestar.com/opinion/commentary/2015/07/02/doctor-pushes-the-boundaries-of-health-care-goar.html.

2014 Apr 25 **Quoted Source**. Solution to homelessness at hand, but it won't be cheap. Interviewer: Swan M. The Catholic Register. Toronto, Ontario, Canada. Available from: http://www.catholicregister.org/home/canada/item/18022-solution-to-homelessness-at-hand-but-it-won-t-be-cheap.

2013 Oct 2 **Quoted Source**. Leaving hospital against doctor's advice is high risk, Canadian study says. Interviewer: Helen Branswell. The Globe and Mail / Calgary Herald, Canadian Press. Canada. Presenter(s): Helen

Branswell.

2013 Oct 1 **Quoted Source**. 25,000 a year left hospital despite doctor's order. CBC News. Canada.

2013 Feb 4 **Personal Profile**. Homelessness And Health: Toronto Hospital Gets Position Dedicated To Helping Those On Street. Available at: http://www.huffingtonpost.ca/2013/02/04/homelessness-and-health_n_2599740.html. Huffington Post. Canada.

2013 Jan 24 **Author of Commentary**. Fixing Homelessness Means Putting Housing First. Available at: http://www.huffingtonpost.ca/stephen-hwang/at-home-homeless-study_b_2536434.html. Huffington Post, Hill Times Online, Hamilton Spectator. Canada. Presenter(s): **Stephen Hwang** & Paula Goering.

2013 Jan 21 **Quoted Source**. Homeless Health Care: Helping People On Street Challenging, But Worthwhile For Doctors. Available at: http://www.huffingtonpost.ca/2013/01/21/homeless-health-care_n_2521460.html. Huffington Post, Canadian Press, Victoria Times Colonist, Vancouver Sun, Calgary Herald, Montreal Gazette, Ottawa Citizen, Yahoo! News Canada. Canada. Presenter(s): Sheryl Ubelacker.

2012 Dec 13 **Quoted Source**. Want to Help the Homeless Thrive? Give Them Homes. Available at: http://www.huffingtonpost.ca/lindsay-jolivet/at-home-homelessness-program-_b_2286441.html. Huffington Post. Canada. Presenter(s): Lindsay Jolivet.

2012 Dec 2 **Quoted Source**. City's outreach workers face myriad challenges. Available at: http://www.montrealgazette.com/news/Unique+hurdles+reaching+risk+youth+city+outreach+workers+face+myriad+challenges/7636486/story.html. Montreal Gazette. Montreal, Quebec, Canada. Presenter(s): Adam Kovac.

2011 May 12 **Quoted Source**. 'Super' bedbugs found in Vancouver's Downtown Eastside. Available at: http://bc.ctvnews.ca/super-bedbugs-found-in-vancouver-s-downtown-eastside-1.642474. Canadian Press, CTV News. Canada. Presenter(s): Sheryl Ubelacker.

2010 Jan 19 **Personal Profile**. Personal Profile. Doctor Dismisses Profitable Career For The Homeless. 100 Huntley Street. Toronto. Ontario, Canada. Presenter(s): Bridget Antwi. Available at: http://100huntley.com/video.php?id=gjrRc-GT8Ww OR http://www.youtube.com/watch?v=gjrRc-GT8Ww. (Presentation to Patients/Public).

2008 Oct 18 **Personal Profile**. Toronto's Street Saviour. Profile of Dr. Stephen Hwang. The Globe and Mail. Toronto, Ontario, Canada. Presenter(s): Hayley Mick. The Globe and Mail. Page M1.

2008 Oct 9 **Quoted Source**. Canadian researchers call for end to 'politicization' of science. CBC News. Toronto, Ontario, Canada. Presenter(s): Paul Jay. http://www.cbc.ca/technology/story/2008/10/09/scientists-letter.html.

2008 Oct 9 **Quoted Source**. Canadian scientists blast 'suppression of research' by Tories. Canwest News Service. Ontario, Canada. Presenter(s): Margaret Munro.

2008 Oct 8 **Quoted Source**. For many, brain injury at root of homelessness. More than half of city's homeless population have experienced severe trauma, researchers find. The Globe and Mail. Toronto, Ontario, Canada. Presenter(s): Caroline Alphonso. The Globe and Mail. Page A11.

2008 Oct 6 **Quoted Source**. Traumatic brain injury common among homeless, study finds. CBC News. Toronto, Ontario, Canada. Presenter(s): Maureen Brosnahan. http://www.cbc.ca/health/story/2008/10/06/homeless-head-injury.html.

2008 May 17 **Quoted Source**. Toronto's white underbelly. Curious anomaly: Multiculturalism stops at the street. The Globe and Mail. Toronto, Ontario, Canada. Presenter(s): Kate Hammer.

2007 Sep 19 **Interview**. Health study of Toronto homeless demands action, says group. CBC News. Toronto, Ontario, Canada.

2007 Sep 15 **Quoted Source**. "Doctors, get tough on drugs": Tony Clement. Minister's mind made up on safe injection site, warn experts. National Review of Medicine. Canada. Presenter(s): Solomon S. Pages 22 and 25.

2007 Aug 30 **Quoted Source**. Complicity with evil or social-justice response? Scientists, Catholic ethicists wrestle with funding of safe-injection sites. The Catholic Register. Toronto, Ontario, Canada. Presenter(s): Swan M.

2007 Aug 27 **Quoted Source**. Renew Insite's license. The Globe and Mail. Canada. Presenter(s): Editorial. Page A14.

2007 Aug 21 **Quoted Source**. 130 Scientists urge Ottawa to base Insite decision on science, not ideology. Canadian Press. Canada. Presenter(s): Branswell H. Article ran in the Globe and Mail, CBC News, CTV News, and Yahoo Canada News.

2007 Aug 14 **Quoted Source**. Panhandler panic: over the top? The Globe and Mail. Toronto, Ontario, Canada. Presenter(s): Mick H. Section L1.

2007 Feb 21 **Speaker**. Physical and Mental Health on the Street. Homelessness Radio Marathon, CKUT Radio. Montreal, Quebec, Canada. Presenter(s): **Hwang SW**.

2006 Dec **Speaker**. Physicians and Discrimination. Omni Television, Omni News Mandarin Weekend Edition. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2005 Jul 12 **Speaker**. Interview on the Impact of Heat Waves on Inner City Populations. CBC News: Morning. Canada. Presenter(s): **Hwang SW**.

2002 Nov 5 **Personal Profile**. Homelessness, health link studied. The Medical Post. Canada. Presenter(s): Moulton D.

3. PROVINCIAL / REGIONAL

Invited Lectures and Presentations

2021 Dec 7 **Invited Speaker**. Improving the Health and Wellbeing of People Experiencing Homelessness. McGill University Health Centre - Medical Grand Rounds. Montreal, Quebec, Canada. Presenter(s): **Hwang SW**.

2020 Oct 7 **Invited Speaker**. Missed and Late Diagnosis of Concussions in Non-Sport Populations. ECHO Concussion. Ontario, Canada. Presenter(s): **Hwang SW**. Online webinar - Medical education programming for primary care providers in Ontario.

2020 Sep 30 **Invited Speaker**. Health, Homelessness, and COVID-19. Ontario Housing First Regional Network Community of Interest. Ontario, Canada. Presenter(s): **Hwang SW**. Online webinar.

2019 May 23 **Invited Speaker**. Housing, Health and Policy Conference 2019. McGill University Institute for Health and Social Policy. Montreal, Quebec, Canada. Presenter(s): **Hwang SW**.

2019 Mar 8 **Invited Speaker**. Screening and Assessment Tools for Housing First. Housing Forum on Evidence-Based Practices, Ontario Housing First Regional Network. Toronto, Ontario, Canada. Presenter(s): Ecker J, **Hwang SW**.

2016 Apr 11 **Keynote Speaker**. Ending Homelessness: Dream or Illusion? Grandes Conférences Paul-Bernard sur les Inégalités Sociales de Santé. Léa Roback Centre de Recherche. Montreal, Quebec, Canada. Presenter(s): **Hwang SW**.

2015 Apr 2 **Invited Speaker**. Solving the Problem of Homelessness. University of Lethbridge - Discovery Lecture. Lethbridge, Alberta, Canada. Presenter(s): **Hwang SW**.

2015 Jan 29 **Invited Speaker**. Assessing Multi-morbidity in Marginalized Populations: A View from the Frontlines. Disability Adjudication Unit, Ontario Ministry of Community and Social Services. Toronto, Ontario, Canada.

2014 Nov 22 **Invited Speaker**. "Think Before You Jump in the River". McMaster LIGHT Humanitarian Health Conference. Hamilton, Ontario, Canada. Presenter(s): **Hwang SW**.

2014 Nov 20 **Invited Speaker**. Research on Homelessness: Housing First. 2nd Annual Shelter Health Network Retreat. Hamilton, Ontario, Canada. Presenter(s): **Hwang SW**.

2014 Jan 31 **Invited Speaker**. Research with Marginalized Populations. Public Health Ontario - Ethics Review Board Retreat. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2013 Nov 28 **Invited Speaker**. The At Home/Chez Soi Project. Ontario Ministry of Municipal Affairs and Housing (MMAH) Homelessness Learning Day. Toronto, Ontario, Canada. Presenter(s): More F and **Hwang SW**.

2011 Nov 9 **Invited Speaker**. Canadian Crisis: The Hidden Cost of Homelessness. Portland Hotel Community Service Society - Knowledge Exchange on Homelessness and Health in Canada. Vancouver, British Columbia, Canada. Presenter(s): **Hwang SW**.

2011 Nov 9 **Invited Speaker**. Challenges in Understanding the Connections between Housing and Health: The Health and Housing in Transition (HHiT) Study. Centre for Health Evaluation and Outcome Sciences, St. Paul's Hospital, University of British Columbia. Vancouver, British Columbia, Canada. Presenter(s): **Hwang SW**.

2011 Oct 29 **Invited Speaker**. Meaningful Measurement of Housing Success. Ontario Non-Profit Housing Association 2011 Annual Conference. Niagara Falls, Ontario, Canada. Presenter(s): Davis B, Witkowski B, Huehn V, **Hwang S**.

2010 Nov 19 **Invited Speaker**. Housing Vulnerability and Health: Canada's Hidden Emergency. Ottawa Alliance to End Homelessness 2010 Community Forum on Homelessness. Ottawa, Ontario, Canada. Presenter(s): **Hwang SW**.

2010 Sep 21 **Invited Speaker**. Patterns of Shelter Utilization in Toronto, Ottawa, and Guelph: Implications for Service Delivery. Ontario Municipal Social Services Association (OMSSA) & the Ontario Association of Hostels (OAH) 2010 Housing and Homelessness Conference. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2010 May 28 **Invited Speaker**. Defining a Typology of Homelessness Based on Shelter Utilization Patterns in Three Ontario Cities. Ottawa Homelessness Roundtable. Ottawa, Ontario, Canada. Presenter(s): **Hwang SW**.

2010 Feb 16 **Invited Speaker**. Homelessness, Housing, and Health. McGill University. Montreal, Quebec, Canada. Presenter(s): **Hwang SW**. McGill University Health Centre, Medical Grand Rounds.

2010 Feb 15 **Invited Speaker**. Is Beauty Only Skin Deep? Apparent Age and Health. McGill University. Montreal, Quebec, Canada. Presenter(s): **Hwang SW**. Inter-Division Rounds, Division of General Internal Medicine.

2009 Sep 22 **Invited Speaker**. Traumatic Brain Injury and Homelessness. Ontario Municipal Social Services Association. 2009 Forum on Social Housing and Homelessness. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2009 Feb 24 **Invited Speaker**. A survey of domiciliary hostel program tenants in Ontario. Ontario Ministry of Community and Social Services & Ontario Ministry of Health and Long-term Care. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**. Chiu S.

2008 Jun 10 **Invited Speaker**. Research Challenges in Homelessness and Health: Feasibility and Relevance. Ontario Training Centre in Health Services and Policy Research. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2007 Nov 22 **Invited Speaker**. Housing Solutions: The Role of Research. Alliance to End Homelessness in Ottawa. Ottawa, Ontario, Canada. Presenter(s): **Hwang SW**. 2007 Community Forum on Homelessness.

2007 Sep 25 **Invited Speaker**. CIHR Cafe Scientifique: Home is Where Your Health Is. Canadian Institutes of Health Research, in partnership with Human Resources and Social Development Canada. Edmonton, Alberta, Canada. Presenter(s): **Hwang S**.

2007 Jan 26 **Invited Speaker**. Housing, Homelessness, and Health. Ontario Ministry of Community and Social Services. Healthy Communities: A Policy Research Knowledge Exchange. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2007 Jan 19 **Invited Speaker**. Current Investigations: An example of a sister hospital, a model for investigation. INTEGRATION (Interdisciplinary Teams Generating Research on Complex Patients) Workshop. Sponsored by St. Paul's Hospital, University of British Columbia, and Simon Fraser University. Vancouver, British Columbia, Canada. Presenter(s): **Hwang SW**.

2006 Nov 17 **Invited Speaker**. Homelessness: Root Causes and Solutions. Keynote Address. 3rd Annual Conference on Diversity and Wellbeing: Taking Action on Homelessness and Health. Sponsored by the Calgary Health Region, United Way of Calgary, and the Calgary Homeless Foundation. Calgary, Alberta, Canada. Presenter(s): **Hwang SW**.

2006 Nov 16 **Invited Speaker**. Solving the Problem of Homelessness: Health Care and Beyond. Calgary Health Region. Calgary, Alberta, Canada. Presenter(s): **Hwang SW**.

2006 Feb 28 **Invited Speaker**. Homelessness and Health. Ontario Ministry of Health and Longterm Care, Human Resources Branch, Lunch 'N' Learn Program. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2005 Nov 30 **Invited Speaker**. Translating Research on Homelessness and Health into Action and Policy. Queen's University, Department of Community Health and Epidemiology and the School of Urban and Regional Planning. Kingston, Ontario, Canada. Presenter(s): **Hwang SW**.

2005 May 3 **Invited Speaker**. Homelessness and Health. The Salvation Army - Ontario Homeless Conference. Jackson's Point, Ontario, Canada. Presenter(s): **Hwang SW**.

2005 Mar 7 **Invited Speaker**. Policy Forum on Improving Access to Health Care and Social Services for People Experiencing Homelessness. McMaster University Centre for Health Economics and Policy Analysis (CHEPA) and the Centre for Research on Inner City Health. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**, Ploeg J, Thomas H, Semogas D.

2004 Nov 22 **Invited Speaker**. Translating Research on Homelessness into Policy and Action. Community Forum on Homelessness: Linking Ottawa Research with Action and Policy. Alliance to End Homelessness in Ottawa. Ottawa, Ontario, Canada. Presenter(s): **Hwang SW**.

2004 Oct 19 **Invited Speaker**. Mortality among Homeless Women. Ontario Association of Hostels and the Ontario Municipal Social Services Association, 2004 Learning Forum on Homelessness. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2004 Apr 13 **Expert Witness**. Homelessness, Housing, and Health. Office of the Chief Coroner for Ontario, Inquest into the Death of Joseph Teigesser (a homeless man who died of tuberculosis). Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2003 Nov 21 **Invited Speaker**. Inner City Health Research. Ontario Ministry of Health and Long-term Care. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2003 Feb 20 **Invited Speaker**. Homelessness, Health, and Public Policy. Queen's University, Faculty of Medicine, Seminar Series on Medicine and Activism. Kingston, Ontario, Canada. Presenter(s): **Hwang SW**.

2003 Jan 10 **Invited Speaker**. A Community-based Program in Increase Cervical and Breast Cancer Screening Among Homeless Women. Cancer Care Ontario, Ontario Cervical Screening Collaborative Group. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2002 Dec 12 **Invited Speaker**. Research on Homelessness and Health. Ontario Ministry of Health and Long-term Care. Toronto, ON, Ontario, Canada. Presenter(s): **Hwang SW**.

2002 Jan **Invited Speaker**. Research on Homelessness and Health. University of British Columbia, Centre for Health Evaluation & Outcome Sciences (CHEOS), Health in the City Conference. Vancouver, British Columbia, Canada. Presenter(s): **Hwang SW**.

2001 May **Invited Speaker**. Health Research Involving Homeless Persons: Pitfalls and Paradigms. University of Western Ontario School of Medicine and the London InterCommunity Health Centre, Bringing Medicine Into the Community Workshop. London, Ontario, Canada. Presenter(s): **Hwang SW**.

2000 Nov **Invited Speaker**. Homelessness: In the Shelters and On the Street. Ontario Ministry of Community and Social Services, Brown Bag Policy Network. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2000 Sep **Invited Speaker**. Ethical and Clinical Issues Affecting the Homeless. Centre for Clinical Ethics, Conference on Affirming an Ethic of Care: Understanding the Needs of Vulnerable Persons. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

1995 Dec **Invited Speaker**. Homelessness and Health. St. Paul's Hospital, Department of Medicine Rounds. Vancouver, British Columbia, Canada. Presenter(s): **Hwang SW**.

Presented Abstracts

2010 Nov 15 **Co-author**. Upstream determinants of health and housing are major contributors to health-related quality of life in HIV infection: Findings from the Positive Spaces, Healthy Places study. Ontario HIV Treatment Network (OHTN) 2010 Research Conference. Toronto, Ontario, Canada. Presenter(s): Rourke ST, Bekele T, Tucker R, Greene S, Monette L, Koornstra J, Sobota M, Byers S, Watson J, Bacon J, Hambly K, **Hwang S**, Guenter D, Dunn J, Hamilton M, Truax J, Hintzen DB, White P, Kayitesi M, Desbiens M, De Blois S, Cubillos M, and The Positive Spaces, Healthy Places Team. (Trainee Presentation).

2009 Nov 16 **Co-author**. Peer Investigator experiences in a community based research study: expression through creative projects. Ontario HIV Treatment Network (OHTN) 2009 Research Conference. Toronto, Ontario, Canada. Presenter(s): Scott AN, Hayhoe B, Walker D, Ewert R, Parsons J, Worthington C, **Hwang SW**, and Peer Investigators. (Trainee Presentation).

2009 Oct 8 **Co-author**. Housing is Health: The Positive Spaces Healthy Places Study. Ministry of Health and Long Term Care 2009 Health Research Showcase. Toronto, Ontario, Canada. Presenter(s): Tucker R, Greene S, Guenter D, Sobota M, Koonstra J, Byers B, Monette L, **Hwang W**, Dunn J, Rourke SB. Poster presentation.

2008 Nov 14 **Co-author**. The Positive Spaces, Health Places Study. Ontario HIV Treatment Network 2008 Research Conference. Toronto, Ontario, Canada. Presenter(s): Tucker R, Greene S, Sobota M, Koornstra J, Monette L, Guenter D, Byers S, Dunn J, **Hwang S**, Rourke SB. Oral session (6 abstracts).

2008 Nov 13 **Co-author**. Conception of a CBR Project on Pregnancy in Street-Involved Young Women: Development of a Strong Service Provider-Researcher Partnership. Ontario HIV Treatment Network (OHTN) 2008 Research Conference. Toronto, Ontario, Canada. Presenter(s): Scott AN, Hayhoe B, Walker D, Ewert R, Parsons J, Worthington C, **Hwang SW**. (Trainee Presentation).

2007 Nov 19 **Co-author**. Positive Spaces, Healthy Places: Health Outcomes at 6 Months. Ontario HIV Treatment Network (OHTN) Research Conference. Toronto, Ontario, Canada. Presenter(s): Tucker R, Greene S, Sobota M, Koornstra J, Monette L, Guenter D, Byers S, Dunn J, **Hwang SW**, Rourke SB.

Media Appearances

2021 Aug 19 **Interview**. The quick fix, Part 4: How to tackle homelessness in Ontario. Interviewer: Matt Gurney. TVO. Ontario, Canada. Available from: https://www.tvo.org/article/the-quick-fix-part-4-how-to-tackle-homelessness-in-ontario.

2016 Oct 11 **Interview**. Rob Snow speaks with Dr. Stephen Hwang, Director for the Centre for Urban Health Solutions at St. Michael's Hospital, about the homeless and housing. Interviewer: Rob Snow. 580 CFRA News Talk Radio. Ottawa, Ontario, Canada. Available from: http://devel.autopod.ca/chum/181/podcasts/6/.

2009 Jan 28 **Quoted Source**. On health and the homeless. The Edmonton Journal. Edmonton, Alberta, Canada. Presenter(s): Richard Warnica. The Edmonton Journal.

2008 Sep 25 **Interview**. Health care for homeless people. CBC Radio: Up to Speed with Margot Watt. Winnipeg, Manitoba, Canada. Presenter(s): **Hwang SW**.

2007 Nov 26 **Interview**. Traumatic Brain Injury among Homeless People. CBC Radio: Ontario Morning. Ontario,

Canada. Presenter(s): **Hwang SW**.

2007 Sep 24 **Interview**. Crack use 'staggering' among homeless. The Globe and Mail. Toronto, Ontario, Canada. Presenter(s): Reinhart A.

2007 Sep 1 **Quoted Source**. Conservatives confuse science and moralizing. The Vancouver Sun. Vancouver, British Columbia, Canada. Presenter(s): McKnight P.

2004 Apr 20 **Speaker**. Women and Homelessness. Television Ontario (TVO), "More to Life" Program. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

4. LOCAL

Invited Lectures and Presentations

2021 Mar 22 **Invited Speaker**. Just the Facts: Affordable Housing, Homelessness, and Healthcare. Toronto Science Policy Network (TSPN), University of Toronto. Toronto, Ontario, Canada. Presenter(s): **Stephen Hwang**, Mikaela Gabriel and Andrew Boozary (panelists); Victoria Gibson (moderator).

2019 Nov 1 **Keynote Speaker**. Caring for People Experiencing Disadvantage and Marginalization. St. Joseph's Health Centre 64th Annual Clinical Day. Toronto, Ontario, Canada.

2019 Oct 16 **Keynote Speaker**. Aging in Place Report Launch. Mainstay Housing. Toronto, Ontario, Canada.

2019 Apr 5 **Invited Speaker**. From the Streets to Solutions: Tackling Homelessness. CRAM University of Toronto. Toronto, Ontario, Canada. Available from: https://cramtoronto.com.

2018 Oct 30 **Invited Lecturer**. Transition to Professional Practice - The Causes of Illness & What We Should Do About It. Global Health Education Initiative, University of Toronto Postgraduate Medical Education. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2018 Oct 2 **Panel Member**. Tackling Toronto's Homelessness Crisis. St. Michael's Hospital Foundation. Toronto, Ontario, Canada. Presenter(s): Katz M (keynote speaker); Aston M, Bedard M, **Hwang SW** (discussion panel); Mediwake AM (moderator).

2018 Jun 27 **Invited Speaker**. Improving health systems and public policy for disadvantaged populations. Grand Rounds, St. Joseph's Health Centre. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2018 Apr 25 **Invited Speaker**. The Quest for Urban Health Solutions. University of Toronto IHPME Graduate Student Union. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2018 Mar 9 **Invited Speaker**. Homelessness and Urban Health Solutions. Metropolitan United Church, A Great Light: Discussion Series. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2017 Nov 6 **Invited Speaker**. Research metrics and health equity research. St. Michael's Hospital, Research Matters Month & Centre Talks. Toronto, Ontario, Canada. Presenter(s): **Hwang SW** and Nelson LA.

2017 Oct 27 **Invited Speaker**. Traumatic Brain Injury in People Experiencing Homelessness. University of Toronto, Department of Surgery - 2017 Interdisciplinary Trauma Conference - Violence Close to Home: Intentional injuries in vulnerable populations. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2017 Sep 8 **Invited Lecturer**. Panel on Basic Income. Introduction to Public Health Sciences (CHL 5004H). Dalla Lana School of Public Health, University of Toronto. Toronto, Ontario, Canada. Presenter(s): **Hwang SW** and Stapleton J.

2017 Jun 15 **Keynote Speaker**. Five Things That I Wish Someone Had Told Me When I Was Your Age. University of Toronto, Division of General Internal Medicine - 2017 GIM Research Day. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2017 Mar 22 **Invited Speaker**. Housing: A Critical Determinant of Urban Health. Massey Grand Rounds 11th Annual Symposium. Health & Environment: Air, Food and Drugs. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2016 Dec 2 **Invited Speaker**. Cold-related Injuries and Deaths among People Experiencing Homelessness. The Paula Goering Memorial Workshop on Coordinating Care for People who are Homeless, Centre for Addiction and Mental Health. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2016 Oct 22 **Invited Speaker**. Homelessness: Symptom or Disease? 9th Annual Dalla Lana School of Public Health Student-Led Conference. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2016 Sep 27 **Invited Speaker**. Inner City Health: Physicians & Marginalized Patients. University of Toronto PGY2 Academic Half Day. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2016 Sep 27 **Keynote Speaker**. Homelessness and Housing Solutions. Homes First Foundation. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2016 Apr 23 **Invited Speaker**. A Biblical View of Social Justice. Thinking Conference: Has God Spoken? Mississauga, Ontario, Canada. Presenter(s): **Hwang SW**.

2016 Feb 9 **Invited Speaker**. Creating Urban Health Solutions. University of Toronto Senior Alumni Association - Canadian Perspectives Lecture Series. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2016 Jan 27 **Invited Speaker**. Faith, Science, and Effective Advocacy. Multifaith Alliance to End Homelessness. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2015 Sep 29 **Invited Speaker**. Inner City Health: Physicians & Marginalized Patients. University of Toronto PGY2 Academic Half Day. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2015 Apr 9 **Invited Speaker**. The Best Kept Secret: What Really Determines Your Health. Li Ka Shing Knowledge Institute of St. Michael's Hospital, Popular Science Lecture. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2015 Mar 16 **Moderator**. Debate: Has Science Made God Irrelevant? Power to Change, RZIM Canada, University of Toronto Secular Alliance, and The Veritas Forum. Toronto, Ontario, Canada. Presenter(s): Prof. John Lennox and Christopher DiCarlo.

2014 Nov 27 **Invited Lecturer**. Understanding the Social Determinants of Health. Interprofessional Health, Arts & Humanities Certificate Program - Humanities Lunch and Learn Session. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2014 Nov 3 **Invited Lecturer**. Homelessness: What's the Real Story? Ryerson University, School of Journalism, JN8104 - Urban Politics and Society for Journalists. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2014 Oct 7 **Invited Speaker**. Homelessness in Downtown Toronto. Street Health, Board of Directors Meeting. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2014 Oct 6 **Speaker**. Academic Promotions at the University of Toronto. North York General Hospital, Department of Medicine Business Meeting. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2014 Sep 21 **Invited Speaker**. Science and Faith: Are they really in conflict? Center for Science and Culture. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2014 Jul 30 **Speaker**. Itchy and Scratchy: A General Internist's Guide to Infestations. St. Michael's Hospital, Medical Grand Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2014 Jun 18 **Invited Speaker**. Housing First: A Common Sense Approach. Affordable Housing Halton. Oakville, Ontario, Canada. Presenter(s): **Hwang SW**.

2014 Jun 10 **Invited Speaker**. Homelessness and Housing First. Homes First Society, Annual General Meeting. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2014 May 14 **Keynote Speaker**. Research and Responsibility: The Science of Homelessness. Sunnybrook Health Sciences Centre Department of Medicine Resident Research Day Grand Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2014 Apr 2 **Keynote Speaker**. Homelessness, Housing, and Hope. 2014 Royacker Lecture, Regis College, University of Toronto. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2014 Apr 1 **Invited Speaker**. Homelessness, Science, and Morality. The Art of Medicine Lecture Series, Ho Ping Kong Centre for Excellence in Education and Practice (CEEP), Toronto Western Hospital. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2014 Feb 18 **Invited Speaker**. Inner City Health: Physicians & Marginalized Patients. University of Toronto PGY2 Academic Half Day. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2014 Feb 7 **Invited Speaker**. Housing First and Intensive Case Management for Homeless Adults with Mental Illness: Results from the At Home Randomized Controlled Trial. St. Michael's Hospital Mental Health Grand Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2014 Jan 13 **Invited Speaker**. Solving the Problem of Homelessness. St. Lawrence Supper Club. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2014 Jan 4 **Keynote Speaker**. A Radical Vision for Medical Mission. Richmond Hill Christian Community Church, Ontario Chinese Christian Medical Fellowship, and Education Medical Aid and Service (EMAS). Richmond Hill, Ontario, Canada. Presenter(s): **Hwang SW**.

2013 Nov 21 **Invited Speaker**. The Aging Homeless: Best Practices for End of Life Care. The Good Neighbours' Club. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2013 Oct 31 **Invited Speaker**. Housing First and Intensive Case Management for Homeless Adults with Mental Illness: Results from the At Home Randomized Controlled Trial. St. Michael's Hospital Clinical and Population Research Round. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2013 Jul 31 **Speaker**. Improving Health and Healthcare for People who are Homeless: What Really Works? St. Michael's Hospital - Medical Grand Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2013 Jul 24 **Invited Speaker**. Solving the Problem of Homelessness. St. Michael's Foundation - A Legacy of Caring. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2013 May 29 **Invited Speaker**. Bridging the Gap: A Closer Look at Addictions, _Mental Health, Brain Injury and the Justice System. Toronto Acquired Brain Injury Network. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**. Available from: http://www.abinetwork.ca/news?news_id=52.

2013 Apr 11 **Invited Speaker**. Caring for the Whole Person: Insights from the Inner City. The Good Neighbours' Club - Annual General Meeting. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2012 Oct 11 **Invited Speaker**. Putting a Roof over Inadequate Housing: "Home Safe" Documentary Screening and Panel Discussion. Canadian Institutes of Health Research - Institute of Population and Public Health. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**, Tarasuk V, Richards C, Adams R, Shapcott M.

2012 May 17 **Invited Speaker**. 24th Annual Higgins Day - Resident Research Day. St. Michael's Hospital - Department of Medicine. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**. Keynote address.

2012 Apr 28 **Invited Speaker**. CIHR Cafe Scientifique: No Room for Health? University of Toronto Public Health Social Justice Collective. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2012 Mar 9 **Invited Lecturer**. Homelessness and the Determinants of Health. University of Toronto - University College, Health Studies Program. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2012 Mar 7 **Speaker**. Prevention of Clostridium difficile Infection in Hospitalized Patients. St. Michael's Hospital - Medical Grand Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2012 Feb 23 **Invited Speaker**. Traumatic Brain Injury and Homelessness. Sherbourne Health Centre. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2012 Feb 21 **Invited Speaker**. Seeking Solutions Symposium: Access to Health Care for the Uninsured in Canada. Hospital for Sick Children, Women's College Hospital, and Ryerson University. Toronto, Ontario, Canada. Presenter(s): Mason K, **Hwang SW**.

2012 Feb 2 **Invited Speaker**. Discrimination in Health Care. St. Michael's Hospital - Clinical and Population Research Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2012 Feb 1 **Invited Speaker**. Pain Management in Homeless and Hard-to-House Patients. Casey House: Physicians and Advanced Practice Clinicians HIV/AIDS Health Care Seminar Series. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2012 Jan 17 **Invited Speaker**. Chronic Pain Management in Homeless and Underhoused Patients. Sherbourne Health Centre. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2011 Dec 5 **Invited Speaker**. Keynote Speaker, "Forty is Too Young to Die: A Call to Action" Report Launch. Mainstay Housing, Early-Onset Illnesses and Mortality Working Group. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2011 May 31 **Invited Speaker**. FitzTalks, in Honor of Graduating Medical Students in the Fitzgerald Academy. "The Patient Appeared Older Than His Stated Age - A Reflection on Curiosity, Empathy, and Privilege.". Faculty of Medicine, University of Toronto. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2010 Nov 22 **Invited Speaker**. Advocacy Rounds. St. Michael's Hospital - Department of Medicine. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2010 Nov 3 **Invited Speaker**. Homelessness and Public Health. Public Health Interest Group at University of Toronto. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2010 Oct 5 **Invited Speaker**. Health care utilization among homeless people. Clinical Epidemiology Unit / Institute for Clinical Evaluative Sciences - Conjoint Evaluative Sciences Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2010 Oct 4 **Invited Speaker**. Homelessness and Health. IMAGINE Community Awareness Lecture Series, University of Toronto Faculty of Medicine. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2010 Sep 23 **Invited Speaker**. Homelessness and Palliative Care. Toronto Central Palliative Care Network. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2010 Jul 22 **Invited Speaker**. Homelessness and Immigration: Toronto's Changing Face. City of Toronto - Immigrant and Refugee Housing Committee. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2010 Jul 14 **Invited Speaker**. Defining a Typology of Homelessness Based on Shelter Utilization Patterns in Three Ontario Cities. Housing & Homeless Service Network, Toronto Shelter, Support & Housing Administration. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2010 May 26 **Invited Speaker**. Defining a Typology of Homelessness Based on Shelter Utilization Patterns in Three Ontario Cities. Street Outreach Steering Committee, Toronto Shelter, Support & Housing Administration. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2010 Mar 1 **Invited Speaker**. Homelessness and Immigration: Toronto's Changing Face. Social Planning Toronto - Research and Policy Forum. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2010 Feb 10 **Invited Lecturer**. Homelessness and Health. Ryerson University, School of Occupational and Public Health (ENH 809). Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2009 Dec 18 **Invited Speaker**. Traumatic Brain Injury and Homelessness. St. Michael's Hospital Mental Health Grand Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**. (Continuing Education).

2009 Nov 16 **Invited Speaker**. Research on homelessness: Moving from problems to solutions. Innovation Night at St. Michael's Hospital. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2009 Jun 2 **Invited Speaker**. Traumatic brain injury and the health of homeless people. Toronto Acquired Brain Injury Network. Brain Injury and Homelessness Workshop. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**. (Continuing Education).

2009 Apr 10 **Invited Speaker**. Good Friday Breakfast Speaker: Homelessness. St. Andrew's Presbyterian Church Humber Heights. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2009 Mar 29 **Invited Speaker**. Lenten Speaker Series: Homelessness. Anglican Church of St. Clement. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2009 Mar 6 **Invited Speaker**. Harm Reduction: A Balanced Approach. Casey House - HIV/AIDS and Mental Health: A Symposium for Health Care Providers. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**. (Continuing Education).

2009 Mar 5 **Invited Speaker**. Unmet needs for health care among homeless people within a universal health insurance system. St. Michael's Hospital - Clinical and Population Research Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2009 Mar 3 **Invited Lecturer**. Homelessness and Health. Ryerson University, School of Occupational and Public Health. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2009 Feb 24 **Invited Speaker**. Homelessness & Immigration: Toronto's Changing Face. Let's Get Talking: Community Discussions on Neighbourhoods & Health - Regent Park Community Health Centre. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2008 Oct 20 **Invited Speaker**. Unmet needs for health care among homeless people within a universal health insurance system. Toronto General Hospital - Clinical Epidemiology Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2008 Oct 3 **Invited Speaker**. Poverty and Health: Partnerships in Action 2008 Conference. Workshop on Homelessness and Health. Public Health Sciences Students Association, University of Toronto. Toronto, Ontario, Canada. Presenter(s): Khandor E, Mason K, **Hwang SW**.

2008 Sep 12 **Invited Speaker**. Addressing Health Disparities in Toronto: Spotlight on Diabetes and Mental Illness. Toronto Central Local Health Integration Network (LHIN). Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2008 Jun 5 **Invited Speaker**. Health Connections 2008. Health Equity: From Challenges to Solutions. Toronto Central Local Health Integration Network (LHIN). Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2008 May 26 **Invited Speaker**. Supportive Housing: How much does Toronto need; how are we going to get it? Wellesley Institute. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2008 May 26 **Invited Speaker**. Homelessness & Brain Injuries: Cause or Effect? Let's Get Talking: Community Discussions on Neighbourhoods & Health - St. Christopher House. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2008 May 24 **Invited Speaker**. Why care about homelessness in Toronto? Ontario Public Service Employees Union (OPSEU) Educational Forum on Poverty in Toronto. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2008 May 10 **Invited Speaker**. Harm Reduction: A Balanced Approach. Casey House Board of Directors Retreat. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2008 Feb 19 **Invited Speaker**. Homelessness and Health. 11th Annual Toronto Catholic District School Board High School Gifted Program Conference, "Perspectives: Challenges, Ideas and Responses 2008". Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2007 Oct 9 **Invited Speaker**. Research on homelessness and health. Innovation Night at St. Michael's Hospital.

Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2007 Mar 13 **Invited Lecturer**. Homelessness and Health. York University, Faculty of Arts, A Critical Study of Health and Society (AS/SOSC 2110). Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2007 Mar 8 **Invited Speaker**. Lenten Speaker Series: Homelessness. Saint Luke's United Church. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2007 Feb 28 **Invited Lecturer**. Homelessness and Health. Ryerson University, School of Occupational and Public Health. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2007 Feb 20 **Invited Speaker**. Homelessness and Health. 10th Annual Toronto Catholic District School Board High School Gifted Program Conference, "Perspectives: Challenges, Ideas and Responses 2007". Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2006 Aug 30 **Speaker**. The Discriminating Physician: Does Prejudice Affect the Provision of Health Care? St. Michael's Hospital, Medical Grand Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2006 Apr 13 **Speaker**. Challenges and Rewards of Research with Homeless Persons. St. Michael's Hospital, Clinical Research Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**, Chiu S.

2006 Apr 5 **Invited Speaker**. Forget Chaoulli: Existing financial barriers in our health care system. Student Medical Reform Group and Diversity in Medicine Speaker Series, Faculty of Medicine, University of Toronto. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**, Glazier RH.

2006 Mar 31 **Invited Lecturer**. Homelessness and Health. Ryerson University, School of Occupational and Public Health. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2006 Mar 7 **Invited Lecturer**. Homelessness and Health. York University, Faculty of Arts, A Critical Study of Health and Society (AS/SOSC 2110). Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2006 Feb 21 **Invited Speaker**. Homelessness and Health. 9th Annual Toronto Catholic District School Board High School Gifted Program Conference, "Perspectives: Challenges, Ideas and Responses". Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2005 Sep 14 **Invited Lecturer**. Marginalized Populations: Homelessness. University of Toronto, Dept. of Public Health Sciences, Introduction to Public Health Sciences (CHL 5004). Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2005 Jun 14 **Invited Speaker**. Bed Bugs and Beyond: Infectious Diseases in Homeless Persons. Sunnybrook and Women's College Health Sciences Centre, Infectious Diseases/Microbiology Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2005 Jun 13 **Invited Speaker**. Homeless People's Trust and Interactions with Paramedics and Police in Toronto. Toronto Police Services Board. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**, Zakrison T.

2005 May 11 **Invited Speaker**. Bedbug Infestations in Homeless Shelters and Other Locations in Toronto. City of Toronto, Community and Neighbourhood Services, Alternative Housing and Services Committee. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2005 May 9 **Invited Speaker**. Bedbug Infestations in Homeless Shelters and Other Locations in Toronto. Toronto Board of Health. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2005 Mar 1 **Invited Lecturer**. Homelessness and Health. York University, Faculty of Arts, A Critical Study of Health and Society. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2005 Feb 23 **Speaker**. Homeless People's Use of Health Care: Too Much, Too Little, or Just Right? St. Michael's Hospital, Medical Grand Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2005 Feb 7 **Invited Lecturer**. Homelessness and Health. University of Toronto, Department of Sociology, Introduction to Health and Social Policy. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2004 Nov 29 **Invited Speaker**. The Reemergence of Bedbugs in the Urban Environment. City of Toronto, Advisory Committee on Homeless and Socially Isolated Persons. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2004 Oct 6 **Invited Lecturer**. Access to Health Care in Disadvantaged Populations. Michener Institute for Applied Health Sciences and University of Torornto Faculty of Medicine, Medical Radiation Sciences Program. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2004 Jun 21 **Invited Speaker**. The Role of Research in Improving Community Health. St. Michael's Hospital Community Advisory Panels and the Wellesley Central Corporation. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2004 Jun 1 **Invited Speaker**. Alarming Death Rates among Homeless Women in Toronto: What's the Story Behind the Story? Wellesley Central Health Corporation, Wellesley Urban Health Seminar Series. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2004 May 19 **Invited Speaker**. Cardiovascular Risk Factors in Homeless Adults. Institute for Clinical Evaluation Sciences and Sunnybrook and Women's Health Sciences Centre, Clinical Epidemiology Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2004 Apr 19 **Invited Speaker**. Cardiovascular Risk Factors in Homeless Adults. Toronto General Hospital, Clinical Epidemiology Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2004 Mar 29 **Invited Lecturer**. Homelessness and Health. Ryerson University, School of Occupational and Public Health. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2004 Mar 9 **Invited Lecturer**. Homelessness and Health. University of Toronto, Population Health Course. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2004 Feb 15 **Invited Lecturer**. Homelessness and Health. Ryerson University, School of Occupational and Public Health. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2004 Jan 14 **Invited Speaker**. Health Care Utilization among Homeless Persons in Toronto. City of Toronto, Community and Neighbourhood Services, Alternative Housing and Services Committee. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2003 Nov 6 **Speaker**. Cardiovascular Risk Factors in Homeless Adults. St. Michael's Hospital, Clinical Epidemiology Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2003 Sep 15 **Invited Speaker**. Keynote Address, 2003 Annual General Meeting. Daily Bread Food Bank Foundation. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2003 Jul 9 **Invited Speaker**. The Health of Rooming House Residents in Toronto. City of Toronto, Community and Neighbourhood Services, Alternative Housing and Services Committee. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2002 Oct **Invited Lecturer**. Community-Based Action Research. Ryerson University, Homelessness in Canadian Society. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2002 Oct **Invited Lecturer**. Access to Health Care: Issues of Class, Ethnicity, and Culture. Michener Institute for Applied Health Sciences and University of Toronto Faculty of Medicine, Medical Radiation Sciences Program. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2001 Dec **Invited Speaker**. Access to Health Care Among the Homeless and Hungry in the Inner City. University Health Network, Clinical Epidemiology Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2001 Nov **Speaker**. Access to Health Care Among the Homeless and Hungry in the Inner City. St. Michael's Hospital, Clinical Epidemiology Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2001 Nov **Invited Speaker**. Leadership. 2nd Annual University of Toronto PGY2 Teaching Residents to Teach Retreat (Millcroft Inn, Alton). Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2001 Oct **Invited Lecturer**. Barriers to Health Care Access for Homeless Persons. Michener Institute for Applied Health Sciences and the University of Toronto, Individual and Social Issues in Health Care Course. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2001 Jul **Invited Speaker**. Health Status of Rooming House Residents in Toronto. Toronto Dept. of Community & Neighbourhood Services, Rooming House Working Group. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2001 Jul **Invited Speaker**. Homelessness and Health. University of Toronto, Summer Mentorship Program. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2001 May **Invited Speaker**. Homelessness and Health. University of Toronto, Community Medicine Residents' Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2001 May **Invited Speaker**. Screening for Cervical and Breast Cancer in Homeless Women. Toronto Homeless Health Reference Group and Ottawa Inner City Health. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2001 Apr **Speaker**. Screening for Cervical and Breast Cancer in Homeless Women: A Community-Academic Partnership. St. Michael's Hospital, Clinical Epidemiology Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2001 Apr **Invited Speaker**. Health Care at Homeless Shelters. Utilization Information Sharing Day, Greater Toronto Area Hospitals. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2001 Mar **Invited Speaker**. Anemia in High-Risk Adult Populations. Anemia Institute for Research and Education, Anemia and Nutrition Forum. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**. (Continuing Education).

2000 Nov **Speaker**. Homelessness: Challenges for Clinical Care and Research. St. Michael's Hospital, Medical Grand Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2000 Nov **Invited Speaker**. Homelessness: Challenges for Clinical Care and Research. University Health Network, Toronto Western Hospital, Medical Grand Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2000 Oct **Invited Speaker**. Deaths among the Homeless. Toronto Disaster Relief Committee, Homelessness Toronto 2000. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2000 Oct **Invited Speaker**. Research in Homelessness and Health. St. Michael's Hospital Foundation, Care & Cure Lecture. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2000 Oct **Invited Lecturer**. Barriers to Health Care Access for Homeless Persons. Michener Institute for Applied Health Sciences and the University of Toronto, Individual and Social Issues in Health Care Course. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2000 Sep **Invited Lecturer**. What is Population Health? University of Toronto, Faculty of Medicine, Determinants of Health Course. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2000 Mar **Speaker**. The Rational Clinical Exam. St. Michael's Hospital, Division of General Internal Medicine, Residents' Educational Retreat Day. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2000 Feb **Invited Speaker**. Patterns of Shelter Use and Mortality Among Homeless Men. University of Toronto, Department of Public Health Sciences, Community Health Research Day. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2000 Feb **Speaker**. Research on Homelessness and Health: Lessons from the McKinney Demonstration Projects. Inner City Health Journal Club, University of Toronto. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2000 Feb **Speaker**. Homelessness and Health in Toronto. St. Michael's Hospital Foundation. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

1999 Dec **Invited Speaker**. The Canadian Health Care System: How Does It Compare to Others? The Course on Gastroenterology and Digestive Endoscopy, The Wellesley Hospital. Toronto, Ontario, Canada. Presenter(s): **Hwang, SW**. (Continuing Education).

1999 Oct **Invited Lecturer**. Barriers to Health Care for Homeless Persons. Michener Institute for Applied Health Sciences and the University of Toronto Dept. of Public Health Sciences, Individual and Social Issues in Health Care Course. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

1999 Oct **Speaker**. Patterns of Shelter Use and Mortality Among Homeless Men. St. Michael's Hospital, Inner City Health Research Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

1999 Oct **Speaker**. Disease Probability for Differential Diagnosis. St. Michael's Hospital, Division of General Internal Medicine, R4 Seminar Series. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

1999 Sep **Invited Speaker**. The Canadian Health Care System: How Does It Compare to Others? The Course on Gastroenterology and Digestive Endoscopy, The Wellesley Hospital. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**. (Continuing Education).

1999 Aug **Invited Lecturer**. What is Population Health? University of Toronto, Faculty of Medicine, Determinants of Health Course. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

1999 Jun **Invited Speaker**. The Canadian Health Care System: How Does It Compare to Others? The Course on Gastroenterology and Digestive Endoscopy, The Wellesley Hospital. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**. (Continuing Education).

1999 Feb **Speaker**. Homelessness and Health Research. St. Michael's Hospital, Homeless and Underhoused Community Advisory Panel. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

1999 Jan **Speaker**. What Do Homeless Families Really Need? Inner City Health Journal Club, University of Toronto. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

1998 Dec **Invited Speaker**. The Canadian Health Care System: How Does It Compare to Others? The Course on Gastroenterology and Digestive Endoscopy, The Wellesley Hospital. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**. (Continuing Education).

1998 Nov **Invited Speaker**. What Happens to Patients Who Leave the Hospital Against Medical Advice? The Toronto Hospital, Clinical Epidemiology Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

1998 Jun **Invited Speaker**. The Canadian Health Care System: How Does It Compare to Others? The Course on Gastroenterology and Digestive Endoscopy, The Wellesley Hospital. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**. (Continuing Education).

1997 Oct **Speaker**. Healthy, Wealthy, and Wise: Why Rich People Live Longer. St. Michael's Hospital, Inner City Health Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

1997 Oct **Invited Speaker**. Statistics for Clinicians. University of Toronto, Department of Family and Community Medicine Core Day. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

1997 Sep **Speaker**. Healthy, Wealthy, and Wise: Why Rich People Live Longer. St. Michael's Hospital, Medical Grand Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

1997 Jul **Invited Speaker**. Healthy, Wealthy, and Wise: Why Rich People Live Longer. St. Michael's Hospital, Department of Family and Community Medicine, Grand Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

1997 Jun **Invited Speaker**. Integrated Health Information Systems. Healthy Connections, East Toronto Conference 1997. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

1997 Apr **Invited Speaker**. Finding and Counting the Homeless. University of Toronto, Department of Public Health Sciences, Graduate Student Seminar in Biostatistics. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

1996 Mar **Invited Speaker**. Death on the Street. St. Michael's Hospital, Medical Grand Rounds. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

Presented Abstracts

2014 Jul 29 **Supervisor**. The effect of advance directive completion on end-of-life care in homeless persons. St. Michael's Hospital, Keenan Research Summer Student Program -- 2014 Research Poster Competition. Toronto, Ontario, Canada. Presenter(s): Matthew To, Linh Luong, and Victor Goncalves. (Trainee Presentation).

2013 May 22 **Supervisor**. Measurement of Retention in Primary Care among Vulnerably Housed Populations: The At Home/Chez Soi Project. St. Michael's Hospital, Department of Family and Community Medicine. Toronto, Ontario, Canada. Presenter(s): Dosani N. (Trainee Presentation).

2012 Nov 8 **Co-author**. Exploring the link between traumatic brain injury and homelessness: a feasibility study. Toronto Acquired Brain Injury Network Conference. Toronto, Ontario, Canada. Presenter(s): Topolovec-Vranic J, Ennis N, Johnson P, Michalak A, Masanic C, Ouchterlony D, Distin K, Stergiopoulos V, **Hwang S**, Kontos P, Colantonio A, Cusimano M.

2007 May 1 **Co-author**. Integrating conceptual frameworks to study pregnancy in street youth. 3rd Annual Epidemiology and Biostatistics Student Society Research Day, McGill University. Montreal, Quebec, Canada. Presenter(s): Scott AN, Boivin JF, **Hwang SW**. Poster presentation.

2000 Jan **Co-author**. Barriers to appropriate diabetes management among homeless persons in Toronto. University of Toronto, Medical Student Research Day. Toronto, Ontario, Canada. Presenter(s): Bugeja A, **Hwang SW**. Poster presentation. Winner of Award for Best Health Services Research Project.

Media Appearances

2022 Jan 29 **Quoted Source**. 'People are stranded:' A downtown hospital is seeing a rise in cold-related injuries as shelters struggle to find spots. Interviewer: Megan Ogilvie. The Toronto Star. Toronto, Ontario, Canada. Available from: https://www.thestar.com/news/gta/2022/01/29/people-are-stranded-a-downtown-hospital-is-seeing-a-rise-in-cold-related-injuries-as-shelters-struggle-to-find-spots.html.

2022 Jan 25 **Televised Interview**. Cold weather and people experiencing homelessness. CP24 News. Toronto, Ontario, Canada. Available from: https://www.cp24.com/video?binId=1.5364204.

2021 Jul 31 **Quoted Source**. A private community housing provider noticed a spike in premature deaths in one of their buildings. So they decided to do something about it. Interviewer: Donovan Vincent. The Toronto Star. Toronto, Ontario, Canada. Available from: https://www.thestar.com/news/gta/2021/07/31/a-private-community-housing-provider-noticed-a-spike-in-premature-deaths-in-one-of-their-buildings-so-they-decided-to-do-something-about-it.html.

2019 Oct 23 **Quoted Source**. Who's to blame for youth homelessness in York Region? Interviewer: Sheila Wang. The Richmond Hill Liberal, King Connection, yorkregion.com. Richmond Hill, Ontario, Canada. Available from: https://www.yorkregion.com/news-story/9637639-analysis-who-s-to-blame-for-youth-homelessness-in-york-region-/.

2017 Jun 25 **Quoted Source**. Toronto faces Catch-22 with impending Seaton House closure. Interviewer: Emma McIntosh. The Toronto Star. Toronto, Ontario, Canada. Available from: https://www.thestar.com/news/gta/2017/06/25/toronto-faces-catch-22-with-impending-seaton-house-closure.html.

2016 Oct 10 **Quoted Source**. Cities' homelessness plans doomed to fail without federal cash: Report. Interviewer: Laurie Monsebraaten and Hin Alam. The Toronto Star. Toronto, Ontario, Canada. Available from: https://www.thestar.com/news/gta/2016/10/10/cities-homelessness-plans-doomed-to-fail-without-federal-cash-report.html.

2016 Feb 21 **Quoted Source**. Ontario's uncounted homeless dead. Interviewer: Mary Ormsby and Kenyon Wallace.

The Toronto Star. Toronto, Ontario, Canada. Available from: http://www.thestar.com/news/insight/2016/02/21/ontarios-uncounted-homeless-dead.html.

2015 Jan 26 **Cited**. Toronto experts to advise Ontario on how to end homelessness. Interviewer: Laurie Monsebraaten. The Toronto Star. Toronto, Ontario, Canada. Available from: http://www.thestar.com/news/queenspark/2015/01/26/toronto-experts-to-advise-ontario-on-how-to-end-homelessness.html.

2015 Jan 15 **Quoted Source**. 780 homeless people have died on Toronto streets since 1985...we think. Interviewer: Ben Spurr. NOW Toronto. Toronto, Ontario, Canada. Available from: https://nowtoronto.com/news/740-homeless-people-have-died-on-toronto-streets-since-1985./.

2014 Mar 5 **Quoted Source**. Make TTC free overnight during cold alerts, Councillor Josh Colle urges. Interviewer: Patty Winsa. The Toronto Star. Toronto, Ontario, Canada. Available from: http://www.thestar.com/news/gta/2014/03/05/make_ttc_free_overnight_during_cold_alerts_councillor_josh_colle_urges.html.

2013 Feb 2 **Personal Profile**. St. Michael's Hospital appoints Dr. Stephen Hwang inaugural chair in homelessness, housing and health. The Toronto Star. Toronto, Ontario, Canada. Presenter(s): Laurie Monsebraaten. The Toronto Star. Available at: http://www.thestar.com/news/gta/2013/02/01/st_michaels_hospital_appoints_dr_stephen_hwang_inaugural_chair_in_homelessness_housing_and_health.html.

2008 Oct 9 **Quoted Source**. Canadian group protests the 'politicization of science'. The Toronto Star. Toronto, Ontario, Canada. Presenter(s): Anne-Marie Tobin. The Toronto Star.

2008 May 5 **Quoted Source**. Outrageous but predictable violence (commentary). The Toronto Star. Toronto, Ontario, Canada. Presenter(s): Nick Falvo.

2007 Nov 23 **Interview**. Traumatic Brain Injury among Homeless People. CBC Radio: Metro Morning with Andy Barry. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2007 Jun 28 **Interview**. Infection control measures during the SARS outbreak and death rates in Toronto. Omni 2 Television, Cantonese News. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

2006 Nov 9 **Letter to the Editor**. Homeless Face More Health Risks. The Toronto Star. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**. The Toronto Star, Page A29.

2005 Feb 14 **Speaker**. Mental and Physical Health on the Street. 3rd Annual Homelessness Radio Marathon, CKUT Radio. Montreal, Quebec, Canada. Presenter(s): **Hwang SW**.

2002 Oct **Speaker**. Daily Bread Food Bank Report: "Turning Our Backs on Our Children: Hunger + Decrepit Housing = Unhealthy, Unsafe Children". Daily Bread Food Bank Foundation. Toronto, Ontario, Canada. Presenter(s): **Hwang SW**.

1997 Sep 21 **Personal Profile**. Caring for the street people: Doctor leads St. Michael's Hospital medical program for Metro's homeless. The Toronto Sun. Toronto, Ontario, Canada. Presenter(s): Linton M.

5. OTHER

Presented and Published Abstracts

2009 May The research alliance for Canadian homelessness, housing and health (REACH3).

Publication Details:
Aubry T, Cowan L, Dunn JR, Evans L, Evans S, Farrell S, Flamand S, Gogosis E, Hoch J, Hubley, Hulchanski D, **Hwang SW**, Khandor E, Klodawsky F, MacLaurin B, Muckle W, Palepu A, Roy E, Worthington C, Wyllie K. The research alliance for Canadian homelessness, housing and health

(REACH3). Journal of Urban Health. May 2009:86(3):386. **Principal Author**.

G. Teaching and Design

1. INNOVATIONS AND DEVELOPMENT IN TEACHING AND EDUCATION

2007 Jan - 2016 Jun — University of Toronto Division of General Internal Medicine Faculty Day, Continuing Education, Faculty of Medicine, Dept of Medicine, General Internal Medicine, University of Toronto
Director. The University of Toronto Division of General Internal Medicine Faculty Day was initiated in 2007. It is now an annual divisional event that brings together 60 faculty members for updates on clinical topics and the activities of the division.

2006 Jul - 2007 Jun — Scenario Rounds. Postgraduate MD, Faculty of Medicine, Dept of Medicine, General Internal Medicine, University of Toronto
Director. Coordinated creation of a university-wide curriculum and evaluation process for these rounds.

H. Research Supervision

1. PRIMARY OR CO-SUPERVISION

Undergraduate Education

2019 Aug - 2020 Aug — **Primary Supervisor**. BA. Dylan Balter. *Patient factors affecting family physicians' prescribing decisions for patients with chronic diseases*, *Non-thesis Project*. Awards: Johns Hopkins University - Second Decade Society - Meg Walsh Award. Completed 2020.

2017 Jun - 2017 Aug — **Primary Supervisor**. B. Sc. Linh Luong. Supervisee Position: Summer Research Student, Supervisee Institution: York University. *Readmissions among Homeless Patients*.

2016 Jun - 2016 Dec — **Primary Supervisor**. Alexandra Patel. Supervisee Position: Undergraduate Student, Supervisee Institution: University of Toronto. *Factors Affecting 90 Day Readmission to a General Medical Unit in the Homeless Population*.

2014 Jun - 2014 Aug — **Primary Supervisor**. B. Sc. Linh Luong. Supervisee Position: Summer Research Student, Supervisee Institution: York University. *The Effect of Advance Directives on the Care of Homeless Persons*.

2012 Jun - 2013 Aug — **Primary Supervisor**. B. Sc. Matthew To. Supervisee Institution: Western University. *Health status, healthcare utilization, and criminal incidents following traumatic brain injury in homeless and vulnerably housed adults in 3 Canadian cities*.

2012 Mar - 2012 Jul — **Primary Supervisor**. High School. Linh Luong. Supervisee Institution: Richmond Hill High School. *Health and Housing in Transition Study*.

2007 May - 2007 Aug — **Primary Supervisor**. B. Sc. Emma Wilkins. Supervisee Institution: University of Alberta. *Barriers to Chronic Pain Management in Homeless People*. Completed 2010.

2007 May - 2007 Aug — **Primary Supervisor**. B. Sc. Stephen VanderHerberg. Supervisee Institution: St. Michael's Hospital, Toronto. *Barriers to Chronic Pain Management in Homeless People*.

2005 Sep - 2006 Aug — **Primary Supervisor**. B. Sc. Michael Chan. Supervisee Institution: University of Toronto. *Access to Mobile Healthcare Services: A Comparison of Toronto and New York City*.

2005 May - 2006 Jun — **Primary Supervisor**. BA. Gabrielle Ramos. Supervisee Institution: Columbia University, NY. *Access to Mobile Healthcare Services: A Comparison of Toronto and New York City*.

2004 May - 2004 Aug — **Primary Supervisor**. BA. Toby Shaw. Supervisee Institution: Wesleyan University,

	Middletown, CT. *Bone Mineral Density in Women using Meal Programs*.
2002 May - 2002 Aug	**Primary Supervisor**. B. Sc. Jessica Ben-David. Supervisee Institution: University of Western Ontario. *Risk factors for cardiovascular disease among homeless people*.
2001 - 2003	**Co-Supervisor**. B. Sc. Diana Chislett and Naomi Ross. Supervisee Institution: St. Michael's Hospital. *Do shelters for the homeless in Toronto provide appropriate menus for those with diabetes?*. Collaborator(s): Primary supervisor: Pauline Darling. Completed 2003.
2000 - 2003	**Primary Supervisor**. B. Sc. Carolyn Tram. Supervisee Institution: University of Toronto. *Do graphic illustrations improve patients' comprehension of medication labels?*.

Graduate Education

2021 Mar - present	**Co-Supervisor**. MSc. Emma Skolnik, MD, Health Policy, Management and Evaluation. Supervisee Position: Fellow in Minimally Invasive Gynecologic Surgery, Supervisee Institution: St. Michael's Hospital. *Access to Advanced Gynecological Care for Patients Experiencing Disadvantage; A Population Based Study*. Supervisor(s): Andrea Simpson & Stephen Hwang.
2019 Jan - 2019 Mar	**Primary Supervisor**. Master of Public Health. Linh Luong, Public Health Sciences. Supervisee Position: MPH Student, Supervisee Institution: University of Toronto. *The "At Home" Research Demonstration Project in Mental Health and Homelessness --Toronto Site*. Completed 2019.
2017 Nov - 2021 Jan	**Co-Supervisor**. PhD. Jesse Jenkinson, Public Health Sciences. Supervisee Position: Graduate Student, Supervisee Institution: University of Toronto. *How does context shape the implementation process of discharging homeless patients from hospitals in Toronto, Canada?*. Supervisor(s): Erica Di Ruggiero and Stephen Hwang. Collaborator(s): Carol Strike. Completed 2021.
2016 Sep - 2021 Jun	**Primary Supervisor**. PhD. Kathryn Wiens, Public Health Sciences. Supervisee Position: MD Student, Supervisee Institution: University of Toronto. *Healthcare utilization among adults with a history of homelessness: The distribution and determinants of high-cost use of the healthcare system*. Supervisor(s): Laura Rosella, Paul Kurdyak. Completed 2021.
2013 Jul - 2015 Dec	**Primary Supervisor**. PhD. Jeyagobi Jeyaratnam, Health Policy, Management and Evaluation. Supervisee Position: Graduate Student, Supervisee Institution: University of Toronto. Collaborator(s): Farah Ahmad, Elizabeth Lin.
2012 Apr - 2014 Sep	**Primary Supervisor**. MSc. Dima Saab, Health Policy, Management and Evaluation. Supervisee Position: Graduate Student, Supervisee Institution: University of Toronto. *Hospital Readmissions among People who are Homeless in Toronto*. Collaborator(s): Rosane Nisenbaum, Irfan Dhalla. Completed 2014.
2011 Sep - 2014 Sep	**Co-Supervisor**. MSc Dental Public Health. Rafael Figueiredo, Dentistry. Supervisee Position: Provincial Dental Public Health Officer, Alberta Health Services, Supervisee Institution: University of Toronto. *Emergency Department Visits for Dental Problems by Homeless People: A Four-Year Observational Cohort Study using Health Care Databases*. Supervisor(s): Carlos Quinonez. Collaborator(s): Laura Dempster. Completed 2014.
2010 Sep - 2014 Sep	**Primary Supervisor**. MSc. Gayathri Naganathan, Health Policy, Management and Evaluation. Supervisee Position: Graduate Student, Supervisee Institution: University of Toronto. *The core features and perceived value of family support for ethnoracial homeless individuals with mental illness: Findings from the At Home/Chez Soi Project*. Collaborator(s): Vicky Stergiopoulos, Paul Williams. Completed 2014.
2005 Jan - 2012	**Co-Supervisor**. PhD. Allison Scott, Department of Epidemiology and Biostatistics. Supervisee Position: Epidemiologist, Alberta Health Services, Supervisee Institution: McGill University. *Incidence of Pregnancy, Identity, and Constructing Belonging in Street Youth*. Supervisor(s): Jean-François Boivin, Robert Platt, Janet Parsons. Completed 2017.
2002 - 2004	**Co-Supervisor**. MSc. Gordon Bargh, Department of Epidemiology and Biostatistics. Supervisee Position: Physician, Supervisee Institution: Western University. *Group A Streptococcus colonization among residents of a homeless shelter.* Supervisor(s): Jeffrey Hoch. Completed 2004.

Undergraduate MD

2019 Mar - 2021 Jun	**Co-Supervisor**. Year 2. Patsy Lee. Supervisee Position: Medical student, Supervisee Institution: McMaster University. *A Scoping review on community integration and social inclusion in formerly or current homeless people:*. Collaborator(s): Cilia Mejia-Lancheros.
2016 Jul - 2017	**Primary Supervisor**. Year 2. David Anderson. Supervisee Position: Medical student, Supervisee Institution: McMaster University. *PICC line for injection drug users*.
2015 Sep - 2016 Aug	**Primary Supervisor**. Year 2. Mei Wen. Supervisee Position: Medical student, Supervisee Institution: University of Toronto. *Factors Affecting 90 Day Readmission to a General Medical Unit in the Homeless Population*.
2014 Sep - 2017 Jun	**Primary Supervisor**. Year 2. Paige Zhang. Supervisee Position: Medical student, Supervisee Institution: University of Toronto. *Extreme Weather and Cold- and Heat-related Injuries among Homeless Individuals*.
2014 Sep - 2016 Jun	**Co-Supervisor**. Year 2. Rafael Sumalinog. Supervisee Position: Medical student, Supervisee Institution: University of Toronto. *Palliative Care for Homeless Patients*.
2014 Jun - 2014 Aug	**Primary Supervisor**. Year 2. Matthew To. Supervisee Position: Summer Research Student, Supervisee Institution: Dalhousie University. *The Effect of Advance Directives on the Care of Homeless Persons*.
2014 Jun - 2014 Aug	**Primary Supervisor**. Year 3. Victor Lucas Goncalves. Supervisee Position: Summer Research Student, Supervisee Institution: University of Sao Paulo, Brasil. *The Effect of Advance Directives on the Care of Homeless Persons*.
2013 Jul - 2016 Jun	**Primary Supervisor**. Year 2. Dhruv Nayyar. Supervisee Position: Medical Student, Supervisee Institution: University of Toronto. *Risk of Cardiovascular Disease in Homeless Adults: 10-Year Follow-Up*.
2013 Jul - 2014 Jun	**Primary Supervisor**. Year 2. Pavan Gill. Supervisee Position: Medical Student, Supervisee Institution: University of Toronto. *Health Needs Assessment of Taxi Drivers in Toronto*. Collaborator(s): Francesca Gany.
2013 Jun - 2013 Aug	**Primary Supervisor**. Year 2. Manisha Sachdeva and Dhruv Nayyar. Supervisee Position: Medical Students, Supervisee Institution: University of Toronto. *The Effect of Advance Directives on the Care of Homeless Persons*.
2012 Oct - 2016 Jun	**Primary Supervisor**. Year 2. Alexander Leung. Supervisee Position: Medical Student, Supervisee Institution: University of Toronto. *The Effect of Advance Directives on the Care of Homeless Persons*. Collaborator(s): John Song (University of Minneapolis).
2012 Jul - 2012 Sep	**Primary Supervisor**. Year 2. Kenneth Lam. Supervisee Position: Medical Student, Supervisee Institution: Western University. *Pragmatic Cluster Randomized Trials as an Evidence Tool for Patient Safety*.
2012 Jun - 2013 Sep	**Primary Supervisor**. Year 1. Charlotte Hunter. Supervisee Position: Medical Student, Supervisee Institution: Western University. *Barriers to prescription medication adherence among homeless and vulnerably housed adults in three Canadian cities.*
2011 Oct - 2013 Dec	**Primary Supervisor**. Year 2. Samantha Young. Supervisee Position: Medical Student, Supervisee Institution: University of Toronto. *Influenza vaccination rates among homeless people with mental illness*.
2011 Aug - 2012 Dec	**Primary Supervisor**. Year 2. Alison Fine & Tony Zhang. Supervisee Position: Medical Students, Supervisee Institution: Western University. *Attitudes towards Homeless People among Medical Students and Emergency Department Staff*.
2011 Jun - 2013 Jun	**Primary Supervisor**. Year 1. Niran Argintaru. Supervisee Position: Medical Student, Supervisee Institution: Western University. *Unmet health needs among homeless and vulnerably housed adults in three Canadian cities.*
2010 Oct - 2012 Dec	**Primary Supervisor**. Year 2. Greg Gaisano & Michelle Olah. Supervisee Position: Medical Students, Supervisee Institution: University of Toronto. *The Effects of Socioeconomic Status and Chronic Health Conditions on the Ability to Find a Family Physician in Toronto.*
2010 Jun - 2011 May	**Primary Supervisor**. Year 2. Matthew Kennedy. Supervisee Institution: University of Toronto, Faculty of Medicine. *Instruments to Assess Food Security among Homeless*

	Individuals.
2010 Apr - 2012 Dec	**Primary Supervisor**. Year 2. Mike Fralick & Zane Gallinger. Supervisee Institution: University of Toronto, Faculty of Medicine. *Drowning and the Influence of Foreign-born Status*.
2009 Oct - 2011 May	**Primary Supervisor**. Year 2. Anna Holland. Supervisee Institution: St. Michael's Hospital. *Instruments to Assess Food Security among Homeless Individuals*.
2009 Jan - 2009 Dec	**Primary Supervisor**. Year 1. Anna Holland. Supervisee Institution: University of Toronto. *At Home: Research Demonstration Project on Homelessness and Mental Health*. Completed 2012.
2008 Oct - 2009 May	**Primary Supervisor**. Year 2. Mina Atia. Supervisee Institution: University of Toronto, Faculty of Medicine. *The Relationship between Apparent Age and Health Status*. Completed 2011.
2008 Apr - 2008 Aug	**Primary Supervisor**. Year 2. Joanna Ueng. Supervisee Institution: Queen's University, School of Medicine. *Unmet needs for health care among homeless people within a system of universal health insurance.*, Completed 2010.
2007 Oct - 2008 May	**Primary Supervisor**. Year 2. Eileen Estrabillo. Supervisee Institution: University of Toronto, Faculty of Medicine. *Barriers to Chronic Pain Management in Homeless People*. Completed 2009.
2006 Oct - 2007 May	**Primary Supervisor**. Year 2. Shaqil Kassam. Supervisee Institution: University of Toronto, Faculty of Medicine. *Infirmary Care for Homeless Adults*. Collaborator(s): Co-Supervisor: Alice Broughton.
2006 Oct - 2007 May	**Primary Supervisor**. Year 2. Anna MacDonald. Supervisee Institution: University of Toronto, Faculty of Medicine. *Barriers to Chronic Pain Management in Homeless People*.
2006 Apr - 2007 Aug	**Primary Supervisor**. Year 1. Ciara Whelan. Supervisee Institution: Queen's University, School of Medicine. *Access to Mobile Healthcare Services: A Comparison of Toronto and New York City*.
2005 Oct - 2006 May	**Primary Supervisor**. Year 2. Andrew Smith. Supervisee Institution: University of Toronto, Faculty of Medicine. *The Effects of Supportive Housing on the Health Status and Service Utilization of Homeless and Hard-to-House Adults*.
2005 May - 2007 May	**Primary Supervisor**. Year 2. Cheryl Leung. Supervisee Institution: University of Western Ontario, Schulich School of Medicine. *Control of Emerging Infectious Diseases in Homeless Populations*.
2004 Oct - 2007 May	**Primary Supervisor**. Year 2. Chuck Wen. Supervisee Institution: University of Toronto, Faculty of Medicine. *Perceptions of Unwelcomeness among Homeless People*. Collaborator(s): Collaborator: Pam Hudak.
2004 Oct - 2005 May	**Primary Supervisor**. Year 2. Theepa Sundaralingam. Supervisee Institution: University of Toronto, Faculty of Medicine. *Bone Mineral Density in Women using Meal Programs*.
2003 Oct - 2004 May	**Primary Supervisor**. Year 2. Emily Lai. Supervisee Institution: University of Toronto, Faculty of Medicine. *Bone Mineral Density in Women using Meal Programs*.
2003 Jan - 2005 Dec	**Primary Supervisor**. Year 2. Fiona Kouyoumdjian. Supervisee Institution: Dalhousie University Medical School. *Systematic review of interventions to improve the health of the homeless*.
2002 Oct - 2003 May	**Primary Supervisor**. Year 2. Melanie Makhija. Supervisee Institution: University of Toronto, Faculty of Medicine. *Factors affecting women's decisions regarding infertility treatment*.
2002 Oct - 2003 May	**Primary Supervisor**. Year 2. John Hanlon. Supervisee Institution: University of Toronto, Faculty of Medicine. *Risk factors for cardiovascular disease among homeless people*.
2001 May - 2001 Aug	**Primary Supervisor**. Year 1. Susan Scarrow. Supervisee Institution: University of Western Ontario, School of Medicine. *Cervical cancer and breast cancer screening among homeless women*.
2001 - 2003	**Primary Supervisor**. Year 2. Pavi Kundhal. Supervisee Institution: University of Toronto, Faculty of Medicine. *The effect of socioeconomic status on waiting time for MRI scans*.
2001 - 2002	**Primary Supervisor**. Year 2. Tony Lee. Supervisee Institution: University of Toronto, Faculty of Medicine. *Risk factors for cardiovascular disease among homeless people*.

2000 - 2003	**Primary Supervisor**. Year 2. Tanya Zakrison. Supervisee Institution: University of Toronto, Faculty of Medicine. *Homeless people's interactions with police officers and paramedics*. Collaborator(s): Collaborator: Paul Hamel.
2000 - 2002	**Primary Supervisor**. Year 2. Rohit Bose. Supervisee Institution: University of Toronto, Faculty of Medicine. *Income and spending among panhandlers*.
1999 - 2001	**Primary Supervisor**. Year 2. Sunny Wong. Supervisee Institution: University of Toronto, Faculty of Medicine. *Dyspepsia among homeless people*.
1999 - 2000	**Primary Supervisor**. Year 2. Nadia Knarr. Supervisee Institution: University of Toronto, Faculty of Medicine. *Do graphic illustrations improve patients' comprehension of medication labels?*.
1998 - 2000	**Primary Supervisor**. Year 2. Ann Bugeja. Supervisee Institution: University of Toronto, Faculty of Medicine. *Barriers to appropriate diabetes management among homeless persons in Toronto*.
1997 - 1999	**Primary Supervisor**. Year 2. Jason Gottlieb. Supervisee Institution: University of Toronto, Faculty of Medicine. *Drug access among homeless men in Toronto*.

Postgraduate MD

2020 Feb - present	**Primary Supervisor**. Core Program. Alison McFadden, MD. Supervisee Institution: University of Toronto. *The effect of a Housing First intervention on COPD management in a population of individuals with mental illness experiencing homelessness in Canada*, *Non-thesis Project*.
2019 Nov - present	**Primary Supervisor**. Core Program. Ashley Jensen, MD. Supervisee Institution: University of Toronto. *The Impact of a Housing First Intervention on Substance Use: Follow-up Analysis of the At Home/Chez Soi Randomized Controlled Trial*, *Non-thesis Project*.
2017 Nov - 2021 Jun	**Primary Supervisor**. Subspecialty. Samantha Liauw, MD. Supervisee Position: Cardiology Resident, Supervisee Institution: University of Toronto. *Outcomes of ST-Segment Elevation Myocardial Infarction in a Canadian Inner City Population*. Collaborator(s): Shuangbo Liu.
2015 Jul - 2017 Jun	**Primary Supervisor**. Core Program. Yayi Huang, MD. Supervisee Institution: University of Toronto. *Factors Affecting 90 Day Readmission to a General Medical Unit in the Homeless Population*, *Non-thesis Project*.
2011 Oct - 2014 Sep	**Primary Supervisor**. Resident in Family Medicine. Naheed Dosani, MD. Supervisee Institution: University of Toronto. *Measurement of Retention in Primary Care among Vulnerably Housed Populations: The At Home/Chez Soi Project*. Awards: First Place, St. Michael's Hospital Resident Research Day (May 2013).
2010 Nov - 2012 Dec	**Primary Supervisor**. Core Program. Shail Rawal, MD. Supervisee Institution: University of Toronto. *Is "Looking Chronically Ill" a Sign of Poor Health?*.
2008 Jul - 2009 Aug	**Primary Supervisor**. Subspecialty. Michelle Grinman, MD. Supervisee Institution: University of Toronto. *The Impact of Drug Problems on Homeless Individuals in Toronto, Ontario*. Completed 2009.
2001 - 2002	**Co-Supervisor**. Resident in Family Medicine. Jennifer Ross, MD and Karen Chien, MD. Supervisee Institution: University of Toronto, Faculty of Medicine. *Adherence and hepatotoxicity among homeless men receiving directly observed prophylactic therapy for tuberculosis*. Collaborator(s): Co-supervisor: Tomislav Svoboda.
2000 - 2001	**Co-Supervisor**. Resident in Psychiatry. Treena Wilkie, MD. Supervisee Institution: University of Toronto, Faculty of Medicine. *Differential treatment of homeless compared to non-homeless patients*. Collaborator(s): Primary Supervisor: Gordon Duval.

Postdoctoral Research Fellow (PhD)

2021 Mar - present	**Primary Supervisor**. Postdoctoral Training. Jesse Jenkinson, PhD. Supervisee Position: Postdoctoral Fellow, Supervisee Institution: St. Michael's Hospital. *Health care transitions among people experiencing homelessness*.
2020 - present	**Co-Supervisor**. Postdoctoral Training. Ambreen Sayani, MD, PhD. Supervisee Position:

Postdoctoral Fellow, Supervisee Institution: Women's College Hospital. *Improving access to lung cancer screening in the underserved & Building capacity for future cancer patient-oriented research in Canada*, *Group Supervision*. Awards: CIHR Patient-Oriented Research Award -- Transition to Leadership stream. Supervisor(s): Aisha Lofters.

2018 May - present — **Primary Supervisor**. Postdoctoral Training. James Lachaud, PhD. Supervisee Position: Postdoctoral Fellow, Supervisee Institution: St. Michael's Hospital. *The At Home Research Demonstration Project in Mental Health and Homelessness*. Awards: CIHR Fellowship - Research & Knowledge Translation on Urban Housing and Health.

2018 Sep - 2019 Jul — **Primary Supervisor**. Postdoctoral Training. David Campbell MD, PhD. Supervisee Position: Postdoctoral Fellow, Supervisee Institution: St. Michael's Hospital. *Understanding and engaging with individuals experiencing homelessness who have diabetes: A participatory research project*. Supervisor(s): Gillian Booth, Stephen Hwang, Pat O'Campo.

2018 Jan - 2022 Feb — **Primary Supervisor**. Postdoctoral Training. Cilia Mejia-Lancheros, PhD. Supervisee Position: Postdoctoral Fellow, Supervisee Institution: St. Michael's Hospital. *The "At Home" Research Demonstration Project in Mental Health and Homelessness --Toronto Site.* Supervisor(s): Stephen Hwang, Pat O'Campo, Vicky Stergiopoulos.

2017 Mar - 2018 Oct — **Primary Supervisor**. Postdoctoral Training. Naomi Thulien, NP, MN, PhD. Supervisee Position: Postdoctoral Fellow, Supervisee Institution: St. Michael's Hospital. *Tackling Social Exclusion: A Peer Support Intervention for Street-Involved and Homeless Youth.*

2014 Jul - 2015 Jun — **Co-Supervisor**. Postdoctoral Training. Daniel Poremski, PhD. Supervisee Position: ACHIEVE Postdoctoral Fellow, Supervisee Institution: St. Michael's Hospital. Supervisor(s): Vicky Stergiopoulos.

2013 Jul - 2016 Jun — **Primary Supervisor**. Postdoctoral Training. Fiona Kouyoumdjian, MD, PhD. Supervisee Position: CIHR Postdoctoral Fellow, Supervisee Institution: St. Michael's Hospital. *Mortality of people incarcerated in provincial facilities in Ontario: A 15 year retrospective cohort study.* Awards: CIHR Postdoctoral Fellowship.

2. OTHER SUPERVISION

Graduate Education

Thesis Committee Member

2021 Mar - present — **PhD**. Volletta Peters, Health Sciences. Supervisee Position: Graduate Student, Supervisee Institution: Ontario Tech University. Supervisor(s): Winnie Sun. Collaborator(s): David Rudoler.

2019 Sep - present — **Master of Medical Science**. Parisa Dastoori, Medical Science. Supervisee Position: Graduate Student, Supervisee Institution: University of Toronto. Supervisor(s): Flora Matheson. Collaborator(s): Paul Kurdyak, Samantha Anthony.

2019 Aug - present — **PhD**. Michael Potvin, Social Work. Supervisee Position: Graduate Student, Supervisee Institution: McMaster University. Supervisor(s): Ann Fudge Schormans. Collaborator(s): Rachel Zhou.

2013 Oct - 2017 Feb — **PhD**. Naomi Thulien, NP, MN, Nursing Science. Supervisee Position: Assistant Professor, McMaster University, Supervisee Institution: University of Toronto. *Tackling Social Exclusion: A Peer Support Intervention for Street-Involved and Homeless Youth*. Supervisor(s): Denise Gastaldo. Collaborator(s): Elizabeth McCay. Completed 2017.

2012 Jun - 2015 Jun — **PhD**. Carrie Marshall, Rehabilitation Therapy. Supervisee Position: Graduate Student, Supervisee Institution: Queen's University, Kingston, Ontario. *Time Use and Health and Wellbeing in the Transition From Homeless to Housed in Chronically Homeless Persons*. Supervisor(s): Rosemary Lysaght. Collaborator(s): Stephen Gaetz, Terry Krupa. Completed 2015.

2012 Apr - 2016 Sep — **SD (Doctor of Science)**. Jill Roncarati, MPH, Public Health. Supervisee Position: Graduate Student, Supervisee Institution: Harvard School of Public Health. *Sleeping Rough: Morbidity,*

mortality, and the effects of housing on the health of Boston's street population. Supervisor(s): Glorian Sorensen. Collaborator(s): Nancy Krieger, Fran Cook. Completed 2016.

2011 Oct - 2013 Aug **MSc**. Tyler Pettes, Nutritional Sciences. Supervisee Position: Psychiatry Resident, Supervisee Institution: University of Toronto. *Responsiveness of Food Provisioning Programs to the Needs of Homeless Populations in Five Canadian Cities*. Supervisor(s): Valerie Tarasuk. Collaborator(s): Stephen Gaetz, Anthony Hanley. Completed 2013.

2010 Jan - 2012 Dec **MSc Nursing**. Lisa Beames, RN, Nursing. Supervisee Position: Clinical Leader/Manager, Mental Health Services, Supervisee Institution: University of Victoria. *Homeless Clients' Perspectives on Health Care Experiences.* Supervisor(s): Bernie Pauly. Collaborator(s): Joan MacNeil. Completed 2012.

2009 Oct - 2011 Jun **MSc**. Rafael Figueiredo, Dentistry. Supervisee Position: Chief Dental Officer, Alberta Health, Supervisee Institution: University of Toronto. *Oral Health of Homeless People in Toronto*. Supervisor(s): Carlos Quinonez. Collaborator(s): David Locker. Completed 2011.

2007 May - 2012 Jun **PhD**. Aisha Lofters, MD, Health Policy, Management and Evaluation, Clinical Epidemiology. Supervisee Position: Assistant Professor, University of Toronto, Supervisee Institution: University of Toronto. *Cervical cancer screening among women who are recent immigrants: A population-based study in Ontario*. Supervisor(s): Richard Glazier. Collaborator(s): Rahim Moineddin. Completed 2012.

Thesis Examiner

2016 Feb **MSc**. Michelle Sholzberg, Health Policy, Management and Evaluation. Supervisee Institution: University of Toronto. *The Influence of Socioeconomic Status on Selection of Anticoagulation for Atrial Fibrillation: A Population-Based Study*. Supervisor(s): Andreas Laupacis. Completed 2016.

2015 Jan **PhD**. Claire Kendall, MD. Supervisee Institution: University of Ottawa. *A Population-Based Evaluation of the Delivery of Care for People Living with HIV in Ontario*. Supervisor(s): William Hogg and Douglas Manuel. Completed 2015.

2009 May **MSc**. Patricia Lee, MD. Supervisee Institution: University of Toronto. *Injury and Neighborhood Marginalization: Does it matter where you live?*. Supervisor(s): Avery Nathens. Completed 2009.

1998 Sep **MSc**. Wendy Wobeser, MD. Supervisee Institution: University of Toronto. *Risk Factors for Active TB Among Foreign Born Persons Arriving in Ontario*. Completed 1998.

Chair for Thesis Defense

2005 Sep **MSc**. Olga Gajic-Veljanoski. Supervisee Institution: University of Toronto. *Predictors of First Clinical Fracture in Patients with Primary Osteoporosis*. Completed 2005.

Collaborator

2003 Sep - 2004 Jun **PhD**. Agnieszka (Iggy) Kosny. Supervisee Institution: University of Toronto, Dept. of Public Health Sciences. *Are nonprofit organizations healthy workplaces? Examining working conditions and occupational health and safety of volunteers and paid workers*. Collaborator(s): Primary supervisor: Joan Eakin. Completed 2006.

Primary Supervisor for Research Practicum

2009 May - 2010 Apr **M.H.Sc**. James Weaver. Supervisee Position: Research Coordinator, Division of Mental Health Services and Policy Research, Department of Psychiatry, Columbia University, New York City. *Hospitalization Costs of Homeless People: Do They Cost More?*. Completed 2010.

2006 Jan - 2006 Apr **M.H.Sc**. Minnie Ho. Supervisee Position: Epidemiologist, Institute for Clinical Evaluative Sciences, Toronto (as of 2012), Supervisee Institution: University of Toronto. *Control of Emerging Infectious Diseases in Homeless Populations*. Completed 2006.

Project Advisor

2012 Sep - 2013 Jun **Master of Public Health**. Shail Rawal, MD. Supervisee Position: Clinical Associate,

Supervisee Institution: University of Toronto. *Translation Services and Outcomes among Non-English Proficient Hospitalized Patients*.

Supervisor for Research Elective

2009 Nov - 2010 Jun **Master of Public Policy**. Anna-Maria Cappella. Supervisee Position: Project Advisor & Program Coordinator, Service Ontario (as of 2012), Supervisee Institution: University of Toronto. *An Impact Analysis of Housing First Programs in the United States and Canada.*

Undergraduate MD

Secondary Supervisor

2013 Oct - 2014 Aug **Year 2**. Christopher Noel and Henry Fung. Supervisee Position: Medical Students, Supervisee Institution: University of Toronto. *Eye Needs of the Homeless Population*. Collaborator(s): Myrna Lichter.

THIS IS EXHIBIT “B” TO THE
AFFIDAVIT OF STEPHEN HWANG
AFFIRMED REMOTELY BEFORE ME AT
THE CITY OF TORONTO DURING A “ZOOM” VIDEOCONFERENCE
IN ACCORDANCE WITH O.REG. 431/20,
ADMINISTERING OATH OR DECLARATION REMOTELY
THIS 27TH DAY OF FEBRUARY, 2023



_____
SHARON CROWE

Commissioner for Taking Affidavits, etc.

Homelessness and health

Stephen W. Hwang

Abstract

HOMELESSNESS AFFECTS TENS OF THOUSANDS OF CANADIANS and has important health implications. Homeless people are at increased risk of dying prematurely and suffer from a wide range of health problems, including seizures, chronic obstructive pulmonary disease, musculoskeletal disorders, tuberculosis, and skin and foot problems. Homeless people also face significant barriers that impair their access to health care. More research is needed to identify better ways to deliver care to this population.

Homelessness, which is a focus of increasing concern in Canadian cities, has important health implications. Homeless people have high levels of morbidity and mortality and may experience significant barriers to accessing health care. This article addresses 3 key issues: first, who are the homeless? Second, what health problems are common among homeless people? Third, how does the health care system respond to the needs of the homeless?

Who are the homeless?

According to the United Nations, "absolute homelessness" describes the condition of people without physical shelter who sleep outdoors, in vehicles, abandoned buildings or other places not intended for human habitation. "Relative homelessness" describes the condition of those who have a physical shelter, but one that does not meet basic standards of health and safety; these include protection from the elements, access to safe water and sanitation, security of tenure, personal safety and affordability.[1] In this review, "homeless people" refers to people who are sleeping in shelters for the homeless and those who are "absolutely homeless."[2] This is the definition that is most frequently used in health-related research. Although homelessness is commonplace in many developing countries, this review focuses on homelessness in Canada.[1]

The capacity of shelters for the homeless is a useful starting point for estimating the size of the homeless population (Table 1). These data suggest that each night about 8000 homeless people, that is, about 5 per 10 000 population, are sleeping in shelters in the 9 largest metropolitan areas of Canada. The number of individuals who use these shelters at least once over the course of a year is about 5 times this figure.[4] In Toronto, for example, 28 800 people used such shelters in 1998.[5]

Shelter counts underestimate the number of homeless people because they do not include individuals who are sleeping on the street. Although these individuals are particularly difficult to count, they represent a sizable population in some cities. In Vancouver as many as 600 homeless people, or 3 per 10 000 population, sleep outside every night, thus exceeding the number of people staying in shelters.[6]

These figures indicate that the total number of homeless people in Canada on any given night is probably of the order of tens of thousands. In many cities, the number of people who are homeless has clearly increased in recent years. Toronto, which has the country's largest homeless population, has seen mean nightly shelter occupancy rise from 1902 individuals in 1990 to 3790 in 1998.[5,7] Between 1992 and 1998, Calgary's homeless population more than doubled from 447 to 988.[8] In Ottawa, the total number of overnight stays at men's shelters increased by about 8% between 1996 and 1998.[9]

The demographic characteristics of the homeless population vary significantly from city to city. Contrary to common stereotypes, homelessness affects a wide

Review

Synthèse

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range of people, including families with children. Families occupy 42% of shelter beds in Toronto[5] and about 35% of shelter beds in Ottawa.[9] The average shelter stay for these families lasts 1.5–2 months.[7,9] In contrast, other Canadian cities do not have significant numbers of homeless families. The phenomenon of homeless families in Toronto and Ottawa may reflect the convergence of multiple factors, including poverty, high housing costs and a shortage of subsidized public housing units.[5,9,10]

Single men constitute the largest segment of homeless people in most Canadian cities: about 70% of the homeless population in Vancouver,[11] Edmonton[12] and Calgary,[8] and about 50% in Ottawa.[9] In Toronto, single men occupy 35% of shelter beds.[7] Although most single men stay in the shelter system for only a few nights, single men also account for 75% of chronically homeless individuals (those who stay in shelters for 1 year or more).[7] Homeless men tend to be relatively young, with the majority between 25 and 44 years old.[8,9,13]

Single women account for about one-quarter of homeless people in Vancouver,[11] Edmonton[12] and Toronto,[14] but as few as 10% of homeless people in cities such as Calgary[8] and Ottawa.[9] Studies in the United States suggest that a number of characteristics distinguish homeless single women from homeless women accompanied by children. Single women are more likely to be chronically homeless, older and to have a history of substance abuse or mental illness.[15]

The terms "homeless youth" and "street youth" are used interchangeably to refer to teenagers and young people below the age of 20–25 years. These young people first leave home at a mean age of 15 years, and many of them come from families where they experienced physical or sexual abuse.[16,17] Toronto, Montreal and Vancouver have the largest numbers of street youth in Canada.[17,18] Because most of these young people do not sleep in homeless shelters, shelter-based counts (Table 1) greatly underestimate the size of these populations. In Toronto, for example, about 75% of homeless youth do not use shelters.[19]

Aboriginal people are overrepresented in Canada's homeless population by a factor of about 10. Individuals of Aboriginal origin account for 35% of the homeless population in Edmonton,[12] 18% in Calgary,[8] 11% in Vancouver[11] and 5% in Toronto,[14] but only 3.8%, 1.9%, 1.7% and 0.4% of the general population of these cities respectively.[20] A disproportionate number of homeless people who sleep on the street rather than in shelters are of Aboriginal origin.[5,12]

Health problems among homeless people

Homeless people have a greatly increased risk of death. Compared with the general youth population of Quebec, mortality rates among street youth in Montreal are 9 times higher for males and 31 times higher for females.[21] Among men using shelters for the homeless in Toronto, mortality rates are 8.3 times higher than the mean for 18–24 year olds, 3.7 times higher than the mean for 25–44 year olds and 2.3 times higher than the mean for 45–64 year olds.[13] However, death rates among homeless men in Toronto are about one-half that of homeless men in US cities.[13] Mortality rates are lower in Canada because of a number of factors, including lower rates of homicide, HIV infection and, possibly, Canada's system of universal health insurance.

Homeless people suffer from a wide range of medical problems.[11,22,23] Disease severity can be remarkably high because of factors such as extreme poverty, delays in seeking care, nonadherence to therapy, cognitive impairment and the adverse health effects of homelessness itself.[22] Homeless people in their forties and fifties often develop health disabilities that are more commonly seen only in people who are decades older.[24] Individuals living on the street tend to have a worse health status than shelter residents.[25]

Medical problems that are particularly prevalent among homeless adults include seizures, chronic obstructive pulmonary disease, arthritis and other musculoskeletal disorders.[23] Conditions such as hypertension, diabetes and anemia are often inadequately controlled and may go undetected for long periods.[25,26] Respiratory tract infections are common. Oral and dental health is often poor.[27,28]

Skin and foot problems are frequently seen among the homeless. People living on the street are particularly prone to develop skin diseases such as cellulitis, impetigo, venous stasis disease, scabies and body lice.[29] Foot disorders such as onychomycosis, tinea pedis, corns and callouses, and immersion foot are usually the result of inadequate footwear, prolonged exposure to moisture, long periods of walking and standing, and repetitive minor trauma.[30,31] Proper foot care requires early detection of problems, education regarding foot hygiene and the provision of adequate shoes and socks.[30]

Table 1: Homeless shelter capacity* in metropolitan areas of Canada with a population greater than 500 000†

Metropolitan area	Population, thousands†	No. of beds			
		Adult shelters	Youth shelters	Family shelters	Total
Toronto	4586	2074	441	1650	4165
Montreal	3424	1118	44	25	1187
Vancouver	1999	339	25	51	415
Ottawa/Hull	1056	325	30	201	556
Edmonton	914	395	29	0	424
Calgary	903	798	80	0	878
Quebec City	687	125	8	15	148
Winnipeg	678	144	24	61	229
Hamilton	658	109	30	65	204
Total	14 905	5427	711	2068	8206

*Homeless shelter capacity excludes overflow, beds at detoxification centres and beds at shelters exclusively for battered women.
†Population of census metropolitan areas in 1998, as determined by Statistics Canada.[3]

Homeless people are at increased risk of contracting tuberculosis (TB), and this diagnosis should be considered in any homeless individual with a fever and a persistent productive cough.[32] Conditions favouring TB outbreaks in shelters include crowding, large transient populations and inadequate ventilation.[33] More than half of all TB cases among homeless people represent clusters of primary tuberculosis rather than reactivation of old disease.[34,35] Published data on TB in Canada's homeless population are limited. The incidence of active TB among homeless people in Toronto is 71 per 100 000 (about 10 times the average Ontario rate).[35]

Treatment of active TB in homeless people can be complicated by nonadherence to therapy, prolonged infectivity and the development of drug resistance.[36] Directly observed therapy results in higher cure rates and fewer relapses.[37,38] Homeless people with positive tuberculin skin tests without active TB may be considered for directly observed prophylaxis.[39]

Common risk factors for HIV infection in homeless youth in Canada include prostitution, multiple sexual partners, inconsistent use of condoms and injection drug use.[17,18,40] Infection rates were 2.2% and 11.3% among homeless youth seeking HIV testing at 2 clinics in Vancouver in 1988.[41] The higher rate was seen at a clinic that served street youth involved in prostitution. In contrast, the prevalence of HIV infection was only 0.6% in a convenience sample of homeless youth surveyed in Toronto in 1990.[42]

The pattern of HIV risk factors in homeless adults is distinct from that of youth. In a 1997 study of a representative sample of adults using shelters for the homeless in Toronto, 25% had a history of using injection drugs and 41% had a history of using crack cocaine.[14] These drug use behaviours, rather than sexual behaviours, were associated with an increased likelihood of HIV infection. The overall HIV infection rate in this study was 1.8%.[14]

Sexual and reproductive health is a major issue for street youth. In Montreal, 25% of homeless youth have engaged in prostitution.[18] Sexually transmitted diseases are widespread, even among street youth who do not work as prostitutes; gonorrhea and *Chlamydia* are the most prevalent infections.[17] Anecdotal reports suggest that pregnancy is common among street youth in Canada; in a recent study in the United States, 10% of homeless females aged 14–17 years were found to be pregnant.[43]

Violence is a constant threat to the health of homeless people. A survey in Toronto found that 40% of homeless individuals had been assaulted and 21% of homeless women had been raped in the previous year.[23] Homeless men are about 9 times more likely to be murdered than their counterparts in the general population.[13]

Unintentional injuries are a leading cause of morbidity and mortality, especially among homeless men.[13] Injuries are often the result of falls or being struck by a motor vehicle.[13] Deaths due to an unintentional overdose of drugs or alcohol, or both, are also common.[13] Exposure to the elements is a major hazard. In cold weather, the risk of frostbite and hypothermia is substantial,[23] and deaths due to freezing are not uncommon.[44] In hot weather, severe sunburn and heatstroke can occur.

The prevalence of mental illness and substance abuse among homeless people is difficult to determine precisely, but consistent patterns have emerged from methodologically rigorous studies conducted in the United States and Canada.[14,45] Contrary to popular misconceptions, only a small proportion of the homeless population has schizophrenia. The lifetime prevalence of schizophrenia is only 6% among Toronto's homeless population,[14] and US studies have found prevalence rates of 10%–13%.[45] Affective disorders are much more common, with lifetime prevalence rates in the range of 20%–40%.[14,45]

Alcohol use disorders are widespread, with lifetime prevalence rates of about 60% among homeless men.[45] Problems with alcohol are 6–7 times more prevalent among homeless people than in the general population.[45] Fewer data are available on the abuse of substances other than alcohol; in US studies, the median prevalence of drug use disorders is 30%.[46] Cocaine (especially crack) and marijuana are the illicit drugs that are most often used by homeless people in Canada.[11,14,47] Dual diagnosis with both mental illness and substance abuse is not uncommon in this population.[14,45,46]

Patterns of substance abuse and mental illness vary across demographic subgroups. Homeless single women are more likely to have mental illness alone, without any substance use disorder.[45] The prevalence of substance use disorders in men is about twice that in single women.[45] Compared with all other subgroups of homeless people, female heads of homeless families have far lower rates of both substance abuse and mental illness.[10]

Homelessness and the health care system

Homeless adults have high levels of health care use[48] and often obtain their care in emergency departments.[23,49] Homeless people are admitted to hospital up to 5 times more often than the general population[50] and stay in hospital longer than other low-income patients.[51] These prolonged stays in hospital result in significant excess health care costs.[51] Unfortunately, homeless patients are sometimes discharged to shelters, even when their ability to cope in such a setting is marginal at best. One solution to this problem is the development of respite facilities to provide homeless people with a protected environment for recuperation after a stay in hospital.[52]

Homeless people face many barriers that impair their access to health care.[53] Lack of health insurance is a problem for most homeless people in the United States.[53] Although Canada has a system of universal health insurance, many homeless people do not possess proof of coverage because their identification has been lost or stolen.[54] In

Toronto, 7% of homeless individuals report having been refused health care at least once because they lacked a health insurance card.[23] In addition, many homeless people do not fill prescriptions they have received because they do not have insurance benefits and cannot afford the cost of the medication.[55]

Homeless people face other barriers to health care that are unrelated to insurance status. Homelessness entails a daily struggle for the essentials of life. These competing priorities may impede homeless adults from using health care services, particularly those perceived as discretionary.[56] In addition, many health recommendations regarding rest or dietary changes may be unattainable. In Toronto, 72% of homeless people with diabetes report difficulties managing their condition that are usually related to their diet and the logistic challenges of coordinating meals with medications.[26]

The health care system often fails to provide adequate treatment for homeless people with mental illness or substance abuse.[22,57,58] The assertive community treatment (ACT) model is an effort to address this problem. An ACT team of psychiatrists, nurses and social workers follows a small caseload of homeless mentally ill clients, seeking them out in the community to provide high-intensity mental health treatment and case management.[59] Compared with usual care, patients receiving ACT have fewer psychiatric inpatient days, more days in community housing and greater improvements in their symptoms.[59,60]

Conclusion

Homelessness affects a significant number of Canadians of all ages and is associated with a high burden of illness, yet the health care system may not adequately meet the needs of homeless people. More research is needed to identify better ways to deliver care to this population. Health interventions alone, however, are unlikely to overcome the adverse effects of homelessness and related social ills. The search for long-term solutions to the problem of homelessness itself must remain a key priority.

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SHARON CROWE

Commissioner for Taking Affidavits, etc.

Handbook of Urban Health

Populations, Methods, and Practice

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Chapter 2

Homeless People

Stephen W. Hwang and James R. Dunn

1.0. INTRODUCTION

Over the last quarter century, homelessness has become one of the symbols of urban blight. Regardless of the accuracy of this perception, homelessness is indeed a serious issue in many cities. More than 800,000 Americans are homeless in a given week, and 3.5 million are homeless over the course of a year (Burt, 2001). About 2-3% of the U.S. population, or 5-8 million people, have experienced at least one night of homelessness in the past five years (Link, *et al.*, 1994). About 70% of homeless people in the U.S. live in urban areas (Burt, 2001). Within the countries of the European Union, estimates of the number of homeless people in 1997 were 580,000 in Germany, 166,000 in the United Kingdom, 30,000 to 40,000 in the Netherlands, 10,000 in Finland, 8,000 in Sweden, and 6,000 in Norway (Menke, *et al.*, 2003).

Contrary to stereotypes, a broad range of people experience homelessness, including not only single men, but also single women, runaway adolescents, and families with young children. In the U.S., these subgroups represent about 60%, 16%, 9%, and 15% of the homeless population, respectively (Burt, 2001). In the European Union, substantial numbers of homeless families with children are found only in Germany and the United Kingdom (Menke, *et al.*, 2003). Here and throughout this chapter, we define homeless people as individuals who lack a fixed, regular, and adequate night-time residence, including those who are living in emergency or transitional shelters, in motels or hotels due to lack of alternative adequate accommodations, or in private or public places not intended for human habitation (such as cars, parks, public spaces, abandoned buildings, or bus or train stations).

The health of the homeless and the role of cities in their health present an important challenge. The relationship between urban living and the health of the homeless raises two intertwined questions. First, how does the urban environment influence the creation and perpetuation of homelessness, especially among (but not limited to) individuals with pre-existing health problems such as mental illness and substance abuse? Second, how does the urban environment affect the health of people after they have become homeless? At first glance, these two questions appear almost identical in terms of the specific characteristics and attributes of the urban

environment that warrant scrutiny. For example, both questions will lead to a consideration of the availability of low-cost housing and the ability of the health care system to care for patients with severe mental illness. However, the distinction between these two questions is important as they distinguish factors associated with the likelihood of being homeless due to health reasons versus the likelihood of consequences given homelessness. At another level, it is also important to distinguish if outcomes and their associated factors vary between cities, both in terms of the structural factors that generate homelessness and (given homelessness) health of those who are homeless. These questions frame the issue of the impact of the urban environment on the health of disadvantaged populations.

In the course of such discussions, disagreement often arises as to whether homelessness should be considered primarily the consequence of individual vulnerabilities and failings, or the result of structural inequities in the social, economic, housing, and health care systems. Rather than creating an either/or distinction, we will approach homelessness as the result of a complex interaction between individual vulnerabilities and structural forces in the urban environment. In most cases, the relative importance of these factors in determining the health of homeless people and the prevalence of homelessness remains the subject of ongoing debate.

2.0. KEY HEALTH ISSUES FOR HOMELESS PEOPLE

The burden of illness and disease is extremely high among homeless people (Levy and O'Connell, 2004). However, any consideration of the common health problems of homeless people must first recognize the large degree of heterogeneity among people who are homeless. Among street youth, single men, single women, and mothers with children, the patterns of illness differ notably. Adolescents suffer from high rates of suicide attempts, sexually transmitted diseases, and pregnancy (Greene and Ringwalt, 1996; Greene and Ringwalt, 1998; Greene, *et al.*, 1999; Feldmann and Middleman, 2003). Female heads of homeless families tend to have far fewer health problems than single homeless women, although their health is poorer than their counterparts in the housed general population (Robertson and Winkleby, 1996). Homeless single men have a higher prevalence of alcohol abuse and drug abuse, whereas single women have a higher prevalence of serious mental illness (Fischer and Breakey, 1991).

Health status also tends to be correlated with a person's history of homelessness. Individuals with severe mental illness, substance abuse, and medical conditions are overrepresented among the chronically homeless, whereas those who are homeless for a transient period lasting only a few weeks or months are more likely to be relatively healthy (Kuhn and Culhane, 1998). Although chronically homeless people make up only about 10% of all individuals who experience homelessness in a given year, they account for a disproportionately large share of the demand for shelter beds and health care services for homeless people (Burt, 2001). In addition, the public's perception of homeless people often reflects a stereotyped image of this highly visible subgroup.

Cross-national comparisons of disease patterns among homeless people reveal the strong effect of social factors within each country. Among homeless men in Tokyo, Japan, morbidity due to alcohol dependence (but not drug use) is common, as are musculoskeletal injuries incurred doing construction work (Takano, *et al.*, 1999b). In contrast, 60% of homeless people in Amsterdam, the Netherlands, suffer from drug abuse or dependence (primarily heroin), and most are chronically homeless (Sleegers, 2000c).

2.1. Mental Illness and Substance Abuse

The prevalence of serious mental illness and substance abuse is high among homeless persons. In a nationwide U.S. survey of homeless people, 39% had mental health problems, 50% had an alcohol and/or drug problem, and 23% had concurrent mental health and substance use problems (Burt, 2001). Common psychiatric diagnoses among homeless people include major depression, bipolar disorder, schizophrenia, and personality disorders. A systematic review of the prevalence of schizophrenia in homeless persons found rates ranging from 4 to 16% and a weighted average of 11% in the ten methodologically strongest studies (Folsom and Jeste, 2002). Characteristics associated with a higher prevalence of schizophrenia were younger age, female sex, and chronic homelessness. Marked cross-national variation is seen in the prevalence of schizophrenia, with prevalence rates of 23-46% reported among homeless people in Sydney, Australia (Teesson, *et al.*, 2004).

The prevalence of substance abuse is extremely high among homeless single adults. In a study from St. Louis, Missouri, large increases were seen in the prevalence of drug use among homeless men and women between 1980 and 2000. In 2000, 84% of men and 58% of women had an alcohol or drug use disorder (North, *et al.*, 2004). In another study, about three-quarters of homeless adults met criteria for substance abuse or dependence (O'Toole, *et al.*, 2004). Homelessness increases the risk of adverse health outcomes among substance abusers: in five Canadian cities, the risk of a non-fatal overdose was twice as high among illicit opiate users who were homeless compared to those who were housed (Fischer, *et al.*, 2004).

Homeless adolescents also have very high rates of mental health problems and substance abuse. In a study from Seattle, 83% of street youths had been physically and/or sexually victimized after leaving home, and 18% met criteria for posttraumatic stress disorder (Stewart, *et al.*, 2004). Across the U.S., 55% of street youth and 34% of shelter youth had used illicit drugs other than marijuana since leaving home, in comparison to 13% of youth who had never been runaway or homeless (Greene, *et al.*, 1997). Street youth use a wide range of drugs, including hallucinogens, amphetamines, sedative/tranquilizers, inhalants, cocaine, and opiates. Unfortunately, the initiation of injection drug use is quite common, with an incidence rate of 8.2 per 100 person-years among street youth in Montreal (Roy, *et al.*, 2003).

2.2. Infectious Diseases

Infectious diseases are a common cause of health problems in homeless people (Raoult, *et al.*, 2001). The most serious of these infections include tuberculosis (TB), human immunodeficiency virus (HIV) infection, viral hepatitis, and other sexually transmitted infections. Outbreaks of TB among homeless people have been reported frequently, especially in individuals co-infected with HIV (Barnes, *et al.*, 1999; McElroy, *et al.*, 2003; Morrow, *et al.*, 2003). The incidence of active TB in a cohort of homeless people in San Francisco between 1992 to 1996 was 270 per 100,000, or 40 times higher than that seen in the U.S. general population in 1998 (Moss, *et al.*, 2000). Homeless people with TB require more hospital-based care than non-homeless people with TB, resulting in average hospital costs that are higher by $2,000 per patient. (Marks, *et al.*, 2000) Contact tracing in the homeless population is difficult, and in one study only 44% of identified contacts completed treatment for latent TB infection (Yun, *et al.*, 2003). Among street youth, latent tuberculosis is more common than in the general population, but probably

less prevalent than among homeless adults. In a study conducted in Sydney, Australia, 9% of homeless young people aged 12-25 years had latent TB infection (Kang, *et al.*, 2000).

Homeless people are at increased risk of HIV infection. Data from an older U.S. survey conducted from 1989 to 1992 in 14 cities found median HIV seroprevalence rates of 4.0% in adult men, 1.8% in adult women, and 2.3% in youths (Allen, *et al.*, 1994). In more recent studies, HIV seroprevalence was 10.5% among homeless and marginally housed adults in San Francisco in 1996, a rate five times higher than in San Francisco generally (Robertson, *et al.*, 2004). HIV infection was present in 1.8% of homeless veterans admitted to residential programs from 1995-2000 (Cheung, *et al.*, 2002). Female street youth and young homeless women who are involved in prostitution are at increased risk of HIV infection, due to both injection drug use and risky sexual behaviors (Weber, *et al.*, 2002). In one study of homeless adolescents, the HIV infection rate was alarmingly high at 16% (Beech, *et al.*, 2003). Among substance users, homelessness is associated with higher rates of HIV seroprevalence (Surratt and Inciardi, 2004; Smereck and Hockman, 1998). Among HIV-infected persons, those who are unstably housed (homeless or temporarily staying with friends or family) are less likely to receive adequate health care than those who are stably housed (Smith, *et al.*, 2000).

Homeless people are at increased risk of viral hepatitis, primarily due to high rates of injection drug use. Infection with hepatitis C was found in 22% of homeless men in Los Angeles (Nyamathi, *et al.*, 2002), 32% of individuals using a mobile medical van in New York City (Rosenblum, *et al.*, 2001), and 27% of homeless persons in Oxford, England (Sherriff and Mayon-White, 2003). In a Veterans Affairs population, the prevalence of anti-hepatitis C virus antibody was 41.7% and the prevalence of hepatitis B surface antigen was 1.2% (Cheung, *et al.*, 2002). Among street youth, the prevalence of these markers of infection was also high: 12.6% and 1.6%, respectively, in Montreal (Roy, *et al.*, 1999; 2001) and 5.0% and 3.6%, respectively, in a northwestern U.S. city (Noell, *et al.*, 2001b).

Sexually transmitted diseases (STDs) are a particularly serious problem among street youth. In a longitudinal study of homeless adolescents, the annual incidence of *Chlamydia trachomatis* infection was 12.1% in females and 7.4% in males; the annual incidence of herpes simplex virus type 2 was 25.4% in females and 11.7% in males. (Noell, *et al.*, 2001) A study of street youth and sex workers in Quebec City, Canada found that 13% of women less than 20 years old were infected with *Chlamydia trachomatis* and 1.7% had *Neisseria gonorrhoeae* (Poulin, *et al.*, 2001). Newer urine-based screening tests make it easier to screen homeless youth for STDs in outreach settings (Van Leeuwen, *et al.*, 2002).

2.3. Chronic Diseases

Common chronic diseases, including hypertension, diabetes, chronic obstructive pulmonary disease (COPD), seizures, and musculoskeletal disorders, are often undiagnosed or inadequately treated in homeless adults. Relatively little research has focused on these medical conditions in the homeless population. The prevalence of hypertension was higher among homeless clinic patients than among non-homeless patients at an inner-city primary care clinic (65% vs. 52%) (Szerlip and Szerlip, 2002). The prevalence of diabetes is similar in homeless and non-homeless individuals, but homeless people with diabetes face a number of serious barriers to appropriate disease management, including lack of access to a suitable diet and dif-

ficulties coordinating medication administration with meal times (Hwang and Bugeja, 2000b). Glycemic control was found to be inadequate in 44% of homeless diabetics in Toronto (Hwang and Bugeja, 2000b).

Smoking rates are extremely high (about 70%) among homeless people (Connor, *et al.*, 2002). As a result, COPD is a common health problem among older adults. In a study of shelter residents in San Francisco, the prevalence of COPD based on spirometry was 15%, or more than twice the prevalence in the general population (Snyder and Eisner, 2004). Smoking also contributes to the high risk of cancer, especially among homeless single men. In a study from Scotland that adjusted for age and socioeconomic deprivation, the incidence of cancer of the oral cavity and pharynx, larynx, esophagus, and lung in homeless men was 139%, 87%, 61%, and 23% higher than expected, respectively (Lamont, *et al.*, 1997). Homeless people are also less likely to receive recommended cancer screening than the general population: among homeless women age 40 and over in Los Angeles County, only 55% had undergone a Pap smear and only 32% had undergone a mammogram within the last year (Chau, *et al.*, 2002). Thus, interventions such as smoking cessation treatment and routine preventive health services may provide significant benefit.

Although it is not surprising that homeless people with mental illness often receive inadequate care for medical comorbidities, the adequacy of care differs according to type of mental illness. Homeless people with schizophrenia receive less detailed physical examinations, fewer primary care visits, and less preventive health services than homeless people with major depression (Folsom, *et al.*, 2002). While it is unknown if these differences are due to patient factors, provider factors, or both, careful attention clearly needs to be paid to the physical health needs of homeless people with psychoses.

2.4. Trauma and Injuries

Trauma and injuries are significant hazards associated with life on the street (Staats, *et al.*, 2002). In a sample of homeless and marginally housed people in San Francisco, 32% of the women and 27% of the men had been sexually or physically assaulted in the last year (Kushel, *et al.*, 2003). Among women, being homeless (compared to being marginally housed) was associated with a more than 3-fold increase in the risk of sexual assault. In Sydney, Australia, 58% of shelter residents reported experiencing a serious physical assault in their lifetime, and half of the women reported having been raped (Buhrich, *et al.*, 2000). Among homeless youth in Los Angeles, reported exposure to violence was found to be equally high among males and females (Kipke, *et al.*, 1997).

2.5. Other Health Conditions

Foot problems are very common among homeless adults due to prolonged standing, long-term exposure to cold and damp, ill-fitting footwear, and inadequate foot hygiene. Problems can range in severity from mild blisters and fungal infections to debilitating chronic venous stasis ulcers, cellulitis, diabetic foot infections, and frostbite. Other common skin problems include sunburn and bites due to infestations by head lice, body lice, scabies, or bedbugs (Stratigos and Katsambas, 2003). The prevalence of serious dermatologic conditions, while probably quite high among street-dwellers, appears to be relatively low among homeless people

living in shelters that provide adequate clothing, laundry facilities, bathing facilities, and medical care. In a study of men staying at such a shelter in Boston, the majority of individuals had relatively normal findings on skin examinations (Stratigos, *et al.*, 1999).

Dental problems are an extremely prevalent and troubling but often-neglected problem for many homeless people. Common conditions include advanced caries, periodontal disease, and ill-fitting or missing dentures. These problems may be related to poverty, lack of access to dental care, and substance use, rather than homelessness *per se*. In a study comparing homeless and domiciled veterans in Veterans Affairs rehabilitation programs for substance abusers, the two groups had similarly poor oral health (Gibson, *et al.*, 2003).

2.6. Mortality

Given the high prevalence of illness among homeless people and the adverse health effects of homelessness itself, it is not surprising that homeless people have very high mortality rates. Men using homeless shelters are 2 to 8 times more likely to die than age-matched men in the general population (Barrow, *et al.*, 1999; Hwang, 2000a). Homeless women 18-44 years of age have mortality rates that are 5 to 31 times higher than in the general population (Cheung and Hwang, 2004). Common causes of death among homeless people under the age of 45 are unintentional injuries, drug overdoses, AIDS, suicide, and homicide (Hwang, *et al.*, 1997; 2000a). In a longitudinal cohort study of street youth in Montreal, the standardized mortality ratio was 11.4; HIV infection, daily alcohol use in the last month, homelessness in the last 6 months, drug injection in the last 6 months, and male sex were independent predictors of mortality (Roy, *et al.*, 2004).

2.7. Pregnancy

Among homeless women, major barriers to contraception include cost, fear of side effects or potential health risks, and the partner's dislike of contraception (Gelberg, *et al.*, 2002). Pregnancy is particularly common among homeless adolescents. In a U.S. survey of runaway females age 14-17 years, 12% of street-dwelling youths and 10% of those residing in shelters were currently pregnant (Greene and Ringwalt, 1998). In a group of pregnant homeless women, the risk of low birth weight (less than 2,500 gm) was 17%, compared to the national average of 6% (Stein, *et al.*, 2000). Lack of prenatal care and severity of homelessness (homelessness in the first trimester of pregnancy, number of times homeless, and percentage of life spent homeless) were independent risk factors for low birth weight.

2.8. Children in Homeless Families

The health of children in homeless families has been the focus of relatively little research. Some but not all studies of these children have found an increased prevalence of behavioral and mental health problems compared to children in housed low-income families (Bassuk, *et al.*, 1997; Vostanis, *et al.*, 1998). Infectious diseases are a significant concern in these children (Ligon, 2000). Up to 40% of children in homeless families in New York City suffer from asthma, a rate six times higher than the national rate in children (McLean, *et al.*, 2004c).

3.0. DIMENSIONS OF THE URBAN ENVIRONMENT THAT AFFECT THE PREVALENCE OF HOMELESSNESS AND THE HEALTH OF HOMELESS PEOPLE

The medical literature has usually examined health problems from the perspective of the individual homeless person, and has given relatively little attention to the urban environment within which these health problems arise and must be ameliorated. This section addresses this gap by highlighting dimensions of the urban environment that affect, through interaction with individual vulnerabilities, the prevalence of homelessness and/or the health of homeless people. The following is not intended to be a comprehensive listing, but rather a selection of important determinants about which at least some information is available. These determinants have been grouped into categories encompassing the demographic and physical characteristics of urban centers (population and climate), their socioeconomic and service-delivery structures (income and poverty, social welfare systems, and health care systems), and their spatial and political organization (urban geography and urban governance). Although these dimensions may have differential effects on the health of various subgroups of homeless people (e.g., youths, single adults, and families), these differences are not discussed in depth here.

3.1. Population Size and Migration

Homelessness is a problem in cities across the U.S., as demonstrated by the fact that federally-funded Health Care for the Homeless Programs exist in 161 cities in all 50 states, the District of Columbia, and Puerto Rico (Health Care for the Homeless Information Resource Center). There is limited information on the relationship between population size and prevalence of homelessness in different urban centers. One reason for this paucity of data is the logistical difficulty of conducting an accurate count of homeless persons, particularly those living on the street. Another reason is that point-prevalence counts of the homeless population cannot be used to determine how many individuals are homeless in a city over an entire year, especially given seasonal fluctuations in the homeless population and the fact that homelessness is a transient state.

Counts of shelter users are particularly informative when all shelters contribute to a common administrative database, because this makes it possible to determine the total number of individuals who use shelters in a particular city over the course of a year, rather than simply the number of shelter users at a single point in time (Metraux, *et al.*, 2001). In 1992, an estimated 1.0% of the 1.5 million residents of Philadelphia and 1.2% of the 7.2 million inhabitants of New York City stayed at a homeless shelter at least once (Culhane, *et al.*, 1994). In Toronto, Canada, 1.3% of the city's total population of 2.5 million used a homeless shelter during 2002. These figures are remarkably similar and strikingly high. Thus, homelessness is quite common in large urban centers, although for many individuals the duration of homelessness is quite brief. In a U.S. survey of homeless people, 28% had been homeless for only 3 months or less, 26% had been homeless for 4-12 months, and 46% had been homeless for more than one year (Burt, 2001).

Cross-sectional counts of the number of shelter residents provide an important but somewhat less accurate picture of the homeless population. The maximum size of a city's shelter population is obviously determined by the number of available shelter beds. In a city with few shelters, this can create the illusion of a smaller

homeless population than is actually the case. In addition, shelter beds may be less widely available in cities that do not experience severe cold weather in the winter. In the nine largest metropolitan areas in Canada, the number of shelter beds per capita ranges more than four-fold, from 21 to 97 per 100,000 population (Hwang, 2001). The number of shelter beds per capita is not significantly correlated with population size. Interestingly, the lowest number of shelter beds per capita in Canada was observed in Vancouver, a city with a very mild climate, and the highest figure was seen in Calgary, a city with extremely cold winters. Overall, this evidence suggests that episodes of homelessness are quite common among residents of major urban centers, but there is significant variation in the prevalence of homelessness across cities that does not necessarily correlate with population size.

A related question is the role of migration in determining the size of the homeless population in urban centers. Whereas some homeless people are migrants who were homeless before or upon their arrival in the city, others are local residents who have become homeless. In a nationwide U.S. survey, 56% of homeless people reported living in the same city where they became homeless (Burt, 2001). Among the 44% of individuals who had moved from one location to another during their current episode of homelessness, the most common pattern was a net flux from urban fringes and medium-sized cities into large central cities. The most commonly cited reasons for these moves were lack of available jobs, lack of affordable housing, and eviction (Burt, 2001).

3.2. Climate

Climate is an interesting example of a characteristic of the urban environment that affects both the prevalence of homelessness and the health of homeless people. Certain cities in warm regions may become a preferred destination for people who are homeless or at high risk for homelessness. As noted above, in cities with warmer climates, a larger proportion of the homeless population is likely to be found on the street rather than in shelters. People living on the street are more likely to be disengaged from the health care and social service systems, and typically these individuals have poorer health than shelter-dwelling homeless people (Cousineau, 1997). In colder climates, exposure to the elements has an obvious adverse impact on the health of homeless people, who face serious risks from trench foot, frostbite, and injury or death from hypothermia (Tanaka and Tokudome, 1991). Conversely, in hot weather, homeless people may experience severe sunburn, heat exhaustion, or heat stroke.

3.3. Income and Housing

The prevalence of severe poverty among the residents of an urban area is certainly an important factor affecting the prevalence of homelessness. Poverty alone, however, does not necessarily lead to homelessness. Data from nine U.S. cities demonstrate wide variation in the proportion of a city's poor residents that stays at a homeless shelter over the course of one year, ranging from a low of 1.3% to a high of 10.2% (Metraux, *et al.*, 2001). Some have argued, based on historical data, that an increase in the number of unmarried men with very low income is a particularly important explanatory factor for adult homelessness (Jencks, 1994). During the latter half of the twentieth century, the earning potential of men with limited education was greatly diminished by the decline of manufacturing jobs in urban centers (Wilson, 1987; 1996). At the same time, the availability of open-market sources of

low-cost housing such as single-room occupancy hotels and rooming houses shrank steadily due to gentrification and urban renewal (Hasson and Ley, 1994). In this setting, the level of government support for subsidized rental housing plays a key role in determining the availability of units that a low-income individual or family can afford; the 1980's saw a decline in this support in both the U.S. and the United Kingdom (Cohen, 1994).

Some have suggested that income distribution, specifically the ratio of middle-income to low-income households within a given city, is an important determinant of homelessness among both single adults and families (O'Flaherty, 1996). O'Flaherty argues that because the construction of new rental housing for low-income individuals is economically unattractive, the main source of housing for poor people is deteriorating housing stock that has been vacated by middle-income people. O'Flaherty theorized that cities with fewer middle-class people relative to the number of poor people have higher rents at the bottom of the market (because middle-income housing is not being "handed down" to the poor), resulting in higher rates of homelessness.

Members of ethnic and racial minorities are disproportionately represented in the homeless population (e.g., blacks and latinos in the U.S., and Aboriginal people in Canada) (Burt, 2001; Hwang, 2001). The higher prevalence of poverty in these disadvantaged groups may explain this observation. However, other race-related factors in the urban environment may contribute to the excess risk of homelessness among people of color, including discrimination in the housing market and segregation of low-income minorities in neighborhoods with fewer economic opportunities than neighborhoods in which low-income whites reside.

Any discussion of the role that urban poverty plays in causing homelessness also raises questions about nature of the causal relationship between homelessness and poor health. Poverty is consistently and strongly associated with poor health (Marmot, *et al.*, 1997). Thus, the poor health observed among homeless people may be explained in large part by the fact that they experience extreme poverty and deprivation, rather than the fact that they happen to be homeless at the present time. This is particularly likely to be the case for individuals who have only recently become homeless, and less so for the chronically homeless, who have been subjected to the adverse health effects of lack of housing for a lengthy period. To extend this concept further, homelessness is a marker for severe poverty in the urban environment, and it may be this level of poverty, rather than the negative impact of homelessness itself, that has the greatest effect on population health in urban centers. This issue is discussed further in section 4 of this chapter.

3.4 Social Welfare System

Social welfare systems in urban centers have a major impact on both the prevalence of homelessness and the health of homeless people. However, these systems are usually governed at the state or national level, rather than at the municipal level. Wide variation is seen in the scope of social welfare programs, with more generous benefits typically seen in countries or regions that have less tolerance for high levels of income inequality and place a higher value on social cohesion (Sleegers, 2000b).

For example, eligibility criteria for welfare benefits in the U.S. vary significantly from state to state. Some states allow single men to collect welfare, whereas others exclude them. These policies would likely affect the risk of homelessness among low-income single men living in any city within a given state. In addition,

U.S. federal funds may not be used to provide Temporary Aid to Needy Families (TANF) if an adult in the family has received assistance for more than 60 months, but individual states may elect to continue providing assistance to these families using state funds (State Policy Documentation Project). In coming years, as families that are unable to become self-supporting begin reaching the 60-month federal time limits on benefits, their risk of becoming homeless may be greatly affected by the policies of the state in which they live. In contrast, most European Union countries have extensive social welfare and public housing systems that make family homelessness less common.

One area of controversy is whether the provision of cash entitlements or disability benefits has significant effects on the health of homeless people. On one hand, the health of homeless people should improve if public benefits allow them to obtain food, housing, and other essentials of life. On the other hand, increased income could be detrimental to health if the money is used to purchase alcohol or drugs. One of the few studies on this issue examined 173 homeless mentally ill veterans who applied for Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI). The 50 individuals who were eventually awarded benefits did not differ in their past history of substance use from the 123 individuals who were eventually denied benefits. Three months after the decision to award or deny benefits, the group that was awarded benefits had significantly higher average total income (by $277 per month) and higher quality of life than the group that was denied benefits. There was no evidence of increased alcohol or drug use or deterioration in psychiatric status among those who received benefits (Rosenheck, *et al.*, 2000).

Most homeless people depend on their city's shelter system for housing, food, and other social services, and these shelters can therefore have a significant impact on the health of homeless people. The availability and quality of homeless shelters vary greatly. As noted previously, homeless people in cities with few shelter beds are more likely to live on the street or other places not intended for human habitation, with potentially adverse health effects. In addition, the staff at homeless shelters can play an important role in connecting homeless people to social services, job training, housing applications, and substance abuse treatment. The quantity and quality of food provided at shelters determines to a large extent the nutritional value of homeless people's diets, with potential downstream health effects (Dachner and Tarasuk, 2002). Finally, the physical environments at shelters range from extremely crowded, poorly ventilated, and unsanitary facilities to modern, clean, and well-run establishments. Adverse shelter conditions have an impact on the transmission of tuberculosis and viral respiratory infections and the prevalence of health conditions such as skin infestations and asthma exacerbations. Shelter conditions could also plausibly have an effect on mental and emotional well-being among residents. To date, however, little research has examined the effects of the physical shelter environment on the health of homeless persons, with the exception of the relationship between crowding and poor ventilation in shelters and the transmission of tuberculosis (Advisory Council for the Elimination of Tuberculosis, 1992b).

3.5. Health Care System

The organization and financing of the urban health care system has an enormous impact on the health of homeless people, and to some extent on the prevalence of homelessness as well. In the U.S., 55% of homeless people lack health insurance,

creating a significant barrier to obtaining care (Kushel, *et al.*, 2001). These individuals are dependent on state- or city-based systems designed to provide care for the indigent. In many large urban centers in the U.S., a designated public, county, or charity hospital provides the majority of hospital-based health care for homeless people. Some cities have free-care clinics or community health centers that provide ambulatory services for homeless persons as well as other low-income residents. In 161 U.S. cities, federally-funded Health Care for the Homeless Programs have established multidisciplinary teams of physicians, nurses, social workers, and outreach workers that provide care to homeless people on the street and in shelters. This limited set of health care providers is typically the only source of care available to homeless people in urban areas in the U.S., and the local funding and staffing level of these organizations is a critical determinant of access to health care. For homeless veterans, the proximity and availability of Veterans Health Administration services is also an important factor.

In countries such as Canada and the United Kingdom that have systems of universal health insurance, homeless people still face non-financial barriers to care. Many access problems stem from the fact that a health care system designed to meet the needs of the general population may not accommodate the unique requirements of homeless people (Crane and Warnes, 2001; Hwang and Bugeja, 2000a, 2000b). For example, the provision of universal health insurance does not necessarily result in the establishment of outreach programs for homeless people, appropriate treatment programs for homeless persons with mental illness or substance abuse, or an adequate supply of health care providers who are willing, able, and trained to work with this challenging population (Buchanan, *et al.*, 2004). In the United Kingdom, individuals must register with a general practitioner to obtain primary care, and some physicians are reluctant to accept homeless people into their practice because of their complex needs and the extra workload entailed (Wood, *et al.*, 1997). Health insurance does not protect against the fragmentation and discontinuity of care that homeless people often experience, nor does it eliminate the daily struggle to meet basic survival needs that may cause homeless people to place a lower priority on seeking health care (Gelberg, *et al.*, 1997).

Inadequate access to primary health care may result in uncontrolled disease progression and frequent emergency department visits and hospitalizations (Han and Wells, 2003). Emergency department visits by homeless people should be seen as an indicator of high levels of unmet health needs, rather than inappropriate health care utilization (Kushel, *et al.*, 2002). About 50% of homeless children with severe persistent asthma have had at least one emergency department visit in the last year, a finding indicative of inadequate access to health care and undertreatment of their disease (McLean, *et al.*, 2004).

Because individuals with severe mental illness who do not receive appropriate health care are at high risk of becoming homeless, the health care system can have a direct impact on the prevalence of homelessness. The role of deinstitutionalization in contributing to the problem of homelessness has been discussed extensively. Beginning in the 1960's and 1970's, the advent of effective anti-psychotic medications to treat schizophrenia and an understandable desire to move people out of chronic mental hospitals, where conditions were sometimes horrendous, led to the discharge of tens of thousands of long-term psychiatric patients (Dear and Wolch, 1987; Jencks, 1994). The number of beds at psychiatric institutions fell precipitously. In theory, these patients were supposed to receive mental health care and social support in the community. In reality, many of these patients received little if

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any services and ended up swelling the ranks of the homeless population in the 1970's and 1980's.

Today, many decades after these events took place, "deinstitutionalization" is no longer the major cause of homelessness among people with serious mental illness. It is now uncommon for people with psychiatric disorders to have ever been institutionalized for an extended period, and any admissions tend to be quite brief. Not surprisingly, individuals with severe illness, few social supports, and/or inadequate access to appropriate outpatient psychiatric care often become homeless. In a sense, homeless shelters have assumed the role that was played by chronic psychiatric hospitals fifty years ago.

For these homeless people with severe mental illness, the delivery of appropriate health care is challenging but essential to improving their health and housing status. The Assertive Community Treatment (ACT) model attempts to address this problem through a team of psychiatrists, nurses, and social workers who follow a small caseload of homeless mentally ill clients, seeking them out in the community to provide high-intensity mental health treatment and case management. Studies have found that mentally ill homeless people receiving ACT spend fewer days hospitalized as a psychiatric inpatient and have somewhat greater improvement in symptoms than those receiving usual care (Lehman, *et al.*, 1997). However, ACT is labor-intensive and costly, and its availability is often quite limited.

The availability and type of addictive substances in the urban environment have an important effect on the prevalence of homelessness and on the health of homeless people (Munoz, *et al.*, 1998). The advent of crack cocaine has been clearly implicated in the rise of homelessness in the U.S. in the 1980's (Jencks, 1994). In Japan, alcoholism is the predominant addiction contributing to homelessness and morbidity among homeless people, whereas in the Netherlands, homelessness is closely linked to chronic heroin addiction (Takano, *et al.*, 1999a; Sleegers, 2000a).

Access to addiction treatment is therefore a vital issue for a large proportion of homeless people. A number of treatment modalities for adults have been shown to be effective in controlled studies: admission to a post-detoxification stabilization program results in longer periods of abstinence than direct release into the shelter system (Kertesz, *et al.*, 2003), and abstinence-contingent work therapy in a long-term residential setting has been shown to improve outcomes (Milby, *et al.*, 2000). Studies have examined the effectiveness of case management for homeless people with addictions, with mixed results (Morse, 1999).

3.6. Urban Geography

The forces underlying the urban geography of homelessness are aptly described in the seminal work of Dear and Wolch (Dear, *et al.*, 1987). They examined how deinstitutionalization, rollbacks in entitlements to social assistance, and changes in the global economy in the late 1970s and early 1980s combined to create complex problems of poverty, inequality, and homelessness in North American cities that persist to this day. Dear and Wolch (1987) argued that these problems manifested themselves in the specific urban form of the "service-dependent ghetto," which refers to the spatial concentration in the inner city of service-dependent populations (such as people with mental illness, physical handicaps, addictions, or recent incarceration) and the organizations that assist them. While on one hand these can be characterized as areas of "urban blight," Dear and Wolch (1987) argued that they serve as a supportive environment and adaptive coping mechanism that can have a positive

effect on the health and well-being of residents who have few other options. Service-dependent ghettos are often the object of antagonism from surrounding communities. Paradoxically, however, these more affluent communities often perpetuate the forces that create the service-dependent ghetto and entrench processes of inner-city decay through citizen resistance to housing and services for low-income people and exclusionary land use policies and zoning practices (Dear and Taylor, 1982).

In some cities, the tendency has been to isolate high-poverty urban neighborhoods rather than attempt to destroy them. Davis argues that in Los Angeles and other cities, a conscious effort has been made to create geographic and physical barriers (such as expressways) that circumscribe poor and minority neighborhoods and cut them off from the rest of the city (Davis, 1990). This spatial isolation can further heighten the marginalization of these communities and limit residents' access to goods, services, and economic opportunities that are vital to health.

Since homeless people spend a great deal of their time in public spaces, the nature of these spaces can have a significant impact on their quality of life. Some cities have numerous well-tended public spaces such as parks and squares that are conducive to those who wish to linger or rest, including homeless people. These spaces can serve a socially cohesive function if urban dwellers of diverse backgrounds perceive them to be safe "neutral" spaces in which to gather and socialize. In contrast, other cities have built environments that lack such public spaces and are instead dominated by privatized quasi-public spaces such as shopping malls. Non-purposeful lingering, which would be generally acceptable in a public space such as a park, is perceived as "loitering" in such places. In a relatively trivial but very specific expression of hostility toward homeless people, some cities have installed "bum-proof" benches that are designed to prevent reclining or sleeping on the seat. While these elements of the urban environment seem relatively minor, they may reflect a city's prevailing sentiment towards homeless and poor people that sets the tone of their daily existence (Davis, 1990).

3.7. Urban Governance

Homelessness is often perceived as having a negative effect on the quality of life in urban centers. Some consider the visible presence of homeless people in parks, street corners, and other public spaces to be a manifestation of "urban disorder" and a barrier to the successful promotion of commerce and tourism. In response to these concerns, a number of cities have enacted by-laws against panhandling, loitering or sleeping in public places, public intoxication, or possession of shopping carts. Some cities have instituted aggressive policing strategies to remove homeless people from public spaces (Graser, 2000). Efforts to displace street youth and homeless people rather than offer them any meaningful help might have negative effects on health and in fact increase high-risk behaviors such as survival sex and unsafe injection drug use practices (O'Grady and Greene, 2003; Wood, *et al.*, 2004).

Homeless people frequently interact with both police and paramedics, but they have much lower levels of trust in police than in paramedics (Zakrison, *et al.*, 2004). By inhibiting homeless people from calling for needed emergency assistance, this distrust could result in serious harms to health. In a study of injection drug users in San Francisco, 56% of those who had been present with an unconscious heroin overdose victim did not call for emergency services due to fear of police involvement (Davidson, *et al.*, 2002). Police action can also have direct adverse effects on the health through the excessive use of force (Cooper, *et al.*, 2004). In a study in

Toronto, 9% of homeless people reported having been assaulted by a police officer in the last 12 months (Zakrison, *et al.*, 2004).

On a larger scale, issues of urban governance such as fiscal disparities affect all urban dwellers, but have the potential to have a particularly severe impact on homeless and poor people. Fiscal disparities typically occur when an older central city with a significant number of high-poverty neighborhoods is surrounded by a ring of higher-income municipalities. The central city's primary revenue stream from property taxes is limited by a weak tax base, but at the same time the city is confronted by a high and rising demand for social services, some of which is driven by the downloading of 'unfunded mandates' by states onto central city municipalities (Drier, *et al.*, 2001). Meanwhile, the nearby ring communities have a strong property tax base and face a lower demand for social services, while at the same time its residents work in the central city and benefit from its economic activities and services (the so-called "free-rider" effect) (Orfield, 1998; Drier, *et al.*, 2001). These fiscal disparities greatly exacerbate the adverse effects of racial and economic segregation on homeless people and others living in extreme poverty in the central city.

In an example of an effort to redress this problem, state legislation in Minnesota, the Fiscal Disparities Act, mandates the sharing of commercial property tax between outlying, high tax base municipalities to central city municipalities to assist in the provision of social services. Enacted in 1971 by the Minnesota legislature, the plan pools 40% of the increase in all communities' commercial/industrial property valuation. All cities and townships keep their pre-1971 tax bases plus 60% of the annual growth. The pool is then taxed at a uniform rate and redistributed among all local government entities. Although this redresses some of the intra-metropolitan disparities, it does little to reduce the payoffs of "externalizing" social problems with tools like exclusionary zoning in typically more affluent communities. Moreover, the Minneapolis-St. Paul example depends on the existence of a strong regional-metropolitan level of governance, the Met Council, which although heavily studied (Orfield, 1998; Rusk, 1999; Katz and Bradley, 1999), is still a concept that is strongly resisted by homeowners' associations, gated communities, and affluent municipalities (McKenzie, 1994; Boudreau and Keil, 2001). An alternative solution is to create cities that encompass lower and higher income areas, rather allowing them to separate into different jurisdictions. In Toronto, Ontario, this was effectively accomplished through the amalgamation of five contiguous cities into a single urban entity, although the amalgamation was motivated by a desire to increase operating efficiency rather than concern regarding fiscal disparities (Boudreau, 2000).

4.0. THE EFFECTS OF HOMELESSNESS ON POPULATION HEALTH

Does homelessness have a sizeable effect on population health? This question raises a number of complex issues. Homeless people, especially those who are chronically homeless, tend to have poor health. However, homelessness is a temporary state, not a permanent trait. As many as 8 millions Americans experience homelessness over a five year period, but most of these episodes of homelessness are quite brief (Link, *et al.*, 1994). Thus, at any single point in time only a very small proportion of a city's population is without a home. Homeless people would therefore be expected to have a minimal impact on indicators of overall population health, such

as health status or mortality rates. Of course, this assumption may be incorrect in urban centers in the developing world, where extremely large numbers of people often live on the street or in encampments.

Some have suggested that homelessness may have an adverse effect on public health through the spread of infectious diseases, such as tuberculosis. Compared to the general population, homeless people are clearly at increased risk of developing latent tuberculosis, which is not infectious to others, as well as active tuberculosis, which can infect those who come in close contact with the individual. During tuberculosis outbreaks, shelter residents, shelter staff, and health care providers are at increased risk of becoming infected (Advisory Council for the Elimination of Tuberculosis, 1992a). To date, however, outbreaks of tuberculosis among homeless people have not spread widely within the general population. The threat of tuberculosis is therefore an important health problem for homeless people, but one that has demonstrated relatively limited potential to affect overall population health in urban areas.

The outbreak of Severe Acute Respiratory Syndrome (SARS) in 2003 has raised the specter of rapid and uncontrolled spread of acute respiratory infections through the homeless population. The 2003 SARS outbreak in Toronto was almost entirely confined to travelers returning from abroad, health care workers, and their household contacts (Svoboda, *et al.*, 2004). No homeless person became infected with SARS. If this had happened, the large, transient, and difficult-to-locate shelter population would have made it almost impossible for Toronto public health officials to implement their core strategy of identifying and quarantining all "household contacts" of patients with SARS. Such a situation could have had devastating effects on efforts to prevent the outbreak from spreading into the city's general population. Given the threat of a recurrence of SARS or the possible emergence of other new and potentially deadly respiratory infections, infection control measures to deal with a severe acute infectious disease outbreak in the homeless population require serious consideration. Although this scenario is currently hypothetical, the potential implications for population health are considerable.

Homelessness may have major implications for population health, for reasons other than those discussed above. Emphasis on the direct impact of homelessness on population health may be misplaced. Instead, homelessness may be viewed as a sentinel event, a marker for dysfunction in multiple sectors including the housing market, job market, health care system, and social welfare system. Homelessness represents the extreme end of a larger distribution of socioeconomic status and housing status, and it attracts attention precisely because of its dire nature.

This conceptualization has been well-described in work by Rose (1985). As shown in Figure 1, the curve shown with a solid line represents the distribution of housing quality within a hypothetical population. Homelessness represents the extreme low point along the dimension of housing quality. This approach views one's housing situation as a continuum and avoids creating a simple dichotomy between being homeless and being housed. For the sake of this discussion, we assume that housing conditions have an impact on health, an assertion for which there is ample support (Fuller-Thomson, *et al.*, 2000; Krieger and Higgins, 2002). Figure 1 also illustrates two different approaches to improving health through improving housing conditions. The greatest effect in terms of population health may be gained through approach A (shifting the entire population distribution for the factor upwards slightly, to the distribution curve indicated by a dotted line) rather than approach B (focusing on improving conditions for the highest-risk

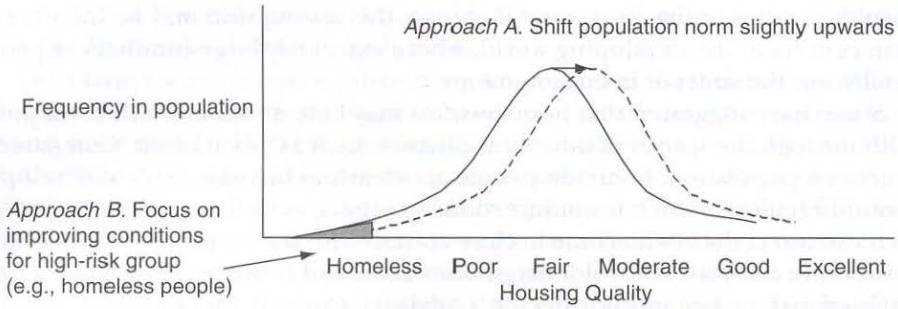


Figure 1. The Distribution of Housing Quality within a Hypothetical Population, and the Effect of Two Different Approaches to Improving Health Through Improving Housing Conditions.

group at the worst extreme of the distribution). A similar argument could be applied to the relationship between poverty and health, where the x-axis on the diagram would represent income rather than housing quality.

The case of asthma is an excellent example of this dilemma. About 40% of children staying at homeless shelters in New York City have asthma (McLean, *et al.*, 2004a). Although this is a disturbingly high rate, the prevalence of asthma is also very high among inner-city children living in substandard housing (Malveaux and Fletcher-Vincent, 1995). Because homeless children represent a relatively small proportion of all children living in poverty in a given city, the population health effect of asthma among homeless children is likely to be far smaller than the population health effect of asthma in the much larger number of children who are housed but living in decrepit buildings. While homeless children are a distressing manifestation of urban poverty, they represent "the tip of the iceberg" of the broader issue of poverty and poor housing. Thus, the problem of asthma among homeless children may be regarded as an extreme example of a much larger population health concern that may be a more appropriate target for intervention.

5.0. POTENTIAL STRATEGIES TO IMPROVE THE HEALTH OF HOMELESS PEOPLE

A consideration of strategies to improve the health of homeless people raises the question of whether our first concern should be to attempt to deal with the problem of homelessness itself, or to intervene to relieve illness among homeless youths, single adults, or families. Of course, this is not an either/or proposition. Nonetheless, an excessive emphasis on the latter approach might result in producing healthier homeless people, yet fail to recognize that homelessness is the result not only of individual vulnerabilities, but also of deeper structural problems within our society. On the other hand, a focus on the former approach may founder on the assumption that providing homeless people with stable housing will necessarily improve their health.

An example of this tension is the emergence of two contrasting service delivery models to meet the needs of chronically homeless adults with concurrent mental illness and substance abuse (Tsemberis, *et al.*, 2004; Hopper and Barrow, 2003). The

first model, known as the "Continuum of Care," attempts to move homeless people from the street into transitional congregate housing, in conjunction with a requirement that the individual engage in treatment for their mental illness and addictions. Under this model, the person is allowed to make the transition to permanent housing only after they achieve abstinence from alcohol and drugs and their clinical status has been stabilized. In contrast, the "Housing First" model is based on the belief that homeless people should be afforded permanent housing as a basic human right, not as a reward contingent on participating in treatment. In this model, homeless people can obtain housing in individual apartments without any preconditions, and they are then offered an array of harm reduction and treatment services through an ACT team (see section 3.5. above). A recent randomized controlled trial assigned 225 homeless adults with concurrent severe mental illness and substance abuse to one of these two approaches. Individuals treated under the "Housing First" model spent significantly less time homeless over the follow-up period, and at the end of 24 months about 80% were in stable housing as compared to only 30% in the "Continuum of Care" model. However, there were no significant differences between the two groups in terms of alcohol use, drug use, or psychiatric symptoms. This study highlights the need to acknowledge that ending homelessness is a worthwhile goal in and of itself, but that it is not synonymous with improving the health of homeless people.

Other strategies include adapting the health care system to better meet the unique needs of homeless adolescents, single men and women, or families. As discussed in Section 3.5 above, a cornerstone of this effort is the use of multidisciplinary teams providing coordinated care at outreach sites, in combination with more traditional clinic-based health care services. For homeless people with severe mental illness, the availability of ACT services is vital, but the effectiveness of less resource-intensive systems of mental health care for homeless people needs to be assessed. For those with addictions, the availability of detoxification beds, post-detoxification stabilization programs, and longer-term (6 to 12 month) residential addiction treatment programs are important issues. In designing these services, the heterogeneous needs of different subgroups of homeless people (e.g., street youth, single men, single women, and mothers with young children) must be taken into account.

While improving conditions at shelters is by no means the preferred route to better health for homeless people, it is important that shelters not contribute to ill health. Certainly, the availability of adequate capacity to accommodate everyone who seeks a shelter bed is a reasonable first step towards protecting homeless adults from the elements. Adherence to basic standards of cleanliness, nutrition, and food hygiene within shelters and the avoidance of overcrowding and inadequate ventilation are mandatory. Perhaps equally important is the creation of a safe and welcoming environment that encourages clients to engage with service providers.

At a broader level, interventions are needed to decrease the prevalence of homelessness and address the systemic issues that contribute to homelessness. These efforts may at least in some cases have health benefits as well. For homeless families, there is compelling evidence that the provision of subsidized housing is both necessary and sufficient to end their homelessness (Shinn, *et al.*, 1998). The "Housing First" strategy appears to be more effective in moving homeless people with concurrent mental illness and substance abuse into stable housing; further research is needed to examine the effectiveness of this approach with other subgroups of homeless people.

Serious attention needs to be paid to the impact of the social welfare system on homelessness and health. Restrictions in eligibility for Temporary Aid for Needy Families and state-run welfare programs threaten to contribute to a potential rise in homelessness among families and single adults in coming years. Further research is needed in this area and on the impact of receipt of welfare or disability benefits on the health of homeless people.

Finally, upstream from the distinctive and visible issue of homelessness is the larger problem of urban poverty. The existence of entire communities and groups who are cut off from a decent education, employment opportunities, housing, and access to health care should raise extremely troubling questions for anyone who cares about the health of our urban centers. While the adverse health effects of homelessness are clearly severe, this phenomenon is only a specific and extreme example of the larger problem of the effects of poverty and inadequate housing on population health.

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TAB 104

Court File No. CV-21-00077817-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, ET AL.

Applicants

-and-

CITY OF HAMILTON

Respondent

ACKNOWLEDGMENT OF EXPERT'S DUTY

1. My name is Stephen Hwang. I live at Toronto, in the Province of Ontario.

2. I have been engaged by or on behalf of the Hamilton Community Legal Clinic to provide evidence in relation to the above-noted court proceeding.

3. I acknowledge that it is my duty to provide evidence in relation to this proceeding as follows:

   (a) to provide opinion evidence that is fair, objective and non-partisan;

   (b) to provide opinion evidence that is related only to matters that are within my area of expertise; and

   (c) to provide such additional assistance as the court may reasonably require, to determine a matter in issue.

4. I acknowledge that the duty referred to above prevails over any obligation which I may owe to any party by whom or on whose behalf I am engaged.

Date June 13, 2022

Stephen Hwang
Signature

TAB 105

COURT FILE NO. CV-21-77187

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL CHRISTINE DELOREY, GLEN GNATUK, TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD

Applicants

-AND-

CITY OF HAMILTON

Respondent

The Cross-Examination of Dr. Stephen Hwang, on an Affidavit dated February 7, 2023 taken upon affirmation in the above action this, 28th of August, 2024, conducted via videoconference hosted by the offices of Nimigan Mihailovich Reporting Inc.

APPEARANCES:

For the Applicants:

SUJIT CHOUDHRY

Haki Chambers Global

SHARON CROWE

CURTIS SELL

MICHELLE SUTHERLAND

For the City of Hamilton:

JORDAN DIACUR

JOJO JOHNSON

Gowling WLG (Canada) LLP

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WITNESS: DR. STEPHEN HWANG

Cross-Examination by MR. DIACUR 5

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NO./DESCRIPTION

1 2009, Chapter 2.1: "The Relationship 9
Between Homelessness and Health: An Overview of
the Research in Canada", Authored by C. James
Frankish, Stephen W. Hwang and Darryl Quantz.

GUIDE TO UNDERTAKINGS, ADVISEMENTS, and REFUSALS:

This should be regarded as a guide and does not necessarily constitute a complete list:

UNDERTAKINGS:

None noted.

UNDER ADVISEMENTS:

None noted.

REFUSALS:

[1] 15/24

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--- Commencing at 2:15 p.m.

DR. STEPHEN HWANG,

THE WITNESS HEREINBEFORE NAMED,

Having been duly sworn by me to testify to the truth,

testified on their oath as follows, to wit:

CROSS-EXAMINATION BY MR. DIACUR:

Q. Sir, can you tell us where you are participating from today?

A. I'm in Toronto, Ontario.

Q. Okay. And are you in your office?

A. I'm actually in my home.

Q. Okay. Well, I want to confirm that you are alone in the room and that there will be no interruptions.

A. That is correct.

Q. And you understand you are not to receive any assistance in giving your answers?

A. Yes.

Q. And I will have questions for you affidavit in this matter sworn February 27, 2023.

Do you have a copy of that available to you?

A. Yes, I do.

Q. Okay. My intention would also be to put it up on the screen. I'm going to raising several of the paragraphs that are in the affidavit. I will bring you to

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the point on the affidavit I'm asking you about before I ask you about it, but feel free to refer to either the copy you have or the copy that's on the screen.

Would you just confirm that you've been affirmed today to tell the truth?

A. Yes, I have.

Q. And, sir, what do you understand your role in this litigation?

A. I'm here to provide expert evidence based on my research and clinical expertise.

Q. And to provide opinion evidence that's fair, objective, and nonpartisan?

A. Yes.

Q. And to provide opinion evidence that is related only to matters within your expertise?

A. Yes, that's correct.

Q. Okay. So briefly before we go to your affidavit there is a document I would like to show you. I have a couple of questions for you about it. It is an article that I understand you participated in authoring and so I will put it up on the screen now and blow it up. Let me know if you can see that.

A. Yes, I can see it.

Q. And it is entitled: "Chapter 2.1". But the authors are listed as C. James Frankish, Stephen W.

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Hwang and Darryl Quantz.

That includes you?

A. Yes, it does.

Q. Okay. And was this a chapter in a larger book?

A. Yes.

Q. Okay. Well, I just wanted to clarify because I referenced it as an article. But it is, in fact, a chapter in a larger monograph?

A. Yes.

Q. And I'll understand, I will take you to it. It is at the bottom of the first page. This was published in 2009 by the University of Toronto; is that right?

A. That's correct.

Q. And the question I have for you stems from part of this chapter and it's actually at the top of page 5 which I will scroll down to.

So it's on the screen now and it's this paragraph that begins:

"There is no single pathway to homelessness[...]"

It states:

"Homelessness is the result of a complex interaction of factors at the individual level such as adverse

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childhood experiences, low educational attainment, lack of job skills, family breakdown, mental illness, and substance abuse; and at the societal level such as poverty, high housing costs, labour market conditions, decreased public benefits, and racism and discrimination[...]"

So my first question is is that an accurate representation of the pathways to homelessness?

A. Yes, I would say that it is.

Q. And it remained so and it wasn't just at that time, but at today we could say the same?

A. I would say, yes.

Q. And I understand from the wording of that "such as" that these are examples of the pathways and may not be comprehensive.

Is that fair to say?

A. Yes.

Q. But is it the idea that these are the principal pathways or the most common pathways to homelessness?

A. Yes. I would say they are among the most salient.

Q. Are there any that are newer that wouldn't

have been listed in 2009?

A. I would say not. I would say perhaps the relative importance of certain factors has increased or decreased over time, but these remain the major factors.

Q. Okay. Thank you for that.

So my intention, counsel, would be to mark that as Exhibit 1 to this examination and it is that article identified or the chapter identified as:

"The Relationship Between Homelessness and Health: An Overview of the Research in Canada."

-- EXHIBIT NO. 1: 2009, Chapter 2.1: "The Relationship Between Homelessness and Health: An Overview of the Research in Canada", Authored by C. James Frankish, Stephen W. Hwang and Darryl Quantz.

BY MR. DIACUR:

Q. So I will stop sharing that document and I will start sharing your affidavit because as I have a few questions for you about that.

Can you see this affidavit of Stephen Hwang sworn February 27, 2023?

A. Yes, I can.

Q. And so I'm going to scroll down to paragraph 5 of this document and you indicate, in your opinion:

"[...]Homelessness has major health indications[...]"

Would you agree that as a general proposition the state of being homeless itself is bad for you?

A. Yes, certainly. It results in adverse health events.

Q. And you indicate that, quote:

"[...]People who become homeless often have physical and mental health problems which worsen over the period that they become homeless."

Would you say that physical and mental health problems are/remain among the principal causes of homelessness?

A. That would really require a more nuanced explanation of what we consider to be causes of homelessness.

Q. Okay. Well, it was certainly on the list of pathways of homelessness that we just looked at.

A. Yes.

Q. Is that fair?

A. If I may just explain myself.

Q. Okay. Yes, please. That nuance is what we are here for.

A. There are individual characteristics that increase a person's likelihood of becoming homeless as prepared to others in the population. However, the prevalence of homelessness in any given community is really driven by societal-level factors such as the availability or lack thereof of affordable housing.

So as affordable housing becomes less and less available, more and more people will lose the competition for housing, so to speak; and those who have physical and mental health problems are among those who are most vulnerable to that loss, but it does not mean that health problems alone are the sole cause of their homelessness.

Q. Right. So the pathways that we were just discussing they can interact with each other. They can be more or less important but there can be more than one of them in an individual's case?

A. That's correct.

Q. Okay. And you indicate that the deterioration in health that you identified during homelessness is due to several factors. You list them.

Lack of stable housing, which we were just discussing: An adverse social environment; the narrow possibility of maintaining health promoting behaviours while homeless, including sleep; barriers to accessing

appropriate healthcare; and --

MR. CHOUDHRY: Mr. --

MR. DIACUR: -- increased exposure vis a vis violence and the elements; is that accurate?

MR. CHOUDHRY: Mr. Diacur?

MR. DIACUR: Yes.

MR. CHOUDHRY: I'm sorry, sir. I think you were recording or reading from part of the affidavit which is not on the screen.

MR. DIACUR: Yes. No, I am more just summarizing what it states. I just wanted to confirm with him --

MR. CHOUDHRY: Sure.

MR. DIACUR: -- that that is all accurate. But, yes. Fair enough, counsel. It is still part of that paragraph 5; lack of stable housing adverse social environment and so forth on the screen now.

MR. CHOUDHRY: Yes.

BY MR. DIACUR:

Q. Now, in terms of that list, lack of stable housing, et cetera, are those the factors or is there anything to be added to that list?

A. These are listed because they are the most important factors. It is certainly not intended to imply there are no other factors.

13

30 Q. Okay. And that's really what I'm getting at. So it is not a comprehensive list, it's the most important of them?

A. Yes.

31 Q. Okay. And would you say that it's the case that the things on a list, to a greater or lesser extent, affect all homeless individuals?

A. No. I would say that one would have to apply the general categories to the individual's situation.

32 Q. No, understood. That's helpful.

You also mentioned, and I will scroll down to this, a number of health conditions that can result from homelessness, and in particular exposure to the elements. So --

A. Yeah.

33 Q. -- for example, and I will put this on the screen. Hypothermia -- I should just say, for the record, this is paragraph 7 of your affidavit.

But you identify hypothermia. You identify trench foot or immersion foot. You mentioned respiratory tract infections. And you mention sunburn, heatstroke, and sleep interruption as issues that affect homeless individuals.

Now, you would agree that the risk of these

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conditions goes up simply from being in a homeless state; correct?

A. Well, some of the factors would be more or less applicable depending on the person's circumstances because homelessness, as has already been mentioned, takes many different forms; and thus one couldn't say that all of these factors apply equally to everyone who is unhoused.

34 Q. Yeah, no. And I'm not saying that they apply equally but I'm saying the risk of these conditions would go up for a homeless individual because they are in a homeless state.

Would that be accurate?

A. I think that in general that would be correct.

35 Q. Have you provided medical treatment to any of the individual applicants in this matter at any time?

A. No, I have not.

36 Q. And are you aware of them, any of them, having suffered from hypothermia, or trench foot, immersion foot, respiratory tract infection, sunburn heatstroke, or sleep interruption?

A. No.

37 Q. All right.

MR. CHOUDHRY: Sorry. And just for the

15

record, we will provide a stipulation that Dr. Hwang hasn't reviewed the medical records of any of the applicants.

MR. DIACUR: I appreciate that. That's really where I'm going with that.

MR. CHOUDHRY: Yeah, he is simply an expert witness.

BY MR. DIACUR:

38 Q. Yes. No, understood. I just want to confirm.

So in this same paragraph you do indicate that a prohibition on erecting rudimentary shelter such as a tent or a tarp or cardboard barriers, there may be health impacts of that.

Is that fair?

A. Yes. That's absolutely correct.

39 Q. To your knowledge, is there presently such a prohibition on raising such rudimentary shelters in the City of Hamilton?

MR. CHOUDHRY: Objection. His knowledge does not extend to the policies of the City of Hamilton. It's about the health issues and his expertise that he is testifying about here.

---REFUSAL

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MR. DIACUR: Yes, well. And I'm trying to test the limits of the opinion.

MR. CHOUDHRY: Yes. So he --

MR. DIACUR: I am just confirming if he's giving any opinion about anything that's occurring in the City of Hamilton at all.

MR. CHOUDHRY: No.

BY MR. DIACUR:

40 Q. All right. And I'm going to scroll down -- I should say scroll up because. I just went past it. There's a citation from an article from the International Journal of Biometeorology in 1991. The article is entitled, "Accidental Hypothermia and Death From Cold in Urban Areas."

My understanding is that that was a study that was done, or that article was based on a study that was done in Tokyo, Japan; is that right?

A. That's correct. But I could add that I myself have conducted research in this area more recently and have published studies examining hypothermia among people who have experienced homelessness in the City of Toronto.

41 Q. Understood. I'm just trying to establish the scope of that study however.

And I understand that that study indicated

that there were two principal causes of accidental hypothermia and death from cold in urban areas. It was inebriation as well as homelessness.

Is that fair?

A. In that particular study those were the factors that they identified, yes.

42 Q. Have you found the same thing to be true in your own work?

A. In my own work, we examined the risk of hypothermia among people exhibiting homelessness versus those not experiencing homelessness; and found that there was a highly increased risk among those experiencing homelessness.

And we also examined the correlation with weather conditions on the day of the injury; and we found that while colder temperatures certainly increase the risk, many of the injuries or hypothermic injuries occurred above the freezing point or when it was not extremely cold and simply between negative 10 and 0 degrees centigrade.

We did not --

43 Q. No. I understand. Sorry, I didn't mean to cut you off.

A. We did not examine other factors, other clinical factors.

44 Q. I understand that a similar finding was made in that study based on the Tokyo review, that it wasn't always below 0 when hypothermic injuries can occur.

But just to be clear, the inebriation, among either homeless individuals or those who were sheltered is not something that you looked at in your own research?

A. In our research, we looked simply at the risk among people experiencing homelessness.

45 Q. And in terms of the article that cited here from 1991, can it be concluded that inebriation and falling asleep in an unsafe place, even in weather that is not considered freezing, can and has caused hypothermia in the past?

A. I would say based on my clinical experience and based on studies, that is correct that decreased level of consciousness increases the risk of injury due to weather conditions.

46 Q. So I have a couple of questions for you about the other -- I should say the exhibits to your affidavit other than your CV. And so that is Exhibits B and C to your affidavit which I will scroll down to.

It will just take me a moment to get to it, but Exhibit B first. And, as I said, it's taking me a

moment to get there because of the very impressive CV that is attached to your affidavit.

So we are now at Exhibit B to your affidavit sworn February 27, 2023. There's an article that you authored entitled "Homelessness and Health" that I understand was published in January of 2001.

Can you see that okay?

MR. CHOUDHRY: Dr. Hwang, sir, can you hear us?

Jordan, let's give him a minute.

---OFF THE RECORD AT 2:33 p.m.

---RESUMING AT 2:35 p.m.

BY MR. DIACUR:

47 Q. So, sir, we are at Exhibit B to your affidavit of February 27, 2023. It's an article that you authored and I pointed out that it looks like it was published in January of 2001; is that correct?

A. That's correct.

48 Q. And so from the fact that this article is attached as an exhibit from your affidavit, can we conclude that there is no better or more contemporary study that you can point to on the subjects of homelessness and health and that's why a 23-year-old article is being relied upon?

A. This is actually a classic article that's been cited probably a thousand times in the literature. There are probably more recent articles that could be cited, but none of them actually have the broad scope that this one does. They've tended more recently to focus on very narrow areas of help.

49 Q. Understood. Okay. But is it fair to say that this article from 2001 and its findings may no longer be applicable to contemporary Ontario?

A. I think it would be correct to say that one should assess whether the findings are still relevant or not. But many of them I would say still are.

50 Q. Okay. And then just a couple of questions about Exhibit C to your which I will scroll down to. So Exhibit C to your affidavit of February 27, 2023.

It is a chapter, again, from a larger book: "The Handbook of Urban Health: Populations, Methods, and Practice," edited by Galea and Vlahov. And it does indicate that it was published in 2005; is that accurate?

A. That's correct.

51 Q. And the extract is chapter 2 entitled, "Homeless People" by Stephen W. Hwang and James R. Dunn.

So you are the co-author of this chapter?

A. That's correct.

52 Q. And there is a section of this that I have a question for you about. It's on page 27 of the extract

21

so I will scroll down to that. So this is page 27. This is a statement about the social welfare systems under the subheading 3.4.

You indicate:

"Social welfare systems in urban centres have a major impact on both the prevalence of homelessness and the health of homeless people. However, these systems are usually governed at the state or national level, rather than at the municipal level."

Is it your understanding that that is true in Ontario?

A. Yes, it is.

53 Q. With, for example, ODSP and Ontario Works being provincial programs?

A. Yes, absolutely.

54 Q. And, again, this is a chapter from a book in 2005. Is it the case that there is no better study or more contemporary study on this chapter and that's why a 19-year-old chapter is being relied upon?

A. Well, there perhaps would be more recent papers. But this is the one that I wrote and I believe that the point made in this particular section still holds true today.

22

55 Q. Is it the case that the entire chapter would be applicable to contemporary Ontario or are there parts that would not be?

A. I would need -- you would need to ask me about specific sessions. I wouldn't be able to generalize about the entire chapter.

56 Q. But it's possible that there are parts of this chapter that would no longer be applicable?

A. That possibility would be one that could be discussed on a point-by-point basis but I would not make a broad generalization.

57 Q. Okay. Well, I really appreciate your time. Thank you, Doctor. Those are all of my questions for you.

MR. CHOUDHRY: Dr. Hwang, I just need a couple of minutes to review my notes and so I'm going to go off camera for a minute. You are still under oath, sir, and so as a consequence all the conditions apply to that. You must still remain where you are unless you have to go to the washroom and please don't communicate with anyone and I will be back within a couple of minutes, okay.

THE WITNESS: Of course.

MR. CHOUDHRY: Thank you very much.

---OFF THE RECORD AT 2:40 p.m.

---RESUMING AT 2:42 p.m.

23

MR. CHOUDHRY: Dr. Hwang, I don't have any questions on redirect so from our perspective this cross-examination has been concluded.

--- The examination concluded at 2:43 p.m.

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I hereby certify the foregoing is a full, true, and correct transcription of all of my oral stenographic notes to the best of my ability so taken at the Cross-Examination of DR. STEPHEN HWANG, given under oath before me on the 28th of August, 2024.

Amy Armstrong, CVR-RVR

Certified Realtime Verbatim Reporter #7305

Certified Commissioner of Oaths

Certified this 29th of August,2024

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Nimigan Mihailovich Reporting Inc.

Chapter 2.1

The Relationship Between Homelessness and Health: An Overview of Research in Canada

C. James Frankish, Stephen W. Hwang, and Darryl Quantz

Canada has long had an international reputation for high quality of life. For a growing number of Canadians, homelessness has become a grim reality and obtaining shelter part of a daily struggle (Begin et al., 1999). Research on homelessness is essential for policy-makers, program planners, service providers, and community groups. This knowledge can play an important role in public education and awareness campaigns, policy decisions, resource allocation, program development, and program or policy evaluation (Quantz & Frankish, 2002). The identification of needs and priorities for research on homelessness is, therefore, a valuable undertaking.

The two primary goals of this article are to provide an overview of previous research on homelessness and the relationship between homelessness and health (with a main focus on Canada), and to spur discussion regarding strategic directions for future research. The National Homelessness Initiative has called for a comprehensive Canadian research agenda to "lay the foundation for understanding the root causes of homelessness, support policy development and serve as a resource for

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accountability and reporting." Development of this agenda will require active engagement by a wide range of stakeholders, including homeless people, those at risk of becoming homeless, service providers and advocates for homeless people, government representatives, researchers and research funding agencies.

Literature review

A variety of strategies were used to identify literature on homelessness that reflected diversity in both geographical and topical focus. This was deemed essential considering that many important sources of information are found in reports from government and community agencies, in addition to the peer-reviewed academic literature. This article is not a comprehensive review of the literature on homelessness in Canada, but rather an effort to frame the different types and areas of research for the purpose of developing future work.

An initial search strategy involved the use of electronic databases, including major social sciences, health and humanities databases. A second strategy sought out examples of literature from government, community, advocacy and service websites. Examples of homelessness research, program descriptions and policy documents were collected. Canadian literature was the primary target of these searches, but review papers from international sources were also included for comparison purposes and to provide additional examples of interventions. Only documents that identified homelessness as a major focus were collected. Papers and reports on housing policy and programs were only included if they focused on homelessness. General reports on housing policy and programs were excluded. Only literature and reports published since 1990 in English were reviewed.

Collected documents were reviewed and categorized. Research was defined broadly to include the systematic generation of new knowledge through a variety of means, including descriptive reports. A more restrictive definition (for example, one based on specific methods such as controlled trials) would have excluded a large proportion of the literature on homelessness in Canada. Research within the following categories were included:

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- conceptual research (examining the definition/meaning of homelessness);
- environmental scans (documenting the extent of homelessness and health and social issues related to homelessness);
- methods research (focusing on the development of new tools for studying homelessness);
- needs assessments (focusing on the needs of the homeless as expressed by the homeless and service providers);
- evaluation research (describing the process and outcomes of programs and policies);
- intervention research (examining the effectiveness of programs and services).

The scope of homelessness in Canada

Many efforts have focused on obtaining a clearer understanding of the nature and extent of homelessness in Canada. Canada's first efforts to provide an estimate of the homeless population began in 1987 through the work of the Canadian Council on Social Development (Begin et al., 1999). Further efforts at measuring homelessness have been undertaken by Statistics Canada. Data from the 2001 Census indicated that over 14,000 individuals were homeless in this country (Statistics Canada, 2002). Most advocates and researchers, however, believe that these numbers vastly under-represent the problem, and new strategies are necessary to accurately capture usable information. Other strategies include the development of the Homeless Individuals and Families Information System (HIFIS) that focuses on capturing more complete information on shelter users in cities across Canada (Canada Mortgage and Housing Corporation, 1999). Specific cities in Canada have also initiated local homelessness counts in an attempt to measure the numbers of homeless and at-risk persons in their jurisdictions.

Examples from large urban areas include a report on homeless and at-risk persons in the Greater Vancouver region (Woodward et al., 2002), the Toronto Report Card on Homelessness (City of Toronto, 2000), and the City of Calgary Homeless Count (Stroik, 2004). A number of smaller cities and regions have produced similar reports.

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The challenges associated with obtaining a clear picture of the scope of homelessness in Canada included the lack of a consistent definition of homelessness, difficulty in identifying homeless persons, the transient nature of homelessness, difficulty in communicating with homeless persons, and lack of participation by local agencies (Bentley, 1995). The definition of homelessness is particularly important. Homelessness can be viewed along a continuum, with those living outdoors and in other places not intended for human habitation at the extreme, followed by those living in shelters. These individuals are referred to as being absolutely homeless. Homelessness also includes people who are staying with friends or family on a temporary basis, often referred to as "couch surfing" or being "doubled up." Those at risk of being homeless include persons who are living in substandard or unsafe housing and persons who are spending a very large proportion of their monthly income on housing. The definition of homelessness is not trivial. It can have profound consequences for policy, resource allocation, and parameters used to evaluate the success of homelessness initiatives. This article focuses on research and interventions related to absolute homelessness. Much of this information has implications for those who are at risk.

Other important aspects of homelessness in Canada are the impact of urbanization, the heterogeneity of the homeless population, and the complexity of the causes of homelessness. Canada is experiencing a rapid and continuing trend towards urbanization, as indicated by the fact that almost 80 percent of Canadians now live in cities with populations of 10,000 or more. Although homelessness is a problem in rural areas of Canada, it has become an obvious crisis in large urban areas, where availability of affordable housing is limited due to a loss of rental units and a shortage of social housing (Woodward et al., 2002).

Heterogeneity within the homeless population is important to recognize. Homelessness affects single men and women, street youth, families with children, people of all races and ethnicities, lifelong Canadians, immigrants and refugees, and these groups often face different health issues (Hwang, 2001). For most individuals, homelessness represents a transient one-time crisis or an episodic problem; for a distinctly different subgroup of individuals, homelessness is a chronic condition (Kuhn & Culhane, 1998).

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There is no single pathway to homelessness. Homelessness is the result of a complex interaction of factors at the individual level such as adverse childhood experiences, low educational attainment, lack of job skills, family breakdown, mental illness and substance abuse (Herman et al., 1997; Koegel et al., 1995; Susser et al., 1993) and at the societal level, such as poverty, high housing costs, labour market conditions, decreased public benefits, and racism and discrimination (Jencks, 1994; O'Flaherty, 1996; Schwartz & Carpenter, 1999) (see Figure 1).

Research on homelessness has often reflected disciplinary traditions, with health researchers focusing on individual risk factors and social scientists looking at marginalization, exclusion and economic forces. This is important because the formulation of the causes of homelessness can become highly politicized and can influence public perceptions and policies related to homelessness.

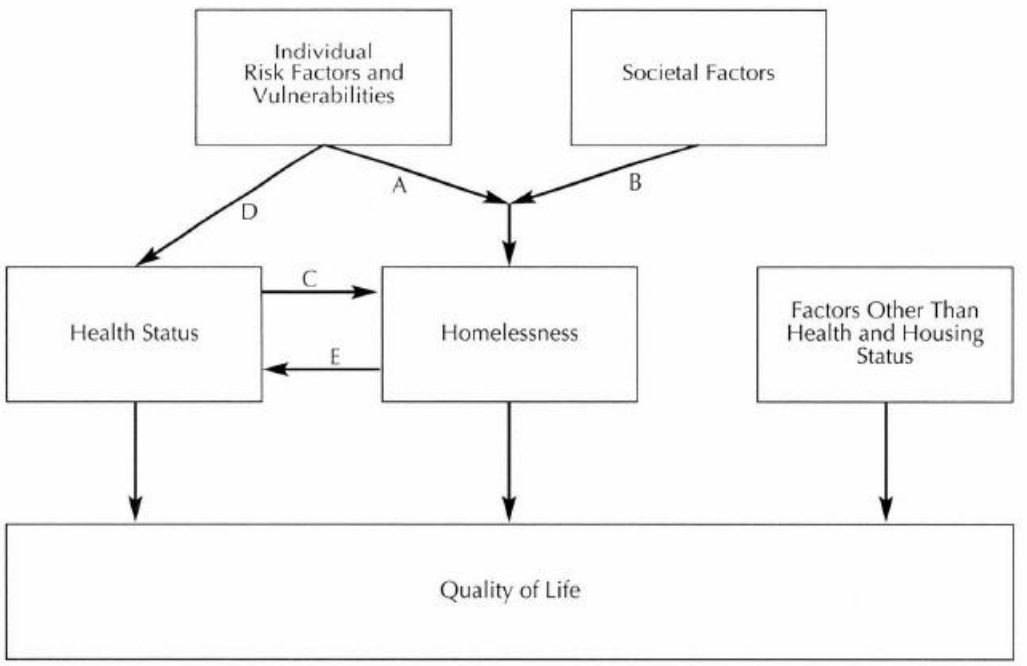


Figure 1. Causal pathways relating homelessness, health, and quality of life.

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The health status of homeless persons

Causal Pathways

Homelessness is clearly associated with poor health. In reviewing the research in this area, a schema of causal pathways underlying this association may be useful. Homelessness has a direct adverse impact on health (Figure 1, arrow C). Crowded shelter conditions can result in exposure to tuberculosis or infestations with scabies and lice, and long periods of walking and standing and prolonged exposure of the feet to moisture and cold can lead to cellulitis, venous stasis and fungal infections (Stratigos & Katsambas, 2003). However, the relationship between homelessness and ill health is far more complex (Hwang, 2002). Many risk factors for homelessness, such as poverty and substance use (Figure 1, arrow A), are also strong independent risk factors for ill health (Figure 1, arrow D). Many people who are homeless remain at risk for poor health even if they obtain stable housing. In addition, certain health conditions (particularly mental illness) may contribute to the onset of homelessness and then in turn be exacerbated by the homeless state (Figure 1, arrows C and E). Finally, improved health and adequate housing are means of achieving the ultimate goal of improved quality of life. Researchers are now recognizing the need to understand and measure the impact of interventions on quality of life, in addition to housing and health outcomes (Lehman et al., 1995).

Specific Health Conditions

Homeless people are at greatly increased risk of death. Mortality rates among street youths in Montreal are nine times higher for males and 31 times higher for females, compared to the general population (Roy et al., 1998a). Men using homeless shelters in Toronto are two to eight times more likely to die than their counterparts in the general population (Hwang, 2000, 2002).

The prevalence of mental illness and substance abuse is much higher among homeless adults than in the general population. Contrary to popular misconceptions, only a small proportion of the homeless population suffers from schizophrenia. The lifetime prevalence of schizophre-

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nia is only 6 percent among Toronto's homeless (Canadian Mental Health Association, 1998). Affective disorders are more common, with lifetime prevalence rates of 20-40 percent (Fischer & Breakey, 1991; Susser et al., 1993). Alcohol use disorders are widespread, with lifetime prevalence rates of about 60 percent in homeless men (Fischer & Breakey, 1991). Cocaine and marijuana are the illicit drugs most often used by homeless Canadians (Smart & Adlaf, 1991). Patterns of substance abuse and mental illness vary across subgroups of homeless people: single women are more likely to have mental illness and less likely to have substance use disorders than single men (Fischer & Breakey, 1991). Female heads of homeless families have far lower rates of both substance abuse and mental illness than other homeless people (Shinn et al., 1998).

Homeless people are at increased risk of tuberculosis (TB) due to alcoholism, poor nutritional status and AIDS (Advisory Council for the Elimination of Tuberculosis, 1992). In addition, the likelihood of exposure to TB is high in shelters due to crowding, large transient populations, and inadequate ventilation (Nolan et al., 1991). Canadian data on the incidence and molecular epidemiology of TB among homeless people are lacking. In the United States, more than half of TB cases among homeless people represent clusters of primary tuberculosis, rather than reactivation of old disease (Barnes et al., 1996). Treatment of active TB in the homeless is complicated by loss to follow-up, non-adherence to therapy, prolonged infectivity and drug resistance (Pablos-Mendez et al., 1997). Directly observed therapy results in higher cure rates and fewer relapses (Advisory Council for the Elimination of Tuberculosis, 1992). Homeless persons with positive skin tests without active TB may be considered for directly observed prophylaxis (Nazar-Stewart & Nolan, 1992).

Among homeless youth in Canada, risk factors for HIV infection include survival sex, multiple sexual partners, inconsistent use of condoms and injection drug use (Roy et al., 1999). Infection rates were 2.2 percent and 11.3 percent among homeless youths seeking HIV testing at two clinics in Vancouver in 1988 (Manzon et al., 1992). In contrast, the prevalence of HIV infection was only 0.6 percent in a group of homeless youths surveyed in Toronto in 1990 (Wang et al., 1991). In a 1997 study of homeless adults in Toronto, the HIV infection rate was 1.8 percent,

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with increased risk observed among individuals with a history of using IV drugs or crack cocaine (Goering et al., 2002). A study of homeless adults and runaway youth in 14 US cities in 1989–92 found HIV infection rates ranging from 0 to 21 percent with a median of 3.3 percent (Allen et al., 1994).

Sexual and reproductive health are major issues for street youth. Studies of street-involved youth in Montreal have documented high rates of involvement in survival sex, sexually transmitted diseases and unplanned pregnancy (Roy et al., 1998b, 1999, 2003). Anecdotal reports suggest that pregnancy is common among street youths in Canada; in the US, 10 percent of homeless female youths aged 14-17 years are currently pregnant (Greene & Ringwalt, 1998).

Injuries and assaults are a serious threat to the health of homeless people. In Toronto, 40 percent of homeless persons have been assaulted and 21 percent of homeless women have been raped in the past year (Crowe & Hardill, 1993). Unintentional injuries due to falls or being struck by a vehicle, as well as drug overdoses, are leading causes of mortality among homeless men in Toronto (Roy et al., 1998a).

Homeless adults suffer from a wide range of chronic medical conditions, including seizures, chronic obstructive pulmonary disease and musculoskeletal disorders (Crowe & Hardill, 1993). Hypertension and diabetes are often inadequately controlled (Hwang & Bugeja, 2000; Kinchen & Wright, 1991). Homeless people in their forties and fifties often develop health disabilities that are commonly seen in persons who are decades older (Gelberg et al., 1990). Oral and dental health is poor (Gibson et al., 2003; Lee et al., 1994; Pizem et al., 1994).

Homeless people face many barriers that impair their access to health care, even under the Canadian system of universal health insurance. Many homeless persons do not have a health card, are unable to make or keep appointments, or lack continuity of care due to their transience (i.e., no permanent address or telephone). Homelessness entails a daily struggle for the essentials of life. Competing priorities may impede homeless people from obtaining needed health services (Gelberg et al., 1997). Access to mental health care and substance abuse treatment remains a crucial issue (Wasylenki et al., 1993). Obtaining prescription medications can be problematic and adhering to medical recommenda-

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tions regarding rest or dietary modification is often impossible (Hwang & Bugeja, 2000; Hwang & Gottlieb, 1999). Studies from the United States have shown that homeless adults have high levels of health-care utilization and often obtain care in emergency departments (Kushel et al., 2002; Kushel et al., 2001). Homeless people are hospitalized up to five times more often than the general public (Martell et al, 1992) and stay in the hospital longer than other low-income patients (Salit et al., 1998).

Interventions to reduce homelessness and improve the health of homeless persons

This section provides an overview of the wide array of interventions reported within the literature that have attempted to decrease the prevalence of homelessness and improve the health of homeless people. We have classified these interventions into four clusters using a taxonomy derived from the literature, theory and past experience:

- biomedical and health care strategies;
- educational and behavioural strategies;
- environmental strategies;
- policy and legislative strategies.

For each cluster, we provide a brief description, examples of interventions of that type, and a summary of research gaps and opportunities within that cluster. These clusters are not mutually exclusive; some interventions may fit under more than one cluster.

Biomedical and Health Care Strategies

This cluster of strategies focuses on medical interventions to improve health status and includes primary health-care programs, clinical services through outreach programs, psychiatric treatment teams and substance abuse treatment. Interventions that are purely biomedical, however, may improve the health of homeless people but fail to address their homelessness. Thus, interventions that combine health care with housing and other social services need to be considered.

Only a small number of studies have examined the effectiveness of biomedical or health care interventions for homeless people using a rigorous controlled design. Most of these studies have focused on homeless

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persons with mental illness or substance abuse. For example, studies have confirmed the effectiveness of the Assertive Community Treatment (ACT) model for homeless people with severe mental illness. ACT involves a team of psychiatrists, nurses, and social workers that follows a small caseload of clients in the community and provides high-intensity treatment and case management (Lehman et al., 1997; Wasylenki et al., 1993). Compared to usual care, patients receiving ACT have fewer psychiatric in-patient days, more days in community housing, and greater symptom improvement.

A recent example of a combined housing and health service program is the New York City Housing Initiative (Metraux et al., 2003). This program made resources available to create 3,300 housing units and social services support for mentally ill homeless persons. Over two years, people in the program stayed in shelters an average of 128 days fewer than similar people in a control group. The treatment of substance abuse in homeless persons has been the subject of a number of studies; a recent review of the literature is available (Zerger, 2002).

Gaps in this area include a lack of research on interventions for homeless youth or families with children, limited research on interventions to address health problems other than mental illness or substance abuse, and little or no data on the effectiveness of various models of primary care delivery for the homeless. Opportunities for future research include a focus on "harm-reduction" programs that seek to minimize adverse health impacts among homeless substance users rather than focusing exclusively on abstinence. Examples include "safe injection sites" for drug users and shelter-based controlled drinking programs in which residents are provided with alcohol on a metered schedule.

Educational and Behavioural Strategies

This cluster of strategies seeks to prevent homelessness or improve the health status of homeless persons through educational programs and behavioural change. Educational programs may focus on homeless people, individuals at risk of homelessness, or the general public. Efforts to promote behavioural change in the homeless include harm-reduction programs, counselling, and referral services. Education of health care workers, shelter workers, and service providers is included in these

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strategies. For example, the Streethealth Coalition in Ottawa provides prevention and education on infectious diseases and health conditions often found in the homeless (Canada Mortgage and Housing Corporation, 1995). The Federation of Non-Profit Housing Organizations of Montreal promotes education on a range of basic life skills. Ontario's Urban Aboriginal homelessness strategy includes culturally appropriate programs, such as cultural counselling and programs, and employment services.

Examples of programs targeting homeless or at-risk individuals include tenants' rights organizations, eviction prevention services, and groups such as the Safe Homes for Youth in Ottawa, which provides education and support for high-risk youth (Canada Mortgage and Housing Corporation, 1995). Alternatively, educational initiatives may focus on increasing public and government awareness of homelessness issues. Examples include a public awareness campaign in Ontario to aid the public in assisting homeless persons (Provincial Task Force on Homelessness, 1998) and efforts by advocacy groups such as the Canadian Housing and Renewal Association, the Centre for Equality Rights in Accommodation and the Housing and Homelessness Network in Ontario to promote changes in government policy related to homelessness.

Very little evaluation research has been undertaken on health education programs for the homeless (May & Evans, 1994). This constitutes a major research gap. Reports of educational and behavioural interventions have often been limited to basic program information. More in-depth descriptions of development and implementation processes are needed; such information could provide a valuable resource for service providers seeking to begin similar initiatives. Opportunities for future research include a need for conceptual research on educational and behavioural interventions for homeless people, studies on how to make these interventions more accessible and appealing for the homeless population, and rigorous studies to evaluate the outcomes of such programs. Such efforts could benefit from attention to three key factors: motivation of individuals toward change through altered knowledge, attitudes, beliefs and values; enabling individuals to take action through skill building and availability and accessibility of supportive resources; and reward or reinforcement of positive action (Green & Kreuter, 1999).

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Environmental Strategies

Environmental strategies are attempts to alter the social, economic, or physical environment in a specific setting to create a supportive environment that enables and facilitates behaviour change. This approach recognizes that the environment or context in which homelessness occurs may be altered to enhance desired behaviours or limit undesirable actions. The environment or context may vary in scale from a single program (e.g., a supportive housing site or outreach program) to a specific neighbourhood to an entire city, province, or country.

Examples of environmental strategies at the program level are Street City in Toronto, which provided services to homeless persons in an environment designed to engage individuals unaccustomed to living indoors (Canada Mortgage and Housing Corporation, 1995), and the Lookout Emergency Aid Society in Vancouver, which provided both short-term shelter as well as long-term supportive housing for adult men and women who were unable independently to meet basic daily needs (Canada Mortgage and Housing Corporation, 1999). A macro-level example is the federal government's Supporting Community Partnerships Initiative (SCPI), which seeks to promote cooperation and coordination at a local level and to provide "communities with the tools and resources needed to set their own course of action" to respond to homelessness in their community.

Research undertaken in environmental strategies has largely taken the form of environmental scans and needs assessments. Two reviews have documented and categorized a number of Canadian programs/projects that included environmental strategies (Canada Mortgage and Housing Corporation, 1995, 1999). A number of projects have provided examples of community development processes in the homeless population. Researchers have outlined lessons learned while conducting community-based research on homelessness in Toronto (Boydell et al., 2000). Others have looked at factors that restrict or facilitate community participation by disadvantaged persons (Boyce, 2001). Opportunities for research include conceptual work to organize and frame these efforts, in-depth evaluations to ensure that programs have measurable

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outcomes, and translation of information into a form useful for planning (Quantz & Frankish, 2002).

Policy and Legislative Strategies

This cluster includes efforts to reduce homelessness through policies and legislation related to poverty and its amelioration, social housing, public health, immigration and law enforcement. Recognizing that a variety of policy, regulatory, legislative and political factors create a climate that has an enormous impact on homelessness and its management, these strategies focus on the creation of "healthy public policies."

Examples of current initiatives include the government of Alberta's framework outlining policy responses to homelessness with respect to housing and support services, local capacity development and governmental coordination (Alberta Community Development, 2000). The 1999 Vancouver Agreement is an example of collaboration at the federal, provincial and municipal levels to focus on economic, social and community development in the Downtown Eastside neighbourhood, where homelessness is a major issue. Examples of public health policies that have been implemented or considered include safe-injection sites, needle exchange programs and other harm reduction policies.

These strategies are foundational to all others, because the absence of a strong policy-legislative approach to homelessness will seriously limit and undermine efforts in other areas. There is a need for work to examine the impact of various health and social policies on the lives of homeless people. Particularly vital (Classer et al., 1999) areas include welfare policy as it affects adults and families with children, policies that impact young women (Novac et al., 2002), and practices in the child welfare system that may contribute to youth homelessness (Appathurai, 1991; Kufeldt, 1991). Comparing policies in different jurisdictions and their impact on homelessness can provide important insights (Classer et al., 1999; Eberle et al., 2001). Government frameworks on homelessness call for efforts to ensure accountability in reaching specific targets and goals. But, there has been relatively little work on policy evaluation in this area. Future research has the potential to provide essential information to guide future policy-making.

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Strategic Directions for Future Research on Homelessness

Based our review, we conclude that Canadian research in the area of homelessness and health faces important challenges. First, the complexity of the issue of homelessness requires the involvement of a wide range of stakeholders, including all levels of government, service providers, health professionals, biomedical/social science researchers, community groups and homeless people themselves. Both horizontal integration (across various sectors such as health, law, housing, social services) and vertical integration (across federal, provincial, territorial, and local governments, and within communities) are needed.

Second, the diversity of values, beliefs and perspectives on homelessness must be acknowledged, and public discourse is needed on the causes of homelessness in Canada and the appropriate response to this problem.

Third, consensus needs to be reached on the definition of homelessness and the measures by which efforts to reduce homelessness or improve the quality of life of homeless people will be judged.

Fourth, researchers need to design and conduct studies on homelessness that are policy-relevant and develop strategies to translate their research into policy and practice. There has been little research evaluating the effects of policy on homelessness or quality of life among the homeless and the vast majority of programs for homeless people have not been evaluated. Many of the evaluations that have been conducted are of modest quality, but at the present time, the resources and expertise that would allow for a robust evaluation are often not available at the local level.

These challenges should not deter or diminish current interests and efforts around research on homelessness and health in Canada. Rather, they call for renewed commitment, strategic planning and wise investment of human and fiscal resources. Within all six categories of research there is significant need for further development. Conceptual research on the definition and meaning of homelessness can provide greater clarity in ongoing discussions of homelessness among advocacy groups and policy-makers. Environmental scans that document the extent of homelessness and the health problems of homeless people are useful, but they

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remain primarily descriptive in nature. There is a need to move from this understanding to outcome measures and interventions. Methods research could make significant contributions through the development of valid/precise measures of quality of life in homeless people and individuals at risk. Needs assessment research needs to be systematically linked to objectives and interventions. Finally, more high-quality evaluation and intervention research is urgently needed.

Community involvement is vital in any work on homelessness and its conceptualization, measurement or change. While this may seem self-evident, the reality is that many groups often have limited capacity for engagement in these efforts. Concrete efforts are needed to ensure that communities are able to contribute to, and participate effectively in, the study of homelessness and use of research findings. The primary need is capacity-building to allow communities to initiate projects in equitable partnerships with government and academia. Resources must be made available to both promote research by various community groups and to teach research skills such as proposal writing and research design. Potential strategies include workshops, access to research courses at academic institutions, the development of easy-to-use research information, and financial support to allow community members to participate in these activities.

The issue of dissemination remains a key challenge in homelessness research. The question is how we can best communicate the lessons, experiences and best practices of dealing with homelessness. How can this information be communicated in a variety of forms and media that are appropriate to their target audiences? Significant barriers exist, including time, personnel, research capacity and resources.

We suggest three strategic priorities towards a better understanding of homelessness and the implementation and evaluation of efforts to reduce homelessness and improve the lives and quality of life among the homeless. The first priority is a nationwide effort to achieve a core, consensus definition and set of indicators related to the definition and extent of homelessness. Second, we need clear definitions and measures for a) the health status of homeless (and at-risk) groups; b) the use of the health and social services by homeless people; and c) relations between homelessness and broader, non-medical determinants of health (e.g., income,

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education, employment, social support, gender, culture, etc.). This effort to create a common dataset would not preclude communities from collecting additional data of local interest and value.

A third priority must be the development of research infrastructure. This effort would include the development of demonstration projects or surveillance systems that could reliably collect data on the indicators of homelessness. Government-funded projects that purport to address either the processes or outcomes of homelessness should be subjected to an "evaluability" assessment. Groups such as the Canadian Consortium for Health Promotion Research could assist all levels of government in determining whether current projects/programs are in fact, evaluable. We suspect that many projects and programs presently lack the necessary and sufficient conditions to be fairly evaluated. This effort could move research toward a model of program evaluation that sets realistic expectations in terms of measurement of focused aspects of homelessness, and one that provides sufficient time and resources to allow for appropriate assessment of homelessness interventions and their effects.

We encourage investment of the needed resources toward the science and application of research on homelessness. Building on its traditions in health promotion and its strengths in population health research, Canada is well placed to be a world leader in intervention research on homelessness. This can be a vehicle for building community health. These efforts may generate additional benefits, including commitment to reducing health disparities, new partnerships across academic disciplines, and intersectoral work on the determinants of health.

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TAB 106

Court File No. CV-21-00077817-0000

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, ET AL.

Applicants

-and-

CITY OF HAMILTON

Respondent

AFFIDAVIT OF AMEIL JOSEPH

SWORN JUNE 14, 2022

---

1. I, AMEIL JOSEPH, of the City of Hamilton in the Province of Ontario, AFFIRM AND STATE:
2. I am an Associate Professor in the School of Social Work at McMaster University in Hamilton, Ontario. I hold a Professorship in Equity, Identity, and Transformation with the Faculty of Social Sciences at McMaster University and am Academic director of Community Engaged Research and Relationships with the Office of Community Engagement at McMaster University. I have over a decade of professional experience in

the mental health field, in Assertive Community Treatment, Supportive Housing, Crisis Respite, Early Intervention, Settlement and governance settings. I also serve on the Board of Directors for the Disability Justice Network of Ontario and helped to found Hamilton's first Anti-Racism Resource Centre. A copy of my CV is attached hereto as Exhibit "A".

3. I study the historical legacies of colonial and eugenic policies on racialized groups, disabled people, newcomers/immigrants, people with mental health issues, and the confluence of ways they are impacted by criminal justice, immigration, and mental health systems, practices, policies, and law. I am particularly interested on how the historical trajectories of dehumanization, exclusion, and rationalized violence shape contemporary policies, programs, and services for these populations. I have written a book, several chapters in edited collections, and peer-reviewed journal publications on these matters.
4. With respect to homelessness in Canada, it has been documented that people with disabilities and mental health needs, LGBTQ2s populations, racialized groups, and Indigenous people are disproportionately underhoused, unhoused, and experience barriers to access affordable, permanent, stable, and supportive housing.[1]
5. In Canada, those who have a disability are also "more likely to have experienced hidden homelessness. More particularly, those who reported at least three disabilities were four times more likely to have experienced hidden homelessness (26%) than those with no

[1] Caryl Patrick, *Aboriginal homelessness in Canada: A literature review* (Toronto: Canadian Homelessness Research Network Press, 2014); Stephen Gaetz, et al., "Without a Home: The National Youth Homelessness Survey," *Canadian Observatory on Homelessness Press*, 2016, https://www.homelesshub.ca/sites/default/files/attachments/WithoutAHome-final.pdf; Samantha Rodrigue, "Hidden homelessness in Canada Insights on Canadian Society," *Statistics Canada Catalogue no. 75-006-X*, November 15, 2016, https://www150.statcan.gc.ca/n1/pub/75-006-x/2016001/article/14678-eng.htm.; Stephanie Baker Collins, and Ann Fudge Schormans, "Making Visible the Prevalence of Self-Identified Disability Among Youth Experiencing Homelessness," *Journal of Social Distress and Homelessness* (2021): 1-9, https://doi.org/10.1080/10530789.2021.1940719.

reported disability (6%)" (1).[2] With respect to youth, an "examination of the percentage of youth in homeless shelters in three sites in southern Ontario reveals that 80% of youth identify with at least one disability" (6).[3]

6. Indigenous people are 8 times more likely to experience homelessness in urban centres, as well as experience the continuing legacies of colonial oppression and exclusion, racism and discrimination when accessing all aspects of social life.[4] A national survey on youth homelessness in Canada has revealed that 29.5% of youth who were homeless were of the LGBTQ2S community, 30.6% were Indigenous, and 28.2% were racialized.[5] While this data reveals the inequities for marginalized groups with respect to housing and homelessness, a respectful attention to the social, historical, and political contexts of exclusion is often underappreciated for the ways they underpin contemporary systemic inequities across systems and services that render these groups at greater risk of harm.
7. Historically, immigration, criminal justice, and institutions including mental health systems and healthcare systems have produced and reproduced a devastating legacy of discrimination, prejudice and exclusion for racialized people, disabled people, and people with mental health issues.[6] Eugenic policies in Canada have scaffolded racism, sanism, and ableism into policy, practice, and law. Specifically, eugenics is understood as the "the study of the agencies under social control that may improve or impair the racial qualities of future generations" (17).[7]

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[2] Rodrigue, "Hidden Homelessness in Canada", 1.
[3] Baker Collins, and Fudge Schormans, "Making Visible the Prevalence", 6.
[4] Patrick, "Aboriginal Homelessness in Canada".
[5] Gaetz et al., "Without a Home".
[6] Ameil J. Joseph, *Deportation and the confluence of violence within forensic mental health and immigration systems* (Springer, 2016).
[7] Ian Robert Dowbiggin, *Keeping America sane: Psychiatry and eugenics in the United States and Canada, 1880-1940* (Cornell University Press, 1997).
*Internal citation omitted. Original quote Francis Galton (1907), *Inquiries into Human Faculty and its Development*.

8. In 1910, House of Commons debates revealed that early 20th century health professionals and government officials propounded the belief that persons with disabilities were *undesirable immigrants* because they were by nature *degenerates, dangerous and dishonest* in disposition.[8] These discriminatory ideas were forged into the Immigration Act of 1910 where the construct of *Prohibited Classes* was established, conflating the erroneous idea that newcomers/immigrants were carriers of some imagined threat of hereditary defectiveness. Under section 3 of the Immigration Act of 1910, the "prohibited classes" are identified in the following order: "Persons mentally defective", "Diseased persons", "Persons physically defective", "Criminals", "Prostitutes or pimps", "Procurers", "Beggars and vagrants", "Charity immigrants" and "Persons not complying with regulations" (208-209).[9] These prejudicial and discriminatory ideas have and continue to shape contemporary policy, practice and law in Canada.[10]
9. These ideas, emerge within the historical context of nation building in Canada where histories of head taxes on Chinese people, chattel slavery, the internment of Japanese peoples, turned away ships with South Asian and Jewish immigrants, residential schools, reserve systems, medical inadmissibility policies for immigrants, and the claiming of lands from Indigenous peoples contour the realities for newcomers/immigrants, racialized people, disabled people, people with mental health issues, and Indigenous people.[11]
10. These specific policy trajectories as well as their embedded discriminatory ideas have and continue to pervasively structure the contemporary realities of longstanding and

[8] Ena Chadha, "" Mentally Defectives" Not Welcome: Mental Disability In Canadian Immigration Law, 1859-1927," *Disability Studies Quarterly* 28, no. 1 (2008).
[9] "An Act Respecting Immigration," (Acts of the parliament of the dominion of Canada, Ottawa, 1910), 208-209, https://www.canadiana.ca/view/oocihm.9_07184.
[10] Joseph, "Deportation and the Confluence".
[11] Ameil Joseph, "Making Civility: Historical Racial Exclusion Technologies within Canadian Democracy," In *Civil Society Engagement*. Edited by Patricia Daenzer, (Routledge, 2017), 17-30.

widespread inequities in healthcare, education systems, housing, employment, food security, access to water, environmental inequities, mental health, criminal justice systems, immigration systems, property ownership, and income.[12] These systemic structural inequities compound the negative impacts of encampment evictions for racialized, disabled, LGBTQ2S, Indigenous people and people with mental health issues.

11. Racialized people with mental health issues are often more likely to be criminalized, deported, detained, and to experience violence within current health, mental health, social services, immigration, and legal systems.[13] The lack of attention to the historical, colonial context of these contemporary forms of injustice and their impacts has been documented for the ways these omissions can reinforce legacies of harm.[14]

[12] John Yinger, "Measuring Racial Discrimination with Fair Housing Audits: Caught in the Act," *The American Economic Review* 76, no. 5 (1986): 881-893; Kenneth Wayne Taylor, "Racism in Canadian Immigration Policy," *Canadian ethnic studies = etudes ethniques au Canada* 23, no. 1 (1991): 1-20; Robert D. Bullard, "Anatomy of Environmental Racism and the Environmental Justice Movement," *Confronting environmental racism: Voices from the grassroots* 15 (1993): 15-39; Gloria Ladson-Billings, and William F. Tate, "Toward a Critical Race Theory of Education," *Teachers college record* 97, no. 1 (1995): 47-68; Angela J. Davis, "Benign Neglect of Racism in the Criminal Justice System," *Michigan law review* 94, no. 6 (1996): 1660-1686; William A. Darity, and Patrick L. Mason, "Evidence on Discrimination in Employment: Codes of Color, Codes of Gender," *Journal of Economic Perspectives* 12, no. 2 (1998): 63-90; Nancy A. Ross, et al., "Relation Between Income Inequality and Mortality in Canada and in the United States: Cross Sectional Assessment Using Census Data and Vital Statistics," *Bmj* 320, no. 7239 (2000): 898-902; Sukhdeo Thorat, and Joel Lee, "Caste Discrimination and Food Security Programmes," *Economic and Political Weekly* 40, no. 39 (2005): 4198-420; Diana Burgess, et al., "Effects of Perceived Discrimination on Mental Health and Mental Health Services Utilization Among Gay, Lesbian, Bisexual and Transgender Persons," *Journal of LGBT health research* 3, no. 4 (2007): 1-14; Sheryl Nestel, "Colour Coded Health Care the Impact of Race and Racism on Canadians' Health," *Wellesley Institute*, January 2012, https://www.wellesleyinstitute.com/wp-content/uploads/2012/02/Colour-Coded-Health-Care-Sheryl-Nestel.pdf; Brenna Bhandar, "Colonial lives of property," In *Colonial Lives of Property* (Duke University Press, 2018); Sue Jackson, "Indigenous Peoples and Water Justice in a Globalizing World," *The Oxford handbook of water politics and policy* (2018): 120; Ameil Joseph, "Equity Data as an Ethical Necessity: Understanding the Viral Confluence of Injustice Through COVID-19," *Canadian Dimension*. June 16, 2020, accessed June 13, 2022, https://canadiandimension.com/articles/view/equity-data-as-an-ethical-necessity-understanding-the-viral-confluence-of-injustice-through-covid-19.

[13] Joseph, "Deportation and the Confluence".

[14] Ameil J. Joseph, "The Necessity of an Attention to Eurocentrism and Colonial Technologies: An Addition to Critical Mental Health Literature," *Disability & Society* 30, no. 7 (2015): 1021-1041.

12. Hamilton is known for having the highest number of per-capital police reported hate crimes of any city in Canada.[15] Also, 27.7% of people living in Hamilton have a disability.[16] (Statistics Canada, 2019). These historical and contemporary contexts of inequity impact Hamilton specifically in ways that have differential effects on Hamilton's population.
13. These specific, known, and documented realities frame how racialized people, disabled people, Indigenous people, and people with mental health issues become more at risk of being homeless as well as how systems view them through a gaze that deems them as threat, risk, burden, or in terms of inferiority and undeservingness. With respect to encampment evictions, this particular intervention continues a historical process of impacting racialized people, Indigenous people, disabled people, and people with mental health issues in ways that channel and exacerbate the harms of disproportionate criminalization, dehumanization, and systemic inequity.
14. The eviction of people from encampments is not a benign endeavour that occurs outside of these social, historical, and contemporary realities. For these reasons, encampment evictions culminate and consolidate historical and contemporary inequities that convene a confluence of systemic injustices for equity seeking populations that exacerbate vulnerabilities and magnify harms. The impacts of encampment evictions are thereby disproportionately harmful for equity seeking groups and therefore deeply and profoundly unjust.

[15] Meagan Deuling, "Hamilton Has the Highest Rate of Hate Crimes in Canada: Report | CBC News," *CBC news*, July 23, 2019, https://www.cbc.ca/news/canada/hamilton/hate-crime-statistics-canada-hamilton-1.5221663.; Don Mitchell, "Hamilton Has Highest Rate of Police-Reported Hate Crime in Canada: StatsCan – Hamilton," *Global News*, July 24, 2019, https://globalnews.ca/news/5672816/hamilton-highest-rate-of-hate-crime-in-canada/.
[16] Statistics Canada, "Persons with and Without Disabilities Age 15 Years and Over, Census Metropolitan Area," *Statistics Canada Table no. 13-10-0750-01*, December 3, 2019, https://doi.org/10.25318/1310075001-eng.

15. I make this Affidavit in support of the Notice of Application, and for no improper purpose.

Sworn remotely by Ameil Joseph at the City of Hamilton, in the Province of Ontario, before me on June 14, 2022 by "zoom" videoconference, in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

Stephanie Cox

Commissioner for Taking Affidavits
Stephanie Cox, LSUC 65464F



Ameil Joseph

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Bullard, Robert D. "Anatomy of environmental racism and the environmental justice movement." *Confronting environmental racism: Voices from the grassroots* 15 (1993): 15-39.

Burgess, Diana, Richard Lee, Alisia Tran, and Michelle Van Ryn. "Effects of perceived discrimination on mental health and mental health services utilization among gay, lesbian, bisexual and transgender persons." *Journal of LGBT health research* 3, no. 4 (2007): 1-14.

Chadha, Ena. "" Mentally Defectives" Not Welcome: Mental Disability In Canadian Immigration Law, 1859-1927." *Disability Studies Quarterly* 28, no. 1 (2008).

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Gaetz, Stephen, Billy O'Grady, Sean Kidd, and Kaitlin Schwan. "Without a home: The national youth homelessness survey." (2016).

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Joseph, Ameil J. "The necessity of an attention to Eurocentrism and colonial technologies: An addition to critical mental health literature." *Disability & Society* 30, no. 7 (2015): 1021-1041.

Joseph, Ameil J. *Deportation and the confluence of violence within forensic mental health and immigration systems*. Springer, 2016.

Joseph, Ameil. "Making Civility: Historical Racial Exclusion Technologies within Canadian Democracy." In *Civil Society Engagement*, pp. 17-30. Routledge, 2017.

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Mitchell, Don. “Hamilton Has Highest Rate of Police-Reported Hate Crime in Canada: StatsCan - Hamilton.” Global News. Global News, July 24, 2019. https://globalnews.ca/news/5672816/hamilton-highest-rate-of-hate-crime-in-canada/.

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Rodrigue, S. "Hidden homelessness in Canada Insights on Canadian Society." (2016).

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Statistics Canada. Table 13-10-0750-01 Persons with and without disabilities aged 15 years and over, census metropolitan areas, 2019, DOI**:** https://doi.org/10.25318/1310075001-eng

Taylor, Kenneth Wayne. "Racism in Canadian immigration policy." *Canadian Ethnic Studies= Etudes Ethniques au Canada* 23, no. 1 (1991): 1.

Thorat, Sukhdeo, and Joel Lee. "Caste discrimination and food security programmes." *Economic and Political Weekly* (2005): 4198-4201.

Yinger, John. "Measuring racial discrimination with fair housing audits: Caught in the act." *The American Economic Review* (1986): 881-893.

THIS IS EXHIBIT “A” TO THE
AFFIDAVIT OF AMEIL JOSEPH
AFFIRMED REMOTELY BEFORE ME AT
THE CITY OF HAMILTON DURING A “ZOOM” VIDEOCONFERENCE
IN ACCORDANCE WITH O.REG. 431/20,
ADMINISTERING OATH OR DECLARATION REMOTELY
THIS 14TH DAY OF JUNE, 2022

Stephanie Cox

STEPHANIE COX
LSO NO. 65464F
Commissioner for Taking Affidavits, etc

Curriculum Vitae

1. Name

AMEIL J. JOSEPH

2. Business Address

McMaster University
School of Social Work
Faculty of Social Sciences
905-525-9140 X23792
Email: ameilj@mcmaster.ca

Associate Professor
1280 Main Street West
Office: KTH 309
Hamilton, Ontario, L8S 4M4
Citizenship: Canada

3. Educational Background

Doctor of Philosophy (PhD): Social Work: York University, Toronto, ON	2014
Master of Social Work (MSW): Wilfrid Laurier University, Kitchener, ON	2007
Social Work Diploma: Renison University College, Waterloo, ON	2004
Bachelor of Arts, Psychology: University of Waterloo, Waterloo, ON	2003

4. Current Status at McMaster

Associate Professor- Tenured, School of Social Work	July 1, 2019- Present
Professorship in Equity, Identity and Transformation, Faculty of Social Sciences	July 1, 2021- Present
Assistant Professor- Tenure Track, School of Social Work	July 1, 2014-June 30, 2019

5. Professional Organizations

International Association of Trauma Professionals: Certified, Grief Counselling Specialist	2020-Present
Archives of Ontario: Registered researcher	2012-Present
Canadian Association for Social Work Education: Member	2011-Present
Ontario College of Social Workers and Social Service Workers: Registered Social Worker	2007-Present
Mental Health Commission of Canada: Network of Ambassadors Member	2016-Present

6. Employment History

a. *Academic*

Academic Director, Community-Engaged Research and Relationships July 2021-Present
Office of Community Engagement
McMaster University

Research Assistant May-August 2014
Professor Sarah Maiter, York University, Toronto, ON
Critical Race Research, methodological issues

Research Coordinator- Toronto-York site Fall 2009-Fall 2010
The Self-Other Issue in the Healing Practices of Racialized Minority Youth

Social Sciences and Humanities Research Council (SSHRC) Funded Standard Research Grant
Primary Investigator: Prof. Martha Kuwee Kumsa, Wilfrid Laurier University

Research Assistant/Volunteer Coordinator November 2003-April 2005
The Canadian Early Childhood Language Project
Canadian Institutes of Health Research (CIHR) Funded
Primary Investigator: Prof. Daniela O'Neill, University of Waterloo

b. *Consultations*

Ontario Ministry of Education: Fact/lens-checking: December 2021-Present
Grade 10 Civics and Citizenship

Government of Canada, Consultation on National Anti-Racism Strategy January 23, 2019
Lincoln Alexander Centre, Hamilton, ON

Niles, C., Jama, S., Joseph, A.J. October 25, 2018
Disability Justice Network of Ontario & The Ontario Council of Agencies Serving Immigrants:
A round-table discussion on supporting newcomers with in/visible disabilities access safe, affordable, and accessible housing, Hamilton, Ontario

Ontario Anti-Racism Directorate Consultation with the Anti-Racism Resource Centre February 9, 2017
City Hall, Hamilton, ON

Ontario Anti-Racism Secretariat Roundtable discussion with Andrea Horwath MPP February 5, 2016
Immigrants Working Centre, Hamilton, ON

Joseph, A. J., Dei-Amoah, M., Cameron, R.W., Komlen, M., Otite, Y. November 18, 2015
Hamilton's Anti-Racism Resource Centre: Presentation to the City of Hamilton's General Issues committee. City Hall, Council Chambers, Hamilton, ON.

Toronto Central LIHN consultation with Community Mental Health May 2, 2013
and Addictions Boards and Executive Directors-St. Paul's Church, Toronto, ON

Think Tank on Racialized Populations and Mental Health and Addictions ED use March 26, 2013
Li Ka Shing Knowledge Institute, St. Michael's Hospital, Toronto, ON

Community of Interest for Racialized Populations and Mental Health and Addictions Jan. 30, 2013
Canadian Mental Health Association: Ontario Division, Toronto, ON

ODSP Roundtable on Mental Health Conditions and Disability Nov. 27, 2012
Ministry Of Community and Social Services: Toronto, ON

Central Local Health Integration Network: Health Equity Roundtable May 19, 2011
York University: Toronto, ON

Central Local Health Integration Network: Creating Quality in the Transitions of Care March. 3, 2011
Westin Prince Hotel: Toronto, ON

c. *Other/Professional*

Canadian Mental Health Association (CMHA), Toronto, ON: Dec. 2012- September 2013
Social Work Practice Lead

Canadian Mental Health Association, Toronto, ON February 2009 – September 2013
Social Worker; MSW, RSW– Mood and Psychosis Early Intervention Team

Canadian Mental Health Association, Toronto, ON July 2007 – February 2009
Social Worker; MSW, RSW– Assertive Community Treatment Team; West Metro

Waterloo Regional Homes for Mental Health, Kitchener, ON March 2004 – July 2007
(Now: Thresholds Homes and Support)
Mental Health Worker

Waterloo Regional Police Service, Cambridge, ON September – December 2006
Community Resources Department - MSW Internship

Kitchener-Waterloo Multicultural Centre, Kitchener, ON June – December 2006
Settlement Worker

Grand River Hospital, Kitchener, ON January – June 2006
Social Work Department – MSW Internship

Waterloo Regional Homes for Mental Health, Kitchener, ON May – November 2005
(Now: Thresholds Homes and Support)
Crisis Respite Program Implementation Team

7. Scholarly and Professional Activities

a. Editorial boards

2022-present-Qualitative Research (Journal Editorial Board Member)

2020 Hamilton Anti-Racism Conference- editorial committee

2021- present- Editorial Advisory Board members for the new book series *The Politics of Mental Health and Illness,* published by Palgrave Macmillan.

2021-present-Co-editor, Special Issue on History and Social Work in *Critical and Radical Social Work*

b. *Grant & Personnel Committees*
N/A

c. *Executive Positions*
N/A

d. *Journal Referee*

Social Work 2022

1 review
Hypatia 2019
1 review
Canadian Social Work Review/ Revue Canadienne de Service Social 2019
1 review
Psychology of Violence 2018 and 2019
2 reviews
New Horizons in Adult Education and Human Resource Development 2018
1 review
Social Theory and Health 2017
1 review
Canadian Journal of Disability Studies 2016 and 2017
For special issue and general
2 reviews
Qualitative Research, Cardiff University 2016 and 2020
2 reviews
Social and Legal Studies, Edinburgh 2016
For Special Issue on Prof. Penelope Pether's work
1 review
British Journal of Social Work 2015, 2019, 2020, 2021
4 reviews
Journal of Progressive Human Services 2012-2013
8 reviews

e. *External Grant Reviews*
N/A

8. Areas of Interest

Critical Mental Health, Forensic Mental Health, Postcolonial Theory and Social Work, Critical Race Theory, Critical Disability Studies, Social Justice, Violence, Ethics, Confluence, Historiography and Social Work.

9. Honours and Awards

John C. Holland Awards: Vince Morgan Ally Award	Community Award	2021
Early Career Research Award, Faculty of Social Sciences, McMaster University	$500	2019
Barbara Godard Prize for the Best York University Dissertation in Canadian Studies Robarts Centre for Canadian Studies, York University	$500	2014
Fourth International Conference on Health, Wellness & Society Graduate Student Award	$300	2013-2014
Nathanson Graduate Fellowship - Osgoode Hall Law School, York University (Nathanson Centre on Transnational Human Rights, Crime and Security)	$15000	2013-2014
Kent Haworth Archival Research Fellowship - Archives of Ontario	$1365	2012-2013

Doctoral Ontario Graduate Scholarship – York University	$30000(Total)	2012&2013
Doctoral Fellowship - York University	$80600(Total)	2009-2014
PhD Graduate Scholarship – York University	$3000	2009-2010
Bettina Russell Social Justice Award - Wilfrid Laurier University	$1248	2007
Helmut Braun Memorial Award - Centre for Community Based Research	$1000	2006

10. Courses Taught

a. *Undergraduate*

Course Instructor September 2019-December 2019
SW 4J03: Social Change: Social Movements and Advocacy
School of Social Work: McMaster University, Hamilton, ON

Course Instructor Jan. 2017- Apr. 2017, Sept. 2018- Dec. 2018, Sept. 2021-Dec. 2021
SW 4Y03**:** Critical Issues in Mental Health & Addiction:
Mad & Critical Disability Studies Perspectives for SW
School of Social Work: McMaster University, Hamilton, ON

Course Instructor September 2016- April 2017, September 2018- April 2019
SW 2A06**:** Theory, Process & Communication Skills for Social Work
School of Social Work: McMaster University, Hamilton, ON

Course Instructor September 2015- December -2015, January 2018- April 2018, January 2020-March 2020, January 2022-April 2022
SW 4C03**:** Racism and Social Marginalization in Canadian Society (changed to SW 4C03 Critical Perspectives on Race, Racialization, Racism and Colonization in Canadian Society in 2018)
School of Social Work: McMaster University, Hamilton, ON

Course Instructor September 2014-April 2015, September 2015- April 2016
SW 4D06/4DD6: General Practice II/Field Practicum II
School of Social Work: McMaster University, Hamilton, ON

Course Instructor Spring, Fall, 2013, Winter, Spring, 2014, Spring 2015, Fall 2015
CINT 907 Teamwork for Community Services
Interdisciplinary Studies: Toronto Metropolitan University, Toronto, ON

Course Instructor Fall 2013
CINT 905 Conflict Resolution in Community Services
Interdisciplinary Studies: Toronto Metropolitan University, Toronto, ON

Course Instructor Spring 2013
CSWP 900 Race and Ethnicity
School of Social Work: Toronto Metropolitan University, Toronto, ON

Tutorial Leader Fall/Winter 2011/12 & 2012/13 & 2013/14
SOWK 1011 Introduction to Critical Social Work
School of Social Work: York University, Toronto, ON

b. *Graduate*

Course Instructor Jan. 2020- Apr. 2020, Sept. 2021-Dec. 2021
SW 721: Changing Communities: Tensions and Possibilities for Citizenship and Social Justice
School of Social Work: McMaster University, Hamilton, ON

c. *Postgraduate*

N/A

d. *Other*

Course Instructor

SW 705: Directed Readings Course January 2022-April 2022
Critical (Historiographical) Analysis of Homelessness as Discourse
School of Social Work: McMaster University, Hamilton

SW 705: Directed Readings Course September 2021-December 2021
Critical Analysis of Motherhood, Race, and Substance Use
School of Social Work: McMaster University, Hamilton

Course Instructor
GLOBHTH 715: Directed Reading/Independent Study September 2021-December 2021
Critical race, Afrocentricity and Intersectionality epistemologies and methodologies
Faculty of Health Sciences, Ph.D. Program Global Health: McMaster University, Hamilton, ON

Course Instructor September 2019-December 2019
SW 705: Directed Readings Course:
Critical Discourse Analysis of Ontario's Long-Term Care Act and its Impact on older LGBTQ+ people in care
School of Social Work: McMaster University, Hamilton, ON

Course Instructor September 2019-December 2019
SW 705: Directed Readings Course: Critical Analysis of South Asian Culture, Violence and Trauma
School of Social Work: McMaster University, Hamilton

Course Instructor September 2018-December 2018
SW 705: Directed Readings Course: Critical Analysis of Children's Participation in Child Custody and Access Disputes
School of Social Work: McMaster University, Hamilton, ON

Course Instructor January 2016-May 2016
SW 705: Directed Readings Course: Critical Analysis of Refugee Experiences
School of Social Work: McMaster University, Hamilton, ON

11. Contributions to Teaching Practice

a. Pedagogic innovation and/or development of technology-enhanced learning

(2021) Hamilton Health Sciences- Presidents Advisory Committee on Equity, Diversity, and Inclusion

Developed a series of 5 training workshops for members and leadership

(2021) Faculty of Health Sciences: Equity, Advocacy, And Allyship Program
Co-developed curriculum, delivered workshop for the Faculty of Health Sciences on Equity, and "Thinking Respectfully about Identity and Difference".

(2017) Three short videos contributed to deBie, A. & Brown, K. (2017). Forward with Flexibility: A Teaching and Learning Resource on Accessibility and Inclusion. https://flexforward.pressbooks.com/front-matter/forward-with-flexibility/

- Disabled Student's Participation in Education https://youtu.be/bOEb3pKZBU4
- Our Responsibility as Educators https://youtu.be/Fp2cg3Ei3io
- Seeking Ongoing Feedback from Students https://youtu.be/8-Wulencl-U

b. *Leadership in delivery of educational program*

Lead the organization and development of an event/symposium with colleagues to examine the politics of anti-oppression in education.

- Anti-Oppression: A Critique and Reimagining Event Date: April 18, 2016 1pm-4pm
  CIBC Hall, McMaster University

c. *Course/curriculum development*

- Redeveloped SW 721 Changing Communities: Tensions and Possibilities for Citizenship and Social Justice, course design, readings, lectures.
- Redeveloped SW 4J03 Social Change: Social Movements and Advocacy, entire course design and readings, lectures.
- Developed new course: SW 4Y03: Critical Issues in Mental Health & Addiction: Mad & Critical Disability Studies Perspectives for SW, McMaster University, Hamilton, ON, 2016
- Redeveloped SW 2A06 Theory, Process and Communication Skills for Social Work in consultation with prior instructors: McMaster University, Hamilton, ON, 2016
- Developed Graduate Directed Reading Course SW 705: Directed Readings Course: Critical Analysis of Refugee Experiences in collaboration with MSW student. McMaster University, Hamilton, ON, 2015
- Developed SW 4C03 Racism and Social Marginalization in Canadian Society for Fall 2015 and taught first run of this course: McMaster University, Hamilton, ON
- Met with Undergraduate course 4D06 instructors to revise and redevelop course/curriculum, suggested and incorporated new provocative readings: McMaster University, Hamilton, ON, 2014
- Developed Undergraduate course: CSWP 900 Race and Ethnicity, School of Social Work**:** Toronto Metropolitan University, Toronto, ON for Spring 2013
- Developed interactive course website using blackboard software for a 13-week online Undergraduate course on interdisciplinary teamwork in community services. Toronto Metropolitan University, Toronto, ON, 2013-2015
- Contributed to revisions of Undergraduate course outline for SOWK 1011 Introduction to Critical social Work to include updated research and literature relevant to the field. York University, Toronto, ON. 2009-2013

d. Development/evaluation of educational materials and programs

Book Proposal Reviewer: *More than a Diagnosis, More than a Clinician: How the Stories of Clinicians and the Individuals We Work With Shape Us and Our Practice* 2019

By Jennifer Gerlach, Routledge

Book Proposal Reviewer: *Critical Clinical Social Work: Counterstorying for Social Justice* 2018
By Catrina Brown and Judy MacDonald, Canadian Scholars Press

Book Proposal Reviewer: *Troubling Care: A Theory of Institutional Violence*, 2017
by Kate Rossiter and Jennifer Rinaldi, Routledge

Book Reviewer: *Working with People: Communication Skills for Reflective Practice* 2016
by Louise Harms and Joanna Pierce, Oxford University Press

e. Other

Deep Diversity Leadership Training- Anima Leadership 2019
Employment Equity Facilitators Training 2019

12. Supervisorships

a. *Master*

Completed: 14 In progress: 4

Gessie Stearns MSW Thesis School of Social Work, McMaster University	2021-Present
Minju Kim MSW Thesis School of Social Work, McMaster University	2021-Present
Nickay Palmer MA, Gender Studies and Feminist Research, McMaster University	2019-2020
Chriselle Vaz MSW Thesis School of Social Work, McMaster University	2019-2020
Shangaari Kanesalinkam MSW Thesis School of Social Work, McMaster University	2019-Present
Fatemah Shamkhi MSW Thesis School of Social Work, McMaster University	2019-2020
Kendra Mackenzie MSW Thesis School of Social Work, McMaster University	2019-2020
Alison Jones MSW Thesis School of Social Work, McMaster University	2018-Present
Amarachi Chukwu MA, Gender Studies and Feminist Research, McMaster University	2017 - 2018
Laura Stothart MSW Thesis School of Social Work, McMaster University	2017- 2018
Beshele Caron MSW Thesis School of Social Work, McMaster University	2017- 2018
Kattawe Henry MA Gender Studies and Feminist Research, McMaster University	2016 - 2017
Teagan Rooney MSW Thesis School of Social Work, McMaster University	2016 - 2017
Amy Rector MSW Thesis School of Social Work, McMaster University	2016 - 2017
Sarah Adjekum MSW Thesis School of Social Work, McMaster University	2015 - 2016
Gillian Martel MSW Thesis School of Social Work, McMaster University	2015 - 2016
Heston Tobias MA MRP Cultural Studies and Critical Theory, McMaster University	2016 – 2016
Jeffrey Corrin MSW Thesis School of Social Work, McMaster University	2014 - 2020

b. *Doctoral*

In progress: 3

Kusum Bhatta Ph.D. Thesis School of Social Work, McMaster University	2021-Present
Shaila Kumbhare Ph.D. Thesis School of Social Work, McMaster University	2019-Present
Michelle Hayes Ph.D. Thesis School of Social Work, McMaster University (withdrawn)	2017-2019
Nicholas Carveth Ph.D. Thesis School of Social Work, McMaster University	2015-Present

c. *Post-doctoral/fellowship*

N/A

d. *Clinical/Professional*

Field Supervisor: BSW Field Placement September 2019- April 2020
Hamilton Center for Civic Inclusion & McMaster University, School of Social Work

Graduate placement supervisor: GENDRST 707 September 2019- December 2019
Hamilton Center for Civic Inclusion & McMaster University, Gender Studies and Feminist Research

Field Supervisor: BSW Field Placement 3DD6 September 2017- April 2018
Self-Directed Placement**,** McMaster University, School of Social Work

University of Toronto: Master of Social Work –Field Placement Supervisor Sept. 2010-April 2011
CMHA Toronto Early Intervention, Provision of Clinical and Professional Supervision

Ryerson University: Internationally Educated Social Work Professionals Bridging Program
Post-Master of Social Work –Canadian Field Placement Supervisor April-June 2011
CMHA Toronto Early Intervention, Provision of Clinical and Professional Supervision

e. *Supervisory Committees*

Mercy Lilian Gichuki. Ph.D. Global Health, McMaster University March 2021-Present
Aisha Wilks. Ph.D. English and Cultural Studies, McMaster University November 2021- Present
Chavon Niles. Ph.D. Department of Social Justice Education,
Ontario Institute for Studies in Education University of Toronto June 2020-November 2020
Ciceley Janet Lawson. Ph.D. Social Work, McMaster University 2020- Present
Nishi Singh. MA in Globalization Studies, McMaster University Completed 2015

f. *Other – second reader on thesis, Undergraduate Student Research Awards*
Pamandeep Jhajj MSW Thesis School of Social Work, McMaster University Completed 2019
Alex Wilson Interdisciplinary Science 4A12 Thesis, McMaster University Completed 2018
Chriselle Vaz Undergraduate Student Research Award, McMaster University 2018 & 2019
Monique Pitt MSW Thesis School of Social Work, McMaster University Completed 2017
Brittany Madigan. MSW Thesis School of Social Work, McMaster University Completed 2015
Joel Martin. MSW Thesis School of Social Work, McMaster University Completed 2015
Madhav Khurana MSW Thesis School of Social Work, McMaster University Completed 2016

13. Lifetime Research Funding

Type: 2021 SSHRC Partnership Grant
Agency: Social Sciences and Humanities Research Council
Amount: $2.5 Million
Purpose: Research
Recipients: Bonny Ibhawoh (PI) (Ameil Joseph's role: Co-Investigator, McMaster University)

Title: Participedia Phase 2: a global network and crowdsourcing platform for researchers, educators, practitioners, and policymakers working on public participation and democratic innovations

Type: 2020 SSHRC Partnership Engage Grant (March competition)
Agency: Social Sciences and Humanities Research Council
Amount: $24984
Purpose: Research
Recipients: Ameil Joseph (PI) & the Disability Justice Network of Ontario
Title: "What happened to you?": The disablement of youth across socioeconomic indicators

Type: 2020 Mitacs Accelerate Research Grant
Agency: Mitacs
Amount: $45000
Purpose: Research
Recipients: Ameil Joseph (PI), Shaila Kumbhare (Intern), CMHA Hamilton (Agency partner)
Title: Grief, Memorials, and Loss through COVID-19: Resources for caring while physical distancing

Type: 2020 McMaster COVID-19 Research Fund
Agency: McMaster University
Amount: $29000
Purpose: Research
Recipients: Ameil Joseph (PI), CMHA Hamilton (Agency partner)
Title: Grief, Memorials, and Loss through COVID-19: Resources for caring while physical distancing

Type: 2020 McMaster Institute for Health Equity Seed Grant
Agency: McMaster Institute for Health Equity
Amount: $6000
Purpose: Research
Recipients: Ameil Joseph & Bernice Downey (Co-PIs)
Title: Hamilton Public Health Equity Data Community Advisory Research Project

Type: 2020 SSHRC Partnership Engage Grant (June competition)
Agency: Social Sciences and Humanities Research Council
Amount: $22228
Purpose: Research
Recipients: Diana Singh (PI), Ameil Joseph (Co-applicant), James Gillett (Co-applicant), CMHA Hamilton (Agency partner)
Title: COVID-19 - Emotions Matter: Skill Building, Emotional Resilience and Social Support for Care Workers

Type: SSHRC Insight Grant 2018 (funded years May 15, 2018-March 31, 2021)
Agency: Social Sciences and Humanities Research Council
Amount: $70862
Purpose: Research
Recipients: Ameil Joseph
Title: The ethics and social relations of undesirability: exploring the experiences of immigration detention and deportation for Canadian immigrants with histories of mental health issues

Type: Fall 2019 SSHRC Explore – Major Collaborative Project Seed Grant
Agency: Arts Research Board, McMaster University

Amount: $9000
Purpose: Research
Recipients: Vanessa Watts (PI), Amber Dean (Co-applicant), Ameil Joseph (Co-applicant)
Title: (Re)imagining Critical Approaches to Social Justice in Higher Education

Type: 2017/2018 Scholar in Community Fellowship
Agency: Faculty of Social Sciences, McMaster University
Amount: $15000
Purpose: Research
Recipients: Ameil Joseph
Title: *Hamilton's Anti-Racism Resource Centre Foundational Research Project*

Type: Priority Areas for Learning and Teaching Research Grant, 2017
Agency: Paul R. MacPherson Institute for Leadership, Innovation & Excellence in Teaching, McMaster University
Amount: $5000
Purpose: Research (or Pedagogical Research)
Recipients: Ameil Joseph
Title: *Enhancing teaching capacity for universal design, accessibility and inclusion through a critical engagement with the confluence of mental health, madness, sanism, eugenics, ability and colonization in the classroom*

Type: Fall 2015 (now named SSHRC Explore) Standard Research and Creative & Performing Arts Grant competition,
Agency: Arts Research Board, McMaster University
Amount: $5950
Purpose: Research
Recipients: Ameil Joseph
Title*: Exploring social relations at the confluence the mental health, criminal justice, and immigration systems*

Conference and Publication Grants

Fall 2019 SSHRC Exchange - Conference Attendance and Representational Activities Grant $3957
Arts Research Board, McMaster University, Hamilton, ON
Crime, Justice and Social Harms in Oxford University, Keble College, UK.

Spring 2017 (now named SSHRC Exchange) Conference Attendance
and Representational Activities Grant competition, $1070
Arts Research Board, McMaster University, Hamilton, ON
Interrogating Social Work's Role in "Nation" Building CASWE-ACFTS 2017 Conference, Toronto, ON

Fall 2015 (now named SSHRC Exchange) Scholarly Publications Grant competition, $842
Arts Research Board, McMaster University, Hamilton, ON
Deportation and the Confluence of Violence within Forensic Mental Health and Immigration Systems

Fall 2015
(now named SSHRC Exchange) Conference Attendance
and Representational Activities Grant competition, $2,272
Arts Research Board, McMaster University, Hamilton, ON

Experiencing Prison - 7th Global Conference in Budapest, Hungary

Fall 2014
(now named SSHRC Exchange) Conference Attendance
and Representational Activities Grant competition, $1,630
Arts Research Board, McMaster University, Hamilton, ON
The International Journal of Arts & Sciences (IJAS) International Conference for Social Sciences and Humanities in Harvard university, Boston, MA

Total $241995

14. Lifetime Publications

a. *Peer Reviewed*

i) Books

Joseph, A.J. (2015). *Deportation and the confluence of violence within forensic mental health and immigration systems.* Basingstoke: Palgrave-Macmillan.

ii) Contributions to Books

Joseph, A.J. (2022). *Maddening intersectionality with assemblages, conviviality and confluence for epistemic dissidence*. In, LeFrançois, B & Shaikh, S. (eds). Critical Social Work, Fernwood Press.

Joseph, A.J. (2021). The subjects of oblivion: subalterity, sanism, and racial erasure. In Beresford, P., Russo, J., & Boxall, K. (eds). Routledge International Handbook of Mad Studies. Routledge.

Joseph, A.J., Double, D. (2020). *Critical perspectives in mental health.* In Savelli, M. Gillett, J. & Andrews, G. (eds). Introduction to Mental Health and Illness: Critical Perspectives (pp. 240-256). Oxford University Press.

Joseph, A.J. (2020). Excavating hostility and rationalizing violence through anti-immigrant confluent discourses of racial threat, risk, burden and lack**.** In Spivakovsky, C., Steele, L. & Weller, P. (eds). *The Legacies of Institutionalisation Disability, Law and Policy in the 'Deinstitutionalised' Community*. (pp.107-122.). Hart-Bloomsbury Publishing.

Joseph, A.J. (2019). Contemporary forms of legislative imprisonment and colonial violence in forensic mental health. In Daley, A., Costa, L., Beresford, P. (eds.). *Madness, violence and power: A radical anthology*. Toronto: UofT Press.

Joseph, A. J. (2018). Traditions of Colonial and Eugenic Violence: Immigration Detention in Canada. In Kilty, J. M., & Dej, E. (eds.). *Containing Madness: Gender and 'Psy'in Institutional Contexts* (pp. 41-65). Palgrave Macmillan, Cham.

Joseph, A.J. (2017). Making Civility: Historical Racial Exclusion Theories within Canadian Democracy. In Daenzer, P. (eds.), *Civil Society Engagement: Achieving Better in Canada*. (pp. 17-30). New York: Routledge.

Joseph, A.J., (2017). Pathologizing distress: The Colonial Master's Tools and Mental Health Services for "Newcomers/Immigrants". In Baines, D. (ed.), *Doing Anti-Oppressive Practice: Social Justice Social work*, (3rd Edition, pp. 233-251). Halifax, Canada: Fernwood.

Joseph, A.J. & Maiter, S. (2015). Post-national Belonging: Strategies of Racialized Youth in Multicultural Western Contexts. In Baffoe, M. Asimeng-Boahene, L. & Ogbuagu, B. (eds.,). *Settlers in Transition: Pathways and Roadblocks to Settlement and Citizenship of New Comers in New Homelands.* (pp.23-31). Ronkonkoma: Linus Learning.

iii) Journal Articles

Joseph, A.J. (2021). Simulating the Other in Social Work Pedagogy: Pathologizing the oppressed through neoliberal/colonial practice teaching. *British Journal of Social Work.* https://doi.org/10.1093/bjsw/bcab048

Adjekum, S. A., & Joseph, A. J. (2021). Violence by any other name: constructing immigration crises, the threat of the sick refugee and rationalising immigration detention through moral panic. *Critical and Radical Social Work.* https://doi.org/10.1332/204986021X16355210292075

Joseph, A.J., Janes, J., Badwall, H., Almeida, S. (2019). Preserving white comfort and safety: the politics of race erasure in academe. *Social Identities: Journal for the Study of Race, Nation and Culture*. https://doi.org/10.1080/13504630.2019.1671184

Joseph, A.J. (2019) Constituting "lived experience" discourses in mental health: The ethics of racialized identification/representation and the erasure of intergeneration colonial violence. *Journal of Ethics in Mental Health. https://jemh.ca/issues/v9/documents/JEMH%20Inclusion%20i.pdf*

Tobias, H., & Joseph, A.J. (2018). Sustaining systemic racism through psychological gaslighting: Denials of racial profiling and justifications of carding by police utilizing local news media. *Race and Justice. http://journals.sagepub.com/doi/full/10.1177/2153368718760969*

Maiter, S., & Joseph, A. J. (2016). Researching racism: The colour of face value, challenges and opportunities. *British Journal of Social Work, 47*(3), 755-772.

Joseph, A.J. (2015). Beyond intersectionalities of identity or interlocking analyses of difference: confluence and the problematic of "anti"-oppression. *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice, 4(1), 15-39.*

Joseph, A. J. (2015). The necessity of an attention to Eurocentrism and colonial technologies: an addition to critical mental health literature. *Disability & Society, 30*(7), 1021-1041.

Lamoureaux, A., Joseph, A., (2014). Toward transformative practice: Facilitating access and barrier-free services with LGBTTIQQ2SA populations**.** *Social Work in Mental Health*, 12(3), 212-230.

Joseph, A. J. (2014). A prescription for violence: The legacy of colonization in contemporary forensic mental health and the production of difference. *Critical Criminology*, 22(2), 273-293.

Joseph, A. J. (2013). Empowering alliances in pursuit of social justice: Social workers supporting psychiatric-survivor movements. *Journal of Progressive Human Services, 24(3),* 265-288.

Maiter, S., Joseph, A., Shan, N., Saeid, A., (2013). Doing participatory qualitative research: Development of a shared critical consciousness with racial minority research advisory group members. *Qualitative Research,* 13(2), 198-213.

Joseph, A. J. (2010). Advocacy in social work: Recovery-focused systems for people living with serious mental health issues. *Canadian Social Work,* 12(2), 25-42.

iv) Journal Abstracts

N/A

v) Other, including Proceedings of Meetings

Joseph, A.J. (2019). Big data and social services: Public overseers of human suffering for private gain. Pp.77-87. Digitization and Challenges to Democracy, *Institute on Globalization & the Human Condition, Globalization Working Papers* 19(1). McMaster University, Hamilton, ON. https://globalization.mcmaster.ca/research/publications/working-papers/2019/working-paper-oct-2019.pdf

Joseph, A. J. (2012). Ancestries of racial and eugenic systems of violence in the mental health sector. In I. Needham, K. McKenna, M. Kingma, N. Oud (Ed.), *Third International Conference on Violence in the Health Sector, Vancouver, BC.* (pp. 234-238). The Netherlands: Kavanah. http://www.oudconsultancy.nl/Resources/Proceedings_3rd_Workplace_Violence_2012.pdf

Vaz, C., & Joseph, A.J. (2018, November). Negotiating Conflicting Understandings of Intimate Relationships: Exploring Meaning Making, Isolation and Identity in Cross Cultural Contexts for South Asian University Students. Poster session presented at the *2018 Undergraduate Student Research Award Poster Session*, McMaster University, Hamilton, ON.

b. *Not Peer Reviewed*

i) Books

N/A

ii) Contributions to Books

N/A

iii) Journal Articles

N/A

iv) Journal Abstracts

N/A

v) Other, including Proceedings of Meetings

Canadian Federal Government Policy Briefs

The Standing Senate Committee on Legal and Constitutional Affairs
RE: Bill C-7: An Act to amend the Criminal Code (medical assistance in dying)
January 27, 2021
https://sencanada.ca/content/sen/committee/432/LCJC/Briefs/Brief_AmeilJoseph_e.pdf

Standing Committee on Citizenship and Immigration
Federal Government Policies and Guidelines Regarding Medical Inadmissibility of Immigrants. Published on: Monday, November 20, 2017 to 8:32 p.m. (EST)

http://www.ourcommons.ca/Committees/en/CIMM/StudyActivity?studyActivityId=9719668

Website Creation:

Home - A Way Through (mcmaster.ca) : Grief, Memorials, and Loss through COVID-19: Resources for caring while physical distancing

Contribution to feature film/Documentary

The World is Bright (Documentary film) https://www.theworldisbright.ca/impact/expert-interviews/

https://boxoffice.hotdocs.ca/websales/pages/info.aspx?evtinfo=125201~741853d5-bf72-40a5-a015-09aded779383

Knowledge Exchange

Television/Live Interviews

- Science table finds lower-income and racialized communities are more frequently ending up in the ICU - CHCH (2021, November 13).
- Hamilton vaccination program to prioritizes black & other racialized populations ages 18+ in hot spots, CHCH Evening News (2021, April 23). https://www.chch.com/hamilton-vaccination-program-to-prioritizes-black-other-racialized-populations-ages-18-in-hot-spots/

  Related pieces:
  - https://www.cbc.ca/news/canada/hamilton/hamilton-bipoc-vaccine-priority-1.5989119
  - 'Good public health policy': The success of vaccine clinics for Black, racialized Canadians, CTV News. https://www.ctvnews.ca/health/coronavirus/good-public-health-policy-the-success-of-vaccine-clinics-for-black-racialized-canadians-1.5416822
  - https://www.thespec.com/news/hamilton-region/2021/04/29/racist-backlash-to-hamiltons-effort-to-vaccinate-black-and-racialized-residents-condemned.html
  - https://www.thespec.com/news/hamilton-region/2021/04/26/hamilton-covid-vaccines-latest-news.html

- White Supremacy in Hamilton. The O Show, Cable 14 (2021, January 12). https://cable14now.com/video-on-demand/video/?videoId=5591
- COVID-19 Stay-at-home order, policing. CHCH evening news (2021, January 13). https://www.chch.com/news/evening-news/
- Sir John A. Macdonald statue in Hamilton vandalized. CHCH (2020, November 9). https://www.chch.com/sir-john-a-macdonald-statue-in-hamilton-vandalized/
- What is Antifa? CTV Newsday (2020, June 1). https://link.quibi.com/PGRFjSUCZ6
- Group urging council to reverse decision to take over setting up anti-racism centre. CBC. (2019, December 11). https://www.cbc.ca/news/canada/hamilton/harrc-1.5391472
- Hate speech and Anti-Racism in Hamilton. *Vital Signs*, Cable 14. (2019, October 9). https://www.cable14.com/tv-shows/vital-signs
- Hate in Hamilton. *The O Show*, Cable 14. (2019, September 17). https://www.cable14.com/tv-shows/o-show-the
- Hate in Hamilton: what went wrong and how we make it right. *CBC*. (2019, August 7). https://www.cbc.ca/news/canada/hamilton/hamilton-hate-live-1.5218029
- Diversity and Representation. *City Matters*, Cable 14. (2019, April 10). https://cable14now.com/video-on-demand/video/?videoId=4271
- Diversity advocates call recently appointed member to Hamilton Police Board a missed opportunity. *CHCH evening news* (2019, April 6). https://www.chch.com/diversity-advocates-call-recently-appointed-member-to-hamilton-police-board-a-missed-opportunity/
- Stoney Creek hate crime exemplifies disturbing trends in racism. *CHCH evening news* (2018, July 29). http://www.chch.com/stoney-creek-hate-crime-exemplifies-disturbing-trends-racism/
- What you need to know about political extremism in 2017, Your Morning with Ben Mulroney, *CTV* (2017, February 15) http://www.ctvnews.ca/politics/is-antifa-activism-a-necessary-answer-to-the-alt-right-1.3327449
- Race and Identity, The Morning Show, *Global T.V. National* (2015, June 16). http://globalnews.ca/video/2057575/race-and-identity-interview-with-ameil-joseph/

Radio Interviews

- CBC Radio, Ontario Today -(2022, May 18): The racist ideas behind the Buffalo shooting: Are you confronting them? https://www.cbc.ca/listen/live-radio/1-45/clip/15913452
- CBC Radio. Ontario today with Rita Celli. (2020, June 17). Renaming Dundas Street: Is it a way to right a wrong? https://www.cbc.ca/listen/live-radio/1-45-ontario-today/clip/15782717-renaming-dundas-street-is-it-a-way-to-right-a-wrong
- AM900 CHML/Global News, the Bill Kelly Show. (2020, June 11). Calls for police to be defunded, Petition to rename Dundas St. & Liberal government did not get support to update rules on CERB. https://omny.fm/shows/bill-kelly-show/the-bill-kelly-show-podcast-calls-for-police-to-be?t=17m33s
- AM900 CHML/Global News, the Bill Kelly Show. (2019, December 11). McMaster's Ameil Joseph talks about the city's decision to take over the Hamilton Anti-Racism Resource Centre (HARRC). https://globalnews.ca/news/6282905/city-takes-over-hamilton-anti-racism-resource-centre/
- AM900 CHML/Global News, the Bill Kelly Show. (2019, September 19). Three instances of Justin Trudeau in brownface have emerged. https://www.iheart.com/podcast/256-bill-kelly-show-31080203/episode/three-instances-of-justin-trudeau-in-49416209/
- Newstalk 1010 Moore in the Morning. (2018, September 30). The Rise of Hate. http://www.iheartradio.ca/newstalk-1010/audio/the-rise-of-hate-1.8470727?mode=Article&autoplay=1.8470727

- AM900 Radio Interview with Anthony Urciuoli (2016, November 26). Anti-Racism Action Initiative https://omny.fm/shows/anthony-urciuoli-show/disappointing-ticket-sales-for-the-grey-cup-game-m?t=29m31s
- 60 Seconds with Ameil Joseph PACBIC (President's Advisory Committee on Building Inclusive Community) (2016, November 8), Morningfile, CFMU 93.3 https://www.youtube.com/watch?v=mW-BMRylrQI

Magazine Articles:

- Joseph, A.J., (2020). Equity data as an ethical necessity: Understanding the viral confluence of injustice through COVID-19. *Canadian Dimension*. https://canadiandimension.com/articles/view/equity-data-as-an-ethical-necessity-understanding-the-viral-confluence-of-injustice-through-covid-19
- Joseph, A.J., (2016). Putting alt-Right's Racism in Context. *Our-Times: Canada's Independent Labour Magazine*. http://ourtimes.ca/Between_Times/article_513.php

Newspaper Articles:

- Joseph, A.J. (2022, May 5). A Way to End Hatred in Hamilton. Hamilton Spectator. https://www.thespec.com/opinion/contributors/2022/05/05/a-way-to-end-hatred-in-hamilton.html
- Joseph, A.J., Jama, S. & Linton, M. (2022, January 23). Our long-term care system must be dismantled | TheSpec.com
- Joseph, A.J. (2021, December 3). Misusing the language of safety and social justice | TheSpec.com
- Joseph, A.J., Damptey, K. (2021, June 7). It's time to be honest about racism in Hamilton | TheSpec.com
- Joseph, A.J. (2020, October 18). Systemic injustices, policing, and mental health. Hamilton Spectator. https://www.thespec.com/opinion/contributors/2020/10/18/systemic-injustices-policing-and-mental-health.html
- Joseph, A.J. (2020, September 27). Hamilton police not mental health professionals. Hamilton Spectator. https://www.thespec.com/opinion/contributors/2020/09/27/hamilton-police-not-mental-health-professionals.html
- Joseph, A.J., (2020, June 15). How Much More Do You Need to See: Black Lives Matter. Hamilton Spectator. https://www.thespec.com/opinion/contributors/2020/06/15/how-much-more-do-you-need-to-see-black-lives-matter.html
- Joseph, A.J., (2019, April 12). Police board ignores city's promises of inclusion and diversity with latest appointment. *Hamilton Spectator*. https://www.thespec.com/opinion-story/9281084-police-board-ignores-city-s-promises-of-inclusion-and-diversity-with-latest-appointment/
- Joseph, A.J., (2016, December 30). Hamilton Police Still not Getting it On Racism. *Hamilton Spectator*. http://m.thespec.com/opinion-story/7041880-hamilton-police-still-not-getting-it-on-racism
- Joseph, A.J. (2014, November 14). *ARRC more than a 'hotline': Centre will be step toward equity, social justice and preventing racial tension*. Hamilton Spectator, Retrieved December 10, 2014 from http://www.thespec.com/opinion-story/5013061-arrc-more-than-a-hotline-/

Online Publications

- Joseph, A.J., Kumbhare, S. (2021). Mental health, grief, loss, and bereavement through COVID-19 - Academic Matters

- Joseph, A.J., Daniel, J., Ibhawoh, B., Deen, J., Coleman, D., Abebe, A., Ogunkoya, F., Kapiriri, L. (2021). Beyond cohorts and clusters: redressing systemic anti-Blackness in higher education — University Affairs
- Joseph, A.J., (2021). Expanding MAiD could worsen discrimination against people with disabilities. https://ipolitics.ca/2021/02/19/expanding-maid-could-worsen-discrimination-against-people-with-disabilities/
- African & Caribbean Faculty Association of McMaster (2020) https://dailynews.mcmaster.ca/articles/statement-on-the-killing-of-george-floyd-and-racial-justice/ (writer 95%)
- Joseph, A.J., (2018). Erasing race but not racism in the Peter Khill trial. The Conversation. http://theconversation.com/erasing-race-but-not-racism-in-the-peter-khill-trial-99337 also published on CBC**,** https://www.cbc.ca/news/canada/hamilton/erasing-race-but-not-racism-in-the-peter-khill-trial-1.4736894
- Joseph, A. J., (2017). We must speak out against racism. *University Affairs/Affaires Universitaires*. https://www.universityaffairs.ca/opinion/in-my-opinion/must-speak-racism/
- Joseph, A.J. (2015) Speaking voice into the silence and naming the deception of "hoaxes": Islamophobia and other forms of racism at McMaster University. PACBIC Dialogues. https://pacbic.mcmaster.ca/documents/PACBICAmeilSpeakingvoiceintothesilence12112015.pdf
- Joseph, A.J. (2015). Food justice or/= Social justice? Systemic exclusion and discrimination: Do we respond by raising issues of access and equity or advocate for transformation. *PACBIC Dialogues*. https://pacbic.mcmaster.ca/documents/PACBICAmeilFoodJusticeorSocialJustice.pdf

c. *Accepted for Publication (in final form)*

d. *Submitted for Publication*

Joseph, A.J. (Submitted). The Said and the Unsaid: Confronting Racism in Social Work as "uncanny". In Webb, S. (eds). The Routledge Handbook of Critical Social Work (2nd Ed.)

e. *Unpublished Documents*

Joseph, A.J. (2019). Hamilton Anti-Racism Resource Centre, Findings and Analysis report 2018-2019. (32 pages)

Joseph, A.J. (2019). McMaster's President's Advisory Committee on Building an Inclusive Community - 2018 (annual report, 19 pages)

Joseph, A.J. (2018). McMaster's President's Advisory Committee on Building an Inclusive Community - 2017 (annual report, 21 pages)

Joseph, A.J. (2017). McMaster's President's Advisory Committee on Building an Inclusive Community - 2016 (annual report, 19 pages)

15. Presentations at Meetings

a. Invited

Joseph, A.J. (2022, January 12). Race, Racism, Racialization and Colonialism: The Context for Governance in Education. HWDSB, Board of Trustees, Hamilton, ON

Joseph, A.J. (2021, December 16). Confronting and Defying Racism in Mental Health. Mental Health and Addiction Program Rounds, St. Joseph's Healthcare, Hamilton, ON.

Joseph, A.J. (2021, September 23). Understanding Inequity in Healthcare Education. Re*Think* Clinical Reasoning Conference. Faculty of Health Sciences, McMaster University. *https://youtu.be/nG8d8CJNAWE*

Joseph, A.J. (2021, October 28). Thinking Respectfully about Identity and Difference (3-hour workshop). Faculty of Health Science, Equity Advocacy and Allyship Program.

Joseph, A.J. (2021, October 26; 2021, November 17). *Racism in Healthcare: Are we talking about the same things?* Anti-Black Racism and Black Exclusion in Medicine Professional Competencies Curriculum, McMaster MD Program, McMaster University.

Joseph, A.J. (2021, October 21). *Racism, Race, and Racialization in Healthcare & Emergency Medicine*. FRCPC, Emergency Medicine Residency Program, McMaster University

Joseph, A.J. (2021, June 23). *Compositional Diversity and Community.* Hamilton Health Sciences, President's Equity Diversity and Inclusion Advisory Council, Hamilton, ON

Joseph, A.J. (2021, June 14). *Professional Practice, Education, and Research.* Hamilton Health Sciences, President's Equity Diversity and Inclusion Advisory Council, Hamilton, ON

Joseph, A.J. (2021, June 13). *White supremacy, Critical Race Theory and Wokeness*. The Communal with Kojo Damptey, Hamilton, ON. https://www.youtube.com/watch?v=s1RWhKUjuoo&t=3s

Joseph, A.J. (2021, June 11). *System Interaction and Culture.* Hamilton Health Sciences, President's Equity Diversity and Inclusion Advisory Council, Hamilton, ON

Joseph, A.J. (2021, June 9). *Equity through Organizational Commitment and Integration.* Hamilton Health Sciences, President's Equity Diversity and Inclusion Advisory Council, Hamilton, ON

Joseph, A.J. (2021, May 19). *Equity, Diversity, and Inclusion in Healthcare: Are we talking about the same thing?* Hamilton Health Sciences, President's Equity Diversity and Inclusion Advisory Council, Hamilton, ON

Joseph, A.J. (2019, November 29). Responding to hate in Hamilton. CityLab, McMaster University, Hamilton, ON.

Joseph, A.J. (2019, November 28). The erasure of experience and the subjects of oblivion: speaking back to the obliviousness of whiteness. *Let's Talk About Race!*, McMaster University, Hamilton, ON.

Joseph, A.J. (2019, September 28). Navigating racial issues in healthcare. *6th Annual Canadian Haemoglobinopathy Conference*, The Canadian Haemaglobinopathy Association, Hamilton, ON.

Joseph, A.J. (2019, May 23). The subjects of oblivion: subalterity and contemporary technologies of transnational eugenics, sanism, and racial eradication. *Southwestern Ontario Disability Scholars Workshop*, Windsor Law, University of Windsor, Windsor, ON.

Joseph, A.J. (2019, May 8). Confronting and Challenging racism in Healthcare: The Ethical Necessity of anti-Racism for Practice. *Ethics and Diversity Grand Rounds*, Hamilton Health Sciences, Hamilton ON.

Joseph, A.J. (2019, February 15). Dismantling Racism in Hamilton. *Vital Signs*, Hamilton Community Foundation. Mulberry Café, Hamilton, ON, https://youtu.be/trJvha3rRv8

Joseph, A.J. (2018, November 29). Freedom of Speech and Race. *Let's Talk About Race!*, McMaster University, Hamilton, ON.

Joseph, A.J. (2018, November 10). Criminalization and Racialization of Poverty and Mental Health. *Town of Ajax 3rd Annual Diversity Conference*, Ajax Convention Centre, Ajax, ON.

Joseph, A.J. (2018, September 15). Big data and social services: Public overseers of human suffering for private gain. *Digital Democracy: Transformations and Public Contestations***.** Institute on Globalization and the Human Condition, McMaster University, Hamilton, ON.

Joseph, A.J. (2018, April 11). From the insidious to the brazen: Realities of racism and resistance *The Trump Talks: Free Public Lecture Series*, McMaster Centre for Continuing Education, Hamilton, ON

Joseph, A.J. (2017, October 24). Overseers of Violence: Big Data & the Role of the Social Worker. *Legacies of Social Welfare Work in Canada Conference*. Wilfrid Laurier University, Brantford, ON**.**

Joseph, A.J. (2016, November 25). Respecting the Histories of Anti-racist Activism in Hamilton: Working towards collective action together. *Anti-Racism Action Initiative Community Meeting*. Hamilton Central Public Library, Hamilton, ON.

Joseph, A.J. (2016, March 9). The criminalization/racialization of poverty. *The Criminalization of Poverty - Race, Poverty, and Policing in Hamilton Event*, McMaster Community Poverty Initiative**.** McMaster University, Hamilton, ON

Joseph, A.J. (2016, January 19). Food justice is social justice: beyond the food security talk. *Feeding Our Faiths 2016*, McMaster Students Union Diversity Services, Interfaith Committee. McMaster University, Hamilton, ON

Invited Keynotes/Plenaries

Joseph, A.J. (2022, June 8). Data and Justice: Mobilizing Solidarities for Action. Action Now-Building Equitable Futures Together: Primary Health Conference. Alliance for Healthier Communities, Delta Hotels by Marriot Toronto Airport and Conference Centre. Toronto, ON

Joseph, A.J. (2022, February 16). Challenging Systemic Racism for Health Equity in Hamilton: Mobilizing Solidarities for Action. McMaster Institute for Health Equity, McMaster University. https://youtu.be/bWai1Prl0ms

Joseph, A.J. (2022, February 17). Confronting and Resisting Racism in Mental Health & Pediatrics. Department of Pediatrics, Grand Rounds, Faculty of Health Sciences, McMaster University. https://www.macvideo.ca/media/Bridging+the+GapA+Confronting+and+Resisting+Racism+in+Mental+Health+%7C+Dr.+Ameil+Joseph+%7C+February+17%2C+2022/1_5mojt3dg

Joseph, A.J., Bedminster, T, Jama, S, Frketich, J. (2021, December 2). *Community Responses to #COVID-19 in Hamilton*. Hamilton Centre for Civic Inclusion, 2020/21 Annual General Meeting. Hamilton, ON

Joseph, A.J. (2021, November 16). *Affordable housing, accessible housing, not-for-profit housing-acknowledging complicities and histories of exclusion*. 2021 Housing Central Conference, BC Not-For-Profit Housing Association. Vancouver, BC.

Joseph, A.J. (2021, June 16). *Courageous solidarities: Listening and supporting the most marginalized in the struggle for a better Hamilton*. Hamilton Community Foundation, Annual General Meeting, Hamilton, ON

Joseph, A.J. (2021, February 10). Beyond the Individual: Confronting and Challenging Racism in Health and Mental Health. Department of Psychiatry and Behavioural Neurosciences, McMaster University, Hamilton, ON, https://youtu.be/LV5hk7A83aM

Joseph, A.J. (2020, October 23). Race & racism in 2020 and beyond: Confronting individual, systemic, and structural complicities for transformative change. *Anti-Racism Day*, Ministry of Economic Development, Job Creation and Trade, Business Partnerships and Programs Division, Toronto, ON.

Joseph, A.J. (2020, September 10). Appreciating Individual, Systemic, and Structural Inequities in Local, Current and Historical Contexts for Change. City of Hamilton, Mayor's Task Force on Economic Recovery. Hamilton, ON.

Joseph, A.J. (2020, September 3). Defunding Harm and Violence. Defunding the Police-Community Teach-in. City of Hamilton, City Hall Forecourt, Hamilton, ON.

Joseph, A.J. (2020, June 24). Defying Racism in Hamilton. *Hamilton Anti-Racism Conference*, Hamilton Center for Civic Inclusion, Hamilton, ON. https://youtu.be/Lf1zOaZJyss

Joseph, A.J. (2019, September 26). Race and racism in Hamilton. *Hamilton Urban Core Community Health Centre, Annual General Meeting*. Hamilton, ON

Joseph, A.J. (2015, May 8). The untreatable mentally ill, the unrehabilitatable criminal and the undeserving alien: Contemporary eugenic and racial technologies of violence at the confluence of forensic mental health and immigration systems. *8th Annual Social Work Research Symposium: Interdisciplinary Conversations on Social Transformation and Critical Practices.* York University, Toronto, ON.

Joseph, A.J. (2014, November 25). Violent interventions: Neo-colonization in contemporary forensic mental health and the (re)production of difference. *UN International Day of Person with Disabilities Lecture, Office of human rights and equity services*, MACCESSIBILITY program, McMaster University, Hamilton, ON.

Invited Panelist

Wilks, A, Joseph, A.J., Kumbhare, S., Suart, C. (2022, June 1). Reframing Disability in Healthcare. Faculty of Heath Sciences, McMaster University, Hamilton, ON.

D'Souza, R. Joseph, A.J., Marshall, L-J, Loen, M. (2022, May 27). The Vax Scene: Understanding Factor in Vaccine Uptake. Canada's Global Nexus for Pandemics and Biological Threats. McMaster University, Hamilton, ON

Joseph, A.J., Damptey, K., Walker, J. (2022, March 25). Data, equity, and justice: respecting relationships for health equity. Greater Hamilton Health Network, Hamilton Centre for Civic Inclusion, Indigenous Health Leaning Lodge, McMaster Office of Community Engagement, Hamilton, ON. https://www.youtube.com/watch?v=NC5zeLJbCaY

Joseph, A.J., Jama, S., Linton, M., Clutterbuck, P., Martin, K. (2022, March 10). Town Hall on changes Needed in Home Care and Community Care. Disability Justice Network of Ontario, Seniors for Social Action, Social Planning and Research Council of Hamilton, Hamilton, ON. Virtual Town Hall on Home Care, Elder Care and Community Care - March 10, 6 to 8 PM (djno.ca)

Joseph, A.J., Peters, G., Hawes, S., Ward, K, Theriault, A. (2021, November 16). Disability & Accessibility Panel. 2021 Housing Central Conference, BC Not-For-Profit Housing Association. Vancouver, BC.

Lepofsky, D., McMeekin, G. and Joseph, A.J. (2021, October 28). Disability Justice, Accessibility and Beyond. Access to Justice Week, Faculty of Law, University of Alberta, Alberta. https://www.albertaaccesstojustice.com/blog/disability-justice-resources

Joseph, A.J., McCradden, M., Singh, D. (2021, October 27). Addressing Inequities in AI and Technology as Clinicians and Researchers. The Hospital for Sick Children. Fifth annual Department of Paediatrics and Faculty of Medicine, We All Belong: Equity and Data Justice for Precision Health and Research. Toronto, ON. http://www.cvent.com/events/we-all-belong-equity-and-data-justice-for-precision-health-and-research/agenda-499720ce21824c0d829adbf31ce32437.aspx

Joseph, A.J., Elghawaby, A., Hashim, M., & Narro-Pérez, R. (2021, August 3). Responding to Hate in Hamilton. Hamilton Centre for Civic Inclusion, Hamilton, ON. https://www.youtube.com/watch?v=aWMB09W8P5g&t=3s

Disability Justice Network of Ontario. (2021, June 30). Abolish The Psych Ward Panel featuring Dr. Ameil Joseph and Dr. Syrus Marcus Ware (djno.ca)

Art Gallery of Hamilton (2021, May 20). Esmaa Mohamoud Exhibit, Play in the Face of Certain Defeat. https://www.artgalleryofhamilton.com/program/free-thursdays-esmaa-mohamoud-panel-talk/

GritLit Festival (2021, April 17). No Place Like Home: Issues Around Homelessness, Hamilton Ontario

Joseph, A.J., (2020, November 17) Racism in Healthcare: Are we talking about the same things? Anti-Black Racism and Black Exclusion in Medicine, Professional Competencies Curriculum, McMaster MD Program, McMaster University.

From Stories to Action: Addressing Anti-Black Racism in Healthcare. (2020, October 1). Chair's Grand Rounds, Hamilton Health Sciences, Department of Medicine, McMaster University, Hamilton, ON.

Resistance in Academia. (2019, January 31). *Diversity Week Panel*, Diversity Services, McMaster Student Union, McMaster University, Hamilton, ON.

Psychiatric Detention: Problem in Policy & Practice. (2019, March 15). *Detained: From supporting Prisoners to Abolishing Prisons. Journal of Law and Social Policy*, Osgoode Hall Law School, York University, Toronto, ON.

Immigration detention in Canada: A historical confluence of gendered ideas of the dangerous, the racialized, the immigrant, the biologically mad threat. (2017, December 5). *Research Forum on Immigration, Borders, and Social Justice.* McMaster University, Hamilton, ON

Mental health and gender violence. (2017, March 30). *Decolonize and Deconstruct Imagining new approaches to sexuality and consent education*. Brock University, St. Catharines, ON

Decolonizing leadership. (2017, March 29). *Leadership Panel - Diversity/Respect/Bias- Strategic Leaders Program*, McMaster University, Ron Joyce Centre, Burlington, ON.

Critical Race/Decolonial Perspectives for Social Justice Practice. (2017, January 27). *Senior Leadership Panel on Anti-Oppressive Practice in Ontario's Child Welfare Field*. The Catholic Children's Aid Society of Hamilton, Hamilton, ON

Crimes against Humanity, the International Criminal Court and the Rome Statute: Reflecting on Resistance to Historical Technologies of Hatred at State levels. (2016, November 16). *Making History Now: Racism, Resistance and Strategies for Building Alliance in the World of Trump*. McMaster University, Hamilton, ON

Hamilton Living Together Symposium (2016, March 29). *Canadian Race Relations Foundation,* Art Gallery of Hamilton, Hamilton, ON

b. Contributed

i) Peer reviewed

Joseph, A.J. & Kumbhare, S. (2021, December 10). Grief, Memorials, and Loss through COVID-19: Resources for caring while physical distancing. World Pandemic Research Network Conference. Grief, Memorials, and Loss through COVID-19: Resources for caring while physical distancing (wprn.org)

Joseph, A.J. (2021, June 2). Occidental appropriations of resistance to systemic racism: The erosion of Anti-Racism work & the maintenance of white supremacy. 2021 Canadian Association of Social Work Education, University of Alberta, Alberta, Canada.

Joseph, A.J., Vaz, C., Millard, B., William Gooding, W., & Niles, C. (2020, April 1 -paper written but not presented due to cancellation/COVID-19). Frozen, invisible, indefinite: Immigration detention in Canada and the carceral violence of temporal torment**.** *Crime, Justice and Social Harms*, Howard League for Penal Reform, Oxford University, Keble College, UK

Joseph, A.J. (2019, July 25). Tradition of Colonial and Eugenic Violence: Immigration Detention in Canada. *XXXVI International Congress on Law and Mental Health*, International Academy of Law and Mental Health, University of International Studies of Rome, Rome, Italy.

Joseph, A.J. (2019, April 29). Invocations of historical colonial, racial, ableist, sanist tropes in contemporary anti-immigration discourse. *Mobilities and Transnationalism in the 21st Century*, University of Iceland, Reykjavik, Iceland.

Joseph, A. J. (2018, June 21). Historical and contemporary uses of immigration detention by the mental health system in Canada: Racist, sanist, and eugenic violence in policy and practice. *Disability and (Virtual) lnstitutions: lnterventions, lntegration and lnclusion*, International Institute for the Sociology of Law, Onati, Spain.

Joseph, A. J. (2018, March 2). Immigration detention in Canada: Constituting ideas of "the threat" and "the Canadian public" through racism, sanism and colonial eugenics. *2018 Canadian Association of Cultural Studies: Carceral Cultures Conference*, Simon Fraser University (Downtown), Vancouver, B.C.

Joseph, A., O'Connell, A., Gibson, M., Chapman, C., Good, B., Chambon, A. (2017, May 30). Panel on Critical History as Social Work Practice 1: Epistemic Interventions through Decolonization, *2017 Canadian Association of Social Work Education Annual Conference,* Ryerson University, Toronto, ON.

Baines, D., Freeman, B., Pon, G., Phillips, D., Clarke, J., Abdillahi, I., Hulko, W., Brotman, S., Ferrer, I., Carter, I., Hanes, R., MacDonald, J., Joseph, A., Barnoff, L., Brown, C., Massaquoi, N., and LaRose, T. (2017, June 1). Panel on Doing Anti-Oppressive Practice: Social Justice Social Work. *2017 Canadian Association of Social Work Education Annual Conference*, Ryerson University, Toronto, ON.

Singh, N., Wahoush, O., Joseph, A.J. (2016, June, 23). Conceptions of Mental Health Within the Punjabi Sikh Diaspora Community in Ottawa, Ontario. *Mental Health and Cultural Diversity International Conference: Exploring Transformative Practices and Service Models*. De Montfort University, Leicester

Joseph, A.J. (2016, March, 17). Imprisoning the mind and the body: Contemporary forms of legislative imprisonment and colonial violence in forensic mental health. *Experiencing Prison 7th Global Conference*. Inter-Disciplinary.Net., Hilton Hotel Castle District, Budapest Hungary.

Joseph, A.J. (2015 May, 28). Tracing contemporary eugenic and racial colonial technologies of dehumanization at the confluence of mental health, criminal justice and immigration systems. Presented at the *International Journal of Arts & Sciences International Conference for Social sciences and Humanities.* Harvard University, Boston, MA.

Joseph, A.J. (2014, November 3). Theorising violence at the confluence of mental health, criminal justice and immigration systems in Canada. Presented at: *6th Global Conference, Strangers, Aliens and Foreigners*, Inter-Disciplinary.net, Prague, Czech Republic.

Joseph, A.J. (2014, March 15). Civilizing disobedience: Contemporary colonization and the regulation of immigrants and indigenous people with mental health issues. Presented at: *Fourth International Conference on Health, Wellness and Society*, University of British Columbia, Vancouver, BC.

Joseph, A.J. (2013, April 26). The confluence of violence and the accretion of "truth": Reading deportation decisions for racialized people classified with serious criminality and mentally illness in Canada**.** Presented at: *Social Work's 6th Annual Research Symposium*, York University, Toronto, ON.

Joseph, A., & Maiter, S. (2012, November, 1). Postnational belonging: Strategies of racialized youth in multicultural western contexts. Presented at the *2012 Strangers in New Homelands- 5th Annual*

Conference on the Social Reconstructing of "Home" Among Immigrants in the Diaspora, University of Manitoba, Winnipeg, MB.

Joseph, A. (2012, October, 25). Ancestries of racial and eugenic systems of violence in the mental health sector. Presented at the *2012 Third International Conference on Violence in the Health Sector*, Sheraton Vancouver Airport Hotel, Richmond, BC.

Joseph, A. (2012, March, 31). Authorities on the subject: Colonial ancestries of hierarchy and hegemony in mental health. Presented at the *2012 Canadian Association of Social Work Education Annual Conference*, University of Waterloo & Wilfrid Laurier University, Waterloo, ON.

Lamoureaux, A., Joseph, A., Feris, C. (2012, March, 22). Toward transformative practice: Facilitating access and barrier-free services with LGBTTIQQ2SA populations. Presented at the *2012 Ontario Working Group on Early Psychosis Intervention Conference,* Sheraton Centre Hotel, Toronto, ON**.**

Joseph, A. (2011, June 2). A prescription for violence: The legacy of colonization in contemporary forensic mental health and the production of difference. Presented at the *2011 Canadian Association of Social Work Education Annual Conference*, University of St. Thomas, Fredericton, NB.

Maiter, S., Joseph, A., Shan, N., Saeid, A. (2010, May 14). Doing participatory qualitative research: Development of a shared critical consciousness with racial minority research advisory group members. Presented at the *27th Annual Qualitative Analysis Conference*, Wilfrid Laurier University, Brantford, ON.

Joseph, A., (2010, April 16). Empowering alliances in pursuit of social justice: Social workers supporting psychiatric-survivor movements. Presented at: *Social Work`s Annual Research Symposium*, York University, Toronto, ON.

i) Not Peer Reviewed

Joseph, A.J. (2022, March 1). Refusing colonial, carceral, eugenic, and surveillance technologies in mental health policy, practice, and law. Guest Lecture. HTH SCI 3RH3 Racism and Health, Faculty of Health Sciences, McMaster University.
Joseph, A.J. (2021, October 25). *From Commitments to Reconciliation: Supporting Decolonizing Work in Community Engaged Research*. Guest Lecture, CMTYENG 2A03, McMaster University

Joseph, A.J. & Kumbhare, S. (2021, July 21). *Loneliness & Mental Health Through COVID-19 and Beyond*. CMHA Ontario, Toronto, ON.

Joseph, A.J. (2021, May 28). Refusing colonial eugenics rationalities in mental health policy, practice, and law. Beyond the Penal and the Carceral: Alternatives to criminalization to address social need. (Panel with Prof. Rinaldo Walcott). Centre for Human Rights and Restorative Justice, McMaster University. "Beyond the Penal and the Carceral: Alternatives to criminalization to address social need" Panel - YouTube

Joseph, A.J. (2020, December 3). Data colonialism and plantation logics in social services, and public health. Data & Sovereignty: Resisting Colonial Logics for Racial Justice, McMaster Institute for Health Equity, The Lewis and Ruth Sherman Centre for Digital Scholarship, The McMaster Indigenous Research Institute, McMaster University, Hamilton, ON.
https://www.macvideo.ca/media/Data+%26+Sovereignty/1_2gxgha0l

Joseph, A.J. & Kumbhare, S. (2020, November 23 & 2021, January 18). *Grief During COVID-19*. CMHA Hamilton, Hamilton, ON.

Joseph, A.J. (2020, November 2). Anti-Racism, Resistance and Change. Invited guest lecture. UNIV 2010, Anti-Discrimination and Anti-Oppression. University of Guelph, Guelph, ON.

Joseph, A.J. (2020, October 27). Race, Racism, Racialization and Colonialism. Invited guest lecture. UNIV 2010, Anti-Discrimination and Anti-Oppression. University of Guelph, Guelph, ON.

Joseph, A.J. (2020, October 21). Relationship, Respect, Complicities, Solidarities & Decolonial Resistance. Invited guest lecture. Advanced Practice. School of Social Work, University of British Columbia., Vancouver, British Columbia.

Joseph, A.J. (2020, November 16, 17, 18, 23). Racism, Race, and Racialization in Healthcare in Canada: Matters of life and death. Invited Guest Lecture. 2RR3 Social Determinant of Health. BScN Program, Faculty of Health Sciences, McMaster University, Hamilton, ON.

Joseph, A.J. (2020, August 12). Confronting and challenging racism: the individual, the systemic, and the structural. CMHA Hamilton, Hamilton, ON.

Joseph, A.J. (2020, August 19). Racism and mental health. CMHA Hamilton, Hamilton, ON.

Joseph, A.J. (2020, October 7). Confronting and challenging racism: the individual, the systemic, and the structural. CMHA Kenora, Kenora, ON.

Joseph, A.J. (2020, October 14). Racism and mental health. CMHA Kenora, Kenora, ON.

16. Administrative Responsibilities

University:

Selection Committee- Vice-Provost, Teaching and Learning	December 2021-present
McMaster Institute for Health Equity- member	2020-present
Centre for Human rights and Restorative Justice- member	2020-present
Selection Committee - Dean, Faculty of Social Sciences	September 2019-October 2019
University Senate	July 2019- Present
School of Graduate Studies Scholarship Committee: SSHRC CGS-M	2019 & 2020, 2021
Chair: President's Advisory Committee on Building an Inclusive Community (PACBIC)	July 2016- July 2019
Hiring Committee: Executive Assistant to the Associate Vice-President Equity and Inclusion	September 2018

Renaissance Award and Chancellor's Gold Medal Selection Committee October 2018

2018 Graduand Awards Selection Committee May 2018

Hiring Committee: Executive Assistant to the AVP Equity and Inclusion July 2018-September 2018

Accessibility Policy Development Committee November 2016-Present

Employment Equity Forum November 2016 & December 2017

Hiring Committee: AVP/ Vice-Provost Equity and Inclusion October 2016- December 2017

Hiring Committee: Human Rights Specialist November 2017

Hiring Committee: Anti-Racism Officer November 2017
Hamilton Centre for Civic Inclusion/McMaster University/Anti-Racism Resource Centre

Hiring Committee: Employment Equity Specialist March 2017

Hiring Committee: Director of Human Rights and Dispute Resolution September 2016

Member, President's Advisory Committee on Building an Inclusive Community October, 2014-July 2020 (PACBIC)

President's Advisory Committee on Building an Inclusive Community September 2015- July 2016
Race, Racialization and Racism working Group-Co-Convener

African-Caribbean Faculty Association of McMaster October, 2014-Present

Faculty:

Tenure and Promotions, Faculty of Social Science July 2021-June 2022

Faculty of Social Sciences Equity, Diversity,
Inclusion and Indigenous Strategies (EDIIS) Advisory Group 2020- Present

McMaster Faculty of Social Science SSHRC Doctoral Ranking Committee 2017/2018, 2018/2019

Department:

Hiring Committee, New Tenure-Track Faculty 2021-Present

United in Colour-Faculty Liaison 2019-Present

Graduate Admissions Reviewer, School of Social Work 2018, 2019

Library Liaison School of Social Work September 2014- Present

School of Social Work's Transformative Social Justice Response Team (TSJRT) (Formerly Anti-Oppression Education Committee) September 2015-September 2017

Undergraduate Studies Committee, School of Social Work — September 2014-December 2014, September 2015-Present

Graduate Studies Committee, School of Social Work — December 2014-May 2015

17. Other Responsibilities

Hamilton Public Health, COVID-19 Vaccine Readiness Network — December 2020-present

President's Task Force on Equity, Diversity- Hamilton Health Sciences — October 2020-present

Ontario COVID-19 Mental Health Network — March 2020-July 2020

City of Hamilton, Community Advisory Panel
Hamilton Anti-Racism Resource Centre, Chair — October 2020-January 2021

Disability Justice Network of Ontario, Advisory Board, Hamilton, ON — 2020-present

Disability Justice Network of Ontario, Research Committee, Hamilton, ON — 2019-present

CIHR Doctoral Research Awards Committee – B — September 2018- August 2019
Reviewer Doctoral Research Awards for the Canadian Institute of Health Research

Houselink Community Homes, Toronto, ON — July 2011 – June 2014
Board of Directors- Vice President (2013), President (2014)
Nominations Committee, (Chair) Policy Committee, Sustainable Fundraising Committee
Mission: to improve the quality of life of psychiatric consumers / survivors including those who are homeless or otherwise marginalized, through the provision of permanent affordable supportive housing and programs.

Local Health Integration Network – Central, Toronto, ON — January 2008- March 2011
Social Worker; MSW, RSW – Health Professionals Advisory Committee
Provided professional advice to Central LHIN on how to achieve patient-centered health care within the local health system for the most diverse and populous LHIN in Ontario.
Considered innovative approaches in health service delivery, health promotion and wellness and the utilization of health human resources. (As legislated: Local Health System Integration Act, 2006 - O. Reg. 264/07)

TAB 107

Court File No. CV-21-00077817-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, ET AL.

Applicants

-and-

CITY OF HAMILTON

Respondent

ACKNOWLEDGMENT OF EXPERT'S DUTY

1. My name is Ameil Joseph. I live in the City of Hamilton, in the Province of Ontario.

2. I have been engaged by or on behalf of the Hamilton Community Legal Clinic to provide evidence in relation to the above-noted court proceeding.

3. I acknowledge that it is my duty to provide evidence in relation to this proceeding as follows:

   (a) to provide opinion evidence that is fair, objective and non-partisan;

   (b) to provide opinion evidence that is related only to matters that are within my area of expertise; and

   (c) to provide such additional assistance as the court may reasonably require, to determine a matter in issue.

4. I acknowledge that the duty referred to above prevails over any obligation which I may owe to any party by whom or on whose behalf I am engaged.

Date June 14, 2022



Signature

TAB 108

Court File No. CV-21-00077817-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, ET AL.

Applicants

-and-

CITY OF HAMILTON

Respondent

ACKNOWLEDGMENT OF EXPERT'S DUTY

1. My name is Ameil Joseph. I live in the City of Hamilton, in the Province of Ontario.

2. I have been engaged by or on behalf of the Hamilton Community Legal Clinic to provide evidence in relation to the above-noted court proceeding.

3. I acknowledge that it is my duty to provide evidence in relation to this proceeding as follows:

   (a) to provide opinion evidence that is fair, objective and non-partisan;

   (b) to provide opinion evidence that is related only to matters that are within my area of expertise; and

   (c) to provide such additional assistance as the court may reasonably require, to determine a matter in issue.

I acknowledge that the duty referred to above prevails over any obligation which I may owe to any party by whom or on whose behalf I am engaged.

Date June 5, 2024



Signature

TAB 109

Court File No. CV-21-00077817-0000

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, ET AL.

Applicants

-and

CITY OF HAMILTON

Respondent

SUPPLEMENTARY AFFIDAVIT OF AMEIL JOSEPH

SWORN June 7, 2024

I, **AMEIL JOSEPH**, of the City of Hamilton in the Province of Ontario, AFFIRM AND STATE:

1. I am an Associate Professor in the School of Social Work at McMaster University in Hamilton, Ontario. I hold a Professorship in Equity, Identity, and Transformation with the Faculty of Social Sciences at McMaster University and am Academic Director of Community Engaged Research and Relationships with the Office of Community Engagement at McMaster University. I have over a decade of professional experience in the mental health field, in Assertive Community Treatment, Supportive Housing, Crisis Respite, Early Intervention, Settlement and governance settings. I also serve on the Board of Directors for the Disability Justice Network of

Ontario and helped to found Hamilton's first Anti-Racism Resource Centre. A copy of my CV is attached to my Affidavit of June 14, 2022.

2. Encampment evictions put unhoused people at an increased risk of death.[1] The increased vulnerability of people living unsheltered, who are most impacted by displacement policies, is widely researched.[2345] It is widely accepted that increased vulnerability indicates a greater need for immediate housing intervention and support services. The City of Hamilton acknowledges this level of vulnerability and identifies factors leading to increased risk of mortality, as a form of "acuity". Specifically, high acuity individuals have corresponding "urgent health and safety considerations". These considerations, in turn, are factors leading to an increased risk of mortality.[67] Additionally, the City measures an individual's acuity as a number on the Vulnerability Index – Service Prioritization Detection Assistance Tool (VI-SPDAT) and the Service Prioritization Detection Assistance Tool (SPDAT) to help determine an individual's priority placement on the By-name priority list. Higher acuity individuals are streamlined into higher service provision level programs due to the City's recognition that these individuals have

[1] The Office of the Federal Housing Advocate. (2024). Upholding dignity and human rights: the Federal Housing Advocate's review of homeless encampments – Final report. Ottawa: The Office of the Federal Housing Advocate.

[2] Montgomery, A. E., Szymkowiak, D., Marcus, J., Howard, P., & Culhane, D. P. (2016). Homelessness, unsheltered status, and risk factors for mortality: findings from the 100 000 homes campaign. *Public Health Reports*, *131*(6), 765-772.

[3] Chang, J. S., Riley, P. B., Aguirre, R. J., Lin, K., Corwin, M., Nelson, N., & Rodriguez, M. (2022). Harms of encampment abatements on the health of unhoused people. *SSM-qualitative research in health*, *2*, 100064.

[4] Feodor Nilsson, S., Laursen, T. M., Hjorthøj, C., & Nordentoft, M. (2018). Homelessness as a predictor of mortality: an 11-year register-based cohort study. *Social psychiatry and psychiatric epidemiology*, *53*, 63-75.

[5] Barocas, J. A., Nall, S. K., Axelrath, S., Pladsen, C., Boyer, A., Kral, A. H., ... & NHBS Study Group. (2023). Population-level health effects of involuntary displacement of people experiencing unsheltered homelessness who inject drugs in US cities. *Jama*, *329*(17), 1478-1486.

[6] City of Hamilton. (March 2022). City of Hamilton Homeless-Serving Coordinated Access System Process Guide [Process Guide]. https://www.hamilton.ca/sites/default/files/2023-05/homeless-coordinated-access-guidelines-2022.pdf

[7] City of Hamilton. (July 2019). Coming together to end homelessness: Hamilton's system planning framework. https://www.homelesshub.ca/sites/default/files/attachments/coming-together-to-end-homelessness-report-final-07252019%20%281%29.pdf

an increased risk to health and safety, and are in need of more imminent and comprehensive housing intervention. In plain language, the City acknowledges that high acuity individuals are at greater risk of serious harms, such as mortality.

3. The Hamilton Homeless Mortality Data project is a group of healthcare providers that collect data on the deaths of people experiencing homelessness. The Hamilton Homeless Mortality Data project has documented 91 deaths amongst the homeless population from June 2021 to November 2023, where mental illness, stimulant use and opioid use were among the top comorbid conditions. Additionally, the most common "last known living location" of the deceased reported to the Hamilton Homeless Mortality Data project (2024), were reported as "unsheltered". Of the deceased known to the Hamilton Homeless Mortality Data project, 13% were also reported as having been shelter restricted at the time of death.[8] The cumulative data to date is attached hereto as Exhibit "A".

4. The involuntary displacement of unhoused people from encampments increases mortality rates. In a United States study conducted over a 10 year period, involuntary displaced unhoused people experienced an increase in overdose deaths, increased hospitalization, fewer initiations of medications for opioid use disorder and there was an increase in overall deaths of "unsheltered people experiencing homelessness who inject drugs".[9]

5. Additionally, the involuntary displacement of unhoused people is significantly associated with self-reported infection disease, substance and alcohol use and worsening mental health.[10]

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[8] Hamilton Homeless Mortality Data (HHMD). (2024). Deaths in the Hamilton Homeless Population, https://hamiltonhomelessmortality.weebly.com/

[9] Barocas, J. A., Nall, S. K., Axelrath, S., Pladsen, C., Boyer, A., Kral, A. H., ... & NHBS Study Group. (2023). Population-level health effects of involuntary displacement of people experiencing unsheltered homelessness who inject drugs in US cities. *Jama*, *329*(17), 1478-1486 at 1449. https://jamanetwork.com/journals/jama/fullarticle/2803839.

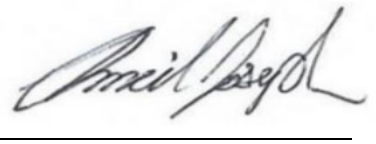
[10] Meehan AA, Milazzo KE, Bien M, Nall SK, Vickery KD, Mosites E, Barocas JA. Involuntary displacement and self-reported health in a cross-sectional survey of people experiencing homelessness in Denver, Colorado, 2018-2019. BMC Public Health. 2024 Apr 25;24(1):1159. doi: 10.1186/s12889-024-18681-w. PMID: 38664800; PMCID: PMC11044435. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC11044435/

6. I make this Affidavit for no improper purpose.

Affirmed remotely by Dr. Ameil Joseph stated as being located in the City of Hamilton in the Regional Municipality of Hamilton-Wentworth, before me in the City of Toronto on June 7, 2024, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.

Commissioner for Taking Affidavits

Curtis Sell LSO#:84128A



Ameil Joseph

This is Exhibit ‘A’ referred to in the affidavit of Dr. Ameil Joseph affirmed before me this 7th day of June, 2024.

EXHIBIT ‘A’

DEATHS IN THE HAMILTON HOMELESS POPULATION

June - November 2021

Total reported deaths: 22*

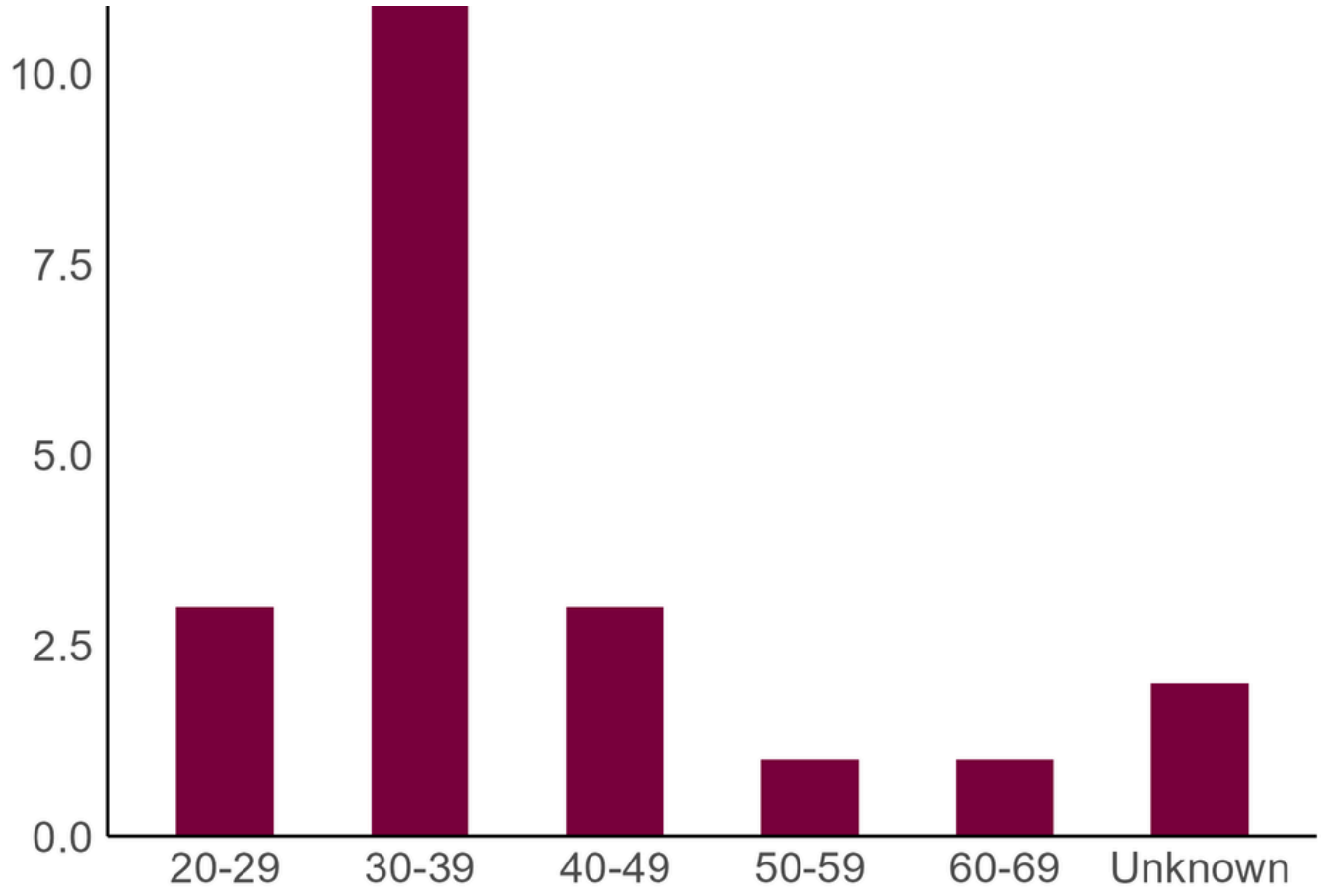
* Please note that this is pending report from the Office of the Chief Coroner and additional deaths for this time period may be reported on this webpage at a later date.

Average age at time of death:

36 years old

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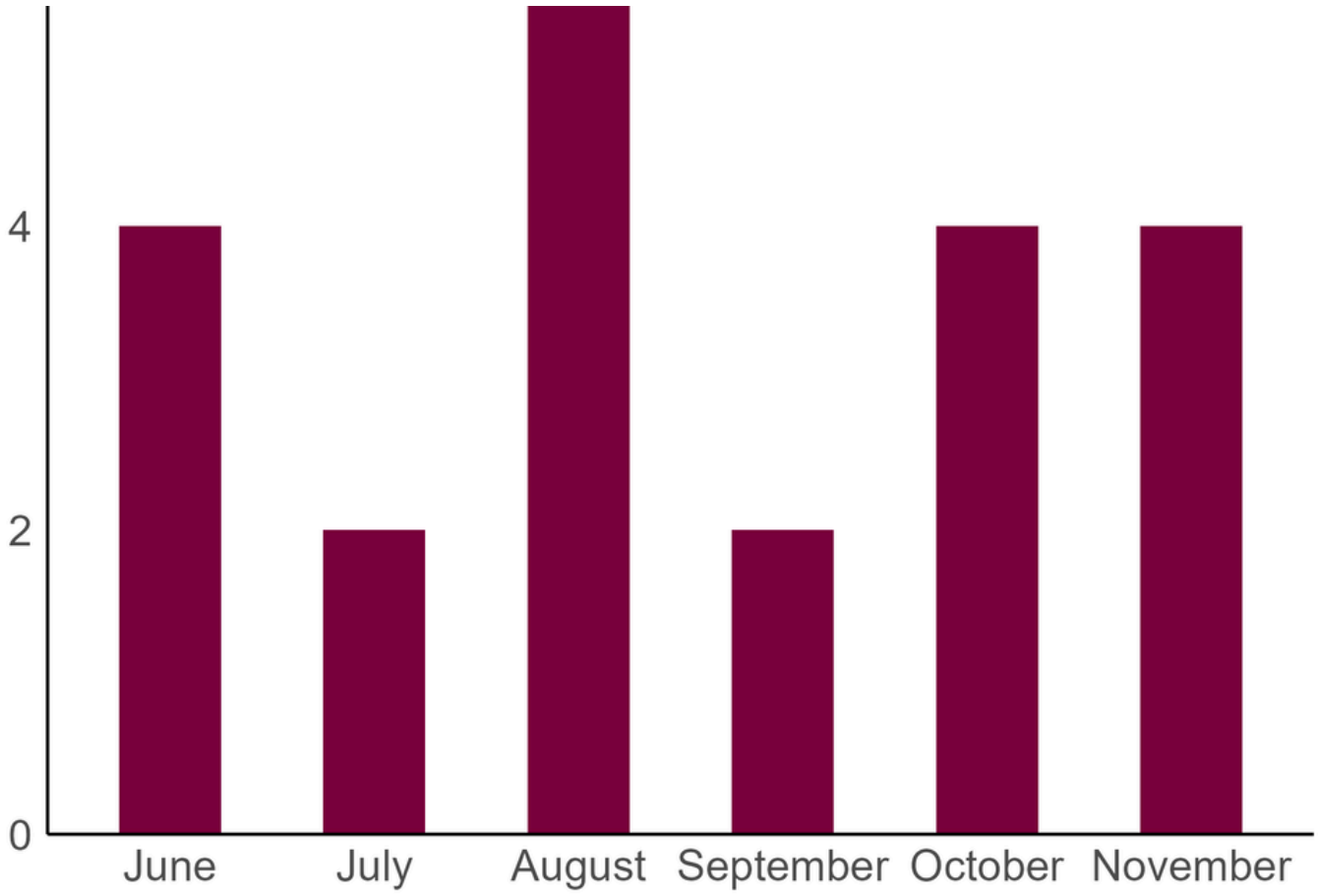
DEATHS IN THE HAMILTON HOMELESS POPULATION



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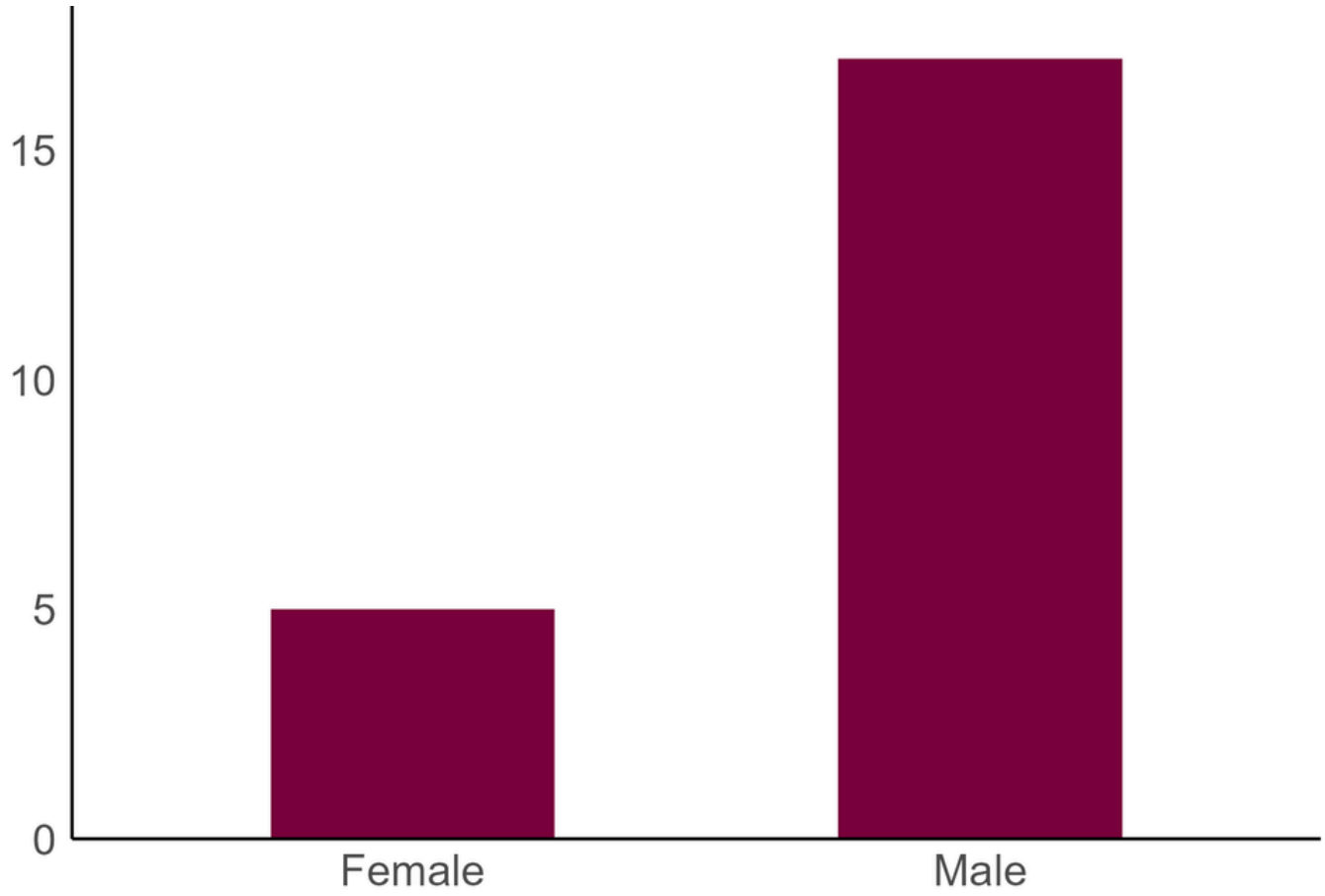
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DEATHS IN THE HAMILTON HOMELESS POPULATION



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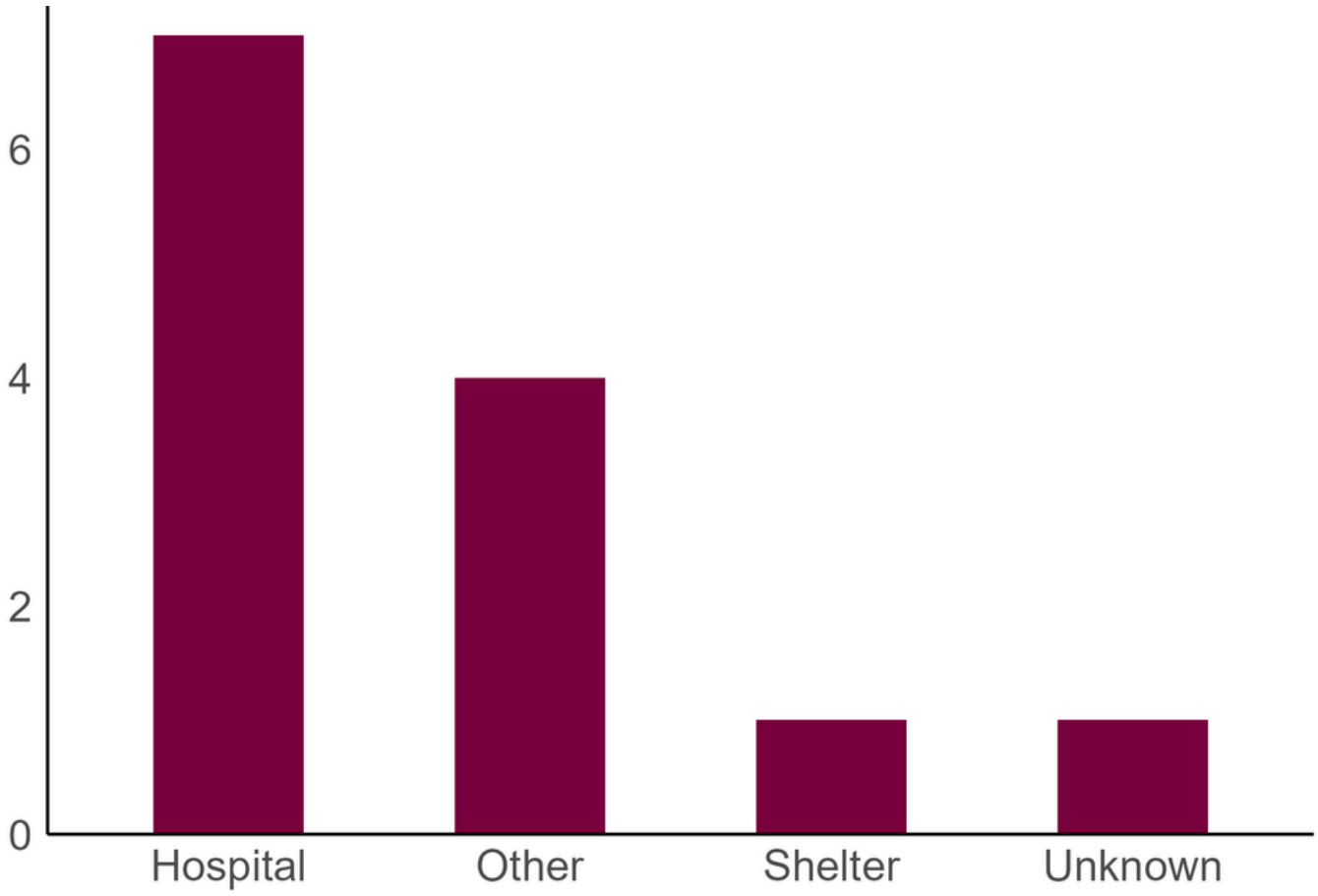
DEATHS IN THE HAMILTON HOMELESS POPULATION



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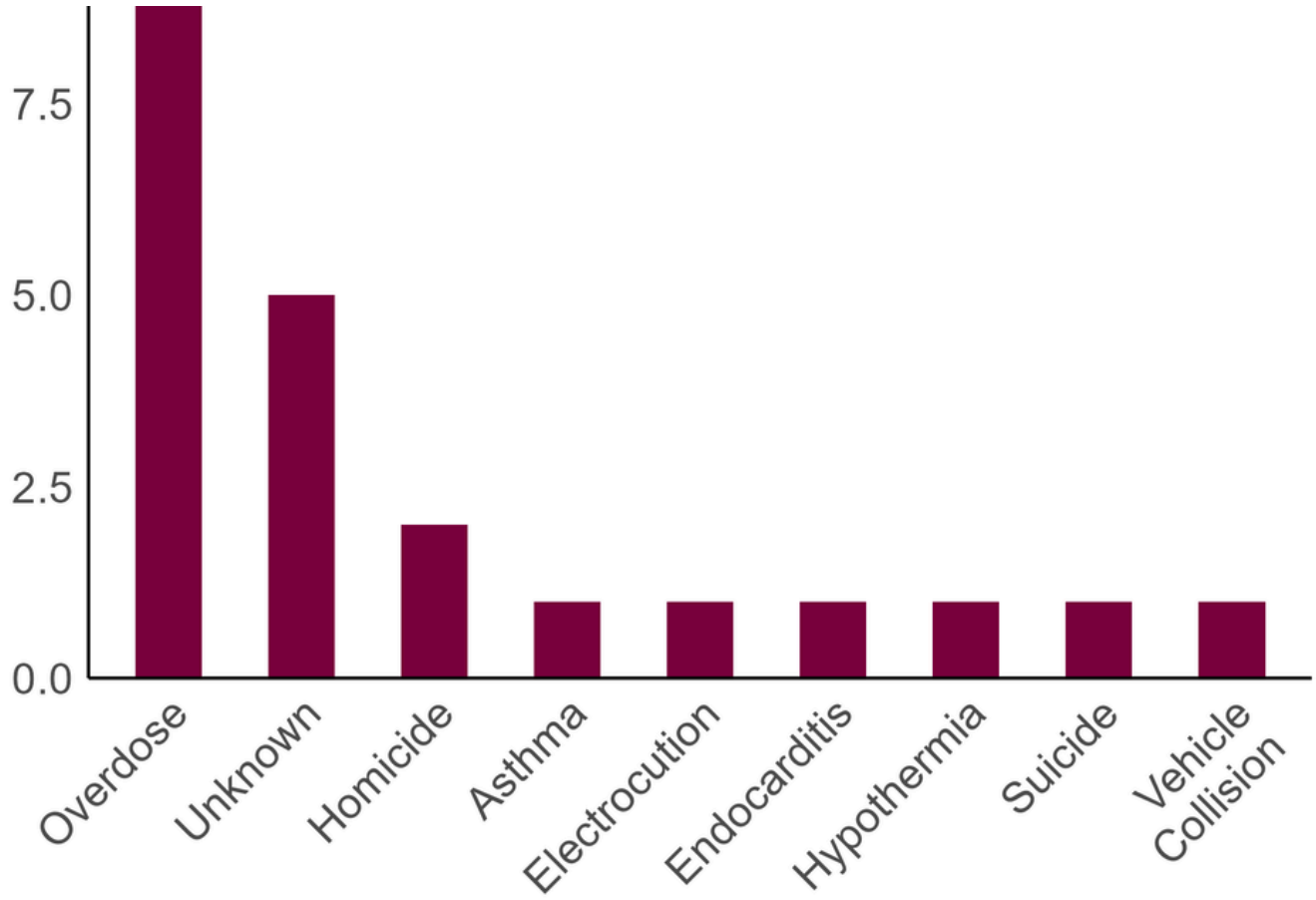
DEATHS IN THE HAMILTON HOMELESS POPULATION



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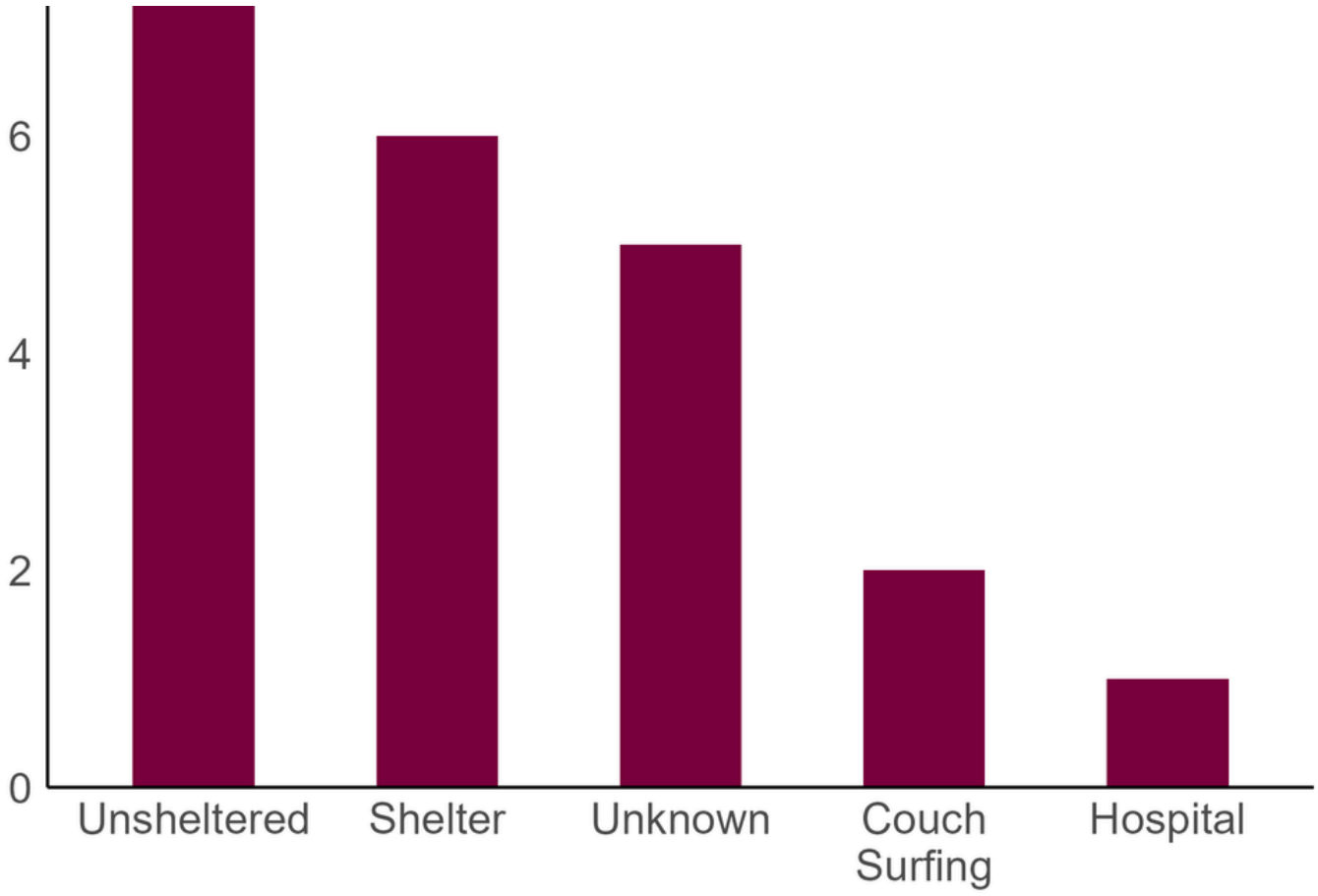
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DEATHS IN THE HAMILTON HOMELESS POPULATION



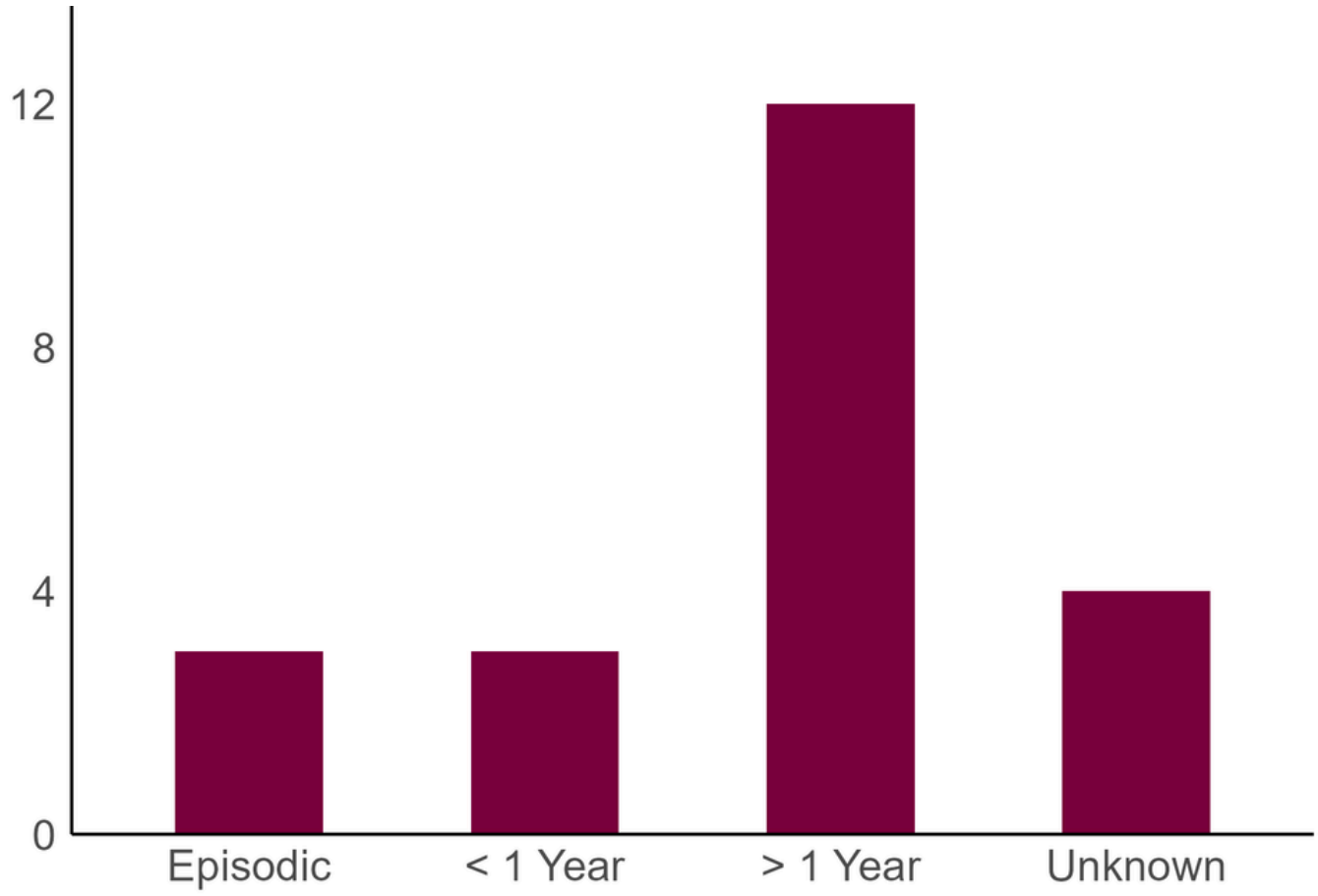
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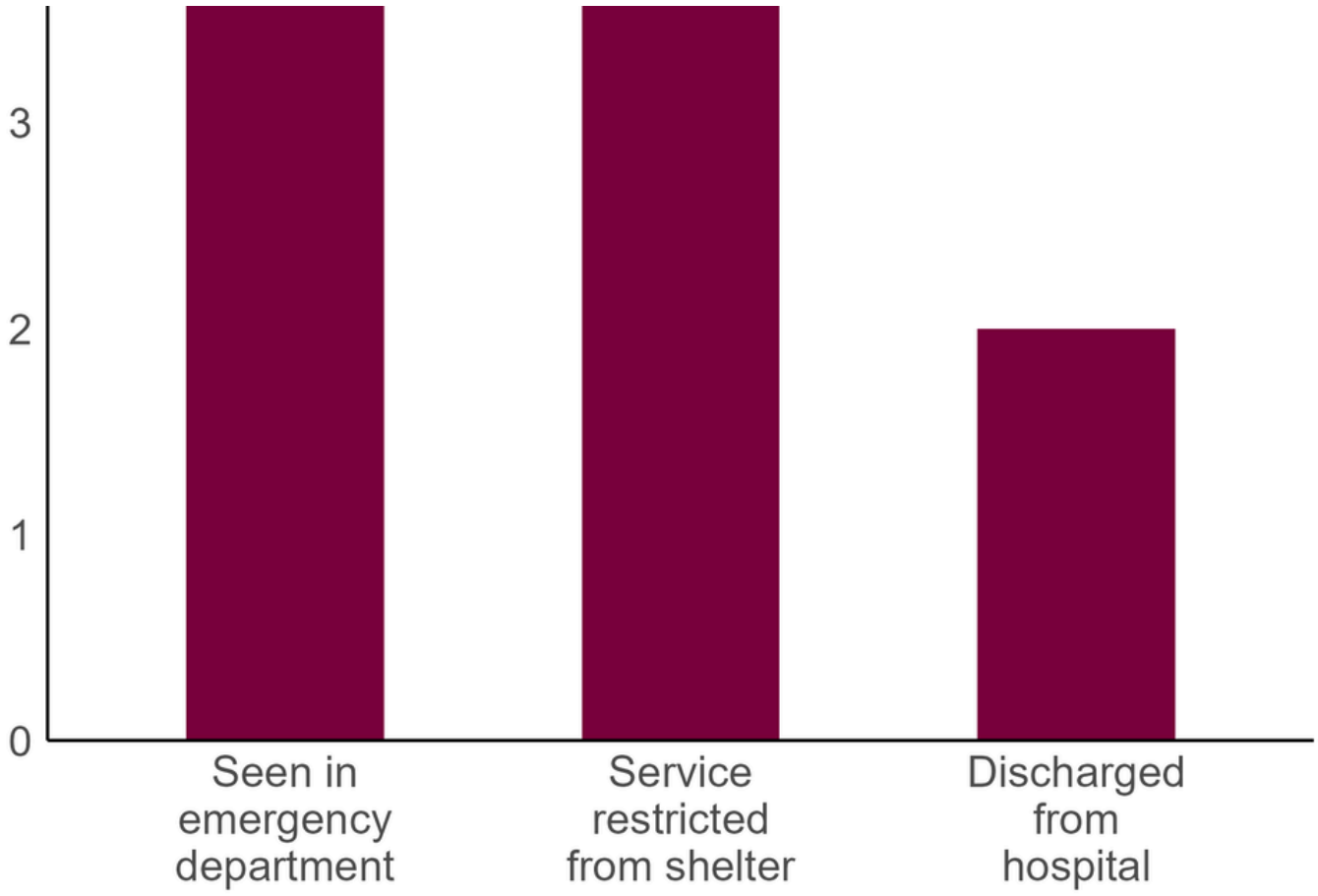
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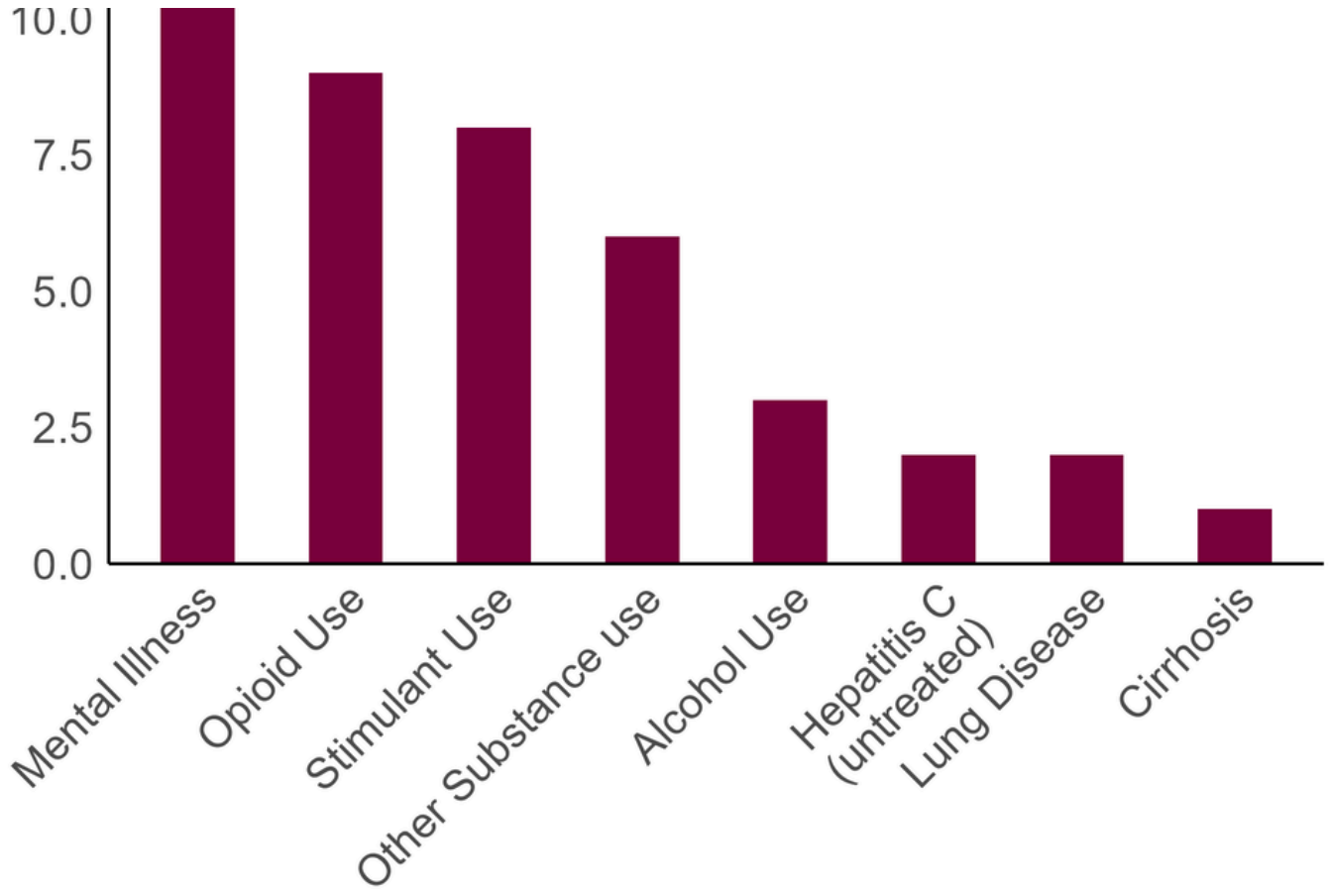
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DEATHS IN THE HAMILTON HOMELESS POPULATION



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DEATHS IN THE HAMILTON HOMELESS POPULATION



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DEATHS IN THE HAMILTON HOMELESS POPULATION

December 2021 - May 2022

Total reported deaths: 12*

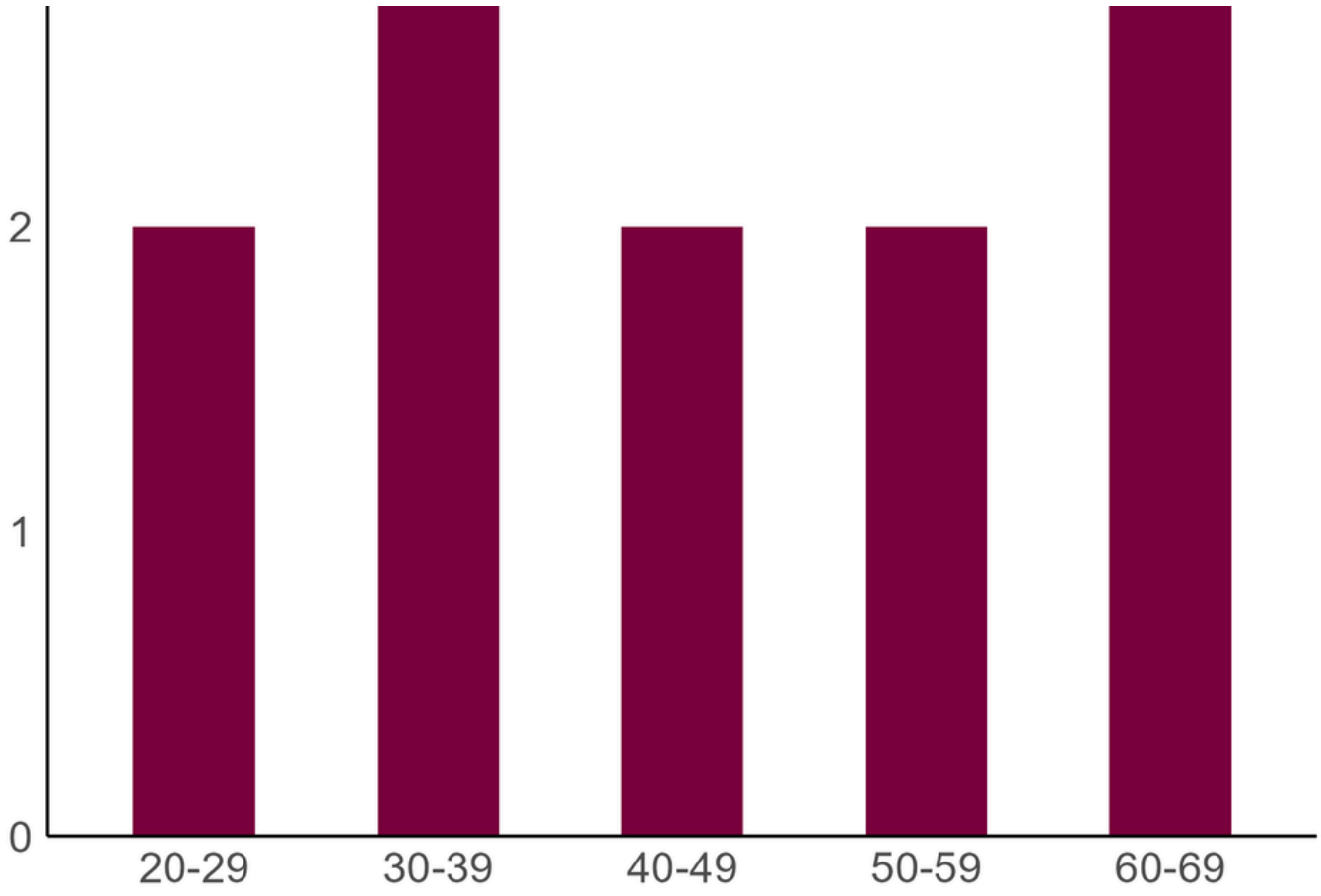
* Please note that this is pending report from the Office of the Chief Coroner and additional deaths for this time period may be reported on this webpage at a later date.

Average age at time of death:

45 years old

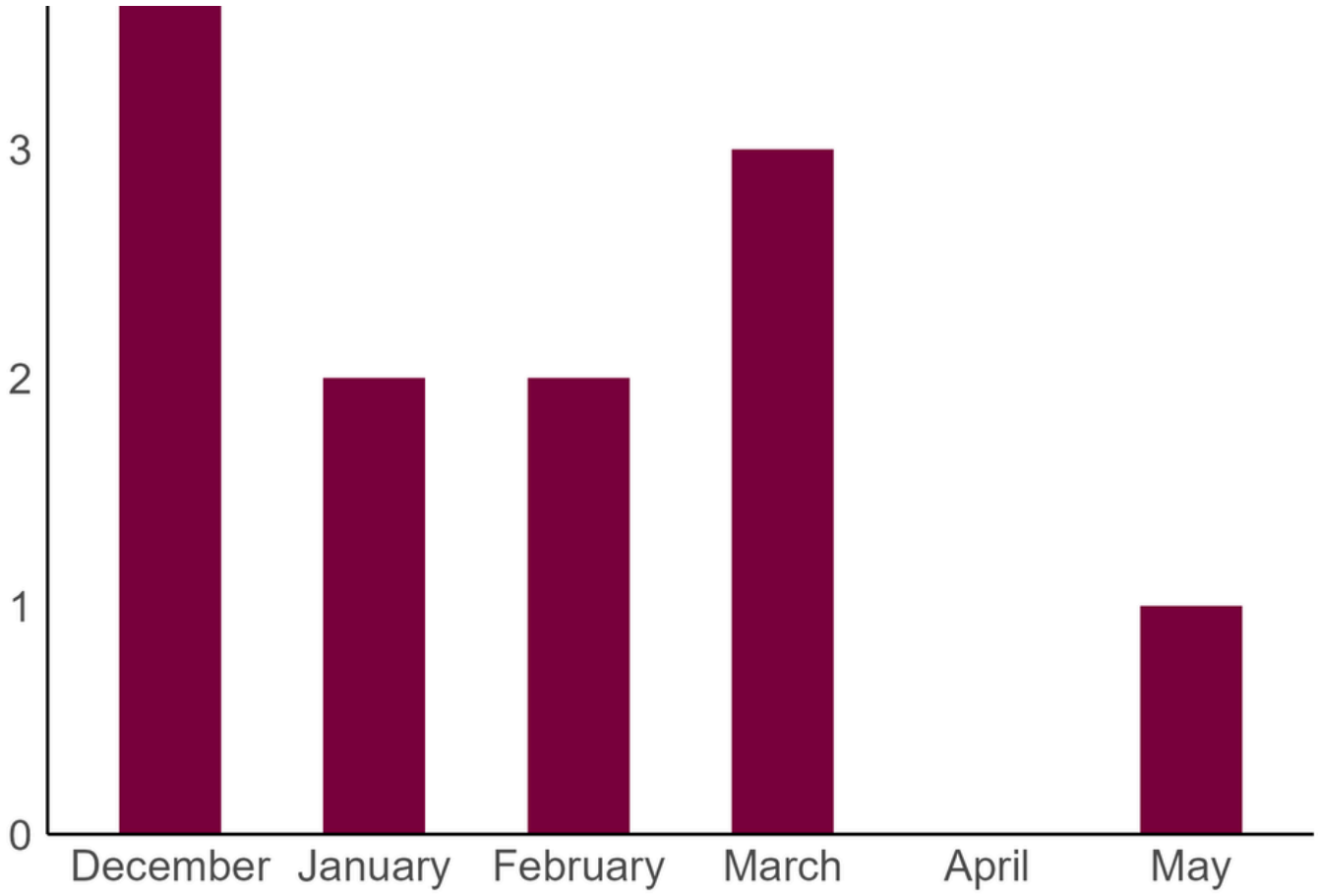
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DEATHS IN THE HAMILTON HOMELESS POPULATION



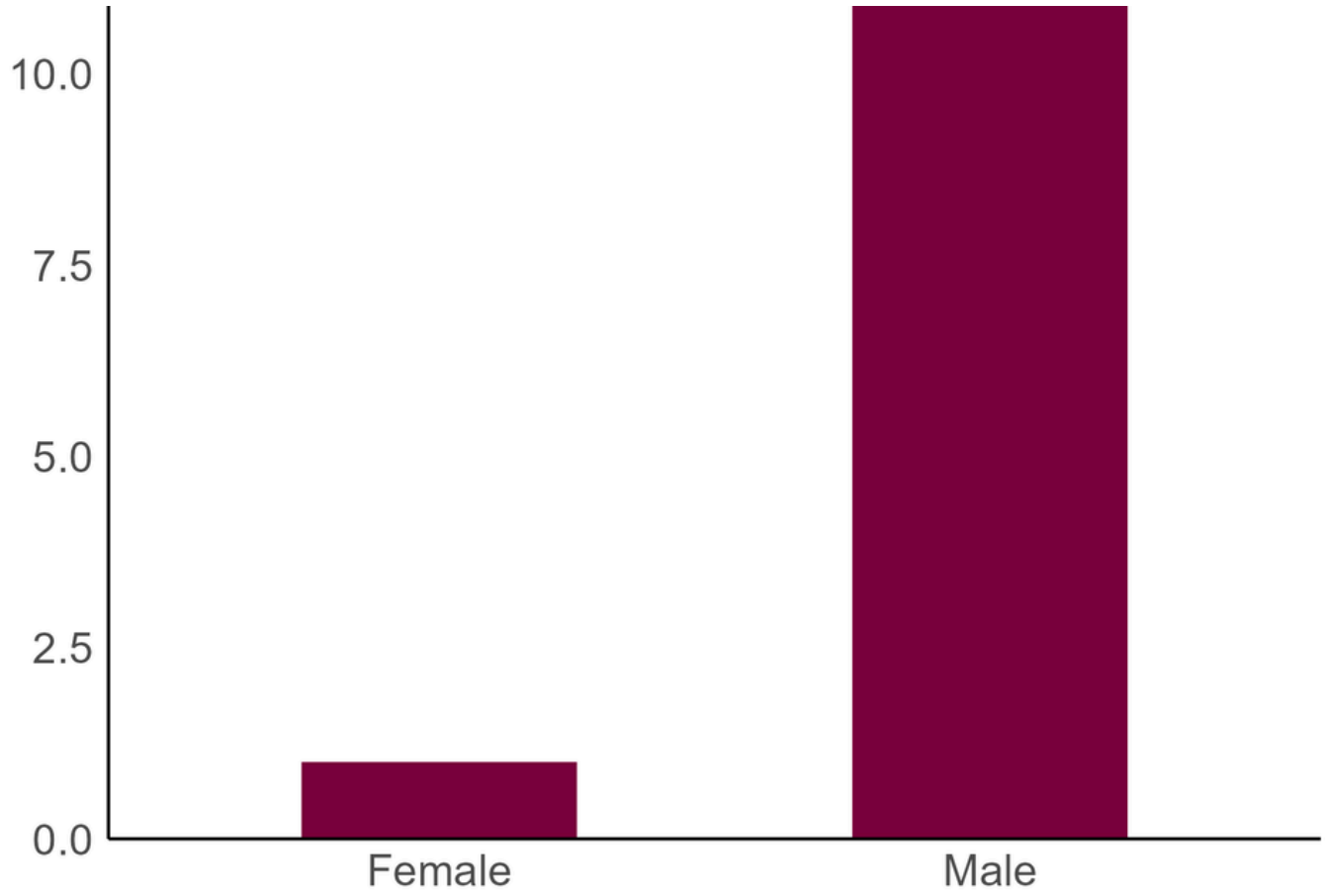
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DEATHS IN THE HAMILTON HOMELESS POPULATION



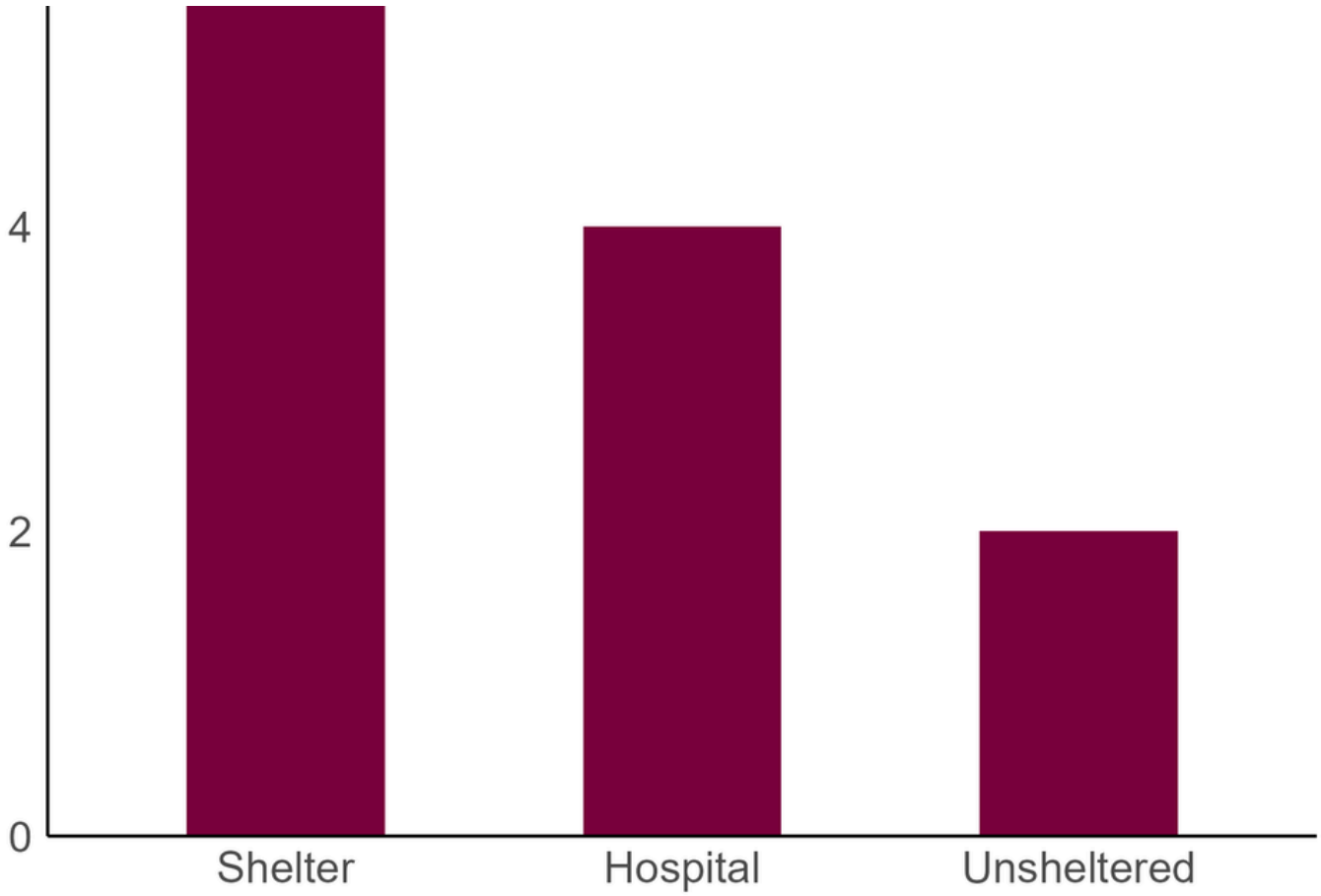
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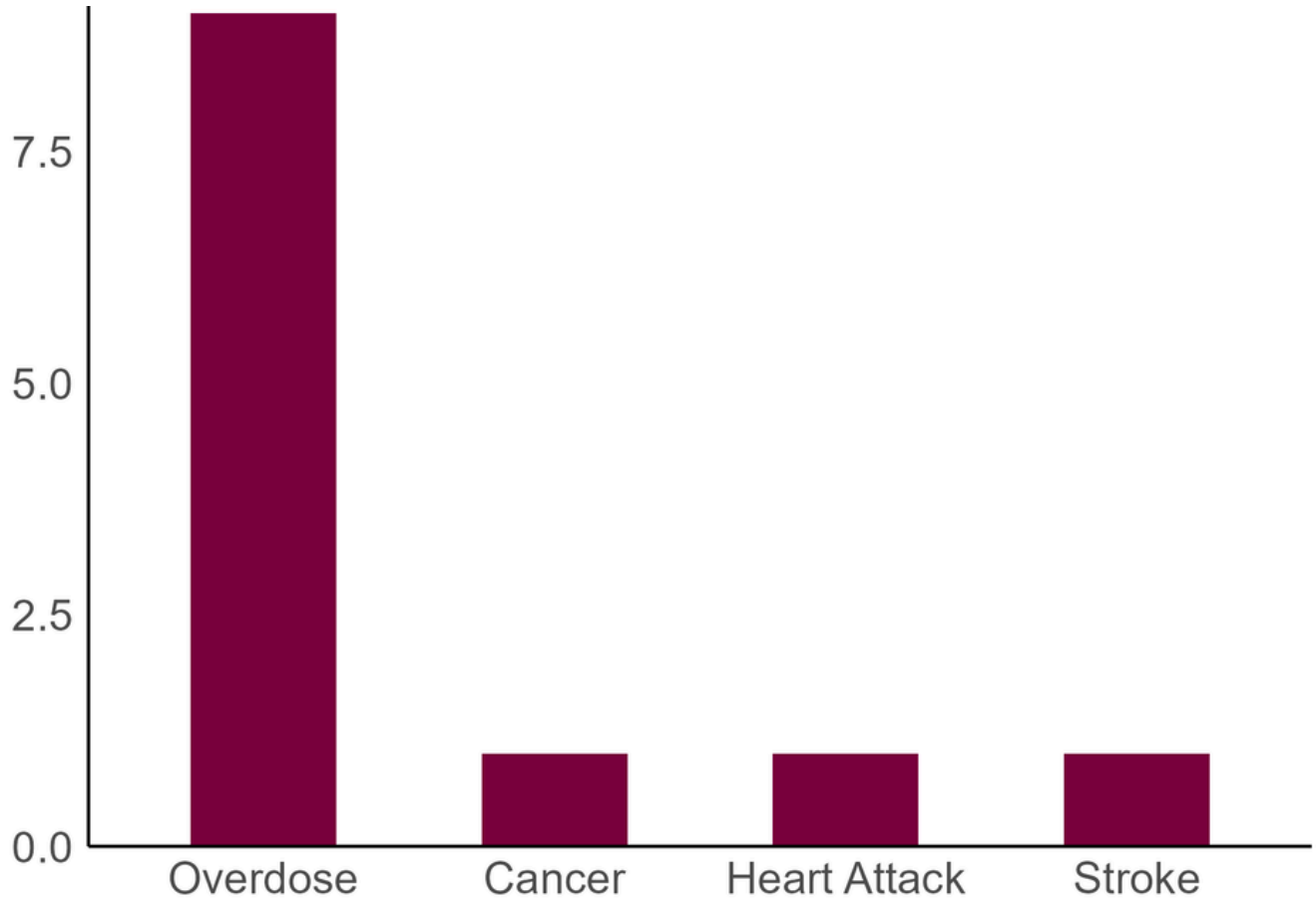
DEATHS IN THE HAMILTON HOMELESS POPULATION



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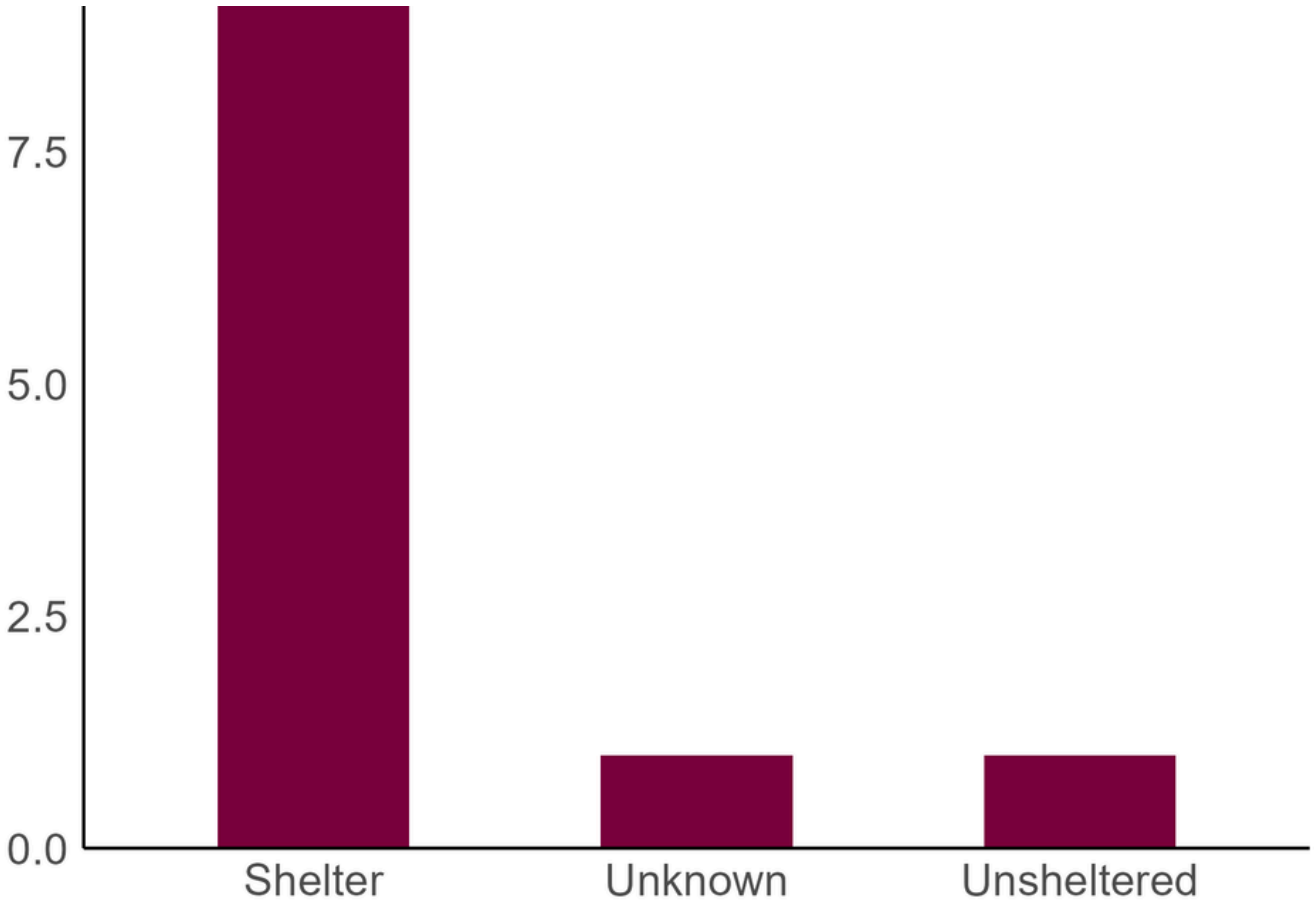
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DEATHS IN THE HAMILTON HOMELESS POPULATION



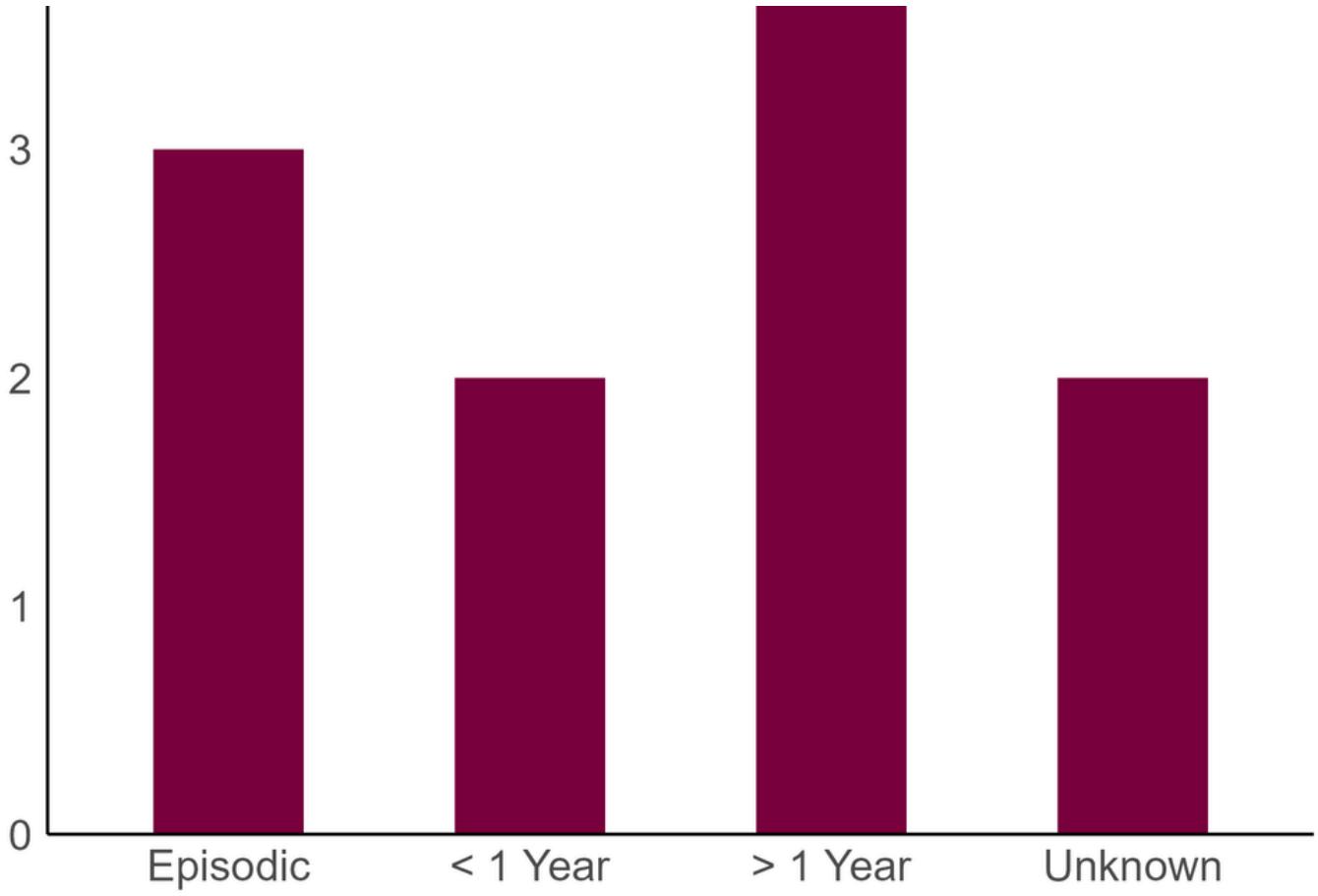
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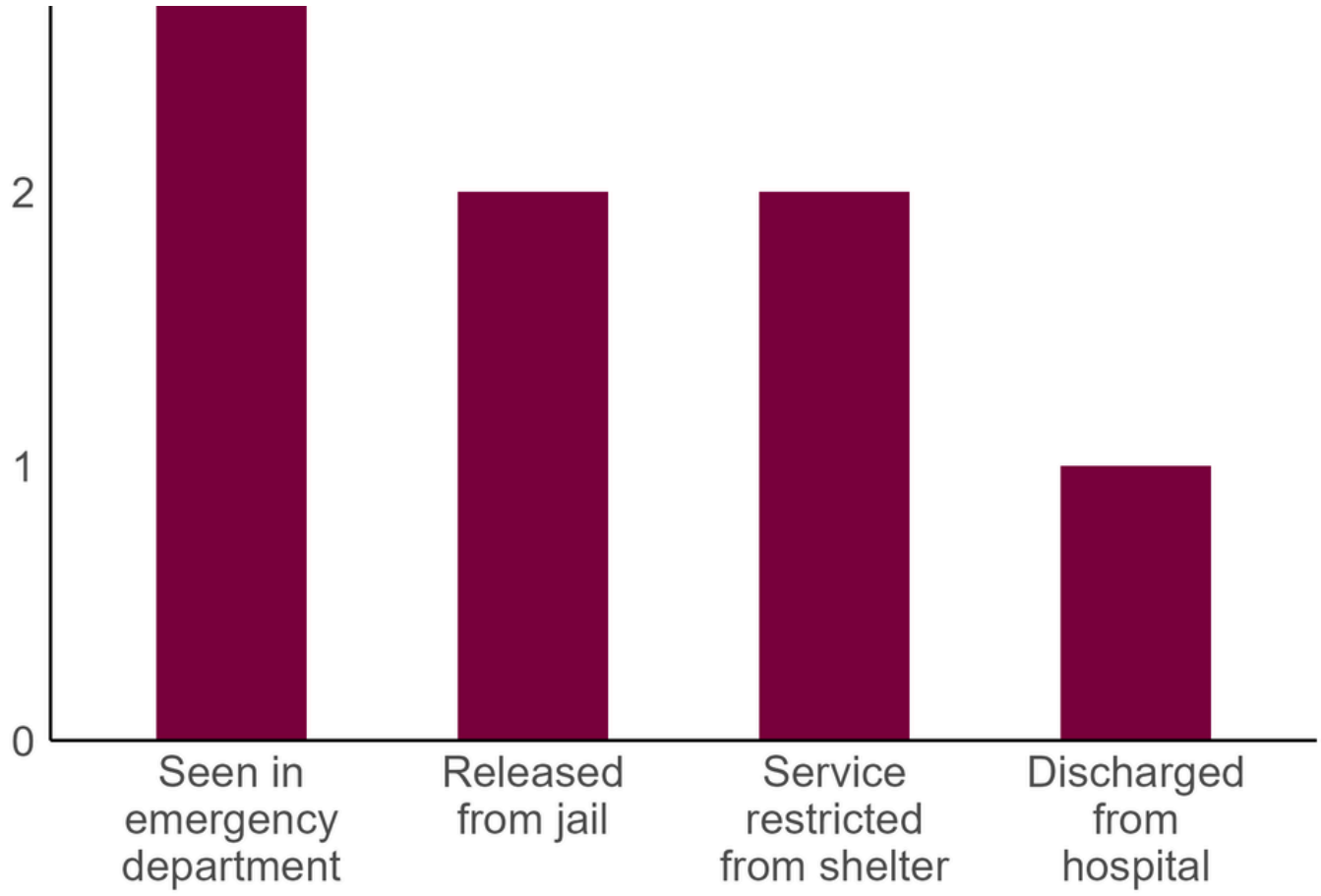
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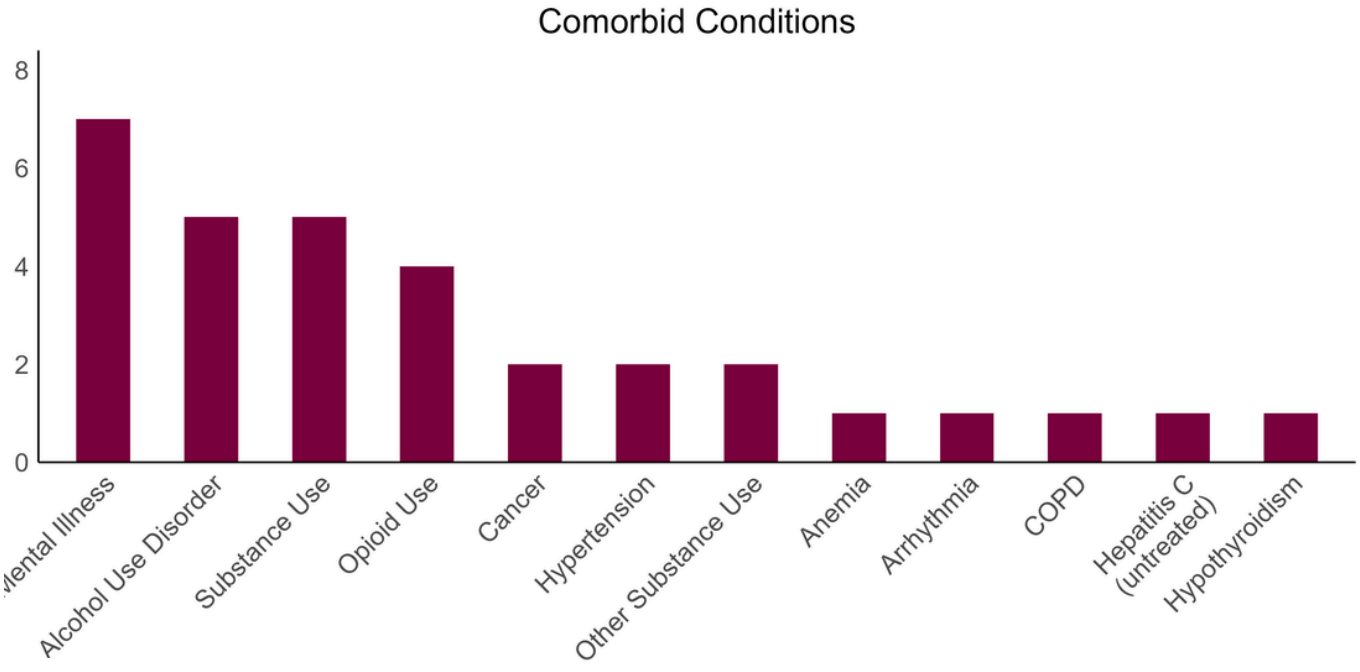
DEATHS IN THE HAMILTON HOMELESS POPULATION



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DEATHS IN THE HAMILTON HOMELESS POPULATION





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DEATHS IN THE HAMILTON HOMELESS POPULATION

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DEATHS IN THE HAMILTON HOMELESS POPULATION

June - November 2022

Total reported deaths: 22*

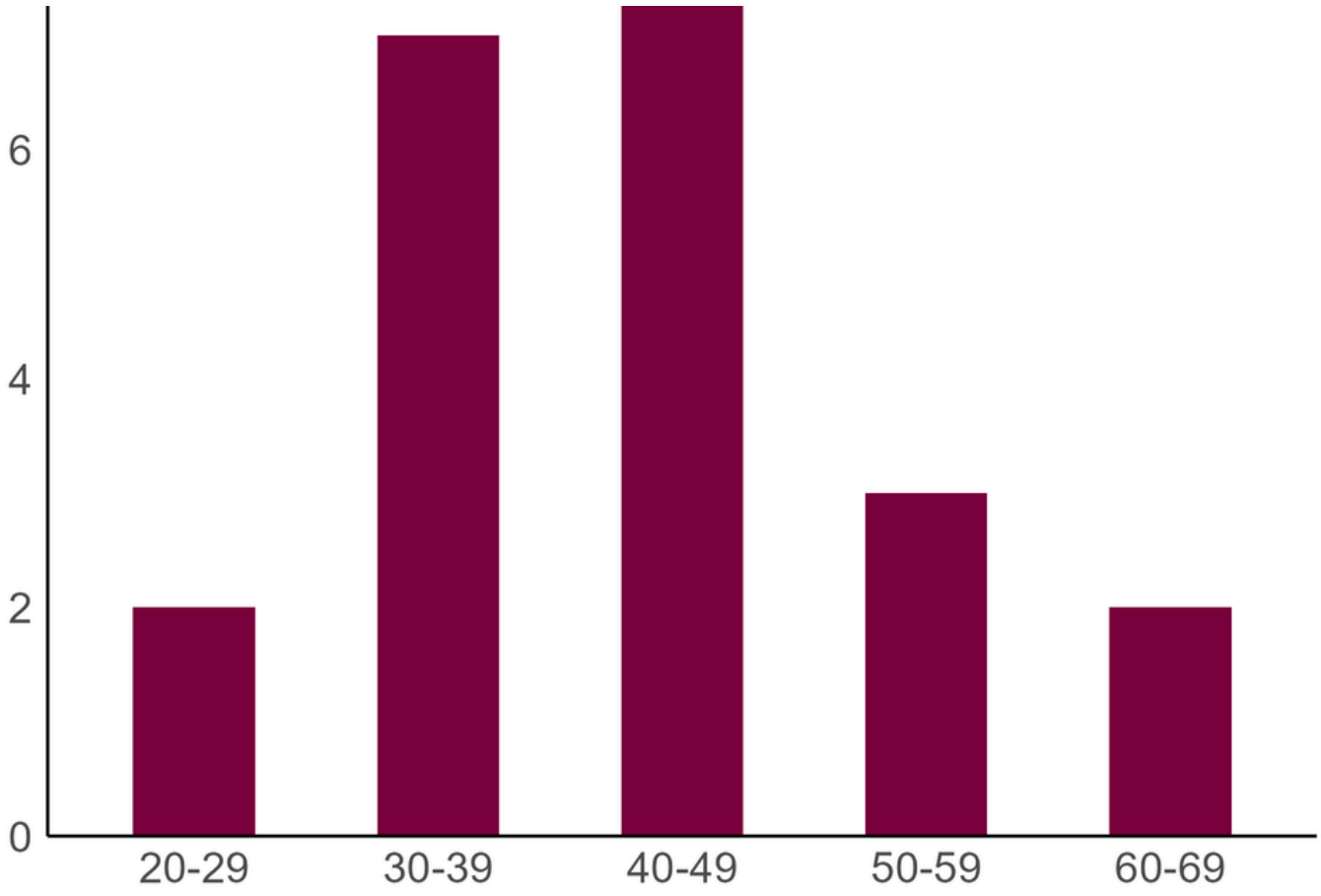
* Please note that this is pending report from the Office of the Chief Coroner and additional deaths for this time period may be reported on this webpage at a later date.

Average age at time of death:

43 years old

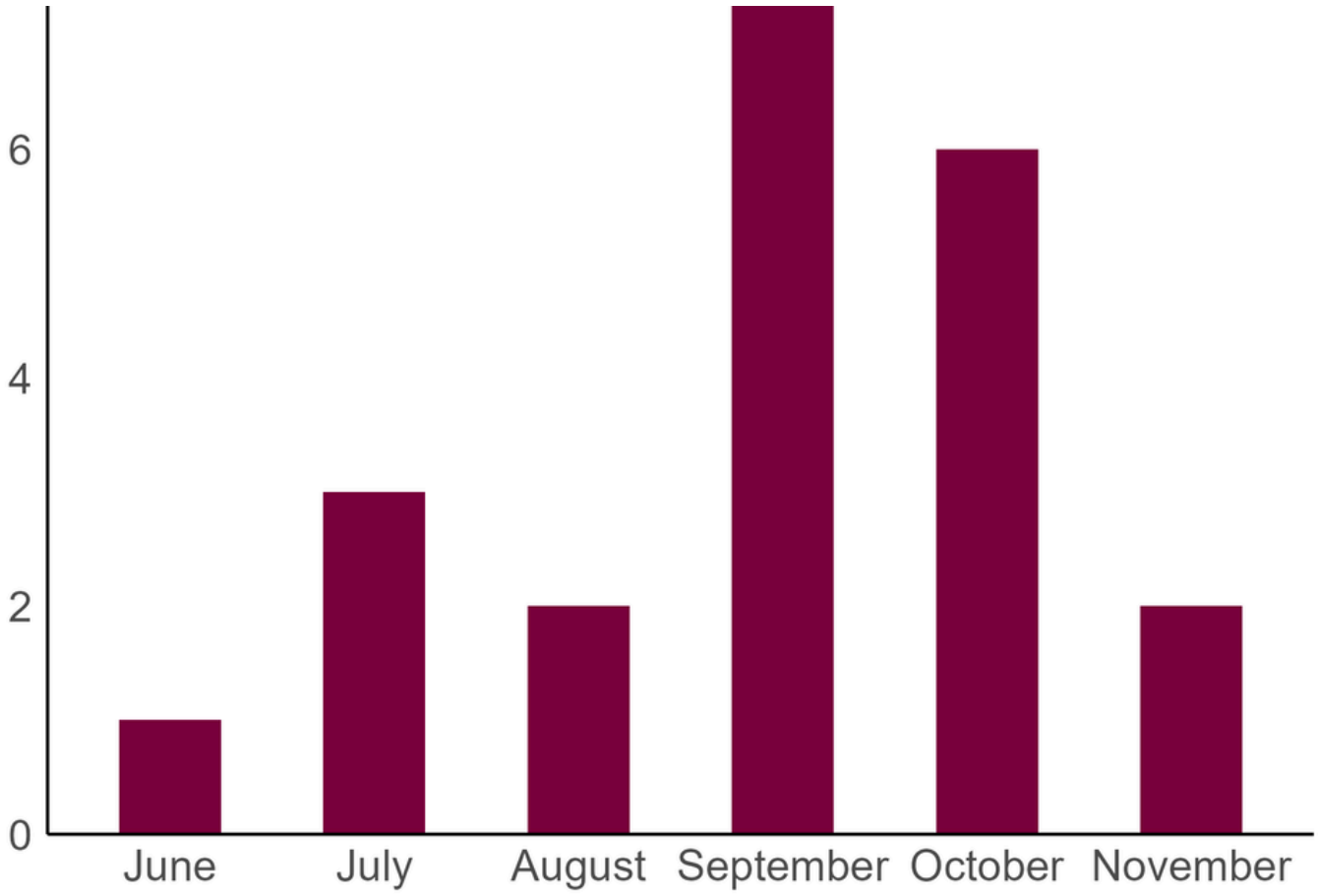
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DEATHS IN THE HAMILTON HOMELESS POPULATION



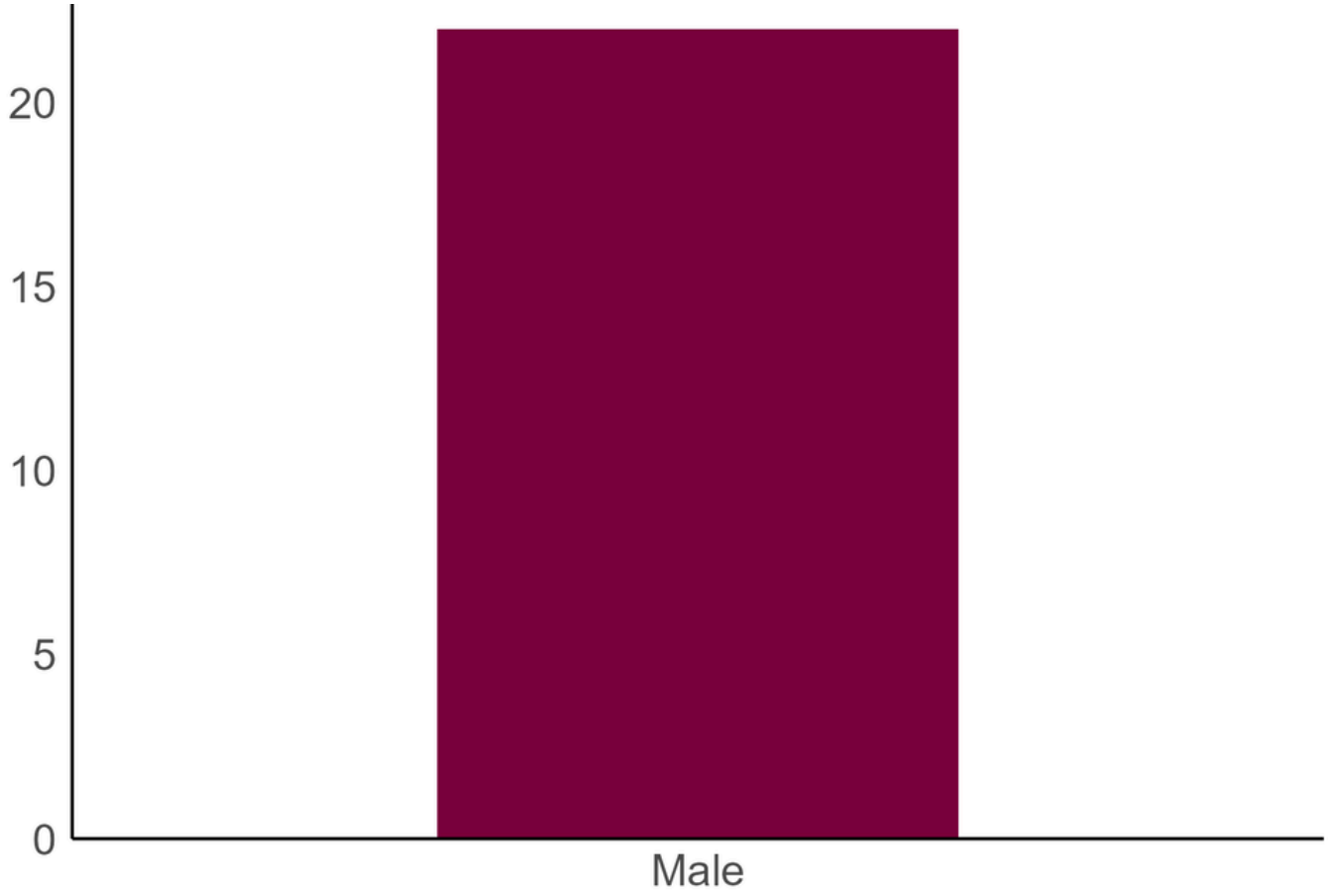
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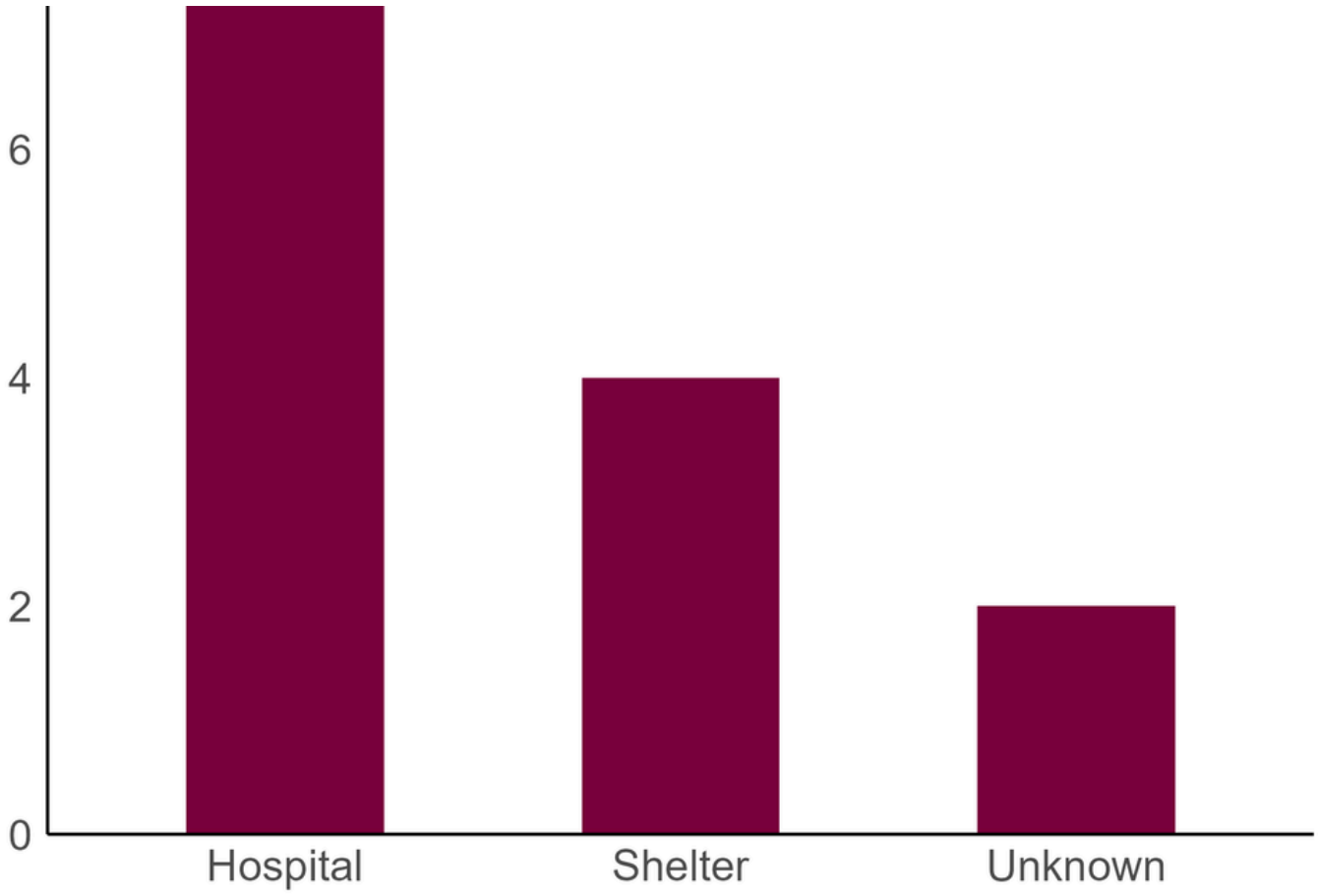
DEATHS IN THE HAMILTON HOMELESS POPULATION



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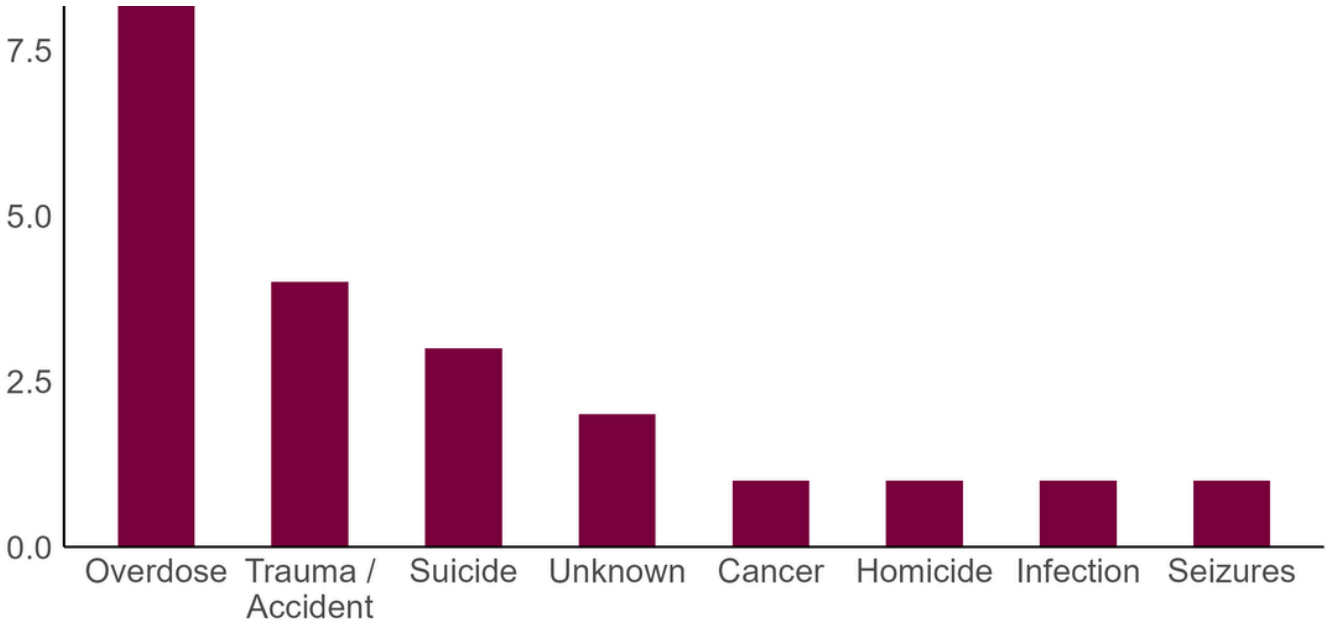
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DEATHS IN THE HAMILTON HOMELESS POPULATION



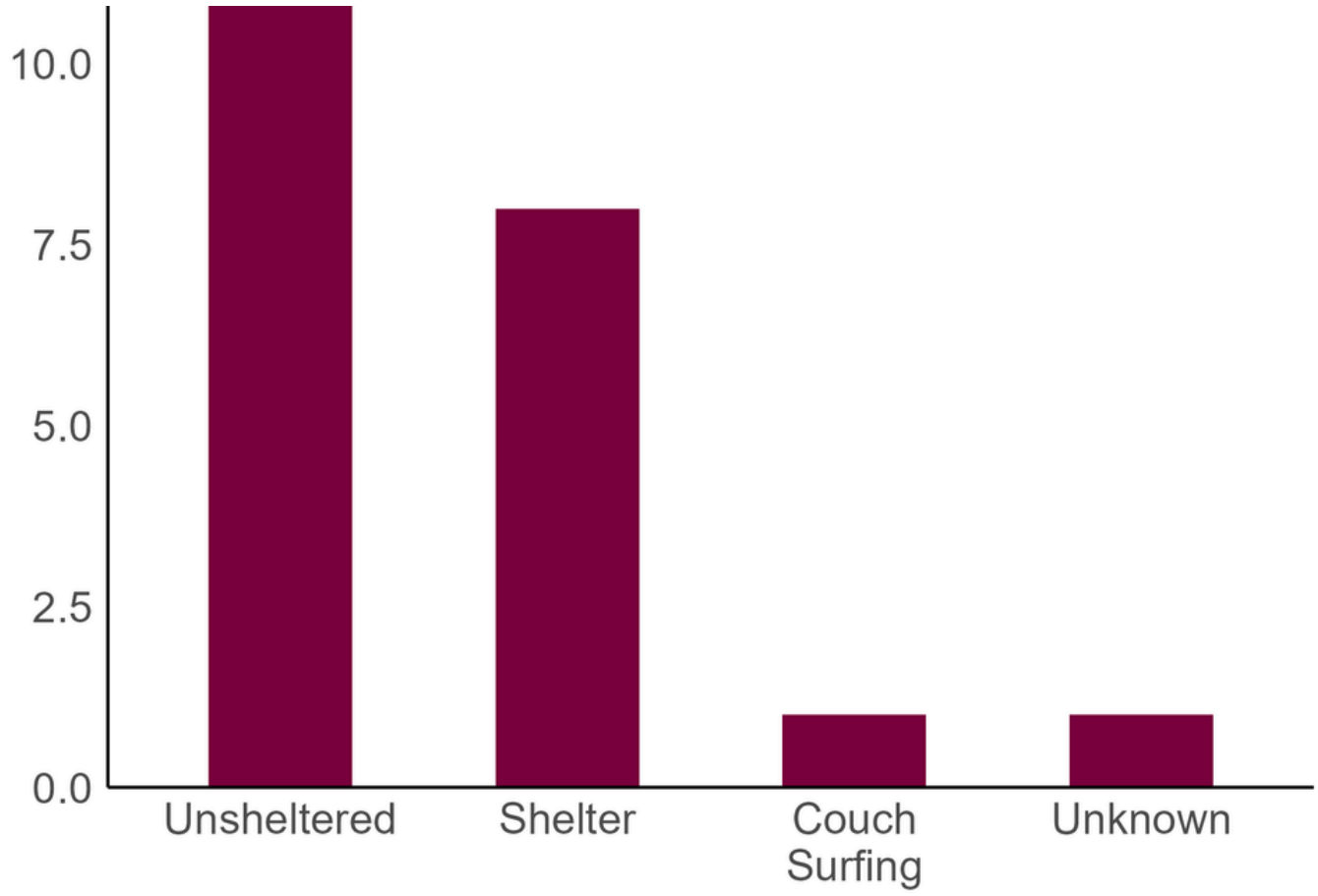
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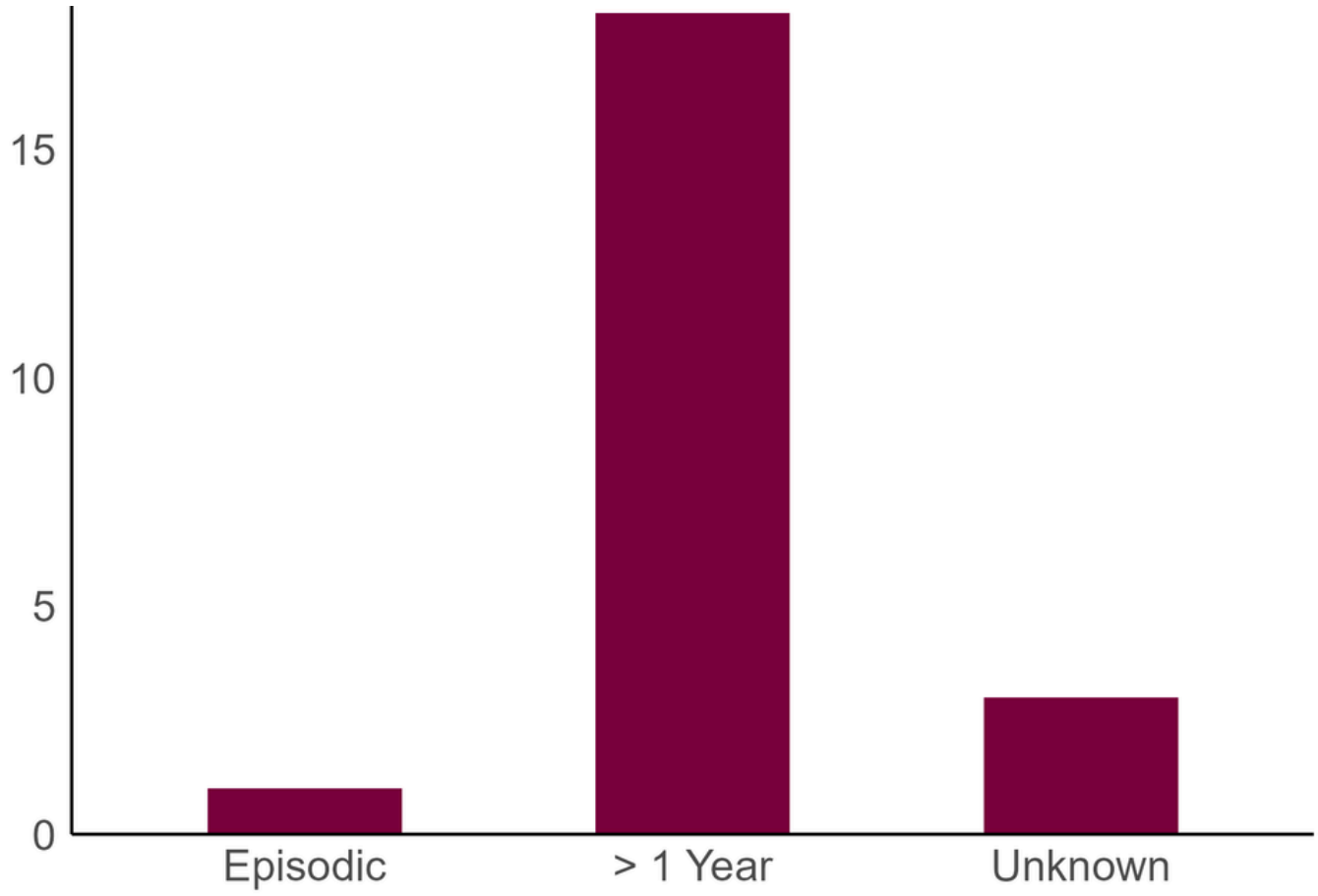
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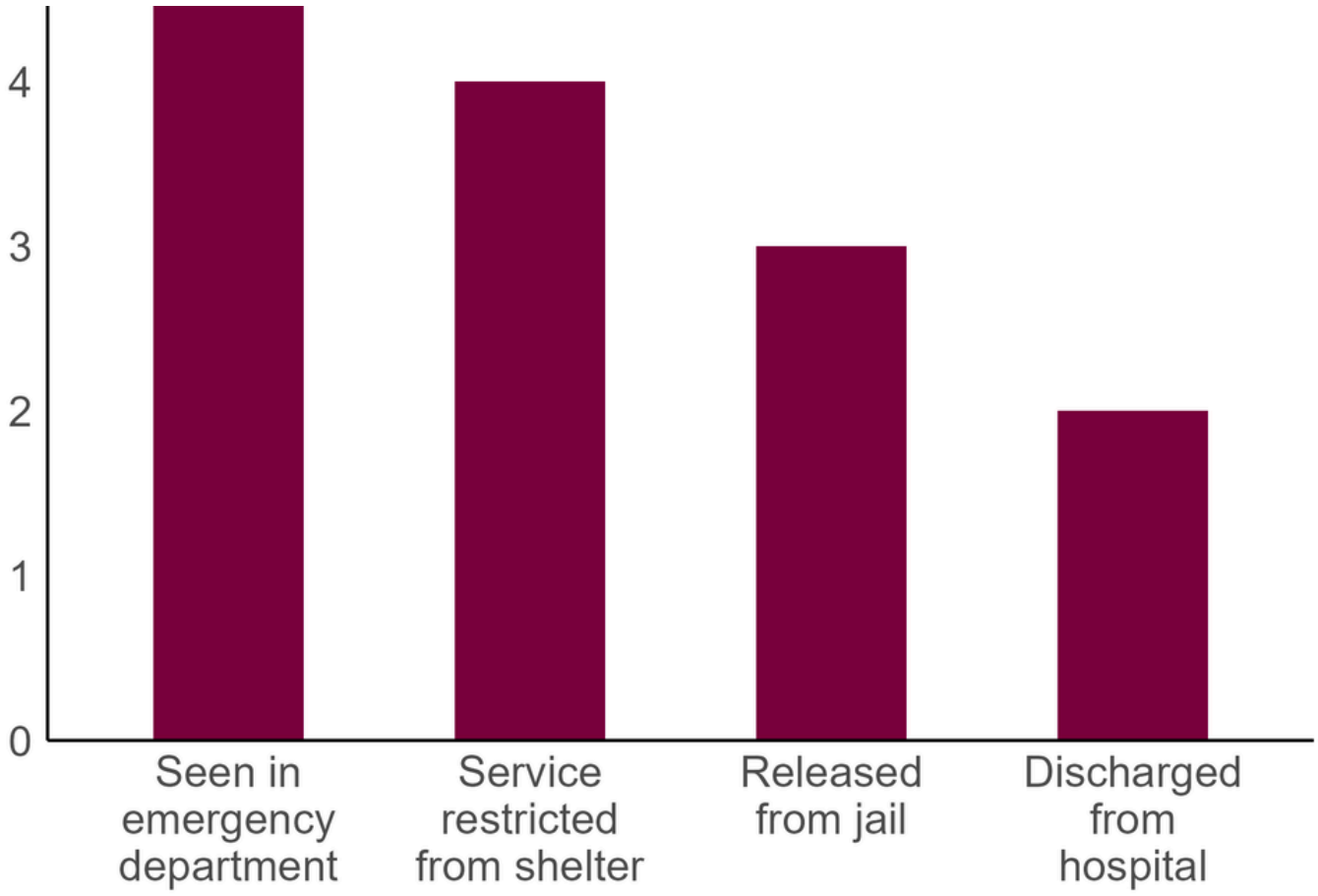
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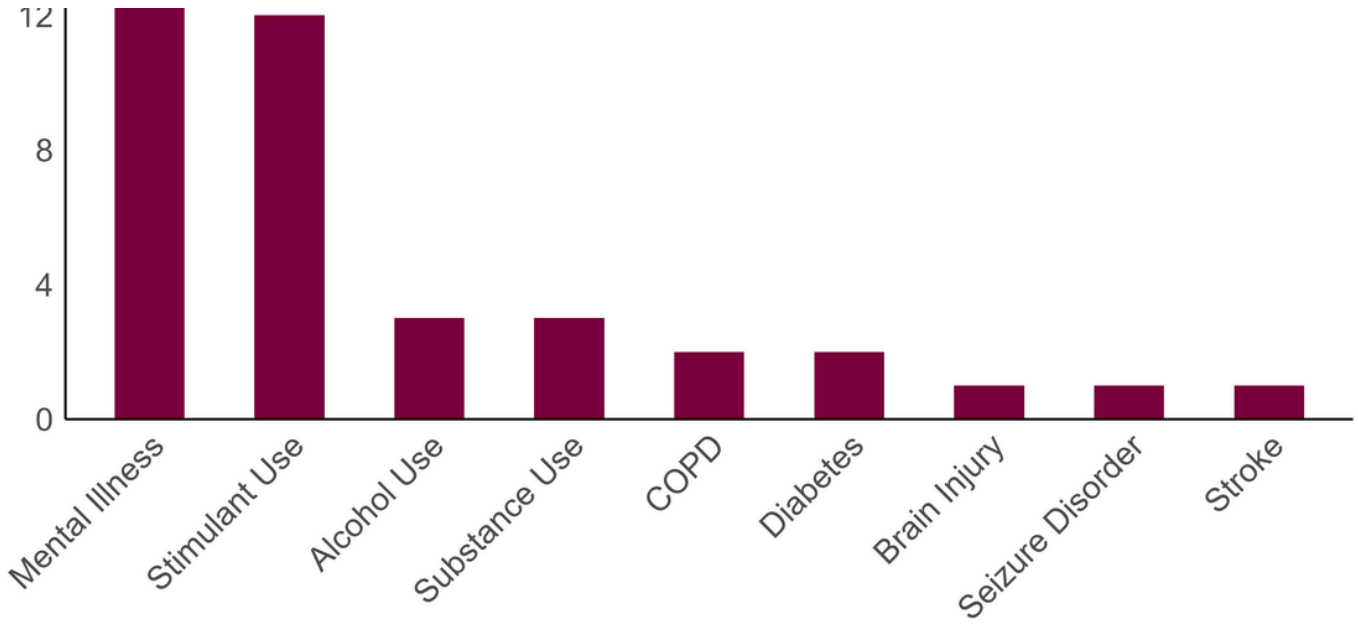
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DEATHS IN THE HAMILTON HOMELESS POPULATION



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DEATHS IN THE HAMILTON HOMELESS POPULATION

December 2022 - May 2023

Total reported deaths: 14*

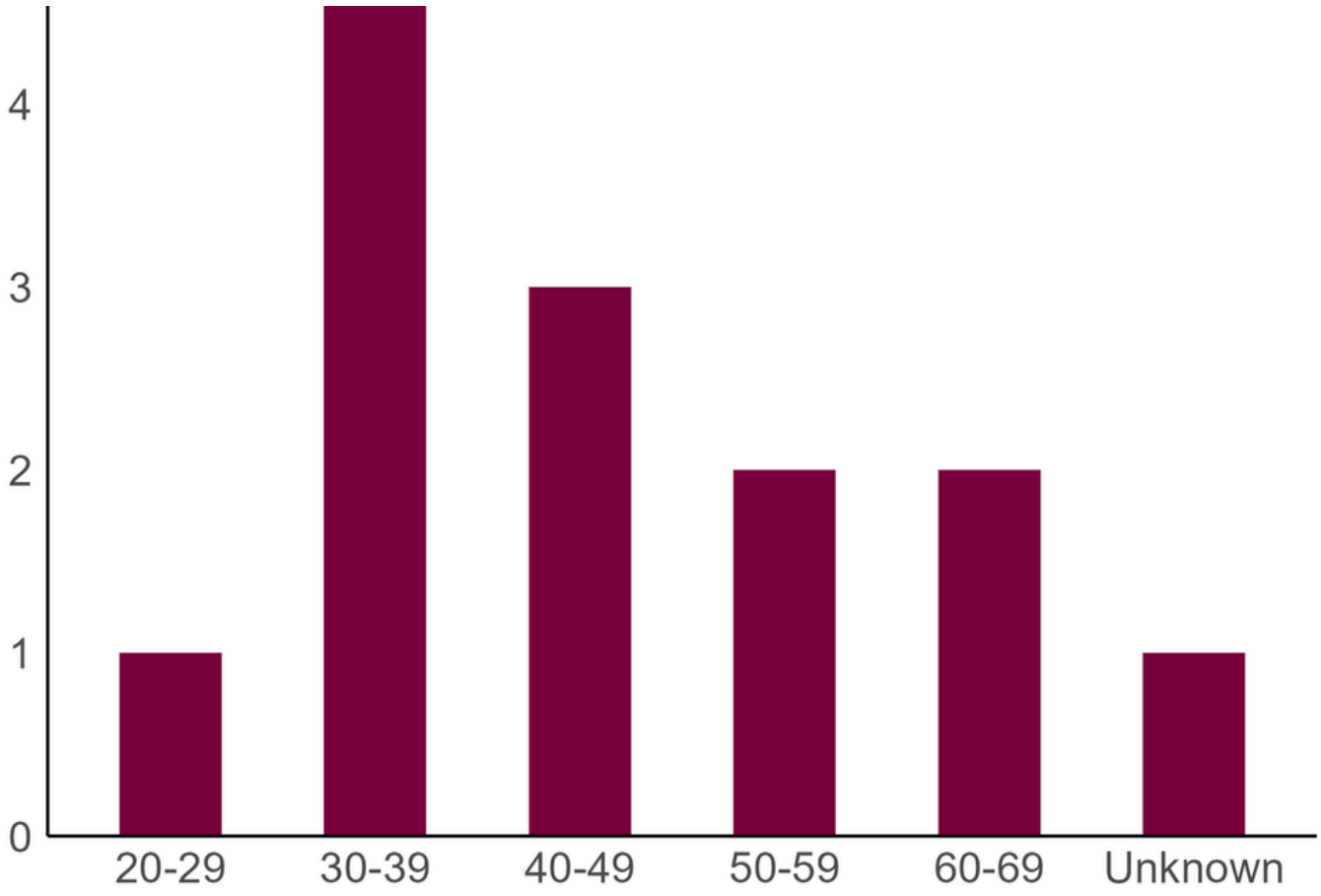
* Please note that this is pending report from the Office of the Chief Coroner and additional deaths for this time period may be reported on this webpage at a later date.

Average age at time of death:

43 years old

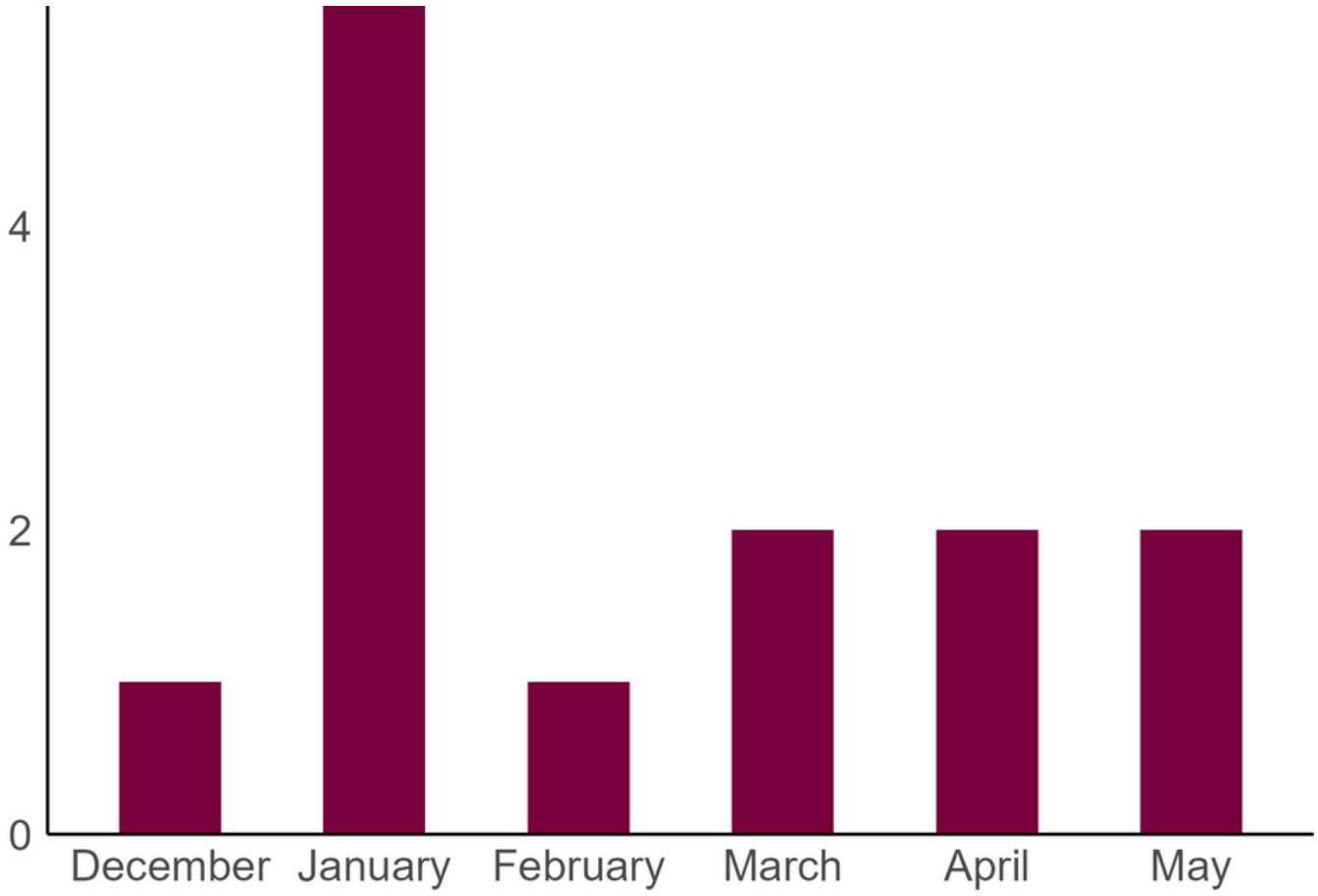
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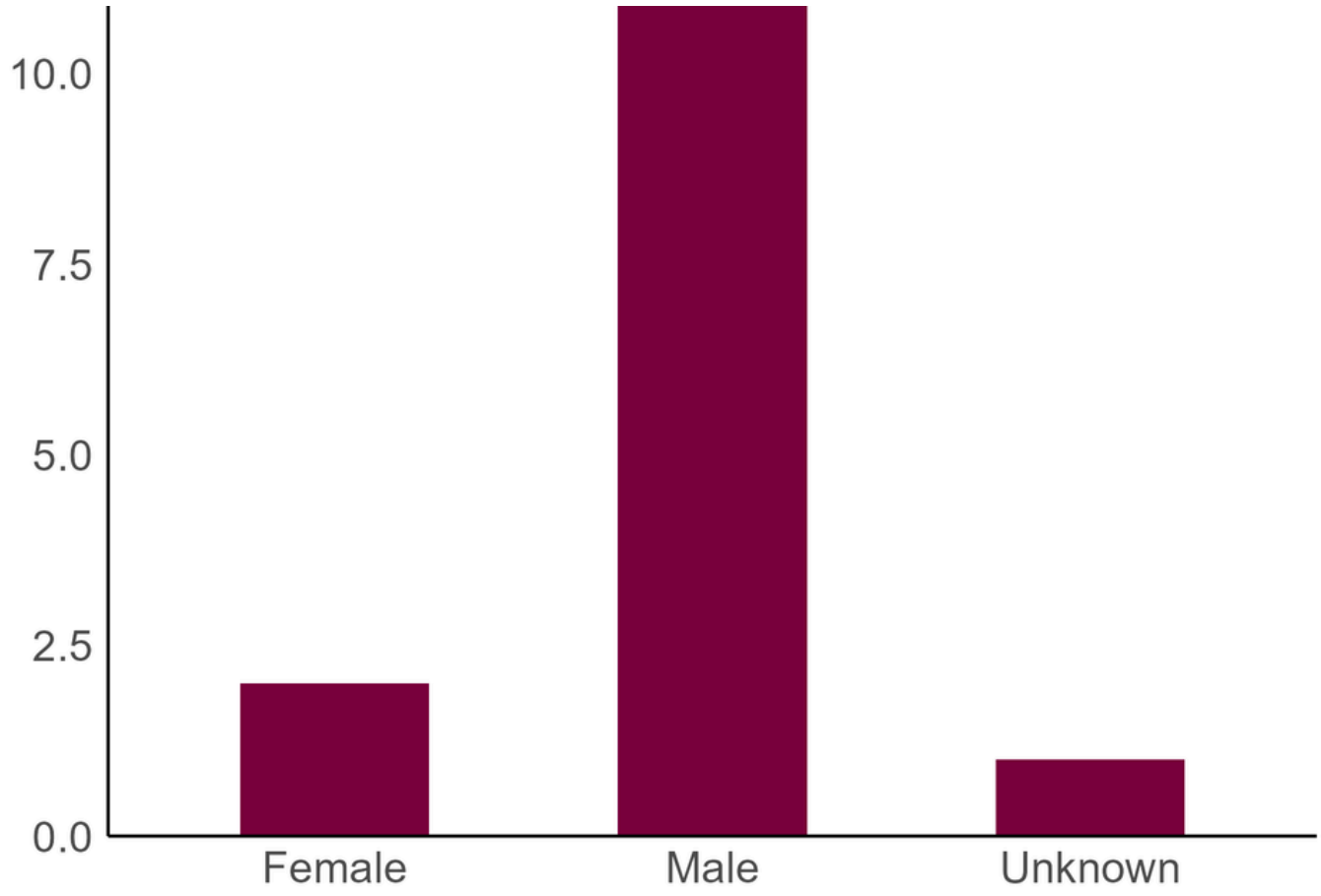
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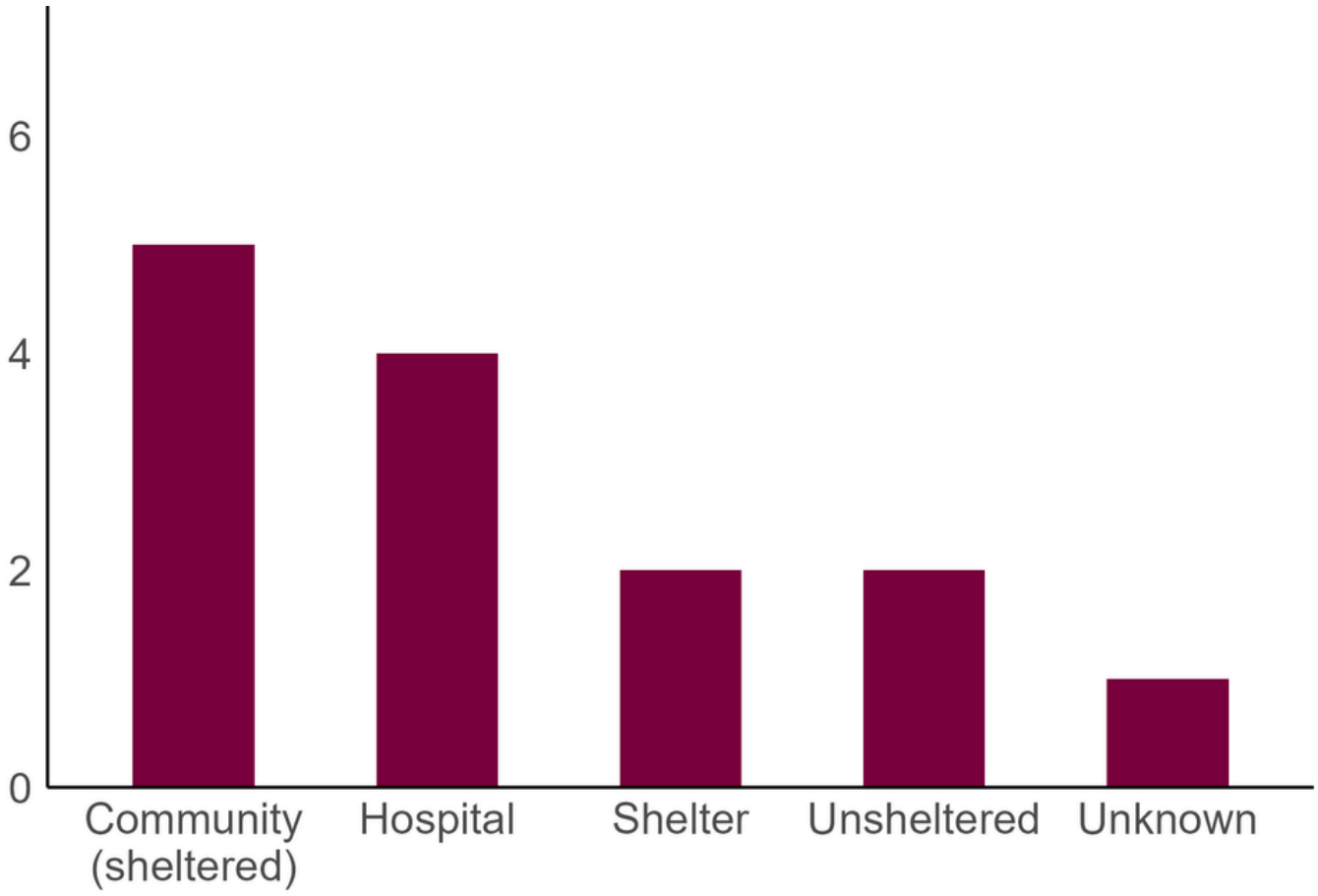
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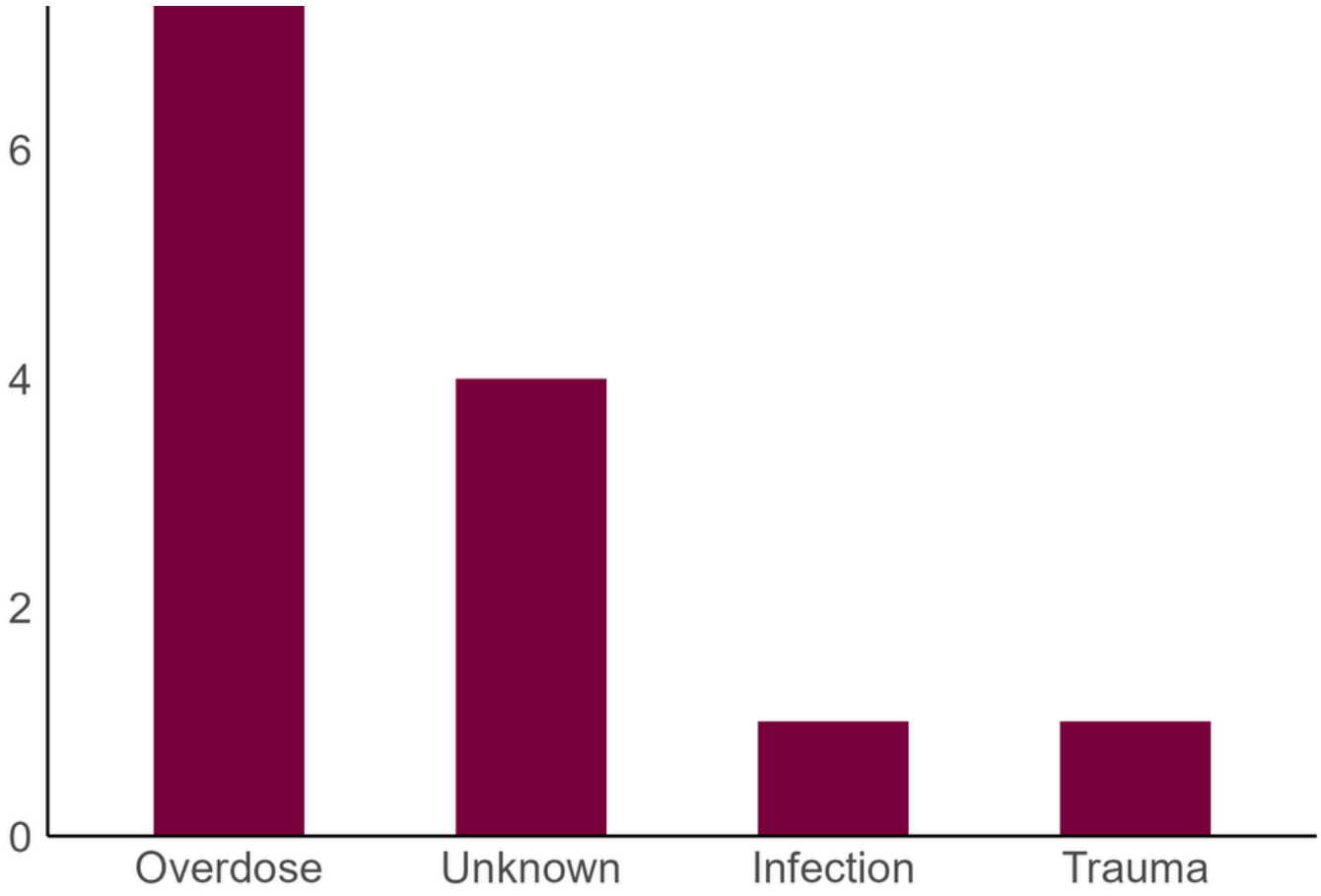
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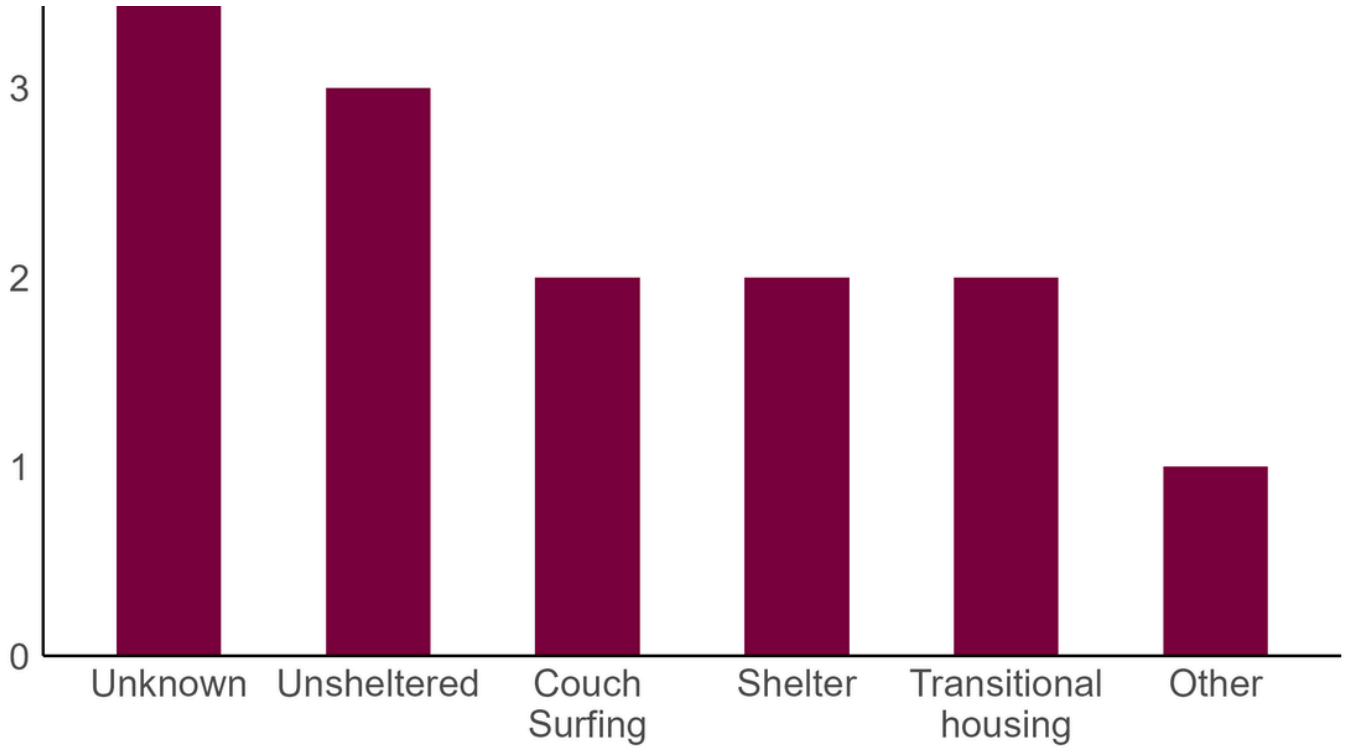
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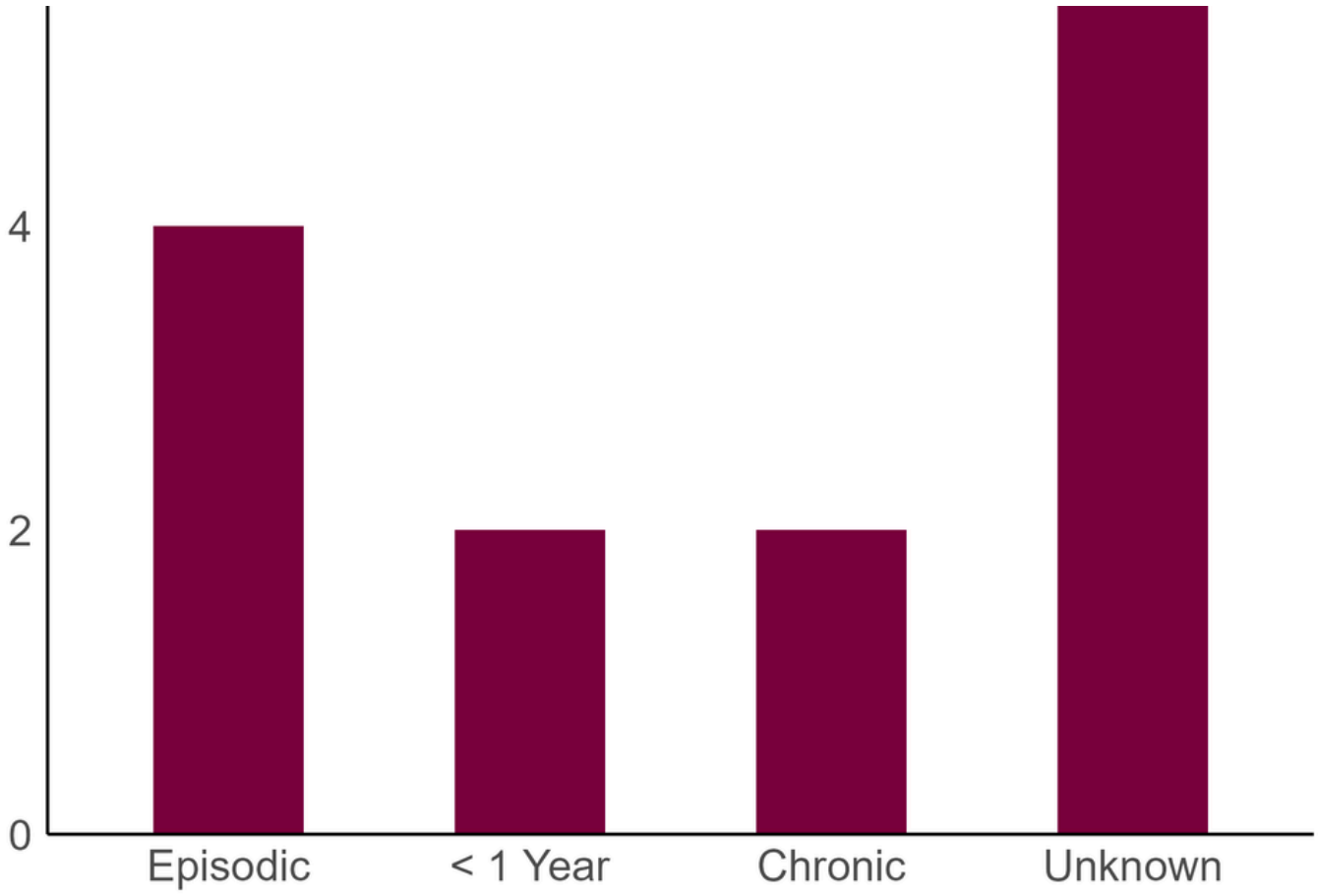
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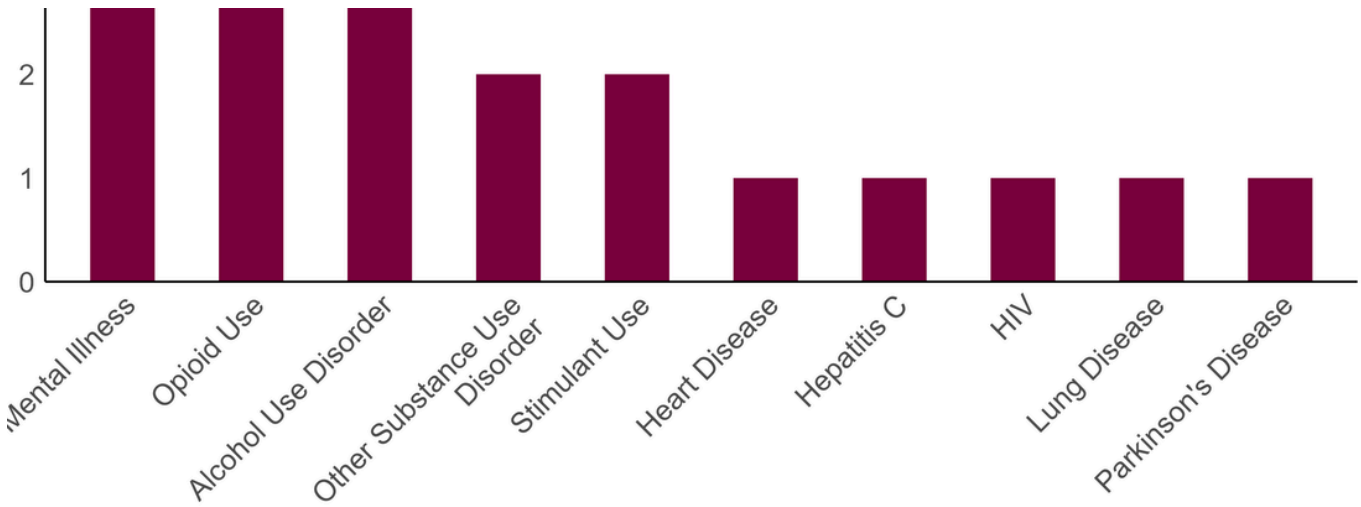
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DEATHS IN THE HAMILTON HOMELESS POPULATION



POWERED BY

DEATHS IN THE HAMILTON HOMELESS POPULATION



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DEATHS IN THE HAMILTON HOMELESS POPULATION

June - November 2023

Total reported deaths: 21*

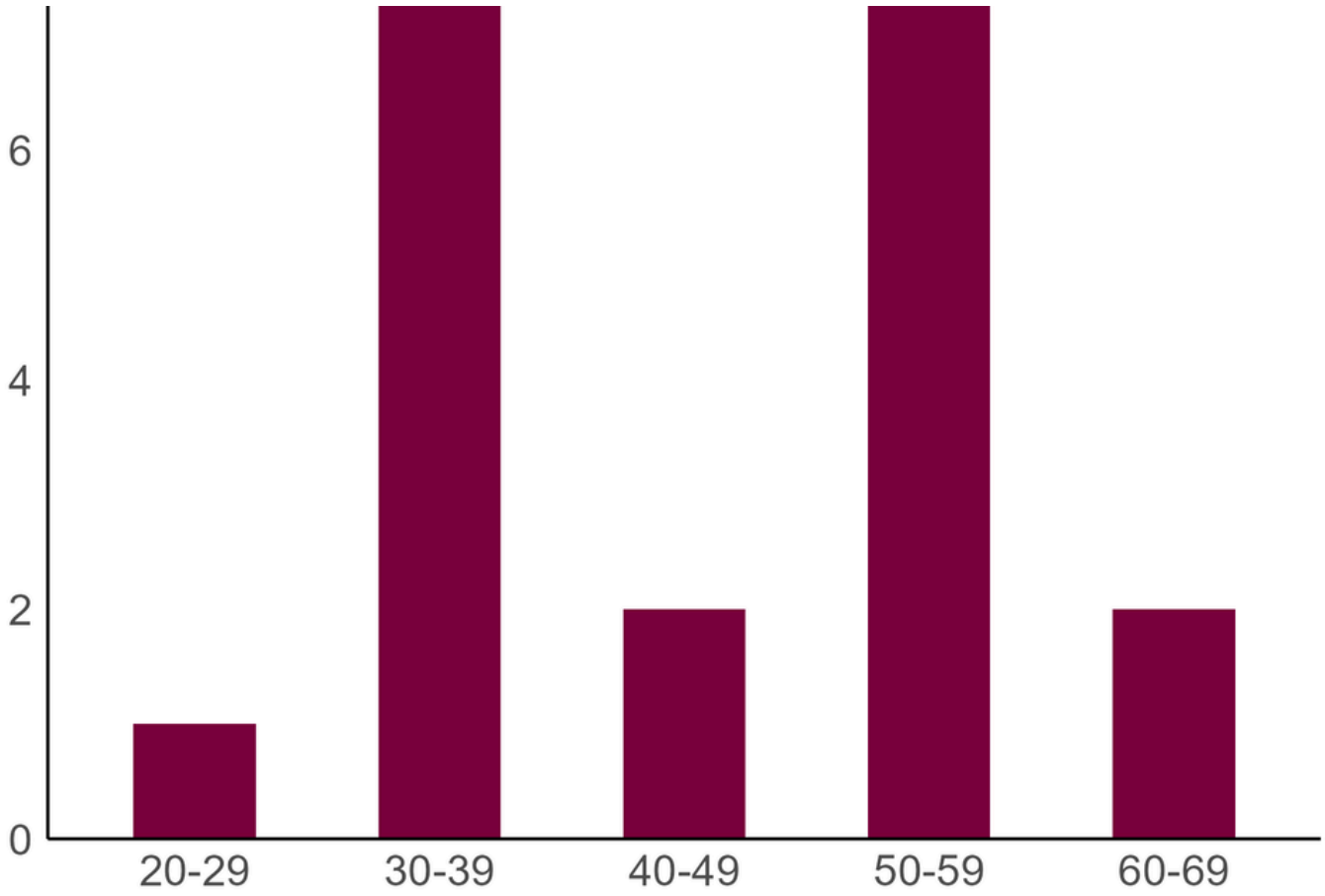
* Please note that this is pending report from the Office of the Chief Coroner and additional deaths for this time period may be reported on this webpage at a later date.

Average age at time of death:

46 years old

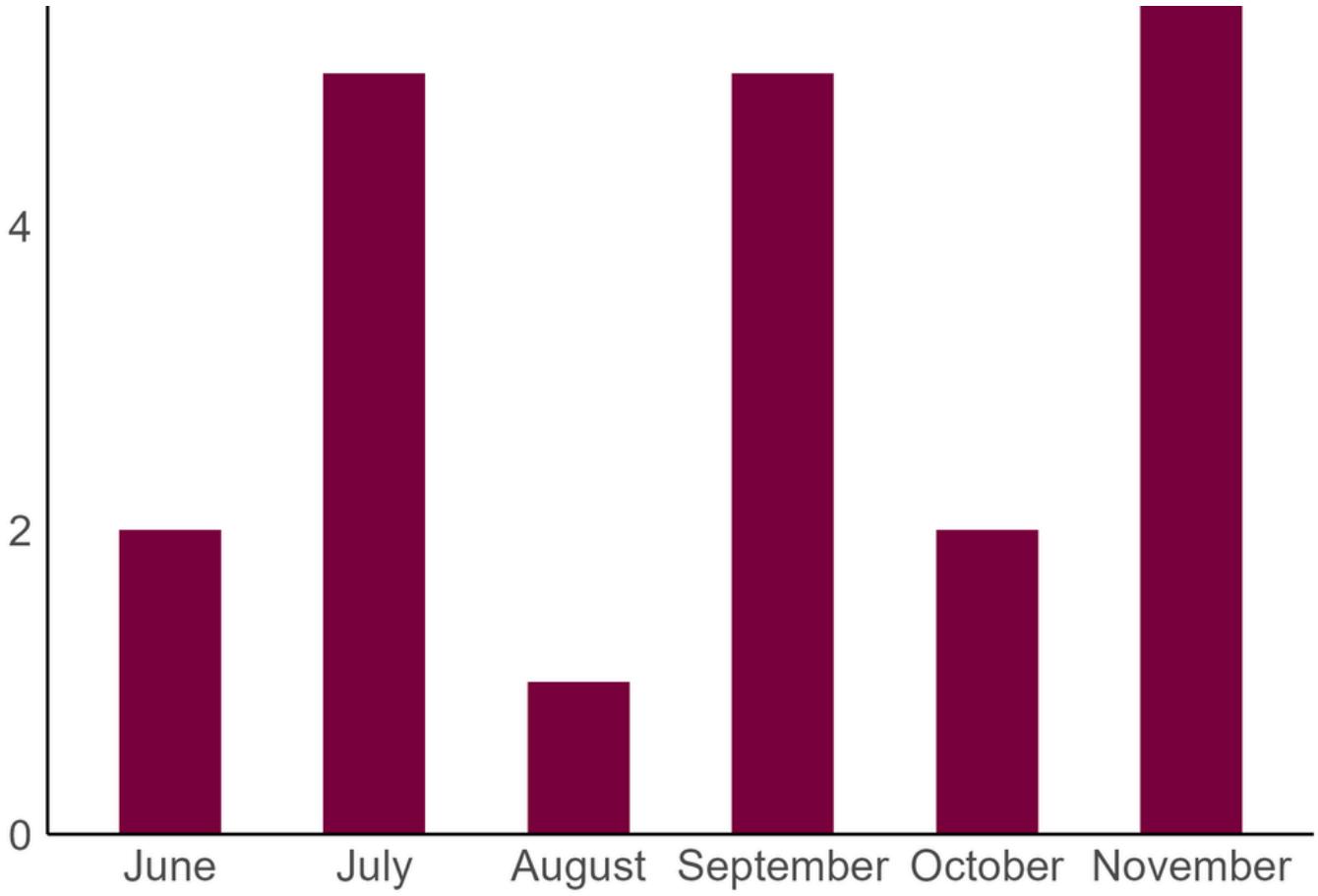
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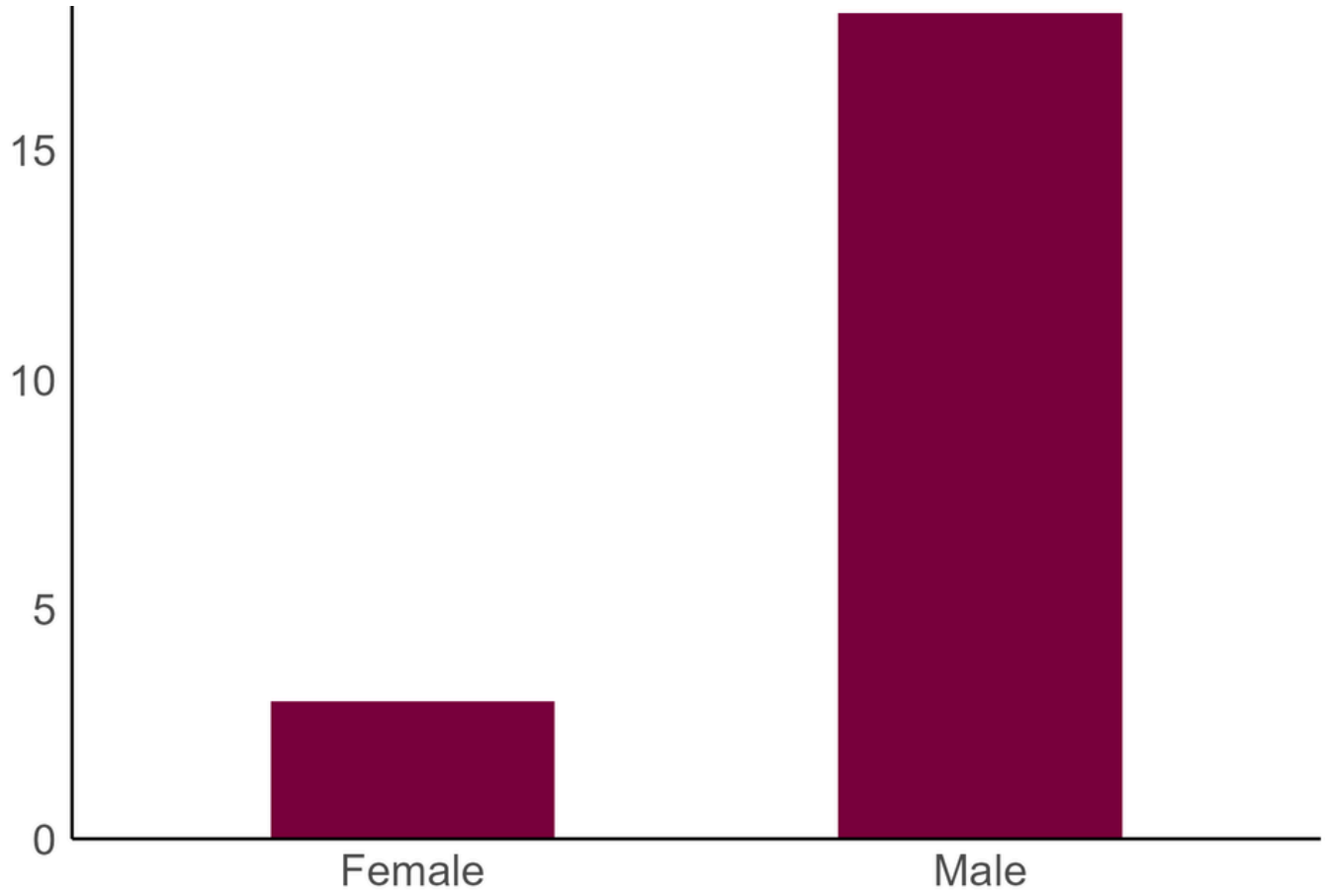
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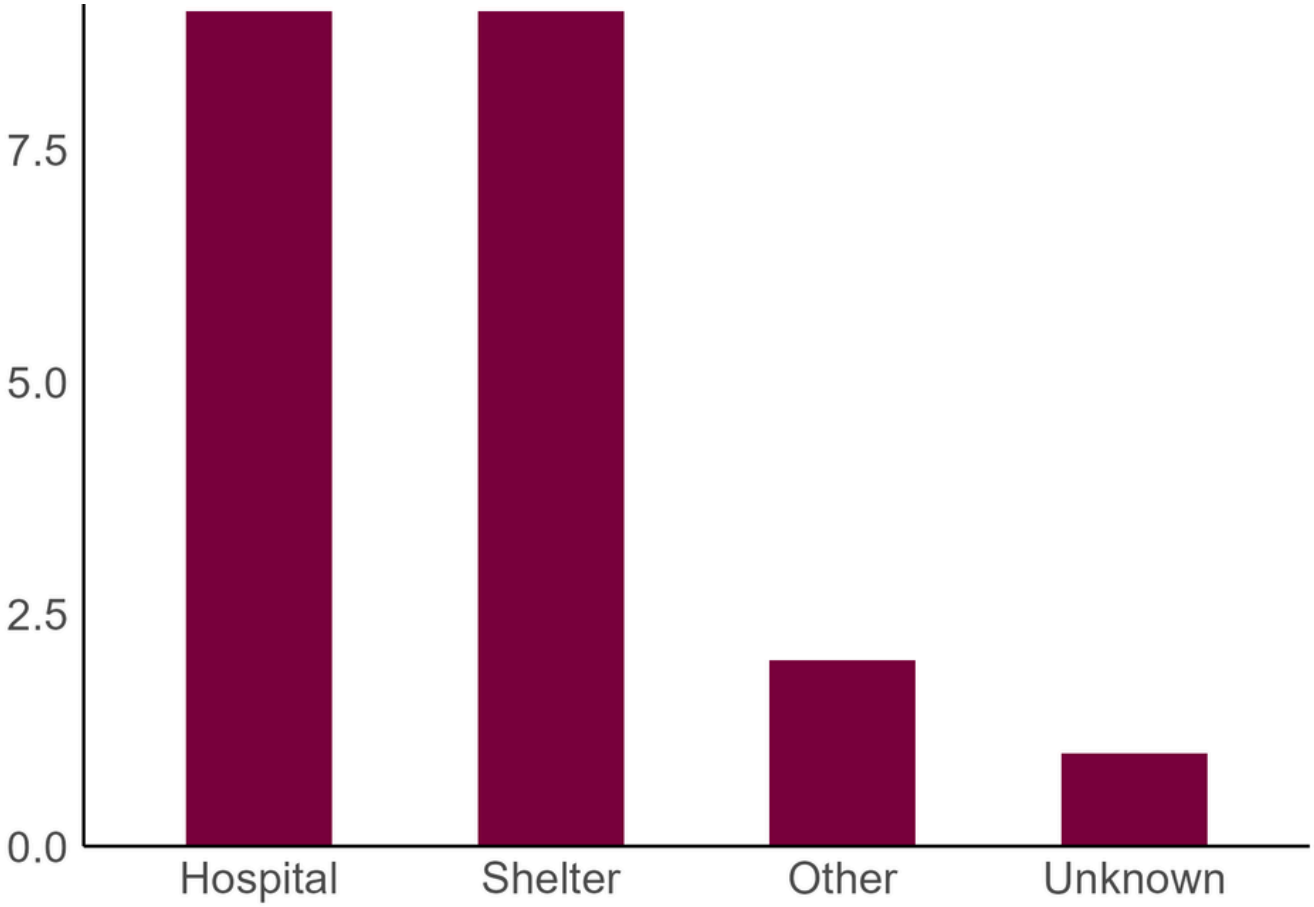
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DEATHS IN THE HAMILTON HOMELESS POPULATION



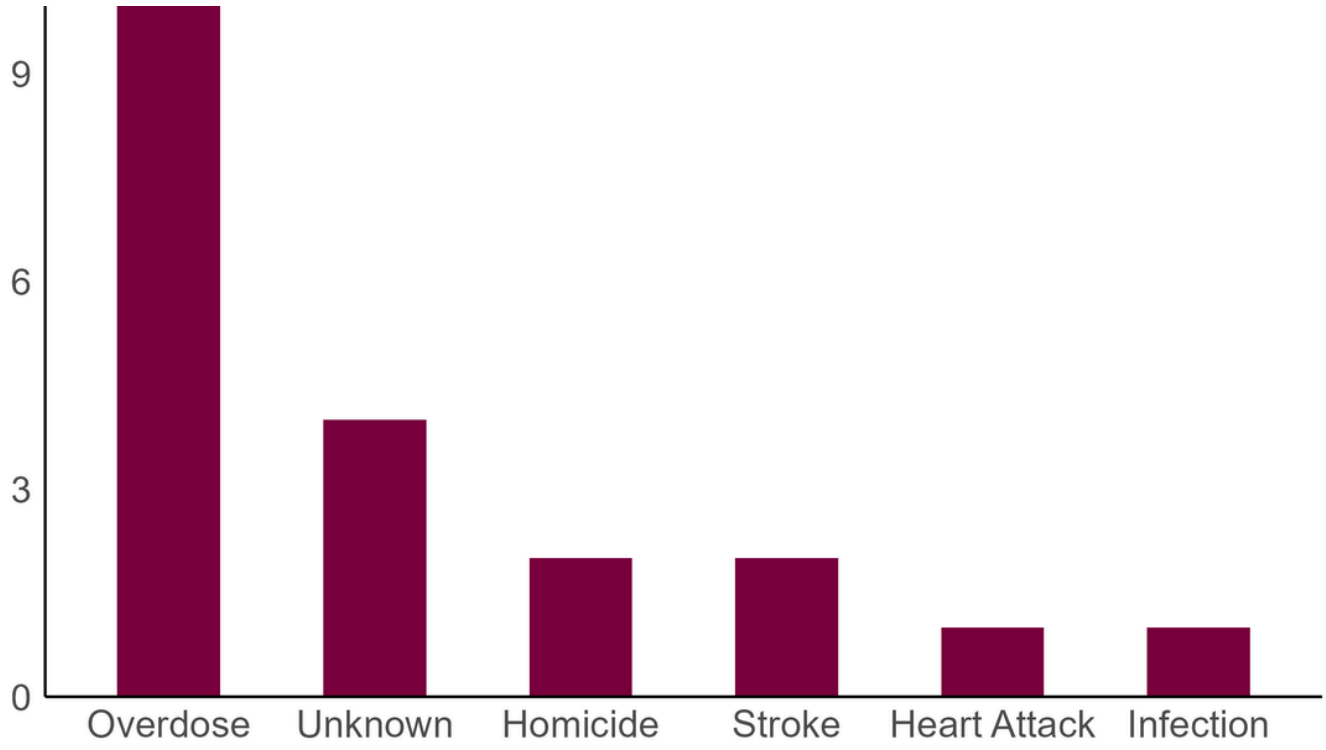
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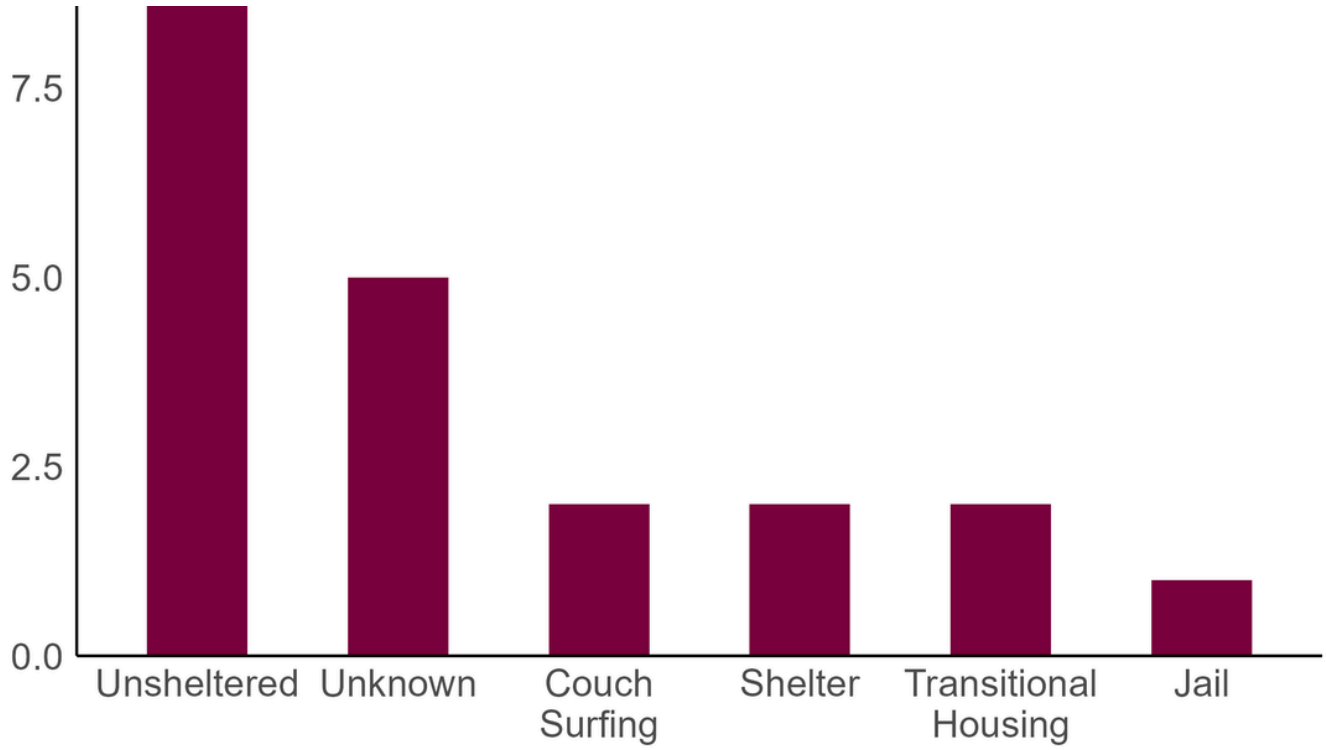
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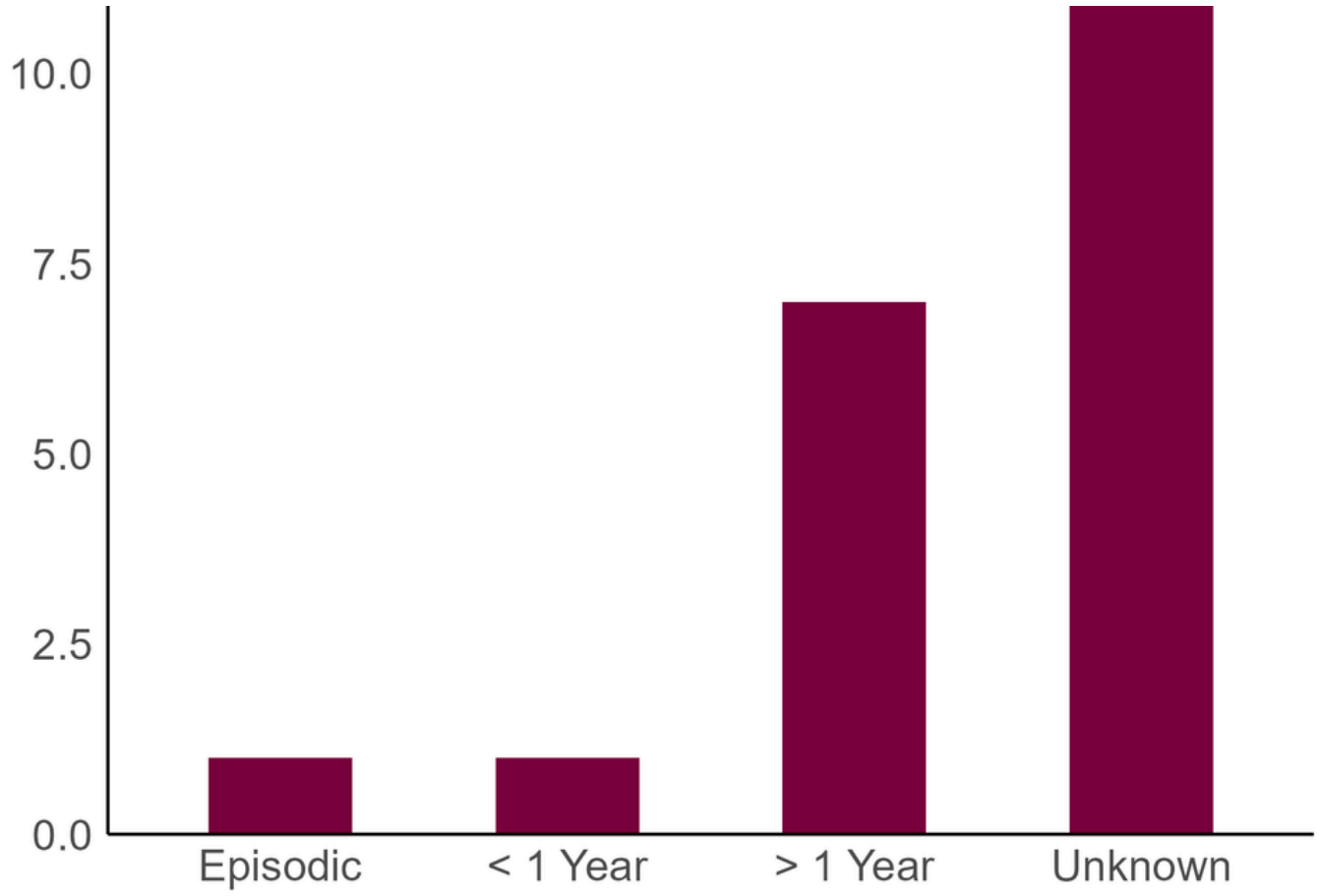
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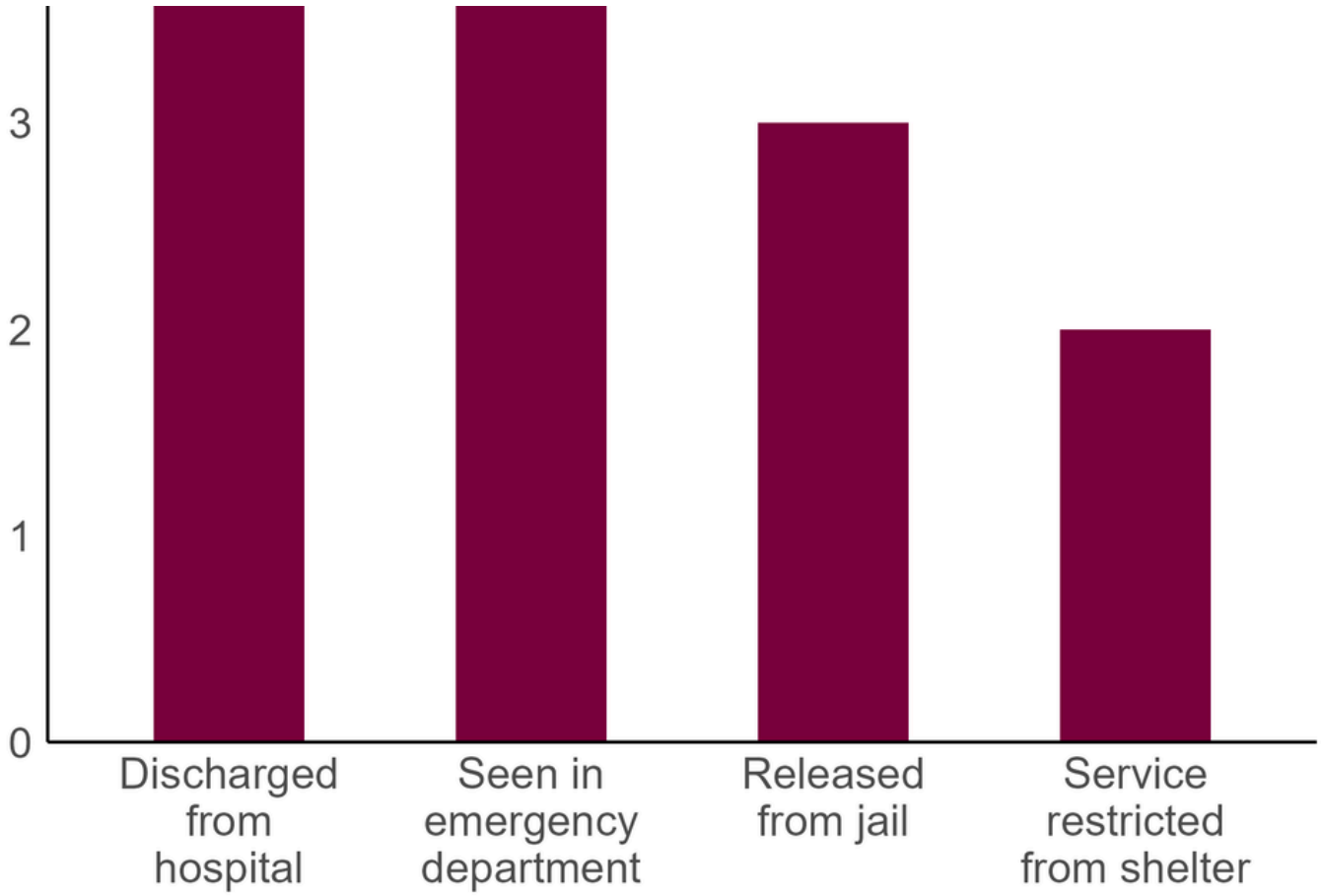
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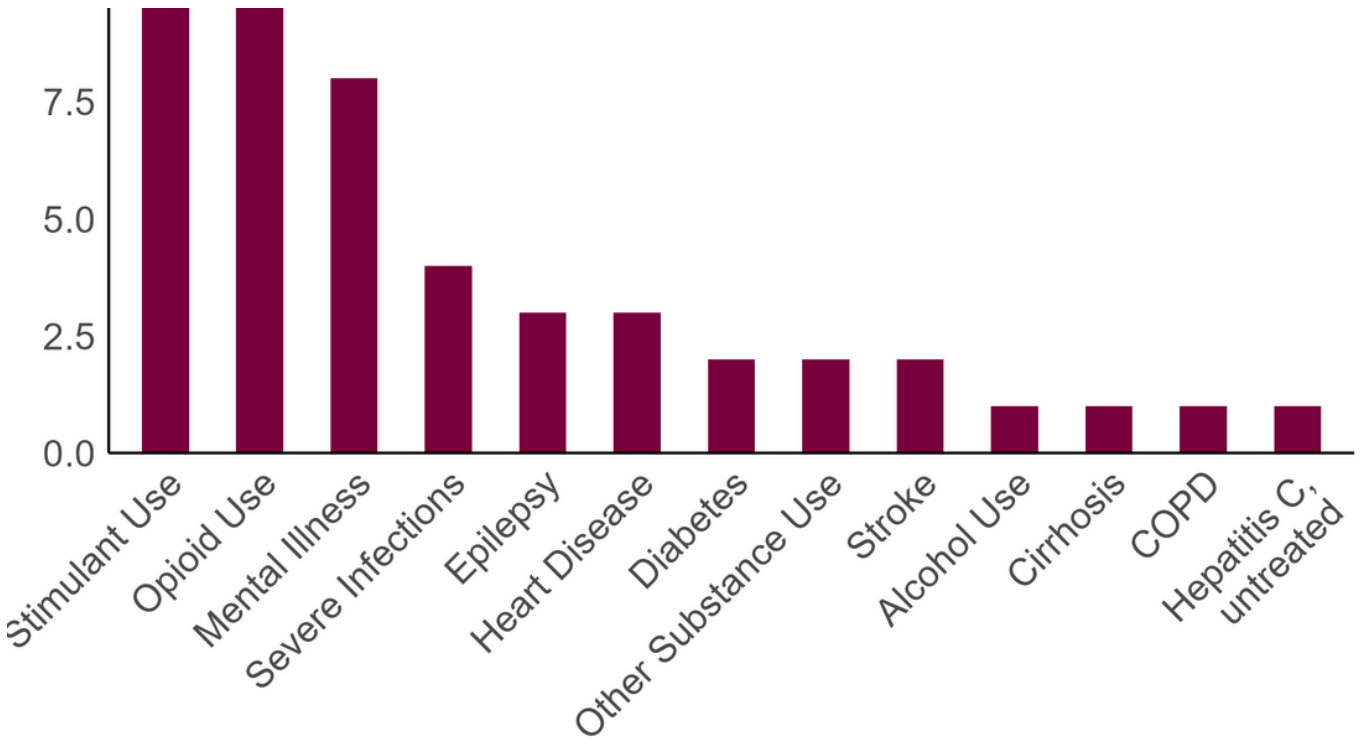
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DEATHS IN THE HAMILTON HOMELESS POPULATION

Cumulative June 2021 - November 2023

Total reported deaths: 91*

* Please note that this is pending report from the Office of the Chief Coroner and additional deaths for this time period may be reported on this webpage at a later date.

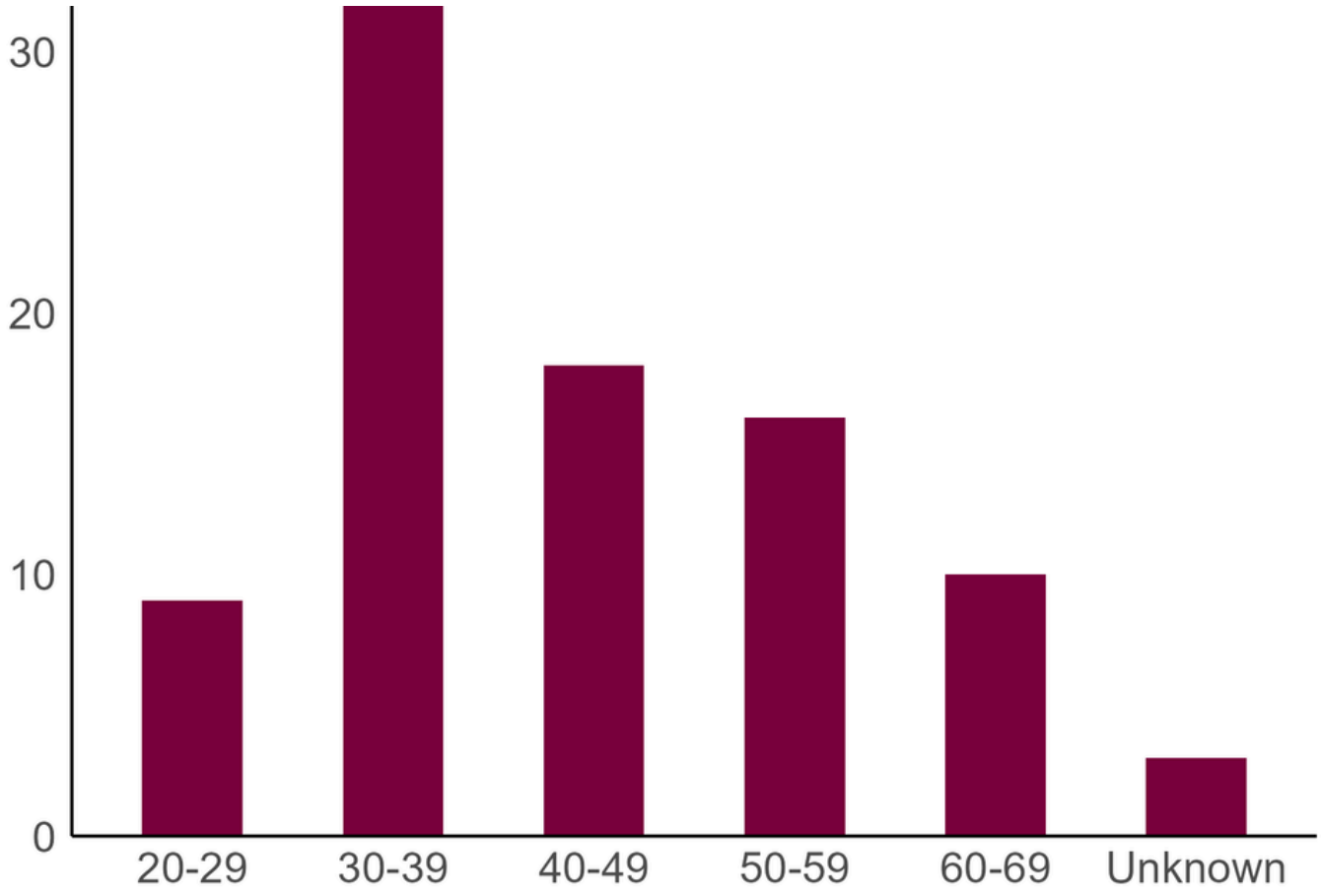
Average age at time of death:

42 years old

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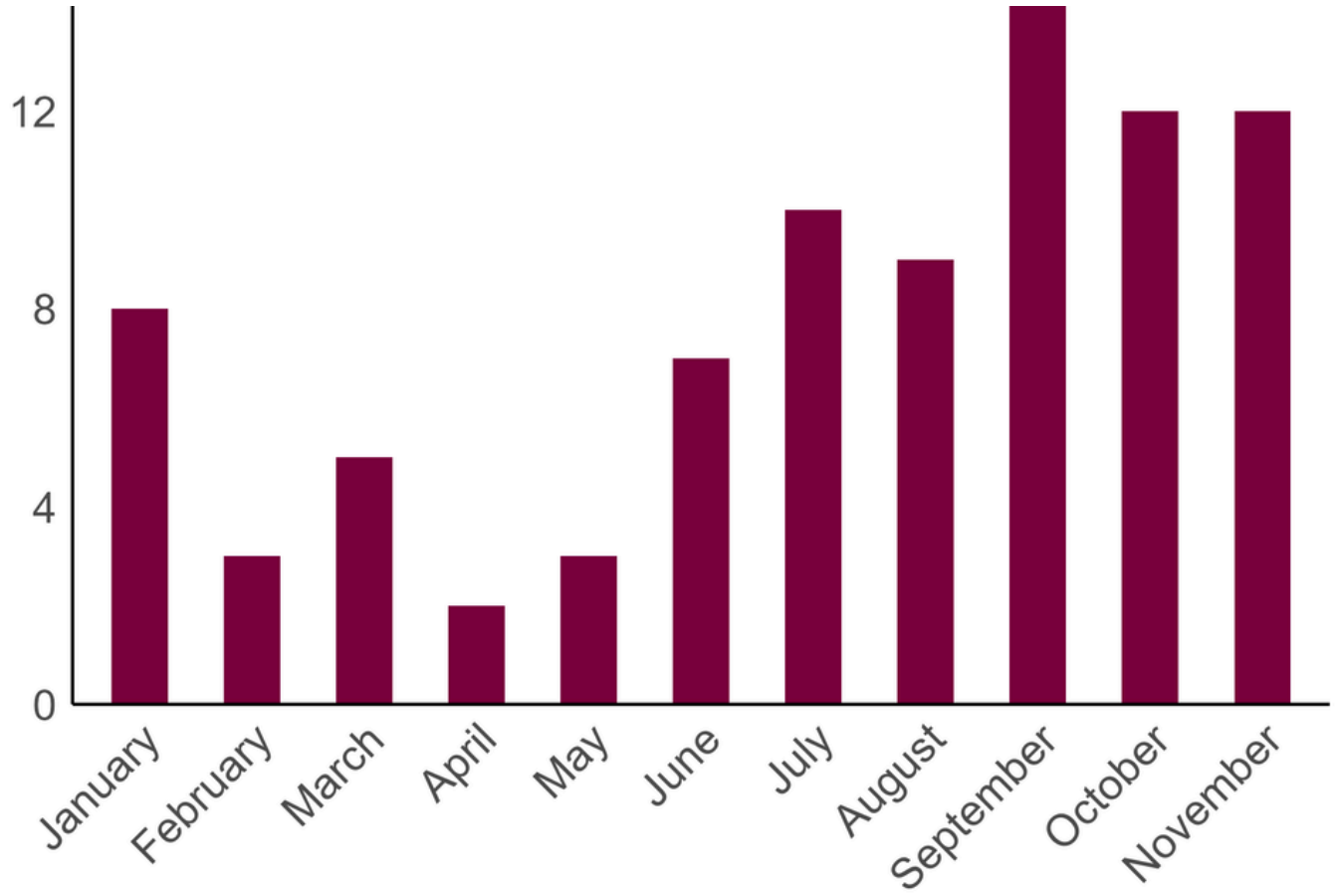
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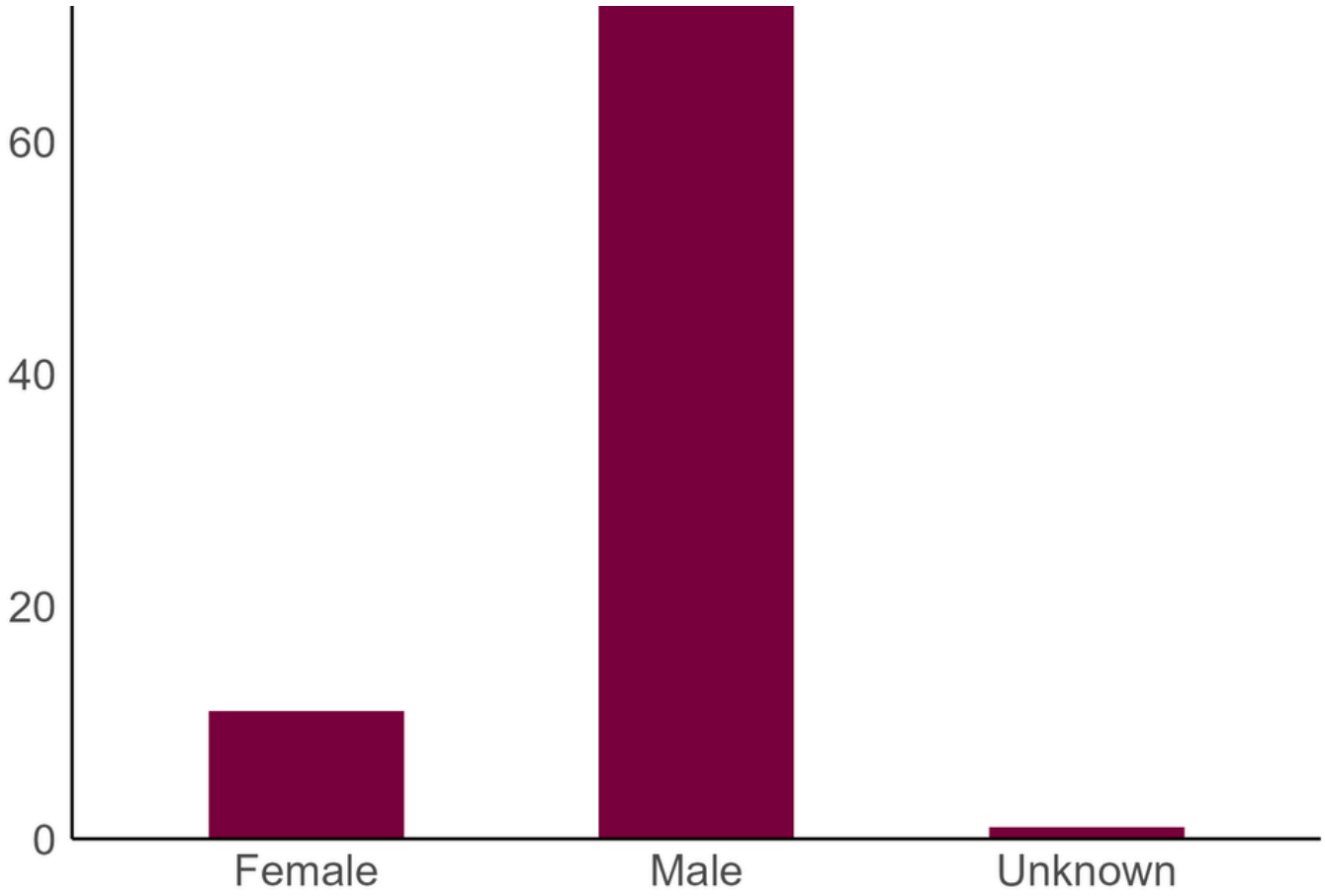
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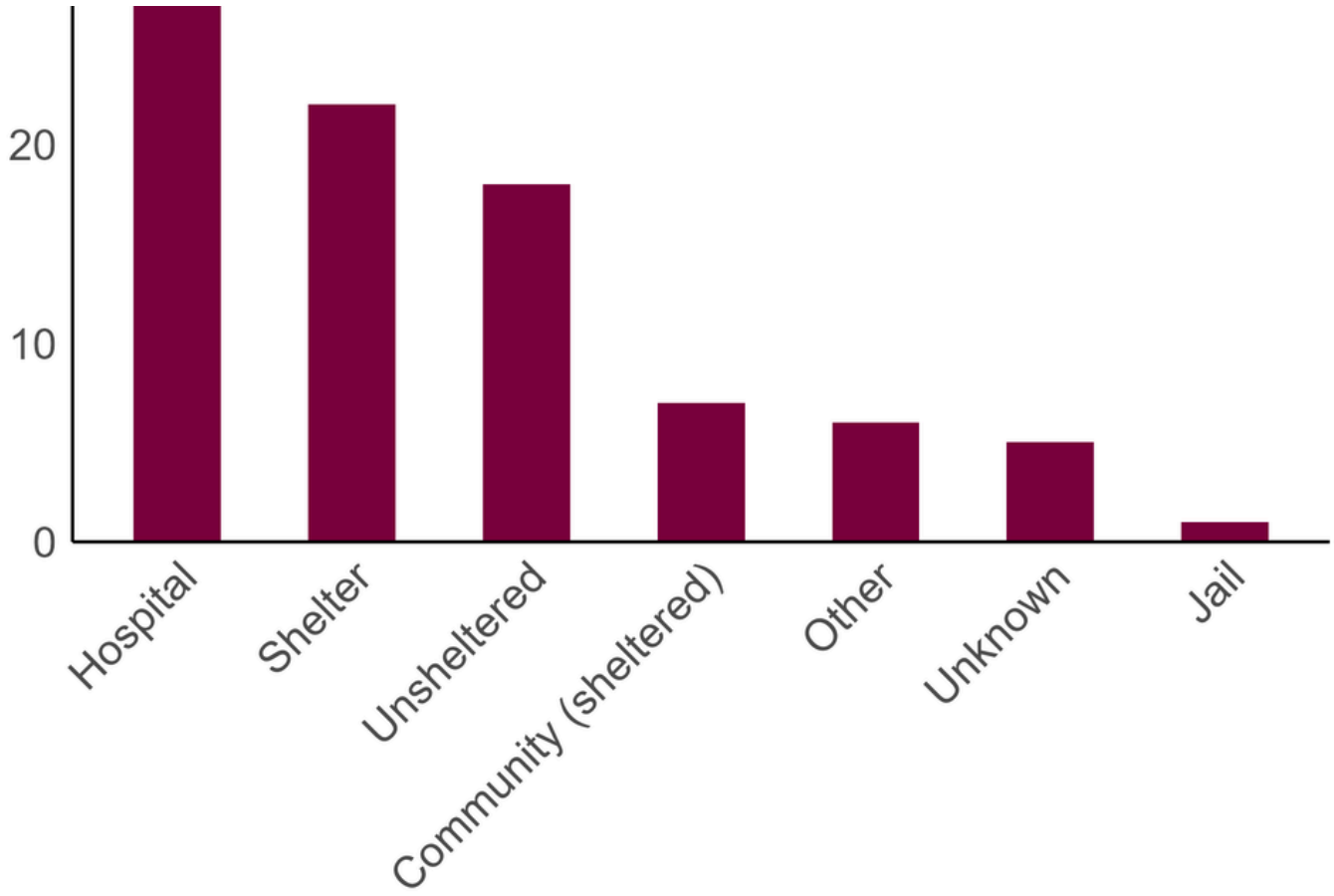
DEATHS IN THE HAMILTON HOMELESS POPULATION



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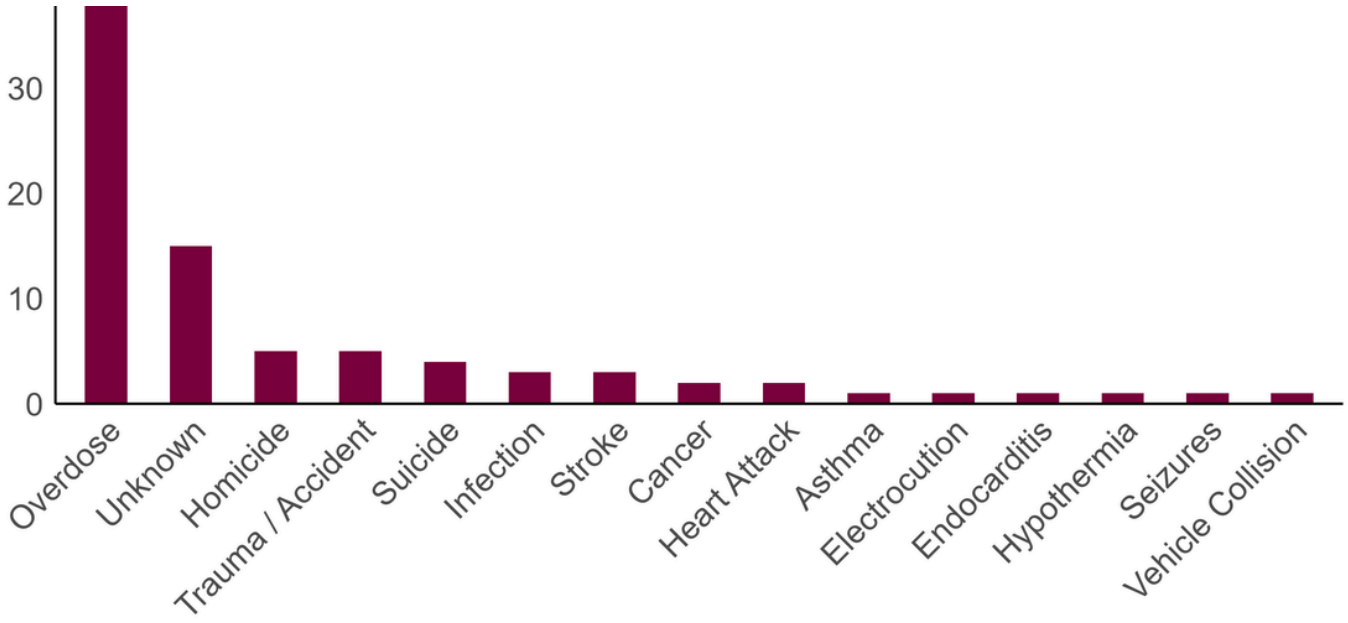
DEATHS IN THE HAMILTON HOMELESS POPULATION



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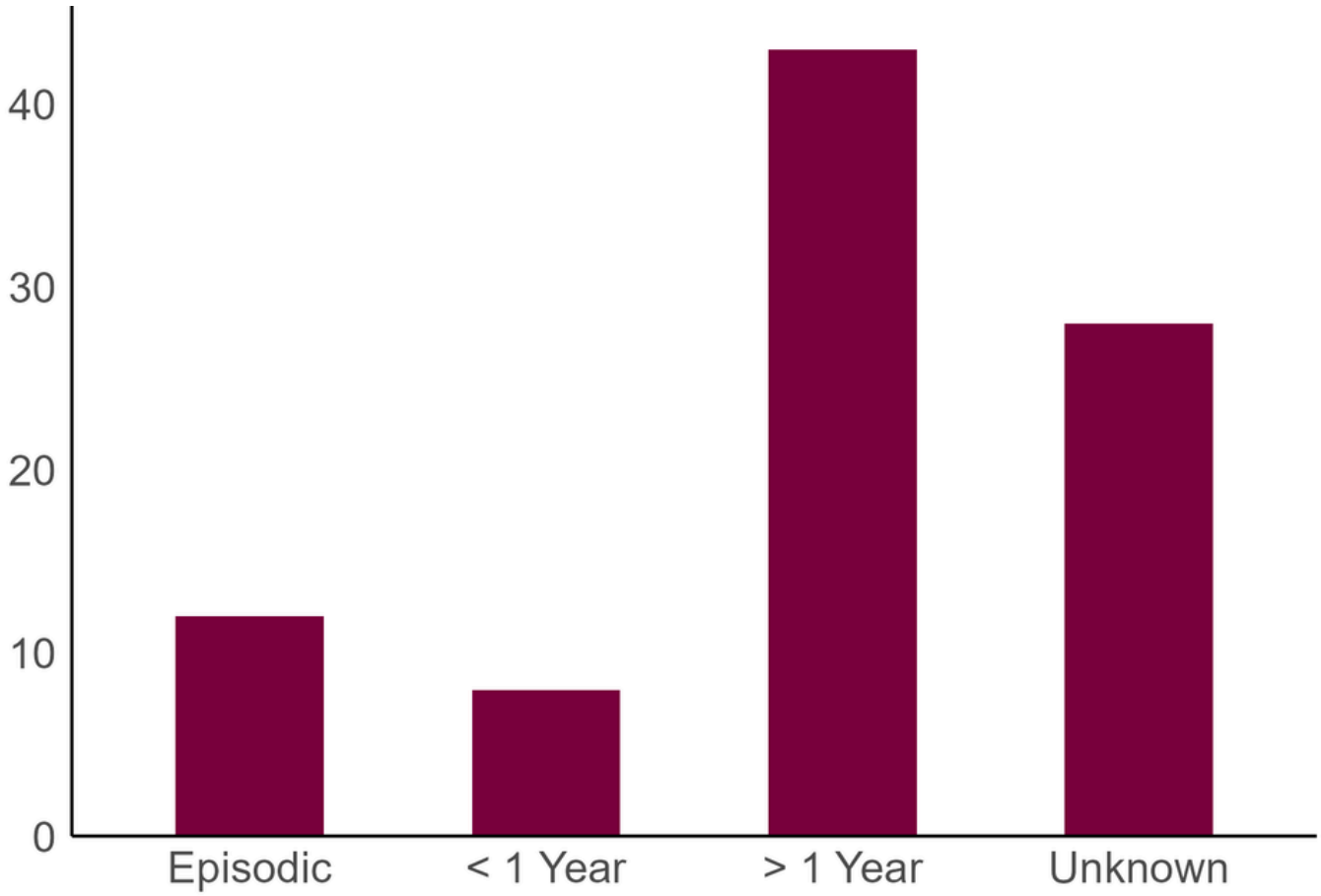
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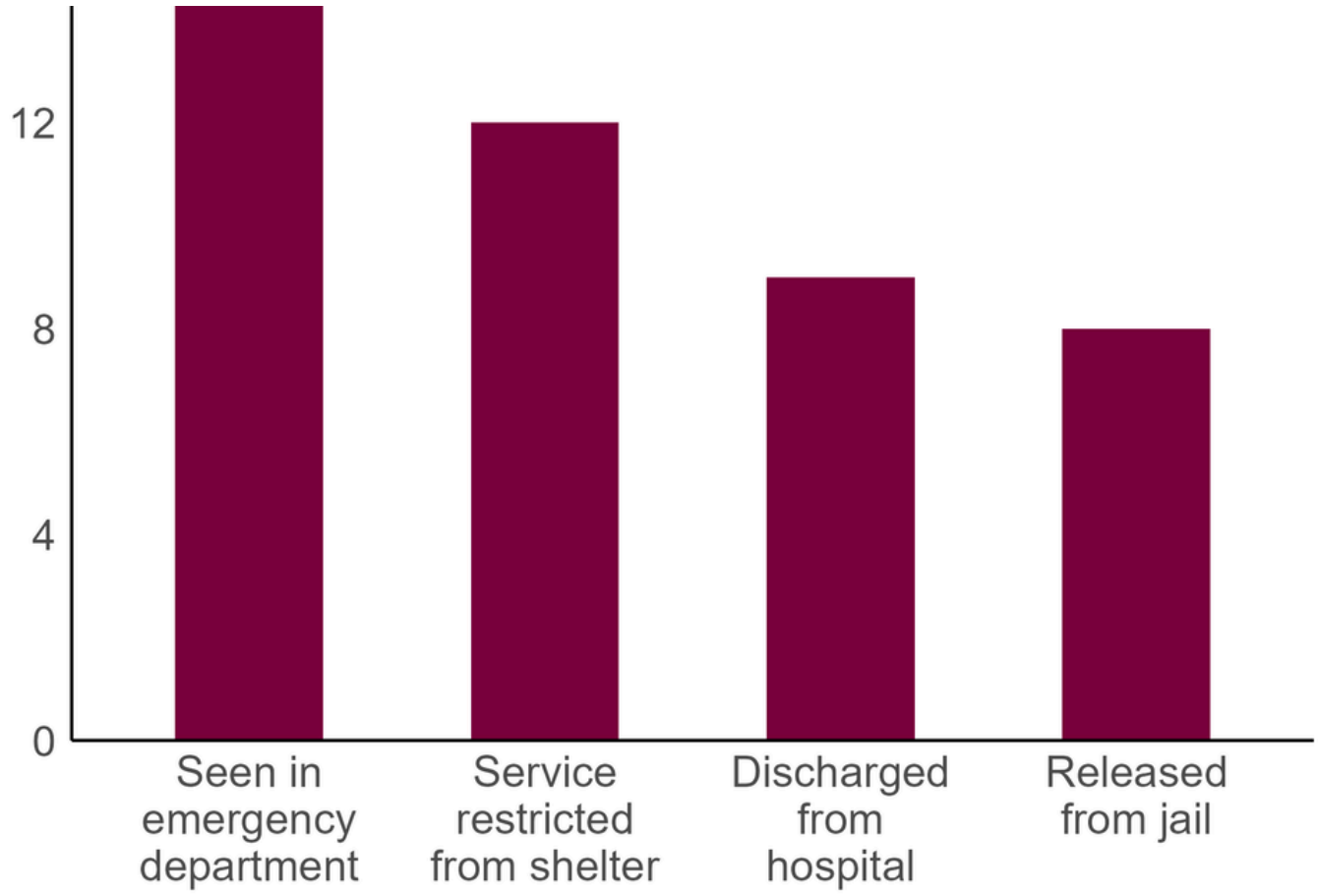
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DEATHS IN THE HAMILTON HOMELESS POPULATION

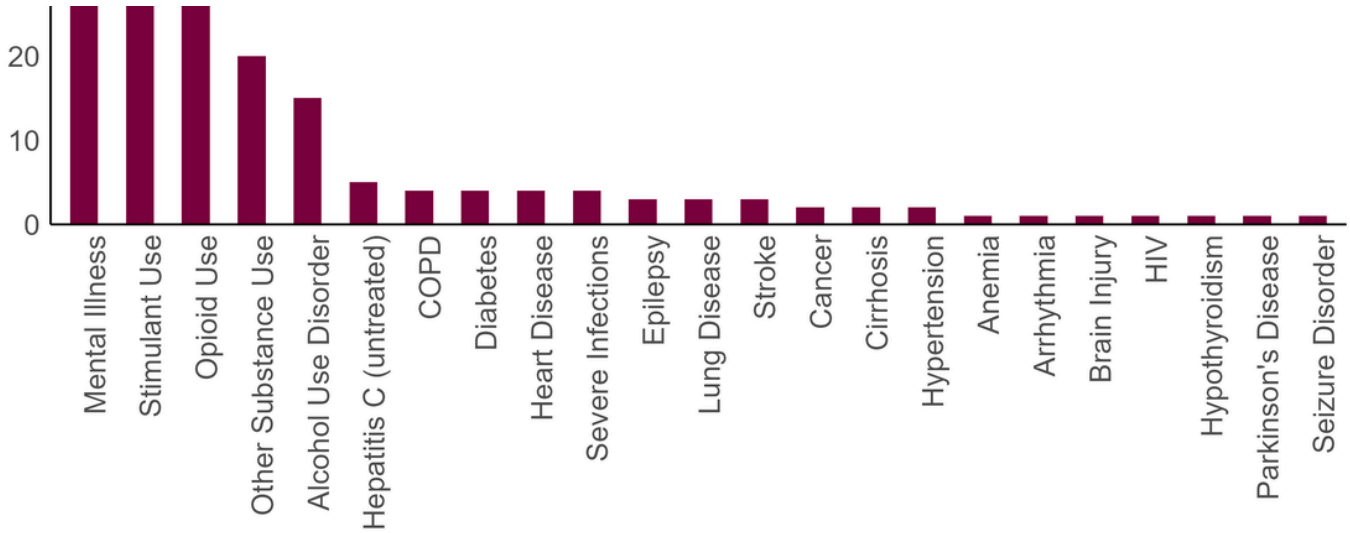


Please note that the above graph was not updated for the Dec 2022-May 2023 period due to lack of reporting.

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DEATHS IN THE HAMILTON HOMELESS POPULATION



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Heegsma et al
Applicants

-and-

CITY of HAMILTON
Respondents

Court File No. CV-21-00077187-0000

Ontario
Superior Court of Justice

PROCEEDING COMMENCED AT HAMILTON

Supplementary Affidavit of Dr. Joseph dated June 7, 2024

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TAB 110

Court File No. CV-21-77187

ONTARIO

SUPERIOR COURT OF JUSTICE

B E T W E E N:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLEN GNATUK, TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD

Applicants

- and -

CITY OF HAMILTON

Respondent

--- This is the Cross-Examination of AMEIL JOSEPH on his Affidavits sworn June 14, 2022 and June 7, 2024, herein, taken via videoconference hosted by Nimigan Mihailovich Reporting Inc. on the 27th day of August 2024.

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CROSS-EXAMINATION BY MR. Diacur.....5

The following list of undertakings, advisements and refusals is meant as a guide only for the assistance of counsel and for no other purpose.

INDEX OF UNDERTAKINGS

The questions/requests undertaken are noted by U/T and appear on the following page/line numbers: 10:15

INDEX OF ADVISEMENTS

The questions/requests taken under advisement are noted by U/A and appear on the following page/line numbers: None noted

INDEX OF REFUSALS

The questions/requests refused are noted by R/F and appear on the following page/line numbers: 48:23

APPEARANCES:

Sujit Choudhry For the Applicants

Jordan Diacur For the Respondent

IN ATTENDANCE:

Curtis Sell - CLCYR
Liz Marr
Sharon Crowe - HCLC

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INDEX OF EXHIBITS

EXHIBIT NO./DESCRIPTION PAGE NO.
NO. 1: CBC article - "Why Hamilton's encampment consultations can - and should - be different, say advocates" 26
NO. 2: SSM - Qualitative Research in Health article 51

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---Upon Commencing at 4:00 p.m.

AMEIL JOSEPH; Affirmed.

CROSS-EXAMINATION BY MR. DIACUR:

1 **Q.** Sir, where are you participating from today?

A. I'm in Hamilton, McMaster University.

2 **Q.** And the room you're in now, you're alone in the room?

A. I am.

3 **Q.** And you understand that you're not to have any assistance from others in giving your answers?

A. I do.

4 **Q.** And if you refer to any materials in giving your answers today, you'll need to state what you're referring to. We may have to make it an exhibit if it's not already part of your affidavit; do you understand that?

A. I do.

5 **Q.** And you may have to explain how it informs your evidence as well; do you understand that, too?

A. I do.

6 **Q.** Okay. There are two affidavits

6

sworn by you in this matter, one is dated June 14th, 2022 and the other is dated June 7th, 2024. Do you have copies of those affidavits available to you?

A. I do.

7 **Q.** Okay. My plan would be to put a copy of it up on the screen as well. You're free to refer to a copy if you have it available to you, or the copy on the screen. I'll scroll through it to the sections that I have questions for you about. If you need to review any section of your affidavit in order to respond, we'll certainly be able to do that.

So, just to confirm, you've been affirmed to tell the truth today?

A. Yes.

8 **Q.** And, sir, what do you understand your role to be in this litigation?

A. To assist the Court.

9 **Q.** To provide opinion evidence that's fair, objective and nonpartisan?

A. Yes.

10 **Q.** And to provide opinion evidence that's related only to matters that are within your area of expertise?

7

A. Correct.

11 **Q.** Have you ever been qualified to give evidence as an expert witness before in a court in Ontario?

A. I have. I was an expert in the KW case, accepted by the Supreme Court.

12 **Q.** I have that reference, thank you.

Sir, in terms of your two affidavits, as I say, June 14th, 2022, June 7th, 2024, at the time those affidavits were prepared what instructions were provided to you?

A. For which of the two?

13 **Q.** Well, of the two. So you can do them individually. Fair enough, there are two of them. So in terms of your first affidavit, June 14th, 2022, what instructions were provided to you at that time?

A. I actually don't recall the specific instructions.

14 **Q.** In terms of the affidavit subsequently prepared dated June 7th, 2024, do you recall what instructions were provided to you at that time?

A. I don't think I do.

8

15 **Q.** In terms of what your opinion is based on, are there any assumptions as opposed to known facts that you base your opinion on?

A. Can you repeat the question?

16 **Q.** Yes. In terms of what your opinion is based on, are there any assumptions that go into your opinion or that your opinion is based upon as opposed to known facts?

A. So as an academic, tenured academic at McMaster University, I've earned that position via the contributions that I've made to research and teaching that begin with an analysis. That appreciates that there isn't a clear difference between the idea of assumption and fact in social analyses or political and social critique. If we're talking about fruit flies contained in a jar, that would be another matter.

17 **Q.** Okay. So before we turn to your affidavits, there's a document that I would like to show you and I have a couple of questions for you about it. I'll put it up on the screen and we'll take a look at it.

So can you see this? It's an article from the CBC and it bears a date of July 21st, 2023.

A. I can see this, yes.

18 **Q.** And it's entitled: "Why Hamilton's encampment consultations can - and should - be different, say advocates". Do you recall this article?

A. I do.

19 **Q.** And just to scroll down a little bit, that's a photo of you at the top?

A. On the top left.

20 **Q.** Top left. Yes, to be fair, there's two photos, the top left is you?

A. Yes.

21 **Q.** And the top right is Gessie Stearns; is that right?

A. Yes.

22 **Q.** And attached to your affidavit, first affidavit, there's a copy of your CV. It identifies that you supervised Ms. Stearns Master's of Social Work thesis; is that right?

A. I believe, yeah. Oh, sorry.

23 **Q.** No, sorry, I didn't mean to cut you off. In other words, she's a graduate student of yours?

A. That's correct. In relation to the CV I also have updates to that. It's out of

date.

24 **Q.** Understood. Actually, that was my next question. Do you have a current copy of your CV that's available?

A. A current copy, yes. I could provide updates if that would help.

25 **Q.** If you have a current copy, my general practice when there's an older CV attached to an affidavit of an expert is to request an updated copy.

A. Sure.

MR. DIACUR: I would request via undertaking, counsel, an updated copy, current copy, of the of the professor's CV be provided.

U/T MR. CHOUDHRY: Sure.

BY MR. DIACUR:

26 **Q.** And Ms. Stearns, who is pictured here, also swore an affidavit in this matter; are you aware of that?

A. No.

27 **Q.** Did you speak to Ms. Stearns about your evidence?

A. No.

28 **Q.** And this articles identifies you and Ms. Stearns as "advocates". That's the

word used in the title. Do you consider yourself an advocate?

A. I really would have to hear more about what it is in reference to.

29 **Q.** Sure, and we can absolutely do that. So this subheading underneath the title of the article says:

"Ameli Joseph and Gessie Stearns share their thoughts on the city's encampment protocol and consultation."

Do you recall being interviewed by the CBC on those subjects?

A. I do.

30 **Q.** And you provided your thoughts as part of an interview?

A. I did.

31 **Q.** Do you consider yourself an advocate for unhoused individuals?

A. I consider myself a researcher scholar and associated tenured professor at McMaster University who has particular areas of focus and expertise. That includes what I shared in the affidavit from June 24th where I overview the particular ways of my analysis that engage with social, historical and political contexts,

very often in relation to marginalized groups or equity seeking groups by considering inequities and disparities. If I would describe myself ever using the term advocate, I would be an advocate for a recognition of knowledge and a respect for it.

32 **Q.** This article, which I'll scroll down to, starts out by saying:

"As Hamilton wrestles with worsening homelessness and how to address it, city councillors are poised to finalize a plan next month to deal with a growing number of encampments.

In June, the city held three in-person public consultation sessions and had an online survey open for people to share their thoughts and offer feedback on the plan." [All quotes are as read]

So I understand overall this article is about public consultations conducted by the City of Hamilton that led to the current encampment protocol with the City of Hamilton that permits indefinite encampments in city parks within certain parameters. Did you participate in the public consultation sessions that are

13

referenced in this article?

A. I attended one.

33 **Q.** And did you participate?

A. I did.

34 **Q.** And this article indicates that, while it's been edited and condensed for clarity, there was an interview process with a CBC journalist in which you and Ms. Stearns participated; is that right?

A. Sorry, that was quite a lengthy question, do you mind repeating it.

35 **Q.** Of course. So this article includes, while it does say it's been edited and condensed for clarity, it's an interview that you and Ms. Stearns had with the CBC journalist; is that correct?

A. I don't think we did the interview together.

36 **Q.** So this was -- these questions were posed to you separately?

A. I actually don't recall, but I don't remember doing it together.

37 **Q.** Just in terms of how the information is presented in the article, there's a question and then there's an answer either from

14

you or Ms. Stearns first, but each of you speak to each of the questions. I can show you, that's the first questions there: "How would you summarize the state of homelessness and housing in Hamilton?" Then an answer from you. I'm happy to have you read that, but that was the response you gave to that question when it was posed to you by the CBC?

A. Not exactly.

38 **Q.** Okay. So because it's been edited and condensed, it's not exactly your words, but it has been presented as your words in this article; is that fair?

A. It has been presented. It is not in the form of quotation.

39 **Q.** Well, it does have your name and then the colon indicating that it is a statement made by you. I can see that it's not in quotation marks, but it is indicated to be a statement that you made; is that fair?

A. I don't have a specific memory, nor was I shared a transcript, nor was I shared a draft of the article before it was published to affirm or confirm that was exactly what I said.

40 **Q.** I would like to scroll down to

15

the last question in this article. As you say, it's possible that it wasn't the last question posed to you or it may have been posed to you and Ms. Stearns separately. The question on screen right now, and this is the very end of the article, you can see the end right there, the last question is:

"Is something different possible? What does that look like to you? And what do we do next?"

Your response, as reported in this article, anyway, in part is:

"It's not just the case we need Ontario Works and ODSP to be higher amounts, it's also the case we can take municipal funding programs and make them livable for people on social assistance in terms of cost by re-sourcing how they're funded ... rather than retreating to 'how do we get rid of these people we see as the worst?'"

Do you recall making that statement?

A. Not specifically.

41 **Q.** Do you agree with that statement?

A. So you're beginning with "it's

16

not just the case" and ending at "the worst"?

42 **Q.** Yes.

A. So I believe I spoke at length about the kind of historical contexts that come from my areas of expertise I refer to, in my affidavit from June 14th, 2022. Particularly around paragraphs 8 and 9 where I describe the historical context of identifying people not worthy of adequate supportive care.

In paragraph 10 of my affidavit I talk about the specific policy trajectories as well as their embedded discriminatory ideas and how those continue to be pervasive and structure the contemporary realities of widespread inequities. That includes healthcare, education systems, housing, employment, food security, access to water, environmental inequities, mental health, criminal justice systems. I talk about income in there as well.

In that conversation I did bring up Ontario Works and ODSP, but I would say that this brief paragraph doesn't do adequate justice to the nuances that I gave in my response during that interview that relied on my specific expertise.

43 **Q.** Understood. We're going to

come to those paragraphs in your affidavit, I'll have some questions for you about them.

But do you agree that we can take municipal funding programs and make them livable for people on social assistance in terms of cost by resourcing how they are funded?

A. Again, I would say that that on its own and on its face would be too brief to engage an analysis that incorporates what I contributed in my affidavit based on my expertise that brings in an analysis of a social, historical and political context that set up inequities for most marginalized, as I made a case for in the affidavit.

44 **Q.** In terms of your participation in the consultation process that this article references, was an increase in municipal funding for individuals on social assistance part of your contribution?

A. I'm sorry, could you repeat that?

45 **Q.** Yeah. So in terms of the consultation process that's referenced in this article in which you participated, was an increase in municipal funding for individuals on social

assistance something that you were seeking?

A. I don't believe so. But I don't specifically recall what I contributed in the consultation. There was a moment where I spoke openly in the group in response to a request for input from members of the arts in attendance. And there was also an option to write down questions on an index card and submit those that selected full responses, because the time period of the consultation was limited. And I don't actually specifically recall what I wrote on that index card in terms of the questions, but I did submit one.

46 **Q.** Have you ever spoken to any municipal councillors or lobbied for an increase in municipal funding programs with respect to people on social assistance in Hamilton?

A. Have I spoken to City councillors?

47 **Q.** Municipal councillors or lobbied in Hamilton for an increase in municipal funding programs for people on social assistance.

A. Again, I don't believe that I have shared any analysis or requests, that would be outside of my area of contribution and research

expertise. That would also engage in considerations of broader social, historical and political contexts and, again, leading to the contribution I made in my June 14th affidavit. I do that intentionally, that analysis, to consider the ways that more marginalized groups are impacted by historical and social inequities. And that those considerations and an analysis in respect for them from the bodies of research that have contributed to that prioritization analysis, which I have also contributed to, are considered.

I feel like I have done that in ways that are evident across my CV, through my journal publications, in conference papers, presentations, through my roles at the university and the courses I teach, the projects I supervise, research grants that I've been awarded, the awards that I've been awarded. So I would say I -- if I have not done the thing that you have asked.

48 **Q.** In terms of your participation in the consultation process, as referenced in this article, it sounds like your participation involved an oral statement and a written statement on an index card that would necessarily have been brief; do you agree with that?

A. No, I don't think so. I think given the opportunity to speak I took my time to share my analysis, also sharing who I was and why I was there and provided some nuance and analysis from my areas of expertise. So I believe it was somewhat lengthy, my oral contributions.

49 **Q.** And I just want to be clear before we leave this article. In terms of what's communicated here in response to the question that I read out, while you can't recall specifically whether or not what's contributed to you here as your answer is a complete record of what you stated in response to that question, you're not saying that what is set out here was not said by you; is that right?

A. I would say, for myself, that what I said was, in my opinion, drawing on my expertise and analysis to allow for a nuanced analysis of the social, historical and political context for the circumstance of what we talked about in terms of housing and homelessness since this depiction of it is actually inaccurate because it doesn't do justice to all of what I said.

50 **Q.** I want to be clear about that.

21

If you're saying that this article is inaccurate, you're not asserting that the CBC put words in your mouth, correct?

A. No, I didn't make that statement.

51 **Q.** No, I know, I'm trying to clarify. You're saying that there's something inaccurate about this article and this representation of your words. You're not saying that they made this up, the CBC?

A. I would reiterate what I shared in the interview was my expert opinion that comes from years of research and analysis.

52 **Q.** I've heard your answer, but my question is somewhat different. You're not asserting that the CBC made up what is set out in this article as your answer to a question; you're not saying that?

A. I never said that. I would say --

53 **Q.** This is a further question. So I'm not saying that you did, I want on the record that you confirm that that is not something that's being asserted. You are not asserting that this answer contributed to you on the screen now, that

22

question in the article that's posed to you was made up?

A. I actually am misinterpreting what you mean as "made up".

54 **Q.** You said this article is inaccurate, that the representation of what you've said is inaccurate, so I want to explore that concept for a moment. You're not saying that it's only made up out of whole cloth, that you never said any of these words, correct?

A. Again, you're using references that are not transparent, made up out of whole cloth.

55 **Q.** Yes. That is a perfectly straightforward statement. The words that are attributed to you in response to this question: "Is something different possible? What does that look like to you? And what do we do next?", you're not saying that a CBC journalist just made all of these words up, that they did not come out of your mouth, correct?

A. I can't say that these are a good representation of the analysis that I provided.

56 **Q.** That's a difference answer.

23

It's an answer to a different question. It might not be a good representation of your answer.

A. Okay.

57 **Q.** I'm saying, these words were not fully made up by the CBC, that's not what you're alleging?

A. I don't think I waged an allegation.

58 **Q.** I'm not saying that you have. I'm trying to get a confirmation on the record that that is not the inaccuracy that you're alleging starting broadly and we're going to drill down into that.

So these words you're not alleging were wholly made up by a CBC journalist, correct?

A. I don't believe they would do such a thing.

59 **Q.** You are not asserting that they did, correct?

A. I don't believe I have.

60 **Q.** Okay. Again, I'm not asserting anything, I'm asking you a question.

A. So you're asking me --

61 **Q.** I'm not saying this is made up.

A. Right, so I'll respond. You

24

asked me if I've asserted something, I'm telling you I don't believe I have. You believe that that question has not been answered.

62 **Q.** You gave an answer saying this is inaccurate in some way.

A. I did.

63 **Q.** I'm examining the nature of the inaccuracy. So to start with, it's not wholly fully made up, correct?

A. So in my opinion that I shared with you, from my areas of expertise I would say that to take a sentence of a contribution without the nuance and analysis that engages the areas of expertise that I drew upon to provide the background for the contributions I was trying to make in the article, to leave those out is a crafting, it is a construction, and it might, to some degree, in someone's opinion, be inaccurate, inadequate and --

64 **Q.** In your opinion. I want to make it clear, it's inaccurate in your opinion, not someone's opinion, right?

A. I would say as a professional tenured academic that to have a robust analysis shared with you and to truncate it and leave

25

important elements out would be something that I wouldn't grade well or evaluate well or ask anyone to do or present, it would be a misrepresentation.

65 **Q.** So that's the nature of the inaccuracy that you're talking about?

A. Correct.

66 **Q.** But you are not sure whether or not that statement, it's not just the case we need Ontario Works and ODSP, we can take municipal funding programs and make them livable for people on social assistance in terms of cost by re-sourcing how they're funded, you're not sure whether that ever came out of your mouth in that order?

A. I believe that last quote, "how do we get rid of these people we see as the worst?", is actually a quote from me. I believe that stems from my analysis that I shared earlier with respect to paragraphs 8, 9 and 10 of the June 14th affidavit that situate the context whereby certain people can be seen as inherently flawed or inherently the worst and inherently undeserving, and those ideas get reconstituted often in policy considerations, which I have also analyzed and published on.

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67 **Q.** I think we've exhausted this subject, so I'm going to stop sharing that document. But, counsel, I will propose that we mark as Exhibit 1 to the examination of Professor Joseph.

EXHIBIT NO. 1: CBC article - "Why Hamilton's encampment consultations can - and should - be different, say advocates"

BY MR. DIACUR:

68 **Q.** I would like to move now to your affidavit, your first affidavit sworn June 14th, 2022. So I'm going to share my screen and put that up. Do you see that there entitled Affidavit of Ameli Joseph sworn June 14th, 2022?

A. I do.

69 **Q.** So I'm going to scroll down to paragraph 3. And in paragraph 3 you start out by saying "I study" and then lay out those subjects. Do I understand your opinion to be that the Canadian criminal justice, immigration and mental health systems have historically dehumanized, excluded and racialized violence against racialized groups, disabled people, newcomers/immigrants and people with mental health issues?

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A. Would you mind repeating your question, please?

70 **Q.** Is your opinion that it is the case that the Canadian criminal justice, immigration and mental health systems have historically dehumanized, excluded and racialized violence against racialized groups, disabled people, newcomers/immigrants and people with mental health issues?

A. I would say paragraph 3 shows that I study, I choose my areas of interest. But I would say it's probably too broad of a statement to say wholeheartedly and in a completely generalizable way that all of criminal justice, immigration, mental health systems, practices, policies in law in every respect in Canada are dehumanizing, exclusive or racializing violence. I would say I have interests that have looked at particular empirical examples.

71 **Q.** Are the subjects of your study purely historical or are they contemporary?

A. They are both historical and contemporary.

72 **Q.** Do the courts in Canada today dehumanize, exclude and rationalize violence

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against racialized groups, disabled people, newcomers/immigrants and people with mental health issues?

A. When you are referring to "the courts", is there a particular court that I am to respond to? I'm just trying to understand the question.

73 **Q.** Well, in terms of our court system, my question has to do with the courts in Canada, but I can be more specific. You say in paragraph 7 of your affidavit, for example, that among other things, criminal justice system is the phrase that you use, but you state that the criminal justice system, among others:

"...have produced and reproduced a devastating legacy of discrimination, prejudice and exclusion for racialized people, disabled people, and people with mental health."

That's true, correct?

A. Yes. It is also a citation, and that citation is a reference to my book, which is a particular study regarding removal orders for racialized people identified with mental health issues in mental health systems. As well as attending to the confluence of mental health

criminal justice and immigration systems. Particularly with an emphasis that I refer to in paragraph 8 in reference to prohibited classes which --

74 **Q.** We'll come to that. I have some questions for you about paragraph 8. But for the moment I just want to focus what you say in paragraph 7.

You indicate that among other systems, the criminal justice system has produced and reproduced what you refer to as a devastating legacy of discrimination, prejudice and exclusion. Now, what timeframe are you talking about in terms of the criminal justice system reproducing those devastating effects?

A. So that first section of paragraph 7 that is cited, that's my book, is in relation to a study on deportation, removal orders. It was conducted during my PhD.

75 **Q.** Is that only historical or is it contemporary? Those devastating effects, are they still occurring or is that only in the past?

A. So it was an analysis of historical, historically established policy, professional practice and law that traces the

genealogy and contemporary effects on ideas shared during an examination of appeals cases of the Immigration and Refugee Board, particularly related to the matter of removal orders.

76 **Q.** And that's what I wanted to ask you about specifically. So you say as a historical study, but that they are contemporary effects. That's what I'm interested in, is the contemporary effects that you're referencing.

A. Okay.

77 **Q.** Is this something that's continuing to be a devastating effect of things the criminal justice is still doing, or is it simply the effect of the historical acts; do you see the distinction I'm drawing?

A. I understand the distinction you are drawing. I don't think that's what paragraph 7 says nor what I articulate in my book.

78 **Q.** So that's what I want to get to. You do say there are contemporary effects, so things are occurring today as a result of what you state in paragraph 7; is that accurate?

A. That's not what I cite there.

79 **Q.** Okay. But you do --

A. Contemporary meaning like not

from 1910, the study I completed in 2013.

80 **Q.** So the extent of your ability to speak about contemporary effects of your study ended in or about 2013 when your book was published?

A. No, that is a study of one publication amongst many studies and many publications in my CV.

81 **Q.** Yes, I understand that. What I'm trying to get at is your statement in paragraph 7. You say historically, various systems, including the criminal justice system, have produced and reproduced a devastating legacy? Discrimination, prejudice and exclusion for racialized people, disabled people, and people with mental health issues. What I want to know is whether it is, in your opinion, the case that the criminal justice system is still discriminatory, prejudicial and excluding racialized people, disabled people and people with mental health issues.

A. I would say that's too broad of a statement. I believe that it's in the specificity of the text that I've cited, I've actually indicated a specific project. So when I

make the statement it's in reference to an empirically study, peer review publication that speaks to that particular context that's outlined in the four lines of the beginning of paragraph 7.

82 **Q.** And that was published in 2013, as you said?

A. That particular citation, yeah.

83 **Q.** And this statement in your affidavit is circumscribed in that same way, that it doesn't extend beyond 2013?

A. It is evidence that's been peer reviewed and published of the historically -- of the historical legacy that has produced and reproduced discrimination and prejudice and exclusion for racialized people and disabled people and people with mental health issues.

84 **Q.** Let me ask it this way. Is it still being reproduced today, in your opinion?

A. I would say the nuances of that particular case would require an analysis that applies, already contributed analysis to a contemporary analysis that's situated in a context that allows for one to not be too general, but be very specific about what one is sharing.

In this case I do that in my

affidavit relying on my expertise to summon my knowledge that comes from an analysis of literature over decades and my own research to state very specifically that this has occurred, the ways that the legacies of discriminatory and unjust ideas, prejudicial ideas impact racialized and disabled people and people with mental health issues carry forward over time and impact policy and practice in law.

85 **Q.** And they do so today?

A. Again, I say that would be a stretch for me to say in particular. But I would say it could be just encapsulated in it today. I would say the more important point is the analysis of the context, that ideas as they are instructive and contrived and arranged have a potential and there's evidence for the ability for those ideas to carry forward and that we should attend to them in analyses today. That's the point. That's actually what my affidavit relies upon in terms of my practice and research and teaching and expertise and attempts to convey, that that analysis is necessary and important.

86 **Q.** Have you conducted that research and analysis?

A. I do many projects that attend to these areas of interest.

87 **Q.** Do you consider the Canadian criminal justice system to still be based upon a legacy of colonial and eugenic policies, as you state in paragraph 7?

A. Which area of the paragraph are you referencing, sorry?

88 **Q.** You say:

"Eugenic policies in Canada have scaffolded racism, sanism, and ableism into policy, practice, and law."

You also state that the Canadian criminal justice system, I can scroll down on this, it's in the reference:

"Eugenic policies in Canada have scaffolded racism, sanism, and ableism into policy, practice, and law."

Do you consider the Canadian criminal justice system to be based today on eugenic policies?

A. I would say that would be inaccurate, or at least incomplete. That particular reference cited there is from a study by Ian Dowbiggin that traced some of the

historical legacies of sanism, in particular, and to establishment of eugenic policies in Canadian law.

As I cite in my book, and also in paragraph 8 is a particular and specific example of that where illusions to the idea of people with disabilities, and I italicize it in paragraph 8, *"undesirable immigrants"* because they were by nature degenerates or dangerous or dishonest in disposition, those discriminatory ideas actually made their way into the *Immigration Act* of 1910. The words were -- they're actually cited there in paragraph 8, where the discriminatory ideas that were eugenic ideas actually were cited as:

"'Persons mentally defective', 'Diseased persons', 'Persons physically defective'..."

Alongside:

"'Criminals', 'Prostitutes or pimps', 'Procurers', 'Beggars and vagrants', 'Charity immigrants' and 'Persons not complying with regulations'. These prejudicial and discriminatory ideas have and continue to shape contemporary policy, practice and law in Canada."

That is, I believe, a study done by.

Ena Chadha in Disabilities Studies Quarterly where she studied House of Commons debates and --

89 **Q.** Sorry, just to clarify, during what period?

A. 1859 to 1927.

90 **Q.** This gets at the fundamental question that I wanted to ask you. So these statements that there are legacies or continuing effects, what I'm getting at is, are you saying that these are effects that are still occurring today due to past laws, past policies, past decisions, or are you saying that the law today, the policies today and decisions made today are based on those same concepts which you refer to in paragraph 3 as colonial and eugenic policies, for example? Are we talking about effects that are occurring today, or are we talking about colonial and eugenic policies in force today?

A. So I would say the ways that we attend to analyses that trace the ideas within eugenics and within colonial project as they encapsulate people into types who are less worthy, that those ideas have legacies that carry forward through time. And I've written about it, studied it, published on it, presented on it.

The ways that that analysis, that those attentions are important for how we consider inequities as we are creating policy in law and practices, in the contemporary moment, that we might attend to the historical context of inequities as we see them today. Not as just disparities, but also within the context of analyses that appreciate that some of those ideas were planted in and crafted and published in policy and practice in law previously.

91 **Q.** At paragraph 6 of your affidavit there's a citation, footnote 5, the second sentence, you mentioned a national survey on youth homelessness in Canada. None of the applicants in this case are youths, correct?

A. I'd have to -- so in different areas of study the definition of youth can go to the age of 29. In some areas of study the definition of youth can go to the age of 36. Youth being a construct in social and political analyses that tends to engage with literature over time as well, and so the kind of age range kind of shifts. This citation here was specific to a national survey to highlight that there were these particular disparities that were noticed and

noted.

92 **Q.** In that national survey, what was the definition of youth?

A. I believe they used the definition that ends at, I believe -- actually, I would have to look at it, but I believe it's the definition that's below 29.

93 **Q.** Well, there's a citation, a national survey on youth, footnote number 5, "Without a Home", so it's not directly to the survey, correct?

A. No, it's a citation.

94 **Q.** And at the bottom of this page, this is page 3 of your affidavit, the end of paragraph 7, there's a number 17 in brackets. That looks to me like it's a Vancouver style numeric citation used in health and other science publications; is that right?

A. Could you ask that question again?

95 **Q.** Yes. At the end of paragraph 7 there's a number 17 in brackets, that looks to me like it's a Vancouver style numeric citation used in health and other science publications; is that right?

A. I would say there's a number of citation practices that would use the bracket.

96 **Q.** Which one is being used here?

A. I use an APA style for citations in my publications, the American Psychological Association, which allows for --

97 **Q.** Is that an APA citation?

A. I believe I wrote this in a way that -- I think I relied upon the way I have written and published on some of our legal documents where there are footnotes. I'm not sure that I actually held with the value of the particular citation you're seeing.

98 **Q.** Okay. At the bottom of this page there's an asterisk and it says, "Internal citation omitted". I don't see another asterisk above that that could be connected to; do you know what that's referring to?

A. So number 7.

99 **Q.** So it's --

A. Sorry, paragraph 7, there's a citation that's also number 7 and in there Francis Galton is referenced from that 1907 document there.

100 **Q.** Understood. So this is in the

Dowbiggin book, there's a citation that's omitted?

A. What that means there is I didn't cite Galton, the original text, which is the 1907 document, "Inquiries into Human Faculty and its Development". That was cited in Dowbiggin's book.

101 **Q.** Understood. Okay, thank you, that's clarified. I appreciate it. I just didn't understand the asterisk.

So if we go to paragraph 8, you referenced this earlier, it's about the *Immigration Act* 1910 and concepts underpinning it, including the concept of undesirable immigrants. Now, you're aware, of course, that the *Immigration Act* 1910 was replaced subsequently, 1952, 1976, 2002; is that right?

A. Correct.

102 **Q.** And that those later statutes were on very different bases than the *Immigration Act* 1910, correct?

A. Incorrect.

103 **Q.** So they continued to use things like the concept of undesirable immigrants in, say, 2002; is that right?

A. I would say from my own study

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and analysis, as well as analyses that I've published, I've shared ways that the idea of undesirability have continued via other discourses in contemporary law. One example --

104 **Q.** Please give -- I didn't mean to cut you off, please give me the example.

A. One example that I published on and presented on is the idea of the excessive demand clause which restricts the amount of service a newcomer can receive in Canada because of the idea that newcomers might be burdensome to the Canadian system. I've shared analyses that allow for us to consider the social and historical political context of these ideas in 1910 and how we think about the ways that an excessive demand clause might see some people, in particular immigrants, as somehow less worthy of receiving the same care as citizens. And the excessive demand clause, in particular, being situated in a context whereby a particular person, Charles Kirk Clarke, advocated for a restriction on immigrants' use of services and in their receipt of charity.

At the original time of his work there was a restriction on receipt of services that was two years, by the end of his tenure it

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was five years, that newcomers, immigrants couldn't access public services or charities. And that that idea of restricting an immigrant's access to health or Social Services is an idea that also has a lineage that could be analyzed as well inside of our analysis of the excessive demand clause today.

105 **Q.** You're saying that there is still a concept of undesirable immigrants built into the system, if I understand you, a clause like that that applies to all immigrants wouldn't differentiate between some as undesirable and others as desirable, as I understand it as what was underpinning the *Immigration Act* 1910, correct?

A. There's a few statements you made there. Could you repeat the question?

106 **Q.** Yes. You're referring to provisions and policies under the existing immigration laws in this country and they apply generally to all immigrants. That's a different concept than the concept of undesirable versus desirable immigrants, which I understand underpinned the *Immigration Act* 1910; would you agree?

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A. No.

107 **Q.** I would like to move on to paragraph 10. The last sentence of paragraph 10 refers to.

"...systemic structural inequities compound the negative impacts of encampment evictions for racialized, disabled, LGBTQ2S, Indigenous people and people with mental health issues."

So the negative impacts that you're referencing there of encampment evictions, what are they?

A. So those three lines above where I mention -- is it three lines above, inequities in the -- sorry.

108 **Q.** I can scroll --

A. You were at the --

109 **Q.** Oh, I was at the section you were talking about, okay, understood.

A.

"...widespread inequities in healthcare, education systems, housing, employment, food security, access to water, environmental inequities, mental health, criminal justice systems, immigration systems, property

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ownership, and income."

That these, together, are widely researched and understood to be social determinants, the social determinants of health and well-being. And for those who we have data and knowledge about in terms of inequities, these marginalized groups that I mention in that last sentence, that because of those contexts where the inequities already produce disparities, that removing someone's ability to have the same access to any of those systems and services would thereby be disproportionally impactful for them.

110 **Q.** I think you anticipated my next question. I'm just asking about the negative impacts that you reference there. What are the negative impacts?

A. So I believe I answered the question by stating that --

111 **Q.** No, you were answering a question about --

A. -- there are negative impacts to accessing --

112 **Q.** -- compounding and why it's compounded for certain people. You're talking about compounding negative impacts, but you

haven't explained what the negative impacts are.

So in order for something to be compounded there have to be impacts in the first place. What are the negative impacts that you're referencing?

A. Thank you for restating your question. As I stated, there are referenced inequities in healthcare, education systems, housing, employment, food security, access to water, environmental inequities, mental health, criminal justice systems, immigration systems, property ownership, and income.

113 **Q.** Those are all negative impacts on encampment evictions?

A. That access to services -- if I could finish, that would be good.

114 **Q.** My job is to keep you focused on my questions. So those things that you just listed are negative impacts of encampment evictions; that's what you're saying?

A. That those together are widely researched and understood as the social determinants of health and well-being. To evict someone from an encampment would be an intrusion upon an ability to access services in relation to

the social determinants of health and well-being which will have negative impacts on their health and well-being.

115 **Q.** Well, I understand your answer, let's move on.

So paragraph 12 of your affidavit cites two articles reporting on hate crime statistics in Canada. I hope we can agree that a hate crime is crime, yes?

A. Yes.

116 **Q.** A crime is not perpetrated by a system but by an individual, yes?

A. A hate crime?

117 **Q.** Well, let's start with a crime. There's a perpetrator of a crime and it's an individual, it's not a system, correct?

A. In terms of a legal definition of crime, a crime is attributed to an individual. There are also --

118 **Q.** It's not perpetrated by a system, that's also part of my question.

A. There are also analyses that share a perspective that appreciate many of the social, historical and political contexts that appreciate the ways that particular groups of

people have been criminalized disproportionately. And some of that analysis helps us appreciate the ways that the idea of crime, the criminalization of certain groups or populations, the charging of certain groups or populations, doesn't happen in ways that are transparent and discreetly so. That there are evidence that there has been analysis, evidence shared that help us understand how bias carries out in systems.

A lot of that helps us appreciate the ways that there's some nuance as to how we understand the word crime and who is understood as criminal. Which I believe also benefits from the analyses that I shared earlier that appreciate the social, historical and political context of discriminatory and prejudicial ideas, as they have been wielded in previous law. I hope that answers your question.

119 **Q.** Well, I'll accept that as an answer to my question.

You understand that in this litigation several of the City of Hamilton's by-laws are impugned; is that right?

A. So that someone is breaching municipal by-laws?

120 **Q.** No. So the fundamental premise of this litigation is that certain by-laws in the City of Hamilton are unconstitutional; are you aware of that?

A. Yes.

121 **Q.** Now, would you agree that none of the impugned by-laws in this litigation are causing or have caused any of the individual applicants to become homeless in your opinion?

MR. CHOUDHRY: That goes beyond the scope of his evidence. You're asking him to provide evidence in relation to the applicants and the way the by-laws cause their homelessness or don't. That's not what he's provided evidence on, Mr. Diacur.

MR. DIACUR: He just has. He's saying that systems are to blame. That was exactly what he said --

MR. CHOUDHRY: But you're --

MR. DIACUR: -- in answer to my last question. So I'm posing the question on the basis of his evidence.

R/F MR. CHOUDHRY: Mr. Diacur, I think that's a refusal because you've asked him about the specific applicants and their specific experiences

and that's beyond the scope of his evidence.

MR. DIACUR: Well, I don't agree. He did just give evidence that makes it a relevant question. I'll accept the refusal, I'll move on.

BY MR. DIACUR:

122 **Q.** So I would like to move to your next affidavit, sir. So I have a few questions for you about it. I don't expect we'll be much longer.

THE REPORTER: Could I ask for a quick break.

MR. DIACUR: Yes, of course.

-- Recessed at 5:09 p.m.

-- Reconvened at 5:15 p.m.

BY MR. DIACUR:

123 **Q.** I'm going to share my screen starting with the affidavit sworn June 7th, 2024. Do you see that?

A. I do.

124 **Q.** I would like to look briefly at paragraph 2 of your affidavit. Paragraph 2 starts:

"Encampment evictions put unhoused people at an increased risk of death. The increased vulnerability of people living

unsheltered, who are most impacted by displacement policies, is widely researched."

There are a number of things cited. One of the things that you cite was a paper, I'll go down to it, it's footnote 3, by J.S. Chang, et al, in 2022 entitled "Harms of encampment abatements on the health of unhoused people". It's from SSM - Qualitative Research in Health.

So I have a copy of that article that I would like to share with you. I have a couple of questions for you about it, particularly about the mechanisms. So I'm going to put that up on the screen. This is the article from SSM - Qualitative Research in Health, Harms of encampment abatements on the health of unhoused people, J.S. Chang, et al. Is this the article that you cited in your affidavit?

A. It is.

125 **Q.** And just from the abstract there's a statement, what it calls encampment abatements. You used the phrase under results here in the abstract, abatements. It says that there are four mechanisms that can harm unhoused people's health. The first is stripping people of their resources and necessities. The second is

pushing unhoused people into less visible spaces, reducing access to health outreach workers and support systems. The third is negative encounters between unhoused people and authorities, such as law enforcement. The fourth is distrust in authorities and law enforcement leading to reluctance to seek or accept formal forms of support and protection.

Would you do agree that those are the mechanisms of harm in terms of encampment abatements?

A. I would say in my expert opinion I would nuance some of the historical and social, political context for how any of the particular four impact marginalized groups disproportionately. I might actually also, which I did actually in the affidavit in paragraph 2 --

126 **Q.** Well, we can go back to that. Just for the record, I'm intending to mark that article referenced in the affidavit as Exhibit 2.

EXHIBIT NO. 2: SSM - Qualitative Research in Health article.

BY MR. DIACUR:

127 **Q.** I'll stop sharing that and go back to your paragraph 2. This is paragraph 2 of

your second affidavit of June 7th, 2024.

A. June 14th -- oh, we're looking at --

128 **Q.** This is the second affidavit.

A. Got it. I just saw the date on the screen and got confused. So, yes, I can see this.

129 **Q.** And you were saying that paragraph 2 expands on the mechanisms of harm involved in encampment abatement?

A. Yeah, so the next two sentences, that it's widely accepted that increased vulnerability indicates a greater need for immediate intervention and support services and that the City of Hamilton acknowledges that and they actually use assessments that consider that. But that increased risk corresponds with increased risk for mortality.

130 **Q.** Understood. I'm talking about the mechanisms that harm can occur through. So I understand what you're stating about vulnerability. But in terms of the mechanisms that were identified in the article you cited, you don't disagree with those mechanisms, correct?

A. Disagree? I would say, no. As

I shared earlier, I would convene additional analyses through academics and researchers that engage with literature that allows for an appreciation of the social, historical and political context as they differentially impact marginalized groups that need specific forms of attention.

131 **Q.** I'm not talking about the need for attention, I'm talking about the mechanisms that cause harm. Are there any mechanisms involved in harm of encampment abatements, in your opinion, other than the four that we just read out from the J.S. Chang article that you cite?

A. Are there mechanisms of harm, other than the four, that relate to housing abatement -- or sorry, encampment abatement?

132 **Q.** Encampment abatement, that's right.

A. I would say I wouldn't want to speculate beyond what I cited in the article as what I believe to be an important emphasis and contribution.

133 **Q.** Okay. I understand from paragraph 5 of this supplementary affidavit, I'll scroll to that now, I understand it to be your

opinion that encampment abatements produce an increased risk of death. You reference infection, disease, substance and alcohol use and worsening mental health. Those are the associated risks of encampment abatements, in your opinion?

A. They are associated with the citation there.

134 **Q.** So you would agree that an encampment being abated or dismantled does not necessarily strip any individual of any resources, right?

A. No, I wouldn't agree with that.

135 **Q.** Possessions could be lost, but that's not necessarily the case, correct?

A. Could you repeat the question?

136 **Q.** Possessions could be lost, but that's not necessarily the case, right?

A. If possessions include the idea that one feels like they are in a place that they've chosen and safely for them, case by case, analyzed and appreciated in a context that sees the uniqueness of each case and appreciates it, I guess it depends on what you determine to be as possession.

137 **Q.** You would agree that not all

individuals who move when an encampment is abated or dismantled necessarily move to a less visible space, correct?

A. If a person living in an encampment voluntarily moves to another space, that they are -- that is less visible, is that, itself, harmful; is that your question?

138 **Q.** That's not my question. You would agree that not all individuals who move when an encampment is abated or dismantled necessarily move to a less visible space, correct?

A. Not all people that leave --

139 **Q.** It's not necessarily the case that they move to a less visible space; is that correct or it's not?

A. I'm sorry, could you state the question again?

140 **Q.** Let me put it a different way. Some people when an encampment is dismantled or abated may move to another location with equal or better access to health outreach workers and support systems, correct?

A. Some people, yes.

141 **Q.** And you would agree that negative encounters between unhoused people and

authorities, such as law enforcement, do not necessarily occur when an encampment is abated or dismantled, correct?

A. Are we referring to item 1 in the terms for the mechanisms or item 4?

142 **Q.** Well, I believe that it would be number 3. But my question is, you would agree that negative encounters between unhoused people and authorities, such as law enforcement, do not necessarily occur when encampments are dismantled or abated, correct?

A. I would say that I would never say that thing. I would probably articulate that there are a number of ways that people move from place to place when living in an encampment.

I would refer to that particular document that I cited for the ways that they've tried to create sort of analytical buckets for the kinds of ways that crime can occur, and that attending to them, all of them, requires specific and necessary attention. So I would rarely, if ever, or probably never, make such a generalized statement.

143 **Q.** Would you agree that individuals do not necessarily become more

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reluctant to seek or accept formal forms of support and protection after an encampment is dismantled or abated?

A. Could you repeat?

144 **Q.** Yes. You would agree that individuals do not necessarily become more reluctant to seek or accept formal forms of support and protection after an encampment was dismantled or abated, correct?

A. I would assess that, I believe, on a case-by-case basis.

145 **Q.** In fact, some people might accept shelter when it's offered to them as part and parcel of a shelter being abated or dismantled, correct?

A. Again, on a case-by-case basis depending on the person, whether shelter is amenable or beneficial to them and whether the shelter space is available.

146 **Q.** Are you aware of any examples of that very thing occurring in the City of Hamilton?

A. Which thing?

147 **Q.** A person accepting shelter when it was offered to them as part and parcel of a

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shelter or an encampment being dismantled.

A. I've experienced more of the case where shelter space is unavailable.

148 **Q.** Are you aware of any examples of that very thing occurring in the City of Hamilton, referencing acceptance of shelter when offered as part and parcel of an encampment being abated or dismantled?

A. Specific examples, I cannot recall.

149 **Q.** And if I'm following you in paragraphs 2 and 3, and I'll put paragraph 3 up on the screen now of your June 7th, 2024 affidavit, you indicate that harms, that are not necessarily part of an encampment abatement occur, those harms are necessarily magnified when an individual experiences them is one of either racialized, Indigenous, disabled or has a mental health issue; is that right?

A. Could you point to the paragraph you're referring to?

150 **Q.** Yes. Well, you do indicate, for example in paragraph 2, that there are, for example, increased vulnerability due to acuity, that that is something that is recognized by the

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City of Hamilton. You also indicate that in paragraph 3 there are references to Hamilton Homeless Mortality Data project. There is also, you reference mental illness, stimulant use and opioid use were among the top comorbid conditions in terms of the individuals who passed away during the period June 2021 to 2023. And there's also reference to the vulnerability of people living unsheltered.

So in terms of the magnification, I'm actually going to search for that word. Wrong document. Instead of keeping you waiting, I'll withdraw that question and move on. I'm missing the reference.

So Exhibit "A" to this June 7th, 2024 affidavit is data produced by the Hamilton Homeless Mortality Data project; is that correct?

A. That's correct.

151 **Q.** That's a project in which you have participated; is that right?

A. It is a project for which one of the lead researchers is a doctoral student that I supervise directly.

152 **Q.** Who is that?

A. Gessie Stearns.

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153 **Q.** That's Gessie Stearns who we were discussing earlier?

A. I also supervised her Master's research.

154 **Q.** I thought that was referenced in your CV.

A couple of brief questions about Exhibit "A" and then we'll be finished. So, as I understand it, the main cause in each of the periods studied in the Hamilton Homeless Mortality Data project of the deaths that occurred was overdose; is that correct?

A. Is there a particular chart that we're referencing?

155 **Q.** Well, there's a couple that we can go to. So, for example, if we go to page 556, which we are at, there is a total reported deaths during the period June to November 2021 of 22 individuals.

A. That's right.

156 **Q.** There's an average age of death that's provided. There's age ranges, time ranges, gender expression of the individuals, the location and then cause.

A. Correct.

157 **Q.** Overdose is the main cause during that period. The largest number of individuals who died during that period, that was the cause of their death; is that correct?

A. Correct.

158 **Q.** And so if we jump forward to the same period the following year, so that's June to November --

A. This one went to May.

159 **Q.** No, so the same period of time the following year, so June to November 2022. So previously we were looking June to November 2021, now we're June to November 2022. The total reported deaths are the same number 22 individuals in this period, correct?

A. Yes.

160 **Q.** And, again, we have an average age of death that's provided, but we have the same sort of cohort data. We have the age ranges, we have the time ranges, we have the gender expression and location and cause. Again, overdose is the principal cause?

A. Mm-hmm.

161 **Q.** Sorry?

A. Yes.

162 **Q.** You have to say "yes" or "no" just for the record. I just want to make sure that we have that clear.

So if we then again jump forward to the same period in 2023, which will be now June to November 2023, total reported deaths during that period is 21. So one fewer during that time period, correct?

A. Correct.

163 **Q.** Compared to the two previous years, correct?

A. Correct.

164 **Q.** And we have average age of death, again age range, time range, gender expression, location and cause. Again, overdose is the principal cause?

A. Correct.

165 **Q.** Would you agree with me that over those three years, the same period being examined in each year, the data does not support an increase in the number of deaths within those periods?

A. I would say that year over year there is not an increase.

166 **Q.** That in most recent periods it

decreased?

A. In total number reported?

167 **Q.** Yes.

A. I would say moving from 22 to 21, given the small sample size, is a gross decrease but not enough to make any conclusions over a period of time. There are five reports to date and one forthcoming. The current data is 29.

168 **Q.** So in a forthcoming report that has not been disclosed in this matter you're saying the number is 29?

A. There's data being collected. There is no report to share. The information that I've submitted is on the published and finalized reports that have been analyzed and published. This is, in answer to your question, 21 is less than 22 and that is a decrease.

169 **Q.** Thank you. Those are all my questions. I appreciate your time.

MR. CHOUDHRY: Dr. Joseph, just give me a minute to consult my notes. You're still under oath, sir, do please remain where you are. Don't communicate with anyone and I'll be back in just two minutes.

-- Recessed at 5:39 p.m.

-- Reconvened at 5:41 p.m.

MR. CHOUDHRY: Professor Joseph, thank you, but the applicants have no questions for you for redirect, so I believe you're free to go, sir.

MR. DIACUR: I agree. Thank you very much for attending and answering.

THE DEPONENT: Thank you very much.

---Whereupon the examination adjourned at 5:41 p.m.

REPORTER'S CERTIFICATE.

I, SHEILA M. FINLAY, CSR, Certified Shorthand Reporter and Commissioner of Oaths within and for the Province of Ontario, certify;

That the foregoing proceedings were taken before me at the time and place therein set forth, at which time the witness was put under oath by me;

That the testimony of the witness and all objections made at the time of the examination were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and correct transcript of my shorthand notes so taken.

Dated this 30th day of August 2024

Sheila Finlay

[Signed Electronically]

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Hamilton

Why Hamilton's encampment consultations can — and should — be different, say advocates

Ameil Joseph and Gessie Stearns share their thoughts on the city's encampment protocol and consultation

CBC News · Posted: Jul 21, 2023 4:00 AM EDT | Last Updated: July 21, 2023



Ameil Joseph, an associate professor in the school of social work at McMaster University and Gessie Stearns, a a homelessness researcher. (Bobby Hristova/CBC and Submitted by Gessie Stearns)

As Hamilton wrestles with worsening homelessness and how to address it, city councillors are poised to finalize a plan next month to deal with a growing number of encampments.

In June, the city held three in-person public consultation sessions and had an online survey open for people to share their thoughts and offer feedback on the plan.

The plan works off the idea that without help from the province and federal government, encampments aren't going away anytime soon.

Lacking affordable housing, emergency shelter space and mental health supports, as well as an ongoing opioid crisis have created the current conditions, the city previously said.

It has put money into house, created an opioid action plan and declared states of emergency related to homelessness, opioid addiction and mental health to try and get extra funding.

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Hamilton's community meetings are supposed to be part of the feedback the city is using to create recommendations for councillors in August. (Samantha Beattie/CBC)

While waiting for a long-term solution, the city's proposed encampment plan explores the idea of sanctioned encampment sites and rules for encampments that aren't in sanctioned areas.

A staff report with a recommended plan and summary of the feedback is due to be presented in August.

But the plan — and its public consultation process about the plan — is facing some criticism.

Ameil Joseph, an associate professor in the school of social work at McMaster University and Gessie Stearns, a homelessness researcher, both have concerns with the plan and process.

In a conversation with CBC Hamilton, they said the current discussions treat encampments like an eyesore instead of being more focused on creating housing. They also say there should be more transparency.

Some of that conversation is here. It has been edited and condensed for clarity.

How would you summarize the state of homelessness and housing in Hamilton?

Joseph: The state is terrible. The state is one that will produce people dying. Sometimes there are allusions to the fact shelters are over capacity or there are thousands of people on a waitlist for housing or waiting for an application to be processed without housing possibilities. People are spending 50 per cent of their income on renting. All these things together remind us of the historical context where we've been pulling out of addressing matters of housing for some time — income support, people with disabilities, ODSP, housing provisions, all inadequate over several years. These things are cascading upon one another without a coherent strategy.

- **People facing homelessness in Hamilton describe what they want the city to do**

Stearns: We focus on homeless people as the problem, and not on the way in which we develop our community or the way in which we plan all kinds of other things. It erases the idea that housing is actually what we need. We have inclusion policies and ideas of what belonging looks like in Hamilton and none of these plans and processes don't actually reflect any of that. We silo many of the things going on in our community as though they're distinct items and as a result, we focus on people's

inability, trauma and drug use, rather than looking at many of the core reasons why we are where we are today.



Storm Mallinson, right, stands next to his partner, as they shared their story about being unhoused and explained what they wanted the city to do to help combat Hamilton's homelessness issue. (Bobby Hristova/CBC)

What do you think about the city's plan and consultation process?

Joseph: We see people outside as something broken that needs to be fixed rather than our policies, programs and resourcing infrastructure that is a problem that needs to be fixed. The consultations are about how do we identify and police those people outside and remove them and place them somewhere else. Every one of these consultations, people are saying, "I live outside, no one has offered me anything, I can't afford any option talked about and none of this makes sense." What about housing? We offer them no guarantee or provision or plan for how they can access anything they need at all.

- **Your questions answered on encampments and Hamilton's proposed plans**

Stearns: Consultation happened, housing wasn't on the table. There are rooms full of people with the will to start talking about solutions, but we're always told housing is not one of them. We were told to not talk about housing all along the way and the reason we were given is we'd have to draw from provincial and federal governments to do that and we're waiting. We're never quite pulling together all the ways we build this community in an inclusive way that people can belong. The way the current documents to draw upon are written, with five metres here or 50 metres there, leaves the responsibility of finding a space to people outside. What we have are a set of prohibitions never quite looking to how we're developing.



Amanda Clarke is unhoused. She previously said she has had trouble accessing services to help her and also said people in encampments face violence daily — from people who are homeless and people who aren't. (Bobby Hristova/CBC)

Is something different possible? What does that look like to you? And what do we do next?

Stearns: What are we doing here waiting for levels of government that aren't responding to this scathing Auditor General of Canada report that says we don't really know if we're doing the thing we set out to do? In this community, we need to be having conversations about how to address the needs of folks we're seeing struggling now. There's the ability to have more transparency to have these discussions. There's a lot of will but this consultation process has not laid out a path for us to have these conversations.

- **Hamilton man stabbed at Woodlands Park encampment in critical but stable condition, police say**

Joseph: When people are telling you over and over again there are a number of ways we can weigh in differently, that's where we need to think about how to get to. The pass the buck kind of conversations where we can't talk about provincial, federal and municipal issues continuously is a strange entry point. It's not just the case we need Ontario Works and ODSP to be higher amounts, it's also the case we can take municipal funding programs and make them livable for people on social assistance in terms of cost by re-sourcing how they're funded ... rather than retreating to "how do we get rid of these people we see as the worst?"

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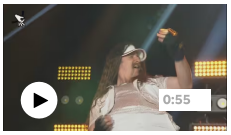
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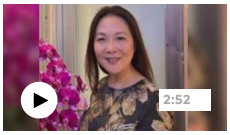
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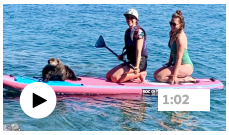
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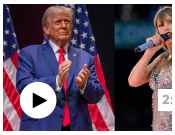
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Harms of encampment abatements on the health of unhoused people

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A B S T R A C T

Introduction: Abatements, or "sweeps," are key instruments used by local governments to address increasing numbers of homeless encampments, but they are controversial, underdocumented, and understudied. To examine how social policies, such as abatements, impact the health of people who are unhoused, we interviewed unhoused people on their recent experiences with local abatement practices.

Materials and methods: Between 2018 and 2020, we used community-based participatory research approaches and the docent method to conduct participant-guided, in-depth, semi-structured interviews with unhoused people in Santa Clara County (n = 29). We used grounded theory approaches to analyze interview data.

Results: Abatements harmed unhoused people's health through four key mechanisms. First, forced relocation and property seizures stripped people of health resources and necessities (e.g., personal belongings, social support) required to survive unhoused. Second, abatements drove unhoused people into hazardous, isolated, less visible spaces, which increased health risks while reducing access to health outreach workers and support systems. Third, abatements were the grounds for frequent negative encounters between unhoused people and authorities such as law enforcement - interactions that produced anger, stress, and distrust. Finally, distrust of authorities and law enforcement led to people's reluctance to seek or accept formal forms of support and protection. The necessity of self-policing in encampments created cycles of interpersonal violence that resulted in suffering, injury, and premature death.

Discussion: Sweeps undermined or directly harmed unhoused people's health, leading to serious health consequences. Common abatement practices are social policies that may be causal factors in the declining health of unhoused people. Improved documentation, reporting, and tracking of abatement practices are needed.

1. Introduction

For the thousands of people in Santa Clara County (SCC) who have no option but to live outdoors due to the lack of shelters and affordable homes, there are few places one can exist uncontested. Laws and systems labeling unhoused people as vagrants, transients, trespassers, and suspicious persons make their presence a perpetual struggle, even a crime, in most spaces. A key battleground in this struggle is the encampment. Encampments are the tents, wooden pallets, tarps, cars, vans, or other materials set up by unhoused people in order to survive without shelter (Cohen et al., 2019). People who are unhoused, housed residents in the community, business interests, and various local government agencies, including public health, criminal justice, and law enforcement, are stakeholders in the social struggle over the existence of encampments and the right to live outdoors when there is nowhere else to live.

A central apparatus in this struggle is *the sweep*. The definition of a sweep (i.e., encampment sweep, abatement, "move-along" order) is varied, but in general, the term refers to authorities removing one or more persons from a location in adherence to ordinances that ban staying on a wide range of public or private spaces. If an individual refuses or cannot move, they are subject to citation and potential arrest, and their belongings can be confiscated and discarded. Abatements, and the controversies surrounding them, have a long history in the United States (Baker, 1990; Simon, 1991). The magnitude of abatements has escalated in many cities since the 1990s due to substantial increases in anti-homeless ordinances and technologies facilitating the reporting of neighbor complaints (Craven et al., 2021; Herring, 2019; Herring et al., 2020; Rankin, 2019; Wilking et al., 2018), despite ongoing legal concerns surrounding the constitutionality of sweeps. One example of a constitutional concern is a Ninth Circuit decision banning local governments from citing and arresting people sleeping on public property in the absence of adequate shelter space (Martin v. City of Boise, 2019). The court's underlying conclusion was that the abatement of unhoused people is cruel and unusual punishment when there is no reasonable alternative place to stay.

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Beyond legality, there are debates surrounding the efficacy, cost, and consequences of abatements. Academic studies examining the effects of abatements are limited, but research emerging around the United States, including from government reports and advocacy organizations, consistently show that abatements are costly to city budgets and ineffective at reducing homelessness. In 2019, the City of San Jose spent $8,557,000 on encampment responses, 57% of which was used for encampment abatements, versus 17% for encampment prevention, and 10% for homeless outreach (Dunton et al., 2020). Due to the lack of effective coordinated documentation and reporting systems, most cities and counties are unable to assess the effectiveness of abatements. However, available detailed reports and audits have shown that abatements result in the dispersal and destabilization of unhoused people, rather than long-term removal from public spaces (e.g. Office of the City Auditor San Diego, 2020; Office of the City Auditor of San Jose, 2018). Arrest records in Chico, California showed that following the passage of anti-homeless "sit-lie" prohibition policies, there were substantial increases in arrests and relocation of unhoused people, at almost twice the cost of official estimates. Locations of arrests occurred incrementally further from the downtown area over time, suggesting that abatement practices pushed unhoused people away from city centers (Wilking et al., 2018). In Greensboro, North Carolina, anti-homeless policies resulted in increased contacts between unhoused people and law enforcement. There were also racial disparities, as Black people who were unhoused reported high rates of racial profiling in police contacts (Craven et al., 2021). During abatements, unhoused people are rarely introduced to viable shelter or housing options. In San Francisco, California, the vast majority (91%) of unhoused people remained outdoors following an abatement, and relocation into housing was rare (Herring et al., 2020). In Denver, Colorado, unhoused survey respondents reported that in over 80% of "move-along" encounters with police, they were forced to move without receiving any information about supportive services (Robinson, 2019).

In health research, there is strong epidemiological evidence that being *unsheltered* while unhoused is a major health risk (Anderson et al., 2021; Lee et al., 2016; Levitt et al., 2009) that is associated with premature mortality (Montgomery et al., 2016; Romaszko et al., 2017; Roncarati et al., 2018). However, evidence specifically linking sweeps to health outcomes is limited. In Denver, Colorado, unhoused people's experiences with abatements led to a range of physical and mental health issues, including poorer sleep, isolation, risk of interpersonal violence, and weather-related health hazards (Westbrook & Robinson, 2021). Ethnographic researchers (Bourgois & Schonberg, 2009; Knight, 2015; Lopez, 2020; Stuart, 2016) have chronicled the ways that policing and criminalization of homelessness - frequently interconnected with policing drug use - have resulted in prolonged exclusion and harassment of unhoused individuals. These ethnographies report a range of poor health outcomes ensuing, from languishing health to overt physical violence. Outside of health research, qualitative studies have examined the effects of abatements on quality of life, justice, and safety. Researchers have shown that abatements result in the loss or destruction of people's property, causing excessive cost and stress for those living unsheltered (Darrah-Okike et al., 2018). The loss of property and continuous relocation are underlying factors in crime and safety risks, as unhoused people are forced to undergo extreme lengths to regain necessities (Herring et al., 2020; Langegger, 2016). Criminalization of homelessness through abatements creates forms of hidden homelessness, as well as a direct pipeline into the criminal justice system, causing additional harm to the unhoused individual (Rankin, 2019, 2021). All together, these studies show that policies that criminalize homelessness are a structural driver of the pervasive destabilization, suffering, and violence that unhoused people experience, which lead to a range of legal, health, and social consequences.

In this study, we set out to investigate the social environmental mechanisms and dynamics created by abatement policies, which set the stage for unhoused people's exposure to health issues and ability to protect themselves. Drawing on community-based participatory research (CBPR) principles, we explored this topic in a place-based, participatory manner to center the often invisible lived experiences and personal narratives of people who are unhoused.

2. Materials and methods

This study was approved by the Institutional Review Board at Santa Clara University. The data used for this manuscript are a subset of an ongoing qualitative study investigating how local policies surrounding abatements shape people's health in the San Francisco Bay Area. Here we report on in-depth, semi-structured interviews conducted with people who are unhoused recruited between 2018 and 2020 (n = 29). We also report based on observations and notes from several months of ethnographic data collection conducted in encampments in SCC during the study period, during which at least one of the authors met and discussed the study topics with unhoused people and wrote detailed memos, but did not formally enroll participants. To be eligible for the study, participants had to be an adult who was unhoused in SCC for at least six months within the last 5 years of enrollment. All participants had personal experiences with encampment abatements.

2.1. Community-based participatory research and the Docent method

Community-based participatory research is a research approach that acknowledges, challenges, and attempts to dismantle the current and historical harm done by academic privilege in health research. It is a set of interrelated principles (Israel et al., 2013; Minkler & Wallerstein, 2011) that informed the study design of this research. Based on CBPR principles, we involved members of the unhoused community as co-leaders of the study development and implementation. We relied on unhoused people's expertise to make decisions about the study, including what topics/concepts to focus on, and what spaces to visit. Based on CBPR, the academic-community partnerships and relationships are ongoing, as we continue to build and strengthen ties between academics and people in the unhoused community.

We used the *docent method* (Chang, 2017) to focus the data collection and analysis on the role of social and built environments, which is a central concept in CBPR. The docent method is a place-based, participant-guided, walking interview approach rooted in grounded theory (Charmaz, 2014) and CBPR principles. The docent method was designed to challenge or reverse the power dynamics of traditional interviews by 1) privileging the leadership and expertise of study participants, and 2) incorporating the everyday spaces and settings that are consequential to health into the semi-structured interviewing process. In the docent method, participants act as docents - resident experts - who guide the researcher on walking interviews through key conceptual sites. In this study, the three "sites of interest" were 1) the personal space of the unhoused person (e.g., tent, vehicle, shelter bed/space), 2) the community space (e.g., shared or open spaces in or around the encampments and shelters), and, for people in encampments, 3) the routes/pathways to and around the encampments. By visiting these conceptual sites guided by the expertise of each participant, the docent method enabled a systematic, participant-led investigation of the environmental, social, neighborhood, and structural factors that impacted people's health.

2.2. Participant recruitment and data collection

Participants were recruited in three stages. First, in Summer 2018, we recruited people living in encampments and vehicles (n = 14) using a convenience sample and snowball sampling approaches. R.J.A., who was formerly unhoused and has longstanding relationships with members of several key encampments, contacted or approached potential participants to inform them about the study. We focused on three semi-durable encampments for recruitment, locally known as the Bassett, Tully, and Roosevelt encampments. Interviews took place on-site at the encampments, in a semi-private location selected by the participant.

Next, we recruited people staying in shelters (n = 9), all of whom had prior experience living in encampments and/or vehicles. Participants were recruited at a large shelter facility in San Jose with the support of staff who posted flyers advertising the study, distributed information sheets, and provided interview rooms. Study participants were interviewed in a private room, then each participant guided us around their personal spaces (e.g., cot, room), and around the facility, including shared spaces and outdoor recreation areas.

In March 2019, at the start of the COVID-19 pandemic, we redesigned the study into a virtual format in order to comply with restrictions to in-person research. Participants (n = 6) were recruited by two community-based organizations that provide services to people who are unhoused. Eligible participants were given information sheets about the study, and asked to contact the researchers, who then set up virtual interviews on Zoom or by telephone.

All study participants provided informed consent prior to enrollment. Interviews were recorded using a digital audio-recorder. We used a semi-structured interview guide to cover interview topics, focusing on experiences with shelters, encampments, abatements, and health. The interview process took between one to two hours. During the docent method interviews, we took photos of the physical surroundings using a cell phone camera, avoiding identifying photographs of people's faces. At the end of the interview, we gave each participant twenty dollars in cash or gift card, and in-person interview participants received a care package containing food and personal care items.

2.3. Data analysis

All audio files were transcribed verbatim with identifying information removed. All participants were assigned pseudonyms. All transcripts were uploaded into ATLAS.ti for storage, coding, and analysis. The transcribed data were analyzed by three researchers using grounded theory data analysis approaches (Charmaz, 2014). First, we listened to all of the interview audio files as we reviewed transcripts and field notes for each interview. Reviewing the transcribed data, we conducted initial line-by-line inductive coding of a portion of the interviews. We wrote memos on broad theoretical and substantive topics drawn from initial impressions and interpretations, and organized these memos into an initial set of inductive codes. Next, we used this initial set of inductive codes to code all transcripts in ATLAS.ti. The initial set of inductive codes was supplemented by emerging concepts from the transcript coding. We then listened to the original audio files while reviewing and re-coding interview transcripts. Some codes clustered thematically and were analyzed together. We focused on queries for the codes "encampment experiences" and "encampment abatements" for analysis.

3. Results

For context, in SCC, abatements are initiated based on neighbor complaints, but also on grounds of environmental protection and sanitation. Santa Clara County, known as Silicon Valley, is a large, 1300 square mile, geographically diverse region, and a substantial portion of unhoused people stay in fairly remote outdoor spaces, such as in sites near the forested hills, rivers, creeks, abandoned lots, and industrial spaces interspersed throughout the county. Santa Clara County has among the highest proportions of *unhoused-unsheltered* people in the United States (Turner, 2017). The 2019 unhoused point-in-time count estimated that approximately 9700 unhoused people live in SCC, with 82% living unsheltered. The unhoused-unsheltered population increased 45% (5448 in 2017 to 7922 in 2019) since the 2017 point-in-time count (Applied Survey Research, 2019).

An audit of homeless service programs in San Jose showed a sharp increase in abatements following a 2015 lawsuit to keep waterfronts clean (Office of the City Auditor of San Jose, 2018). Abatements involve a constellation of city departments (e.g., housing, transportation, police, fire, parks and recreation, etc.), abatement contractors, and community organizations. Though the protocols and practices involved vary, in general, unhoused people are required to remove themselves and their property from a location within 72-hour following notification ("getting posted"). Abatement workers are typically accompanied by law enforcement, who have the authority to seize and discard belongings, issue citations, or even arrest people who do not comply with orders to move (Office of the City Auditor of San Jose, 2018).

The study participants were closely split between women (51.7%) and men (48.3%). Almost half of participants self-identified as Latino (48.3%), 31% as White, 17.2% as Black, and 3.4% Asian Pacific Islander. At the time of the interview, 15 (51.7%) participants were living in encampments, 9 (31%) in shelters, 4 (13.8%) in vehicles, and 1 (3.4%) recently in supportive housing. Most participants were older than 50 (27.6% age 50–59, 31% age 60+), 9 (31%) were in their forties, 2 (6.9%) in their thirties, and 1 (3.4%) was in their twenties.

We report on our grounded theory analysis of participants' experiences with encampments and abatements, focusing on the social environmental mechanisms through which abatements affected their health.

3.1. Forced removal and property seizure destabilized people, and dispossessed them from resources (belongings, social support) needed to survive unhoused

At a basic level, abatements harmed the physical and emotional health of unhoused people by dispossessing them of the belongings they need to survive outdoors - belongings that were often painstakingly procured. Participants reported that during sweeps, their personal belongings of all kinds were taken and discarded by authorities (Image 1). Belongings that were necessities for survival (e.g., medications, tents, blankets, essential records/documents) were routinely seized. Nina, a Latina woman in her fifties and a San Jose native, had been living intermittently in her encampment located in a forested area near Coyote Creek for eleven years. She stayed in a tent, situated under a tarp strung between tree branches. During her interview, she thought back on the destabilizing effects of the prior year when her area was swept every few weeks. She became hypervigilant and unable to let her guard down, because sometimes, her camp would be given a 72-hour notification of an impending sweep, and other times, abatement contractors came without warning. If Nina could not carry her belongings away, everything she needed to survive would be gone, decimating her ability to stay healthy:

> Every two weeks … They would come, and they would sweep. Sometimes they would put up [72-hour] notices, sometimes they wouldn't. A few times, they came and wiped out everything of everybody's. Clothes, food … It didn't matter what it was. If you had it there, they took everything. Tents. Then you were left with no clothes, no food, nowhere to stay, no blankets or anything. What they're doing is, they're keeping us down. Because then you gotta work harder. You're not able to go to work and make money.

Another participant, Sammy, exemplified the dehumanization and psychological stress of abatement property seizures, and used the term "inhumane" to describe them. Sammy is a White woman in her thirties, and a U.S. Military Veteran, who we met while she was staying at a shelter. During her service and following discharge, Sammy experienced a series of violent traumas and became addicted to opioids. She was a young mother, but tragically lost her youngest son when he was an infant. Sammy, a poised and articulate soldier, choked back tears as she recounted the first major sweep she endured, during which the only remaining photograph she had of her son was discarded. Her account of personal, irreplaceable possessions being seized and tossed away was common among participants. Sammy thought she had an arrangement with the abatement authorities - if she kept the area tidy, they would not sweep the encampment. One day, she discovered the deal was off:

> Our first real experience with being swept, we had a guy come up and check our camp out. He goes, "If you clean it up and it looks good, you



Image 1. July 2019. The final day of the abatements at Bassett encampment, after most residents, including Maria, had vacated. Pictured is a tent being discarded as abatement workers cleared the site.

> can stay." And I said, "Okay! I'll have it cleaned." We got it spotless. There was not a piece of paper anywhere in the half block radius of my spot. We made it habitable. Well, they took everything. They took the last picture I had of my son. One of their workers ripped it up, in front of me. It's just inhumane.

Beyond causing material losses, psychological distress, and emotional trauma, encampment sweeps disrupted social connections. Encampments are frequently depicted as nuisances or dangerous spaces, but participants were clear that, in the absence of alternatives, their encampment site was the safest place available to them. We recorded numerous examples of unhoused individuals bonding at their sites, watching out for one another's property, gathering for meals, and checking in on each other regularly. Even strangers, tacitly understanding their common circumstances, went out of their way to help one another. For example, Ted is a White man in his late thirties, a U.S. Military Veteran, and the informal leader of his tight-knit encampment. Abatements break up communities, which, Ted explained, were cautiously constructed over time. In his encampment, people supported one another, a dynamic that was hard to come by:

> We enclose this area to people that we know, or that we can trust. Because you start getting a camp full of people you don't know, then you don't know what's going on with your stuff while you're gone. People start stealing your things. So we try to keep it a community here. We've got a group of people around us that we've known for a while, so we consider it more of a community. We help each other out with food. Some of these people who get food stamps pitch in for food during dinner and we all throw in something to cook, so that helps out with the people who don't get stamps.

These participants described how common abatement practices resulted in the increased destabilization of unhoused people through the seizure of health necessities and irreplaceable personal belongings, and displacement of community support needed to survive outdoors.

3.2. Abatements pushed unhoused people into hazardous, isolated, often remote areas that were less accessible to health outreach workers

To avoid being swept or forced to move along, unhoused people need to be invisible in plain sight. In response to the threat of abatement orders, unhoused people in SCC have adapted by moving to more isolated, secluded areas that are less likely to be seen and swept. Largely through personal experiences and word of mouth, they have deciphered some of the myriad of abatement patterns and practices, and learned what areas are safer from frequent sweeps. Oftentimes, places that are safer from abatement are those that are difficult to access and less visible to the public. In SCC, these are hazardous spaces, such as the land along train tracks, along or under freeways, behind industrial buildings, on construction sites or empty lots, and deep in forested creeks and hills. That is, sweeping practices effectively push unhoused people into acutely risky places that are isolated, remote, and largely out of reach from public health services and homeless service providers.

For example, Maria, a Latina woman in her fifties, is one of the original members of the Bassett encampment whom we interviewed on several occasions. She settled on the spot alongside the train tracks upon figuring out that three local jurisdictions, who did not coordinate their efforts, owned different parts of the property - the City of San Jose, Union Pacific Railroad, and CalTrans. An abatement by one jurisdiction simply meant that encampment residents could relocate across the street to another jurisdiction's property. As she guided us along the stretch of land occupied by tents, the health risks were apparent. There were no sources of water or bathrooms nearby. Tents, which were often on dirt and gravel, flooded in the rain. Staying alongside the train tracks exposed residents to smog and pollution, including noise pollution, as screeching freight trains passed through every hour, every day, around the clock. The location put the encampment residents at risk of mortal injury. Maria recounted several incidents of people being injured or killed by trains. Media reports have shown that in California, the number of unhoused people dying from collisions with trains is increasing (Swan, 2019). Yet amid these risks, Maria lived twenty unprotected feet from a moving freight train line because it was a good place to avoid abatements (Image 2). She put herself at risk to reduce the impact of sweeps:

> Interviewer: How did you decide on this particular site, out of all of the places in San Jose, to set up?
>
> Maria: Because they can't come over here and give us a paper and tell us to move. They can't. They can't sweep up. This belongs to the train company. So if the train company comes and tells us, “Out!”, because it's dirty or whatever, then we have to leave. But we've been here going on five months. All the other camps they had to leave [because it was] too messy, and it wasn't a proper place to be.

The Bassett encampment was fairly conspicuous, visible to residents in an adjacent apartment complex and office building. For most unhoused people, reducing visibility was an essential adaptation to abatements. For example, Martha, a White woman in her fifties, lived in a van with her spouse. The couple was unhoused and unsheltered in encampments for years, but five years ago purchased the van. They equipped it with a narrow twin mattress, mini-fridge, storage, and a hotplate. They usually stayed in the parking lot of a mall, where Martha got informal “permission” from the store manager to park occasionally. In her van, Martha could stay hidden from public judgment, and drive away if detected. She informed us that people staying in visible encampments did not fare well:

> They sweep them all the time. There's a small encampment over there at that park over there, Columbus Park. There's one in the middle of the field, and then there's another one across the way in the trees over there. You can see them from the street, that's why they're not going to last that long … That's just the way it is. [Abatement authorities] say, “I don't care where you go, but you can't stay here."



Image 2. June 2018. Peering out of Maria's tent at Bassett encampment. A man sleeps under a blanket on the reclining couch as a freight train screeches by. Maria stayed in this community with several dozen other individuals because the site was swept less frequently.

The risk of visibility forced unhoused people into living long term in environments that were unsustainable and inadequate for maintaining health (Image 3). Nina, introduced above, lived near the creek, in a spot sheltered by tarps tied to tree branches. Residents staying by the creek explained that the location had no access to electricity or clean water for cooking, cleaning, or bathing. The cellular phone signal was spotty. Without electricity, it was pitch black most nights. We saw several camps burned to the ground from campfires, and other sites were washed away by the creek during seasonal floods (Image 4). Amid these hazards, fifty or more people lived in small camps on a half-mile footpath along the creek. The invisibility and inaccessibility of the location - which could only be accessed by hiking along a dirt path, crossing car gates and wire fences - exposed Nina to health and safety risks, but it appealed to her because it was safer from abatements. When looking for a place to set up in the forest, she said, "You look for the flattest spot. The almost hidden, but not hidden. And you look for who you're living next to you, because that truly matters … You want to try to get a spot where it's not that accessible."

When unhoused people become invisible to escape abatements, they are also invisible to health outreach workers and other "outside" support systems, cutting off a lifeline. For example, in SCC, public health workers, such as the Backpack Homeless Healthcare Program ("backpack medicine" teams) - a street medicine program run through the county hospital - play an essential role in homeless outreach. Teams of health care providers travel to encampments and provide on-site emergency and basic health care services, as well as providing referrals. Several participants knew the backpack medicine providers by name and eagerly anticipated their visits. However, because unhoused people's risk assessment favored remaining hidden, medical teams encountered persistent issues locating patients in encampments. In one example, Ted, introduced above, told us he suffered from injuries related to his time in the military. The backpack medicine team visited his encampment every few months, but Ted had not seen them in a year because he had to move to a more secluded location (Image 5):

> There is a really great group of doctors who come through here on foot. I think they come through maybe every few months … I haven't seen them in a little while and it seems like every time they do, they've asked about me, but I haven't actually talked to them. My sister has talked to them … I don't know if they've been down here or not. Or if I've just missed them because I'm off in the bushes now, further away, or if they just haven't been here in a while.

In adapting to sweeps, unhoused people relocated to hazardous, riskier, often less visible spaces, an outcome that had detrimental impacts on health. Moreover, this was at odds with public health efforts to locate people, provide on-site services, and maintain consistent contact, further magnifying the harm of social exclusion on unhoused people's health.

3.3. Abatements increased hostility and distrust between unhoused people and authorities, especially law enforcement

Orders to move were commonly carried out by or alongside law enforcement, resulting in frequent tense, hostile interactions between unhoused people and police. Several participants mentioned their efforts to be friendly and stay on the "good side" of police and abatement workers. Some recounted positive interactions, in which specific police officers offered support. However, such interactions were rare. Most commonly, participants reported that police officers used their authority to harass, disrupt, and, notably, to send the message that unhoused people were unwelcome. Ted, introduced above, was convinced that the purpose of the sweeps was not to clean up encampment sites or promote sanitation, but to cause suffering to the extent that unhoused people do not, or cannot, return. From his perspective, causing distress to unhoused people was itself the objective. He referred to abatements as a form of "state-sponsored harassment." He told us about one morning when he returned to his encampment to find his tent and belongings were gone:

> Slowly but surely, [abatement workers] have come more frequently, but cleaned up less. They're just trying to bounce us from place to



Image 3. June 2021. A small section of the Columbus Park encampment, referenced by Martha as a site that will eventually be swept. The large encampment is located on empty, open lots adjacent to San Jose Mineta International Airport, which were razed and abandoned decades ago to create a flight path. The encampment population swelled during the COVID-19 pandemic.



Image 4. July 2018. The remainder of a campsite near the Guadalupe River, a secluded, forested area where Nina preferred to stay hidden from sweeps. Sites at the bank of the river were prone to being swept away by seasonal flooding.



Image 5. August 2018. Ted's former encampment under the freeway overpass, occupied by his younger brother. We reached this site by traversing the unpaved path between the freeways and creek system. We hiked along the creek, crossed an abandoned train rail, and jumped over security gates to access this location. Ted relocated from this section to an even more secluded area in a nearby field.

> place hoping that we don't come back …. Most of the time the cops come down the minute the [abatement workers] are here. Cops let anyone who's still around know that they can no longer grab their stuff. Whatever is left now belongs to [the abatement workers]. People gotta get out of here or they'll be arrested … Now, they don't clean up any of the garbage. What they do is they just take our personal property if we haven't been able to move it out in time.

Ted's descriptions of the aggravation and grief caused by law enforcement during abatements were echoed by several other participants. Izza is a Latinx transgender woman in her fifties who has been unhoused in SCC for over ten years. When we met her, she and her partner were staying in a collection of tents, cardboard, shopping carts, and tarps alongside a fence surrounding a vacant lot that had been cleared for a construction project. During the daylight hours, the couple

pushed a shopping cart with five-gallon water containers and a small dog to a sidewalk with tree shade near a strip mall parking lot. By moving to the shade, Izza risked being noticed and encountering police, but decided it was worth the momentary reprieve from the heat. She told us that from her perspective, the police were the source of instability and greatest misery:

> (*Translated from Spanish*) Things have been awful. There has been a lot of trouble. Not only with other people, but with the police. They are very cruel. They give me citations for no reason, they tell me to move - all in the same day. Throw me out, and look through my things for no reason. They treat me like I am a criminal. I will tell you, my only crime is not having a place to live or sleep in. Even on rainy days they don't have compassion, they kick me out, too, and we get all wet. We have had to move too many times in the same night.

Steven, a Black man in his fifties, occasionally stayed at the Bassett encampment when he was unable to get a bed at the large homeless shelter. He became unhoused four years prior, when his wife's terminal illness put their family in major medical debt. Staying near the train tracks in a tent, working to recover from financial and emotional grief, Steven grappled with what he viewed as law enforcement's indifference toward people's personal hardships. He viewed sweeps as a form of harassment that worsened an already painful period in his life:

> The police, when they [sweep], they come on the premises at 6 o'clock or 7 o'clock in the morning, beating on people's tents, say, "Hey. Come on out here. We've got some goodies for you." And then you find out it's the police. They serve you, put a notification on your tent. That's their strategy. They come in their gear and all that. And there's nothing you can do. [Police,] why are you bothering me? You see what I'm going through. Why are you over here bothering me? Some of these encampments are clean. Some of these encampments are kept well up. The police are aware, but it's harassment.

Maria, introduced above, described her efforts to de-escalate the stressful encounters with abatement authorities at the Bassett encampment, back when the site was swept every three months. She recalled when the police tried to intimidate her into leaving ("running"), but she remained, refusing to be treated like a criminal when she had done nothing wrong in her mind:

> Packing our bags, packing our carts, and moving to a different spot, that's tough … I bribe [abatement authorities]. I make them burritos. I give them a sandwich and water … But they bring a [police] officer. They don't scare us! Maybe they can help us instead of trying to scare people! The [unhoused] people that get scared, they all run. They see a cop, they run. But why are you guys running? They'll go, "Run, Maria, run." Why am I gonna run? Why should I run? I haven't been in trouble since 1988, and that was just for tickets.

The psychological stress and dehumanization experienced by unhoused people, resulting from abatement practices oriented around law enforcement, fortified participants' skepticism and distrust of authorities.

3.4. Distrust in law enforcement increased self-policing and interpersonal violence in unhoused communities

> I want the police officers to apologize for all these years, for degrading my humanity … I'm just so angry every time I see them. Oh, my God, if I could just … Maybe they'll disappear, because you made my life pure hell, every time I walk down the street. Every time. Every time.

Alexa, a Black woman in her forties, who is quoted above, expressed her outrage at the treatment she received from the police while living unsheltered on the streets. Partly due to the hostility spurred by abatements, law enforcement was largely viewed by participants as a threat and risk. As a result, participants often refused or were reluctant to contact or interact with police, even in serious, life-threatening situations. To participants, contact with police placed them at greater risk of harassment and arrest, which outweighed the potential benefit of protection. For example, Miranda is a Latina woman in her fifties who was born and raised in San Jose, and was unhoused for several years, but was living in supportive housing when we met her. She recalled the day, five years prior, when her ex-husband was fatally stabbed in a large encampment north of downtown San Jose, known as the Jungle. Miranda called 911 for an ambulance, angering other residents of the encampment:

> Because of everything that is going on, a lot of [unhoused] people take justice into their own hands. Which they shouldn't … They don't trust the cops at all … Before my ex passed away, they stabbed him up there in the Jungle. I had to [call] 911. Had to wait for enough officers to go down there. They had 15 officers behind me carrying their guns … I pointed out the direction where my ex was, because he didn't want to get help. He had been stabbed six times … Everybody was mad at me because I called the cops. Dude, I didn't call the cops, I called the ambulance! But they assume I sent the whole city of San Jose. Still, I think I did the right thing.

In the absence of police, Miranda described that people "take justice into their own hands" in encampments. Over the course of the interviews, several participants described brutal accounts of violence in the encampments, including sexual violence. Sammy, who is introduced above, informed us in detail that in the prior year, she was kidnapped, and physically and sexually assaulted by a stranger. Not trusting law enforcement, and viewing them as ineffective, she did not inform the police or file a police report. One morning, months after the assault, she saw the attacker on the street. When she told her husband, he was determined to seek retribution and settle matters himself. She pleaded with him that retribution was not worth the risk of being caught by law enforcement:

> [In encampments] you have no restrictions, you have no rules, except for the rules of law. Even those have been bent, broken, and moseyed around. Even the law will overlook you sometimes. I didn't report [the attack], but [the police] already knew [about the attacker], and that guy's still out there. I encountered him once riding my bike. I almost crashed my bike as soon as I saw him. I rode back as fast as I could, and [my husband was] like, "what was that about?" I told him, "that was him." My husband was like, 'I will chop his head off right now." I said, "you can't do that. There's too many cameras, you can't do that. I'm not condoning the [assault], but you just can't do that." That's just too much to have to put up with, and I don't want that on my conscience, or on his conscience.

As noted in Finding 1, many congregate encampments were self-managed, with residents developing their own cultures and systems for surviving. There were several examples of self-managed encampments that were operated by tight-knit and supportive communities, such as the one Ted described. In most cases however, self-management in encampments involved self-policing, and, at times, forceful and violent enforcement of informal rules. Nina, who is introduced above, told us about the unofficial "leader" of her encampment by the creek, who created and enforced rules. Interpersonal violence between unhoused people frequently erupted as a result:

> Everybody has their little ways. Just recently, we've been having a problem with Little Hitler, I call him. He's trying to be a Hitler here. He has a new rule, and I don't live by his rules … Basically we're all together, and we try to live together. If we can't, then we either tell the person higher up. If [higher ups] don't do anything, then we try to not be vigilantes. But me? I'm tired. I'm going to hit you if I feel threatened. I'm going to hit you. It's not like I want to do it, but I'm going to do it. If I feel like you're going to come and ruin my space or ruin anything for me or mess with mine, I'm going to do it.

Nina resorts to physical violence to protect herself because she cannot rely on others to help her - not the police, or even others in her encampment. In this context of exclusion from forms of support, she described that encampments can become susceptible to influence from organized crime.

> [The gangs] had their laws down there. If you weren't wanted there, they would get your stuff, pack you up, and throw you out. You were gone. A lot of killings, a lot of bodies. Lots of, lots of bodies. That is MS-13's territory. What do they do when they do something? There were a lot of murders, a lot of things like that.

With no formal ways to pursue justice, these conditions entangled some unhoused people into cyclical, entrenched forms of violence, with serious health outcomes. For these individuals, encampment sweeps were an upstream, fundamental cause of downstream interpersonal violence, injury, and death.

4. Discussion

Drawing from unhoused people's narratives of their lived experiences in encampments in SCC, we described four interconnected ways abatements harmed their health: 1) forced relocation and property seizures severed people from possessions, resources, and social supports needed to sustain health; 2) abatements were the underlying reason people relocated into more isolated, hazardous, and remote spaces, which amplified health risks while reducing access to support systems such as health outreach workers; 3) abatements were viewed as a form of harassment, a persistent source of distress and tension between unhoused people and authorities; and 4) distrust caused unhoused people to avoid law enforcement and other authorities altogether, increasing self-policing and the risk of interpersonal violence in encampments. In these ways, we argue that unhoused people's health is harmed directly through encampment sweeps, or through the perilous social environmental conditions created by them.

There are several implications of this research and areas of needed future inquiry. First, in light of the health harms of abatements, we hypothesize that abatement practices may be a key structural factor explaining the soaring numbers of people who are dying while unhoused in SCC. The number of unhoused people dying annually in SCC has increased from 60 deaths per year in 2011, to 203 deaths in 2020 - rising almost every year (Jordan & Wells, 2017), a stark indication of worsening health in this population. Abatement rates are not routinely reported, but an audit of San Jose homeless services showed that in an overlapping time frame, there was a sharp increase in abatements taking place - one estimate indicating a leap from 49 sites in 2013 to 564 sites in 2018 (Office of the City Auditor San Jose, 2018). Overlapping increases do not necessarily indicate a relationship, but given our findings on the health harms of abatements, further research is warranted investigating the scope, dimensions, and directionality of the relationship between abatement practices and health outcomes such as mortality.

Given the growing body of research showing the consequences of abatements on human health, findings like these call into question the practical effectiveness and acceptability of common abatement practices. Abatements have been shown to have destabilizing effects, major health consequences, and cause psychological suffering to unhoused people. They create logistical burdens to public health outreach efforts. Abatements also counter public health logic and street medicine practice recommendations for unhoused people, which call for increasing stability, developing trust, and maintaining ongoing contact with outreach workers and health systems (Stefanowicz et al., 2021; Withers, 2011). In some regions, moratoriums and restrictions on abatements have been enacted given the potential health harms. In California, some counties (e.g., Alameda County) placed limitations on encampment abatement practices, restricting abatements when there are no shelter beds available (per the 2018 decision by the 9th U.S. Circuit Court of Appeals cited above). In response to COVID-19, several counties in California, including SCC, initially enacted moratoriums on encampment abatements to reduce capacity in the shelter system and allow unhoused people to practice social distancing outside. However, since March 2021, abatements have resumed.

One theme that is apparent through the interviews is that society's heavy reliance on law enforcement in the management of encampments has long term, serious ramifications on people's health. As an alternative to current practices, researchers and advocacy organizations have supported restructuring abatements in favor of models that are less police-oriented and more driven by public health. These can involve specialized police units that exclusively focus on homelessness (e.g., Wichita, Kansas), that respond alongside providers or social workers (e.g., Philadelphia, Pennsylvania; Eugene and Portland, Oregon), and models where service providers or social workers respond to calls without automatic police involvement (e.g., San Francisco, California; New York, New York) (Batko et al., 2020; Townley & Leickly, 2021). In 2020, the San Jose Police Department began a small new pilot program, Mobile Crisis Assessment Team (MCAT), partnering police officers with behavioral health teams to provide a police presence in encampments geared toward de-escalating conflict, crisis management, and harm reduction, instead of only enforcement. These alternative models to police-focused abatements are promising strategies in reducing the health harms of abatements if they are appropriately scaled.

There is also an urgent need for improved documentation, reporting, and tracking of abatement practices, such as types of outreach efforts provided, prevention efforts, demographics of unhoused people who are posted and swept, and abatement-related incidents. In most counties, there is no integrated system for documenting abatements, and sweeps are conducted by a network of organizations - public, private, non-profit. There is no systematic, coordinated way to track, analyze, or report the effectiveness of abatements, nor to assess accountability during abatements. Such data and coordinated tracking systems are needed in local governments to understand the impact of sweeps on unhoused people and the broader community.

Fundamentally, the vast majority of people who are unhoused are living in encampments because there is no alternative when the cost of living is substantially higher than wages. A home is a necessity for basic health and safety. There is an urgent need for long term housing for unhoused people, an issue that requires stronger housing policies beyond the local level, needing to be addressed at the state and federal levels. At the local level in SCC, there is a commendable focus on prioritizing permanent supportive housing, but given the severity of the current housing crisis, there is also an immediate need for wide ranging solutions to unhoused people's health needs. Recognizing the persistent harms that stem from living on the streets for thousands of people, alternative interventions include moving people into hotels, expanding capacity in the shelter systems, providing basic health services in encampments (e.g., food, water, bathrooms, hygiene, medical services), creating safe parking locations with supportive services, funding substance use treatment outreach, and bolstering street medicine outreach. Policy efforts should also focus on interventions that prevent low income individuals from losing housing, such as investments in affordable housing and stronger eviction protections for renters.

There are limitations to this study that require future research. One limitation is that we focused on the health effects of abatements in encampment settings and did not examine how abatements shape people's medical care in health care settings. People of different genders, races, ethnicities, sexualities, and documentation statuses have wide-ranging experiences with encampment dynamics, law enforcement, and abatement authorities that we were not able to analyze fully for this manuscript. In the interviews with unhoused participants, we did not differentiate between abatement practices of different magnitudes (e.g., large-scale abatement of congregant, durable encampments; routine move-along orders of individuals).

The health harms of encampment abatements are preventable. It is common in health research to focus on individual-level factors, such as age or health comorbidities, including substance use or mental health. Another frequent area of focus is social determinants of health, which can include built environments or social networks. This analysis contributes to a growing body of evidence that demonstrates how structural determinants - such as *social policies* created to manage homelessness - ultimately undermine their health. As the numbers of unhoused people's deaths continue to soar every year, there is an urgent need to reimagine social policies with the goal of reducing preventable suffering and untimely deaths of unhoused people.

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Office of the City Auditor San Jose. (2018, November). Audit of the city's homeless assistance programs: More coordination and better monitoring can help improve the effectiveness of programs. *City of San Jose*. http://sanjose.granicus.com/DocumentViewer.php?file=sanjose_3ae28b1ca45aff1a33edc83a56618382.pdf&view=1.

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Roncarati, J. S., Baggett, T. P., O'Connell, J. J., Hwang, S. W., Cook, E. F., Krieger, N., & Sorensen, G. (2018). Mortality among unsheltered homeless adults in Boston, Massachusetts, 2000-2009. *JAMA Internal Medicine, 178*(9), 1242–1248. https://doi.org/10.1001/jamainternmed.2018.2924

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Stefanowicz, M., Feldman, B., & Robinson, J. (2021). House calls without walls: Street medicine delivers primary care to unsheltered persons experiencing homelessness. *The Annals of Family Medicine, 19*(1), 84. https://doi.org/10.1370/afm.2639

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Westbrook, M., & Robinson, T. (2021). Unhealthy by design: Health & safety consequences of the criminalization of homelessness. *Journal of Social Distress and the Homeless, 30*(2), 107–115. https://doi.org/10.1080/10530789.2020.1763573

Wilking, J., Roll, S., Philhour, D., Hansen, P., & Nevarez, H. (2018). Understanding the implications of a punitive approach to homelessness: A local case study. *Poverty & Public Policy, 10*(2), 159–176. https://doi.org/10.1002/pop4.210

Withers, J. (2011). Street medicine: An example of reality-based health care. *Journal of Health Care for the Poor and Underserved, 22*(1), 1–4. https://doi.org/10.1353/hpu.2011.0025

TAB 111

Curriculum Vitae

1. Name

AMEIL J. JOSEPH

2. Business Address

McMaster University
School of Social Work
Faculty of Social Sciences
905-525-9140 X23792
Email: ameilj@mcmaster.ca

Associate Professor
1280 Main Street West
Office: KTH 309
Hamilton, Ontario, L8S 4M4
Citizenship: Canada

3. Educational Background

Doctor of Philosophy (PhD): Social Work: York University, Toronto, ON	2014
Master of Social Work (MSW): Wilfrid Laurier University, Kitchener, ON	2007
Social Work Diploma: Renison University College, Waterloo, ON	2004
Bachelor of Arts, Psychology: University of Waterloo, Waterloo, ON	2003

4. Current Status at McMaster

Associate Professor- Tenured, School of Social Work July 1, 2019- Present

Professorship in Equity, Identity and Transformation, Faculty of Social Sciences July 1, 2021- Present

Assistant Professor- Tenure Track, School of Social Work July 1, 2014-June 30, 2019

Current Centre/Institute Memberships:

Centre of Human Rights and Restorative Justice
https://chrrj.humanities.mcmaster.ca/people/

McMaster Institute for Health Equity
https://mihe.mcmaster.ca/members/

Centre for Advanced Research on Mental Health and Society
https://socialsciences.mcmaster.ca/advanced-research-on-mental-health-and-society/people

5. Professional Organizations

Archives of Ontario: Registered researcher	2012-Present
Canadian Association for Social Work Education: Member	2011-Present
Ontario College of Social Workers and Social Service Workers: Registered Social Worker	2007-Present
Mental Health Commission of Canada: Network of Ambassadors Member	2016-Present

6. Employment History

a. *Academic*

Academic Director, Community-Engaged Research and Relationships July 2021-Present
Office of Community Engagement
McMaster University

Research Assistant May-August 2014
Professor Sarah Maiter, York University, Toronto, ON
Critical Race Research, methodological issues

Research Coordinator- Toronto-York site Fall 2009-Fall 2010
The Self-Other Issue in the Healing Practices of Racialized Minority Youth
Social Sciences and Humanities Research Council (SSHRC) Funded Standard Research Grant
Primary Investigator: Prof. Martha Kuwee Kumsa, Wilfrid Laurier University

Research Assistant/Volunteer Coordinator November 2003-April 2005
The Canadian Early Childhood Language Project
Canadian Institutes of Health Research (CIHR) Funded
Primary Investigator: Prof. Daniela O'Neill, University of Waterloo

b. *Consultations*

Ontario Ministry of Education: Fact/lens-checking: December 2021-2023
Grade 10 Civics and Citizenship

Hamilton Community Legal Clinic June 2022-Present
Charter Challenge to Encampment Evictions

Waterloo Region Community Legal Services August 2022-September 2022
Superior Court Challenge to Encampment Evictions

Government of Canada, Consultation on National Anti-Racism Strategy January 23, 2019
Lincoln Alexander Centre, Hamilton, ON

Niles, C., Jama, S., Joseph, A.J. October 25, 2018
Disability Justice Network of Ontario & The Ontario Council of Agencies Serving Immigrants:
A round-table discussion on supporting newcomers with in/visible disabilities access safe, affordable, and accessible housing, Hamilton, Ontario

Ontario Anti-Racism Directorate Consultation with the Anti-Racism Resource Centre February 9, 2017
City Hall, Hamilton, ON

Ontario Anti-Racism Secretariat Roundtable discussion with Andrea Horwath MPP February 5, 2016
Immigrants Working Centre, Hamilton, ON

Joseph, A. J., Dei-Amoah, M., Cameron, R.W., Komlen, M., Otite, Y. November 18, 2015
Hamilton's Anti-Racism Resource Centre: Presentation to the City of Hamilton's General Issues committee. City Hall, Council Chambers, Hamilton, ON.

Toronto Central LHIN consultation with Community Mental Health May 2, 2013

and Addictions Boards and Executive Directors-St. Paul's Church, Toronto, ON

Think Tank on Racialized Populations and Mental Health and Addictions ED use March 26, 2013
Li Ka Shing Knowledge Institute, St. Michael's Hospital, Toronto, ON

Community of Interest for Racialized Populations and Mental Health and Addictions Jan. 30, 2013
Canadian Mental Health Association: Ontario Division, Toronto, ON

ODSP Roundtable on Mental Health Conditions and Disability Nov. 27, 2012
Ministry Of Community and Social Services: Toronto, ON

Central Local Health Integration Network: Health Equity Roundtable May 19, 2011
York University: Toronto, ON

Central Local Health Integration Network: Creating Quality in the Transitions of Care March. 3, 2011
Westin Prince Hotel: Toronto, ON

c. *Other/Professional*

Canadian Mental Health Association, Toronto, ON: Dec. 2012- September 2013
Social Work Practice Lead

Canadian Mental Health Association, Toronto, ON February 2009 – September 2013
Social Worker; MSW, RSW– Mood and Psychosis Early Intervention Team

Canadian Mental Health Association, Toronto, ON July 2007 – February 2009
Social Worker; MSW, RSW– Assertive Community Treatment Team; West Metro

Waterloo Regional Homes for Mental Health, Kitchener, ON March 2004 – July 2007
(Now: Thresholds Homes and Support)
Mental Health Worker

Waterloo Regional Police Service, Cambridge, ON September – December 2006
Community Resources Department - MSW Internship

Kitchener-Waterloo Multicultural Centre, Kitchener, ON June – December 2006
Settlement Worker

Grand River Hospital, Kitchener, ON January – June 2006
Social Work Department – MSW Internship

Waterloo Regional Homes for Mental Health, Kitchener, ON May – November 2005
(Now: Thresholds Homes and Support)
Crisis Respite Program Implementation Team

7. Scholarly and Professional Activities

a. Editorial boards

2022-present-Qualitative Research (Journal Editorial Board Member)

2020 Hamilton Anti-Racism Conference- editorial committee

2021- present- Editorial Advisory Board members for the new book series *The Politics of Mental Health and Illness*, published by Palgrave Macmillan.

2021-present-Co-editor, Special Issue on History and Social Work in *Critical and Radical Social Work*

b. *Grant & Personnel Committees*
N/A

c. *Executive Positions*
N/A

d. *Journal Referee*

Social Work *2 reviews*	2022
Hypatia 1 review	2019
Canadian Social Work Review/ Revue Canadienne de Service Social 1 review	2019
Psychology of Violence 2 reviews	2018 and 2019
New Horizons in Adult Education and Human Resource Development 1 review	2018
Social Theory and Health 1 review	2017
Canadian Journal of Disability Studies For special issue and general 2 reviews	2016 and 2017
Qualitative Research, Cardiff University 2 reviews	2016 and 2020
Social and Legal Studies, Edinburgh For Special Issue on Prof. Penelope Pether's work 1 review	2016
British Journal of Social Work 4 reviews	2015, 2019, 2020, 2021
Journal of Progressive Human Services 8 reviews	2012-2013

e. *External Grant Reviews*
N/A

8. Areas of Interest

Critical Mental Health, Forensic Mental Health, Postcolonial Theory and Social Work, Critical Race Theory, Critical Disability Studies, Social Justice, Violence, Ethics, Confluence, Historiography and Social Work.

9. Honours and Awards

John C. Holland Awards: Vince Morgan Ally Award	Community Award	2021
Early Career Research Award, Faculty of Social Sciences, McMaster University	$500	2019
Barbara Godard Prize for the Best York University Dissertation in Canadian Studies Robarts Centre for Canadian Studies, York University	$500	2014
Fourth International Conference on Health, Wellness & Society Graduate Student Award	$300	2013-2014
Nathanson Graduate Fellowship - Osgoode Hall Law School, York University (Nathanson Centre on Transnational Human Rights, Crime and Security)	$15000	2013-2014
Kent Haworth Archival Research Fellowship - Archives of Ontario	$1365	2012-2013
Doctoral Ontario Graduate Scholarship – York University	$30000(Total)	2012&2013
Doctoral Fellowship - York University	$80600(Total)	2009-2014
PhD Graduate Scholarship – York University	$3000	2009-2010
Bettina Russell Social Justice Award - Wilfrid Laurier University	$1248	2007
Helmut Braun Memorial Award - Centre for Community Based Research	$1000	2006

10. Courses Taught

a. *Undergraduate*

Course Instructor September 2019-December 2019
SW 4J03: Social Change: Social Movements and Advocacy
School of Social Work: McMaster University, Hamilton, ON

Course Instructor Jan. 2017- Apr. 2017, Sept. 2018- Dec. 2018, Sept. 2021-Dec. 2021, Sept. 2023-December 2023
SW 4Y03**:** Critical Issues in Mental Health & Addiction:
Mad & Critical Disability Studies Perspectives for SW
School of Social Work: McMaster University, Hamilton, ON

Course Instructor September 2016- April 2017, September 2018- April 2019
SW 2A06**:** Theory, Process & Communication Skills for Social Work
School of Social Work: McMaster University, Hamilton, ON

Course Instructor September 2015- December -2015, January 2018- April 2018, January 2020-March 2020, January 2022-April 2022, January 2024-April 2024
SW 4C03**:** Racism and Social Marginalization in Canadian Society (changed to SW 4C03 Critical Perspectives on Race, Racialization, Racism and Colonization in Canadian Society in 2018)
School of Social Work: McMaster University, Hamilton, ON

Course Instructor September 2014-April 2015, September 2015- April 2016
SW 4D06/4DD6: General Practice II/Field Practicum II

School of Social Work: McMaster University, Hamilton, ON

Course Instructor Spring, Fall, 2013, Winter, Spring, 2014, Spring 2015, Fall 2015
CINT 907 Teamwork for Community Services
Interdisciplinary Studies: Toronto Metropolitan University, Toronto, ON

Course Instructor Fall 2013
CINT 905 Conflict Resolution in Community Services
Interdisciplinary Studies: Toronto Metropolitan University, Toronto, ON

Course Instructor Spring 2013
CSWP 900 Race and Ethnicity
School of Social Work: Toronto Metropolitan University, Toronto, ON

Tutorial Leader Fall/Winter 2011/12 & 2012/13 & 2013/14
SOWK 1011 Introduction to Critical Social Work
School of Social Work: York University, Toronto, ON

b. *Graduate*
Course Instructor Jan. 2020- Apr. 2020, Sept. 2021-Dec. 2021, Sept. 2022-Dec. 2022, Sept. 2023-December 2023
SW 721: Changing Communities: Tensions and Possibilities for Citizenship and Social Justice
School of Social Work: McMaster University, Hamilton, ON

c. *Postgraduate*
N/A

d. *Other*
Course Instructor

SW 705: Directed Readings Course January 2023-April 2023
Critical Analysis of Intimate Partner Violence and Judicial Responses
School of Social Work: McMaster University, Hamilton

SW 705: Directed Readings Course January 2023-April 2023
Critical Discourse Analysis of the roles of Immigrant Grandparents Working as Care Providers in Canada
School of Social Work: McMaster University, Hamilton

SW 705: Directed Readings Course January 2022-April 2022
Critical (Historiographical) Analysis of Homelessness as Discourse
School of Social Work: McMaster University, Hamilton

SW 705: Directed Readings Course September 2021-December 2021
Critical Analysis of Motherhood, Race, and Substance Use
School of Social Work: McMaster University, Hamilton

Course Instructor
GLOBHTH 715: Directed Reading/Independent Study September 2021-December 2021
Critical race, Afrocentricity and Intersectionality epistemologies and methodologies
Faculty of Health Sciences, Ph.D. Program Global Health: McMaster University, Hamilton, ON

Course Instructor September 2019-December 2019
SW 705: Directed Readings Course:
Critical Discourse Analysis of Ontario's Long-Term Care Act and its Impact on older LGBTQ+ people in care
School of Social Work: McMaster University, Hamilton, ON

Course Instructor September 2019-December 2019
SW 705: Directed Readings Course: Critical Analysis of South Asian Culture, Violence and Trauma
School of Social Work: McMaster University, Hamilton

Course Instructor September 2018-December 2018
SW 705: Directed Readings Course: Critical Analysis of Children's Participation in Child Custody and Access Disputes
School of Social Work: McMaster University, Hamilton, ON

Course Instructor January 2016-May 2016
SW 705: Directed Readings Course: Critical Analysis of Refugee Experiences
School of Social Work: McMaster University, Hamilton, ON

11. Contributions to Teaching Practice

a. Pedagogic innovation and/or development of technology-enhanced learning

(2022). Championing EDI at McMaster. Art of Change Podcast, McMaster University, Office of Community Engagement. 8. Championing EDI at McMaster University (Part 1) by The Art of Change (anchor.fm)

(2021) Hamilton Health Sciences- Presidents Advisory Committee on Equity, Diversity, and Inclusion
Developed a series of 5 training workshops for members and leadership

(2021) Faculty of Health Sciences: Equity, Advocacy, And Allyship Program
Co-developed curriculum, delivered workshop for the Faculty of Health Sciences on Equity, and "Thinking Respectfully about Identity and Difference".

(2017) Three short videos contributed to deBie, A. & Brown, K. (2017). Forward with Flexibility: A Teaching and Learning Resource on Accessibility and Inclusion. https://flexforward.pressbooks.com/front-matter/forward-with-flexibility/

- Disabled Student's Participation in Education https://youtu.be/bOEb3pKZBU4
- Our Responsibility as Educators https://youtu.be/Fp2cg3Ei3io
- Seeking Ongoing Feedback from Students https://youtu.be/8-Wulencl-U

b. *Leadership in delivery of educational program*

Lead the organization and development of an event/symposium with colleagues to examine the politics of anti-oppression in education.

- Anti-Oppression: A Critique and Reimagining Event Date: April 18, 2016 1pm-4pm
  CIBC Hall, McMaster University

c. *Course/curriculum development*

- Redeveloped SW 721 Changing Communities: Tensions and Possibilities for Citizenship and Social Justice, course design, readings, lectures.
- Redeveloped SW 4J03 Social Change: Social Movements and Advocacy, entire course design and readings, lectures.
- Developed new course: SW 4Y03: Critical Issues in Mental Health & Addiction: Mad & Critical Disability Studies Perspectives for SW, McMaster University, Hamilton, ON, 2016
- Redeveloped SW 2A06 Theory, Process and Communication Skills for Social Work in consultation with prior instructors: McMaster University, Hamilton, ON, 2016
- Developed Graduate Directed Reading Course SW 705: Directed Readings Course: Critical Analysis of Refugee Experiences in collaboration with MSW student. McMaster University, Hamilton, ON, 2015
- Developed SW 4C03 Racism and Social Marginalization in Canadian Society for Fall 2015 and taught first run of this course: McMaster University, Hamilton, ON
- Met with Undergraduate course 4D06 instructors to revise and redevelop course/curriculum, suggested and incorporated new provocative readings: McMaster University, Hamilton, ON, 2014
- Developed Undergraduate course: CSWP 900 Race and Ethnicity, School of Social Work**:** Toronto Metropolitan University, Toronto, ON for Spring 2013
- Developed interactive course website using blackboard software for a 13-week online Undergraduate course on interdisciplinary teamwork in community services. Toronto Metropolitan University, Toronto, ON, 2013-2015
- Contributed to revisions of Undergraduate course outline for SOWK 1011 Introduction to Critical social Work to include updated research and literature relevant to the field. York University, Toronto, ON. 2009-2013

d. Development/evaluation of educational materials and programs

Book Proposal Reviewer: *More than a Diagnosis, More than a Clinician:* 2019
How the Stories of Clinicians and the Individuals We Work With Shape Us and Our Practice
By Jennifer Gerlach, Routledge

Book Proposal Reviewer: *Critical Clinical Social Work: Counterstorying for Social Justice* 2018
By Catrina Brown and Judy MacDonald, Canadian Scholars Press

Book Proposal Reviewer: *Troubling Care: A Theory of Institutional Violence*, 2017
by Kate Rossiter and Jennifer Rinaldi, Routledge

Book Reviewer: *Working with People: Communication Skills for Reflective Practice* 2016
by Louise Harms and Joanna Pierce, Oxford University Press

e. Other

Deep Diversity Leadership Training- Anima Leadership 2019
Employment Equity Facilitators Training 2019

12. Supervisorships

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a. *Master*

Completed: 18 In progress: 1

Kaiden Penny MSW Thesis School of Social Work, McMaster University	2023-2024
Mariana Martinez Guevara MA Gender Studies and Social Justice	2022-2023
Gessie Stearns MSW Thesis School of Social Work, McMaster University	2021-2022
Nickay Palmer MA, Gender Studies and Feminist Research, McMaster University	2019-2020
Chriselle Vaz MSW Thesis School of Social Work, McMaster University	2019-2020
Shangaari Kanesalinkam MSW Thesis School of Social Work, McMaster University	2019-Present
Fatemah Shamkhi MSW Thesis School of Social Work, McMaster University	2019-2020
Kendra Mackenzie MSW Thesis School of Social Work, McMaster University	2019-2020
Alison Jones MSW Thesis School of Social Work, McMaster University	2018-2023
Amarachi Chukwu MA, Gender Studies and Feminist Research, McMaster University	2017 - 2018
Laura Stothart MSW Thesis School of Social Work, McMaster University	2017- 2018
Beshele Caron MSW Thesis School of Social Work, McMaster University	2017- 2018
Kattawe Henry MA Gender Studies and Feminist Research, McMaster University	2016 - 2017
Teagan Rooney MSW Thesis School of Social Work, McMaster University	2016 - 2017
Amy Rector MSW Thesis School of Social Work, McMaster University	2016 - 2017
Sarah Adjekum MSW Thesis School of Social Work, McMaster University	2015 - 2016
Gillian Martel MSW Thesis School of Social Work, McMaster University	2015 - 2016
Heston Tobias MA MRP Cultural Studies and Critical Theory, McMaster University	2016 – 2016
Jeffrey Corrin MSW Thesis School of Social Work, McMaster University	2014 - 2020

b. *Doctoral*

In progress: 4

Zoha Salam Ph.D. Global Health, McMaster University	2022-2024 (Completed)
Gessie Stearns Ph.D. School of Social Work, McMaster University	2023-Present
Mercy Lilian Gichuki. Ph.D. Global Health, McMaster University	2022-Present
Sherry Barrett Ph.D. School of Social Work, McMaster University	2022-Present
Kusum Bhatta Ph.D. Thesis School of Social Work, McMaster University	2021-2024
Shaila Kumbhare Ph.D. Thesis School of Social Work, McMaster University	2019-Present
Michelle Hayes Ph.D. Thesis School of Social Work, McMaster University (withdrawn)	2017-2019
Nicholas Carveth Ph.D. Thesis School of Social Work, McMaster University	2015-2021

c. *Post-doctoral/fellowship*

Nicole Schott. Post-Doctoral Fellowship in Critical Mental Health Equity and Community Engaged Research September 2022-September 2023

d. *Clinical/Professional*

Field Supervisor: BSW Field Placement September 2019- April 2020
Hamilton Center for Civic Inclusion & McMaster University, School of Social Work

Graduate placement supervisor: GENDRST 707 September 2019- December 2019
Hamilton Center for Civic Inclusion & McMaster University, Gender Studies and Feminist Research

Field Supervisor: BSW Field Placement 3DD6 September 2017- April 2018

Self-Directed Placement**,** McMaster University, School of Social Work

University of Toronto: Master of Social Work –Field Placement Supervisor Sept. 2010-April 2011
CMHA Toronto Early Intervention, Provision of Clinical and Professional Supervision

Ryerson University: Internationally Educated Social Work Professionals Bridging Program
Post-Master of Social Work –Canadian Field Placement Supervisor April-June 2011
CMHA Toronto Early Intervention, Provision of Clinical and Professional Supervision

e. *Supervisory Committees*

Nagham Azzam. Doctor of Science in Rehabilitation and Health Leadership 2023-Present
Queens University
Mercy Lilian Gichuki. Ph.D. Global Health, McMaster University March 2021-September 2022
Aisha Wilks. Ph.D. English and Cultural Studies, McMaster University November 2021- Present
Chavon Niles. Ph.D. Department of Social Justice Education,
Ontario Institute for Studies in Education University of Toronto June 2020-November 2020
Rochelle Maurice. Ph.D. Social Work, McMaster University 2020-Present
Ciceley Janet Lawson. Ph.D. Social Work, McMaster University 2020-Present
Nishi Singh. MA in Globalization Studies, McMaster University Completed 2015

f. *Other – second reader on thesis, Undergraduate Student Research Awards*

Mona Xin Huang Undergraduate Student Research Award, McMaster University 2022
Pamandeep Jhajj MSW Thesis School of Social Work, McMaster University Completed 2019
Alex Wilson Interdisciplinary Science 4A12 Thesis, McMaster University Completed 2018
Chriselle Vaz Undergraduate Student Research Award, McMaster University 2018 & 2019
Monique Pitt MSW Thesis School of Social Work, McMaster University Completed 2017
Brittany Madigan. MSW Thesis School of Social Work, McMaster University Completed 2015
Joel Martin. MSW Thesis School of Social Work, McMaster University Completed 2015
Madhav Khurana MSW Thesis School of Social Work, McMaster University Completed 2016

g. *External Examination*

Savitri Sabrina Persaud, Ph.D. Thesis, Social and Political Thought, York University 2022
No Sovereign Remedy: Distress, Madness, and Mental Health Care in Guyana.

13. Lifetime Research Funding

Type: 2023 SSHRC Knowledge Synthesis Grant: Shifting Dynamics of Privilege and Marginalization
Agency: Social Sciences and Humanities Research Council
Amount: $29873
Purpose: Research
Recipients: Jennifer Ma (PI), Ameil Joseph (Co-applicant), Chelsea Gabel (Co-applicant), Aasiya Satia (Collaborator)
Title: Dismantling white supremacy through anti-racist and decolonial pedagogies: Mapping postsecondary education's capacity for shifting dynamics

Type: 2022 SSHRC Research for Post Pandemic Recovery
Agency: Social Sciences and Humanities Research Council

Amount: $499319
Purpose: Research
Recipients: Trudo Lemmens (PI), Alison Thompson (co-PI), (co-applicants):Fernando Aith, Sonia Alima, Kevin Bardosh, Neil Belanger, Megan Boler, Alex de Figueiredo, Lisa Forman, Patrick Garon-Sayegh, Sarah Jama, **Ameil Joseph**, Robert Lattanzio, Tara Levandier, Lisa Schwartz, Neil Seeman, Deborah Stienstra
Title: Rebuilding Public Trust after COVID-19: Examining Public Health Measures and Their Impacts on Disadvantaged Communities

Type: 2022 Future of Canada Project
Agency: McMaster University
Amount: $150000
Purpose: Research
Recipients: Ameil Joseph
Title: Defying Systemic Racism and Hate: Building Community Solidarity for Knowledge Sharing, Mutual Aid and Action for the Future

Type: 2021 SSHRC Partnership Grant
Agency: Social Sciences and Humanities Research Council
Amount: $2.5 Million
Purpose: Research
Recipients: Bonny Ibhawoh (PI) (Ameil Joseph's role: Co-Investigator, McMaster University)
Title: Participedia Phase 2: a global network and crowdsourcing platform for researchers, educators, practitioners, and policymakers working on public participation and democratic innovations

Type: 2020 SSHRC Partnership Engage Grants (PEG) COVID-19 Special Initiative
Agency: Social Sciences and Humanities Research Council
Amount: $22228
Purpose: Research
Recipients: Diana Singh (PI) & Ameil Joseph & James Gillett (Co-Applicants)
Title: COVID-19 - Emotions Matter: Skill Building, Emotional Resilience and Social Support for Care Workers

Type: 2020 SSHRC Partnership Engage Grant (March competition)
Agency: Social Sciences and Humanities Research Council
Amount: $24984
Purpose: Research
Recipients: Ameil Joseph (PI) & the Disability Justice Network of Ontario
Title: "What happened to you?": The disablement of youth across socioeconomic indicators

Type: 2020 Mitacs Accelerate Research Grant
Agency: Mitacs
Amount: $45000
Purpose: Research
Recipients: Ameil Joseph (PI), Shaila Kumbhare (Intern), CMHA Hamilton (Agency partner)
Title: Grief, Memorials, and Loss through COVID-19: Resources for caring while physical distancing

Type: 2020 McMaster COVID-19 Research Fund
Agency: McMaster University
Amount: $29000

Purpose: Research
Recipients: Ameil Joseph (PI), CMHA Hamilton (Agency partner)
Title: Grief, Memorials, and Loss through COVID-19: Resources for caring while physical distancing

Type: 2020 McMaster Institute for Health Equity Seed Grant
Agency: McMaster Institute for Health Equity
Amount: $6000
Purpose: Research
Recipients: Ameil Joseph & Bernice Downey (Co-PIs)
Title: Hamilton Public Health Equity Data Community Advisory Research Project

Type: SSHRC Insight Grant 2018 (funded years May 15, 2018-March 31, 2021)
Agency: Social Sciences and Humanities Research Council
Amount: $70862
Purpose: Research
Recipients: Ameil Joseph
Title: The ethics and social relations of undesirability: exploring the experiences of immigration detention and deportation for Canadian immigrants with histories of mental health issues

Type: Fall 2019 SSHRC Explore – Major Collaborative Project Seed Grant
Agency: Arts Research Board, McMaster University
Amount: $9000
Purpose: Research
Recipients: Vanessa Watts (PI), Amber Dean (Co-applicant), Ameil Joseph (Co-applicant)
Title: (Re)imagining Critical Approaches to Social Justice in Higher Education

Type: 2017/2018 Scholar in Community Fellowship
Agency: Faculty of Social Sciences, McMaster University
Amount: $15000
Purpose: Research
Recipients: Ameil Joseph
Title: *Hamilton's Anti-Racism Resource Centre Foundational Research Project*

Type: Priority Areas for Learning and Teaching Research Grant, 2017
Agency: Paul R. MacPherson Institute for Leadership, Innovation & Excellence in Teaching, McMaster University
Amount: $5000
Purpose: Research (or Pedagogical Research)
Recipients: Ameil Joseph
Title: *Enhancing teaching capacity for universal design, accessibility and inclusion through a critical engagement with the confluence of mental health, madness, sanism, eugenics, ability and colonization in the classroom*

Type: Fall 2015 (now named SSHRC Explore) Standard Research and Creative & Performing Arts Grant competition,
Agency: Arts Research Board, McMaster University
Amount: $5950
Purpose: Research
Recipients: Ameil Joseph
Title*: Exploring social relations at the confluence the mental health, criminal justice, and immigration systems*

Conference and Publication Grants

Fall 2019 SSHRC Exchange - Conference Attendance and Representational Activities Grant $3957
Arts Research Board, McMaster University, Hamilton, ON
Crime, Justice and Social Harms in Oxford University, Keble College, UK.

Spring 2017 (now named SSHRC Exchange) Conference Attendance
and Representational Activities Grant competition, $1070
Arts Research Board, McMaster University, Hamilton, ON
Interrogating Social Work's Role in "Nation" Building CASWE-ACFTS 2017 Conference, Toronto, ON

Fall 2015 (now named SSHRC Exchange) Scholarly Publications Grant competition, $842
Arts Research Board, McMaster University, Hamilton, ON
Deportation and the Confluence of Violence within Forensic Mental Health and Immigration Systems

Fall 2015
(now named SSHRC Exchange) Conference Attendance
and Representational Activities Grant competition, $2,272
Arts Research Board, McMaster University, Hamilton, ON
Experiencing Prison - 7th Global Conference in Budapest, Hungary

Fall 2014
(now named SSHRC Exchange) Conference Attendance
and Representational Activities Grant competition, $1,630
Arts Research Board, McMaster University, Hamilton, ON
The International Journal of Arts & Sciences (IJAS) International Conference for Social Sciences and Humanities in Harvard university, Boston, MA

Total $943415

14. Lifetime Publications

a. *Peer Reviewed*

i) Books

Joseph, A.J. (2015). *Deportation and the confluence of violence within forensic mental health and immigration systems.* Basingstoke: Palgrave-Macmillan.

ii) Contributions to Books

Joseph, A. (2022). The said and the unsaid: Confronting Racism in Social Work as "Uncanny". In *The Routledge Handbook of International Critical Social Work* (pp. 379-388). Routledge.

Joseph, A.J. (2022). Maddening intersectionality with assemblages, conviviality and confluence for epistemic dissidence. In, LeFrançois, B & Shaikh, S. (eds). *Critical Social Work Praxis* (pp. 477-490). Fernwood Press.

Joseph, A.J. (2021). The subjects of oblivion: subalterity, sanism, and racial erasure. In Beresford, P., Russo, J., & Boxall, K. (eds). Routledge International Handbook of Mad Studies. Routledge.

Joseph, A.J., Double, D. (2020). *Critical perspectives in mental health.* In Savelli, M. Gillett, J. & Andrews, G. (eds). Introduction to Mental Health and Illness: Critical Perspectives (pp. 240-256). Oxford University Press.

Joseph, A.J. (2020). Excavating hostility and rationalizing violence through anti-immigrant confluent discourses of racial threat, risk, burden and lack. In Spivakovsky, C., Steele, L. & Weller, P. (eds). *The Legacies of Institutionalisation Disability, Law and Policy in the 'Deinstitutionalised' Community*. (pp.107-122.). Hart-Bloomsbury Publishing.

Joseph, A.J. (2019). Contemporary forms of legislative imprisonment and colonial violence in forensic mental health. In Daley, A., Costa, L., Beresford, P. (eds.). *Madness, violence and power: A radical anthology*. Toronto: UofT Press.

Joseph, A. J. (2018). Traditions of Colonial and Eugenic Violence: Immigration Detention in Canada. In Kilty, J. M., & Dej, E. (eds.). *Containing Madness: Gender and 'Psy'in Institutional Contexts* (pp. 41-65). Palgrave Macmillan, Cham.

Joseph, A.J. (2017). Making Civility: Historical Racial Exclusion Theories within Canadian Democracy. In Daenzer, P. (eds.), *Civil Society Engagement: Achieving Better in Canada*. (pp. 17-30). New York: Routledge.

Joseph, A.J., (2017). Pathologizing distress: The Colonial Master's Tools and Mental Health Services for "Newcomers/Immigrants". In Baines, D. (ed.), *Doing Anti-Oppressive Practice: Social Justice Social work*, (3rd Edition, pp. 233-251). Halifax, Canada: Fernwood.

Joseph, A.J. & Maiter, S. (2015). Post-national Belonging: Strategies of Racialized Youth in Multicultural Western Contexts. In Baffoe, M. Asimeng-Boahene, L. & Ogbuagu, B. (eds.,). *Settlers in Transition: Pathways and Roadblocks to Settlement and Citizenship of New Comers in New Homelands.* (pp.23-31). Ronkonkoma: Linus Learning.

iii) Journal Articles

Joseph, A. J. (2024). Justice and ethics from the horizons of totality and infinity: Challenging the violence of obliteration in the proposed entry to practice exams in Ontario and beyond**.** *Critical Social Work, 25(1).* ***DOI:*** *https://doi.org/10.22329/csw.v25i1.8939*

Salam, Z., Carranza, M., Newbold, B., Wahoush, O., & Joseph, A. (2024). Racialized Immigrants' Encounters of Barriers and Facilitators in Seeking Mental Healthcare Services in Ontario, Canada. *Community Mental Health Journal*, 1-12. doi: 10.1007/s10597-024-01362-8

Wilson, T. E., & Joseph, A. J. (2023). Critical temporalities in social work after 'the end of history'. *Critical and Radical Social Work*, *11*(3), 327-331. Retrieved Jan 18, 2024, from https://doi.org/10.1332/20498608Y2023D000000005

Joseph A, Bedminster T, Damptey K, Jama S, Stearns G, Brockbank M. (2023). The Restoration House COVID-19 Vaccination Clinic: Challenging Systemic Racism and Ableism through Community Solidarity and Action. Health Reform Observer - Observatoire des Réformes de Santé 11 (1): Article 6. https://doi.org/10.13162/hro-ors.v11i1.5435.

Joseph, A.J. (2021). Simulating the Other in Social Work Pedagogy: Pathologizing the oppressed through neoliberal/colonial practice teaching. *British Journal of Social Work*. https://doi.org/10.1093/bjsw/bcab048

Adjekum, S. A., & Joseph, A. J. (2021). Violence by any other name: constructing immigration crises, the threat of the sick refugee and rationalising immigration detention through moral panic. *Critical and Radical Social Work*. https://doi.org/10.1332/204986021X16355210292075

Joseph, A.J., Janes, J., Badwall, H., Almeida, S. (2019). Preserving white comfort and safety: the politics of race erasure in academe. *Social Identities: Journal for the Study of Race, Nation and Culture*. https://doi.org/10.1080/13504630.2019.1671184

Joseph, A.J. (2019) Constituting "lived experience" discourses in mental health: The ethics of racialized identification/representation and the erasure of intergeneration colonial violence. *Journal of Ethics in Mental Health. https://jemh.ca/issues/v9/documents/JEMH%20Inclusion%20i.pdf*

Tobias, H., & Joseph, A.J. (2018). Sustaining systemic racism through psychological gaslighting: Denials of racial profiling and justifications of carding by police utilizing local news media. *Race and Justice. http://journals.sagepub.com/doi/full/10.1177/2153368718760969*

Maiter, S., & Joseph, A. J. (2016). Researching racism: The colour of face value, challenges and opportunities. *British Journal of Social Work*, *47*(3), 755-772.

Joseph, A.J. (2015). Beyond intersectionalities of identity or interlocking analyses of difference: confluence and the problematic of "anti"-oppression. *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice, 4(1), 15-39.*

Joseph, A. J. (2015). The necessity of an attention to Eurocentrism and colonial technologies: an addition to critical mental health literature. *Disability & Society*, *30*(7), 1021-1041.

Lamoureaux, A., Joseph, A., (2014). Toward transformative practice: Facilitating access and barrier-free services with LGBTTIQQ2SA populations**.** *Social Work in Mental Health*, 12(3), 212-230.

Joseph, A. J. (2014). A prescription for violence: The legacy of colonization in contemporary forensic mental health and the production of difference. *Critical Criminology*, 22(2), 273-293.

Joseph, A. J. (2013). Empowering alliances in pursuit of social justice: Social workers supporting psychiatric-survivor movements. *Journal of Progressive Human Services, 24(3),* 265-288.

Maiter, S., Joseph, A., Shan, N., Saeid, A., (2013). Doing participatory qualitative research: Development of a shared critical consciousness with racial minority research advisory group members. *Qualitative Research,* 13(2)*,* 198-213.

Joseph, A. J. (2010). Advocacy in social work: Recovery-focused systems for people living with serious mental health issues. *Canadian Social Work,* 12(2)*,* 25-42.

iv) Journal Abstracts

N/A

v) Other, including Proceedings of Meetings

Joseph, A.J. (2019). Big data and social services: Public overseers of human suffering for private gain. Pp.77-87. Digitization and Challenges to Democracy, *Institute on Globalization & the Human Condition, Globalization Working Papers* 19(1). McMaster University, Hamilton, ON. https://globalization.mcmaster.ca/research/publications/working-papers/2019/working-paper-oct-2019.pdf

Joseph, A. J. (2012). Ancestries of racial and eugenic systems of violence in the mental health sector. In I. Needham, K. McKenna, M. Kingma, N. Oud (Ed.), *Third International Conference on Violence in the Health Sector, Vancouver, BC.* (pp. 234-238). The Netherlands: Kavanah. http://www.oudconsultancy.nl/Resources/Proceedings_3rd_Workplace_Violence_2012.pdf

Vaz, C., & Joseph, A.J. (2018, November). Negotiating Conflicting Understandings of Intimate Relationships: Exploring Meaning Making, Isolation and Identity in Cross Cultural Contexts for South Asian University Students. Poster session presented at the *2018 Undergraduate Student Research Award Poster Session*, McMaster University, Hamilton, ON.

b. *Not Peer Reviewed*

i) Books

N/A

ii) Contributions to Books

N/A

iii) Journal Articles

N/A

iv) Journal Abstracts

N/A

v) Other, including Proceedings of Meetings

Canadian Federal Government Policy Briefs

The Standing Senate Committee on Legal and Constitutional Affairs
RE: Bill C-7: An Act to amend the Criminal Code (medical assistance in dying)
January 27, 2021
https://sencanada.ca/content/sen/committee/432/LCJC/Briefs/Brief_AmeilJoseph_e.pdf

Standing Committee on Citizenship and Immigration
Federal Government Policies and Guidelines Regarding Medical Inadmissibility of Immigrants. Published on: Monday, November 20, 2017 to 8:32 p.m. (EST)

http://www.ourcommons.ca/Committees/en/CIMM/StudyActivity?studyActivityId=9719668

Website Creation:

Home - A Way Through (mcmaster.ca) : Grief, Memorials, and Loss through COVID-19: Resources for caring while physical distancing

Contribution to feature film/Documentary

Frost Bites 2023, The Community Impact Map: An incomplete account of Hamilton's community work. https://youtu.be/6K0VYqpEUIw?si=2POW70DjilyGzoFP

The World is Bright (Documentary film) https://www.theworldisbright.ca/impact/expert-interviews/

https://boxoffice.hotdocs.ca/websales/pages/info.aspx?evtinfo=125201~741853d5-bf72-40a5-a015-09aded779383

Contribution to Documentary Production, "The World is Bright"- "History": https://youtu.be/WIqRmchoS5I

Knowledge Exchange

Television/Live Interviews

- Reflecting on the rise of Islamophobia as Ramadan begins (chch.com) (2023, March 22). https://www.chch.com/reflecting-on-the-rise-of-islamophobia-as-ramadan-begins/
- Science table finds lower-income and racialized communities are more frequently ending up in the ICU - CHCH (2021, November 13).
- Hamilton vaccination program to prioritizes black & other racialized populations ages 18+ in hot spots, CHCH Evening News (2021, April 23). https://www.chch.com/hamilton-vaccination-program-to-prioritizes-black-other-racialized-populations-ages-18-in-hot-spots/

  Related pieces:
  - https://www.cbc.ca/news/canada/hamilton/hamilton-bipoc-vaccine-priority-1.5989119
  - 'Good public health policy': The success of vaccine clinics for Black, racialized Canadians, CTV News. https://www.ctvnews.ca/health/coronavirus/good-public-health-policy-the-success-of-vaccine-clinics-for-black-racialized-canadians-1.5416822
  - https://www.thespec.com/news/hamilton-region/2021/04/29/racist-backlash-to-hamiltons-effort-to-vaccinate-black-and-racialized-residents-condemned.html
- https://www.thespec.com/news/hamilton-region/2021/04/26/hamilton-covid-vaccines-latest-news.html
- White Supremacy in Hamilton. The O Show, Cable 14 (2021, January 12). https://cable14now.com/video-on-demand/video/?videoId=5591
- COVID-19 Stay-at-home order, policing. CHCH evening news (2021, January 13). https://www.chch.com/news/evening-news/
- Sir John A. Macdonald statue in Hamilton vandalized. CHCH (2020, November 9). https://www.chch.com/sir-john-a-macdonald-statue-in-hamilton-vandalized/
- What is Antifa? CTV Newsday (2020, June 1). https://link.quibi.com/PGRFjSUCZ6
- Group urging council to reverse decision to take over setting up anti-racism centre. CBC. (2019, December 11). https://www.cbc.ca/news/canada/hamilton/harrc-1.5391472

- Hate speech and Anti-Racism in Hamilton. *Vital Signs,* Cable 14. (2019, October 9). https://www.cable14.com/tv-shows/vital-signs
- Hate in Hamilton. *The O Show*, Cable 14. (2019, September 17). https://www.cable14.com/tv-shows/o-show-the
- Hate in Hamilton: what went wrong and how we make it right. *CBC*. (2019, August 7). https://www.cbc.ca/news/canada/hamilton/hamilton-hate-live-1.5218029
- Diversity and Representation. *City Matters*, Cable 14. (2019, April 10). https://cable14now.com/video-on-demand/video/?videoId=4271
- Diversity advocates call recently appointed member to Hamilton Police Board a missed opportunity. *CHCH evening news* (2019, April 6). https://www.chch.com/diversity-advocates-call-recently-appointed-member-to-hamilton-police-board-a-missed-opportunity/
- Stoney Creek hate crime exemplifies disturbing trends in racism. *CHCH evening news* (2018, July 29). http://www.chch.com/stoney-creek-hate-crime-exemplifies-disturbing-trends-racism/
- What you need to know about political extremism in 2017, Your Morning with Ben Mulroney, *CTV* (2017, February 15) http://www.ctvnews.ca/politics/is-antifa-activism-a-necessary-answer-to-the-alt-right-1.3327449
- Race and Identity, The Morning Show, *Global T.V. National* (2015, June 16). http://globalnews.ca/video/2057575/race-and-identity-interview-with-ameil-joseph/

Radio Interviews

- CBC Radio-Canada (2023, Sept. 20) Hamilton's Homeless Encampments: Report by Julie-Anne Lamoureux. Catch-up: Protests and counter-protests on gender identity in Canada, and Volodymyr Zelensky at the UN Security Council (radio-canada.ca)
- CBC Radio, Ontario Today -(2022, May 18): The racist ideas behind the Buffalo shooting: Are you confronting them? https://www.cbc.ca/listen/live-radio/1-45/clip/15913452
- Globalnews, 640 Toronto, Toronto Today with Greg Brady (2022, Nov. 2) Worker's rights https://cms.megaphone.fm/channel/CORU7809549774?selected=CORU5881817303
- CBC Radio. Ontario today with Rita Celli. (2020, June 17). Renaming Dundas Street: Is it a way to right a wrong? https://www.cbc.ca/listen/live-radio/1-45-ontario-today/clip/15782717-renaming-dundas-street-is-it-a-way-to-right-a-wrong
- AM900 CHML/Global News, the Bill Kelly Show. (2020, June 11). Calls for police to be defunded, Petition to rename Dundas St. & Liberal government did not get support to update rules on CERB. https://omny.fm/shows/bill-kelly-show/the-bill-kelly-show-podcast-calls-for-police-to-be?t=17m33s
- AM900 CHML/Global News, the Bill Kelly Show. (2019, December 11). McMaster's Ameil Joseph talks about the city's decision to take over the Hamilton Anti-Racism Resource Centre (HARRC). https://globalnews.ca/news/6282905/city-takes-over-hamilton-anti-racism-resource-centre/
- AM900 CHML/Global News, the Bill Kelly Show. (2019, September 19). Three instances of Justin Trudeau in brownface have emerged. https://www.iheart.com/podcast/256-bill-kelly-show-31080203/episode/three-instances-of-justin-trudeau-in-49416209/
- Newstalk 1010 Moore in the Morning. (2018, September 30). The Rise of Hate. http://www.iheartradio.ca/newstalk-1010/audio/the-rise-of-hate-1.8470727?mode=Article&autoplay=1.8470727
- AM900 Radio Interview with Anthony Urciuoli (2016, November 26). Anti-Racism Action Initiative https://omny.fm/shows/anthony-urciuoli-show/disappointing-ticket-sales-for-the-grey-cup-game-m?t=29m31s

- 60 Seconds with Ameil Joseph PACBIC (President's Advisory Committee on Building Inclusive Community) (2016, November 8), Morningfile, CFMU 93.3 https://www.youtube.com/watch?v=mW-BMRylrQI

Magazine Articles:

- Joseph, A.J. & Briarpatch Staff (2022). Migration has Always been a Disability Justice Issue. Briarpatch Magazine. https://briarpatchmagazine.com/articles/view/migration-has-always-been-a-disability-justice-issue
- Joseph, A.J. (2022). The integrity of McMaster University is at stake in the CUPE 3906 strike. Spring Magazine. https://springmag.ca/the-integrity-of-mcmaster-university-is-at-stake-in-the-cupe-3906-strike
- Joseph, A.J. & Kumbhare, S. (2022) Mental health, grief, loss, and bereavement through COVID-19. Academic Matters. https://academicmatters.ca/mental-health-grief-loss-and-bereavement-through-covid-19/
- Joseph, A.J., (2020). Equity data as an ethical necessity: Understanding the viral confluence of injustice through COVID-19. *Canadian Dimension*. https://canadiandimension.com/articles/view/equity-data-as-an-ethical-necessity-understanding-the-viral-confluence-of-injustice-through-covid-19
- Joseph, A.J., (2016). Putting alt-Right's Racism in Context. *Our-Times: Canada's Independent Labour Magazine*. http://ourtimes.ca/Between_Times/article_513.php

Newspaper Articles:

- El-Dakhakhni, W., Haddara, Y., Joseph, A., & Palestine, F. 4 M. (2024, May 30). *Dear mcmaster: Encampment students are your "Brighter world."* The Hamilton Spectator. https://www.thespec.com/opinion/contributors/dear-mcmaster-encampment-students-are-your-brighter-world/article_18db82aa-4852-508e-881f-6ea1453254f7.html
- Joseph, A. J., & Adjekum, S. (2023, November 14). *Israel's war against civilians is not self-defence*. The Hamilton Spectator. https://www.thespec.com/opinion/contributors/israel-s-war-against-civilians-is-not-self-defence/article_4c6fde8c-3610-5bd3-8c4b-0ecaddb0d526.html
- Adjekum, S., & Joseph, A. J. (2023, October 27). *Canada once recognized the humanity of Palestinians and it can do so again*. The Hamilton Spectator. https://www.thespec.com/opinion/contributors/canada-once-recognized-the-humanity-of-palestinians-and-it-can-do-so-again/article_87d74932-c695-5893-b99e-c59db6c074dc.html?utm_source=twitter&utm_medium=social&utm_campaign&utm_content=ap_8uj92liy7q
- Joseph, A. J. (2023, March 27). *Student protest should cause McMaster to reconsider divestment*. The Hamilton Spectator. https://www.thespec.com/opinion/contributors/student-protest-should-cause-mcmaster-to-reconsider-divestment/article_70e44bc4-e310-5eb7-80d4-0213f618d4b5.html
- Joseph, A., & Adjekum, S. (2023, February 17). *Another Hamilton is possible*. The Hamilton Spectator. https://www.thespec.com/opinion/contributors/another-hamilton-is-possible/article_c0223c76-98c8-562d-a804-7193b303e029.html
- Robson, K. & Joseph, A.J. (2022). McMaster Faculty Members Need to Unionize. https://www.thespec.com/opinion/contributors/2022/12/02/mcmaster-faculty-members-need-to-unionize.html
- Joseph, A.J. (2022, May 5). A Way to End Hatred in Hamilton. Hamilton Spectator. https://www.thespec.com/opinion/contributors/2022/05/05/a-way-to-end-hatred-in-hamilton.html

- Joseph, A.J., Jama, S. & Linton, M. (2022, January 23). Our long-term care system must be dismantled | TheSpec.com
- Joseph, A.J. (2021, December 3). Misusing the language of safety and social justice | TheSpec.com
- Joseph, A.J., Damptey, K. (2021, June 7). It's time to be honest about racism in Hamilton | TheSpec.com
- Joseph, A.J. (2020, October 18). Systemic injustices, policing, and mental health. Hamilton Spectator. https://www.thespec.com/opinion/contributors/2020/10/18/systemic-injustices-policing-and-mental-health.html
- Joseph, A.J. (2020, September 27). Hamilton police not mental health professionals. Hamilton Spectator. https://www.thespec.com/opinion/contributors/2020/09/27/hamilton-police-not-mental-health-professionals.html
- Joseph, A.J., (2020, June 15). How Much More Do You Need to See: Black Lives Matter. Hamilton Spectator. https://www.thespec.com/opinion/contributors/2020/06/15/how-much-more-do-you-need-to-see-black-lives-matter.html
- Joseph, A.J., (2019, April 12). Police board ignores city's promises of inclusion and diversity with latest appointment. *Hamilton Spectator*. https://www.thespec.com/opinion-story/9281084-police-board-ignores-city-s-promises-of-inclusion-and-diversity-with-latest-appointment/
- Joseph, A.J., (2016, December 30). Hamilton Police Still not Getting it On Racism. *Hamilton Spectator*. http://m.thespec.com/opinion-story/7041880-hamilton-police-still-not-getting-it-on-racism
- Joseph, A.J. (2014, November 14). *ARRC more than a 'hotline': Centre will be step toward equity, social justice and preventing racial tension*. Hamilton Spectator, Retrieved December 10, 2014 from http://www.thespec.com/opinion-story/5013061-arrc-more-than-a-hotline-/

Online Publications

- Joseph, A., & Stearns, G. (2023, July 21). *Why Hamilton's encampment consultations can - and should - be different, say advocates | CBC News*. CBCnews. https://www.cbc.ca/news/canada/hamilton/encampment-plan-question-answer-response-1.6902080
- Stearns, G., & Joseph, A. (2023, July 10). *Sanctioned encampment sites a slippery path*. The Hamilton Spectator. https://www.thespec.com/opinion/contributors/sanctioned-encampment-sites-a-slippery-path/article_58175ecf-8481-5fc6-b271-69fe1e43f66c.html
- Joseph, A.J. (2022). Labour negotiations can't be in 'good faith' without acknowledging the cruelties workers face. CBC NEWS. https://www.cbc.ca/news/canada/hamilton/labour-talks-in-good-faith-1.6659193
- Joseph, A.J., Daniel, J., Ibhawoh, B., Deen, J., Coleman, D., Abebe, A., Ogunkoya, F., Kapiriri, L. (2021). Beyond cohorts and clusters: redressing systemic anti-Blackness in higher education — University Affairs
- Joseph, A.J., (2021). Expanding MAiD could worsen discrimination against people with disabilities. https://ipolitics.ca/2021/02/19/expanding-maid-could-worsen-discrimination-against-people-with-disabilities/
- African & Caribbean Faculty Association of McMaster (2020) https://dailynews.mcmaster.ca/articles/statement-on-the-killing-of-george-floyd-and-racial-justice/ (writer 95%)
- Joseph, A.J., (2018). Erasing race but not racism in the Peter Khill trial. The Conversation. http://theconversation.com/erasing-race-but-not-racism-in-the-peter-khill-trial-99337 also published on CBC, https://www.cbc.ca/news/canada/hamilton/erasing-race-but-not-racism-in-the-peter-khill-trial-1.4736894

- Joseph, A. J., (2017). We must speak out against racism. *University Affairs/Affaires Universitaires*. https://www.universityaffairs.ca/opinion/in-my-opinion/must-speak-racism/
- Joseph, A.J. (2015) Speaking voice into the silence and naming the deception of "hoaxes": Islamophobia and other forms of racism at McMaster University. PACBIC Dialogues. https://pacbic.mcmaster.ca/documents/PACBICAmeilSpeakingvoiceintothesilence12112015.pdf
- Joseph, A.J. (2015). Food justice or/= Social justice? Systemic exclusion and discrimination: Do we respond by raising issues of access and equity or advocate for transformation. *PACBIC Dialogues*. https://pacbic.mcmaster.ca/documents/PACBICAmeilFoodJusticeorSocialJustice.pdf

c. *Accepted for Publication (in final form)*

d. *Submitted for Publication*

Joseph, A.J., Niles, C., Vaz, C., Gooding, W., Millard, B. (Under Review). Frozen, invisible, indefinite: Immigration detention in Canada and the carceral violence of temporal torment. *Journal of Human Rights and Social Work*

e. *Unpublished Documents*

Joseph, A.J. (2019). Hamilton Anti-Racism Resource Centre, Findings and Analysis report 2018-2019. (32 pages)

Joseph, A.J. (2019). McMaster's President's Advisory Committee on Building an Inclusive Community - 2018 (annual report, 19 pages)

Joseph, A.J. (2018). McMaster's President's Advisory Committee on Building an Inclusive Community - 2017 (annual report, 21 pages)

Joseph, A.J. (2017). McMaster's President's Advisory Committee on Building an Inclusive Community - 2016 (annual report, 19 pages)

15. Presentations at Meetings

a. Invited

Joseph, A.J. (2024, February 28). Equitable Vaccine Access: Bridging Gaps for Health Equity. Ontario Public Health Association, Harnessing Perspectives Conference, Online.

Joseph, A.J. (2023, December 8). The Restoration House Clinic. Emerging lessons from health systems policies and reforms during COVID-19. Institute for Pandemics, University of Toronto, Toronto, ON

Joseph, A.J. (2023, November 13). Systemic and structural problems require systemic and structural analyses and solutions. Hamilton Anti-Racism Resource Centre Press Conference on Hamilton Board of Health Reform. Hamilton City Hall, Hamilton, ON.

Joseph, A.J. (2023, November 2). Defying Systemic Racism and Hate: Building Community Solidarity for Knowledge Sharing, Mutual Aid and Action for the Future. Future of Canada Symposium. McMaster University, Hamilton, ON.

Joseph, A.J. (2023, June 22). The Wielding of Racial Tropes of Dangerousness in Police Use of Force Analyses. Hamilton City Hall, Hamilton, ON.

Joseph, A.J. (2023, May 8). We Support Hamilton, A history of community advocacy and action to challenge hate. Hamilton City Hall. WeSupportHamilton.ca Launch Event. Hamilton, ON.

Joseph, A,J, (2023, March 3). Racial discrimination and bias in context in the ASWB exam data. ASWB Teach-In. School of Social Work, McMaster University, Hamilton, ON.

Joseph, A.J. (2023, March 1). The Necropolitical and Thanatopolitical. MAiD (Medical Assistance in Dying), social inequalities and structural vulnerabilities: why it matters. Rady Faculty of Health Sciences, University of Manitoba, Winnipeg, MB. https://youtu.be/UHmCyFBhp6s?si=3-HN-CiU6aYfSj8g

Joseph, A.J. (2022, January 12). Race, Racism, Racialization and Colonialism: The Context for Governance in Education. HWDSB, Board of Trustees, Hamilton, ON

Joseph, A.J. (2021, December 16). Confronting and Defying Racism in Mental Health. Mental Health and Addiction Program Rounds, St. Joseph's Healthcare, Hamilton, ON.

Joseph, A.J. (2021, September 23). Understanding Inequity in Healthcare Education. Re*Think* Clinical Reasoning Conference. Faculty of Health Sciences, McMaster University. *https://youtu.be/nG8d8CJNAWE*

Joseph, A.J. (2021, October 28). Thinking Respectfully about Identity and Difference (3-hour workshop). Faculty of Health Science, Equity Advocacy and Allyship Program.

Joseph, A.J. (2021, October 26; 2021, November 17; 2022, January 11; 2023, January 10). *Racism in Healthcare: Are we talking about the same things?* Anti-Black Racism and Black Exclusion in Medicine Professional Competencies Curriculum, McMaster MD Program, McMaster University.

Joseph, A.J. (2021, October 21). *Racism, Race, and Racialization in Healthcare & Emergency Medicine*. FRCPC, Emergency Medicine Residency Program, McMaster University

Joseph, A.J. (2021, June 23). *Compositional Diversity and Community.* Hamilton Health Sciences, President's Equity Diversity and Inclusion Advisory Council, Hamilton, ON

Joseph, A.J. (2021, June 14). *Professional Practice, Education, and Research.* Hamilton Health Sciences, President's Equity Diversity and Inclusion Advisory Council, Hamilton, ON

Joseph, A.J. (2021, June 13). *White supremacy, Critical Race Theory and Wokeness*. The Communal with Kojo Damptey, Hamilton, ON. https://www.youtube.com/watch?v=s1RWhKUjuoo&t=3s

Joseph, A.J. (2021, June 11). *System Interaction and Culture.* Hamilton Health Sciences, President's Equity Diversity and Inclusion Advisory Council, Hamilton, ON

Joseph, A.J. (2021, June 9). *Equity through Organizational Commitment and Integration.* Hamilton Health Sciences, President's Equity Diversity and Inclusion Advisory Council, Hamilton, ON

Joseph, A.J. (2021, May 19). *Equity, Diversity, and Inclusion in Healthcare: Are we talking about the same thing?* Hamilton Health Sciences, President's Equity Diversity and Inclusion Advisory Council, Hamilton, ON

Joseph, A.J. (2019, November 29). Responding to hate in Hamilton. CityLab, McMaster University, Hamilton, ON.

Joseph, A.J. (2019, November 28). The erasure of experience and the subjects of oblivion: speaking back to the obliviousness of whiteness. *Let's Talk About Race!*, McMaster University, Hamilton, ON.

Joseph, A.J. (2019, September 28). Navigating racial issues in healthcare. *6th Annual Canadian Haemoglobinopathy Conference*, The Canadian Haemaglobinopathy Association, Hamilton, ON.

Joseph, A.J. (2019, May 23). The subjects of oblivion: subalterity and contemporary technologies of transnational eugenics, sanism, and racial eradication. *Southwestern Ontario Disability Scholars Workshop*, Windsor Law, University of Windsor, Windsor, ON.

Joseph, A.J. (2019, May 8). Confronting and Challenging racism in Healthcare: The Ethical Necessity of anti-Racism for Practice. *Ethics and Diversity Grand Rounds*, Hamilton Health Sciences, Hamilton ON.

Joseph, A.J. (2019, February 15). Dismantling Racism in Hamilton. *Vital Signs*, Hamilton Community Foundation. Mulberry Café, Hamilton, ON, https://youtu.be/trJvha3rRv8

Joseph, A.J. (2018, November 29). Freedom of Speech and Race. *Let's Talk About Race!*, McMaster University, Hamilton, ON.

Joseph, A.J. (2018, November 10). Criminalization and Racialization of Poverty and Mental Health. *Town of Ajax 3rd Annual Diversity Conference*, Ajax Convention Centre, Ajax, ON.

Joseph, A.J. (2018, September 15). Big data and social services: Public overseers of human suffering for private gain. *Digital Democracy: Transformations and Public Contestations***.** Institute on Globalization and the Human Condition, McMaster University, Hamilton, ON.

Joseph, A.J. (2018, April 11). From the insidious to the brazen: Realities of racism and resistance *The Trump Talks: Free Public Lecture Series*, McMaster Centre for Continuing Education, Hamilton, ON

Joseph, A.J. (2017, October 24). Overseers of Violence: Big Data & the Role of the Social Worker. *Legacies of Social Welfare Work in Canada Conference*. Wilfrid Laurier University, Brantford, ON**.**

Joseph, A.J. (2016, November 25). Respecting the Histories of Anti-racist Activism in Hamilton: Working towards collective action together. *Anti-Racism Action Initiative Community Meeting*. Hamilton Central Public Library, Hamilton, ON.

Joseph, A.J. (2016, March 9). The criminalization/racialization of poverty. *The Criminalization of Poverty - Race, Poverty, and Policing in Hamilton Event*, McMaster Community Poverty Initiative**.** McMaster University, Hamilton, ON

Joseph, A.J. (2016, January 19). Food justice is social justice: beyond the food security talk. *Feeding Our Faiths 2016,* McMaster Students Union Diversity Services, Interfaith Committee. McMaster University, Hamilton, ON

Invited Keynotes/Plenaries

Ali, H., Umaigba, B., Rashid, M., Joseph, A.J., Uppal, M., Arya, N. (2024, May10). A Changing Landscape - Increased urgency to respond to the needs of Black and Refugee populations - the time is now! *Symposium: Refugee Health, Black Health and Social Services*, Advancing Health Equity for Communities Made Marginalized. (Plenary Panel). David Braley Health Sciences, McMaster University, Hamilton, ON.

Joseph, A.J. (2023, June 9). Equitable Community Compensation. Community Based Research Canada. Waterloo, ON

Joseph, A.J. (2023, February 2). *Health Equity Advocacy Through Community Mobilization & Solidarity. Community-Based Research Canada, Moving the Dial. https://youtu.be/jXltlMfnfhM*

Joseph, A.J. (2022, June 8). Data and Justice: Mobilizing Solidarities for Action. Action Now-Building Equitable Futures Together: Primary Health Conference. Alliance for Healthier Communities, Delta Hotels by Marriot Toronto Airport and Conference Centre. Toronto, ON

Joseph, A.J. (2022, February 16). Challenging Systemic Racism for Health Equity in Hamilton: Mobilizing Solidarities for Action. McMaster Institute for Health Equity, McMaster University. https://youtu.be/bWai1Prl0ms

Joseph, A.J. (2022, February 17). Confronting and Resisting Racism in Mental Health & Pediatrics. Department of Pediatrics, Grand Rounds, Faculty of Health Sciences, McMaster University. https://www.macvideo.ca/media/Bridging+the+GapA+Confronting+and+Resisting+Racism+in+Mental+Health+%7C+Dr.+Ameil+Joseph+%7C+February+17%2C+2022/1_5mojt3dg

Joseph, A.J., Bedminster, T, Jama, S, Frketich, J. (2021, December 2). *Community Responses to #COVID-19 in Hamilton*. Hamilton Centre for Civic Inclusion, 2020/21 Annual General Meeting. Hamilton, ON

Joseph, A.J. (2021, November 16). *Affordable housing, accessible housing, not-for-profit housing-acknowledging complicities and histories of exclusion*. 2021 Housing Central Conference, BC Not-For-Profit Housing Association. Vancouver, BC.

Joseph, A.J. (2021, June 16). *Courageous solidarities: Listening and supporting the most marginalized in the struggle for a better Hamilton*. Hamilton Community Foundation, Annual General Meeting, Hamilton, ON

Joseph, A.J. (2021, February 10). Beyond the Individual: Confronting and Challenging Racism in Health and Mental Health. Department of Psychiatry and Behavioural Neurosciences, McMaster University, Hamilton, ON, https://youtu.be/LV5hk7A83aM

Joseph, A.J. (2020, October 23). Race & racism in 2020 and beyond: Confronting individual, systemic, and structural complicities for transformative change. *Anti-Racism Day*, Ministry of Economic Development, Job Creation and Trade, Business Partnerships and Programs Division, Toronto, ON.

Joseph, A.J. (2020, September 10). Appreciating Individual, Systemic, and Structural Inequities in Local, Current and Historical Contexts for Change. City of Hamilton, Mayor's Task Force on Economic Recovery. Hamilton, ON.

Joseph, A.J. (2020, September 3). Defunding Harm and Violence. Defunding the Police-Community Teach-in. City of Hamilton, City Hall Forecourt, Hamilton, ON.

Joseph, A.J. (2020, June 24). Defying Racism in Hamilton. *Hamilton Anti-Racism Conference*, Hamilton Center for Civic Inclusion, Hamilton, ON. https://youtu.be/Lf1zOaZJyss

Joseph, A.J. (2019, September 26). Race and racism in Hamilton. *Hamilton Urban Core Community Health Centre, Annual General Meeting*. Hamilton, ON

Joseph, A.J. (2015, May 8). The untreatable mentally ill, the unrehabilitatable criminal and the undeserving alien: Contemporary eugenic and racial technologies of violence at the confluence of forensic mental health and immigration systems. *8th Annual Social Work Research Symposium: Interdisciplinary Conversations on Social Transformation and Critical Practices.* York University, Toronto, ON.

Joseph, A.J. (2014, November 25). Violent interventions: Neo-colonization in contemporary forensic mental health and the (re)production of difference. *UN International Day of Person with Disabilities Lecture, Office of human rights and equity services*, MACCESSIBILITY program, McMaster University, Hamilton, ON.

Invited Panelist

Shail, M., Ahmed, I, Caid, N, Joseph, A.J. (2024, April 18.). Learning from approaches to community engagement and equity initiatives to foster trust in health systems. 2024 Interdisciplinary Symposium, Institute for Pandemics, University of Toronto. https://youtu.be/wtoahxDx6yM

Joseph, A.J. Sekha, S. (2022, October 22). Building Just Communities: Abolition work across carceral domains touching on the work of clinics. Parkdale Community Legal Services at 50: Defining our Future, Symposium. Toronto, ON

He, B., Joseph, A.J., Anciano, F., Warren, M., Montambeault, F. (2022, June 10). Democracy in Times of Crisis: Reflection and Action in Participedia Research. Participedia Partners Conference 2022, McMaster University, Hamilton, ON.

Wilks, A, Joseph, A.J., Kumbhare, S., Suart, C. (2022, June 1). Reframing Disability in Healthcare. Faculty of Heath Sciences, McMaster University, Hamilton, ON.

D'Souza, R. Joseph, A.J., Marshall, L-J, Loen, M. (2022, May 27). The Vax Scene: Understanding Factor in Vaccine Uptake. Canada's Global Nexus for Pandemics and Biological Threats. McMaster University, Hamilton, ON

Joseph, A.J., Damptey, K., Walker, J. (2022, March 25). Data, equity, and justice: respecting relationships for health equity. Greater Hamilton Health Network, Hamilton Centre for Civic Inclusion, Indigenous Health Leaning Lodge, McMaster Office of Community Engagement, Hamilton, ON. https://www.youtube.com/watch?v=NC5zeLJbCaY

Joseph, A.J., Jama, S., Linton, M., Clutterbuck, P., Martin, K. (2022, March 10). Town Hall on changes Needed in Home Care and Community Care. Disability Justice Network of Ontario, Seniors for Social Action, Social Planning and Research Council of Hamilton, Hamilton, ON. Virtual Town Hall on Home Care, Elder Care and Community Care - March 10, 6 to 8 PM (djno.ca)

Joseph, A.J., Peters, G., Hawes, S., Ward, K, Theriault, A. (2021, November 16). Disability & Accessibility Panel. 2021 Housing Central Conference, BC Not-For-Profit Housing Association. Vancouver, BC.

Lepofsky, D., McMeekin, G. and Joseph, A.J. (2021, October 28). Disability Justice, Accessibility and Beyond. Access to Justice Week, Faculty of Law, University of Alberta, Alberta. https://www.albertaaccesstojustice.com/blog/disability-justice-resources

Joseph, A.J., McCradden, M., Singh, D. (2021, October 27). Addressing Inequities in AI and Technology as Clinicians and Researchers. The Hospital for Sick Children. Fifth annual Department of Paediatrics and Faculty of Medicine, We All Belong: Equity and Data Justice for Precision Health and Research. Toronto, ON. http://www.cvent.com/events/we-all-belong-equity-and-data-justice-for-precision-health-and-research/agenda-499720ce21824c0d829adbf31ce32437.aspx

Joseph, A.J., Elghawaby, A., Hashim, M., & Narro-Pérez, R. (2021, August 3). Responding to Hate in Hamilton. Hamilton Centre for Civic Inclusion, Hamilton, ON. https://www.youtube.com/watch?v=aWMB09W8P5g&t=3s

Disability Justice Network of Ontario. (2021, June 30). Abolish The Psych Ward Panel featuring Dr. Ameil Joseph and Dr. Syrus Marcus Ware (djno.ca)

Art Gallery of Hamilton (2021, May 20). Esmaa Mohamoud Exhibit, Play in the Face of Certain Defeat. https://www.artgalleryofhamilton.com/program/free-thursdays-esmaa-mohamoud-panel-talk/

GritLit Festival (2021, April 17). No Place Like Home: Issues Around Homelessness, Hamilton Ontario

Joseph, A.J., (2020, November 17) Racism in Healthcare: Are we talking about the same things? Anti-Black Racism and Black Exclusion in Medicine, Professional Competencies Curriculum, McMaster MD Program, McMaster University.

From Stories to Action: Addressing Anti-Black Racism in Healthcare. (2020, October 1). Chair's Grand Rounds, Hamilton Health Sciences, Department of Medicine, McMaster University, Hamilton, ON.

Resistance in Academia. (2019, January 31). *Diversity Week Panel*, Diversity Services, McMaster Student Union, McMaster University, Hamilton, ON.

Psychiatric Detention: Problem in Policy & Practice. (2019, March 15). *Detained: From supporting Prisoners to Abolishing Prisons. Journal of Law and Social Policy*, Osgoode Hall Law School, York University, Toronto, ON.

Immigration detention in Canada: A historical confluence of gendered ideas of the dangerous, the racialized, the immigrant, the biologically mad threat. (2017, December 5). *Research Forum on Immigration, Borders, and Social Justice.* McMaster University, Hamilton, ON

Mental health and gender violence. (2017, March 30). *Decolonize and Deconstruct*

Imagining new approaches to sexuality and consent education. Brock University, St. Catharines, ON

Decolonizing leadership. (2017, March 29). *Leadership Panel - Diversity/Respect/Bias- Strategic Leaders Program*, McMaster University, Ron Joyce Centre, Burlington, ON.

Critical Race/Decolonial Perspectives for Social Justice Practice. (2017, January 27). *Senior Leadership Panel on Anti-Oppressive Practice in Ontario's Child Welfare Field*. The Catholic Children's Aid Society of Hamilton, Hamilton, ON

Crimes against Humanity, the International Criminal Court and the Rome Statute: Reflecting on Resistance to Historical Technologies of Hatred at State levels. (2016, November 16). *Making History Now: Racism, Resistance and Strategies for Building Alliance in the World of Trump*. McMaster University, Hamilton, ON

Hamilton Living Together Symposium (2016, March 29). *Canadian Race Relations Foundation*, Art Gallery of Hamilton, Hamilton, ON

b. Contributed

i) Peer reviewed

Joseph, A. (2024, July 23). Colonial Cyborg Carceralities of Decomposition: Immigration Detention in Canada. XXXVIIIth *International Congress on Law and Mental Health*, International Academy of Law and Mental Health. Faculty of Law, University of Barcelona, Barcelona, Spain,

Joseph, A. (2024, June 19). Challenging the violence of obliteration in the proposed entry to practice exams in Ontario and beyond. Canadian Association for Social Work Education (CASWE-ACFTS) 2023 Conference, University of Montreal, Montreal, QC.

Bent-Womack, C., Satia, A., Khan, M. S., Ma, J., Salih, A., Esemu-Ezewu, J., Rukh-E-Qamar, H., Huang, X., Maradiaga Rivas, V., Joseph, A., & Gabel., C. (2024, June). *Dismantling white supremacy through anti-racist and decolonial pedagogies.* Paper presentation. 2024 STLHE Annual Conference, Society for Teaching and Learning in Higher Education, Niagara Falls, ON, Canada.

Ma, J., Joseph, A.J., Satia, A. Maimuna S. Khan, M., Huang, X., Rivas, V. (2023, November 10). Post-secondary education's capacity for dismantling White supremacy through anti-racist and decolonial pedagogies. XII Decolonizing Conference: Speaking Out & Speaking Up in Fugitive Spaces. OISE, University of Toronto, Toronto, ON

Joseph, A.J. (2023, August 25). Beyond the prison industrial complex: Colonial cyborg carceralities, and the technologies of decomposition. International Consortium for Social Development 2023 Biennial Conference, University of Gävle, Gävle, Sweden.

Joseph, A.J. (2023, August 24) Mobilizing solidarities for health equity: Challenging systemic racism through COVID-19. International Consortium for Social Development 2023 Biennial Conference, University of Gävle, Gävle, Sweden.

Joseph, A.J. (2023, June 1). Racial Injustice: Entry-to-Practice Examination for New Social Work Graduates Conversation Circle. Canadian Association for Social Work Education (CASWE-ACFTS) 2023 Conference, York University, Toronto, ON.

Joseph, A.J. (2023, May 31). Beyond the prison industrial complex: Colonial cyborg carceralities, and the technologies of decomposition. Canadian Association for Social Work Education (CASWE-ACFTS) 2023 Conference, York University, Toronto, ON.

Joseph, A.J. (2023, May 31). Critical Social Praxis: Transformation, Justice and Abolition. Canadian Association for Social Work Education (CASWE-ACFTS) 2023 Conference, York University, Toronto, ON.

Joseph, A.J. (2023, May 31). Remembering Amy Rossiter: Unsettling Social Work. Canadian Association for Social Work Education (CASWE-ACFTS) 2023 Conference, York University, Toronto, ON.

Watts, V., Joseph, A.J., Dean, A., (2022, October 21). Against the Corporatization of EDI and Reconciliation: Reimagining social justice approaches for another university, now. Another University, Now, Canadian Association of Cultural Studies / Association Canadienne des Études Culturelles Annual Conference, University of Toronto, Toronto, ON.

Joseph, A.J. (2022, October 17). Challenging Systemic Racism for Health Equity: Mobilizing Solidarities for Change Through COVID-19. 7th International Conference on Global Public Health 2022, Bali, Indonesia

Joseph, A.J. & Kumbhare, S. (2021, December 10). Grief, Memorials, and Loss through COVID-19: Resources for caring while physical distancing. World Pandemic Research Network Conference. Grief, Memorials, and Loss through COVID-19: Resources for caring while physical distancing (wprn.org)

Joseph, A.J. (2021, June 2). Occidental appropriations of resistance to systemic racism: The erosion of Anti-Racism work & the maintenance of white supremacy. 2021 Canadian Association of Social Work Education, University of Alberta, Alberta, Canada.

Joseph, A.J., Vaz, C., Millard, B., William Gooding, W., & Niles, C. (2020, April 1 -paper written but not presented due to cancellation/COVID-19). Frozen, invisible, indefinite: Immigration detention in Canada and the carceral violence of temporal torment. *Crime, Justice and Social Harms*, Howard League for Penal Reform, Oxford University, Keble College, UK

Joseph, A.J. (2019, July 25). Tradition of Colonial and Eugenic Violence: Immigration Detention in Canada. *XXXVI International Congress on Law and Mental Health*, International Academy of Law and Mental Health, University of International Studies of Rome, Rome, Italy.

Joseph, A.J. (2019, April 29). Invocations of historical colonial, racial, ableist, sanist tropes in contemporary anti-immigration discourse. *Mobilities and Transnationalism in the 21st Century*, University of Iceland, Reykjavik, Iceland.

Joseph, A. J. (2018, June 21). Historical and contemporary uses of immigration detention by the mental health system in Canada: Racist, sanist, and eugenic violence in policy and practice. *Disability and (Virtual) lnstitutions: lnterventions, lntegration and lnclusion*, International Institute for the Sociology of Law, Onati, Spain.

Joseph, A. J. (2018, March 2). Immigration detention in Canada: Constituting ideas of "the threat" and "the Canadian public" through racism, sanism and colonial eugenics. *2018 Canadian Association of Cultural Studies: Carceral Cultures Conference*, Simon Fraser University (Downtown), Vancouver, B.C.

Joseph, A., O'Connell, A., Gibson, M., Chapman, C., Good, B., Chambon, A. (2017, May 30). Panel on Critical History as Social Work Practice 1: Epistemic Interventions through Decolonization, *2017 Canadian Association of Social Work Education Annual Conference,* Ryerson University, Toronto, ON.

Baines, D., Freeman, B., Pon, G., Phillips, D., Clarke, J., Abdillahi, I., Hulko, W., Brotman, S., Ferrer, I., Carter, I., Hanes, R., MacDonald, J., Joseph, A., Barnoff, L., Brown, C., Massaquoi, N., and LaRose, T. (2017, June 1). Panel on Doing Anti-Oppressive Practice: Social Justice Social Work. *2017 Canadian Association of Social Work Education Annual Conference,* Ryerson University, Toronto, ON.

Singh, N., Wahoush, O., Joseph, A.J. (2016, June, 23). Conceptions of Mental Health Within the Punjabi Sikh Diaspora Community in Ottawa, Ontario. *Mental Health and Cultural Diversity International Conference: Exploring Transformative Practices and Service Models.*.De Montfort University, Leicester

Joseph, A.J. (2016, March, 17). Imprisoning the mind and the body: Contemporary forms of legislative imprisonment and colonial violence in forensic mental health. *Experiencing Prison 7th Global Conference*. Inter-Disciplinary.Net., Hilton Hotel Castle District, Budapest Hungary.

Joseph, A.J. (2015 May, 28). Tracing contemporary eugenic and racial colonial technologies of dehumanization at the confluence of mental health, criminal justice and immigration systems. Presented at the *International Journal of Arts & Sciences International Conference for Social sciences and Humanities.* Harvard University, Boston, MA.

Joseph, A.J. (2014, November 3). Theorising violence at the confluence of mental health, criminal justice and immigration systems in Canada. Presented at: *6th Global Conference, Strangers, Aliens and Foreigners*, Inter-Disciplinary.net, Prague, Czech Republic.

Joseph, A.J. (2014, March 15). Civilizing disobedience: Contemporary colonization and the regulation of immigrants and indigenous people with mental health issues. Presented at: *Fourth International Conference on Health, Wellness and Society,* University of British Columbia, Vancouver, BC.

Joseph, A.J. (2013, April 26). The confluence of violence and the accretion of "truth": Reading deportation decisions for racialized people classified with serious criminality and mentally illness in Canada**.** Presented at: *Social Work's 6th Annual Research Symposium*, York University, Toronto, ON.

Joseph, A., & Maiter, S. (2012, November, 1). Postnational belonging: Strategies of racialized youth in multicultural western contexts. Presented at the *2012 Strangers in New Homelands- 5th Annual Conference on the Social Reconstructing of "Home" Among Immigrants in the Diaspora,* University of Manitoba, Winnipeg, MB.

Joseph, A. (2012, October, 25). Ancestries of racial and eugenic systems of violence in the mental health sector. Presented at the *2012 Third International Conference on Violence in the Health Sector*, Sheraton Vancouver Airport Hotel, Richmond, BC.

Joseph, A. (2012, March, 31). Authorities on the subject: Colonial ancestries of hierarchy and hegemony in mental health. Presented at the *2012 Canadian Association of Social Work Education Annual Conference*, University of Waterloo & Wilfrid Laurier University, Waterloo, ON.

Lamoureaux, A., Joseph, A., Feris, C. (2012, March, 22). Toward transformative practice: Facilitating access and barrier-free services with LGBTTIQQ2SA populations. Presented at the *2012 Ontario Working Group on Early Psychosis Intervention Conference*, Sheraton Centre Hotel, Toronto, ON**.**

Joseph, A. (2011, June 2). A prescription for violence: The legacy of colonization in contemporary forensic mental health and the production of difference. Presented at the *2011 Canadian Association of Social Work Education Annual Conference*, University of St. Thomas, Fredericton, NB.

Maiter, S., Joseph, A., Shan, N., Saeid, A. (2010, May 14). Doing participatory qualitative research: Development of a shared critical consciousness with racial minority research advisory group members. Presented at the *27th Annual Qualitative Analysis Conference*, Wilfrid Laurier University, Brantford, ON.

Joseph, A., (2010, April 16). Empowering alliances in pursuit of social justice: Social workers supporting psychiatric-survivor movements. Presented at: *Social Work`s Annual Research Symposium*, York University, Toronto, ON.

i) Not Peer Reviewed

Joseph, A.J., Mehdi, A., Stearns, G, Ahmad, S. (2024, March 25). Critical Community Perspectives on Housing and Homelessness in Hamilton, CityLab Hamilton, Office of Community Engagement, McMaster University, Hamilton, ON.

Joseph, A.J. (2022, March 1). Refusing colonial, carceral, eugenic, and surveillance technologies in mental health policy, practice, and law. Guest Lecture. HTH SCI 3RH3 Racism and Health, Faculty of Health Sciences, McMaster University.

Joseph, A.J. (2022, February 2). Beyond Intersectionality and Confluence. Guest Discussion/Lecture. Alice Salomon University of Applied Sciences, Berlin, Germany.

Joseph, A.J. (2021, October 25). *From Commitments to Reconciliation: Supporting Decolonizing Work in Community Engaged Research*. Guest Lecture, CMTYENG 2A03, McMaster University

Joseph, A.J. & Kumbhare, S. (2021, July 21). *Loneliness & Mental Health Through COVID-19 and Beyond*. CMHA Ontario, Toronto, ON.

Joseph, A.J. (2021, May 28). Refusing colonial eugenics rationalities in mental health policy, practice, and law. Beyond the Penal and the Carceral: Alternatives to criminalization to address social need. (Panel with Prof. Rinaldo Walcott). Centre for Human Rights and Restorative Justice, McMaster University. "Beyond the Penal and the Carceral: Alternatives to criminalization to address social need" Panel - YouTube

Joseph, A.J., James, L, Damptey, K. Downey, B. (2020, December 3). Data colonialism and plantation logics in social services, and public health. Data & Sovereignty: Resisting Colonial Logics for Racial Justice, McMaster Institute for Health Equity, The Lewis and Ruth Sherman Centre for Digital Scholarship, The McMaster Indigenous Research Institute, McMaster University, Hamilton, ON. https://www.macvideo.ca/media/Data+%26+Sovereignty/1_2gxgha0l

Joseph, A.J. & Kumbhare, S. (2020, November 23 & 2021, January 18). *Grief During COVID-19*. CMHA Hamilton, Hamilton, ON.

Joseph, A.J. (2020, November 2). Anti-Racism, Resistance and Change. Invited guest lecture. UNIV 2010, Anti-Discrimination and Anti-Oppression. University of Guelph, Guelph, ON.

Joseph, A.J. (2020, October 27). Race, Racism, Racialization and Colonialism. Invited guest lecture. UNIV 2010, Anti-Discrimination and Anti-Oppression. University of Guelph, Guelph, ON.

Joseph, A.J. (2020, October 21). Relationship, Respect, Complicities, Solidarities & Decolonial Resistance. Invited guest lecture. Advanced Practice. School of Social Work, University of British Columbia., Vancouver, British Columbia.

Joseph, A.J. (2020, November 16, 17, 18, 23). Racism, Race, and Racialization in Healthcare in Canada: Matters of life and death. Invited Guest Lecture. 2RR3 Social Determinant of Health. BScN Program, Faculty of Health Sciences, McMaster University, Hamilton, ON.

Joseph, A.J. (2020, August 12). Confronting and challenging racism: the individual, the systemic, and the structural. CMHA Hamilton, Hamilton, ON.

Joseph, A.J. (2020, August 19). Racism and mental health. CMHA Hamilton, Hamilton, ON.

Joseph, A.J. (2020, October 7). Confronting and challenging racism: the individual, the systemic, and the structural. CMHA Kenora, Kenora, ON.

Joseph, A.J. (2020, October 14). Racism and mental health. CMHA Kenora, Kenora, ON.

16. Administrative Responsibilities

University:

Selection Committee Associate Vice President Research (Society & Impact)	2023
Selection Committee-Senior Manager Office of Community Engagement	2023
Selection Committee-Strategic Community Engaged Research Manager Office of Community Engagement	2022
Selection Committee- Knowledge Broker Manager Office of Community Engagement	2022
Selection Committee- Vice-Provost, Teaching and Learning	December 2021-January 2022
McMaster Institute for Health Equity- member	2020-present
Centre for Human rights and Restorative Justice- member	2020-present
Selection Committee - Dean, Faculty of Social Sciences	September 2019-October 2019
University Senate	July 2019- July 2022

School of Graduate Studies Scholarship Committee: SSHRC CGS-M 2019, 2020, 2021, 2022, 2023

Chair: President's Advisory Committee on Building an Inclusive Community (PACBIC) July 2016- July 2019

Hiring Committee: Executive Assistant to the Associate Vice-President Equity and Inclusion September 2018

Renaissance Award and Chancellor's Gold Medal Selection Committee October 2018

2018 Graduand Awards Selection Committee May 2018

Hiring Committee: Executive Assistant to the AVP Equity and Inclusion July 2018-September 2018

Accessibility Policy Development Committee November 2016-2019

Employment Equity Forum November 2016 & December 2017

Hiring Committee: AVP/ Vice-Provost Equity and Inclusion October 2016- December 2017

Hiring Committee: Human Rights Specialist November 2017

Hiring Committee: Anti-Racism Officer November 2017
Hamilton Centre for Civic Inclusion/McMaster University/Anti-Racism Resource Centre

Hiring Committee: Employment Equity Specialist March 2017

Hiring Committee: Director of Human Rights and Dispute Resolution September 2016

Member, President's Advisory Committee on Building an Inclusive Community October, 2014-July 2020 (PACBIC)

President's Advisory Committee on Building an Inclusive Community September 2015- July 2016
Race, Racialization and Racism working Group-Co-Convener

African-Caribbean Faculty Association of McMaster October, 2014-Present

Faculty:

Tenure and Promotions, Faculty of Social Science July 2021-June 2022

Faculty of Social Sciences Equity, Diversity,
Inclusion and Indigenous Strategies (EDIIS) Advisory Group 2020- Present

McMaster Faculty of Social Science SSHRC Doctoral Ranking Committee 2017/2018, 2018/2019

Department:

Graduate Program Director 2022-Present

Hiring Committee, New Tenure-Track Faculty 2021-2022

United in Colour-Faculty Liaison 2019-2022

Graduate Admissions Reviewer, School of Social Work 2018, 2019

Library Liaison School of Social Work September 2014- Present

School of Social Work's Transformative Social Justice Response Team (TSJRT) (Formerly Anti-Oppression Education Committee) September 2015-September 2017

Undergraduate Studies Committee, School of Social Work September 2014-December 2014, September 2015-Present

Graduate Studies Committee, School of Social Work December 2014-May 2015

17. Other Responsibilities

Hamilton Public Health, COVID-19 Vaccine Readiness Network 2020-2022

President's Task Force on Equity, Diversity- Hamilton Health Sciences 2020-2022

Ontario COVID-19 Mental Health Network March 2020-July 2020

City of Hamilton, Community Advisory Panel
Hamilton Anti-Racism Resource Centre, Chair October 2020-January 2021

Disability Justice Network of Ontario, Advisory Board, Hamilton, ON 2020-present

Disability Justice Network of Ontario, Research Committee, Hamilton, ON 2019-present

CIHR Doctoral Research Awards Committee – B September 2018- August 2019
Reviewer Doctoral Research Awards for the Canadian Institute of Health Research

Houselink Community Homes, Toronto, ON July 2011 – June 2014
Board of Directors- Vice President (2013), President (2014)
Nominations Committee, (Chair) Policy Committee, Sustainable Fundraising Committee
Mission: to improve the quality of life of psychiatric consumers / survivors including those who are homeless or otherwise marginalized, through the provision of permanent affordable supportive housing and programs.

Local Health Integration Network – Central, Toronto, ON January 2008- March 2011
Social Worker; MSW, RSW – Health Professionals Advisory Committee
Provided professional advice to Central LHIN on how to achieve patient-centered health care within the local health system for the most diverse and populous LHIN in Ontario.
Considered innovative approaches in health service delivery, health promotion and wellness and the utilization of health human resources. (As legislated: Local Health System Integration Act, 2006 - O. Reg. 264/07)

TAB 112

Court File No. CV-21-00077817-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, AND SHAWN ARNOLD, ET AL.

Applicants

-and-

CITY OF HAMILTON

Respondent

AFFIDAVIT OF AARON ORKIN

SWORN SEPTEMBER 14, 2022

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1. I, Aaron Orkin, MD MSc MPH PhD CCFP(EM) FCFP FRCPC , of the City of TORONTO in the Province of Ontario, MAKE OATH AND SAY:
2. I have personal knowledge with respect to the facts set out below, except where stated otherwise. Where the information is not based on my personal knowledge, it is based upon information provided by others which I believe to be credible and true
3. I provide these statements in my capacity as an independent physician, epidemiologist and researcher, and not on behalf of nor as a representative of any of the organizations or institutions with which I am affiliated.
4. I am providing this affidavit for the purpose of having the expertise of a physician and epidemiologist considered in proceedings concerning the coercive relocation of people

experiencing homelessness from encampments to shelters or other settings, and for no other or improper purpose.

A. MY QUALIFICATIONS AND EXPERIENCE:

5. I am a physician and epidemiologist, and Associate Professor in the Department of Family and Community Medicine and the Dalla Lana School of Public Health at the University of Toronto. I hold graduate degrees in History and Philosophy of Medicine (University of Oxford) and Public Health (University of Toronto), and a doctorate in Clinical Epidemiology (University of Toronto). I completed fellowships in family medicine research (Northern Ontario School of Medicine) and Clinical Public Health (University of Toronto).

6. My curriculum vitae is attached as **Exhibit A** to this affidavit.

7. I have been previously qualified as an expert witness, with respect to the opioid crisis, opioid overdose first aid and overdose prevention, and the risks of COVID-19 in correctional facilities.

8. I practice emergency medicine at St. Joseph's Health Centre, Unity Health Toronto. I serve as the Director of Population Health for Inner City Health Associates, an organization providing health services to people experiencing homelessness across Toronto.

9. I am a clinician scientist. This means that I spend a large portion of my time on research. That research focuses on health equity and vulnerable populations.

10. In my clinical, population health, and research work over the last 10 years, I spend a large portion of my time with people experiencing homelessness, other professionals and service

providers who work with this population, and with colleagues in other jurisdictions in Canada and internationally who work on homelessness and with people experiencing homelessness.

B. PEOPLE EXPERIENCING HOMELESSNESS MAKE HOUSING CHOICES

11. In most Canadian municipalities, people experiencing homelessness have restricted, but real choices regarding where they choose to reside. Real options include shelters, drop-ins, temporary settings like stairwells or transit settings, or creating encampment-type dwellings. These options exist regardless of the legality of each option, or whether they are socially sanctioned. Among those who choose to live in encampments, people may choose to do so alone or in groups, in highly visible public settings or in settings that are more hidden or removed from public view. Although choices are very limited, my experience is that people who reside in shelters rather than bus stops do so by choice, and people who live in a tent encampment rather than a shelter do so by choice. They make these choices based on their experiences, needs, goals, and priorities. They change their choices over time for a variety of reasons.

12. These choices are rational for the people who make them. For example, shelters can be restrictive regarding the number and volume of personal possessions, accessibility for pets, ability to live a partner, or use of drugs and alcohol. Shelters do however have a roof and heating in winter. A person who feels more comfortable when they have access to their possessions, has a pet, or cannot sleep in a communal environment with strangers, and for whom these factors are more important than a solid roof or heating, may choose to live in an encampment rather than a homeless shelter. Or they may choose to live in an

encampment in the summer and a shelter in the winter. These choices are not based only on means or need. That is, people living in encampments or bus shelters do not simply represent the excess number of people experiencing homelessness municipality relative to the number of shelter beds. People experiencing homelessness make choices in the face of limited and difficult options, but they nevertheless make choices.

13. These choices are not fundamentally different to housing choices made by other community members who enjoy greater means. For example, a person on a limited housing budget in a municipality with inflated housing prices might choose to live in a small basement apartment, move somewhere with lower housing prices, spend more time commuting, live with roommates, or allocate more of their resources to housing costs. That person would weigh these options based on their preferences, needs, and other factors. For one person on a limited housing budget, moving to a rural setting might be the obvious choice; for another person with identical financial means, the rural setting might seem horrible, but a dark metropolitan basement unit might seem ideal. This choice is different to the choice made by a person experience homelessness with respect to the available options and resources; but it is identical with respect to the rationality of the choice and the individual's role in making that decision.

C. CHOICES ARE RELATED TO HEALTH

14. The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity." I accept this definition for its pervasiveness, and note in particular the crucial and often overlooked role of "social well-being" in health. Scholars have also criticized the WHO definition for

enabling the medicalization of society and advancing a professionalized and bio-technical view of health care and health protection.[1,2]

15. A 2013 federal Library of Parliament publication *The Federal Role in Health and Health Care* remarks that "*Health* (in its broadest sense) refers to the desirability of maintaining or achieving a positive state of overall well-being."[3]

16. More recent conceptualizations refer to health as the "ability to adapt and self-manage". This includes adapting to and managing physical and mental health ailments, as well as social health, where people have the "capacity to fulfil their potential and obligations, the ability to manage their life with some degree of independence despite a medical condition, and the ability to participate in social activities including work."[4]

17. Based on these definitions, when people who experience homelessness make choices about where they want to live, those decisions are related to health. This relationship takes two forms:

    a. The person's preferred place of residence may directly affirm their health better than another place of residence. For example, a person may know that they experience better health when they have their pet, their friend, or their possessions and may therefore be making a health-informed decision when they choose to

[1] World Health Organization. Constitution of the World Health Organization. 2021. Available from: https://www.who.int/about/who-we-are/constitution.
[2] Huber M, Knottnerus JA, Green L, Horst Hvd, Jadad AR, Kromhout D, et al. How should we define health? BMJ. 2011;343:d4163.
[3] Butler M, Tiedmann M. The Federal Role in Health and Health Care. Ottawa: Library of Parliament. Publication No. 2011-91-E, 22 September 2011, Revised 20 September 2013. Available from: https://lop.parl.ca/staticfiles/PublicWebsite/Home/ResearchPublications/InBriefs/PDF/2011-91-e.pdf
[4] Huber M, Knottnerus JA, Green L, Horst Hvd, Jadad AR, Kromhout D, et al. How should we define health? BMJ. 2011;343:d4163.

reside in a place where they maintain access to these assets. I refer to this as "making healthy choices" and address its implications for involuntary removals from encampments in Section E, below.

b. The person's ability to make a choice and have that choice respected is itself related to health. For example, if we revisit the two people with limited housing budgets (one who chose rural life and one who chose a metropolitan basement unit), we can see that it could be hazardous to treat these two individuals as interchangeable. If the rural resident were forcibly relocated to the metropolitan basement unit (or vice versa), we might discover that the individual's ability to adapt and self-manage had been compromised — that is, their health had suffered. I refer to this as "choices make healthy", and address its implications for involuntary removals from encampments in Section F, below.

D. INVOLUNTARY REMOVAL

18. Involuntary relocation or resettlement refers to circumstances where individuals or groups are compelled to change their place or residence by coercion, physical force, or imposed will. Coercion in this case includes real or perceived the threats of force, imposition of fear, or other harmful consequences should the individual or group remain in their preferred place of residence. Involuntary relocation is therefore not limited to instances that involve an actual display of force or use of force.

19. What may be perceived as coercive by one individual may not be perceived as coercive by another. For example, informing a large housing corporation of a $500 fine may not be

coercive, while that same fine could be coercive for an individual experiencing absolute poverty.

20. Perceptions of force, fear, or harm vary widely from person to person. These perceptions of coercion are based in part on past experiences and other knowledge including a history of trauma, conflict with authorities, and other marginalization. An individual who has experienced personal or multigenerational trauma and conflict with law enforcement, or involuntary relocation, may experience fears of force or harm and act based on coercion at a different threshold than individuals who have no such experience.

21. Racialized communities, religious minority groups, Indigenous communities, LGBTQ populations, newcomers and refugees have experienced involuntary relocation and coercion, including in Canada. These groups are overrepresented among people experiencing homelessness.

E. INVOLUNTARY REMOVAL AND MAKING A HEALTHY CHOICE

22. Various disease processes and threats to safety may be associated with homeless encampments. These include for example unsafe use of generators, fires and other heating devices, sanitation, conflicts and assaults, and harms associated with substance use such as overdose. These safety threats have been reported in the popular press in Canada, including instances in Hamilton, Ontario. I am not aware of any epidemiological or public health research on the health and health risks of living in a homeless encampment in Canada or internationally.

23. The health risks of homelessness, including among people living in shelters, is well known and has been widely researched and studied. Homelessness, including when living in a shelter, is associated with elevated risks of chronic and communicable disease, mental health and substance use problems including opioid overdose, and injury both intentional and unintentional.[5]

24. Therefore, there is no basis in the public health or epidemiological literature to conclude that living in an encampment is more or less healthy than living in a shelter. There is to my knowledge no available research to support the conclusion that individuals who choose to live in an encampment are making a choice that is objectively or universally less (or more) healthy than those who choose to live in a homeless shelter.

25. The corollary is that there is no available research to support the position that relocating individuals (or communities of individuals) from an encampment to a shelter will serve to protect or improve their health in any objective or absolute way. Stated differently, there is no scientific or health research to support the position that municipalities or other actors can involuntarily relocate people from encampments to shelters in order to protect their health.

F. INVOLUNTARY REMOVAL AND CHOICES MAKE HEALTH

26. Broadly speaking, coercion is itself harmful, and choice is itself healthful. People experience harms and threats to their health when they are unable to make decisions about

[5] Guirguis-Younger M, Hwang SW, McNeil R, editors. Homelessness & health in Canada. University of Ottawa Press; 2014 Apr 24.

key aspects of their lives. The mechanism of this harm is straightforward: eliminating reasonable choices inhibits an individual or community from adapting and self-managing by artificially constraining the available options for that self-management. Conventionally, we consider healthy choices as the ability to choose between options with a health differential — choosing between eating vegetables and eating fried food. We must also consider the choice itself as a contributor to health, especially when there is a limited health differential between the available options. For example, forcing an individual to eat a nutritious meal may have adverse health effects, especially if that individual would eat almost as healthily if they were positioned to choose themselves. As discussed above (Para 23), there is no known health differential between shelter and encampment dwelling.

27. There are of course limits to the principle that choices make health. Limited circumstances where coercive and involuntary actions can be taken to protect an individual or community's health include involuntary admission under the Mental Health Act, protections from health hazards under the Health Protection and Promotion Act, or child welfare concerns under the Child, Youth, and Family Services Act. None of these acts or circumstances apply in a general way to individuals who choose to live in an encampment.

28. The harms of eliminating choices become more severe as they are compounded and as they recur. For example, people who experience homelessness often have profound and recurrent experiences of stigma and marginalization, including adverse experiences with state officials and enforcement, health care providers, landlords and other authority figures, housing workers, the finance system, and even in grocery stores. Each of these experiences

can serve to further restrict the options that an individual perceives as safe and reasonable, making it increasingly difficult to find a sense of security, safety, and health. For individuals who have experienced this kind of marginalization, further marginalization and conflict can spell a loss of access to social services, substance use treatment, medical care, community supports, and safety. In these circumstances, increasing isolation and dispossession become the primary drivers of poor health, and that isolation is often a proximal contributor to untimely death.

29. For this reason, involuntary removals from encampments are a particularly egregious threat to health. Among a severely marginalized and stigmatized population, with tenuous and fragile connections with existing services, involuntary removals deepen existing traumas, eliminate choice, and distance people from social services and state institutions. At the moment of displacement, this can result in immediate injuries, stressors, and health crises. In the short term, this can trigger health decompensations and instability. In the longer term, these events threaten health because they undermine broader efforts to build trust and a shared sense of health and safety between state actors and people experiencing homelessness.

30. Therefore, it is my professional opinion that, in general, involuntary relocations of people living in homeless encampments is deleterious to their health.

Sworn remotely by Aaron Orkin at the City of Toronto in the Province of Ontario, before me on September 14, 2022 in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

Commissioner for Taking Affidavits
Sharon Crowe

Aaron Orkin

Bibliography

Butler Martha Anne, and Marlisa Tiedemann. “The Federal Role in Health and Health Care.” Publication No. 2011-91-E. Ottawa: *Library of Parliament*. September 22, 2011, revised September 20, 2013. https://lop.parl.ca/staticfiles/PublicWebsite/Home/ResearchPublications/InBriefs/PDF/2011-91-e.pdf.

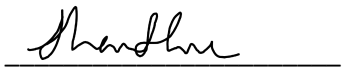
Guirguis-Younger, Manal, Stephen Hwang, and Ryan McNeil, eds. *Homelessness & health in Canada*. University of Ottawa Press, 2014.

Huber, Machteld, J. André Knottnerus, Lawrence Green, Henriëtte Van Der Horst, Alejandro R. Jadad, Daan Kromhout, Brian Leonard, Kate Lorig, Maria Isabel Loureiro, Jos W.M. van der Meer, Paul Schnabel, Richard Smith, Chris van Weel, and Henk Smid. "How Should we Define Health?." *Bmj* 343 (2011): d4163.

Library of Parliament. “The Federal Role in Health and Health Care (In Brief).”

World Health Organization. “Constitution.” 2022. Accessed June 11, 2022. https://www.who.int/about/governance/constitution.

THIS IS EXHIBIT “A” TO THE
AFFIDAVIT OF AARON ORKIN
AFFIRMED REMOTELY BEFORE ME AT THE
CITY OF TORONTO DURING A “ZOOM” VIDEOCONFERENCE
IN ACCORDANCE WITH O.REG.431/20,
ADMINISTERNG OATH OR DECLARATION REMOTELY
THIS 14TH DAY OF SEPTEMBER, 2022



SHARON CROWE
LSO NO. 47108R
Commissioner for Taking Affidavits, etc

Curriculum Vitae

Aaron M Orkin
BArtsSc, MD, MSc, MPH, PhD, CCFP(EM), FCFP, FRCPC

A. Date Curriculum Vitae is Prepared: 22 Mar 2022

B. Biographical Information

Primary Office	Li Ka Shing Knowledge Institute at Unity Health Toronto 250 Yonge St Toronto, ON M5B 2L7
Telephone	647 923 7551
Email	aaron.orkin@mail.utoronto.ca

1. EDUCATION

Degrees

2021 Dec	**PhD**. Clinical Epidemiology and Health Services Research, Institute of Health Policy, Management, and Evaluation, University of Toronto, Toronto, ON.
2013	**MPH**. Epidemiology, Dalla Lana School of Public Health University of Toronto, Toronto, ON.
2010	**MSc**. History of Science, Medicine & Technology, Linacre College, Oxford University, Oxford, UK.
2007	**MD**. McMaster University, Hamilton, ON.
2004	**BArtsSc**. McMaster University, Hamilton, ON.

Postgraduate, Research and Specialty Training

2015-2016	**Fellow**. Clinical Public Health and Emergency Medicine**,** Dalla Lana School of Public Health and St Michael's Hospital, University of Toronto, Toronto, ON.
2014-2015	**Fellow**. Clinician Investigator Program, Royal College of Physicians and Surgeons, University of Toronto, Toronto, ON.
2014-2015	**Editorial Fellow**. *Annals of Family Medicine.*
2012-2013	**Junior Fellow.** Massey College, University of Toronto, Toronto, ON.
2012-2013	**Collaborative Program in Resuscitation Science**. School of Graduate Studies, University of Toronto, Toronto, ON.
2010 - 2014	**Medical Resident**. Public Health & Preventive Medicine, Dalla Lana School of Public Health, University of Toronto, Toronto, ON.
2010	**Research Fellow**. Family Medicine, Northern Ontario School of Medicine, Lakehead University, Thunder Bay, ON.
2007-2009	**Medical Resident**. Family Medicine, Northern Ontario School of Medicine, Lakehead University, Thunder Bay, ON.

Qualifications, Certifications and Licenses

2020	**Fellow.** College of Family Physicians of Canada, FCFP.

2015	**Certificant**. College of Family Physicians of Canada, Added Competency in Emergency Medicine, CCFP(EM)
2014	**Fellow**. Royal College of Physicians & Surgeons of Canada, Public Health & Preventive Medicine, FRCPC
2009	**Licensure**. College of Physicians and Surgeons of Ontario, License / Membership #: 86358
2009	**Certificant**. College of Family Physicians of Canada, CCFP
2008	**Licentiate**. Medical Council of Canada

2. EMPLOYMENT

Current Appointments

2022 Feb-pres	**Research Lead**. Department of Emergency Medicine. St Joseph's Health Center, Unity Health, Toronto, ON.
2022 Jan-pres	**Associate Member.** School of Graduate Studies, University of Toronto, Toronto, ON.
2022 Jan-pres	**Assistant Professor.** (non-budgetary cross-appointment). Dalla Lana School of Public Health, University of Toronto, Toronto, ON.
2021-pres	**Director of Population Health**. Inner City Health Associates, Toronto, ON.
2020-pres	**Co-Medical Director**. COVID-19 Assessment Centre and COVID-19 Vaccination Centre, St. Joseph's Health Centre, Unity Health, Toronto, ON.
2019-pres	**Staff Physician**. Department of Emergency Medicine, St. Joseph's Health Centre, Unity Health, Toronto, ON.
2019-pres	**Staff Physician**. Inner City Health Associates, Toronto, ON.
2019-pres	**Staff Physician**. Department of Emergency Medicine, Humber River Hospital, Toronto, ON.
2017-pres	**Faculty Affiliate**. Centre for Rural and Northern Health Research, Laurentian University. Sudbury, ON.
2016-pres	**Assistant Professor (Clinician Investigator)**. Department of Family and Community Medicine, Faculty of Medicine, University of Toronto, Toronto, ON.
2016-pres	**Volunteer Medical Director**. Canoe North Adventures. Mono, ON and Norman Wells, NWT.
2013-pres	**Volunteer Medical Director**. Camp Pathfinder, Algonquin Park, ON.
2011-pres	**President (volunteer)**. Remote Health Initiative.

Previous Appointments

2019-2021	**Population Health Lead.** Inner City Health Associates, Toronto, ON.
2019	**Locum Physician**. Muskoka Algonquin Health Centre, Huntsville, ON.
2016-2019	**Clinician Scientist**. Department of Emergency Medicine, Sinai Health System, Toronto, ON.
2016-2019	**Staff Physician**. Department of Emergency Medicine, Sinai Health System, Toronto, Ontario, Canada
2016-2019	**Staff Physician**. Seaton House Shelter Infirmary, Inner City Health Associates, Toronto, ON.
2012	**Co-Chief Resident**. Residency Program, Public Health & Preventive Medicine University of Toronto, Toronto, ON.
2011-2016	**Staff Physician**. Department of Emergency Medicine, Humber River Hospital, Toronto, ON.
2010-2015	**Assistant Professor**. Division of Clinical Sciences, Northern Ontario School of Medicine, Lakehead University, Thunder Bay, ON.
2010-2012	**Locum Physician**. Taddle Creek Family Health Team, Toronto, ON.
2009-2012	**Staff Physician**. Emergency Medicine, Groves Memorial Hospital, Fergus, ON.
2009-2012	**Locum Physician**. Marathon Family Health Team, Marathon, ON.

2009-2011	**Locum Physician**. Meno-Ya-Win Health Centre, Sioux Lookout, ON.
2009	**Locum Physician**. Dilico Nishnawbek Family Health Team, Thunder Bay, ON.

3. HONOURS AND CAREER AWARDS

Distinctions and Research Awards

INTERNATIONAL

Received

2008	**Commonwealth Master's Scholarship** (Canada – United Kingdom). (£40,000). *Declined to complete Canadian postgraduate medical training*
2009	**Wellcome Master's Scholarship for the History of Medicine**, Oxford University, Oxford, UK. (£22,000).

NATIONAL

Received

2021 Nov	**Best Research Paper**. Royal College of Physicians and Surgeons Simulation Summit 2021. Whittall JP, **Orkin AM**, Handford C, Klaiman M, Leece P, Charles M, Wright A, Turner S, Morrison L, Strike C, Campbell DM. Resuscitation simulation among people who are likely to witness opioid overdose: Experiences from the SOONER Trial. Presenter: Jonathan Whittall.
2021	**Prix Claude Beaudoin**. Département de médecine de famille et de médecine d'urgence (DMFMU). Universite de Montreal, Montreal, QC. Prize for excellence and originality of published research article: Kaczorowski J, Bilodeau J, M **Orkin A**, Dong K, Daoust R**,** Kestler A. Emergency department-initiated interventions for patients with opioid use disorder: A systematic review. *Acad Emerg Med*. 2020 Nov;27(11):1173-1182.
2018	**Dr Walter Mackenzie Visiting Professor Award**. University of Alberta Faculty of Medicine and Dentistry, Edmonton, AB ($1000).
2016	**Travel Award**. Institute of Aboriginal Peoples Health**,** Canadian Institutes of Health Research. ($1300).
2009	**College of Family Physicians of Canada Murray Stalker Award**. Northern Ontario School of Medicine, Thunder Bay, ON.
2009	**Northern Ontario School of Medicine Resident Leadership Award**. Northern Ontario School of Medicine, Thunder Bay, ON.
2007	**Honor "M" Award**. McMaster University and Students' Union. Hamilton, ON.
2006	**Dorothy Mann Award in Reproductive Biology.** McMaster University, Hamilton, ON.

Nominated

2022	**Canadian Association for Graduate Studies (CAGS)/ProQuest-UMI Distinguished Dissertation Award.**

LOCAL

Received

2022 Jan	**St Josephs Mission Award** (inaugural recipient). St Joseph's Health Centre (SJHC), Unity Health Toronto, Toronto ON. $1000 (donated to organization of recipient's choice).
2020 Oct	**Excellence in Clinical Teaching Award (Post Graduate Preceptor Category).** St. Joseph's Health Centre (SJHC) and the Department of Medical Education & Scholarship (DMES), University of Toronto, Toronto, ON.
2014	**Edward Christie Stevens Fellowship and Joseph M. West Family Memorial Fund Award**.Post- Graduate Medical Research Award, University of Toronto, Toronto, ON. $6175.
2014	**C.P. Shah Resident Research in Public Health and Preventative Medicine Award**. University of Toronto, Toronto, ON.
2013	**Bart Harvey Resident Service in Public Health and Preventative Medicine Award**. University of Toronto, Toronto, ON.

Nominated

2020	**Excellence in Teaching Emergency Medicine (Early Career)** University of Toronto, Department of Family and Community Medicine, Division of Emergency Medicine.

4. PROFESSIONAL AFFILIATIONS AND ACTIVITIES

Professional Associations

2017-pres	Canadian Point of Care Ultrasound Society (Independent practitioner)
2013-pres	Royal College of Physicians and Surgeons of Canada
2012-pres	Canadian Public Health Association
2012-pres	Canadian Association of Emergency Physicians
2012-pres	Public Health Physicians of Canada
2007-pres	Canadian Doctors for Medicare
2006-pres	College of Family Physicians of Canada
2004-pres	Ontario Medical Association & Canadian Medical Association
2006-2017	Society of Rural Physicians of Canada

Administrative Activities

INTERNATIONAL

2019-pres	**Member**. First Aid Task Force, International Liaison Committee on Resuscitation (ILCOR)
2019-pres	**Member**. First Aid Subcouncil, American Red Cross Scientific Advisory Committee
2013-2015	**Project Advisor**. Dignitas International, Aboriginal Health Initiatives

NATIONAL

2020-pres	**Member**. Working Group on Homelessness, Royal Society of Canada (RSC)
2020-pres	**Lead**. Population and Public Health Community of Practice, Canadian Network of the Health and Housing of People Experiencing Homelessness (CNH3)
2020	**Expert Witness**. Ontario Superior Court of Justice, Ontario Court of Justice, Superior Court of Saskatchewan, Alberta Court of Appeal: Testimony concerning the risk of COVID-19 in correctional facilities. 2020 ONSC 2879 / ONSC 1938 / ONCJ 198 / ONSC 2870 / ONSC 2824/ ONSC 3152 / ABCA 194 / ONSC 2374 / ONSC 2997 / ONSC 2626 / ONSC 2946 / ONSC 2632 / ONSC 2671 / ONSC 2497 / ONCJ 236 / SKCA 45 / ONSC 3275 / ONSC 3102 / ONCJ 260 / ONSC 2694 / ONSC 2880.
2017-2019	**Member**. Community-based emergency care program development committee, Government of Northwest Territories
2017-2018	**Member**. Public Health Physicians of Canada Opioid Crisis Working Group
2013	**Member**. Royal College of Physicians and Surgeons of Canada Injury Control Advisory Committee
2011-pres	**Member**. Médecins Sans Frontières Association Canada.

PROVINCIAL / REGIONAL

2018	**Expert Witness**. Office of the Chief Coroner of Ontario, Inquest into the death of Mr Bradley Chapman (OCC: 2015_09519). Testimony concerning the opioid crisis, overdose first aid, homelessness, and stigma.
2017-2019	**Co-chair**. Windigo First Nations Council Community-Based Emergency Care Working Group, Sioux Lookout, ON. Co-chair Chief Frank McKay
2017-2019	**Member**. Ontario Addictions Advisory Panel, Canadian Mental Health Association
2015-2016	**Member**. First Do No Harm Overdose and Overdose Death Prevention Project Team. Canadian Centre on Substance Abuse, Ottawa, ON.
2012-2018	**Member**. Ontario Opioid Overdose Prevention and Naloxone Access Working Group.

LOCAL

2020-pres	**Member**. Public Health and Preventive Medicine Postgraduate (Residency) Program Research Committee. Dalla Lana School of Public Health, University of Toronto, Toronto, ON.
2019-pres	**Member**. Strategic Planning Committee, Inner City Health Associates, Toronto, ON.
2017-2018	**Member**. City of Toronto Overdose Early Warning and Alert Committee, Toronto, ON.
2016-2019	**Physician Member**. Inner City Family Health Team, Toronto, ON.
2015	**Member**. Humber River Hospital Emergency Medicine Vision Committee, Etobicoke, ON.
2015-2016	**Member**. Dalla Lana School of Public Health Strategic Planning Committee, Subcommittee on Synergy between Population Health and Health Systems.
2014-2016	**Member**. Awards Committee, Public Health & Preventive Medicine Residency Program,
2014-2015	**Member**. Dalla Lana School of Public Health Governing Council. Public Health & Preventive Medicine Residency Program
2011-2013	**Member**. Global Health Division Education Advisory Committee, Dalla Lana School of Public Health.

Peer Review Activities

ASSOCIATE OR SECTION EDITING

2018-pres	**Member**. Writing Group, American Heart Association/Heart & Stroke Foundation Canada and Red Cross First Aid Guidelines 2019
2018-pres	**Member**. Editorial Advisory Board, *Annals of Family Medicine*
2010-pres	**Editor**. *Ars Medica,* University of Toronto journal of medicine, arts and humanities

MANUSCRIPT REVIEWS

Reviewer

2022	**Peer Reviewer.** *JAMA Open* Number of Reviews: *1*
2021	**Peer Reviewer**. *Canadian Journal of Emergency Medicine* Number of Reviews: 1
2020	**Peer Reviewer**. *Public Health Ontario Environmental Scan (COVID-19 and homelessness)*
2020	**Peer Reviewer**. *Canadian Research Initiative in Substance Misuse (Covid 19 Guidelines)*
2017-2018	**Peer Reviewer**. *Annals of Family Medicine* Number of Reviews: 4
2016	**Peer Reviewer**. *CMAJ Open* Number of Reviews: 1
2016	**Peer Reviewer**. *Addiction* Number of Reviews: 1
2015	**Peer Reviewer**. *Drug and Alcohol Dependence* Number of Reviews: 1
2014	**Peer Reviewer**. *BMC Health Services Research* Number of Reviews: 3
2013-2015	**Peer Reviewer**. *Canadian Journal of Public Health* Number of Reviews: 2
2008-2016	**Peer Reviewer**. *Canadian Family Physician* Number of Reviews: 4
2012-2015	**Peer Reviewer**. *Open Medicine* Number of Reviews: 1

Other Research and Professional Activities

PROFESSIONAL ACTIVITIES

2014-2015	**Co-lead and Adjudicator**. Humanities Poetry and Prose Competition, *Ars Medica* and *Canadian Medical Association Journal (CMAJ)*
2014-2015	**Evidence Reviewer**. International Liaison Committee on Resuscitation. Basic Life Support Interventions: 'Resuscitation care for opioid-associated emergencies' and 'Opioid overdose bystander education'.
2005-2011	**Curriculum developer/Instructor**. Wilderness Medical Associates Canada. (Founded a wilderness medicine elective now offered to students across Canada)

C. Research Funding

1. GRANTS, CONTRACTS AND CLINICAL TRIALS

PEER-REVIEWED GRANTS

FUNDED

2022 Mar	**Co-Investigator**. Effects of Recreational Cannabis Legalization on Polysubstance Use, Mental Health, and Injury in Canada: The RCL IMPACT Study. Canadian Institutes of Health Research. PI: Cusimano M. Co-Investigators: Bhalerao S, Mann R, Vaz E, Saarela O, Fairgrieve C, **Orkin A**, Isaranuwatchai W, Lurie E, Selby P.

2022 Mar-2027 Feb	**Co-Investigator**. TRACE STUDY: An RCT using tranexamic acid in the treatment of subdural hematoma. Canadian Institutes of Health Research. PI: Cusimano M. Co-Investigators: **Orkin A**, Taslimi S, Callum J, Priola SM, Moran P, Marcoux J, Prud'homme M, Laroche M, Katerina, Sholzberg M, Munoz D, Moreland R, Colak E, Yoon JY, Fish J, Sadeghian A, Rossiter J, Khellaf A, Saarela O, Thorpe K, Ming Y, Isaranuwatchai W.
2021 Aug-2022 Aug	**Co-Investigator**. Implementation of rapid antigen testing for SARS-CoV-2 and Influenza A and B in congregate living settings. Health Canada, Safe Restart. PI: Straus S. Co-Investigators: Baral S, Chen A, **Orkin A**. 1,260,000.000 CAD
2021 Aug-2023 Mar	**Principal Investigator**. Increasing confidence, uptake and access to the COVID-19 vaccine. Public Health Agency of Canada (PHAC), Immunization Partnership Fund: Community Health Ambassador Program (CHAMP). Co-investigators: Svoboda T, Baral S, El-Khechen Richandi G, Kaur T**,** Siddiqui A, Sarty M. 490,000 CAD.
2021 Jun-2022 Dec	**Co-Investigator**. A Qualitative Exploration of Vaccine Uptake and Hesitancy Among People Experiencing Homelessness in Toronto. Canadian Institutes for Health Research (CIHR). PI: Wang SW. Co-investigators: Jenkinson J, **Orkin A**, Kiran T, Thulien N. 100,258 CAD
2020 Jul-2020 Dec	**Principal Investigator**. COVID-Alert Risk Evaluation and Management (CARE). Co-RIG Program Phase I. The Foundation for Advancing Family Medicine and the CMA Foundation. Co-Principal Investigators: Svoboda T, Baral S, Vasa P. 176,643.18 CAD
2019-2022	**Co-Investigator**. Study of Post-Hospital care for Opioid Overdoses that are Non-Fatal (SPOON). Canadian Institutes of Health Research (CIHR). PI: Bayoumi A and Leece P. Co-Investigators: Antoniou T, Caudarella A, Challacombe L, Firestone M, **Orkin A**, Gomes T, Guilcher S, Guimond T, Kendall C, Powis J, Strike C. 459,000.00 CAD
2018-2019	**Principal Investigator**. Community-Based Emergency Care in Tsiigehtchic, Northwest Territories. Government of the Northwest Territories, Department of Health and Social Services. Co-Investigators: VanderBurgh D, Ritchie S. 150,000.00 CAD
2018	**Co-Principal Investigator**. Advancing Care for People Who Use Opioids Through Co-education for Harm Reduction and Emergency Care Workers. Meta-Phi Project, Women's College Hospital, Toronto, Ontario. Co-Principal Investigators: Lim C, Primiani N. 36,000 CAD
2017-2022	**Co-Investigator.** CRISM Implementation Science Program on Opioid Interventions and Services – QC/Maritimes. Canadian Institutes of Health Research (CIHR). PI: Bruneau J. 1,875,000.00 CAD
2017-2018	**Co-Investigator**. Resuscitation in Motion (RiM) 2018: From Research to Real World-Dissemination and Knowledge Exchange for Best Practice. Canadian Institutes of Health Research (Heath Services and Policy Research). PI: Laurie Morrison. Co-Investigators: A Baker, S. Brooks, J. Buick, T. Chan, S. Cheskes, J. Christenson, K. Dainty, P. Dorian I. Drennan, B. Gruneau, S. Gupta, J. Jensen, S. Lin, **A. Orkin**, J. Parsons, S. Rizoli, L. Rose, O. Rotstein, D. Scales, B. Thoma, M. Welsford, C. Vaillancourt, S. Vaillancourt, P. Verbeek, M. Welsford, A. deCaen. 15,000.00 CAD
2017	**Co-Investigator**. A blinded, randomized controlled trial of opioid analgesics for the management of acute fracture pain in older adults discharged from the emergency

department. Canadian Association of Emergency Physicians: EM Advancement Fund. PI: Varner C. Co-Investigators: McLeod S, **Orkin A**, Melady D, Borgundvaag B. 10,000.00 CAD

2017 **Principal Investigator**. Community-Based Emergency Care in Tsiigehtchic, Northwest Territories. Government of the Northwest Territories, Department of Health and Social Services. Co-Investigators: VanderBurgh D, Ritchie S. 37,245.00 CAD

2016-2019 **Co-Investigator**. The Surviving Opioid Overdose with Naloxone Education and Resuscitation (SOON-ER) trial: a randomized study of an opioid overdose education and naloxone distribution intervention for laypeople in ambulatory and inpatient settings. Canadian Institutes of Health Research (Neurosciences, Mental Health and Addiction). PI: Strike C, Morrison L, Campbell D, Handford C, Sellen K. Co-Investigators: Hopkins S, Hunt R, Klaiman M, Leece P, **Orkin A**, Parsons J, Shahin R, Stergiopoulos V, Thorpe K, Turner S, Werb D. 844,772.00 CAD

2015-2018 **Co-Principal Investigator**. Community-Based Emergency Care: Developing a Prehospital Care System with the Windigo First Nations Council in Northwestern Ontario. Northern Ontario Academic Medical Association. Co-PI: VanderBurgh D. Co-Investigators: Ritchie S, Bocking N. 49,990 CAD.

2012-2014 **Principal Investigator**. Knowledge translation for emergency management in remote and resource-poor communities. Indigenous Health Research Development Program. Dignitas International. Co-Investigators: VanderBurgh D, Ritchie S. Community Partners: Tait J, Morris J. $25,000 CAD (IHRDP) 5,000 CAD (Dignitas)

2012-2013 **Co-Investigator**. Surviving Opioid Overdose with Naloxone (SOON) Project and Roundtable. CIHR Partnerships for Health Systems Improvement Planning Grant. PI: Hu H. Co-Investigators: Morrison L, **Orkin A**, Leece P, Bingham K, Klaiman M. 24,922.00 CAD

2011-2013 **Co-Principal Investigator.** The Access to Justice and Health Project. CIHR Café Scientifique Spring 2012 Competition. Co-PI: Baxter J. Co-Investigators: Cole D (Faculty Supervisor). 3,000 CAD

2009-2013 **Co-Principal Investigator**. Sachigo Lake Wilderness Emergency Response Education Initiative. Northern Ontario Academic Medical Association Innovation Fund, Canadian Institute of Health Research (CIHR) Meetings, Planning and Dissemination Grants – Aboriginal Health. Co-PI: VanderBurgh D. 98,000.00 CAD (NOAMAIF), 21,000.00 CAD (CIHR)

2008-2009 **Co-Principal Investigator**. Marathon Maternity Oral History Project. College of Family Physicians of Canada Janus Research Program, D.M. Robb Research Grant. Co-PI: Newbery S. 5,000 CAD

2. NON-PEER-REVIEWED GRANTS

2019 **Co-Investigator**. The Surviving Opioid Overdose with Naloxone Education and Resuscitation (SOON-ER) trial: a randomized study of an opioid overdose education and naloxone distribution intervention for laypeople in ambulatory and inpatient settings. PI: Strike C, Morrison L, Campbell D, Handford C, Sellen K. Co-Investigators: Hopkins S, Hunt R, Klaiman M, Leece P, **Orkin A**, Parsons J, Shahin R, Stergiopoulos V, Thorpe K, Turner S, Werb D. Canadian Centre on Substance Abuse. 11,630.00 CAD

3. SALARY SUPPORT AND OTHER FUNDING

PERSONAL SALARY SUPPORT

2016-2018	Schwartz-Reisman Emergency Medicine Institute and the Sinai Health System Department of Emergency Medicine ($40000)

TRAINEE SALARY SUPPORT

2017-2022	**Graduate Investigator Award**, Department of Family and Community Medicine, University of Toronto ($100,000).
2016-2021	**Post-Doctoral Fellowship**, Institution of Population and Public Health, Canadian Institutes of Health Research (CIHR). ($250000).
2014-2015	**Fellowship**. University of Toronto Clinician Investigator Program. ($75000)

E. Publications

1. PEER REVIEWED PUBLICATIONS

Journal Articles

1. Douma M, Handley A, MacKenzie E, Raitt J, **Orkin A**, Berry D, Bendall J, O'Dochartaigh D, Picard C, Carlson J, Djarv T, Zideman D, Singletary EM. The Recovery Position for Maintenance of Adequate Ventilation and the Prevention of Cardiac Arrest: A Systematic Review. *Resuscitation Plus* 10; 2022 Jun. https://doi.org/10.1016/j.resplu.2022.100236**. Co-author**.

2. Xie, E.C., Chan, K., Khangura, J.K. Jek-Khan Koh J, **Orkin AM**, Sheikh H, Hayman K, Gupta S, Kumar T, Hulme J, Mrochuk M, Dong K. CAEP position statement on improving emergency care for persons experiencing homelessness: executive summary. *Can J Emerg Med*. 2022 Apr 7. https://doi.org/10.1007/s43678-022-00303-2. **Co-author**.

3. Zhu A, Bruketa E, Svoboda T, Patel J, Elmi N, Richandi G, Baral S, **Orkin A**. Respiratory infectious disease outbreaks among people experiencing homelessness: a systematic review of prevention and mitigation strategies. *Annals of Epidemiology*. 2022 Jun 9. https://doi.org/10.1016/j.annepidem.2022.03.004**. Senior Responsible Author.**

4. Luong L, Beder M, Nisenbaum R, **Orkin A**, Wong J, Damba C, Emond R, Loutfy M, Wright V, Bruce-Barrett C, Cheung W, Cheung K, Williams V, Vanmeurs M, Lena S, Boozary A, Manning H, Hester H, Hwang SW. Prevalence of SARS-CoV-2 infection among people experiencing homelessness in Toronto during the first wave of the COVID-19 pandemic. *Canadian Journal of Public Health*. 2021 Dec 17: 1-9. doi: 10.17269/s41997-021-00591-8**. Co-author**.

5. Wyckoff MH, Singletary EM, Soar, J Olasveengen, T et al. 2021 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations: Summary From the Basic Life Support; Advanced Life Support; Neonatal Life Support; Education, Implementation, and Teams; First Aid Task Forces; and the COVID-19 Working Group. *Circulation*. 2021 Nov. https://doi.org/10.1161/CIR.0000000000001017. **Co-author**.

6. Sturgiss L, Phillips WR, Moriarty F, **Orkin A**, Lucassen P, van der Wouden JC. Consensus Reporting Items for Studies in Primary Care (CRISP): An international Delphi survey of researchers and end-users. *Australian Journal of Primary Health*. 2021 Aug 6; 27(4): XLVII-XLVII. **Co-author**.

7. Galarneau LR, Hilburt J, O'Neill ZR, Buxton JA, Scheuermeyer FX, Dong K, Kaczorowski J, **Orkin AM**, Barbic SP, Bath M, Moe J, Miles I, Tobin D, Grier S, Garrod E, Kestler A. Experiences of people with opioid disorder during the COVID-19 pandemic: A qualitative study. *PLOS ONE*. 2021 Jul 29. doi: https://doi.org/10.1371/journal.pone.0255396 **Co-author**.

8. **Orkin AM**, Venugopal J, Curran JD, Fortune MK, McArthur M, Mew E, Ritchie SD, Drennan IR, Exley A, Jamieson R, Johnson DE, MacPherson A, Martiniuk A, McDonald N, Osei-Ampofo M, Wegier P, Van de Velde S, VanderBurgh D. Emergency care with lay responders in underserved populations: a systematic review. *Bull World Health Organ*. 2021 Jul 9; 99:514–528H doi: http://dx.doi.org/10.2471/BLT.20.270249. **Principal Author.**

9. **Orkin AM**, Gill PJ, Ghersi D, Campbell L, Sugarman J, Emsley R, Steg PG, Weijer C, Simes J, Rombey T, Williams HC, Wittes J, Moher D, Richards DP, Kasamon Y, Getz K, Hopewell S, Dickersin K, Wu T, Ayala AP, Schulz KF, Calleja S, Boutron I, Ross JR, Golub RM, Khan KM, Mulrow C, Siegfried N, Heber J, Kearney PR, Wanyenze RK, Hróbjartsson A, Williams R, Bhandari N, Jüni P, Chan A, CONSERVE Group. Guidelines for Reporting Trial Protocols and Completed Trials Modified Due to COVID-19 and Other Extenuating Circumstances: CONSERVE 2021 Statement. *JAMA*. 2021 June 21. doi:10.1001/jama.2021.9941. **Principal Author**.

10. Baral S, Bond A, Boozary A, Bruketa E, Elmi N, Freiheit D, Ghosh M, Goyer ME, **Orkin AM**, Patel J, Richter T, Robertson A, Sutherland C, Svoboda T, Turnbull J, Wong A. Seeking Shelter: Homelessness and COVID-19. *FACETS*. 2021 Jun 10. doi: https://doi.org/10.1139/facets-2021-0004. **Co-author**.

11. **Orkin A**, Charles M, Norris K, Thomas R, Chapman L, Wright A, Campbell D, Handford C, Klaiman M, Hopkins S, Shahin R, Thorpe K, Juni P, Parsons J, Sellen K, Goso N, Hunt R, Leece P, Morrison L, Stergiopolous V. Mixed Methods Feasibility Study for the Surviving Opioid Overdose with Naloxone Education and Resuscitation (SOONER) Trial. *Resuscitation Plus*, 6, 2021 June 100131. http://dx.doi.org/10.1016/j.resplu.2021.100131. Corrigendum: *Resuscitation Plus* 7, 2021 Sep; 100158. https://doi.org/10.1016/j.resplu.2021.100158 **Principal Author**.

12. **Orkin A**, Rao S, Venugopal J, Kithulegoda N, Wegier P, Ritchie SD, VanderBurgh D, Martiniuk A, Salamanca-Buentello F, Upshur R. Conceptual framework for task shifting and task sharing: An international Delphi study. *Human Resources for Health*. 2021 May. https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-021-00605-z. **Principal Author.**

13. Phillips WR, Sturgiss E, Yang A, Glasziou P, olde Hartman T, **Orkin A**, Russell GM, van Weel C. Clinician use of primary care research reports. *J Am Board Fam Med*. 2021 May 5; 34(3): 648-660. **Co-author**.

14. Dong KA, Lavergne KJ, Salvalaggio G, Weber SM, Xue CJ, Kestler A, Kaczorowski J, **Orkin A,** Pugh A, Hyshka E. Emergency physician perspectives on initiating buprenorphine/naloxone in the emergency department: A qualitative study. *Journal of American College of Emergency Physicians Open*. 2021 Apr. doi.org/10.1002/emp2.12409 **Co-author.**

15. Dezfulian C, **Orkin AM**, Maron BA, Elmer J, Girotra S, Gladwin MT, Merchant RM, Panchal AR, Perman SM, Starks MA, van Diepen S, Lavonas EJ. Opioid-associated out-of-hospital cardiac arrest: Distinctive clinical features and implications for health care and public responses: A scientific statement from the American Heart Association. *Circulation*. 2021 Apr 20; 143(16): e836-e870. **Co-author**.

16. **Orkin A,** Nicoll G, Persaud N, Pinto AD. Missing Demographics: Reporting of socio-demographic variables in randomized clinical trials, 2014-2020. *JAMA Netw Open.* 2021; 4(6):e2110700. doi:10.1001/jamanetworkopen.2021.10700. **Principal Author**.

17. Kestler A, Kaczorowski J, Dong K, Orkin A, Daoust R, Moe J, Van Pelt K, Andolfatto G, Klaiman M, Yan J, Koh J, Crowder K, Webster D, Atkinson P, Savage D, Stempien J, Besserer F, Wale J, Lam A, Scheuermeyer F. A survey on buprenorphine practice and attitudes in 22 Canadian emergency physician groups. *CMAJ Open*. 2021 Sep 21; 9(3): E864-E873; doi: https://doi.org/10.9778/cmajo.20200190. **Co-author**.

18. Phillips WR, Sturgiss E, Hunik L, Glasziou P, Olde Hartman T, **Orkin AM**, Reeve J, Russell GM, Van Weel C. Improving the reporting of primary care research: An international survey of researchers. *J Am Board Fam Med.* 2021 Jan-Feb; 34(1). doi: 10.3122/jabfm.2021.01.200266. **Co-author.**

19. Dezfulian C, **Orkin A**, Maron BA, Elmer J, Girotra S, Gladwin MT, Merchant RM, Panchal AR, Perman SM, Starks MA, Van Diepen S, Lavonas EJ, on behalf of the American Heart Association Council on Cardiopulmonary Critical Care, Perioperative and Resuscitation; Council on Arteriosclerosis, Thrombosis and Vascular Biology; Council on Cardiovascular and Stroke Nursing; and Council on Clinical Cardiology. Opioid-associated out-of-hospital cardiac arrest: Distinctive clinical features and implications for healthcare and public responses. A Scientific Statement from the American Heart Association. *Circulation.* 2021 Jan; 14(3): e1-e34. **Co-author.**

20. Pellegrino J, Krob JL, **Orkin AM**. First aid education for opioid overdose poisoning: Scoping review. *Cureus.* 2021 Jan; 13(1): e12454. doi:10.7759/cureus.12454. **Senior Responsible Author.**

21. Kaczorowski J, Bilodeau J, **Orkin AM**, Dong K, Daoust R, Kestler A. Emergency department-initiated interventions for patients with opioid use disorder: a systematic review. *Academic Emergency Medicine*. 2020 Nov. 27(11):1173-1182. doi:10.1111/acem.14054**. Co-author**

22. Greif R, Bhanji F, Bigham BL, Bray J, Breckwoldt J, Cheng A, Duff JP, Gilfoyle E, Hsieh MJ, Iwami T, Lauridsen KG, Lockey AS, Ma MH, Monsieurs KG, Okamoto D, Pellegrino JL, Yeung J, Finn JC and on behalf of the Education, Implementation, and Teams Collaborators. Education, Implementation, and Teams: 2020 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science with Treatment Recommendations. *Circulation*. 2020 Oct 20; 142(16_suppl_1):S222-S283. https://doi.org/10.1161/CIR.0000000000000896. **Co-author.**

23. Greif R, Bhanji F, Bigham BL, Bray J, Breckwoldt J, Cheng A, Duff JP, Gilfoyle E, Hsieh MJ, Iwami T, Lauridsen KG, Lockey AS, Ma MH, Monsieurs KG, Okamoto D, Pellegrino JL, Yeung J, Finn JC and on behalf of the Education, Implementation, and Teams Collaborators. Education, Implementation, and Teams: 2020 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science with Treatment Recommendations. *Resuscitation*. 2020 Nov;156:A240-A282. doi: 10.1016/j.resuscitation.2020.09.016. **Co-author**.

24. Singletary EM, Zideman D, Bendall JC, Berry D, Borra V, Carlson JN, Cassan P, Chang W-T, Charlton N, Djäry T, Douma MJ, Epstein JL, Hood NA, Markenson D, Meyran D, **Orkin AM**, Sakamoto T, Swain J, Woodin JA. 2020 International Consensus on First Aid Science with Treatment Recommendations. *Circulation.* 2020 Oct; 142 (16_suppl_1). doi: 10.1161/CIR.0000000000000897. **Co-author.**

25. Singletary EM, Zideman D, Bendall JC, Berry D, Borra V, Carlson JN, Cassan P, Chang W-T, Charlton N, Djäry T, Douma MJ, Epstein JL, Hood NA, Markenson D, Meyran D, **Orkin AM**, Sakamoto T, Swain J, Woodin JA. 2020 International Consensus on First Aid Science with Treatment Recommendations. *Resuscitation*. 2020;156:A240-A282. doi: 10.1016/j.resuscitation.2020.09.016. **Co-author.**

26. Pellegrino JL, Charlton NP, Carlson J, Flores GE, Goolsby CA, Hoover AV, Kule A, Magid DJ, **Orkin AM**, Singletary EM, Slater TM, Swain JM. 2020 American Heart Association and American Red Cross Focused Update for First Aid. *Circulation.* 2020 Oct 27; 142(17): e287–e303. doi: 10.1161/CIR.0000000000000900**. Co-author.**

27. De Brier N, O Dorien, Borra V, Singletary EM, Zideman DA, De Buck E, International Liaison Committee on Resuscitation First Aid Task Force, Bendall JC, Berry DC, Carlson JN, Cassan P, Chang WT, Charlton NP, Djärv T, Douma M, Epstein JL, Hood NA, Markenson DS, Meyran D, **Orkin A**, Sakamoto T, Swain JM, Woodin JA. Storage of an avulsed tooth prior to replantation: A systematic review and meta-analysis. *Dental Traumatology*. 2020 Oct; 36(5):453-476. **Co-author**.

28. Reid N, Chartier L, **Orkin AM**, Klaiman M, Naidoo K, Stergiopoulos V. Rethinking involuntary admission for individuals presenting to Canadian emergency departments with life-threatening substance use disorders. *CJEM*. 2020 June. doi: 10.1017/cem.2020.385**. Co-author.**

29. VanderBurgh D, Savage D, Dubois S, Binguis N, Maxwell S, Bocking N, Farrell T, Tien H, Ritchie S, **Orkin AM**. Epidemiologic features of medical emergencies in remote First Nations in northern Ontario: a cross-sectional descriptive study using air ambulance transport data. *CMAJ Open*. 2020 May 23; 8(2); E400-E406. doi: 10.9778/cmajo.20190186. **Senior Responsible Author.**

30. Kouyoumdjian FG, **Orkin AM**. Improving health and healthcare access for people who experience imprisonment in Ontario. *Healthcare Quarterly*. 2020 Apr; 23(1):6-9. PMID: 3224973. **Co-author.**

31. Tuinema J, **Orkin AM**, Cheng S, Fung K, Kouyoumdjian FG. Emergency department use in people who experience imprisonment in Ontario, Canada. *CJEM*. 2020 Mar; 22(2):232-240. doi: 10.1017/cem.2019.401. **Co-author.**

32. Porcino A, Chan AW, Kravitz R, **Orkin AM**, Punja S, Ravaud P, Schmid C, Vohra S. SPIRIT extension and elaboration for n-of-1 trials: SPENT 2019 checklist. *BMJ.* 2020 Feb 27; 368; m122. doi: /10.1136/bmj.m122. **Co-author.**

33. Kouyoumdjian FG, Lee JY, **Orkin AM**, Cheng SY, Fung K, O'Shea T, Guyatt G. Thirty-day readmission after medical-surgical hospitalization for people who experience imprisonment in Ontario, Canada: A retrospective cohort study. *PLOS One.* 2020 Jan; 15(1): e0227588. doi: 10.1371/journal.pone.0227588. **Co-author.**

34. Charlton NP, Pellegrino JL, Kule A, Slater TM, Epstein JL, Flores GE, Goolsby CA, **Orkin AM**, Singletary EM, Swain JM. 2019 American Heart Association and American Red Cross Focused Update for First Aid: Presyncope. *Circulation*. 2019 Dec 10; 140(24): e931-e938. doi: 10.1161/CIR.0000000000000730. **Co-author.**

35. **Orkin AM**, Campbell D, Handford C, et al. on behalf of the SOONER Investigators. Protocol for a mixed methods feasibility study for the Surviving Opioid Overdose with Naloxone Education and Resuscitation (SOONER) Randomized Control Trial. *BMJ Open.* 2019 Nov; 12;9(11):e0294369: doi: 10.1136/bmjopen-2019-029436. **Principal Author.**

36. Kouyoudjian F, Kim M, Kiran T, Cheng S, Fung K, **Orkin AM**, Kendall K, Green S, Matheson F, Kiefer L. Attachment to primary care and team-based primary care: Retrospective cohort study of people who experienced imprisonment in Ontario. *Can. Fam. Phys.* 2019 Oct; 65(10):e433-e442. PMID: 31604754. **Co-author.**

37. Leece P, Chen C, Manson H, **Orkin AM**, Schwartz B, Juurlink D, Gomes T. One-year mortality following emergency department visit for non-fatal opioid poisoning: A population-based analysis. *Annals of Emerg Med.* 2019 Sept 24; 75(1): 20-28. doi: 10.1016/j.annemergmed.2019.07.021. **Co-author.**

38. Sturgiss E, Phillips WR, Russell G, olde Hartman T, **Orkin A**, Reeve J, Glasziou P, van Weel C. Reporting guidelines for primary care research: what are the needs? *Australian Journal of Primary Health*. 2019 Jun 5; 25(3): xlix. **Co-author**.

39. **Orkin AM,** McArthur A, Venugopal J*, Kithulegoda N*, Martiniuk A, Buchman D, Kouyoumdjian F, Rachlis B, Strike C, Upshur REG. Defining and measuring health equity in research on task shifting in high-income countries: A systematic review. *Social Science and Medicine-Population Health.* 2019 Jan; 7: 100366. doi: 10.1016/j.ssmph.2019.100366. **Principal Author.**

40. Kouyoumdjian FG, Cheng SY, Fung K, Humphreys-Mahaffey S, **Orkin AM**, Kendall C, Kiefer L, Matheson FI, Green S, Hwang SW. Primary care utilization in people who experience imprisonment in Ontario Canada: A retrospective cohort study. *BMC Health Services Research*. 2018 Nov 9; 18(1):845. doi:10.1186/s12913-018-3660-2. **Co-author.**

41. **Orkin AM,** Ivers NM. "Is reducing ED visits an important outcome?" Invited comment on Kiran et al, Emergency department use and enrollment in a medical home providing after-hours care. Letter. *Annals of Family Medicine.* 2018 Sept/Oct;16:419-27; doi:10.1370/afm.2291. **Principal Author.**

42. **Orkin A**, Ovens H, McLeod S, Varner C, Melady D, Thompson C, Penciner R, Sidhu K, Dushenski D, Borgundvaag B. Letter in response to: "CJEM Debate Series: # Social Media—Social media has created emergency medicine celebrities who now influence practice more than published evidence." *CJEM*. 2018 Oct; 20(S2), S89. **Principal Author**.

43. Kouyoumdjian FG, Cheng SY, Fung K, Kirk M, **Orkin AM**, McIsaac KE, Kendall C, Kiefer L, Matheson F, Green S, Hwang SW. The health care utilization of people in prison and after prison release: A population-based cohort study in Ontario, Canada. *PLOS One*. 2018 Aug 3; 13(8): e0201592. doi: 10.1371/journal.pone.0201592. **Co-author.**

44. **Orkin AM,** McArthur A, McDonald A*, Mew E*, Martiniuk A, Buchman D, Kouyoumdjian F, Rachlis B, Strike C, Upshur REG. Defining and measuring health equity effects in research on task shifting interventions in high-income countries: a systematic review protocol. *BMJ Open.* 2018 Aug 1; 8(7):e021172. doi: 10.1136/bmjopen-2017-021172. **Principal Author.**

45. **Orkin A**, Curran J, Ritchie S, van de Velde S, VanderBurgh D. Health effects of training laypeople to deliver emergency are in underserviced populations: preliminary results of a systematic review. *CJEM*. 2018 May; 20(S1): S7-S8. doi: https://doi.org/10.1017/cem.2018.66. **Principal Author**

46. Nolan B, Ackery A, Mamakwa S, Glenn S, VanderBurg D, **Orkin A**, Kirlew M, Dell EM, Tien H. Care of the injured patients at remote nursing stations and during aeromedical transport. *Air Medical Journal.* 2018 May 1; 37(3):161-164. doi: https://doi.org/10.1016/j.amj.2017.11.013. **Co-author.**

47. Curran J, Ritchie SD, Beardy J, Vanderburgh D, Born K, Lewko J, **Orkin AM**. Conceptualizing and managing medical emergencies where no formal paramedical service exists: Perspectives from a remote Indigenous community in Canada. *International Journal of Environmental Research and Public Health.* 2018 Feb 4; 15(2):267, doi:10.3390/ijerph15020267. **Senior Responsible Author.**

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50. Lacroix L, Thurgur L, **Orkin AM**, Perry JJ, Stiel IG. Emergency physicians' attitudes and perceived barriers to the implementation of take-home naloxone programs in Canadian emergency departments. *CJEM.* 2018 Jan 20; 20(1): 45-62. doi: 10.1017/cem.2017.390. **Co-author**.

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1. NON-PEER REVIEWED PUBLICATIONS

1. Savage DW, Fisher A, Choudhury S, Ohle R, Strasser RR, **Orkin AM**, Mago V. Investigating the implications of COVID-19 for the rural and remote population of Northern Ontario using a mathematical model. Posted to pre-publication server-- medRxiv. https://www.medrxiv.org/content/10.1101/2020.09.17.20196949v1. **Co-author.**

Books and Invited Contributions to Published Works

1. Vanderburgh D, Webster M, Burton J, Carriere B, Ritchie S, Russell J, Sorsa L, Boriss E, Orkin A. (eds). *Community-Based Emergency Care: Remote Community First Aid Textbook*. Toronto: Community-Based Emergency Care, 2019. (CC BY-NC-SA 4.0). **Co-editor.**

2. Vanderburgh D, Webster M, Burton J, Carriere B, Ritchie S, Russell J, Sorsa L, Boriss E, Orkin A. (eds). *Community-Based Emergency Care: Instructor Companion Book*. Toronto: Community-Based Emergency Care, 2019. (CC BY-NC-SA 4.0). **Co-editor.**

3. Piggott T, **Orkin A**. "Deconstructing the Concept of Special Populations for Health Care, Research and Policy." In *Under-Served: Health determinants of Indigenous, Inner-City and Migrant Populations in Canada*. Toronto: Canadian Scholars Press, 2018. **Co-editor.**

4. Ritchie SD, Wabano MJ, Beardy J, Curran J, **Orkin A**, Vanderburgh D, Born K, & Young NL. Community-Based Participatory Research and Realist Evaluation: Complimentary Approaches for Aboriginal Health and Adventure Therapy. In C. L. Norton, C. Carpenter, & A. Prior (Eds.), *Adventure therapy around the globe: International perspectives and diverse approaches* Champaign, IL: Common Ground Publishing, 2015: 195-217. **Chapter co-author.**

5. Crawford A, Kay R, Peterkin A, Roger R, Ruskin R with **Orkin A** (eds). *Body & Soul: Narratives of Healing from Ars Medica,* University of Toronto Press, Toronto, 2011. **Co-editor.**

6. VanderBurgh D, **Orkin A**. "Professors, Parents and Partners: A Novel Typology of Community Preceptors" in *Community-Based Medical Education*, Len Kelly (ed.), Radcliffe Press, Oxford, 2011. **Chapter co-author.**

Reports and Position Papers

1. **Orkin A**. Improving Care in the Shelter Community: The CARE Model. In Advancing Family Medicine During the Pandemic: Co-RIG Phase 1 Report. Foundation for Advancing Family Medicine, The College of Family Physicians of Canada. 2021 Sept 20. https://fafm.cfpc.ca/corig-phaseone/. **Principal Author.**

2. Baral S, Bond A, Boozary A, Bruketa E, Elmi N, Freiheit D, Ghosh M, Goyer ME, **Orkin AM**, Patel J, Richter T, Robertson A, Sutherland C, Svoboda T, Turnbull J, Wong A. Seeking Shelter: Homelessness and COVID-19. Policy Brief. Royal Society of Canada. 2021 Feb. https://rsc-src.ca/sites/default/files/Homelessness%20PB_EN_0.pdf. **Co-author**.

3. International Federation of Red Cross and Red Crescent Societies. International first aid, resuscitation, and education guidelines 2020. Paris. 2021 Feb. https://www.globalfirstaidcentre.org/first-aid-guidelines-2020/. **Content contributor**.

4. Koh JJ, Klaiman M, Miles I, Cook J, Kumar T, Sheikh H, Dong K, **Orkin AM**, Ali S. CAEP Position Statement: Emergency department management of people with opioid use disorder. *CJEM*. 2020 Nov; 22(6): 768-771. doi: 10.1017/cem.2020.459. **Co-author**

5. **Orkin AM.** Expert report concerning the risk of COVID-19 in correctional facilities and other congregate settings. Ontario Superior Court of Justice, Ontario Court of Justice, Superior Court of Saskatchewan, Alberta Court of Appeal. 2020 April - May. **Principal Author.**

6. Xie E, Bond A, Hayman K, Hulme J, Sheikh H, **Orkin A**. "COVID-19 and persons experiencing homelessness or vulnerable housing". Canadian Association of Emergency Physicians (CAEP). 2020 Mar. https://caep.ca/wp-content/uploads/2020/03/COVID-19-and-homelessness-CAEP-updated-0321.pdf. **Co-author.**

7. Pellegrino JL, Krob, J, **Orkin A**, Bhanji F, Bigham B, Bray J, Breckwoldt J, Cheng A, Duff J, Glerup Lauridsen K, Gilfoyle E, Hiese M, Iwami T, Lockey A, Ma M, Monsieurs K, Okamoto D, Yeung J, Finn J, Greif R. on behalf of the International Liaison Committee on Resuscitation Education, Implementation, and Teams Task Force. Opioid Overdose First Aid Education: Scoping Review and Task Force Insights [Internet] Brussels, Belgium: International Liaison Committee on Resuscitation (ILCOR) Education, Implementation, and Teams Task Force, 2020 Jan. Available from: http://ilcor.org **Co-author.**

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9. **Orkin AM.** Clinical population medicine: A population health roadmap for Ontario Health Teams. 2019 Nov 26. *Longwoods.* https://www.longwoods.com/content/26010 **Principal Author.**

10. **Orkin AM,** VanderBurgh D, Webster M, Russell J, Ritchie S. Tsiigehtchic community-based emergency care program evaluation, report and recommendations. Report for the Government of the Northwest Territories. 2019 Mar. (Commissioned research report) **Principal Author.**

11. **Orkin AM.** Expert report concerning the death of Mr. Bradley Chapman. Inquest of the Office of the Chief Coroner of Ontario No. 2015_09519. 2018 May. **Principal Author.**

12. **Orkin AM**, Russell J, VanderBurgh D, Ritchie S. Tsiigehtchic Community-based emergency care consultation report. Report for the Tsiigehtchic Charter Community, Gwichya Gwich'in Council and the Government of the Northwest Territories. 2017 Jun. (Commissioned research report). **Principal Author.**

13. **Orkin A**, VanderBurgh D, Ritchie S, Fortune M. Community-based emergency care: An open report for Nishnawbe Aski Nation. Thunder Bay: Northern Ontario School of Medicine. 2014. www.nosm.ca/cbec. **Principal Author.**

4. SUBMITTED PUBLICATIONS

1. Stephen G, Burton J, Detsky AS, Ivors N, Berthelot S, Atzema CL, **Orkin AM**. Absence of evidence that emergency department care is more costly than other outpatient settings for low-acuity conditions: Cost difference for treating patients with low-acuity ambulatory conditions in emergency department versus other outpatient settings: An empty systematic review. **Submitted to**: *JACEP Open*. 2022 May. **Co-author**.

2. D'Angelo JJJ, Ritchie SD, Oddson B, Little J, Johnson DE, Vanderburgh D, **Orkin A**. Validating the Remote First Aid Self-Efficacy Scale for Use in Evaluation and Training of First Responders in Remote Contexts. **Submitted to** *Wilderness and Environmental Medicine*. 2022 May. **Co-author**.

3. Jenkinson J, Sniderman R, Gogosis E, Liu M, Nisenbaum R, Pederson C, Spandier O, Tibebu T, Dyer A, Chrichlow F, Richard L, **Orkin A**, Thulien N, Kiran T, Kayseas J, Hwang S. Exploring COVID-19 vaccine uptake, confidence, and hesitancy among people experiencing homelessness in Toronto, Canada: Protocol for COVENANT qualitative study. **Submitted to** *BMJ Open*. 2022 Apr. **Co-author.**

4. Sturgiss E, Prathivadi P, Phillips WR, Moriarty F, Lucassen P, Van der Wouden JC, Glasziou P, Olde Hartman T, **Orkin A**, Reeve J, Russell GM, Van Weel C. Key items for reports of primary care research: An international delphi study. **Submitted to** *Annals of Family Medicine.* 2021 Dec. **Co-author**.

5. Whitthall JP, **Orkin AM**, Handford C, Klaiman M, Leece P, Charles M, Wright A, Turner S, Morrison L, Strike C, Campbell DM. Resuscitation simulation among people who are likely to witness opioid overdose: Experiences from the SOONER Trial. **Submitted to** *PLOS ONE*. 2021 Sep. **Co-author**.

6. Sellen K, Markowitz B, Parsons JA, Leece P, Goso N, Handford C, Hopkins S, Klaiman M, Shahin R, Milos G, Wright A, Charles M, Morrison L, Strike C, **Orkin A**. Design considerations for overdose education and Naloxone distribution: Results of a multi-stakeholder workshop. **Submitted** to *Health Expectations*. 2021 Jun. Preprint available at Research Square, doi: 10.21203/rs.3.rs-978690/v1. **Senior Responsible Author**.

7. Xie EC, Chan K, Khangura JK, Koh JJ-K, Orkin AM, Sheikh H, Hayman K, Gupta S, Kumar T, Hulme J, Mrochuk M, Dong K. CAEP Position Statement - Executive Summary: Improving Emergency Care for Persons Experiencing Homelessness. **Submitted to** *CJEM*. 2022 Feb. **Co-author.**

F. Presentations and Lectures

Papers/Posters/Abtracts

INTERNATIONAL

2021 Nov 19 Phillips W, Sturgiss E, olde Hartman T, **Orkin A**, Reeve J, Russell G, Prathivadi P, van Weel C. CRISP - Consensus Reporting Items for Studies in Primary Care—New guidance for reporting your research. 49th North American Primary Care Research Group (NAPCRG) Meeting, Virtual Meeting. (Workshop) Presenter(s): William Phillips, Elizabeth Sturgiss, Tim olde Hartman, Aaron Orkin, Joanne Reeve, Grant Russell, Pallavi Prathivadi, Chris van Weel.

2020 Nov 20 Phillips W, Sturgiss E, Hunik L, Glasziou P, olde Hartman T, **Orkin A**, Reeve J, Russell G, van Weel C. Opportunities to improve primary care research reports to meet needs of researchers, clinicians, patients and policymakers. 48th North American Primary Care Research Group (NAPCRG) Meeting, Virtual Meeting. (Poster) Presenter(s): William Phillips, Elizabeth Sturgiss.

2015 Oct 24 **Orkin A**, Phillips W, Peterson L, Acheson L, Balasubramanian B, Bayliss E, Cohen D, Ferrer R, Frey J, Gill J, Marino M, Williams R, Stange K. Writing and publishing research using standardized reporting

guidelines. North American Primary Care Research Group (NAPCRG), Cancun, Mexico.

2014 Nov 15 Salcido D, Koller AC, Torres C, **Orkin A**, Schmicker RH, Morrison LJ, Nichol G, Stephens S, Menegazzi JJ and the Resuscitation Outcomes Consortium Investigators. Regional incidence and outcomes of out-of-hospital cardiac arrest associated with overdose. American Heart Association Resuscitation Science Symposium (ReSS), Chicago IL. Presenter: David Salcido.

Publication Details: Salcido D, Koller AC, Torres C, **Orkin A**, Schmicker RH, Morrison LJ, Nichol G, Stephens S, Menegazzi JJ and the Resuscitation Outcomes Consortium Investigators. Regional Incidence and Outcomes of Out-of-Hospital Cardiac Arrest Associated with Overdose. Circulation 2014;130: A236.

NATIONAL

2021 Dec D'Angelo JJ, Little J, **Orkin AM**, Vanderburgh D, Oddson B, Johnson DW, Gagnon V, DRS. (2021). The Remote First Aid Self-Efficacy Scale: Development and Validation of a Novel Tool for Remote First Aid Training, Evaluation, and Reflection. In C. Dallat & J. Jackson (Eds.), *Adventure Risk Research Symposium, Proceedings 2019-2021*: 1-7. Algonquin Thompson. https://www.kobo.com/ca/en/ebook/adventure-risk-research-symposium-proceedings-2019-2021

2021 Nov 4 Whittall JP, **Orkin AM**, Handford C, Klaiman M, Leece P, Charles M, Wright A, Turner S, Morrison L, Strike C, Campbell DM. Resuscitation simulation among people who are likely to witness opioid overdose: Experiences from the SOONER Trial. Royal College of Physicians and Surgeons of Canada, Simulation Summit. (Virtual) Presenter: Jonathan Whittall. Awarded Best Research Paper Prize.

2020 May 4 Bilodeau J, Kaczorowski J, **Orkin AM**, Dong K, Kestler A. L'efficacité des interventions visant les troubles consammations liés aux opioids dans les départements d'urgence: revue systématique de la littérature. 88e Congres de l'Acfas, Sherbrooke, QC. Presenter: J Bilodeau. (*postponed due to Covid-19*).

2019 Nov 19 **Orkin AM** on behalf of the SOONER Investigators and Community Advisors. "Design and Findings of the Surviving Opioid Overdose with Naloxone Education and Resuscitation (SOONER) Feasibility Study" North American Primary Care Research Group (NAPCRG), Toronto, ON.

2019 Nov 17 Phillips W, Sturgiss E, olde Hartman T, Russell G, Reeve J, **Orkin AM**, Glasziou P, van Weel C. Improving the reporting of primary care research: Survey of needs of researchers, clinicians, patients and policymakers. Poster. North American Primary Care Research Group (NAPCRG), Toronto, ON. Presenter: E Sturgiss.

2019 Oct 24 Dong K, Van Pelt K, Scheuermeyer F, Moe J, Kaczorowski J, **Orkin AM**, Kestler A. "Emergency physician attitudes and practices on prescribing buprenorphine/naloxone: A national survey. Poster. Can Soc. Addictions Med Conference, Halifax, NS. Presenter: K Dong.

2019 Oct 24 Dong K, Salvalaggio G, Pugh A, Hyshka E, Xue J, Kaczorowski J, **Orkin AM**, Keslter A. Emergency Department physician attitudes towards buprenorphine initiation in the ED: A Qualitative Study. Poster. Canadian Society of Addiction Medicine Conference, Halifax, NS. Presenter: K Dong.

2018 May **Orkin A**, Curran J, Ritchie S, Van de Velde S, VanderBurgh D. Health effects of training laypeople to deliver emergency care in underserviced populations: preliminary results of a systematic review. Canadian Association of Emergency Physicians Conference (CAEP), Calgary, AB.

2018 May 2 **Orkin A**, Leece P, Hopkins S, Shahin R, Handford C, Campbell D, Parsons J, Strike C, Charles M,

Sniderman R, Sellen K, Hunt R, Wright A, Milos G, Morrison L, on behalf of the SOONER Investigators. The Surviving Opioid Overdose with Naloxone Education and Resuscitation (SOONER) Feasibility Study: Combining design, simulation, and resuscitation science to respond to the opioid crisis. Resuscitation in Motion (RiM2018), Toronto, ON.

2018 May 2 Parsons J, **Orkin A**, Fowler M, Wright A, Burnett J, Scheuermeyer F. First aid, rescue breathing and chest compressions in opioid overdose education programs: A brokered dialogue. Resuscitation in Motion (RiM2018), Toronto, ON**.**

2016 Oct 20 Leece P, Timmings C, Buchman D, **Orkin A**, Kahan M, Furlan A. Improving primary care opioid prescribing with an educational and self-monitoring strategy. Workshop. Canadian Society of Addiction Medicine Symposium, Montreal, QC. Presenter: P Leece.

2016 Jun 4 Lacroix L, Thurgur L, **Orkin A**, Stiell I. Emergency physician attitudes and perceived barriers to take-home naloxone programs in Canadian Emergency Departments. Poster. Canadian Association of Emergency Physicians (CAEP) Conference, Québec City, QC. Presenter: L Lacroix.

2015 Jun 2 Klaiman M, Bingham K, Leece P, **Orkin A**, Morrison L, Hu H. Surviving Opioid Overdose with Naloxone (SOON): Results of an International Working Group. Poster. Canadian Association of Emergency Physicians (CAEP), Edmonton AB.

2015 Jun 2 **Orkin A**, Zhan C, Buick J, Drennan I, Klaiman M, Leece P, Bingham K, Morrison LJ. Survival from drug-related out-of-hospital cardiac arrests: A retrospective cohort study. Canadian Association of Emergency Physicians (CAEP), Edmonton, AB.

2014 Oct 23 **Orkin A**. VanderBurgh D, Ritchie S, Beardy J. "Community-Based Emergency Care: A novel approach to the development and delivery of first response medical services in remote First Nations communities. Canadian Risk and Hazards Network Symposium, Toronto, ON.

2014 Oct 19 Schwandt M, **Orkin A**, McLaughlin J, Lay M, Cole D. Medical Repatriation of Migrant Farm Workers in Canada. International Safety and Health in Agricultural and Rural Populations Symposium. Saskatoon, SK. Presenter: M Schwandt

PROVINCIAL/REGIONAL

2019 Sep 10 **Orkin AM** on behalf of the SOONER Investigators and Community Advisors. Feasibility of the Surviving Opioid Overdose with Naloxone (SOONER) Trial. Ontario Node Canadian Research Initiative in Substance Misuse (CRISM) Summit, Toronto, ON.

2018 Sep 28 Campbell D, **Orkin AM**, Klaiman M, Hopkins S, Shahin R et al on behalf of the SOONER Investigators. The Surviving Opioid Overdose with Naloxone Education and Resuscitation Project: Combining design, simulation and resuscitation science to respond to the opioid crisis." Royal College of Physicians and Surgeons Simulation Summit, Toronto, ON

2018 May 25 **Orkin A**, Russell J, VanderBurgh D, Ritchie S, Maxwell S, McKay F. Community-based emergency care: Developing an emergency first response program with remote Indigenous Communities." Indigenous Health Conference, Toronto, ON.

2018 Apr 24 **Orkin A**, Curran J, Ritchie S, van de Velde S, VanderBurgh D. What is first aid really good for? Preliminary results and implications from a systematic review on the health impacts of first aid education in underserviced populations and low-resource settings. Plenary presentation. International First Aid Education Conference, Niagara Falls, ON.

2018 Apr 24 **Orkin A**, Taylor T, Oliver E. Qualitative insights for developing first aid education on drug overdose. International First Aid Education Conference, Niagara Falls, ON.

2017 Nov Leece P, Chen C, Manson M, **Orkin A**, Schwartz B, Juurlink D, Rosella L, Gomes T. One year mortality following emergency department visit for non-fatal opioid overdose in Ontario. Canadian Centre on Substance Use Conference, Calgary, AB. Presenter: P Leece.

2017 May 30 Orkin A. Designing first aid for the opioid epidemic. Public Health Agency of Canada Special Advisory Committee on the Epidemic of Opioid Overdoses, Ottawa, ON.

2017 May Buchman DZ, **Orkin A.** Overdose education and naloxone distribution programs: Unintentionally entrenching stigma and inequities? 26th Annual Bioethics Society Conference, Toronto, ON. Presenter: DZ Buchman.

2016 Sep 14 Young M, **Orkin A**, Malek A. Overdose prevention with naloxone: National and provincial landscape. CAMH Opioid Resource Hub and Registered Nurses Association of Ontario Webinar.

2016 Jun Ritchie S, Mew E, VanderBurgh D, **Orkin A. "**Emergency response systems and services in remote First Nations communities in Northern Ontario: An environmental scan." Northern Health Research Conference, Sault Ste. Marie, ON. Presenter: S Ritchie.

2016 Jun Ritchie S, Mew E, VanderBurgh D, **Orkin A. "**Three-pronged approach to address gaps in Northern Ontario First Nations emergency services and related health data. Northern Health Research Conference, Sault Ste. Marie, ON. Presenter: S Ritchie.

2016 Feb 22 **Orkin A**. Overdose education and naloxone distribution: How first aid can help address the opioid overdose epidemic. Oral Presentation. Canadian Emergency Care Conference, Red Cross and Heart and Stroke Canada, Toronto, ON.

2016 Feb 22 Mew E, Ritchie S, VanderBurgh D, **Orkin A**. Community-based emergency care: Accounting for data inadequacies in remote health systems development. Poster. Chiefs of Ontario First Nation Health Research Symposium, Toronto, ON.

2015 Mar 21 **Orkin A**. Access to data as a form of resistance: Epidemiology of migrant farm worker medical repatriation. Ontario Public Interest Research Group Global Citizenship Conference, McMaster University, Hamilton, ON.

2013 Nov 28 **Orkin A**, VanderBurgh D. "Community-based emergency care: First response innovations in remote First Nations. Poster. Ontario Ministry of Health and Long-Term Care Innovation Showcase, Toronto, ON.

2013 Jan 31 **Orkin A**, Baxter J, Cole D. Does your health depend on your access to justice? Public Café Scientifique and discussion panel, Toronto, ON.

LOCAL

2020 Oct 6 **Orkin, A** and Hwang, S. Homelessness in the ED: Three Problems. St. Joseph's Health Centre Department of Emergency Medicine Educational Rounds, University of Toronto, Toronto, ON.

2019 Apr 5 Primiani N, Lim C, Lall V, Wen S, **Orkin AM** on behalf of the Co-Education Working Group. A pilot co-education workshop for harm reduction and emergency health providers. Poster. Department of Family and Community Medicine Conference, University of Toronto, Toronto, ON.

2019 Mar 21 **Orkin A**, on behalf of the SOONER Investigators. SOONER: Combining design, simulation and trial methods to bring naloxone into everyday practice. Department of Family and Community Medicine City-Wide Research Rounds, University of Toronto, Toronto, ON.

2018 Nov 15 **Orkin AM**, Curran J, Van de Velde S, VanderBurgh D. Effects of training laypeople to deliver emergency care in underserviced populations: Systematic review. Family Medicine Forum, University of Toronto, Toronto, ON.

2018 Nov 15 **Orkin AM**, Sellen K, et al. on behalf of the SOONER Investigators. Co-design of a naloxone distribution kit for family practice, emergency departments and addictions medicine. Family Medicine Forum,

University of Toronto, Toronto, ON.

2018 Nov 15 Foote J, Chorny Y, **Orkin AM**. Mitigating the opioid epidemic from the emergency room. Family Medicine Forum, University of Toronto, Toronto, ON.

2018 Nov 17 Gravel J, Foote J, Borgundvaag B, **Orkin AM**. Treating acute pain in patients with opioid use disorder in the emergency department. Family Medicine Forum, University of Toronto, Toronto, ON.

2018 May 23 **Orkin A**, Klaiman M, Leece P, Hopkins S, Shahin R, Handford C, Campbell D, Parsons J, Strike C, Charles M, Sniderman R, Sellen K, Hunt R, Wright A, Milos G, Morrison L, on behalf of the SOONER Investigators. Is it even possible? Feasibility study for the Surviving Opioid Overdose with Naloxone Education and Resuscitation (SOONER) Project. University of Toronto Division of Emergency Medicine Research Day, Toronto, ON.

2015 Nov 25 **Orkin A**, Zhan C, Buick J, Drennan I, Klaiman M, Leece P, Bingham K, Morrison LJ. Survival from drug-related out-of-hospital cardiac arrests: A retrospective cohort study. Clinician Investigator Trainee Association of Canada, University of Toronto, Toronto, ON.

2014 Nov 28 **Orkin A,** Leece P, Pinto A. Recent and New Public Health & Preventive Medicine Graduate Panel on Research. Public Health & Preventive Medicine Resident Research Day, Dalla Lana School of Public Health, University of Toronto.

2014 May 27 Klaiman M for the Surviving Opioid Overdose with Naloxone (SOON) Research Team. The SOON Project and Roundtable. University of Toronto Division of Emergency Medicine Research Day, Toronto, ON. Presenter: M Klaiman.

2014 Apr 8 Bingham K, Klaiman M, Leece P, **Orkin A**. "Surviving opioid overdose with naloxone. Resuscitation in Motion Conference, Li Ka Shing Knowledge Institute at St. Michael's Hospital, Toronto, ON. Presenters: M Klaiman, P Leece.

2013 Apr 3 Leece P, Gassanov M, **Orkin A**, Marchall C, Hopkins S, Shahin R. Engaging the community on opioid overdose: development, implementation, and evaluation of an overdose prevention and resuscitation training program. The Ontario Public Health Convention, Toronto, ON. Presenter: P Leece.

Invited Lectures

INTERNATIONAL

2021 May 4 Dezfulian C, **Orkin A**, Lavonas E, Dineen E, Hsu J. Opioid-associated Out-of-Hospital Cardiac Arrest (OA-OHCA). American Heart Association HeartBEATS from Lifelong Learning Science Series. https://learn.heart.org/lms/activity?@curriculum.id=-1&@activity.id=7344737&@activity.bundleActivityId=-1 **Invited Speaker/Faculty**.

2018 Apr 24 **Orkin A**, Curran J, Ritchie S, van de Velde S, VanderBurgh D. What is first aid really good for? Preliminary results and implications from a systematic review on the health impacts of first aid education in underserviced populations and low-resource settings. Plenary presentation. International First Aid Education Conference, Niagara Falls, ON. **Invited International Plenary Speaker.**

2018 Apr 24 MacPherson A, **Orkin A**, Cassan P, Burke S. Brace Yourselves: The role of prevention and safety education in emergency readiness and responding to crisis. International First Aid Education Conference, Niagara Falls, ON. **Invited International Plenary panel**.

2014 Nov 23 **Orkin A**. and the Annals of Family Medicine Editorial team. Shorter is Better — Writing Effective Research Reports. Workshop. North American Primary Care Research Group (NAPCRG) Annual Meeting, New York City, NY. **Invited Speaker/Facilitator.**

2011 Jul 8 **Orkin A**. Persistent Debates in the Work and Purpose of MSF. Doctors Without Borders (MSF) USA, New York, NY. **Invited Speaker**.

NATIONAL

2022 Mar 1 Orkin A. Consort for RCTS affected by adversity. Network of Canadian Emergency Researchers (NCER) Unplugged Meeting (Virtual). **Invited Speaker**.

2021 Dec 2 **Orkin A**. The CONSERVE 2021 Statement, or, What to report when your trial gets hit by a bus. Clinical Trials BC – Ask Us Series. **Invited Panelist**.

2021 Nov 25 Gill P and **Orkin A**. Guidelines for Reporting Trial Protocols and Completed Trials Modified Due to the COVID-19 Pandemic and Other Extenuating Circumstances. University of British Columbia Physical Therapy Research Rounds. **Invited Speaker**.

2020 Apr Arbour L, Maynard R, **Orkin A**. Coronavirus: Equalizer or Magnifier? *Appointed* (Podcast) Episode 8. Interviewers: Kim Pate, Fregine Sheehy. https://appointedpod.simplecast.fm/75a42a64. **Invited Speaker/Panelist**.

2018 Sep Dong K, Klaiman M, **Orkin AM.** ED Management of Opioid Addiction. *EMCases* www.emergencymedicinecases.com . **Invited Speaker**.

2018 Jun 11 **Orkin A.** Hacking health care: How lay people can treat sick patients, solve epidemics, and create healthier societies. University of Alberta Dr. Walter Mackenzie Lecture. **Invited Keynote Speaker**.

2018 Jun 12 **Orkin A.** The SOONER Project: Combining design, simulation and trial methods to bring naloxone into everyday practice. University of Alberta Department of Emergency Medicine Research Forum. **Invited Keynote Speaker**.

2016 Nov 18 **Orkin A.** It is the context that kills. Invited address. Canadian National Opioid Summit, Ottawa ON. **Invited Speaker**.

2016 Oct **Orkin AM**, Klaiman M. Naloxone Autoinjectors and Opioid Overdose. *EMRap.* www.emrap.org **Invited Speaker/Panelist**.

2015 Jan 14 **Orkin A**, VanderBurgh D, Beardy J, Beardy J. "Community-based emergency care: Developing first response medical services with remote First Nations communities. Invited presentation. Assembly of First Nations National Public Health Expert Advisory Committee, Ottawa, ON. **Invited Speaker**.

2014 Oct 21 Goodchild M, Diabo, D, **Orkin A**, Swan T. Panel discussion: Aboriginal involvement in planning and preparing for disasters. Canada's Platform for Disaster Risk Reduction, Toronto, ON. **Invited Panelist**.

2011 May 14 **Orkin A**. Movement or Organization? Medical or Humanitarian? MSF and the Future of Humanitarianism. MSF-Canada Association General Assembly, Montreal, QC. **Invited Speaker.**

PROVINCIAL

2021 Mar 18 **Orkin A**. Doing Population Health in Ontario Health Teams. Chatham-Kent Ontario Health Team. Virtual presentation. **Invited Speaker**.

2021 Feb 12 **Orkin A**. Doing Population Health in Ontario Health Teams. Ontario Primary Care Council. Virtual presentation. **Invited Speaker**.

2019 Apr 16 **Orkin A** and Klaiman M. Opioid Issues in the Emergency Department. Markham-Stoufville Hospital Emergency Medicine Rounds, Markham, ON. **Invited Speaker.**

2018 Feb 8 **Orkin A**, Sellen K. A Timely Update on the SOONER Study. Canadian Centre on Substance Use and Addiction and the Canadian Joint Statement of Action Committee on the Opioid Crisis, Toronto, ON.

Invited Speaker.

2014 Feb 26 **Orkin A**, VanderBurgh D, Beardy J. Community-Based Emergency Care: A Novel approach to first response medical services in remote First Nations. Chiefs of Ontario Health Forum, Toronto ON. **Invited Speaker**.

2012 Oct 10 VanderBurgh D, **Orkin A**, Ritchie S, Jamieson R, Mukhopadhyay B, Sacevich C, Beardy J. Where there is no paramedic: The Sachigo Lake Wilderness Emergency Response Education Initiative. WONCA Rendez-Vous 2012, Thunder Bay, ON. **Invited Speaker.**

2012 Oct 10 Curran J, Ritchie S, VanderBurgh D, **Orkin A**. 'How does a first aid training program build resilience and community capacity for one First Nations community in Canada?" WONCA Rendez-Vous 2012, Thunder Bay, ON. **Invited Speaker.**

2012 Oct 9 **Orkin A**, Newbery S. "What do rural birthing stories teach us about rural birthing? The Marathon Maternity Oral History Project." WONCA Rendez-Vous 2012, Thunder Bay, ON. **Invited Speaker.**

2011 May 4 **Orkin A**. "Medical Intervention: An Alibi for Humanitarian Practice?" MSF Canada, Toronto, ON. **Invited Speaker**.

LOCAL

2019 Mar 21 **Orkin A**, on behalf of the SOONER Investigators. "SOONER: Combining design, simulation and trial methods to bring naloxone into everyday practice." Department of Family and Community Medicine City-Wide Research Rounds, University of Toronto, Toronto, ON. **Invited Speaker**.

2012 Oct 19 Leece P, **Orkin A**, Hopkins S, Shahin R. "Can naloxone prescription and overdose training save lives among opioid users in family practice?" Workshop. College of Family Physicians of Canada, Family Medicine Forum, University of Toronto, Toronto, ON. **Invited Speaker/Facilitator.**

2011 Nov 9 **Orkin A**. "'A doctor is there to be a doctor, not advocate for the poor': Doctorhood and History of MSF." Joint Centre for Bioethics, University of Toronto, Toronto, ON. **Invited Speaker**.

Media Appearances

INTERNATIONAL

2017 Webster, PC. "Calls for medically safe heroin mount in Canada." *The Lancet News.* 389: 239.

NATIONAL

2021 Mar 16 Ghosh M, Turnbull J, Macdonald N, Bond A, **Orkin A.** How to innovate for vulnerable populations: COVID immunization for people experiencing homelessness. Editorial. *The Globe and Mail*. https://www.theglobeandmail.com/canada/article-how-to-innovate-for-vulnerable-populations-covid-immunization-for/

2021 Mar 1 Canadian Medical Association (CMA). Toronto population health team helps homeless shelters contain Covid-19 outbreaks. *Boldly.* https://boldly.cma.ca/stories/toronto-population-health-team-helps-homeless-shelters-contain-covid-19-outbreaks

2019 Sept Weeks, C. Ontario pharmacist facing Ontario pharmacist facing disciplinary action for distributing naloxone kits door-to-door says he will keep distributing. *Globe & Mail.* Available from: https://www.theglobeandmail.com/canada/article-ontario-pharmacist-facing-disciplinary-action-for-

distributing/

2018 Nov 30 Gee, M. “Danger beyond the prison gates: One in 10 overdose deaths happen to ex-inmates within year of release” *Globe & Mail.* Available from: http://www.webcitation.org/74guZC0cP

2017 Dec 18 Champagne, S. “Retour à l’expéditeur” *Le Devoir.*

2017 Nov 2 Lavelle, C. “How Ontario is failing to help stop opioid deaths.” *Macleans.*

2016 Dec 2 Roussy, K. “People are dying: Life-saving opioid antidote hard to find.” CBC Print News, CBC Radio *The World at Six*, and CBC Television *The National*.

2016 Nov 22 Falk, S. “Reaction to Ottawa’s Opioid Summit.” *Global News BC*.

2014 Oct 26 Picard, A. “Better health coverage needed for temporary foreign workers: A new research paper provides a rare glimpse into some of the health challenges these workers face.” *The Globe and Mail*.

2013 May 12 Desjardins, L. “Current CPR Guidelines May Not Suit Rural Patients” *Radio Canada International*.

2013 May 2 Taylor P. “Hands Only CPR May Not Be Enough”. *The Globe & Mail*.

PROVINCIAL / REGIONAL

2018 Apr 10 Burke, A. “Ontario makes controversial change on how to help overdose victims.” *CBC News.* http://www.webcitation.org/6ybdaOLyu

2014 Mar 10 CBC Radio Sudbury. “Report on emergency medical care in remote First Nations.” *Morning North with Markus Schwabe*. Interviewed with Deputy Grand Chief Alvin Fiddler of Nishnawbe Aski Nation.

2014 Mar 5 CBC Radio Thunder Bay. “Who responds when there are no first responders?” *Superior Morning with Lisa Laco*. Interviewed with Deputy Grand Chief Alvin Fiddler of Nishnawbe Aski Nation

2013 Oct 30 CBC Radio Thunder Bay. “When 911 is not an option.” Superior Morning with Lisa Laco. Interviewed with Deputy Grand Chief Alvin Fiddler of Nishnawbe Aski Nation.

2013 Jul 12 Bell Shawn. ‘Preparing for emergencies in Sachigo Lake.’ *Wawatay News*. .

LOCAL

2021 Jul 20 University of Toronto Dala Lana School of Public Health. The Undervalued Potential of Good Samaritans. *What’s New*. https://www.dlsph.utoronto.ca/2021/07/20/the-undervalued-potential-of-good-samaritans/

2020 Apr 15 Yu, A. “‘People are sleeping in the streets or ravines because shelters are unsafe’: This doctor is helping restructure homeless shelters during the COVID crisis”. *Toronto Life*. https://torontolife.com/city/people-are-sleeping-in-the-streets-or-ravines-because-shelters-are-unsafe-this-doctor-is-helping-restructure-homeless-shelters-during-the-covid-crisis/

2019 Jun 30 **Orkin AM**. “Sidewalk Labs project is a public health opportunity.” *The Toronto Star*. https://www.thestar.com/opinion/contributors/2019/06/30/sidewalk-labs-project-is-a-public-health-opportunity.html

2018 Apr 14 Beattie, S. “Experts agree naloxone is central to fighting Canada’s opioid crisis — but that also say it’s not a ‘wonder drug’.” *Toronto Star.* https://www.webcitation.org/6yj97t3eL

2017 Apr 3 Buck, G. “Do you know what to do if someone overdoses?” *Metro News*. http://www.webcitation.org/6pcW7ePWe

2017 Mar 8 Siebarth, T. Universities come to grips with Canada’s opioid overdose crisis. *University Affairs.* https://www.universityaffairs.ca/news/news-article/universities-come-grips-canadas-opioid-overdose-

crisis/

2014 Oct 4 Keung, N. "'Medical repatriation' puts sick, injured migrant farm workers out of sight and mind". *The Toronto Star.*

2014 Sep 19 Bodnar, N. "Sick, fired and deported: what happens to injured or ill migrant farm workers in Ontario." *UofT News*. http://www.webcitation.org/6So1tVmS0

2013 May 20 Chan P. "Lifetime: A second look at Hands-Only CPR" *CTV News Toronto*.

G. Teaching and Design

2021 Nov 1 **Orkin A**. The Opioid Epidemic and its Effects on Resuscitation. University of Toronto Collaborative Specialization in Resuscitation Sciences, Foundations in Resuscitation Science Research (MSC4001H), St. Michael's Hospital.

2021 Oct 28 **Orkin A**. Quantitative Research and Evidence-Based Medicine Methods. Seminar for Empirical Approaches in Bioethics (MSC3003Y), Joint Centre for Bioethics, University of Toronto.

2021 May 7 **Orkin A**. An imperfect approach to health equity in PHPM practice, or why health inequities demand the independent, stateless practice of collective health. Public Health and Preventive Medicine Residency Program Rounds. Dala Lana School of Public Health, University of Toronto.

2020 Oct 29 **Orkin A**. Quantitative Research and Evidence-Based Medicine Methods. Seminar for Empirical Approaches in Bioethics (MSC3003Y), Joint Centre for Bioethics, University of Toronto.

2020 Jan 27 **Orkin A**, Sellen K. Innovation and Design Thinking in Resuscitation Research - SOONER Project. University of Toronto Collaborative Specialization in Resuscitation Science, Graduate Seminar Series (SRM3333H-Y), St Michael's Hospital.

2019 Jan 29 **Orkin A**. Population Medicine: What is it and why do we need it? Institute of Health Policy, Management, and Evaluation Policy Rounds, University of Toronto.

2019 Jan 17 **Orkin A**. Quantitative Research and Evidence-Based Medicine Methods. Seminar for Empirical Approaches in Bioethics (MSC3003Y), Joint Centre for Bioethics, University of Toronto.

2018 Sep 12 **Orkin A** on behalf of the SOONER Investigators. Combining design, simulation and trial methods to bring naloxone distribution into everyday practice. Applied Health Research Centre Rounds, St. Michael's Hospital.

2018 Jun 11 **Orkin A**. "Making interdisciplinary work: Career notes from a PGY-12. University of Alberta Emergency Medicine Residency Program Workshop.

2018 May 23 **Orkin A**, Drennan I. Responding to the Unexpected. University of Toronto Family Medicine Residency Program Rounds.

2018 Apr 23 **Orkin A**, Leece P. "The Opioid Epidemic and Public Health" University of Toronto School of Medicine Public Health Interest Group.

2017 Oct 12 **Orkin A**. Quantitative Research and Evidence-Based Medicine Methods. Seminar for Empirical Approaches in Bioethics (MSC3003Y), Joint Centre for Bioethics, University of Toronto.

2017 Oct 2 **Orkin A**. Bystander Resuscitation in Overdose: Naloxone Distribution and the SOONER Trial. University of Toronto Collaborative Specialization in Resuscitation Science, Graduate Seminar Series (SRM3333H-Y), St Michael's Hospital.

2017 May 31 Foote J, **Orkin A**. "Optimizing care for patients with opioid use disorder in the emergency department." Mt. Sinai Hospital Emergency Department Rounds.

2017 Mar 30 **Orkin A**. Task shifting for emergency care: Protocol for a mixed methods feasibility study and conceptual framework. Clinical and Population Research Rounds, St. Michael's Hospital.

2017 Feb 24 **Orkin A**. "Feasibility of the Surviving Opioid Overdose with Naloxone Education and Resuscitation (SOONER) Trial." Research Training Seminar, St. Michael's Hospital.

2017 Jan 24 **Orkin A**. Overdose Education and Naloxone Distribution. Peterborough Regional Health Centre Emergency Department Grand Rounds, Peterborough, ON.

2017 Jan 20 **Orkin A**. "What is Clinical Public Health?" University Health Network and Dalla Lana School of Public Health Dietetics Program, University of Toronto.

2017 Jan 9 **Orkin A**. Stigma and resuscitation: The mysterious case of opioid overdose and naloxone distribution. University of Toronto Collaborative Specialization in Resuscitation Sciences, Foundations in Resuscitation Science Research (MSC4001H), St. Michael's Hospital.

2016 Nov 11 **Orkin A**, VanderBurgh D. Go Big or Go Home? Exploring Scale-Up in Health Programs. Northern Ontario School of Medicine, Public Health & Preventive Medicine Residency Program Rounds.

2016 Oct 13 **Orkin A**. Quantitative Research and Evidence-Based Medicine Methods. Seminar for Empirical Approaches in Bioethics (MSC3003Y), Joint Centre for Bioethics, University of Toronto.

2016 Sep 7 **Orkin A**. What is Clinical Public Health? Introduction to Public Health Course., Dalla Lana School of Public Health, University of Toronto.

2016 Jan 23 **Orkin A**. Overdose education and naloxone distribution: How first aid can help address the opioid overdose epidemic. University of Toronto Collaborative Specialization in Resuscitation Sciences, Foundations in Resuscitation Science Research (MSC4001H), St. Michael's Hospital.

2015 Nov 27 **Orkin A**. Community-Based Emergency Care: What does First Response have to do with Public Health? Northern Ontario School of Medicine, Public Health & Preventive Medicine Residency Program Rounds.

2015 Nov 26 **Orkin A**. Quantitative Research and Evidence-Based Medicine Methods. Empirical Approaches in Bioethics (MSC3003Y), Joint Centre for Bioethics, University of Toronto.

2015 Jan 9 **Orkin A**. Guideline Development and Practice at the Fringe. University of Toronto Collaborative Specialization in Resuscitation Sciences, St. Michael's Hospital.

2014 Nov 20 **Orkin A**. Quantitative Research and Evidence-Based Medicine Methods. Seminar for Empirical Approaches in Bioethics (MSC3003Y), Joint Centre for Bioethics, University of Toronto.

2014 Nov 3 **Orkin A**. Compost, Crowd-Sourcing and Computation: Medical Repatriation of Migrant Farm Workers in Canada. Migration and Health (CHL3113H), Dalla Lana School of Public Health, University of Toronto.

2014 Aug 27 **Orkin A**. Geographically Remote First Nations Populations. Social Determinants of Health Panel for Community, Population & Public Health course, Undergraduate Medicine, University of Toronto.

2014 May 14 **Orkin A**. Remote and Isolated First Nations Communities. Social Determinants of Health Panel for Determinants of Community Health, Undergraduate Medicine, University of Toronto.

2013 Nov 12 **Orkin A**. "Rural vs. Urban: Equity Considerations in Resuscitation Guidelines and Services."\ University of Toronto Collaborative Program in Resuscitation Sciences, Foundations in Resuscitation Science Research (MSC4001H), St. Michael's Hospital.

2013 Mar 4 **Orkin A**. My Research Matters *to Whom*? Upstream and Downstream Knowledge Translation. University of Toronto Collaborative Program in Resuscitation Sciences, Graduate Seminar Series (SRM3333H-Y), St. Michael's Hospital.

H. Research Supervision

Clinical and Research Fellow

Postgraduate MD

2018 Justin Burton. University of Toronto, Family Medicine Resident. Research Project: Community-based emergency care in Tsiigehtchic Northwest Territories. **Primary Supervisor.**

2018 Gaibrie Stephen. University of Toronto, Family Medicine Resident. Research Project: Systematic review on the cost of managing non-urgent conditions in the emergency department vs. other outpatient ambulatory care settings. **Primary Supervisor.**

2018 Jonathan Gravel. University of Toronto, Family Medicine Resident. Research Project: Managing acute pain in people who use opioids in the emergency department. **Primary Supervisor.**

2017 Aamir Bharmal and Jennifer Cram. University of Toronto, Medical Residents. Research Project: Clinical Population Medicine: What it is and what it isn't. **Co-supervisor.**

2013 Baijayanta Mukhopadhyay. Northern Ontario School of Medicine, Family Medicine Resident. Research Project Co-supervisor: First response in psychiatric crises: teaching and learning mental health first aid in a remote First Nation. **Primary Supervisor.**

Undergraduate MD

2020 Alice Zhu. University of Toronto, Undergraduate Medicine. Research Project: Respiratory infectious disease outbreaks among people experiencing homeless: A systematic review of prevention and mitigation strategies. **Co-supervisor**

2020 Eva Bruketa. Queen's University, Undergraduate Medicine. Research Project: Respiratory infectious disease outbreaks among people experiencing homeless: A systematic review of prevention and mitigation strategies. **Co-supervisor**

2020 Sampreeth Rao. University of Toronto, Undergraduate Medicine. Research Project: Task shifting delphi study. **Primary Supervisor.**

2017 Jeffrey Curran. Northern Ontario School of Medicine, Undergraduate Medicine. Research Project: Systematic Review: Health effects of training laypeople to deliver emergency care. **Primary Supervisor**.

2013 Calen Sacevich. Northern Ontario School of Medicine, Undergraduate Medicine. Research Project **Co-supervisor**:

- Automatic Electronic Defibrillators in Pre-hospital Rural and Remote Settings: What effect does prolonged transport time to hospital have on survival.
- Access to Automated External Defibrillators in Remote Ontario First Nations Communities: A Survey of Local Health Directors.

Graduate Education (MSc/MPH)

2019 Natasha Kithulegoda. University of Toronto, Masters of Public Health. Task shifting and health equity. **Practicum Supervisor**.

2018 Emma Mew. University of Toronto, Masters of Public Health. Community-Based Emergency Care Project. **Practicum Co-supervisor**.

2017 André McDonald. University of Toronto, Masters of Public Health. Defining and measuring health equity effects in research on task shifting interventions: a systematic review. **Practicum Supervisor**.

2014 Jeffrey Curran. Laurentian University, Masters of Arts (Human Development. Thesis Co-supervisor: Building Resilience and Community Capacity: The Sachigo Lake Wilderness Emergency Response Education Initiative. http://www.webcitation.org/6So23fyp2. **Thesis Co-supervisor.**

TAB 113

Court File No. CV-21-00077817-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, ET AL.

Applicants

-and-

CITY OF HAMILTON

Respondent

ACKNOWLEDGMENT OF EXPERT'S DUTY

1. My name is Aaron Orkin. I live at Toronto, in the Province of Ontario.

2. I have been engaged by or on behalf of the Hamilton Community Legal Clinic to provide evidence in relation to the above-noted court proceeding.

3. I acknowledge that it is my duty to provide evidence in relation to this proceeding as follows:

   (a) to provide opinion evidence that is fair, objective and non-partisan;

   (b) to provide opinion evidence that is related only to matters that are within my area of expertise; and

   (c) to provide such additional assistance as the court may reasonably require, to determine a matter in issue.

4. I acknowledge that the duty referred to above prevails over any obligation which I may owe to any party by whom or on whose behalf I am engaged.

Date Sept 14, 2022

Aaron Orkin
_____
Signature

TAB 114

Court File No. CV-21-77187

ONTARIO SUPERIOR COURT OF JUSTICE

B E T W E E N:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLEN GNATUK, TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES, and PATRICK WARD

Applicants

- and -

CITY OF HAMILTON

Respondent

The Cross-Examination of Dr. Aaron Orkin on his Affidavit sworn September 14th, 2022, taken upon affirmation in the above action this 26th day of August, 2024, conducted via Zoom videoconference hosted by the offices of Nimigan Mihailovich Reporting Inc.

NIMIGAN MIHAILOVICH REPORTING INC.

INDEX OF PROCEEDINGS

AFFIRMED: James Moulton

EXAMINATION BY: PAGE NO.
Ms. Shores.....5

GUIDE TO UNDERTAKINGS, UNDER ADVISEMENTS AND REFUSALS

This should be regarded as merely a guide and does not necessarily constitute a full and complete list.

Undertakings are found on the following pages:

None entered

Under advisements are found on the following pages:

None entered

Refusals are found on the following pages:

None entered

APPEARANCES:

Sujit Choudhry — For the Applicants
Haki Chambers

Nonye Okenwa
Community Legal Clinic

Curtis Sell
Community Legal Clinic

Sharon Crowe
Community Legal Clinic

Bevin Shores — For the Respondent
Gowling WLG

Vivian Caldas
Gowling WLG

Jojo Johnson - student at Gowling WLG

EXHIBITS

Exhibit No.	Description	Page
1	Form 53 dated September 14th, 2022.	9
2	Huber et al, "How should we define health?"	22
3	Article "A 25-year-old woman with diabetes in custody"	51
4	"Homelessness and Health in Canada"	67
5	"Rethinking involuntary admission for individuals presenting to Canadian emergency departments with life-threatening substance use disorders"	67
6	"Pressure and coercion in the care for the addicted: ethical perspectives"	67

---UPON COMMENCING AT 10:00 a.m.

Dr. Aaron Orkin,
having been duly affirmed,
was examined and testified as follows:

BY MS. SHORES:

1 **Q.** Good morning, Dr. Orkin. As I introduced offline, my name is Bevin Shores. My pronouns are she and her. I'm one of the lawyers for the respondent in this proceeding and we'll be cross-examining you today on your Affidavit affirmed September 14th, 2022. Can you start by stating your full name for the record, please?

A. I'm Aaron Michael Orkin.

2 **Q.** Okay. And is there a particular name that you go by or would like to be addressed?

A. Aaron is fine.

3 **Q.** Okay. And do you have any pronouns that you use?

A. He/him.

4 **Q.** Okay. And where are you participating from today?

A. I'm in Toronto, Ontario.

5 **Q.** You previously told us you're alone in the room that you're participating from?

A. Correct.

6 **Q.** And you've confirmed that you're aware you are to have no assistance in giving your answers?

A. Correct.

7 **Q.** And you've previously confirmed that the only thing you have in front of you is your Affidavit affirmed September 14th, 2022, and I think you said the exhibit to it as well?

A. That's right.

8 **Q.** Okay. And as I indicated offline, if you were referring to any materials in giving your answers you would need to state what you're referring to, we'll make it an exhibit and explore how it informs your evidence. Anything else that I intend to refer you to I will place up on the screen. Is that understood?

A. Yes, thank you.

9 **Q.** All right. And you've been affirmed to tell the truth today?

A. Yes.

10 **Q.** All right. So what do you understand your role is in this litigation?

A. My purpose is an expert witness to serve the Court and provide information based on my expertise that can serve the Court in its

deliberations and decision-making.

11 **Q.** Okay. And I'm going to put your Affidavit on the screen and I'll be referring you to parts of it. Are you able to see on your screen your Affidavit sworn September 14th, 2022?

A. Let me open that window here. Yes, I have that. I have that same one in another window that allows me to scroll so yes, I can see yours but --

12 **Q.** Okay.

A. -- I have another version.

13 **Q.** You can use whatever one is more comfortable for you. I'm going to direct you to paragraph seven where you state, "I have been previously qualified as an expert witness with respect to the opioid crisis, opioid overdose, first-aid and overdose prevention and the risks of COVID-19 in correctional facilities." That's correct?

A. Correct.

14 **Q.** Okay. Which courts have you been previously qualified as an expert in those subjects for?

A. Those courts are listed in my CV. I can take you to the page. In multiple provinces and

territories, page five of my CV, and that's in 2020 and then you'll see in 2018 the Office of the Chief Coroner of Ontario.

15 **Q.** Okay. Now, your Affidavit affirmed September 14th, 2022 did not append a Rules of Civil Procedure Form 53; correct?

A. Sorry, repeat.

16 **Q.** Your --

MR. CHOUDHRY: Ms. Shores, may I?

MS. SHORES: Yes.

MR. CHOUDHRY: Ms. Shores, I believe that my co-counsel, Ms. Crowe, provided you with that form this morning.

BY MS. SHORES:

17 **Q.** Yes, I received a copy this morning and I'll put it to Dr. Orkin but the question is it wasn't appended to the September 14th, 2022 Affidavit?

A. No, that's not an appendix to this document.

18 **Q.** Okay. And I'll -- now, I'm going to place up on the screen the Acknowledgment of Expert's Duty that we received, we, my office received this morning by e-mail by counsel for the applicants. So I'll show this to you, Dr. Orkin.

It's an Acknowledgment of Expert's Duty.

A. Correct.

19 **Q.** And your name and that's your signature?

A. It is.

20 **Q.** Okay. The document is dated September 14th, 2022. When was it actually signed?

A. It was submitted alongside the Affidavit so September 14th, 2022.

21 **Q.** Okay. All right.

MS. SHORES: So we're going to mark this Form 53 dated September 14th, 2022 as Exhibit A to your examination.

---EXHIBIT NO. 1: Form 53 dated September 14th, 2022.

BY MS. SHORES:

22 **Q.** Dr. Orkin, returning to your Affidavit, at the time you wrote or sorry, at the time you affirmed your Affidavit, what instructions had been provided to you with respect to your Affidavit?

A. The instructions were twofold. They were first, substance of the -- sorry, is it a Form 53 you just said? My duty was to the Court, which is, was the first set of instructions and second was

to share my opinions relevant to the relocation of people in encampments and its affect on health.

23 **Q.** And any factual assumptions your opinions are based on are set-out in your Affidavit?

A. So the factual assumptions are -- sorry, I'm trying to understand what you mean by factual assumptions.

24 **Q.** Well, that's one of the components of what is required of an expert opinion under Rule 53, any factual assumptions on which your opinion is based.

A. Yeah, so the factual assumptions, where relevant, are either cited or are, like, discussed in the document itself, how I come to that conclusion.

25 **Q.** And any documents you relied on forming the opinions set-out in your Affidavit, those are also in your Affidavit, either in the body or in the footnotes?

A. Correct.

26 **Q.** And I don't believe I saw any reference to research that you conducted on your own to form the opinions set-out in your Affidavit; correct?

A. No, I did not ascribe my own research.

27 **Q.** At paragraph three of your Affidavit you state that you provide your statements in your capacity as an independent physician, epidemiologist and researcher so I'd like to talk about your background briefly.

A. Sure.

28 **Q.** If I can take you to your CV, which is Exhibit A to your Affidavit, you indicate at the bottom of page one going on to page two, you're a physician licensed with the College of Physicians and Surgeons of Ontario?

A. Correct.

29 **Q.** Okay. Since 2009?

A. Correct.

30 **Q.** Your specialties are family medicine with a certificate of Added Competency in Emergency Medicine?

A. Yes, as well as Public Health and Preventive Medicine.

31 **Q.** Okay. And so emergency medicine, was that at, I believe in 2015, if I'm reading this correctly, and Public Health and Preventive Medicine in 2014?

A. Correct.

32 **Q.** All right. At the time you affirmed this Affidavit in September 2022, how much time -- how much of your time was spent treating patients versus doing research?

A. So Public Health and Preventive Medicine, so to be treating patients directly or practicing medicine?

33 **Q.** Uh --

A. I raise this because Public Health and Preventive Medicine is a non-clinical specialty. So at the time I write this, I spent about 60 to 80 percent of my time depending on, you know, the month and what was going on with COVID on practicing medicine. Public Health and Preventive Medicine is a non-clinical specialty. We work with groups, we work with programs but we don't work with individuals.

It's the same as people who are Medical Officers of Health and so forth and so I spent about 60 to 80 percent of my time practicing medicine and the remainder of my time doing research. And some of that time practicing medicine was direct patient care and some of it was Public Health and Preventive Medicine practice. It's a little bit like a radiologist who might be looking

after patients all the time but they only look at pictures, they never actually see a real patient.

34 **Q.** Understood. And for the proportion that was spent in direct patient care, I think you phrased it, what proportion would that have been around September of 2022?

A. About half my time in any given week.

35 **Q.** So about -- sorry, was that half your time overall or half your time practicing medicine?

A. Half my time overall.

36 **Q.** So about half your time overall was spent in direct patient care within the, approximately, 60 to 80 percent that you were practicing medicine and then the roughly 20 to 40 remainder was doing research?

A. That's right.

37 **Q.** And is that more or less still the breakdown of how your practice is today?

A. My practice is a little bit more patient care now. You'll see that in the -- back in 2022, and somewhere in my Affidavit, I mention that then I was the Director of Population Medicine for Inner City Health Associates. I no longer hold that

appointment and I spend more time in emergency medicine practice and so I spend more time in direct patient care right now.

38 **Q.** And where is your patient care practice based?

A. I split my emergency medicine practice between St. Joseph's Health Centre in Toronto and Muskoka Algonquin Health Centre in Huntsville.

39 **Q.** So not in Hamilton?

A. No.

40 **Q.** Okay. And your Public Health and Preventive Medicine practice, is that also based Toronto and Huntsville?

A. I don't practice Public Health and Preventive Medicine in Huntsville, only in Toronto.

41 **Q.** Only in Toronto. And I also see on your CV, and you've described yourself as an epidemiologist, particularly in December of 2021 you have a PhD in Clinical Epidemiology and Health Services Research?

A. Correct.

42 **Q.** And I think your thesis was on "Care Redistribution: Reassembling Task Shifting with Naloxone Distribution and First Aid"?

A. Yes, that is the title of my thesis.

43 **Q.** Okay. And in very general terms, that would be about involving a lay public directly and providing health services such as Naloxone or first aid?

A. Yes, specifically for the purpose of achieving health equity.

44 **Q.** I'm going to take you back to the body of your Affidavit and start at paragraph 12. In the preceding paragraph to paragraph 12 or sorry, let me say the subheading B, People Experiencing Homelessness Make Housing Choices. Over to paragraph 12 you state, "These choices are rational for people who make them."

Dr. Orkin, I'll put it to you, as a general proposition, that choices are informed by needs and wants. Would you agree?

A. Partly informed by needs and wants.

45 **Q.** Okay. And what else do you say that choices are informed by?

A. By rationed preferences like cultural values, by aversions, previous trauma and experiences and by things that are, I think quite often, difficult to characterize or quantify.

46 **Q.** And those things may be either a

need or a want depending on the individual?

A. Right. Again, needs, wants and other elements. So I think the needs and wants are much of what informs a decision but probably not sufficient cause for decision or a choice.

47 **Q.** Do you agree that some needs are higher priority than others?

A. Yes.

48 **Q.** And more generally, some factors that inform a person's choice are higher priority than other factors?

A. Yes, and that varies from person to person. So it would be highest priority for me, might be third highest priority for another person.

49 **Q.** And that may be subjective?

A. Yeah, they may be subjective, objective and what may be subjective for one person may be objective for another.

50 **Q.** I'm going to take you to the Affidavit of another witness who's given evidence in this proceeding. It's Dr. Andrea Sereda. Her Affidavit, for the record, was sworn May 12th, 2023. I'm going to specifically refer you to Exhibit B of Dr. Sereda's Affidavit, which Dr. Sereda has appended and described as the needs

pyramid. Do you see that?

A. Yes, this is very closely mapped to a widely cited hierarchy that has been mostly discredited. I haven't read this Affidavit and so I'd have a very hard time just commenting on the pyramid or its application.

51 **Q.** Okay. When you say the hierarchy has been widely discredited, can you expand on that?

A. Well, the hierarchy of needs has been used across a huge range of psychology, biology, epidemiology to try to assign what ought to be or is the most important elements in how both societies are built and in how people make decisions and make their choices.

What we find is that in much of the more recent literature, especially with people facing absolute marginalization, is that people often will, say, pursue issues of self-actualization even when their physiological needs are not met and vice versa. That it doesn't work in a pyramid in that you can only pursue, say, your esteem needs when your physiological needs are met. And that appears to be the case across a range of biomes, not just humans.

And so this pyramid, when it was initially proposed, was structured in that an organism, a person could only pursue these higher elements if they have the lower ones met, and that's what I mean by structure. Like building a pyramid, it doesn't just turn out to be true.

52 **Q.** So what you're describing, if I understand correctly, is that this needs pyramid at Exhibit B was conceptualized as something where the needs at the bottom of the pyramid must necessarily be fulfilled before it is possible to address those higher up in the pyramid?

A. Yeah, that's how it was initially conceptualized.

53 **Q.** Understood. I'm going to take you back to your Affidavit at paragraph 12 again and bear with me as I find it to place on the screen. So reading the second and third sentences, "For example, shelters can be restrictive regarding the number and volume of personal possessions, accessibility for pets, ability to live a partner", I think you probably meant to live --

A. Yeah, that's an error. With a partner.

54 **Q.** "Or use of drugs and alcohol.

Shelters, do, however, have a roof and heating in the winter."

So I put to you, Dr. Orkin, that there would be circumstances where the need for a roof or heating may be more pressing than another need such as a need for avoiding a communal environment?

A. So I think my only way to answer your question is pressing with respect to what? And so there's -- when it comes to someone's health or choices, the idea of something being absolutely pressing as it would appear in that pyramid doesn't seem to be the driving factor when it comes to people's health or choices or the sole driving factor.

So we will see that many people, even though if we take a theoretical frame like that pyramid, we would think that all rational people will choose a roof or heating over drugs, alcohol, partner, accessibility for pets and personal possessions because those things are higher up on the pyramid and that there's some sort of absolute understanding of what is pressing this, as you put it.

But it doesn't turn out that way.

That theory breaks down both the practice for the many thousands of parents that I've seen and in more recent research about how health or how wellbeing is pursued. And so pressing with respect to what will be the only way to answer that question. Or pressing with respect to whom. And so, many people die cuddled with their pet knowing that a roof and heating might be important to them but that may not be an expression of how they understand their health or wellbeing. Or vice versa. People pursue, you know, a roof and heating in winter and end up much less healthy because they sacrificed other aspects of, say, self-actualization that was higher on that defunct pyramid.

55 **Q.** So if I understand correctly, the need for, for example, shelter would change depending on the individual and the circumstances and their subjective views of what is best for their health?

A. Right. Or their objective use of what's best on their health. That's what I meant by what's subjective for one may be objective for another in that one person's ability to stay healthy when they have a roof or heating but no access to their pet may be objectively different to another's,

but those two people may perceive one as subjective and another as objective.

56 **Q.** To take the example of someone freezing to death outside with their pet, I mean, you'd agree that that's not objectively better for their health because a person passes away?

A. Yes, but I think we should be very careful about what we mean by health in that context. But yes, that -- like, freezing to death with your pet is generally bad for your health, yes.

57 **Q.** Paragraph 16 of your Affidavit you state that more recent conceptualizations -- and I'm not reading this verbatim. So paragraph 16 of the Affidavit is under the heading "Choices Are Related to Health". And in paragraph 14 you described the World Health Organization's definition of health. What I'd like to take you to is paragraph 16 where you state, "More recent conceptualizations refer to health as the ability to adapt and self manage."

A. Correct.

58 **Q.** And I want to talk a little bit more about what the ability to adapt and self manage means. So you footnoted, footnote four here is a source for that. The document Huber et al, "How

should we define health?" That's a source for your statement?

A. Correct.

59 **Q.** Okay. So I believe I found that article so I'm placing up on the screen here an article from BMJ, which I believe is the British Medical Journal and was formally known as the British Medical Journal and then you can see the citation underneath "*BMJ* 2011;343:d4163"?

A. Correct.

60 **Q.** And then the doi there. So this is the article?

A. Yes.

MS. SHORES: So I'd like to mark this for identification as Exhibit B or I'm sorry, mark this as Exhibit B to your examination.

---EXHIBIT NO. 2: Huber et al, "How should we define health?"

MR. CHOUDHRY: Ms. Shores?

MS. SHORES: Yes.

MR. CHOUDHRY: I'm sorry, Ms. Shores, should we maybe number the exhibits to the cross given that we've got lettered exhibits to the Affidavit?

MS. SHORES: I don't -- yeah, that's

fine. So let's go back. Exhibit A we'll now make Exhibit 1 and Exhibit B we'll make Exhibit 2. I think, generally, marked for identification is lettered exhibits but there's no hard and fast rule.

So just so it's clear for the record, we're now on Exhibit 2 and that's the Huber et al article, "How should we define health?" All right.

BY MS. SHORES:

61 **Q.** Sorry for the diversion, Mr. Orkin. I'd like to take you to the first sentence under the heading "How should we define health?" as a bit of a tag line it looks like. "The WHO definition of health as complete wellbeing is no longer fit for purpose given the rise of chronic disease."

Essentially, what is being communicated here is that people can experience health notwithstanding that they face social, physical and emotional challenges; correct?

A. It's a much broader conceptualization than that or re-conceptualization than that, but that is one of the really important elements that health is not simply the absence of disease or the absence of threats to the absence of disease.

62 **Q.** And the authors, and I'll take you to this in a minute, but the authors will also argue that health is not defined as a complete absence of social, physical and emotional challenges as well; correct?

A. Correct.

63 **Q.** I'm going to take you down to the second page under the heading "Need for reformulation". And the third paragraph down, the paragraph beginning with the word "redefining health". There's a reference to a Dutch conference, so I'll start with the second sentence for context but I'm going to actually direct you to the last sentence.

So I'll read from the article: "The discussions of experts at the Dutch conference, however, led to broad support for moving from the present static formulation towards a more dynamic one based on the resilience or capacity to cope and maintain and restore one's integrity, equilibrium, and sense of wellbeing. The preferred view on health was "the ability to adapt and self manage"."

A. Right.

64 **Q.** So it took us a while to get here but that's what you're citing when you refer to the

more recent conceptualizations of health as the ability to adapt and self manage?

A. Yes. And critically, although this is the citation that I gave, it's a really nice overview, what I was -- what I'm really going to is the, the main article, not just this commentary where that tag line, the ability to adapt and self manage, comes from.

65 **Q.** Okay. But the main article is not cited in your Affidavit, is it?

A. Right. But this article is the, is an entry point to that literature.

66 **Q.** Let's stick with the, this entry point because that's the one that we have. The last paragraph under the heading "Need for reformulation" states, "The first step towards using the concept of "health, as the ability to adapt and to self manage" is to identify and characterize it for the three domains of health: physical mental and social. The following examples attempt to illustrate this." So I'd like to just take you to those examples. The next heading is "Physical health", you see that?

A. Yes.

67 **Q.** And so the authors state, "In the

physical domain a healthy organism is capable of "allostasis" - the maintenance of physiological homeostasis through changing circumstances. When confronted with a physiological stress, a healthy organism is able to mount a protective response, to reduce the potential for harm, and restore an (adapted) equilibrium. If this physiological coping strategy is not successful, damage (or "allostatic load") remains, which may finally result in illness."

So trying to boil this down a little bit into lay terms. Basically what they're referring to here is the body's ability to adapt and self manage as a physiological process?

A. I don't think it's quite the body's ability to adapt or self manage, it's the organism which includes both the body as well as that organism's -- that's what's meant by self manage. The organism's decision-making capacity. So the self as well as the body that it inhabits. And so yes, it's the ability of that, like, of that organism to manage and the ability of that organism's brain to make choices to allow it to manage.

68 **Q.** Okay.

A. So adaptation and self-management, the self is quite present in this definition of physical health. So allostasis refers to self, allo, and when confronted with a physiological stress, a healthy organism is able to mount to protective response which is not just, say, does my immune system respond but can I make choices that move me further away from bad water or closer to family that makes me healthy or otherwise. So it's both the mind and the body is part of the organism here.

69 **Q.** Okay. The authors in this article, though, don't refer to choice or making choices that affect those physiological processes, do they?

A. My expertise on the meaning of all of these terminologies and my training directly under some of its authors would say that's definitely what these words mean.

70 **Q.** But you haven't cited any sources for that in your paper or I'm sorry, in your Affidavit?

A. I've cited this source. That's what these words mean.

71 **Q.** Well --

A. So allostasis as well as coping

strategies are terminologies that do not suggest a separation of bodied mind. They are -- especially when we're talking about human health. They're a phenomenon that is integrative.

72 **Q.** So even though the author states, "'allostasis' - the maintenance of physiological homeostasis through changing circumstances", your evidence is that that actually also includes conscious exercise of choice?

A. Definitely.

73 **Q.** Under the subheading "Mental health", the author states, "In the mental domain Antonovsky describes the "sense of coherence" as a factor that contributes to a successful capacity to cope, recover from strong psychological stress, and prevent post-traumatic stress disorders."

So I'm going to take you to the citation for that. So it's number 12. "Antonovsky A. Health, stress and coping. Jossey-Bass, 1979." I got to tell you, Dr. Orkin, I wasn't sure what was meant by sense of coherence so I went down a little bit of a rabbit hole. I wasn't able to find the book *Health, Stress and Coping* but I think I found a quotation of it so I just want to take you to that and have you confirm whether or not we've

found what Antonovsky defined as the sense of coherence.

A. Just also on your previous question, you've helpfully scrolled down to citation 11 there which was cited on the previous questions that you asked me.

74 **Q.** Yes.

A. "Interacting mediators of allostasis and allostatic load: towards an understanding of resilience in aging." So that paper, and we can go to it, doesn't only talk about the biological factors of an aging organism as it moves through time but also what makes older adults more resilient is full of choice, and you'll see it's cited into the elements around physiology of aging, not just biology of aging.

75 **Q.** Okay. So thank you, Dr. Orkin. I'm going to take you back again to -- so this is a document that I've located. So this is not cited in your, in the paper or in your Affidavit. This is called *The Handbook of Salutogenesis, 2nd edition*. It's dated, if you can see the small type, 2017. Now, I'm only taking you to this because it appears to have a direct quote from the 1979 Antonovsky text.

So at page 11 of this text, the authors state, "In its narrower meaning, salutogenesis is often equated with one part of the *model*, the *sense of coherence*, specifically defined as: a global orientation that expresses the extent to which one a pervasive, enduring though dynamic feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected." And then they cite Antonovsky 1979.

So this is all a very roundabout way of asking is that Antonovsky's definition of a sense of coherence?

A. Yeah, that's Antonovsky's definition of a sense of coherence.

76 **Q.** So you'd agree, returning to the discussion of mental health and the "How should we define health?", conscious exercise of choice can be part of that sense of coherence; correct?

A. Yes.

77 **Q.** But you'd also agree that the sense of coherence is not only the conscious exercise of choice, agreed?

A. Yes.

78 **Q.** Now, turning to the third example by the authors, "Social health" under the heading, and again, we're on the second page of the article that's at Exhibit 2. The authors state, the first part of the first paragraph:

"Several dimensions of health can be identified in the social domain, including people's capacity to fulfill their potential and obligations, the ability to manage their life with some degree of independence despite a medical condition, and the ability to participate in social activities including work. Health in this domain can be regarded as a dynamic balance between opportunities and limitations, shifting through life and affected by external conditions such as social and environmental challenges. By successfully adapting to an illness, people are able to work or to participate in social activities and feel healthy despite limitations?"

So having read that, Dr. Orkin, what's being described here is basically being able to adapt to an illness. You'd agree?

A. I think it's -- this description is much broader than illness especially until it, until the sentence "by successfully adapting to an

illness", but yes, the social elements that produce the ability to adapt and self manage is what they're referring to here.

79 **Q.** So conscious exercise by choice may be a part of that but not the only part of that. You'd agree?

A. Yes.

80 **Q.** And so I put to you, Dr. Orkin, that this definition of health as the ability to adapt and self manage is not constructed as being defined by the conscious exercise of choice; correct?

A. No. Health is not -- like, a Venn diagram of health and choice does not overlap as a, like, in a one hundred percent way. You asked me not to speak in a way that's visual here. So health and choice are not the same thing. A life with the total absence of choice, however, cannot be healthy and so the elimination of choice, in general, is a threat to health, but choice itself is not defining of health.

81 **Q.** And while this article, the "How should we define health?" article, it's only three pages and as you said, is an introductory or, I'm not purporting to quote you verbatim but it's introductory material?

A. Right.

82 **Q.** You'd agree this article doesn't state that making choices about where one wants to live in particular is part of this definition of health?

A. No, this article does not -- is not about homelessness.

83 **Q.** Dr. Orkin, you'd agree, as a general proposition, that not every factor that affects health has the same degree of impact on health?

A. Correct.

84 **Q.** So in other words, some things that affect health can have a small effect and other things that affect health can have a more significant effect on health?

A. Correct.

85 **Q.** And you'd agree, as a general proposition as well, that people can make choices that are bad for them?

A. Correct. For their health you mean?

86 **Q.** Well --

A. When you say bad for them, bad for --

87 **Q.** Yes, I'll say that. Bad for their health. I think that's a useful clarification.

A. Yeah.

88 **Q.** So even in that circumstance, even though people are exercising their choice, if they're exercising their choice to do something harmful to their health, that effect may still be a negative outcome for their health. You'd agree?

A. They may be making an unhealthy choice, yes.

89 **Q.** So to put a finer point on it, not every choice made by a person is healthy for them; correct?

A. Correct.

90 **Q.** I'm going to take you back to your Affidavit and turn you to paragraph 17. So paragraph 17 starts, "Based on these definitions, when people who experience homelessness make choices about where they want to live, those decisions are related to health."

So "these definitions", you're referring to the World Health Organization definition in that more recent conception of the definition of health that we just discussed?

A. Correct.

91 **Q.** Now, you don't cite any sources in the first paragraph or sorry, the first

subparagraph, paragraph 17 saying that decisions about where people experiencing homelessness want to live are related to health so that's your opinion?

A. Yes, this is analytic opinion, not a regurgitative opinion.

92 **Q.** So that's based on your interpretation of those two definitions that we just discussed?

A. Yes, and my care for many thousands of people who experience homelessness and make choices related to their health in that context.

93 **Q.** And the fact that people are making choices about where they want to live is not determinant of their level of health, you'd agree?

A. Okay, can you describe what you mean by determinant?

94 **Q.** Sure. Person's level of health is not determined by whether or not they are making choices about where they want to live?

A. Some aspects of our health is, I think for all people, related to the choices they make about where they want to live and crucially related to their ability to make that choice, and I would say that that is a mere universal phenomenon

regarding homeless people and not homeless people. That both the choices we make about where we want to live, so whether we choose somewhere healthy or not healthy has an effect on our health and the fact that we have that choice has an effect on our health.

95 **Q.** But if a person makes a choice about where to live that has a negative effect on their health, that choice may -- the negative effect of that choice may outweigh the positive effect that they are making that choice. You'd agree?

A. In some circumstances. The alternatives, however, need to be examined in the same breath and so yes, somebody may choose to live somewhere that is objectively less healthy than another available alternative but there's quite a profound difference and this is what my -- this is the thrust of my Affidavit.

There's quite a profound difference between that person choosing option B, where they oh, that's a little healthier over there, I'm going to go live there versus being relocated to that alternative which then eliminates the choice. So there's a profound health harm in that, in that avenue to a seemingly healthier location.

And so yes, people can make choices that are less healthy than another choice but the elimination of choice may nevertheless be more harmful than the choice they've made.

96 **Q.** But it's not always more harmful, you'd agree with that?

A. No, not always more harmful. There are circumstances where the relocation of individuals, and we see this in the context of public health orders, for example, can be beneficial for health.

97 **Q.** We'll come back to that point later but I want to stay on paragraph 17. So paragraph 17(b) you state here, "The person's ability to make a choice and have that choice respected is itself related to health." I understand that you've just explained a bit of that but with this subparagraph in particular, you didn't cite any sources so that's, again, your opinion?

A. It is my opinion.

98 **Q.** And you haven't referred to any studies or scholarly works concluding that the ability to make a choice and have the choice respected is related to health?

A. This paragraph doesn't provide any

citations.

99 **Q.** Okay. Well, I'll put it to you that there are no studies or scholarly works cited in your Affidavit concluding that the ability to make a choice and have a choice respected is related to health; is that correct?

A. Correct.

100 **Q.** And also, your Affidavit doesn't refer to any studies or scholarly works quantifying the degree of impact choice may have on health; correct?

A. Correct.

101 **Q.** And I also didn't see any studies or articles on your CV that are focussed on the relationship of choice and health; correct?

A. So choice, yes, but there's very closely related concept which is autonomy and the relationship between autonomy state authority and health which I have studied.

102 **Q.** Okay. And where --

A. And published on in detail.

103 **Q.** So let's take -- can you point me to where that is on your Affidavit or not your Affidavit --

A. So for example, two chapters of my

thesis relate to the history and structure of medical humanitarianism which is very closely related to how state choices impact individual health and how non-state factors, such as humanitarian organizations, can allow people to have a different approach to health in individual autonomy within a medical one health frame.

So yeah, the relationship between autonomy, health equity and medical authority is something that I have studied and published on substantially.

104 **Q.** So let's go back to the body of your Affidavit, paragraph 18 under the heading involuntarily -- "Involuntary Removal". And under paragraph 18, first sentence you state, "Involuntary relocation or resettlement refers to circumstances where individuals or groups are compelled to change their place or residence by coercion, physical force or imposed will."

Again, there's nothing cited for that so that's your definition?

A. Correct.

105 **Q.** Okay. And you're not referring in your Affidavit to any studies or scholarly works or sorry, research or scholarly works on how

individuals perceive coercion?

A. So I haven't cited which is just a matter of academic style. All of these definitions come from my expertise in reading work in this area. So adding citation certainly wouldn't be the, wouldn't be the barrier here but that's just not my scholarly style for this kind of work.

106 **Q.** You said --

A. I'm happy to explain for the Court why I choose that approach in writing these documents but wherever definitions or references would actually be helpful, happy to provide.

107 **Q.** Well, what we've got is your Affidavit that contains your opinion and is being put forth as Rule 53 compliant including both the factual assumptions and the information relied upon in forming your opinion so that's what I have to go on.

Now, going to the second sentence of paragraph 18, you state, "Coercion, in this case, includes real or perceived threats of force, imposition of fear or other harmful consequences should the individual or group remain in their preferred place of residence." Again, this is -- there's no sources cited for that?

A. No, there's no citation on that sentence.

108 **Q.** At paragraph 20 you state, "Perception of force, fear or harm vary widely from person to person." And again, there's no citation in this paragraph but I wanted to confirm, you're also not referring to any studies or scholarly works about the effects of coercion on individuals; correct?

A. This paragraph does not include a citation.

109 **Q.** Well, and more broadly, in your Affidavit, you don't include any references to research or scholarly works about the effects of coercion on individuals; correct?

A. Correct.

110 **Q.** Second sentence --

A. Actually, I do want to say something specific because I think I've been asked to provide input based on expertise, not just academic and scholarly but as a physician, as somebody who looks after patients, which is something you asked me about in terms of the time I spend on specifically.

I think when it comes to expertise about the health threats of coercion as well as

forceful relocation and stuff like that, is certainly a core aspect of medical expertise to know the limitations and health effects of coercive actions, which is why there's very, very limited circumstances where medical experts such as myself or clinicians attempting to improve the health of individuals or communities in a therapeutic way rely on coercive action. That doesn't come from scholarly knowledge, that's core expertise for health provider and specifically for a physician.

So I'm happy to provide details on the expertise that supports the very core, like, absolutely core expertise of a physician in the use of coercion both for physical restraint, mental health restraint, restraint of the rights of children and restraints of the right of a marginalized population such as people experiencing homelessness, prisoners, people without status in a country and otherwise. But I think it's key that I believe I was asked to provide expertise and not just based on scholarly knowledge but based on medical knowledge.

And the paragraphs you're referring to here about the health harms of coercion are founded in medical knowledge as well as scholarly

knowledge but you're right, there's no citations there so I'm happy to provide medical knowledge to support that.

111 **Q.** Okay. But when we're talking about populations in general, and I'll take you to the second sentence of paragraph 20 momentarily, you'd agree it would be helpful to have some research or scholarly works talking about any trends or quantifications in those populations; right?

A. What I'm saying is that I believe that it could be helpful but that the source of expertise that causes me to write that sentence is not scholarship or book learning. It's medical expertise. It's core to -- you asked me at the beginning am I a licensed member of the College of Physicians and Surgeons of Ontario, being able to comment especially as an emergency and public health physician on the limits of coercion in order to protect health is core to my medical expertise.

112 **Q.** So returning to the second sentence of paragraph 20 you state, "An individual who has experienced personal or multi-generational trauma and conflict with the law enforcement or involuntary relocation may experience fears of force or harm and act based on coercion at a

different threshold than individuals who have no such experience."

So again, you're not, in your Affidavit, referring to any studies or scholarly works about the effects of coercion on individuals with or without experiences of trauma; correct?

A. Correct. The health effects of multi-generational trauma are, well, perhaps most authoritatively not just refer to the findings of Canada's Truth and Reconciliation Commission, which make the health effects of multi-generational trauma and the effects of involuntary relocation on populations that have experienced that nationally and authoritative.

113 **Q.** At paragraph 21 you state, "Racialized communities, religious minority groups, Indigenous communities, LGBTQ populations, newcomers and refugees have experienced involuntary relocation and coercion, including in Canada. These groups are overrepresented among people experiencing homelessness."

So I'm going to break this down a little bit. When you say including in Canada, Dr. Orkin, you mean in places other than Canada, too?

A. Yes. And the reason why I said including in Canada is that the, you know, we have data specific to Canada on these factors and data from other parts of the world.

114 **Q.** And certainly there are individuals within these groups who may not have personally experienced involuntary relocation or coercion; correct?

A. Correct. But it is also known that the health effects of those phenomena, involuntary relocation, coercion and adverse health effects of those interactions especially with State authorities are multi-generational. So personal effects are not or personal experiences are not defining of health effects.

So if -- well, I can provide example in detail but the concept, I think, is understood. That's why the previous sentence says multi-generational. Multi-generational trauma is a real biological and expressed phenomenon that issues of coercion and relocation that happened to my mother or grandmother can alter my behaviours and my -- the effects on my health from equivalent experiences.

115 **Q.** But you'd also agree that

individuals within these groups may also not have a generational history of involuntary relocation and coercion; correct?

A. Within their generation?

116 **Q.** Well, you said in generational history so what I'm putting to you, Dr. Orkin, is that not everybody who is in a racialized community, religious minority group, Indigenous community, LGBTQ population, who is a newcomer to Canada or who is a refugee, not everybody in those groups may have a multi-generational experience of trauma; correct?

A. Correct.

117 **Q.** Now, you haven't cited any sources, research or scholarly works that quantify the affect of involuntary relocation or coercion on any of these groups; correct?

A. Correct.

118 **Q.** And based on your CV, you haven't done any work yourself on the effect of involuntary relocation or coercion on those groups; correct?

A. Incorrect. There are several papers I can point you to related to appropriate actions when it comes to involuntary or coercive actions in medicine in Canada and several of these groups -

newcomers and refugees, Indigenous communities, racialized communities - I have worked in that area.

119 **Q.** You said --

A. And published in that area.

120 **Q.** You said appropriate actions but my question was the effect of involuntary or relocation or coercion on any of these groups?

A. Yeah. So in order to write papers on, say, the appropriate use of coercive actions for people with substance use and addiction, one needs to first conduct literature reviews on the background literature.

So in order to write those papers on the appropriate use of coercion, I have to do research and understand the literature of the health effects of coercion.

121 **Q.** Okay. So let's take a look at your CV, then, and tell me which papers involve that research.

A. I'm using the search function so that I can find the correct paper. Paper 51 has contents in this. "The epidemic as stigma: the bioethics and biopolitics of opioids". And --

122 **Q.** Bear with me one moment, Dr. Orkin.

A. Yeah.

123 **Q.** So for the record, we're on your CV under the heading "Publications" and publication number 51, "The epidemic as stigma: the bioethics and biopolitics of opioids"?

A. Yeah, there's content in there around coercion. There's content in, let me find the paper.

124 **Q.** And Dr. Orkin, I don't mean to interrupt your train of thought but before we move on from number 51, you'll agree the focus of that paper is not on the effect of coercion; correct?

A. No, it is not a paper printed on coercion but I'll get you one. Paper 59 is about the appropriate management of people in custody in emergency practice which talks -- which is directly about the coercive elements of care. And I'm trying to find a paper about Form 1s and people who have used drugs.

125 **Q.** And again, Dr. Orkin, while you're looking for that, so paper 59, the paper titled "A 25-year-old woman with diabetes in custody", but again, the focus of that is not on the effect of coercion on the groups you list in paragraph 21 of your Affidavit, correct? This is a study on one woman with diabetes who is in a correctional

context?

A. No, it is a case study on the broader issues. She's a hypothetical person written in order to highlight the -- how coercion can affect care for patients in emergency departments. It's not actually about one woman.

126 **Q.** And are there any other papers that you'd like to point me --

A. There is, I'm just having a hard time finding it. It's a commentary in CJEM.

127 **Q.** Is it possibly number 28, Dr. Orkin?

A. Yes, thank you. "Rethinking involuntary admission for individuals presenting to Canadian emergency departments with life-threatening substance use disorders". Correct. That paper is about the appropriate use of coercive admission orders for individuals with life-threatening substance use disorders.

128 **Q.** Okay. I'll take you to that in a moment but I'd like to just take you back to number 59 and I'm going to change the window that I'm sharing. Now, I've just pulled up, this is a website, National Library of Medicine and it's got the heading "Canadian Medical Association Journal" and the title is "A 25-year-old woman with diabetes

in custody" and your name is on it. Is this the --

A. That's the paper.

129 **Q.** -- paper cited at number 59? Okay. And so in this paper, it's described:

"A 25-year-old woman who is handcuffed was brought to the emergency department in the custody of police officers. She has type 1 diabetes and last took her insulin over a day ago. She is slurring her words and appears fatigued. She asks if her sugar can be checked. The officers request that she be treated and stabilized before she is taken to a local correctional facility. They expect the patient to remain in detention for several days and ask if her urine can be checked for drugs?"

And then subsequently in this article, there's a few questions. So does the plaintiff -- I'm sorry. "Does the patient" --

A. Patient.

130 **Q.** Thank you. "Have to remain in handcuffs?" "Are the patient's charges or convictions a part of history-taking?" "What clinical information can be shared with the police officers?" "Should the patient's urine be tested for drugs at the officer's request?" "How should

continuity of care be assured at the time of discharge for this patient?" And then finally under the subheading "Case Revisited".

So again, Dr. Orkin, I'll just put it to you that this article doesn't address the extent to which the -- I'm sorry, the effect of involuntary relocation or coercion on the groups that you've identified at paragraph 21 of your Affidavit, namely racialized communities, religious minority groups, Indigenous communities, LGBTQ populations, newcomers or refugees?

A. Sure. What I'd say is that, you know, I would equally add the term people who've experienced incarceration to that first sentence in paragraph 20.

MS. SHORES: But this article, which I'm going to mark for identification, this is now Exhibit 3.

---EXHIBIT NO. 3: "A 25-year-old woman with diabetes in custody"

BY MS. SHORES:

131 **Q.** This article doesn't address the effect of coercion on those communities; correct?

A. This article is overtly about the medical responsibility and expertise required to

make choices and to provide care that is actually affirming to health in order to care for people who are experiencing restrictions on their choices.

For example, in this case, somebody is incarcerated, a choice of where they might be living right now, this person is living in prison and doesn't have access to that choice. There are very specific steps that a medical expert must take. And when I say medical expert, I don't just mean somebody looking after an individual but somebody purporting to provide medical care to a population in order to affirm their health. There are very specific steps that somebody, that a medical expert must take in order to be doing things to somebody who is under coercion in order to protect their health. That's what this article is about. Very directly.

132 **Q.** So this article is not quantifying the effect on health of the lack of choice that this person experience -- this hypothetical person experienced by virtue of being in custody?

A. No. And as you'll see from my Affidavit, the quantification of these effects is not what I am purporting to have expertise on. But the relative weighing of effects is possible,

meaningful and within my expertise outside of the quantification, and there's a key reason why I haven't taken on quantification just that there's no research whatsoever both on the health effects of encampment living, shelter living or choice that would enable that quantification. That -- and that -- the absence of that evidence, the absence of such an ability to perform a quantification today is what I'm trying to offer you as part of that expertise.

133 **Q.** But Dr. Orkin, you'd agree that without some sort of quantification, you can't accurately engage in that weighing of which is preferable choice or the alternative; correct?

A. Being -- in fact, what we don't have the ability to do is assert that it is possible to eliminate someone's choice in order to say that this option is healthier for you than that one. So what you just described is exactly the point that, in an overarching way, that my Affidavit was seeking to provide is that my opinion is that there is no science to suggest that coercively relocating somebody from an encampment to a shelter in a way that purports to protect their health, that there is nobody who could weigh that and say that they are

doing so to protect that person's health.

And the point that I think you're asking me do I have evidence to say -- do I have the ability to weigh in the opposite direction and say in fact, I can prove that the choice to not relocate somebody, that I have data to weigh in the opposite direction, no, I have no such data. But I have very compelling, I believe both data and theory that shows us that that choice has a profound effect on people's health.

It is not a weight -- if we use the example of weighing, it is not a weightless element in this calculus and that the value of that element in this calculus is what I am hoping to highlight here.

134 **Q.** Okay. We'll take you to that in a minute, Dr. Orkin. I want to, if we can, just stay on paragraph 21 before I move on. So I'm going to re-share your Affidavit. So at paragraph 21, the last sentence where you state, "These groups are overrepresented among people experiencing homelessness." In your report, you're not speaking specifically about groups of people experiencing homelessness in the City of Hamilton; correct?

A. No, I am not speaking specifically

about Hamilton.

135 **Q.** And as a related point, you are not addressing in your report whether to what extent involuntary relocation and coercion is part of the lived experience of people experiencing homelessness in Hamilton specifically; correct?

A. So I will say that I grew up in Hamilton, my family lives in Hamilton, I'm in Hamilton roughly monthly. I went to high school in Hamilton, I went to medical school in Hamilton, did rotations of my residency in Hamilton and so my familiarity with the City of Hamilton, with the communities in Hamilton, I've worked with Indigenous communities in Hamilton, I'm comfortable in saying that there's no profound difference in these factors and the community of Hamilton than there is in Toronto.

So I live in Toronto and provide care in Toronto and don't have specific data to Toronto on any of these factors. I have data for Canada. There's been studies in Vancouver, Edmonton, Toronto, some in Hamilton related to these factors but I'm -- it's not different than Hamilton.

136 **Q.** And your statement is based on your anecdotal experience interacting these groups when

you are present in Hamilton?

A. Correct.

137 **Q.** I want to go to a source that you cited elsewhere in your Affidavit. So at paragraph 23, footnote five is by Guirguis-Younger et al. "Homelessness and Health in Canada". If you bear with me, I'll pull it up.

A. If we could pause for one minute, I need to send my regrets to somebody who I was going to be connecting with at 11:00.

138 **Q.** Of course.

(OFF THE RECORD AT 11:10 a.m.)

BY MS. SHORES:

139 **Q.** So before we took that very brief break, Dr. Orkin, I placed on the screen a document titled "Homelessness and Health in Canada" edited by Manal Guirguis-Younger, Ryan McNeil and Stephen W. Hwang. And on the fourth page of the PDF, it's University of Ottawa Press 2014. Is this the document cited at footnote five of your Affidavit?

A. Yes.

140 **Q.** One of the authors is Stephen Hwang, do you have any knowledge, is that the same Stephen Hwang who is giving evidence as another witness in this proceeding?

A. Well, I know that he's the one who wrote the book. I don't actually know that that's -- yes. Yes, but I don't have any proof.

141 **Q.** Fair enough.

A. I assume it is.

142 **Q.** You cited this source in your Affidavit because you view it as a reliable authority?

A. On certain things. I don't actually agree with every chapter in this book or every finding in this book but yeah, it's a good piece of research and an important part of the, like, of the information in Canada on this issue.

143 **Q.** Okay. I'm going to take you to the introduction. So heading "Introduction", and recognizing that this is just the introduction, the second to last sentence of the first paragraph, the authors state, "Although some groups are overrepresented among the nation's homeless population due to wider social inequities embedded in Canadian society, notably people of Aboriginal ancestry (Hwang 2001), homelessness does not discriminate on the basis of age, gender, sexuality or race. In turn, Canada's homeless population reflects the country's overall diversity."

Do you agree with that statement?

A. Yes, in very specific ways. So what this is trying -- what this statement means to me working in this field is that if we choose a population that is part of the -- of Canadian society, we will find members of those groups who experience homelessness. I've had multi-millionaires who were experiencing homelessness for certain periods for one reason or another and people who have come from great privilege who are experiencing homelessness for one reason or another in my practice. What this means is there's no exceptions. What it doesn't mean is that homelessness is simply representative of the Canadian population.

So because it says most notably people of Aboriginal ancestry, I do not read that to mean that is the only group that is heavily overrepresented among people experiencing homelessness. People experiencing homelessness are more often male than the general Canadian population, more often of a non-binary gender identity than a general Canadian population, more often they're younger than the Canadian population. So this sentence is simply saying there's people

from every walk of life who experience homelessness but it does not mean that the demography of homelessness is simply representation of the Canadian population.

144 **Q.** Thank you. I'm going to take you back to paragraph 22 of your Affidavit. So under the heading "Involuntary Removal and Making a Healthy Choice", first sentence of paragraph 22, "Various disease processes and threats to safety may be associated with homeless encampments. These include, for example, unsafe use of generators, fires and other heating devices, sanitation, conflicts and assaults, and harms associated with substance use such as overdose."

Dr. Orkin, you'd agree that those disease processes and threats to safety can also affect people other than those living in the encampment; correct?

A. Correct.

145 **Q.** So fires, for example, can threaten the safety of people in the surrounding area?

A. Oh, you mean a fire in an encampment can threaten people in a surrounding area?

146 **Q.** Yes.

A. Hypothetically, yes, but I'm not

aware of any data to that effect. I'm not aware of any data that found that people surrounding a homeless encampment faced health threats because there was a homeless encampment there. I'm aware of deeply stigmatizing media stories to that effect, highly pervasive media stories to that effect but I'm not aware of any science that shows that the health of people in proximity to homeless encampments is harmed by the presence of the homeless encampment.

147 **Q.** And --

A. By fire or any other element.

148 **Q.** Okay. And so then I take it you wouldn't agree that poor sanitation in a homeless encampment can be a threat to the safety of people in the surrounding area?

A. Again, I'm not aware of any study that has shown that somebody living in a home but close to an encampment got cholera, giardia, yersinia, any type of pathogen from poor sanitization because there was an encampment in the adjacent park. Hypothetically, I can see how that could occur but I'm not aware of any circumstance where it's happened.

149 **Q.** And not only people housed, who are

living in houses in the immediate area but people passing through the area?

A. Yeah. I'm not aware of -- I'm not aware of harms that have happened other than perceived threats. You know, I saw a needle, I was worried I'd be, you know, that I would touch that needle, I was worried that my child would touch that needle. I'm not aware of any cases where somebody has had an actual threat to their health because of an adjacent encampment. Certainly not in an epidemiological level. There may be anecdotal things but not at a, not at a pattern. Level of pattern.

150 **Q.** So taking your example on a needle or being afraid specifically that a child may touch a needle, your evidence is that presence of a needle is not a threat to a child or even a pet who may not recognize what a needle is?

A. No. That's -- I'm not saying that needles are not a threat to people's health or that, you know, anyone can touch a needle. That is not what I'm saying. What I'm saying is that it would require a different kind of evidence and a different kind of study. As you've requested on some of the other things that I've raised, it would require they

had some ability to cite a paper or conduct some kind of research that showed me that encampments as opposed to some other public substance use or other detritus cause more concentration of health harms to children or pets than the presence of those, that detritus in our society any ways.

I'm not aware of any such study so yes, fecal matter in our community or needles in our community or things that are burning in our community are bad for our health, that's a substantially different or a potential threat to adjacent people's health. That's profoundly different to showing that homeless encampments produce a systematic threat to the health of people who are adjacent to those encampments.

151 **Q.** I want to take you to paragraph 25 because I think we've already talked about some of what you said in paragraph 23 and 24 about the lack of research about living in encampments and the health effects but paragraph 25 in particular, the last sentence you state, "Stated differently, there is no scientific or health research to support the position that municipalities or other actors can involuntarily relocate people from encampments to shelters in order to protect their health."

So again, to put an even finer point on it, Dr. Orkin, in the absence of that scientific or health research, it also cannot be said that involuntarily relocating people from encampments in order to protect their health is not supportable; correct?

A. So that's actually not true. So, and I can provide some citations for this. I think there's a paper by Rodriguez on this phenomenon. We do know that involuntary relocations, encampment sweeps and other forms of coercion is harmful and harmful specifically to this population's health and so we do have evidence that shows that involuntary relocation has health harms. We do not have any evidence to show that involuntary relocations produce systematic benefits.

As I said, I really appreciate your language about weighing it. We do not have the kind of research that allows us to weigh those things relative to one another but we do have evidence of harm. So we know that coercively relocating people within encampments harms their health. We don't know whether letting them choose is good or bad.

152 **Q.** When you say we do --

A. So all we have is evidence of harm.

153 **Q.** When you say we do know that coercively relocating people from encampments, and I may not have been quoting you verbatim there, Dr. Orkin, that research isn't cited in your Affidavit, is it?

A. So no, the research itself isn't cited. My Affidavit is about the health harms of eliminating choice but not specifically about that, no.

154 **Q.** At paragraph 26 of your Affidavit you state, "Broadly speaking, coercion is itself harmful and choice is itself helpful." And earlier in your testimony today you had referred to what I think could be fairly characterized as some nuance or an exception to that concept. For example, an involuntary admission for treatment where someone is in a mental health crisis. You'd agree?

A. Correct. There are circumstances where the broad consensus or the professional opinion is that coercion is in that health benefit and we have very clear professional standards. One of the only areas where medical expertise and legal expertise are supposed to overlap. There's a few areas of legislation that doctors are supposed to know about and by in large, they refer to coercion

and the very limited circumstances where coercion is appropriate for health.

155 **Q.** And so I'm going to take you to, we had previously discussed -- I'm sorry, item number 28 on your CV. So let's just go there so we're all on the same figurative page of what we're speaking about. So item 28 on your CV, page 11 of your CV, Reid et al, article titled "Rethinking involuntary admission for individuals presenting to Canadian emergency departments with life-threatening substance use disorders". I believe I located that article and so I placed it up on the screen. Do you see the document that's on the screen here?

A. Correct.

156 **Q.** It's an article titled "Rethinking involuntary admission for individuals presenting to Canadian emergency departments with life-threatening substance use disorders". Nadine Reid and then also Aaron Orkin, MD. That's you?

A. Correct.

157 **Q.** This is a document that's at paragraph -- sorry, item 28 of your CV?

A. Correct.

158 **Q.** So I want to take you down to the second page of this document and bear with me while

I find my spot. Under the subheading "Ethical Basis", so towards the bottom, the first sentence reads, "Under a bioethics lens, support for involuntary admission in mental health is clear under certain circumstances. From this perspective, involuntary admission can be ethically justified if the imperatives of medical care, beneficence, nonmaleficence, or justice, are significantly challenged by an individual's presentation and risks." I take it you'd agree with those statements?

A. Correct.

159 **Q.** I want to look at item, I'm sorry, footnote 11 in particular. So footnote 11 corresponds to an article by Janssens et al, "Pressure and coercion in the care for the addicted: ethical perspectives" and the Journal of Medical Ethics 2004;30:453–458. I believe I've located that article so I'm placing up on the screen here a document titled "Pressure and coercion in the care for the addicted: ethical perspectives". You'll see the citation, Journal of Medical Ethics 2004, 453-458?

Is that the article cited in your paper?

A. It is.

160 **Q.** Okay.

MS. SHORES: So let's just continue with the marking of exhibits. So I'm going to make -- actually, I apologize. Bear with me with some housekeeping. So "Homelessness and Health in Canada" we had not previously made an exhibit. I'd like to make that Exhibit 4.

---EXHIBIT NO. 4: "Homelessness and Health in Canada"

MS. SHORES: Exhibit 5 will be the article "Rethinking involuntary admission" and then this article that's currently on the screen "Pressure and coercion in the care for the addicted", that will be Exhibit 6.

---EXHIBIT NO. 5: "Rethinking involuntary admission for individuals presenting to Canadian emergency departments with life-threatening substance use disorders"

---EXHIBIT NO. 6: "Pressure and coercion in the care for the addicted: ethical perspectives"

THE WITNESS: Can I make a pre-ambulatory statement just because it might help in this track? The ethical framework for the decision-making of the use of coercive measures for

populations and Public Health and Preventive Medicine and the ethical framework for the use of coercive measures for care of individual patients such as mental health and addiction do not map to one another. They are not the same. And so the use of this framework for the application to coercive measures for a population would be, for me, and I just think this is -- I'm happy to go down this path with you but for me would be a misapplication. It's just simply moot. These frameworks don't apply to populations. They apply to individual care, which is like a -- it's civil law versus criminal law. It's a completely different framework.

BY MS. SHORES:

161 **Q.** Okay. But in your Affidavit, you don't provide any sort of indication that these -- I'm sorry. In your Affidavit you don't cite any source materials to stand for the proposition that coercive measures in individual care do not apply when we're talking about groups of people, do you?

A. I do. Actually, the -- you'll -- let me go to the right paragraph. Paragraph 27, "There are of course limits to the principle that choices make health. Limited circumstances when coercive and involuntary actions can be taken to

protect an individual or community's health include involuntary admissions under the *Mental Health Act.*" That's individuals.

"Protections from health hazards under the *Health Protection and Promotion Act*", which is the population health lens, this is the legal context but they all are supported by well-developed bioethical frameworks, which public health experts would be responsible for knowing quite separately from clinical experts who would be responsible for knowing about coercion in individual patients or child welfare concern under the *Child Youth and Family Services Act* which have elements of both individual and community health because there's a family dynamic in child and youth and family services.

And so medical experts, and this is a very common error that medical experts think they can wander between them because very few clinicians are trained in the difference between individual and population health. So population health ethics is quite different to clinical bioethics and require different framework. So there's a reason why in this paragraph I cited the different legal frameworks because they're rooted in different

bioethical frameworks.

So I'm willing to discuss any citation or any paper that I've written and to discuss the appropriate use of coercion for patients under the *Mental Health Act*, which is what that commentary is about in CJEM, but the bioethical framework that I referred to simply don't map to the, to population health choices. And it might also be useful to highlight that I'm not aware of the, like, legal details and circumstances in Hamilton but I don't think that an order was ever placed under the *Health Protection and Promotion Act*.

162 **Q.** And specifically with respect to the last sentence of paragraph 27, which I think encapsulates what you were just describing, that none of these *Acts* or circumstances apply in a general way to individuals who choose to live in an encampment. Again, though, Dr. Orkin, you're not citing any research or scholarly works that say this, are you?

A. No. But again, as pointed out, just like I'm an emergency physician and a public health physician, if you ask me whether the patient in front of me, if the actual individual patient that I

was seeing last night in the emergency department 11:00 o'clock who was placed under an Order under the *Mental Health Act* and you asked me do you have a citation or reference that could support your decision to complete a Form 1 under the *Mental Health Act*, I'd say citations aren't how we make that decision. It's an area of medical expertise and application of my assessment of the patient, bioethical framework, legal framework and the document that then requires signing.

The application of the *Health Protection and Promotion Act* to a homeless encampment is a core feature of practice as a Public Health and Preventive Medicine physician. And well, I'm simply not aware of any municipality or circumstance in recent history in Canada where the *Health Protection and Promotion Act* and bioethical frameworks that underlie it have been used in order to clear an encampment.

163 **Q.** I'm not talking about what legal instruments or statutes may apply, I'm talking specifically about your statement that the *Acts* or circumstances don't apply in a general way to individuals who choose to live in encampment.

A. Right.

164 **Q.** So are you saying --

A. What I'm saying is that's a medical expertise. That's a feature of medical expertise, not a feature of scholarly expertise. So the idea -- let's take the *Mental Health Act*, for example, right, which we can go through the elements but the idea that we could use the *Mental Health Act* to say I'm going to approach somebody in an encampment, say that your choice is unhealthy to be in this encampment, place you under a Form 1 and move you to a mental health facility because we think that's a way to move you out of this encampment, I'd say that it's not that I need to go to the scholarship on that, I just go to the medical expertise on that and say that that's -- that would be preposterously bad practice and malpractice to go down that avenue unless there were other mental health circumstances involved there.

It is the identical work of expertise to apply the *Health Protection and Promotion Act* to this area of work. It's not area of legal expertise, it's an area of medical expertise. Say that the idea that we would empty an encampment using an order under the *Health Protection and Promotion Act*, that would be the

bioethical -- that would be the legal expression of the bioethical framework that public health physicians, population health physicians are expected to use in order to see whether we have met the bar to use coercive measures to change a community's -- to eliminate a set of community's choices. It simply doesn't apply. To do so would be medically inappropriate.

165 **Q.** So I'm --

A. That's what I mean when I say -- and I mean, none -- *Child Youth and Family Services Act* is just, like, I mean, it doesn't apply just because it's out of left field. It's not related.

166 **Q.** So I want to go back to Exhibit 6 in particular. So this is the Janssens et al article "Pressure and coercion in the care for the addicted: ethical perspectives". So the very first paragraph, the last sentence states, "Some coercive measures need not be interpreted as an infringement of autonomy - rather, they should be interpreted as a way to provide good care."

I mean, you'd agree with that statement, though, correct? This is cited in your article?

A. Yes, and those are under specific

circumstances where the nature of a mental health disorder, which this author, and this is a key part of what the authors -- of that citation in my name are arguing is that addiction is one of the many conditions that can have a greater effect on an individual's autonomy than the coercive measure itself.

So when we talk about at an individual level, the bioethical framework that's relevant here, the disease is the major threat to the person's autonomy. And so the legal and bioethical framework given to health professionals, physicians, mental health institutions and otherwise, have an affirming effect on people's autonomy to give them an opportunity to return to a place where they have the choice to act on their illness and disease.

And many people, once they are treated, actually, are very grateful to have a restoration of that autonomy. That's quite different and profoundly different to the appropriate frameworks for populations and crucially is hinged on disease that is already undermining the person's autonomy.

So conditions like severe mental

health conditions are perhaps the most profound assault on people's autonomy and sometimes coercive measures from health providers and the State therefore have an autonomy affirming feature. Not an autonomy eliminating feature.

167 **Q.** And so Dr. Orkin, if we return to Exhibit 5, which is the article titled "Rethinking involuntary admissions", this is the article that you authored. Continuing with the third sentence, "Substance use disorders are characterized by compulsory use of substances and impaired capacity to reflect on and overcome cravings and urges, undermining affected individuals' autonomy and placing them at risk of serious and imminent harm."

So Dr. Orkin, you gave the example of a person with a mental health condition but substance use problems is something, you'd agree as well, presents a possible case for use of coercive measures, you'd agree?

A. Under some very, very specific circumstances. So not in all cases by any stretch and again, an absolutely key term in this sentence is "individuals' autonomy". And so this is a framework, again, for individuals. It does not map to populations. A different framework is used for

populations.

168 **Q.** And when you say it -- I'm sorry, Dr. Orkin, I didn't mean to interrupt you.

A. No, that's fine.

169 **Q.** When you say it doesn't map to populations, again, you haven't cited any scholarly works or research that confirms that it doesn't map to populations. If I understand your evidence correctly, you're stating that's within medical practice, in other words, your own expertise as a doctor; right?

A. Yeah. Although, you'll see that this framework came up just by following one of my citations. The Upshur of framework for population and public health ethics doesn't refer to autonomy, it refers to justice as the somewhat equivalent element that would be followed in order to make a decision about whether the use of coercive measures is appropriate. And you'd find that just by following my citations as well in other papers that are not related to individual patients but related to the development of population health programs.

So if we had to take the framework that you asked me about at the beginning, how do I spend my time, this is in the individual clinical

care bucket, this paper. But the relevant bucket for the type of coercion that is at play when we say to a whole community, this encampment is closed, you all have to move, is not the individual patient care bucket, it's the population health bucket and we'd have to follow other citations for that.

170 **Q.** And speaking of individuals, Dr. Orkin, you'd agree that in an individual's circumstances, a choice to live in an encampment may not be a healthy choice for that individual?

A. Yes. So my Affidavit refer to two uses of the term health and choice. There are healthy choices and there are choices make health and so just like choosing to eat poutine rather than salad, people can make unhealthy choices and people can choose to live in an encampment that may present threats or limitations to their health. But that choice also makes health in that the elimination of that choice can harm their health, the use of coercion can harm their health. We don't tend to lock people up because they choose to eat poutine rather than salad. So we know that just because people make bad choices doesn't mean we always have the authority as a profession or as a State to impose a healthier choice on them.

171 **Q.** And as I believe we've already established with respect to encampments in particular, there is no sources, research, scholarly works to balance the harm of eliminating choice on one hand versus the harms that an individual may experience from the bad choice to live in encampment if it is, in fact, a bad choice for them; correct?

A. Sorry, can you repeat that question? I got a little bit lost in it.

172 **Q.** Yes. There's no research or scholarly works to assess the weight of, on one hand, the harm of eliminating a choice and the relative harm for a person of the bad choice of living in encampment if that is, in fact, a bad choice for them?

A. If, in fact, it is a bad choice, correct. There are no papers -- there are papers that look at the harms of coercive relocation for people experiencing homelessness away from encampments. There are no papers showing us the relative health benefit of people moving from one place to another under their own choice and so we simply don't know how to weigh these elements. But the only data that we have is related to the harms

of coercive relocation. We do not have any evidence that would say well, it might be good for them. We only have some evidence that shows it does hurt.

173 **Q.** And that data, again, is the data that's not cited in your Affidavit?

A. Correct.

174 **Q.** At paragraph 29 of your Affidavit you state, "For this reason, involuntary removals from encampments are a particularly egregious threat to health." You don't state how you determine that the level of threat is particularly egregious?

A. So again, particularly egregious, I'm not trying to make a quantitative assertion, I'm simply talking about in a population that has ongoing threats to their autonomy and limitations on their choices, that further threats to their choices, that that's a key resource that is undermined in that process.

So egregiousness is not me saying that there's a, you know, a massive effect size and I can show you a statistical p-value. Egregiousness refers to where the fountain of health comes from for this population and that it's a direct assault on it. And so it's -- that's what I mean by

egregiousness.

175 **Q.** You said it's not quantitative but I'll put it to you that it's a qualitative statement. You didn't say it's a minor threat to health, for example, you're conveying something that is significant, you'd agree?

A. Correct.

176 **Q.** But you aren't able to rely on any quantification to confirm the level of significance?

A. Sorry, I use significance in a very particular way. The meaningfulness? Is that what you mean by significance?

177 **Q.** I can work with meaningfulness if that's how you'd like to capture --

A. Yes. I don't have any -- well, the papers that I can provide you or the reference I can provide you such as the paper by Rodriguez and colleagues shows that it really hits people where it hurts and affects their health profoundly and meaningfully. I can't give you a p-value or a statistical significance on it. That's not the style of research done in that domain.

178 **Q.** And so to perhaps illustrate this, if we go back to paragraph 22 of your Affidavit

where you state, "Various disease processes and threats to safety may be associated with homeless encampments", based on your Affidavit, you haven't investigated how the threat to health presented by involuntary removal compares to these disease processes and threats to safety that may be associated with homeless encampments?

A. No, there's no such weighing that has been performed, to my knowledge.

179 **Q.** Thank you, Dr. Orkin. You understood all my questions today?

A. I have.

180 **Q.** Are there any of your answers that you want to change?

A. No, thank you.

181 **Q.** Those are my questions. Thank you.

MR. CHOUDHRY: Can we go off the record for a minute, Ms. Thompson?

(OFF THE RECORD AT 11:44 a.m.)

MR. CHOUDHRY: Mr. Orkin, we have no questions for re-direct so thank you for your time very much, sir. I know we ran over and you're busy seeing patients and things but we appreciate your time. Thank you so much.

THE WITNESS: Thank you.

MS. SHORES: Yes, thank you, Dr. Orkin.

---WHEREUPON THE EXAMINATION CONCLUDED AT 11:51 a.m.

I hereby certify the foregoing to be the evidence of Dr. Aaron Orkin, given under oath before me on the 26th day of August, 2024, recorded stenographically and later transcribed by me.



Rachel Thompson
Court Reporter
Commissioner of Oaths (expiring November 2024)

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ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, ET AL.

Applicants

-and-

CITY OF HAMILTON

Respondent

ACKNOWLEDGMENT OF EXPERT'S DUTY

1. My name is Aaron Orkin. I live at Toronto, in the Province of Ontario.

2. I have been engaged by or on behalf of the Hamilton Community Legal Clinic to provide evidence in relation to the above-noted court proceeding.

3. I acknowledge that it is my duty to provide evidence in relation to this proceeding as follows:

   (a) to provide opinion evidence that is fair, objective and non-partisan;

   (b) to provide opinion evidence that is related only to matters that are within my area of expertise; and

   (c) to provide such additional assistance as the court may reasonably require, to determine a matter in issue.

4. I acknowledge that the duty referred to above prevails over any obligation which I may owe to any party by whom or on whose behalf I am engaged.

Date Sept 14, 2022

Aaron Orkin
Signature

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Exam of Dr Aaron Orkin
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Ex # 2 m/d/y 8/26/2024 Pg 1 of 3
Exam of Dr. Aaron Orkin
Heegsma etal v. City of Hamilton
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ANALYSIS

How should we define health?

The WHO definition of health as complete wellbeing is no longer fit for purpose given the rise of chronic disease. **Machteld Huber and colleagues** propose changing the emphasis towards the ability to adapt and self manage in the face of social, physical, and emotional challenges

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The current WHO definition of health, formulated in 1948, describes health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[1] At that time this formulation was groundbreaking because of its breadth and ambition. It overcame the negative definition of health as absence of disease and included the physical, mental, and social domains. Although the definition has been criticised over the past 60 years, it has never been adapted. Criticism is now intensifying,[2-5] and as populations age and the pattern of illnesses changes the definition may even be counterproductive. The paper summarises the limitations of the WHO definition and describes the proposals for making it more useful that were developed at a conference of international health experts held in the Netherlands.[6]

Limitations of WHO definition

Most criticism of the WHO definition concerns the absoluteness of the word "complete" in relation to wellbeing. The first problem is that it unintentionally contributes to the medicalisation of society. The requirement for complete health "would leave most of us unhealthy most of the time."[4] It therefore supports the tendencies of the medical technology and drug industries, in association with professional organisations, to redefine diseases, expanding the scope of the healthcare system. New screening technologies detect abnormalities at levels that might never cause illness and pharmaceutical companies produce drugs for "conditions" not previously defined as health problems. Thresholds for intervention tend to be lowered—for example, with blood pressure, lipids, and sugar. The persistent emphasis on complete physical wellbeing could lead to large groups of people becoming eligible for screening or for expensive interventions even when only one person might benefit, and it might result in higher levels of medical dependency and risk.

The second problem is that since 1948 the demography of populations and the nature of disease have changed considerably. In 1948 acute diseases presented the main burden of illness and chronic diseases led to early death. In that context WHO articulated a helpful ambition. Disease patterns have changed, with public health measures such as improved nutrition, hygiene, and sanitation and more powerful healthcare interventions. The number of people living with chronic diseases for decades is increasing worldwide; even in the slums of India the mortality pattern is increasingly burdened by chronic diseases.[7]

Ageing with chronic illnesses has become the norm, and chronic diseases account for most of the expenditures of the healthcare system, putting pressure on its sustainability. In this context the

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WHO definition becomes counterproductive as it declares people with chronic diseases and disabilities definitively ill. It minimises the role of the human capacity to cope autonomously with life's ever changing physical, emotional, and social challenges and to function with fulfilment and a feeling of wellbeing with a chronic disease or disability.

The third problem is the operationalisation of the definition. WHO has developed several systems to classify diseases and describe aspects of health, disability, functioning, and quality of life. Yet because of the reference to a complete state, the definition remains "impracticable, because 'complete' is neither operational nor measurable."[3 4]

Need for reformulation

Various proposals have been made for adapting the definition of health. The best known is the Ottawa Charter,[8] which emphasises social and personal resources as well as physical capacity. However, WHO has taken up none of these proposals.

Nevertheless, the limitations of the current definition are increasingly affecting health policy. For example, in prevention programmes and healthcare the definition of health determines the outcome measures: health gain in survival years may be less relevant than societal participation, and an increase in coping capacity may be more relevant and realistic than complete recovery.

Redefining health is an ambitious and complex goal; many aspects need to be considered, many stakeholders consulted, and many cultures reflected, and it must also take into account future scientific and technological advances. The discussion of experts at the Dutch conference, however, led to broad support for moving from the present static formulation towards a more dynamic one based on the resilience or capacity to cope and maintain and restore one's integrity, equilibrium, and sense of wellbeing.[6] The preferred view on health was "the ability to adapt and to self manage."

Participants questioned whether a new formulation should be called a definition, because this implied set boundaries and trying to arrive at a precise meaning. They preferred that the definition should be replaced by a concept or conceptual framework of health. A general concept, according to sociologist Blumer,[9] represents a characterisation of a generally agreed direction in which to look, as reference. But operational definitions are also needed for practical life such as measurement purposes.

The first step towards using the concept of "health, as the ability to adapt and to self manage" is to identify and characterise it for the three domains of health: physical, mental, and social. The following examples attempt to illustrate this.

Physical health

In the physical domain a healthy organism is capable of "allostasis"—the maintenance of physiological homoeostasis through changing circumstances.[10] When confronted with physiological stress, a healthy organism is able to mount a protective response, to reduce the potential for harm, and restore an (adapted) equilibrium. If this physiological coping strategy is not successful, damage (or "allostatic load") remains, which may finally result in illness.[11]

Mental health

In the mental domain Antonovsky describes the "sense of coherence" as a factor that contributes to a successful capacity to cope, recover from strong psychological stress, and prevent post-traumatic stress disorders.[12 13] The sense of coherence includes the subjective faculties enhancing the comprehensibility, manageability, and meaningfulness of a difficult situation. A strengthened capability to adapt and to manage yourself often improves subjective wellbeing and may result in a positive interaction between mind and body—for example, patients with chronic fatigue syndrome treated with cognitive behavioural therapy reported positive effects on symptoms and wellbeing. This was accompanied by an increase in brain grey matter volume, although the causal relation and direction of this association are still unclear.[14]

Social health

Several dimensions of health can be identified in the social domain, including people's capacity to fulfil their potential and obligations, the ability to manage their life with some degree of independence despite a medical condition, and the ability to participate in social activities including work. Health in this domain can be regarded as a dynamic balance between opportunities and limitations, shifting through life and affected by external conditions such as social and environmental challenges. By successfully adapting to an illness, people are able to work or to participate in social activities and feel healthy despite limitations. This is shown in evaluations of the Stanford chronic disease self management programme: extensively monitored patients with chronic illnesses, who learnt to manage their life better and to cope with their disease, reported improved self rated health, less distress, less fatigue, more energy, and fewer perceived disabilities and limitations in social activities after the training. Healthcare costs also fell.[15 16]

If people are able to develop successful strategies for coping, (age related) impaired functioning does not strongly change the perceived quality of life, a phenomenon known as the disability paradox.[17]

Measuring health

The general concept of health is useful for management and policies, and it can also support doctors in their daily communication with patients because it focuses on empowerment of the patient (for example, by changing a lifestyle), which the doctor can explain instead of just removing symptoms by a drug. However, operational definitions are needed for measurement purposes, research, and evaluating interventions.

Measurement might be helped by constructing health frames that systematise different operational needs—for example, differentiating between the health status of individuals and populations and between objective and subjective indicators of health. The measurement instruments should relate to health as the ability to adapt and to self manage. Good first operational tools include the existing methods for assessing functional status and measuring quality of life and sense of wellbeing. WHO has developed several classification systems measuring gradations of health.[18] These assess aspects like disability, functioning, and perceived quality of life and wellbeing.

In primary care, the Dartmouth Cooperative Group (COOP)/Wonca (the world organisation of family doctors) assessment of functional status, validated for different social and cultural settings, has been developed to obtain insight into the perceived health of individuals. The COOP/Wonca Functional Health Assessment Charts present six different dimensions of health, each supported by cartoon-like drawings.[19 20] Each measures the ability to perform daily life activities on a 1 to 5 scale.

Such instruments offer valuable information about a variety of aspects, from functioning to the experienced quality of life. Yet there are few instruments for measuring aspects of health like the individual's capacity to cope and to adapt, or to measure the strength of a person's physiological resilience. A new formulation about health could stimulate research on this.

Conclusion

Just as environmental scientists describe the health of the earth as the capacity of a complex system to maintain a stable environment within a relatively narrow range,[21] we propose the formulation of health as the ability to adapt and to self manage. This could be a starting point for a similarly fresh, 21st century way of conceptualising human health with a set of dynamic features and dimensions that can be measured. Discussion about this should continue and involve other stakeholders, including patients and lay members of the public.

We thank Jennie Popay, Atie Schipaanboord, Eert Schoten, and Rudy Westendorp for their thoughts.

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Competing interests: All authors have completed the ICJME unified disclosure form at www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and declare no support from any organisation for the submitted work; no financial relationships with any organisation that might have an interest in the submitted work in the previous three years; and no other relationships or activities that could appear to have influenced the submitted work.

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Ex # 3 m/d/y 8/26/2024 Pg 1 of 4
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A 25-year-old woman with diabetes in custody

Fiona G. Kouyoumdjian, MD PhD, Wendy Lai, MD, Aaron Orkin, MD MSc, and Barbora Pek, MD

A 25-year-old woman who is handcuffed was brought to the emergency department in the custody of police officers. She has type 1 diabetes and last took her insulin over a day ago. She is slurring her words and appears fatigued. She asks if her sugar can be checked. The officers request that she be treated and stabilized before she is taken to the local correctional facility. They expect the patient to remain in detention for several days and ask if her urine can be checked for drugs.

Does the patient have to remain in handcuffs?

Concerns regarding privacy, confidentiality and legal consequences may prevent a patient in custody from discussing relevant aspects of medical history in the presence of security staff. Physical restraints, such as handcuffs, may cause physical and emotional discomfort, obstruct the physical examination and undermine the patient's trust and confidence in the physician's professional independence.[1] This is particularly important because there are high rates of morbidity and mortality across a variety of health status indicators in patients who experience detention and incarceration.[2,3] Health care encounters can be an affirmative opportunity to enhance health in this population, and a recent systematic review showed that health care interventions can improve the health of this population while in custody and at the time of release.[4]

It is reasonable for physicians to request accommodations to facilitate an assessment, such as asking security staff to leave the room, stand on the other side of a curtain or barrier, or remove restraints during an examination. Police officers and correctional authorities have the authority to decide whether to remove restraints or to leave the patient, and may make this decision in consideration of the risk of danger or flight by the patient.

Are the patient's charges or convictions a part of history-taking?

This information is usually not pertinent to patient care in any clinical setting, but there are exceptions such as a forensic psychiatric assessment. A recent observational study in the United States found that knowledge of criminal history may lead to discrimination by health care workers.[5] In the absence of clinical rele-

Feedback

vance and with the risk of bias in mind, it is not necessary to ask this patient for details of criminal involvement as part of the routine history.

What clinical information can be shared with the police officers?

A physician's ethical obligations regarding confidentiality, including legislated exceptions,[6] are not contingent on legal status and therefore extend to persons in custody.[7]

It may be clinically useful for physicians to obtain collateral history from police or correctional officers.[7] Physicians should not disclose information about the patient's clinical status or management to security staff, except for the patient's disposition (e.g., whether the patient requires admission to hospital) and any information that would be considered essential while the patient is in their custody.[8] In Ontario, for example, essential information is limited to information that could eliminate or reduce "a significant risk of serious bodily harm to a person [including the patient] or group of persons."[8]

Should the patient's urine be tested for drugs at the officers' request?

In specific situations (e.g., when a person is suspected of having operated a vehicle under the influence of drugs or alcohol within the previous 3 hr), police and correctional officers in Canada are authorized to ask physicians to obtain samples, such as blood or urine, for investigation.[9] Treating physicians are not obligated to comply with such police requests and should only comply with the patient's consent.[10] Therefore, for this patient, as with any other, the physician should only test her urine for illicit drugs if clinically indicated, and if the patient consents to the test.

International guidelines for physicians treating patients who are detained or imprisoned specify that, regardless of known or suspected charges or convictions, physicians "shall not countenance, condone or participate in … forms of cruel, inhuman or degrading procedures,"[11] such as examinations or procedures for the purposes of a criminal investigation.[12] Further, the physician "must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible."[11]

How should continuity of care be assured at the time of discharge for this patient?

When the patient is ready for discharge, the physician should outline the requirements for follow-up at the correctional facility, including access to glucose testing equipment, insulin and health care staff. Consistent with practice standards for discharge,[6] this may include calling the health care staff at the correctional facility to discuss the patient's clinical status and need for follow-up. Depending on the complexity and urgency of the information to be shared, this communication may be done by fax or by sending information in a sealed envelope that is addressed to the health care staff at the correctional facility and either given to the patient or security staff accompanying her.

Health care staff at correctional facilities are licensed health care professionals, and it is appropriate to share relevant clinical information with them for continuity of care unless the patient expressly withdraws or withholds consent to the disclosure of this information.[13]

Case revisited

Based on the physician's request, the police agreed to remove the handcuffs and leave the room. The police were told that it would take several hours to complete the patient assessment and that the physician would update them about the patient's disposition when possible. The physician took a history and performed a physical examination, guided by the patient's request to have her glucose checked, her history of type 1 diabetes and statement that she had not taken insulin for more than a day. The patient reported that she injected oxycodone several times the previous day and her drug use made it hard for her to manage her diabetes.

The physician determined that the patient was capable of providing informed consent and ordered laboratory investigations. These tests showed that the patient was in diabetic ketoacidosis and appropriate treatment was started.

The physician explained to the officers that there was no clinical indication for drug screening, and the test would not be ordered. The physician also updated the officers about the anticipated length of the patient's stay in hospital, but did not discuss the patient's drug use or other aspects of the patient's assessment and management with them.

The following morning, the patient was ready to be discharged. The physician contacted the health care staff at the correctional facility to discuss the treatment plan and provided the patient with written discharge instructions to share with them. The physician explained to the patient that her care had been discussed with health care staff at the facility and then reviewed symptoms that she should report to the police officers or correctional staff. The physician also recommended that the patient meet with health care staff at the facilty to discuss the management of her diabetes and her drug use.

Footnotes

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The clinical scenario is fictional.

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HOMELESSNESS AND HEALTH IN CANADA

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HOMELESSNESS AND HEALTH IN CANADA

EDITED BY

Manal Guirguis-Younger

Ryan McNeil

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Introduction

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Why This Book?

Stereotypical images of homeless persons, such as those of 'junkies', 'squeegee kids' or 'bag ladies', shape popular understandings of homelessness but obscure the scope and diversity of Canada's homeless population. Over the past thirty years, the retreat of the federal government from social housing, along with reforms to social welfare programs and health care, has contributed to a growing homelessness crisis that affects tens of thousands of people every year (Hulchanski et al. 2009). This steady growth in Canada's homeless population has been accompanied by greater awareness that this population is highly heterogeneous (Gaetz 2010; Laird 2007). Although some groups are overrepresented among the nation's homeless population due to wider social inequities embedded in Canadian society, notably people of Aboriginal ancestry (Hwang 2001), homelessness does not discriminate on the basis of age, gender, sexuality or race. In turn, Canada's homeless population reflects the country's overall diversity.

Increased recognition of the diversity of Canada's homeless population has led to greater acknowledgement that homelessness encompasses a wide range of living situations (Canadian Homelessness Research Network 2012). Recently, Canadian researchers have advanced a definition of homelessness that recognizes this diversity by situating homelessness along a continuum of living

arrangements, including: (1) living outside or in places not fit for human habitation; (2) staying in temporary or emergency accommodations (e.g., emergency and transition shelters); (3) living in accommodations without security of tenure (e.g., 'couch surfing' or staying with friends or acquaintances); and (4) living at risk of homelessness due to lack of financial security or other factors (e.g., intimate partner violence, separation or divorce, etc.) that may compromise housing (Canadian Homelessness Research Network 2012). In many regards, this definition underscores the fact that *homelessness is experienced differently by different people,* often in accordance with the unique constellation of individual, social and structural factors that shape their lives (see, for example, Karabanow 2004; Menzies 2009; Walsh, Rutherford and Kumak 2009). For example, women and their children escaping intimate partner violence by staying in a transition shelter, street-involved youth sleeping on a friend or acquaintance's sofa and an individual staying in an emergency shelter or sleeping outside may all be characterized as homeless, in that they lack access to secure and stable housing.

While these diverse categories of homelessness underscore the varied needs and experiences of Canada's homeless population, more than two decades of research indicates that one factor linking this population is poor overall health (Dunn 2000; Frankish, Hwang and Quantz 2005; Hwang 2001). Homelessness is associated with high levels of morbidity and mortality (Hwang 2000; Hwang et al. 2009; Street Health Toronto 2007), with homeless populations in Canada experiencing higher incidences of alcohol and drug use (Grinman, Chiu and Rederlmeier 2010; Kerr et al. 2009; Torchalla, Strehlau and Krausz 2011), mental illness (Stergiopoulos et al. 2010) and infectious diseases, such as HIV/AIDS and hepatitis C (Corneil et al. 2006; Roy, Haley and LeClerc 2001), than their housed counterparts. In addition, an array of chronic health problems are common among homeless populations, including but not limited to diabetes (Hwang and Bugeja 2000), cardiovascular disease (Lee et al. 2005) and respiratory illnesses (Raoult, Foucault and Brouqi 2001). Unsurprisingly, the cumulative disease burden experienced by homeless persons, when combined with high levels of suicide, fatal injury and homicide, results in some of the highest all-cause mortality rates of any population in Canada (Cheung and Hwang 2004; Hwang, 2000; Hwang et al. 2009).

Paradoxically, whereas homeless populations have high levels of health services utilization, especially emergency department and

in-patient care (Hwang et al. 2011; Palepu et al. 1999), they frequently have unmet health needs due to the barriers that they face to accessing care and adhering to treatment (Hwang et al. 2010; Khandor et al. 2011; McNeil and Guirguis-Younger 2012). The reasons for this are complex and, to a great extent, largely the product of the challenges experienced by homeless persons. For example, the daily struggle for survival, such as addressing immediate needs (e.g., food, shelter etc.), often takes precedence over health needs, leading homeless persons to delay seeking treatment (Gelberg et al. 1997). Furthermore, researchers have found that homeless persons often feel unwelcome in health care settings due to discrimination and subsequent to these experiences are less likely to seek care (Wen, Hudak and Hwang 2007).

Against this backdrop, homelessness has been increasingly characterized as Canada's most significant public health challenge (Frankish, Hwang and Quantz 2005; Hulchanski et al. 2009; Hwang 2001; Layton 2000) and yet no book or edited collection has unpacked the relationship between homelessness and health to identify potential solutions. This book seeks to remedy this by bringing together, for the first time, contributions by leading and emerging Canadian researchers exploring the relationship between homelessness and health. In doing so, it signifies an important step towards advancing our understanding of this relationship and identifying future directions. While fully accounting for the impact of homelessness on health lies beyond the scope of any one project, this book disentangles many important dimensions of this relationship. Accordingly, it has considerable potential to inform the response to one of Canada's enduring social challenges and, to that end, contributors have linked their chapters to policy and practice recommendations. The chapters in this book have been organized into three distinct but complementary sections that address a range of topics, spanning from youth homelessness to hospice and palliative care, and together constitute a blueprint for improving the health of homeless persons in Canada.

The Organization of This Book

Part 1 of this book highlights the diversity of Canada's homeless population by exploring the health needs and experiences of particular populations. Researchers have increasingly turned their attention toward how individual characteristics intersect with social

and structural factors to shape the health of *particular* homeless populations (i.e., women, persons of Aboriginal ancestry, etc.) and, in many cases, increase their vulnerability to adverse health outcomes (see, for example, Gelberg et al. 2004; Reading and Wien 2010). The chapters in this section of the book expand on this literature, while providing policy and practice recommendations that aim to mitigate these health disparities within the larger homeless population.

The first two chapters explore the experiences of homeless youth. In Chapter 1, Jeff Karabanow and Sean Kidd review social and structural factors that contribute to youth homelessness, while highlighting the diversity of homeless and street-involved youth. Given that the lived experiences of homeless youth vary in accordance with their age, gender, sexuality and race, Karabanow and Kidd argue that it is critical that interventions to address youth homelessness account for this diversity. Importantly, this chapter seeks to inform the response to youth homelessness by outlining policy and practice recommendations that take into consideration the needs and experiences of homeless youth. In Chapter 2, Danielle Schwartz and her colleagues provide an overview of the individual, social and structural factors that shape sexual health outcomes among homeless and street-involved youth. In light of epidemiological data indicating that homeless youth experience adverse sexual health outcomes (see, for example, Marshall et al. 2009; Shields et al. 2004), this chapter contributes to the literature by outlining how homelessness constrains the ability of youth to adhere to risk reduction strategies.

Chapters 3 and 4 situate the disproportionate levels of homelessness and unstable housing experienced by people of Aboriginal ancestry within the context of Canada's history of colonialism and racism. In Chapter 3, Billie Allan and Izumi Sakamoto report findings from the Coming Together project, a community-based participatory research project that explored how Aboriginal women and transwomen negotiate and survive the many challenges of homelessness and unstable housing. This chapter highlights the severe marginalization that Aboriginal women and transwomen encounter in Canadian society and presents recommendations for policymakers and service providers that seek to empower these women. In Chapter 4, Nathanael Lauster and Frank Tester report findings from a survey that explored the impact of residential crowding on Inuit people in Nunavut, focusing in particular on the implications for population health. Lauster and Tester link the shortage of safe,

affordable housing to high levels of residential crowding and self-reported health problems.

In Chapter 5, Fran Klodawsky and her colleagues explore how homelessness impacts self-reported health status and health care access among immigrants and refugees. Klodawsky and her colleagues draw upon data from the Ottawa Panel Study on Homelessness, a longitudinal study that examined changes in housing status and health among a cohort of homeless persons in the Greater Ottawa region. This study found that immigrants and refugees experienced better physical and mental health than their Canadian-born counterparts. However, Klodawsky and her colleagues note that, given that health and social service utilization increased among immigrants and refugees over time, greater attention is needed to how well existing services meet the needs of this population.

Part 2 explores potential policy and programmatic responses to improve health access and outcomes among homeless populations. Over the past two decades, greater attention to the impact that homelessness has on health has been accompanied by calls to implement policy and programmatic reforms to increase access to affordable housing and health care services (Frankish, Hwang and Quantz 2005; Hwang 2001). To date, policy approaches to addressing the intersection of homelessness and health have been lacking, with Canada being notably without a national housing strategy. In many regards, this section of the book adds an important dimension to this ongoing discussion by mapping policies and programs that have the potential to improve our overall response to homelessness at the local, regional and national level.

Chapters 6 and 7 explore innovative housing policies and interventions with the potential to improve health outcomes among homeless populations. In Chapter 6, Brandon Marshall and Thomas Kerr review the relationship between housing and HIV/AIDS among people who inject drugs. They explore policy and programmatic reforms that have the potential to minimize HIV risks and increase support among this population. Importantly, Marshall and Kerr suggest that integrating housing interventions with addictions treatment, health services and other evidence-based interventions have the potential to achieve the greatest possible benefits. In Chapter 7, Tim Aubry and his colleagues present findings of a review exploring the impact of supported housing initiatives on people with severe

and persistent mental illness. They link the history and impact of deinstitutionalization to high levels of homelessness among people with severe and persistent mental illness. Aubry and his colleagues demonstrate that supported housing has been shown to be effective in helping people with severe and persistent mental illness achieve housing stability and should be considered as a central plank of the larger response to homelessness.

The remaining chapters in Part 2 explore policy and programmatic strategies with the potential to improve health services delivery to homeless populations. In Chapter 8, Bruce Wallace and his colleagues explore the oral health care needs of homeless populations, which have been largely overlooked by researchers. This chapter reviews barriers that homeless populations encounter to accessing oral health care services, linking unmet oral health needs to poor overall health outcomes. Wallace and his colleagues examine how community dental clinics, and in particular those integrated into existing community health clinics, have the potential to minimize barriers that homeless populations encounter to accessing oral health care services and thus improve oral health outcomes. In Chapter 9, Bernadette Pauly explores how nurse–patient interactions shape health care access among homeless and street-involved populations. Drawing on ethnographic fieldwork, including participant observation in community health clinics and an urban emergency department, Pauly reports that by adopting non-judgmental, harm reduction approaches, nurses are able to establish trust with homeless and street-involved populations and thereby facilitate access to health care services. This chapter argues that the widespread adoption of these approaches is critical to increasing health equity. In Chapter 10, Ryan McNeil and Manal Guirguis-Younger draw on qualitative interviews conducted with health and social services professionals to examine factors that influence the siting and design of community and shelter-based health facilities for homeless populations. Given that community and shelter-based health facilities occupy an increasingly prominent role in health services delivery to homeless populations, this chapter outlines important recommendations to inform the continued development of these services across Canada and internationally.

The final section of this book highlights innovative programs that have emerged to address the unmet health needs of homeless populations. Across Canada, communities have developed programs responsive to

the needs of local homeless populations that, in many cases, represent innovative service delivery models. While, in many respects, these programs are tailored to the unique social, structural and environmental factors that shape health access and outcomes among homeless persons in these communities, they may be adapted and implemented elsewhere to respond to similar challenges. In Chapter 11, Susan Farrell and her colleagues present findings from research conducted at Ottawa's managed alcohol program, an innovative shelter-based harm reduction program for homeless persons with alcohol dependency. This chapter reviews this innovative service delivery model, which has since been replicated in several Canadian cities, and evaluates the integration of psychiatric services into this program. Farrell and her colleagues found that program participants experienced improvements in mental health outcomes, thereby underscoring the significant potential of integrating housing, harm reduction and mental health services.

In Chapter 12, Vicky Stergiopoulos discusses Toronto's Inner City Health Associates, a program funded by the Ontario Ministry of Health and Long Term Care that aims to improve access to health care services for homeless persons by placing physicians in homeless health care settings (e.g., emergency shelters and drop-in shelters). This program has been critical in the development of innovative health care programs, such as shelter-based collaborative mental health care teams and interdisciplinary mental health outreach teams. Accordingly, this chapter provides many insights that could inform the development of similar approach in other provinces. Finally, in Chapter 13, Guirguis-Younger and McNeil discuss the dynamics that shaped the development of the Ottawa Mission Hospice, a shelter-based hospice that provides end-of-life care to homeless persons. Drawing on qualitative fieldwork, they discuss the complexities of delivering compassionate palliative care in the context of homelessness. Guirguis-Younger and McNeil contend that the development of shelter-based palliative services required a higher level of integration across the health and social care system and map the relationships between the Ottawa Mission Hospice and its partnering organizations, notably Ottawa Inner City Health. By focusing on the planning and implementation of this program, this chapter presents a framework for those who wish to adapt this model to their community.

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PART I

HOMELESSNESS & HEALTH IN CANADIAN POPULATIONS

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CHAPTER 1

Being Young and Homeless: Addressing Youth Homelessness from Drop-in to Drafting Policy

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I met this chick that I was squeegeeing with two years ago. We were squeegeeing together. And I don't know how it happened but she got in this fight with this lady and this bitch took her garbage out of her car and threw it in the chick's face and said "Here's a bunch of trash for street trash like you" or something like that. And this girl had just left home, and she was like 16 or 17 or something, maybe a year older than me, she was just dealing with the whole leaving home situation, and this happened, and the car drove away and she came back to the sidewalk and she was like "fucking bitch blah blah blah", and then she just lost it. She started crying.

– 19-year-old girl, Toronto,
interviewed between squeegee runs

Introduction

Street youth populations are increasingly understood as being diverse, complex and heterogeneous. The generic terms *street youth* and *homeless youth* are made up of a number of intersecting subcultures including hardcore street entrenched young people, squatters, group home kids, child welfare kids, softcore twinkies, in-and-outers, punks, runaways, throwaways, refugees and immigrants, young single mothers and those who are homeless because their entire family is homeless. Within these makeshift categories are

numerous labels that tend to be associated with street activities, such as *gang bangers, sex trade workers, drug dealers, drug users, panhandlers* and *squeegeers.* While these labels may denote some of the actions of young people on the street, for the purposes of this chapter, street youth or homeless youth (terms used interchangeably throughout the text) are defined as young people between the ages of 12 and 24 who do not have a permanent place to call home and who instead spend a significant amount of time and energy on the street, in squats (abandoned buildings), at youth shelters and centres and/or with friends (referred to as *couch surfers*) (Karabanow 2004a; Kidd and Scrimenti 2004).

While many estimates have been made regarding the number of homeless youth at city and national levels in Canada, to date there have been no enumerations that might be considered definitive. This is due to the tremendous difficulty identifying youths who do not regularly use youth services and ambiguity regarding the definition of homelessness. A generally accepted estimate for all homeless persons in Canada is 150,000 (National Homelessness Initiative 2006), with youth between the ages of 16 and 24 considered the fastest growing segment of the homeless population in Canada.

In the following literature review, we draw upon the North American literature, a large proportion of which is American. While there are clearly marked differences in the homeless child and youth experiences in South America and Africa (two other substantial bodies of literature), findings across studies in Canada and the United States are very similar. As such, we draw on a wider literature to frame this discussion highlighting key issues specific to the Canadian context. With research into the determinants of youth homelessness having largely run its course and a policy landscape that is, in most contexts, inadequate to take on the task of effectively addressing this pervasive social problem, it would seem timely to 'take a step back' and consider the knowledge gathered to date. We have sought, through this comprehensive review, to consolidate the research base and highlight domains where research and action needs to turn if we are to make inroads into this problem that compromises the health and lives of so many young people and has major impacts on their families and our communities.

Shifting Conceptualizations of Youth Homelessness

By far the most common question asked in both research and public commentary is, why are these young people living on the street? As is the case with many social problems, the answers to these questions tend to be totalistic, with a range of themes waxing and waning as a function of the cultural norms in a given time. For instance, early 19th-century labelling referred to street youth as "petty thieves", "street sinners", "street urchins" and "begging impostors", while in the early 20th century, street youth were commonly branded as "young barbarians" and "street wandering children". In the late 19th century, an official from the Children's Aid Society commented:

> Enjoying the idle and lazzaroni life on the docks, living in the summer almost in the water, and curling down at night, as the animals do, in any corner they can find . . . this is without a doubt in the blood of most children—as an inheritance, perhaps from some remote barbarian ancestor—a passion for roving. (Rivlin and Manzo 1988: 27–28)

By the 1950s, popular perceptions of this same population were influenced by notions of psychological deviance, and street youth were thought to be mentally disturbed (Rivlin and Manzo 1988). Robertson (1992: 288) describes the common psychiatric understanding of homeless youth that helped shape the image of this population in the 1950s and 1960s, during a period when psychoanalysis was at the forefront of accepted wisdom:

> Individuals characteristically escape from threatening situations by running away from home for a day or more without permission . . . typically they are immature and timid and often feel rejected at home, inadequate, friendless. They often steal furtively.

The present day image of street kids is that of the sexually and/or physically abused runaway. Ruddick's (1996) comprehensive analysis of homeless youth in Hollywood highlights a series of changes from the 1970s onward that were responsible for the shift away from the image of the street youth as a *juvenile delinquent* and *criminal*. The deinstitutionalization of the runaway from the juvenile penal system,

combined with an increase in public recognition of the reality of abuse within dysfunctional families and the lack of employment and shelter opportunities, all played central roles in the transformation of the popular perception of street youth (Karabanow 2000). A crucial outcome of those changes was the novel awareness that these children had been forgotten or had 'slipped through the cracks' of the conventional child welfare system. The street kid/homeless youth of today evokes varied images that include young mothers, runaways, immigrant youth and squeegee kids. A single, though significant, element binding these perceptions together is the growing acceptance that youth are homeless because of reasons beyond their own control. A study of street youth in Halifax found that over 60 percent of public citizens interviewed perceived the root causes of youth homelessness as other than individual pathology (Karabanow 2004b). Today's street kid is often thought to be fleeing an abusive, dysfunctional family life or a miserable institutional situation and finding refuge on the street or in a short-term emergency shelter.

Etiology

In the past 20 years, a consensus has emerged around the pathways to youth homelessness. There is growing agreement that for the most part, homeless youth are 'running away' from problematic and traumatic environments rather than 'running towards' street cultures (Karabanow 2003). The major commonality lies in various forms of troubled/strained family histories. High rates of drug and alcohol abuse and criminality are found among the parents of many homeless youth (Hagan and McCarthy 1997; MacLean, Embry and Cauce 1999). Poverty is a prominent finding with a high percentage of the families on social assistance (Ringwalt, Greene and Robertson 1998) and disrupted families are common, with few homeless youth reporting having lived with both biological parents (Hagan and McCarthy 1997). Also common are reports of marital discord (Dadds et al. 1993), domestic violence and a greater than average number of household moves involving frequent changes of school (Buckner and Bassuk 1997; Karabanow 2004a). Reports of childhood physical and sexual abuse are consistently high, as are histories of emotional abuse and neglect (Karabanow 2003, 2004a; Kidd 2006; MacLean, Embry and Cauce 1999; Molnar et al. 1998; Ringwalt, Greene and Robertson 1998). These negative home experiences intersect with a host of other

problems, including poor performance in school, conflict with teachers and other adults in positions of authority and conduct problems (Feitel et al. 1992; Hagan and McCarthy 1997; Rotheram-Borus 1993).

Another disturbing finding is that street youth populations in numerous studies speak to problematic child welfare placements as a major reason for their entry into street life (Karabanow 2003, 2004a, 2008; Kurtz, Jarvis and Kurtz 1991; van der Ploeg 1989). These experiences were most often described as uncaring, exploitative and unstable (Michaud 1989; Raychaba 1989). Numerous moves from group home to group home or between foster parents, coupled with feelings of being treated as 'criminals', 'delinquents' or 'unwanted', shaped young people's transition to street life (Edney 1988a, 1988b; Morrisette and MacIntyre 1989). Child welfare settings were routinely described by young people as unresponsive to their needs and perceived as 'prison' environments rather than loving and home-like structures (Raychaba 1989). Street life became an enticing option for young people who either experienced episodes of 'running away' from or graduating from child welfare placements. Finally, in line with the above body of research, most homeless youths with mental illness on the streets report that their mental illness began prior to their leaving home and, not surprisingly, was exacerbated by street living (Craig and Hodson 1998; Karabanow et al. 2007).

One topic that has been largely absent throughout the discussion of youth homelessness in the media and in research is diversity. Similar to other subcultures, the culture of street life is diverse and complex. Street youth are equally diverse in terms of background, present experiences and future aspirations. Labels such as *squeegee kids, punks, street-entrenched, group-home, in-and-outers, runaways* or *shelter youth* are used in the literature as an attempt to make sense of the diverse population and to organize analytical discussions (see, e.g., Kufeldt and Nimmo 1987; McCarthy 1990; Morrisette and McIntyre 1989; Shane 1989; van der Ploeg 1989). Only a few studies have addressed the implications and outcomes of various subgroups of homeless youth. Kipke and colleagues (1997) typologized homeless youths into five groups: punks, gang members, loners, hustlers (sex trade involved youth) and druggies, with the participants indicating which group they most strongly identified with. It was found that group affiliation had a major impact on residential status (e.g., punks are more likely to live on the streets or in an abandoned building), subsistence pattern (e.g., gang members are more involved

in drug dealing) and service use (e.g., hustlers are most often accessed by outreach workers). In line with Kipke's work, studies looking at the experiences of sex trade involved youth have highlighted the unique risks and heightened discrimination experienced by these youth (Cusick 2002; Kidd and Kral 2002; Kidd and Liborio 2011; Yates et al. 1991). Those who use the sex trade as a primary source of income and become associated with it as an identity have markedly poorer mental health and far worse trajectories of risk than most other youth.

Some studies in the past few years have also started to take a closer look at gender and sexual orientation on the streets. It has been found that, relative to boys, girls have more extensive sexual abuse histories, are more often sexually victimized on the streets and have a harder time subsisting on the streets (Cauce et al. 2000; Karabanow 2004a; O'Grady and Gaetz 2004). Youth with lesbian, gay, bisexual or transgendered (LGBT) sexual orientation are in many cases homeless because of abuse and rejection by family who are intolerant of their revealing and exploring their sexual orientation (Karabanow 2008). LGBT youth have more often been abused at home, are victimized more often on the streets and generally have poorer mental health and greater involvement in risk activities relative to other homeless youth (Noell and Ochs 2001; Kruks 1991; Cochran et al. 2002).

In sum, the vast majority of youth become homeless due to external circumstances. For the most part, these are young people who have rarely experienced a stable, loving family unit—rarely did they feel loved, cared for, supported or experience a sense of belonging. As such, it is of little wonder why street life is consistently perceived by the vast majority of the street youth population as a safer and more stable environment than home.

Street Contexts and Cultures

Complementing the large body of work documenting pathways to homelessness, a substantial body of work has developed in recent years documenting risks and subsistence strategies on the streets. This line of work has revealed diverse, complex and, at times, contradictory narratives of survival among homeless youth. While street life may be perceived initially as a place of freedom, community and relative security, these feelings quickly fade or become demystified (Karabanow 2006, 2008; Visano 1990). As such, street cultures present

complex and often dichotomous narratives; they can be sites of excitement, belonging and acceptance as well as exploitation, violence, hunger, boredom and stress (Karabanow 2003, 2006; Karabanow et al. 2007). Much of the literature has focused upon these negative attributes of street culture. More recent focus of academic investigations has explored street youth survival strategies (Karabanow et al. 2009; O'Grady and Greene 2003).

To support themselves, homeless youth engage in numerous activities including employment seeking, seeking money from family/friends, panhandling, prostitution, survival sex (sex for food, shelter etc.), dealing drugs and theft (Greene, Ennett and Ringwalt 1999; Hagan and McCarthy 1997; Kipke et al. 1997). The difficulty of surviving on the streets is evident in the large number of homeless youth who regularly lack shelter and go hungry (Antoniades and Tarasuk 1998). Moreover, street life presents numerous dangers and stresses in the form of physical and sexual assaults and other types of victimization (Karabanow et al. 2007; Whitbeck, Hoyt and Bao 2000). Drug abuse is a common way of coping with these stressors (Adlaf, Zdanowicz and Smart 1996; Karabanow et al. 2007), and addiction is a major problem among this population (Greene and Ringwalt 1996). There is a high incidence of mental disorders among homeless youth, with depression, post-traumatic stress disorder and suicidal behaviours highlighted as common problem areas (Karabanow et al. 2007; Kidd 2004; Whitbeck, Hoyt and Bao 2000; Yoder 1999). Mortality rates for these youth have been found to be 12 to 40 times that of the general population (Shaw and Dorling 1998), with suicide and drug overdose having been found as the leading cause of death among Canadian homeless youth (Roy et al. 2004). In general, it has been found that victimization and decline in physical and mental health on the streets would seem to occur as a function of the degree of victimization in the lives of homeless youth prior to coming to the streets.

Youths characterize their lives on the streets, for the most part, as unhealthy, difficult, boring, requiring an unrelenting effort to meet basic needs, violent and dangerous and lonely and exploitative (Karabanow et al. 2007; Karabanow 2004a; Kidd 2004). However, the street continues to be seen by many as the best option in their lives, especially within the context of their youth, poverty, low self-esteem/confidence, instability, lack of education and lack of employment/life skills (Karabanow 2008). They are consistently in survival mode—spending much of their talents, energies and resources securing

food, shelter, clothing, emotional support and some form of formal or informal employment. Travel makes up some of their activity—moving from place to place, city to city, province to province—for the most part searching for, first, better supports; second, a new environment (in order to clean up, escape problematic situations, etc.); and, third, building different communities (punk, squatter, squeegee) (Karabanow 2006; Karabanow et al. 2007). While the majority of these young people work in informal or formal sectors, employment tends to be sporadic, fluid and uncompromising (Karabanow et al. 2009). Some seek out jobs as day labourers, others squeegee/pan to survive, others perform on the street (playing music), others act as drug peddlers, while others sell their bodies. Work is important to this population, providing a means to survive and/or a means to feel good about themselves (Karabanow et al. 2009).

Finally, youths describe extensive experiences with social stigma. Most regularly experience insulting interactions with the general public based upon their appearance and homeless status, and stigmatization extends to difficulty finding work and housing and to criminalization (Kidd 2003, 2004; Karabanow 2004a; Karabanow et al. 2009; Schissel 1997). Numerous studies have highlighted how street youth feel outside of civil society, alienated from mainstream culture and without a sense of belonging or acceptance (e.g., Kidd and Davidson 2007). This stigma is particularly salient for visibly homeless youth and youths who face multiple forms of stigma based on other aspects of identity (e.g., sexual minorities) and activities (e.g., sex trade involved youth) and has been linked to a greater risk of suicide and negative mental health outcomes (Kidd 2006).

The topics of resilience, strength and survival have increasingly been addressed in the North American youth homelessness literature. The coping literature has highlighted several themes which emerged in this study including self-reliance, the support of other youth, spirituality and caring for others (Karabanow 2003, 2004a, 2008; Kidd 2003; Lindsey et al. 2000; Rew and Horner 2003; Williams et al. 2001). There has also been some emerging work addressing the deeper identity and cultural shifts that determine how homeless youth understand and experience their world which, in turn, defines and drives their coping efforts (Karabanow 2006; Visano 1990). In a large study examining the experiences of youth in New York City and Toronto, Kidd and Davidson (2007) highlighted the manner in which coping efforts were framed within youths testing, adopting

and rejecting the various meaning systems made available in the street context. This adaptation, or the particular version of 'normal' used, has major implications for their trajectories on and off the streets. For youths who don't take on street value systems and norms, the streets are far more difficult to survive in and these youth are much more motivated to make use of services to exit the street. For those who take on one or more of the value systems/subcultures on the streets, they might experience a better quality of life in the street context but also face far greater risks and are more difficult to engage in interventions (e.g., youths for whom sex trade work has become the norm). Such meaning systems are typically challenged many times over the course of youths' time on the streets in the face of any number of contradictions: friends prove untrustworthy, serious criminal charges arise, health fails, assaults occur, addictions take over, caring and respected supports describe other ways of living that are more meaningful and healthier. However it is described, be it shift in worldview, value systems, or culture, it is the person's own view of their world that sets the nature and parameters of their coping, efforts to survive and sources of happiness.

Street Disengagement

While much of the literature concerning street youth has focused upon trajectories onto the streets and youths' efforts to survive in street contexts, there have been few systematic analyses of strategies employed by this population to disengage from homelessness. Karabanow and colleagues (2005) and Karabanow (2006, 2008) explored how Canadian street youth successfully and unsuccessfully disengaged from street culture through in-depth qualitative interviews with youth and service providers in Halifax, Montreal, Ottawa, Toronto, Calgary and Vancouver. A comprehensive portrait of street exiting involves numerous stages or dimensions:

1. *Precipitating Factors:* The precipitating factors that propel contemplation of street disengagement tend to include the experience of a traumatic event (such as physical/sexual assault, drug overdoses, witness of street violence or involvement with the criminal justice system), becoming disenchanted with street culture and/or becoming worn down, physically, emotionally and/or spiritually, by daily street existence.

2. *Courage to Change:* Layer two involves the individual's courage to change and this was highly influenced by such factors as increased responsibility (becoming pregnant, having an intimate partner or recognition that someone was dependent on them), having someone who cares, having support from family and/or friends and being internally motivated and committed to street transitioning. Young people talked about having "strong will power" to combat impressive obstacles like drug addiction, trauma and lack of supports. Knowing someone truly cares for you, or having steady support builds motivation.
3. *Seeking Support:* The third step is highly interrelated with layer two and involves seeking available support (primarily in relation to housing and employment) within the initial stages of street disembarking. This aspect is about asking for help—being able to use available services and being able to articulate one's needs, in many instances, to service providers.
4. *Transitioning away from the Street:* Layer four deals with transitioning away from the street and entailed physically leaving the downtown core, reducing ties with street culture and street friends and constructing or reconstructing relationships with mainstream society. Cutting street ties meant leaving friends, surrogate families and a culture associated with the downtown core. Participants expressed that it was as difficult leaving the street culture/street friends as it was entering into the more mainstream society and building new relationships. Despite the emotional strains of leaving relationships with people who had helped support them on the street, building new relationships outside of street culture was highlighted as essential for healthy transitioning. New friends and communities tended to be seen by participants as "good influences" in their day-to-day living. But this transitional time was also characterized by feelings of loneliness and uncertainty.
5. *Restructuring:* Next there is a clear restructuring of one's routine in terms of employment, education and housing; a shift in thinking about future aspirations; and the ability to acquire some form of financial assistance to support one's transitioning. During this stage, young people highlighted a renewed sense of health/wellness, self-confidence and personal motivation. Participants described both physical

and psychological shifts occurring in their lives, such as sleeping better, feeling healthier and experiencing increased self-esteem and self-confidence. Such changes tended to be linked to young people having more stability and consistency in their lives. Shifts in routine were commonly seen as interwoven with the notion of building new communities and tended to focus upon replacing street activities with formal employment and returning to school. However, subtle day-to-day shifts in routine (such as waking up and making some coffee or coming home and watching television) were as celebrated as more tangible elements such as living in one's own apartment or going to work each day. These transitions allowed many youth to reflect upon their past experiences, and for the majority of participants, this meant perceiving the street as an unhealthy and destructive environment. Along with a healthier sense of self, young people were more ready to develop longer-term plans and envision some control in their futures.

6. *Successful Exiting:* The final stage primarily embodies young people's emotional and spiritual sense of identity. "Successful exiting" was exemplified by a sense of "being in control" and "having direction" in one's life. The majority of participants spoke of feeling proud of their movements out of street life, being able to finally enjoy life on their own terms, having healthy self-esteem and self-confidence, being able to take care of themselves and feeling stable in terms of both housing/security and wellness. "Getting off the street" translated into more than simply finding an apartment and physically removing oneself from a street lifestyle. Truly becoming an "ex-street youth" entailed emotional and spiritual shifts within the individual.

Challenges and obstacles pepper young people's travels throughout these layers of street exiting. Structural and personal barriers include drug and alcohol addictions, past and present traumas, mental health issues, discrimination, lack of reasonable employment, a dearth of affordable housing stock, loneliness and isolation and the often difficult process of breaking ties with street culture and street friends. At times, these challenges appear monumental and young people are forced back to the street an average of six times; however, with the

support of innovative and caring service providers throughout the country, each exiting attempt creates greater distance, both physically and emotionally, between them and street culture (Karabanow 2008).

Intervention

There exists a vast array of shelters, drop-ins, clinics and other emergency services that do primary basic-needs support, some outreach/prevention and short term counselling. Unfortunately, relative to the large body of research literature describing homeless youth and their various risk trajectories, there are very few studies and informal descriptions of services, their strengths and limitations. The literature developed to date tends to cluster around the following areas.

Basic Needs and Physical Health

Many researchers recommend that the first priority is to ensure that youths are provided with the basic necessities of life in an immediate fashion (Cauce et al. 1994; Karabanow and Clement 2004; Terrell 1997). This includes assistance with obtaining adequate food, shelter and attention to physical ailments. Assessment of needs in this area is crucial, with many suffering from multiple health problems, including poor nutrition (Antoniades and Tarasuk 1998; Yates et al. 1991). Related to health issues, there is a need to ensure that youth are educated regarding the risks of communicable diseases, unprotected sex and sharing needles, by both peers and trusted workers or other individuals whose opinions are respected (Booth, Zhang and Kwiatkowski 1999; Ensign and Gittelsohn 1998; Greene and Ringwalt 1996). Of the intervention strategies that focus on interventions to reduce sexually transmitted disease, peer-based strategies have been found to increase street youths' HIV knowledge (Podschun 1993). Tenner and colleagues (1998) described an intensive case management approach with HIV-positive youth, noting the importance of a flexible and responsive service system that responds to both the medical and other social service needs of its clients. A recent study has also shown that cognitive behavioural intervention that focuses on skill building and education was more effective than treatment as usual in increasing condom use (Slesnick and Kang 2008). Lastly, researchers have highlighted the importance of making prenatal education and care available given the high rates of pregnancy among street-involved youth (Greene and Ringwalt 1998).

Drug Use and Addiction

Assessment of substance use is regarded as a necessary aspect of services for homeless youths given the extremely high rates of alcohol and drug use (Baron 1999). It is important to recognize that the mechanisms underlying substance abuse may differ greatly from youth to youth. MacLean, Embry and Cauce (1999) have found different motives for drug use as a function of gender and other factors such as affect regulation. Several researchers caution, however, that too heavy a focus on drug use alone is ineffective and that drug use is likely a symptom of other problems that need to be addressed just as urgently (Adlaf, Zdanowicz and Smart 1996; Sibthorpe et al. 1995). With respect to specific interventions, Natasha Slesnick has done a considerable amount of work in the area of family therapy. She has found that ecologically based family therapy, with both family and individual sessions focused on decision-making, emotion regulation or other intrapersonal factors, results in greater reductions in substance use when compared with treatment as usual (Slesnick and Prestopnik 2005). Several studies in this area have also discussed motivational intervention as a model for working with substance-using street youth (Baer, Peterson and Wells 2004), with findings indicating a sustained reduction in substance use following a brief group-based motivational enhancement intervention (Peterson et al. 2006). Lastly, peer-led groups have also been cited as more effective for substance-using homeless youths than adult-led groups (Fors and Jarvis 1995). While concurrent mental illness and addictions problems are undoubtedly present in this group, integrated treatment models have yet to receive substantial attention in the research literature.

Mental Health

Many researchers stress the importance of screening for symptoms of mental health problems. Specifically, it has been suggested that workers screen for suicidality, depression and histories of maltreatment and abuse, which are potentially indicative of increased vulnerability (Kidd 2006; Kurtz, Jarvis and Kurtz 1991; Ringwalt, Greene and Robertson 1998; Rotheram-Borus 1993; Stiffman 1989; Yoder 1999; Yoder et al. 1998). It has also been recommended that interventions be tailored to specific subpopulations of youth. For example, Cauce and colleagues (2000) recommended that service providers working with males who have experienced physical violence and are more likely to have conduct-related problems develop interventions that

focus on limit setting and impulse control. Other recommendations include training in a wide range of best practice approaches to mental health intervention for staff (Cauce et al. 2000), the integration of peers as supports (Fisk, Rowe and Brooks 2000) and the importance of providing effective interventions for trauma in mental health counselling with this population (McManus and Thompson 2008). Outcome research on specific mental health interventions for this group are, however, very rare. One exception is an evaluation of the Community Reinforcement Approach (CRA), which used a cognitive behavioural approach to address the systematic challenges faced by youth and demonstrated better outcomes than treatment as usual across a number of domains (Slesnick et al. 2007).

Housing

The most common housing service for street youth is short-term emergency shelters that provide basic sleeping arrangements and often case management support/guidance. These shelters proliferated in the seventies and eighties due to the growing number of runaways and street kids in need of a safe refuge. Alleva (1988) and Karabanow (1999, 2000, 2004) argue that these shelters were portrayed as alternatives for youth who mistrusted traditional services. While street youth have objected to particular sets of rules and structures within shelters, for the most part, they have perceived such settings as surrogate families and its workers as highly supportive (Alleva 1988; Karabanow 2004a). Karabanow (2003, 2008) has argued that the vast diversity of street youth shelters are for the most part "symbolic spaces" for troubled and alienated youth to find acceptance/belonging, satisfy immediate basic needs, explore options for street exiting, manage personal traumas and structural challenges and gain self esteem and confidence. However, access is generally more complicated for youths with addictions who do not view abstinence-focused shelters as a viable option (Krusi et al. 2010).

Service Provider Perspectives

With respect to service provider perspectives on their work, a study of the narratives of 15 youth workers in Toronto suggested that what they viewed as effective revolved mostly around their relationships with clients (Kidd et al. 2007). Themes included a need to have a versatile approach that can be tailored to an individual youth's circumstances and establishing a connection based upon valuing, respecting

and 'liking' youths. This trusting relationship was, in turn, essential; youths are drawn to that rare experience of trust, which serves as a platform for effective work. Youth workers also described the challenges associated with working with street-involved youth. These challenges included the complexity of the needs of youths, the various barriers that exist as a function of social stigma and marginalization and the minimal resources available to do the work. These challenges can readily lead to burnout and high staff turnover, both of which can negatively affect the services provided.

Policy

Of the range of factors involved in youth homelessness, socio-cultural and policy issues have arguably received the least attention in the literature. This circumstance exists despite emerging evidence that social stigma at both public (e.g., insults, physical assaults, etc.) and structural levels (e.g., multiple arrests, inadequate funding for services, etc.) have a profound impact on the health and well-being of this population (Karabanow 2004a; Kidd 2003; Kidd and Carroll 2007; Schissel 1997). Specific difficulties present in the Canadian context include, first, difficulty accessing income support, unemployment insurance and disability payments; second, increasing criminalization and disproportionate arrests; third, declines in affordable housing, difficulty accessing socially supported housing and increasing evictions; fourth, breakdowns in continuity of care due to child welfare service age cutoffs (ranging from 16 to 19) and youth services age cutoffs (typically 24); and, finally, a lack of services specific to the needs of homeless youths, such as adequate discharge planning from health care and criminal justice systems (Kidd and Davidson 2006). Additionally, prevention efforts, which are almost ubiquitously called for across all forums, have yet to materialize and be evaluated in a substantive manner.

At the policy level, there are a range of approaches that might serve to reduce both the extent of youth homelessness and the degree of risk faced by homeless youths. Such strategies might include reducing criminalization of minor non-violent and victimless crimes (e.g., panhandling), as this serves to hamper access to public assistance and supported housing. Underlying such an argument is the need to initiate preventive structures that tap into the true reasons for youth homelessness: child welfare failures, poverty,

family distress, abuse and neglect and violence. We need thoughtful educational strategies (such as runaway prevention programs carried out by numerous street youth organizations) to disentangle myths and stereotypes as to why these young people enter street life and remain on the street.

Another need area is the provision of sustained funding that is commensurate with both the extent of the problem in terms of number of homeless youth and the complexity of their needs. At present, most services operate within budget restrictions that markedly hamper their ability to provide the sorts of comprehensive approaches highlighted in the review above. Furthermore, the fierce competition that exists for the small amount of funding available in a given city can impede inter-agency cooperation. Numerous scholars have argued for the emergence of thoughtful long-term structural development initiatives including supportive and independent housing and meaningful employment opportunities (see, for example, Karabanow 2008; Kidd and Davidson 2006). There are many case examples throughout North America of innovative linkages between government, business and non-profit sectors to build such initiatives (e.g., Montreal's Dans La Rue, Toronto's Covenant House and Eva's Place and Calgary's Open Door). Young people have been unequivocal about the need for safe and sustainable housing in order to seek out employment opportunities.

Conclusion

The last twenty years have witnessed a more sympathetic perspective on homeless youth in both the academic literature and popular media. Rather than being seen as social misfits, increasingly they are understood as victims of social structures. The academic literature reviewed makes it clear that street youth are a highly marginalized and alienated population, and forms of intervention that attempt to support, care for and show genuine interest towards these adolescents have the best chance of proving successful.

We conclude that youth homelessness is fundamentally a systemic problem that requires a systemic response. We highlight the key domains that would form such a response, but how such an effort might be undertaken in a coherent and coordinated manner is less clear. We suggest that, following the example of the Mental Health Commission of Canada, a body be formed that cuts across research,

policy and practice sectors to facilitate a coordinated response to youth homelessness and stimulate partnerships. Until such a response is developed, we will continue to have young people funnelling through pathways of inadequate supports onto our streets—at profound personal and social cost.

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CHAPTER 2

Sexual Risk Behaviours and Sexual Health Outcomes among Homeless Youth in Canada

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Introduction

Homeless youth are a high-risk population that experiences a range of adverse sexual health outcomes. This chapter provides an overview of the sexual health of homeless youth in Canada, describing the various factors that contribute to sexual risk behaviours and poor sexual health outcomes and offering suggestions for future research and clinical interventions. This chapter first reviews the prevalence of sexual risk behaviours and poor sexual health outcomes among homeless youth. It then examines the various determinants of sexual risk behaviours and highlights the structural barriers influencing poor sexual health in this population. The chapter concludes by examining how knowledge of these risk factors can be implemented toward the development of intervention strategies and policy changes in order to improve the sexual health of homeless youth in Canada.

Prevalence of Sexually Transmitted Infections, HIV and Pregnancy

In 2006, the Public Health Agency of Canada (PHAC) published findings from the Enhanced Surveillance of Canadian Street Youth (E-SYS), a three-year cross-sectional study examining the sexual health of homeless youth (ages 15–24) in seven urban centres across Canada (PHAC 2006a, 2006b). The goal of E-SYS was to obtain national data on the sexual health and sexual behaviours of this high-risk population in order to guide the development of disease prevention programs. To date, E-SYS is the largest and most comprehensive Canadian study of homeless youth. A summary of major E-SYS findings across the three-year study period is presented in Table 2-1.

According to E-SYS, the overall proportion of homeless youth reporting a lifetime sexually transmitted infection (STI) ranged from 20.8 percent to 26.6 percent (PHAC, 2006b). Lifetime STI prevalence was even higher in a separate sample of Montreal street youth (ages 13–25), in which 31.7 percent reported a past STI (Roy et al. 2000). These rates appear significantly higher than the STI prevalence among the general Canadian youth population (ages 15–24), which has been estimated at 4 percent (Rotermann 2005).

Table 2-1. Overview of major E-SYS findings in 1999, 2001 and 2003

	Prevalence Rates/Mean		
	1999 (*n* = 1645)	**2001 (*n* = 1427)**	**2003 (*n* = 1656)**
Sexual Health Outcomes			
Chlamydia	8.6%	11.5%	11.0%
Gonorrhoea	1.4%	1.4%	3.1%
Syphilis	—	0% (< 0.01%)	0.7%
HSV-2	—	14.2%	18.8%
Hepatitis B	2.5%	2.1%	2.3%
Hepatitis C	4.0%	3.6%	4.5%
HIV	< 1.0%	< 1.0%	< 1.0%
Sexual Behaviours			
Lifetime sexual partners*	19.0	21.5	22.5
Past STI	20.8%	22.7%	26.6%
Lifetime involvement in sex trade	20.2%	20.9%	22.6%

*Mean of male and female lifetime sexual partners is reported as no overall mean was provided.

Prevalence rates are also higher for specific STIs and HIV. In E-SYS, the prevalence of chlamydia ranged from 8.6 percent to 11.5 percent, approximately 10 times higher than the prevalence among youth in the general population (PHAC 2006a). Other Canadian studies of homeless youth have reported similar chlamydia rates of 6.6 percent (Haley et al. 2002) and 8.6 percent (Shields et al. 2004). In E-SYS, the prevalence of gonorrhea was 20 to 30 times higher than rates in the general youth population and increased significantly over the study period (PHAC 2006a). Prevalence rates were also high for hepatitis B and herpes simplex virus 2 (HSV-2), the primary cause of genital herpes. Studies in Toronto, Montreal and Vancouver have reported high HIV prevalence among homeless youth, ranging from 1.9 percent to 2.8 percent (DeMatteo et al. 1999; Marshall et al. 2008; Roy et al. 2000). Comparable data on HIV prevalence rates among youth in the general population are not available, likely because this age group makes up an extremely small proportion (approximately 3.5%) of the total number of HIV cases in Canada (PHAC 2007).

Unintended pregnancy is also common among homeless youth. In one Canadian study of homeless youth ages 13–25, 47.1 percent of the females reported at least one past pregnancy and 35.6 percent of the males reported having impregnated a female (Roy et al. 2000). This is markedly higher than rates from a national sample of Canadian students in grades 9 and 11, in which 3.0 percent of females reported lifetime pregnancy and 1.7 percent of males reported having impregnated a female (Boyce et al. 2006).

Sexual Risk Behaviours among Canadian Homeless Youth

Results from E-SYS and the aforementioned studies highlight that poor sexual health among homeless youth is a significant public health concern in Canada. A full discussion of the factors influencing these high rates of sexual risk behaviours will be discussed later in the chapter. Compared to youth in the general population, homeless youth are more likely to be sexually active and more likely to engage in specific sexual behaviours known to be related to negative outcomes. In Canadian studies, nearly all homeless youth (> 95%) report having ever engaged in sexual intercourse, and the average age of first intercourse was approximately 14 (PHAC 2006a; Roy et al. 2000). This is notably younger than the average age among the general population in Canada (16.8 years; Hansen et al. 2004).

Homeless youth are more likely to engage in unprotected sex than youth in the general population. Among Montreal homeless youth, 86.8 percent who had engaged in vaginal intercourse and 67.6 percent who had engaged in anal intercourse did not always use a condom (Roy et al. 2000). In an analysis of sexually active youth in E-SYS, 41–51 percent reported not using a condom with a female partner and 47–56 percent reported not using a condom with a male partner at their last sexual encounter (PHAC 2006a). These proportions are higher than those reported in two nationally representative studies of Canadian youth, in which 26.4 percent of sexually active youth who had been with multiple partners in the past year and/or who were not married reported not using a condom at last intercourse (Rotermann 2008).

Homeless youth also report high numbers of sexual partners. Across the three years of E-SYS, male youth reported an average of 21–23 lifetime sexual partners and female youth reported an average of 17–22 lifetime sexual partners. Male youth who reported same-sex sexual activity reported an average of 45 lifetime sexual partners (PHAC 2006a). Roy and colleagues (2000) found that 20.6 percent of sexually active youth reported between 6 and 20 sexual partners in the past six months, and 7.6 percent reported more than 20 sexual partners. High proportions of youth in E-SYS engaged in sexual activity with high-risk sexual partners, including partners who had an STI, partners who were involved in sex trading and partners who were under the influence of drugs during their sexual encounter. On average, 21.2 percent of homeless youth reported lifetime involvement in sex trade (PHAC 2006a). Other Canadian studies have reported similar or higher rates of lifetime sex trade involvement (25.9% and 27% respectively; Roy et al. 2000; Weber et al. 2002).

Predictors of Poor Sexual Health among Homeless Youth in Canada

In light of these findings, a substantial amount of research has been conducted examining why homeless youth demonstrate such poor sexual health. For the purpose of this chapter, risk factors for poor sexual health will be broadly broken down into multiple categories. These categories include socio-demographic factors, family environment and early life experiences and individual/psychological factors. Further, an exploration of the structural barriers associated

with street life is critical for a comprehensive understanding of why homeless youth may demonstrate poor sexual health.

Socio-Demographic Risk Factors

Gender and sexual orientation. Although both male and female homeless youth are at considerable risk for STIs, HIV and pregnancy, there are gender differences in disease prevalence as well as reported frequency and nature of sexual risk behaviours. In studies from Canada and the United States, females had higher STI prevalence rates (excluding HIV), were less likely to report consistent condom use, were more likely to report having had a sexual partner with an STI history and were more likely to report past sex trading. Males reported more frequent intercourse with regular and casual partners and more lifetime sex partners and were also more likely to have engaged in anal sex (Halcón and Lifson 2004; PHAC 2006a; Roy et al. 2000; Solorio et al. 2006; Tevendale, Lightfoot, and Slocum 2009). HIV prevalence was also higher among males than females (DeMatteo et al. 1999; Roy et al. 2000).

One possible explanation for these gender disparities is that male and female homeless youth have different life experiences and are thus differentially predisposed to engage in certain behaviours. For example, female homeless youth are more likely than male homeless youth to report childhood sexual abuse and sexual victimization (e.g., Rew, Taylor-Seehafer and Fitzgerald 2001; Tyler et al. 2004), which are known risk factors for sexual risk behaviours such as sex trading and unprotected sex (Senn, Carey, and Vanable 2008). Further, from a sociological perspective, it has been proposed that gender-based power imbalances play an important role in determining individuals' sexual behaviours (e.g., Amaro 1995). In several studies of non-homeless females from diverse ethnic backgrounds, individuals who were low in relationship power (e.g., decision-making abilities, assertiveness, control) demonstrated an increased risk of sexual risk behaviours and poor sexual health outcomes, including unprotected sex and HIV (e.g., Bralock and Koniak-Griffin 2007; Campbell et al. 2009; Jewkes et al. 2010). This power differential may make it difficult for girls and women to assert themselves sexually and to resist coercion in sexual situations (Tyler and Johnson 2006). Future studies would benefit from investigating the ways in which gender-based power dynamics interact with factors related to homelessness to influence youths' sexual behaviour and health.

When examining HIV specifically, its relatively high prevalence among male homeless youth may be accounted for by the large proportion of HIV-positive homeless youth who identify as gay or bisexual (DeMatteo et al. 1999), since Canadian gay and bisexual males have disproportionately high HIV prevalence (PHAC 2007). The high number of male gay and bisexual youth involved in sex trading (Tyler 2009) and the higher number of sexual partners among lesbian, gay and bisexual (LGB) youth (Cochran et al. 2002) may also explain higher prevalence of HIV among LGB youth. However, there is a clear need for more research examining how sexual orientation is associated with sexual health among homeless youth.

Age. Greater age has consistently been identified as a predictor of sexual risk behaviours and poor sexual health among homeless youth (e.g., DeMatteo et al. 1999; Ennett, Federman, Bailey, Ringwalt, and Hubbard 1999; Linton et al. 2009). In E-SYS, the prevalence of gonorrhea and infectious syphilis were higher among older youth (ages 20–25) compared to younger youth (ages 15–19). Older youth had a higher prevalence of HIV infection and HSV-2 and a higher prevalence of hepatitis B and C (PHAC 2006a). Similarly, two studies of homeless youth in Toronto found that HIV prevalence was significantly higher among older youth compared to younger youth (DeMatteo et al. 1999; Linton et al. 2009). Greater age is also associated with sex trading, with one study reporting that homeless youth were 37 percent more likely to have traded sex with each additional year of age (Tyler 2009). There are several explanations for the association between older age and increased HIV risk. First, youth who are older in age have had more years and greater opportunity to engage in sexual risk behaviours and may therefore have increased exposure to HIV or other STIS (Linton et al. 2009). As all youth age, they gain more freedoms that allow them to engage in risky behaviours, and such behaviours are considered a natural part of the maturation process. However, these freedoms are likely to be exaggerated among homeless youth, who may be forced to make many decisions about their sexual behaviour without the cognitive maturity to do so (Milburn et al. 2007).

Linton and colleagues (2009) examined predictors of HIV in a Toronto sample of youth (ages 18–30) and noted that homeless youth under age 25 have an easier time accessing preventive health and social service support networks and in obtaining welfare assistance.

They indicated that, in Ontario, the network of health and social service organizations that are available to youth under 25 are not available to individuals over this age. Further, in order to receive financial assistance for unemployment through welfare agencies, individuals over age 25 require proof of address (Linton et al. 2009). Finally, there may be a lag in time between exposure to an infection or virus, seroconversion (in the case of HIV) and manifestation of symptoms. Therefore, some younger youth may be unaware that they have contracted an STI or HIV or may demonstrate negative test results (Linton et al. 2009).

Ethnicity. Canadian studies that have examined ethnic differences in sexual heath have primarily compared non-Aboriginal youth to Aboriginal youth (e.g., Marshall et al. 2008; Miller et al. 2006; Shields et al. 2004). Studies have consistently reported that Aboriginal youth demonstrate more sexual risk behaviours and higher prevalence rates of STIs and HIV. In Vancouver, Aboriginal homeless youth were nearly three times more likely to be HIV positive than non-Aboriginal youth (Marshall et al. 2008). In Toronto, a higher proportion of Aboriginal youth (5.0%) and black youth (4.3%) self-reported their HIV status as positive compared to white youth (3.0%; Linton et al. 2009). Further, in a cross-sectional study of homeless youth across seven Canadian urban centres, higher chlamydia prevalence was found among Aboriginal youth (13.7%) compared to non-Aboriginal youth (6.6%; Shields et al. 2004). Aboriginal individuals are more likely to experience a range of adverse health outcomes, including substance abuse, trauma, poverty and discrimination (Pearce et al. 2008). These factors, coupled with common stressors experienced by all homeless youth, may predispose Aboriginal homeless youth towards poor sexual health outcomes.

Family Environment and Early Life Experiences

Past studies have demonstrated that a large proportion of homeless youth are raised in troubled and disorganized family environments (Cauce et al. 2000; Ringwalt, Greene and Robertson 1998). Youth who have grown up in unsupportive, neglectful or abusive family environments may resort to homelessness as an escape from their adverse living situations. Once on the street, they may be more susceptible to negative influences, as they have not developed the social support, coping skills or resources to protect them from adverse health

consequences (PHAC 2006b; Tyler 2006; Tyler et al. 2004). In one qualitative study, many participants reported parental substance misuse and criminal activity (Tyler 2006). Childhood abuse and neglect are also identified as primary reasons for leaving home (Ringwalt, Greene and Robertson 1998; Tyler 2006). Across studies of homeless youth, 38–70 percent of females and 23–24 percent of males reported childhood sexual abuse, and 35–51 percent of males and females reported childhood physical abuse (Cauce et al. 2000; Molnar et al. 1998; Noell et al. 2001; Rew, Taylor-Seehafer and Fitzgerald 2001).

Childhood sexual abuse has been particularly emphasized as a risk factor for poor sexual health outcomes, including unprotected sex, high numbers of sexual partners, early age of first intercourse and sex trading (Johnson, Rew and Sternglanz 2006; Rotheram-Borus et al. 1996; Senn, Carey and Vanable 2008; Simons and Whitbeck 1991). LGB homeless youth, who report even higher rates of childhood sexual abuse compared to heterosexual homeless youth (Tyler and Cauce 2002), have been found to engage in sex trading at the same rate as heterosexual female homeless youth and at a higher rate than heterosexual male homeless youth (Gangamma et al. 2008). Childhood physical and emotional abuse are also correlates of sexual risk behaviours and poor sexual health among homeless youth, including sex trading (Greene, Ennett and Ringwalt 1999) and unintended pregnancy (Thompson et al. 2008).

Individual/Psychological Factors

Past research has demonstrated that certain cognitive, perceptual and behavioural factors may predict sexual health outcomes among homeless youth. In one study of homeless youth, Rew, Fouladi and Yockey (2002) examined the association between a range of cognitive-perceptual and behavioural factors and sexual health practices. Results of a path analysis indicated a direct link from safe sex behaviours to future time perspective (i.e., concern about future consequences), intention to use condoms and self-efficacy to use condoms. Further, an indirect association was found between safe sex behaviours and social support, connectedness, perceived health status and assertive communication. Other studies have further highlighted the importance of social support networks in reducing sexual risk behaviours such as sex trading (Ennett, Bailey and Federman 1999; Milburn et al. 2007) and unprotected sex (Tevendale, Lightfoot and Slocum 2009).

Findings from Tevendale, Lightfoot and Slocum's (2009) study provided additional evidence for the importance of social support and future time perspective as protective factors among homeless youth. Specifically, having positive expectations for the future was associated with fewer sex partners, and, among females, having a mentor (i.e., an individual to go to for support and guidance) reduced the risk of having unprotected sex. In terms of future time perspective, the authors suggested that youth who have future-oriented goals (e.g., family, career) may be less inclined to engage in certain sexual risk behaviours as they might interfere with their long-term goals. Conversely, individuals without such goals may be less concerned with the long-term implications of their actions. Other protective factors that emerged from this study include goal setting and decision-making skills, which presumably assist youth to manage stress and make more health-conscious and future-oriented decisions. In addition, self-esteem appeared to reduce the likelihood of engaging in unprotected sex among females (Tevendale, Lightfoot and Slocum 2009).

Although homeless youth demonstrate elevated rates of mental health problems (Cauce et al. 2000), limited research has examined their association with sexual health in this population. One study demonstrated that depressive symptoms were a risk factor for sex trading among homeless youth (Tyler 2009). Another study found that conduct disorder, which is highly prevalent among homeless youth (Cauce et al. 2000), is associated with a range of HIV-risk behaviours including sex trading, multiple sexual partners and drug use (Booth and Zhang 1997). Emotional dysregulation models have been applied to explain various risk behaviours among homeless youth, including substance use (MacLean, Paradise and Cauce 1999) and self-mutilation (Tyler et al. 2003). However, future studies are needed to examine the impact of emotional dysregulation on sexual health in this population.

Substance use is also a key variable to explore when examining the sexual health of homeless youth. According to E-SYS, among injection and non-injection drug users, 36.3 percent reported sex trading in the past three months. Compared to non-injection drug users, injection drug users were more likely to have had sex with a high-risk partner, to have been involved in sex trading, to have had unprotected sex during their last sexual encounter and to have had more lifetime sexual partners. Similarly, a study of homeless youth

in Vancouver found that the use of non-injection crack and crystal methamphetamine increased the odds of engaging in survival sex (i.e., sexual activities to meet subsistence needs such as acquiring food, shelter or money) 3.45 and 2.02 times, respectively (Chettiar et al. 2010). These findings are consistent with US studies of homeless youth showing that substance use is associated with sex with multiple partners, inconsistent condom use and lifetime involvement in sex trade (Greene, Ennett and Ringwalt 1999; Halcón and Lifson 2004; Solorio et al. 2008). Substance use is also associated with higher STI rates among homeless youth (PHAC 2006a). In E-SYS, the prevalence of chlamydia and gonorrhea was higher among crystal methamphetamine users compared to non-users, and the prevalence of genital herpes was significantly higher among youth who reported any (injection or non-injection) drug use compared to no drug use. Compared to non-injection drug users, injection drug users were more likely to have had an STI (PHAC 2006a).

Although the higher prevalence of STIS among injection drug users may be partially accounted for by intravenous transmission, other important contextual variables likely account for sexual risk behaviours and poor sexual health among drug users in general relative to non-drug users. Drug users may engage in sexual risk behaviours such as sex trade as a means of obtaining drugs or money to purchase drugs (Tyler and Johnson 2006). Further, being under the influence of drugs may increase vulnerability to sexual coercion or assault. In a qualitative study, Bungay and colleagues (2010) reported that gendered power dynamics diminished the sexual safety of women who used crack cocaine. Specifically, the women reported that men waited for them to be in a position of heightened vulnerability while under the influence of drugs to sexually assault or coerce them.

Structural Barriers

Homeless youth face significant barriers to obtaining stable housing. Many landlords will not rent to youth who are on welfare, and alternative and affordable housing options such as single-room occupancy hotels are often viewed as unsafe by youth. Additionally, such accommodations may be considered undesirable by youth, as single-room occupancy hotels are often viewed as a last resort and the domain of adults who are homeless (Krüsi et al. 2010). Youth who

engage in substance use are particularly disadvantaged in finding stable housing, as the majority of shelters require abstinence, often an unfeasible task for youth with competing needs. Collectively, structural and societal barriers, such as the presence of enforcement-based policies and a lack of affordable options, make finding stable housing for street-involved youth extremely challenging (Krüsi et al. 2010).

Research has found that not having a regular, safe place to stay has implications for the sexual health of homeless youth. In one study, male and female homeless youth who had ever spent the night in public places or with strangers engaged in a greater number of sexual risk behaviours (e.g., no condom use, sex with a high-risk partner) than those who had not experienced such circumstances (Ennett et al. 1999). Additionally, in a Vancouver study examining housing status and sexual risk among street-involved youth, youth living on the streets were more likely to report inconsistent condom use than were youth who were stably housed (i.e., in an apartment, house or single-room occupancy hotel), adjusting for sociodemographic and drug-related variables (Marshall, Kerr, Shoveller, Patterson et al. 2009). On the streets, there is likely limited access to sexual health resources such as condoms that might be available in shelters. However, despite greater amenities in shelters versus sleeping on the streets, youth living in a shelter had more sexual partners in the past six months compared to youth who were stably housed. The authors posited that high turnover rates at shelters and sharing of unstable sleeping quarters may encourage multiple sexual partnerships (Marshall, Kerr, Shoveller, Patterson et al. 2009).

The context of street life may also limit homeless youth's access to social and health services, which may influence sexual health practices (Kelly and Caputo 2007; Marshall, Kerr, Shoveller, Montaner et al. 2009). In Canada, not having a fixed address makes it challenging to get a provincial health card, which may lead to denied access to health services (Kelly and Caputo 2007). Additionally, street-involved youth may fear discrimination and may distrust adult service providers, creating further barriers to accessing services (Geber 1997). For youth who are not utilizing health care and social services, it may be difficult to obtain contraceptives, information regarding safe sex skills and the social support systems to encourage safe sex behaviours (Rew, Chambers and Kulkarni 2002). Enforcement-based policies resulting in the criminalization of street youth may also strongly contribute to sexual risk behaviours in this population (Marshall, Kerr, Shoveller,

Montaner et al. 2009). For example, in a study of female homeless crack users, individuals described using dangerous, secluded locations, such as alleys, for drug use in order to avoid detection by police. These locations often increased their vulnerability to sexual assault (Bungay et al. 2010). Furthermore, homeless youth who are engaging in illegal activity such as sex trading or illicit drug use may fear contact with police or social service agencies and thus be deterred from accessing health care services (Chettiar et al. 2010; Kelly and Caputo 2007).

Duration of homelessness has consistently shown associations with increased sexual risk (Milburn et al. 2005; Rew, Fouladi, and Yockey 2002; Rew et al. 2008). The longer youth remain homeless, the more likely they are to become part of marginalized subcultures that may encourage increasingly dysfunctional risk behaviours (Tyler et al. 2001). For example, youth who had been homeless for more than one year engaged in more sexual risk behaviours and fewer safer-sex behaviours than those who were homeless for less than six months (Rew et al. 2008). Given that many homeless youth enter the streets as a result of family conflict and poor social support, they are likely to form new social networks involving other homeless youth (PHAC 2006b). Although these networks may be beneficial in providing youth with the social support they previously lacked, they may also lead youth to engage in risky behaviours. Homeless youth often become embedded in criminal street networks and gain exposure to criminal mentors who pass on information and skills that facilitate criminal involvement. This form of mentorship may also promote and normalize behaviours such as sex trading or survival sex (Hagan and McCarthy 1997).

Survival sex is a sexual risk behaviour that appears strongly linked to the context of street life (Greene, Ennett and Ringwalt 1999). In a recent study of Canadian street youth, only 10 percent were working a consistently paid job, and these formal positions offered considerably less income than illicit activities, such as selling drugs or trading sex (Benoit, Jansson and Anderson 2007). Gwadz and colleagues (2009) qualitatively examined homeless youths' initiation into the street economy, including sex trading. The authors identified five factors that influenced youths' involvement in these illicit activities: (1) social control (i.e., decreased attachment to conventional society and increased attachment to unconventional society), (2) barriers to the formal economy (i.e., no fixed address, educational deficits,

perceived stigma and past incarceration), (3) benefits to street economy (i.e., immediate financial support, emotional gratification, sense of empowerment, independence and flexibility), (4) severe/immediate economic need (i.e., need for food, clothing and shelter) and (5) active recruitment into the street economy by predatory adults or homeless peers. In another qualitative study, Tyler and Johnson (2006) found that, although youth generally did not want to engage in sex trading, most did so in a desperate attempt to gain access to resources they deemed necessary for survival (i.e., money, shelter, food, drugs). Further, in some circumstances, youth's involvement in sex trading was involuntary. A number of youth stated that they likely would not have traded sex if not for pressure from others. Furthermore, several youth explained that although they did not engage in sex trading, they had friends who did. Evidently, sex trading is considered a relatively normative behaviour among homeless youth and therefore a viable strategy for fulfilling subsistence needs (Gwadz et al. 2009; Tyler and Johnson 2006).

Limitations and Future Directions

When describing the current status of sexual health among homeless youth in Canada, several limitations are noteworthy. First, for certain sexual risk behaviours and STIs, incidence rates are more likely to be reported than prevalence rates, making cross-study comparisons inappropriate. Furthermore, there is a lack of large-scale Canadian studies comparing the sexual health in homeless youth to youth in the general population. E-SYS (PHAC 2006a, 200b) provides detailed information regarding the sexual health of homeless youth in Canada; however, findings are only released once every few years, provide retrospective data and do not statistically compare homeless youth to the general population. In addition, E-SYS does not compare the sexual health of homeless youth on important socio-demographic variables such as ethnicity or sexual orientation, which are known correlates of sexual risk (Halcón and Lifson 2004; Tyler 2009). Studies that do examine ethnicity typically use broad and often dichotomous ethnic categories and do not provide a detailed exploration of sexual health differences among individuals of varying ethnicities. Given the considerable ethnic diversity in most urban centres in Canada, ethnic differences in sexual health outcomes should be better addressed in the literature. Future large-scale studies of Canadian

homeless youth should consider examining socio-demographic risk factors, including detailed information on youths' ethnic identities and comparative data from normative youth samples, in order to ascertain how much more at risk this population is relative to youth in the general Canadian population.

Another limitation of this literature is that certain sexual health variables may be strongly correlated, which could potentially lead to inaccurate reporting of results. For example, many studies examine sex trading as a dichotomous variable without assessing the number of sexual partners youth have had within the context of sex trading versus outside of sex trading. Therefore, if an individual has traded sex with multiple sexual partners, this may increase the overall sample mean of lifetime sexual partners and give the impression that high numbers of sexual partners are common to all homeless youth. Another example is the reporting of age at first intercourse. Given that many homeless youth experience childhood sexual abuse (Molnar et al. 1998; Rew, Taylor-Seehafer and Fitzgerald 2001; Rew et al. 2001), it is possible that they are reporting age of childhood sexual abuse rather than age of first consensual intercourse. This could decrease the overall mean and give the impression that most youth first engaged in consensual intercourse at a young age.

Gender biases in reporting of sexual risk behaviours may also limit the research in this area. For example, as a result of social norms and expectations, males may be less likely than females to report certain behaviours (e.g., involvement in sex trading) whereas females may be less likely than males to report other behaviours (e.g., high numbers of lifetime sexual partners). Throughout the literature, males consistently report higher numbers of sexual partners than females (e.g., Halcón and Lifson 2004; PHAC 2006a). However, in theory, if males are engaging in sexual behaviours with female partners, then males and females should report roughly similar numbers of sexual partners. It is possible that these differences may be partially due to the fact that many homeless male youth identify as gay or bisexual; however, this is not clarified in the literature. Although these concerns are important to underscore, there is ample evidence to demonstrate that homeless youth, in general, are a very high-risk population who engage in a wide range of sexual risk behaviours. Nevertheless, future studies should make efforts to clearly differentiate sexual health variables and avoid reporting bias in order to ensure that an accurate picture of homeless youth is being presented.

Finally, it is important to highlight that various studies define 'youth' differently, making it difficult to draw direct comparisons between studies. For example, the Linton and colleagues (2009) study defined youth as ages 18–30, whereas other studies have used age groupings of 15–24 (PHAC 2006a) and 13–25 (Roy et al. 2000). Thus, although many studies indicate that they are using youth samples, it is unlikely that the same populations are being compared across studies. Future research would benefit from developing more consistent guidelines as to what age groups constitute youth.

Implications for Intervention Strategies and Policy Changes

Canadian homeless youth demonstrate elevated rates of sexual risk behaviours compared to youth in the general population, placing them at risk for a host of adverse sexual health outcomes. An examination of the risk factors for poor sexual health within this population highlights the complexity of this problem. Homeless youth represent a group of individuals who have experienced inordinate life stressors. Many use homelessness as an escape from a family environment that is unsupportive, neglectful and abusive. Once on the streets or in shelters, homeless youth become immersed in a culture that promotes high-risk behaviour as a normative way of life. Without adequate social support, coping skills and access to education and health care, these youth are vulnerable to a range of poor health outcomes.

Effective interventions to reduce aversive sexual health consequences among homeless youth in Canada must be based upon comprehensive models that take multiple factors into account. Harm reduction strategies are effective ways to prevent risk for poor sexual health and should be applied in both school systems and community-based programs (PHAC 2006b). These strategies should include information on the importance of safe sex strategies and condom use, as well as behavioural skills training to ensure that youth are aware of how to use condoms correctly and consistently. This type of intervention should be accessible through community-based programs to ensure that homeless youth are receiving this information regardless of whether or not they are attending school. At the school level, prevention programs can be applied, not only by enforcing sexual education programs, but also by identifying youth who may be at an increased risk of leaving their homes and applying

individualized interventions to prevent them from becoming homeless. Community-based programs should also include outreach services that provide STI screening and treatment programs to prevent transmission of STIs (PHAC 2006b). These programs should adopt youth-friendly, sex-positive policies that reduce barriers to traditional health care environments (e.g., using street-based STI testing as part of outreach services) (Marshall, Kerr, Shoveller, Montaner et al. 2009). Incorporating these preventative activities into the health care strategy for street-involved youth could increase health care utilization and uptake beyond traditionally mandated programs.

Changes at the structural and policy levels must also be considered in the development of effective sexual health interventions for homeless youth. Policy changes promoting safe, affordable and harm-reduction focused, as opposed to abstinence-requiring, housing options would allow for easier access to a fixed address. Marshall, Kerr, Shoveller, Patterson and colleagues (2009) proposed that future policies should implement rent and subsidy programs that provide safe and stable housing for homeless youth. Increased housing opportunities would help to improve barriers to formal employment, potentially reducing youths' involvement in the street economy, including sex trading (Gwadz et al. 2009). Given that many youth desire to be part of the formal economy but face significant barriers in obtaining employment, vocational counselling, job training programs and transitional support services would also help to re-connect youth with conventional society and encourage alternatives to the street economy. Overall, there is a clear emphasis in the literature for the need to target structural barriers preventing youth from accessing essential resources including housing, education, employment and health care (Zerger, Strehlow and Gundlapalli 2008).

In conclusion, homeless youth are at increased risk for a variety of sexual risk behaviours and poor sexual health outcomes. These sexual risk behaviours occur in a social context including lack of housing, formal employment and financial resources, low social support, mental health problems and other psychological outcomes related to their marginalization. Sufficient literature exists on the risk factors affecting homeless youth to create much-needed preventative and supportive interventions to decrease sexual health risk. These interventions should include strategies at the individual and structural levels to improve poor sexual health outcomes in this vulnerable population.

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CHAPTER 3

Helpers, Not Helpless: Honouring the Strength, Wisdom and Vision of Aboriginal Women Experiencing Homelessness or Marginal Housing

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Introduction

In reviewing the health of homeless persons in Canadian cities, Hwang (2001) estimates that the representation of Aboriginal peoples in urban homeless populations is approximately 10 times that of their relative proportion of the general populations of urban centres. Research on homelessness experienced by Aboriginal peoples is slowly increasing, but literature addressing the intersections of identities (e.g., Aboriginal women) that builds on a strengths-based model appears to be scarce. Homelessness does not occur in a vacuum (Jahiel 1992); creating effective solutions means moving far beyond narrow, deficit-based stereotypical constructions that paint homelessness as resulting from individual choices and personal characteristics (e.g., drug use, mental illness, unemployment) and effectively ignore underlying structural issues. For Aboriginal peoples, this means constructing an understanding of, and response to, the needs of those experiencing homelessness and marginal housing that acknowledges and resists the effects of colonization. We propose an Aboriginal approach to conceptualizing and advancing the health and well-being of Aboriginal women experiencing marginal housing

or homelessness. This approach would be centred on the vision, voices, strengths and agency of Aboriginal women in determining their health and well-being and would honour their roles and contributions as helpers, not helpless.

Coming Together: Homeless Women, Housing and Social Support was a community- and arts-based, participatory action research project that explored how ciswomen build support networks with each other when experiencing homelessness or marginal housing. This chapter focuses specifically on the findings relating to the Aboriginal women who participated in the project. The project data were initially collected, coded and analyzed using a grounded theory approach (Charmaz 2006). Later in the research process, the research team focused on the Aboriginal sub-sample, drawing from Indigenous methodology (Smith 1999) in order to more fully understand the experiences of Aboriginal women in the context of an Aboriginal worldview. (While the research team would see this process as the second phase of the data analysis, this can be considered a secondary data analysis to some others.)

The findings from the subset of Aboriginal women participants revealed the kinds of marginalization and violence that they faced on the streets while attempting to access or maintain housing. At the same time, they were actively helping each other by offering social support, sharing stories and resources, accepting each other, promoting safety and volunteering. Moreover, these women offered significant insight into what was needed to improve their situations and the services they accessed and received. This chapter will focus on the recommendations for service providers and policy-makers offered by the participants. The results challenge health and social service providers, policy-makers, educators and researchers to revise discourses of housing and homelessness, to resist colonial history and practices and to instead honour the strength and agency of Aboriginal women.

Context of the Research

Aboriginal Health and Well-Being in Canada

Trying to capture a snapshot of the health and well-being of Aboriginal peoples generally is quite difficult (Health Council of Canada 2005), and that of Aboriginal women experiencing homelessness even more so. Indeed, the landscape of Aboriginal health statistics is not easily navigated. For example, census data gathered

by Statistics Canada is impacted by incomplete enumeration or non-participation of several First Nations (Anderson et al. 2006). Health data collected through provincial and territorial health systems do not necessarily or consistently utilize markers for Aboriginal identity. Even where ethno-racial identification markers are included, Aboriginal peoples accessing health services may elect not to identify for fear of racism. Aboriginal health statistics may be gathered from one specific subpopulation, for example, First Nations (status or non-status Indians), and yet be generalized to Aboriginal peoples as a whole. Indeed, the majority of available information regarding Aboriginal peoples is drawn from data collected from the status Indian population (CIHI 2004, as cited in Health Council of Canada 2005). As such, Aboriginal health data should be appreciated, with clear acknowledgement of all of its complications and challenges, for what it offers in helping to further our understanding.

There is a need for a general statement regarding the use of statistics (and other research data) relating to Aboriginal peoples, not only in terms of data collection (methods, sampling, generalizability, etc.), but in the responsibility to avoid inadvertently reinforcing stereotypes and systemic racism through the application of statistics. While this may seem like an obvious statement to some, the deeply painful history of both research and social policy directed towards Aboriginal peoples underlines the responsibility of researchers, educators, policy-makers, health professionals and community and social workers to gather, share and apply statistics in ways that disrupt stereotypical, one-dimensional ideas about Aboriginal peoples and instead advance the health, well-being and self-determination of Aboriginal communities. One means of responsibly utilizing statistics and other data derived from research is to ensure adequate discussion of the historical and ongoing colonial context faced by Aboriginal peoples. Another is to ensure the data is framed within the perspectives and voices of Aboriginal peoples. The purpose of including this statement here is to contextualize the challenges of engaging in and contributing to discussions of Aboriginal peoples' health and to stress the importance of doing so in ways that clearly identify limitations and actively move towards disrupting rather than reinforcing negative discourses of Aboriginal peoples. In the section that follows, we review available information on the health and well-being of Aboriginal women, as well as examining the impacts of historical and contemporary colonialism on Aboriginal women.

Aboriginal Women: Looking at Our Past, in the Present, for the Future

To look at our past, in the present, for the future is a traditional teaching shared across many nations. In the case of Aboriginal women experiencing homelessness and marginal housing, this means looking at the history of colonization and its effects within the contemporary context, with an eye towards positively transforming their health and well-being and the social conditions they face.

The past. The effects of colonization on the lives of Aboriginal peoples are undeniable even though the colonial history of Canada receives limited attention in our public schools and public discourse (Kempf 2006). The intersectional effect of gender and racialization has amplified the impact of colonization on Aboriginal women. Attacking the roles of Aboriginal women was, in fact, a key strategy in destabilizing First Nations and establishing colonial control (Anderson 2004; Lawrence and Anderson 2005; Walters and Simoni 2002). Mohanram (1999) describes the fundamental role of women in building and maintaining a nation, in that women quite literally reproduce the nation through childbirth. She further highlights the patriarchal discourses of colonization that have and continue to portray women as existing without agency. The very idea of women without agency directly contravenes the status, roles and responsibilities of Aboriginal women on Turtle Island (North America) prior to European contact. Within the tremendous diversity of Aboriginal nations and their traditions across Turtle Island, Aboriginal women were understood as powerful and sacred; they held multiple and varying roles as helpers, healers, teachers, leaders, warriors, knowledge keepers and lifegivers (Walters and Simoni 2002). In matriarchal societies, Aboriginal women carried responsibilities for or control over property and leadership, for example, within the Haudenosanee Nations in which women held all property rights, and Clan Mothers were charged with selecting and deposing of leaders.

The colonial project of European settlers, aided by the work of Christian missionaries, undertook to 'civilize' Aboriginal peoples by upending traditional governance structures and cultural values and practices and by imposing and enforcing European values and norms, including patriarchy and the consequent subordination of women (Bourassa, McKay-McNabb and Hampton 2005; Lawrence and Anderson 2005). These efforts were ultimately institutionalized in the *Indian Act of 1876*, legislation that resulted in multiple human

rights violations, including the political exclusion of women. The Act usurped the role of Aboriginal women in selecting and deposing leaders (i.e., the role of Clan Mothers) and prevented them from holding leadership positions themselves. The legislation instead inserted band chief and council structures in which only men were eligible for election and in which women held no right to vote (Blair 2005). The *Indian Act* further removed the real property rights of Aboriginal women and regulated their status such that women who married non-Aboriginal men (or non-status Aboriginal men) would lose their status, as would their children. This stood in contradiction to the treatment of status Aboriginal men who, upon marrying non-Aboriginal women, conferred their status on their wife and, subsequently, their children.

In response to activism and legal action by Aboriginal women, the federal government passed Bill C-31 in 1985, rescinding the 'enfranchisement' provisions of the *Indian Act* and reinstating those who had lost their status. Bill C-31 was meant to ensure the conformity of the *Indian Act* with the *Canadian Charter of Rights and Freedoms*, specifically section 15—the equality rights section. Using a 'gender neutral' approach, Bill C-31 removed the purely patrilineal eligibility for status, but it did not also provide Aboriginal women with the right to confer status onto their spouses and children. Instead, it situated status men in a position similar to that of status women, such that children of status women or men who married non-status or non-Aboriginal individuals could no longer confer their status on their own children if they too married a non-status or non-Aboriginal partner. The irony of Bill C-31, which was touted as a vehicle to restore gender equity for Aboriginal women and increase the number of people who qualify for Indian status, is that it actually works to speed the extinction of status Indians—since hundreds of thousands of descendants of today's status Indians will be excluded from status rights over the coming decades. This policy action has arguably significantly benefited the federal government by decreasing the status Indian population, for whom the government has a fiduciary duty to provide, thereby reducing associated obligations and costs (Daniels 1998).

The removal of property rights through the *Indian Act* continues to significantly impact Aboriginal women today. Provincial matrimonial real property laws do not apply to Aboriginal women living on reserve, as reserve land is a matter of federal jurisdiction

and the use of reserve lands, including housing, is controlled directly by band councils (Blair 2005). This is especially problematic for women experiencing violence, which Blair (2005) has estimated to be approximately one in three among Aboriginal women. The violence faced by Aboriginal women is compounded by chronic and severe on-reserve housing shortages, such that the lack of matrimonial real property rights means that Aboriginal women experiencing violence may be forced to choose between fleeing at the cost of their housing or continuing to live in violence in order to maintain housing (Blair 2005). Violence is a well-documented force in the migration of Aboriginal women to urban centres (NAFC 2012; RCAP 1996). The federal government has been engaged in consultation around and the development of multiple (failed) bills for more than thirteen years, including Bill S-2. However, the legacy of this legal limbo and the continued strain of housing shortages will not simply disappear with one new piece of legislation.

The denigration of Aboriginal women was a central goal in the colonial project of European settlement (Walters and Simoni 2002), achieved through multiple means, including legislated and systemic oppression, social and economic exclusion, physical and sexual violence and the rupture and erosion of the role of Aboriginal women in having and caring for their children. This has included forced sterilization of Aboriginal women in both Canada and the United States (the division of which was only created through a colonial imposed border). In the 1970s, approximately 40 percent of Aboriginal women of childbearing age in the United States experienced non-consensual sterilization administered by the federally run Indian Health Services (Walters and Simoni 2002). This practice of eugenics also occurred here in Canada, although to a lesser degree and primarily in Alberta and British Columbia (Grekul, Krahn and Odynak 2004). More than 2,800 Aboriginal women underwent forced sterilization in Alberta alone between 1928 and 1972 (Truth Commission into Genocide in Canada 2001). Testimony provided to the Truth Commission into Genocide in Canada (2001), indicated that sterilization of Aboriginal women was in fact a standard practice in some places (i.e., provincial training schools). Additional testimonial evidence provided to the Commission suggests that the Department of Indian Affairs provided a financial reward to physicians for each Aboriginal woman sterilized, in particularly "if they weren't churchgoers" (Truth Commission 2001: 13).

In addition to eugenics, the goals of cultural annihilation were enacted by the mass removal of Aboriginal children from their families, homes and communities, first in the era of residential schools and then through the assertion of child welfare authority in the lives of Aboriginal families, which saw thousands of children taken into foster care or placed in cross-cultural adoption. While some may wish to relegate residential schooling or invasive child welfare practices to the distant past, the last residential school in Canada closed in 1996, and recent data from the National Household Survey suggests that Aboriginal children presently constitute nearly half of the estimated 30,000 children in care in Canada (Woods and Kirkey 2013), despite the fact that Aboriginal peoples are thought to compose less than 5 percent of the Canadian population (Statistics Canada 2011). Residential schooling and child welfare involvement have been associated directly with adverse health outcomes, such as, increased risk and rates of HIV and hepatitis C (Pearce et al. 2008) as well as social determinants of poorer health, including homelessness (Baskin 2007; Sinclair 2009).

Colonization has had an undeniably devastating, intergenerational and collective impact on Aboriginal peoples, tearing at the fabric of Aboriginal ways of knowing and being, including substantive damage to roles of and respect accorded to Aboriginal women prior to contact and to family and community cohesion. In the context of decolonizing communities and improving Aboriginal health and well-being as a whole, the health and well-being, wisdom and vision of Aboriginal women is integral. An often cited Cheyenne saying states that "A Nation is not defeated, until the hearts of its women are on the ground", so that by caring for our women, honouring our women, raising their voices and raising their hearts, we are also caring for, honouring and renewing our nations.

The present. Subsequent to colonization, Aboriginal women face severe marginalization in Canadian society. Aboriginal women are more likely than their non-Aboriginal counterparts to experience poverty, under- or unemployment, under housing, homelessness or incarceration (Dion Stout, Kipling and Stout 2001; NWAC, 2007a). They are also more likely than non-Aboriginal women to have lower levels of educational achievement and to live with poorer community infrastructure and resources as a result of the persistent economic marginalization of Aboriginal peoples in Canada (Adelson 2005;

Benoit, Carroll and Chaudhry 2003; NWAC, 2007b; Smylie 2001; Loppie-Reading and Wien 2009). Aboriginal women experience substantial violence; those with status are five times more likely than non-Aboriginal women to die as a result of violence and eight times more likely to die by spousal homicide (CAEFS n.d.). The violence levelled at Aboriginal girls and women is painfully captured in the epidemic of missing and murdered Aboriginal women in Canada, an issue that has recently been identified as a subject of inquiry by the United Nations Committee on the Elimination of Discrimination Against Women (Talaga 2012). While the Native Women's Association of Canada (NWAC 2010) has verified nearly 600 cases of missing and murdered Aboriginal women, other activists suggest that the actual number may be much higher (Kraus 2011; Talaga 2012).

Aboriginal women experience alarming disparities in health, with higher rates of heart disease, hypertension, diabetes, multiple forms of cancer (including cervical and gallbladder), HIV/AIDS, mental illness, substance abuse and suicide (Dion Stout, Kipling and Stout 2001; Gatali and Archibald 2003; NWAC 2007b). They not only experience a shorter life expectancy and higher infant mortality rate than non-Aboriginal women (Statistics Canada 2006; Smylie, Fell and Ohlsson 2010) but also higher rates of chronic disease than Aboriginal men (Bourassa, McKay-McNabb and Hampton 2005). This disproportionate burden of ill-health reflects the inequities Aboriginal women face in foundational determinants of health, including housing, income, food security, education, violence and environmental degradation (NAFC 2012).

While recent census data estimates 54 percent of the overall Aboriginal population now resides in urban centres (Statistics Canada 2008), fully 78 percent of Aboriginal women live off-reserve (Statistics Canada 2006). Among Aboriginal women living off reserve, 52 percent have been diagnosed with a chronic health condition by a health professional (Vancouver Women's Health Collective 2006). Homelessness and marginal housing are in no way limited to urban contexts; however, the Coming Together Project was conducted in an urban centre (Toronto) and reflects the types of experiences and services accessed by Aboriginal women in a large, metropolitan city. As such, we focus our discussion and recommendations within the realm of urban housing and homelessness, while recognizing that homelessness and marginal housing are issues that abide by no geographical bounds. In fact, there is a need, beyond the scope

of this chapter, to ensure more attention to issues of homelessness and marginal housing in rural, remote and Northern environments (see, for example, Qulliit Nunavut Status of Women Council 2007; Yukon Status of Women Council 2007).

Urban Aboriginal peoples earn substantially less than the median income of their non-urban counterparts and face higher rates of homelessness, tuberculosis, diabetes, HIV/AIDS, substance abuse and suicide than their non-Aboriginal peers (Benoit et al. 2003). Urban Aboriginal women are more likely than non-Aboriginal women to be lone mothers and to face difficulty in providing basic necessities for their children, including food, clothing and housing (UATF 2007). Homelessness statistics for the city of Toronto indicate that while Aboriginal peoples are estimated to compose less than 1 percent of the city's entire population, they account for approximately 15 percent of the homeless population but fully 26 percent of 'rough sleepers', meaning those who sleep outside (Novac et al. 2006; Khandor and Mason 2007).

Methods

Description of the Project

The research findings presented herein are part of a larger, multimethod community-based research project entitled Coming Together: Homeless Women, Housing and Social Support, which explored how ciswomen[1] and transwomen with experiences of homelessness build support networks with each other in Toronto, Canada. Adhering to the community-based research approach (e.g., Flicker and Savan 2006; Israel et al. 1998), the Coming Together Project was a collaborative effort between a university and two community agencies serving people who are homeless.

These findings were derived from a secondary analysis of the data, particularly focusing on the subset of the data comprising of Aboriginal ciswomen and transwomen participants, whose experiences were contrasted to that of the non-Aboriginal participants. Unlike what is typically seen when the term *secondary data analysis* is used, which typically involves an analysis of a large data set previously collected by a governmental body (e.g., Statistics Canada survey data sets, health utilization data from a provincial/territorial registries, etc.) or other researchers, this process involved a second phase analysis of our own data (from interviews and arts-based focus

groups) with the intention of generating a deeper understanding of the experiences of Aboriginal participants through the application of a more 'Indigenized' approach to data analysis.

The analysis drew upon both a constructivist grounded theory approach (Charmaz 2006), where data collection and analysis are conducted hand-in-hand in a cyclical manner involving multiple reiteration of coding strategies, and upon Aboriginal/Indigenous knowledge and principles regarding the gathering and care of knowledge (research). Maori scholar Linda Tuhiwai Smith (1999) sets out several projects for Indigenous research, including 'reframing', which seeks to transform how social issues of Indigenous peoples are discussed and addressed. In the context of this project, reframing required continuous attention to the historical context of the lives and circumstances of the participants with an eye to what could be done now to disrupt the chronic, colonial marginalization of Aboriginal women and create change for our future.

The project's advisory board was comprised of seven ciswomen and transwomen who had experienced homelessness, including two Aboriginal members. During the project implementation and follow-up, two Aboriginal PhD students (Billie Allan and Rose Cameron) also became research assistants, helping with data collection, transcription, data management, data analysis and dissemination. The analysis presented herein was led by one of the Aboriginal researchers involved in the project (Billie) in consultation with the rest of the team, including the advisory board. She also integrated Indigenous research methodology (Smith 1999) during the analysis process so that we can understand and describe the experiences of Aboriginal women more fully.

As is often the case with community-based participatory research, the ethics approval process involved multiple steps to allow for flexibility in research design to reflect participants' opinions and increase the trustworthiness of research findings. In Phase I, in-depth face-to-face semi-structured interviews for both service providers and researchers as key informants (n = 13) and service users (women and transwomen who were homeless; n = 20) were conducted at either the participant's location or at a mutually designated location. For service user participants, each interview participant received a $25 honorarium and two transit tokens as a token of appreciation and partially to compensate for their time and contribution.

Of the 20 ciswomen and transwomen with experiences of homelessness interviewed, 11 were between the ages of 40 and 59

and nine were between 25 and 39 years old. Six identified as transwomen and 14 identified as women (ciswomen, non-transwomen). Nine of the ciswomen and transwomen with experiences of homelessness interviewed identified as Aboriginal or Metis, seven as white or of European descent and four identified as people of colour. At the time of their interviews, five ciswomen/transwomen had been homeless or marginally housed for over 10 years, two had been homeless or marginally housed between five and 10 years, six had been in similar situations between one and five years and seven had been without stable housing for up to a year. The living situations of the ciswomen and transwomen at the time of the study varied. Two ciswomen/transwomen were living on the street, two were living in subsidized housing, four were living in private housing, five were staying with relatives or friends and seven were accessing shelter or hostel services. Of 13 service providers interviewed, five service providers worked mostly with Aboriginal women, while one worked specifically with transwomen (including Aboriginal transwomen), and the rest worked with a range of ciswomen/transwomen who are marginally housed or homeless. While the experiences and insights of the service providers were a valuable part of our project, giving us a deeper understanding of the issues, due to space limitations, in this chapter we have chosen to focus mainly on the voices of ciswomen and transwomen who were actively experiencing homelessness or marginal housing themselves.

Based on the findings from Phase I, Phase II of the project was designed to be more participatory, action oriented and arts based. To ensure that this project was based on participatory, anti-oppressive and empowerment approaches (Gutiérrez and Lewis 1999; Ristock and Pennel 1996; Sakamoto and Pitner 2005), an advisory board was created consisting of women and transwomen who used their own experiences of being homeless and/or marginally housed to critically reflect on the information previously collected through interviews. These ciswomen/transwomen were recruited from the communities where the initial interviews had been conducted. Many of the members were asked to participate because of their reputations for supporting other homeless women. Out of seven advisory board members, three were transwomen, two were Aboriginal (one identified as a transwoman) and two were ciswomen or transwomen of colour. Advisory board members acted as consultants and peer researchers throughout the rest of the research process, participating



Figure 3-1. Members of the advisory board and research team

in the arts-making sessions, brainstorming the results with the rest of the team and helping the team make key decisions in analysis and dissemination strategies.

In Phase II, in order to examine and expand the earlier findings and generate more voices from ciswomen and transwomen who have experienced homelessness, the research team proposed to conduct arts-based group activities. Art has the power to bring people together in ways that verbal interaction alone may not be able. Further, the process of making art can allow for the creation of alternative and inclusive knowledge. To design and facilitate the process, a community artist, Natalie Wood, who had experience with art education, community organizing and working with ciswomen and transwomen who have experienced homelessness and poverty was hired to be as part of the research team.

The advisory board first met to review the project material and develop the key themes through discussion and brainstorming. In collaboration with the artist (Natalie), the advisory board members chose method of 'staged photography'[2] for the next phase of data collection. The artistic form was based on Natalie's experience teaching art with homeless and marginally housed women and her commitment to applying collaborative methodology and using a form of artistic expression in which all could participate. We also set

a two-to-three-hour time limit for the discussion and distillation of ideas and experiences into visual form, because it was unlikely that exactly the same group of ciswomen and transwomen would return to the drop-in centres on a subsequent date had more than one session been required to complete the activity. The advisory board members were given a 'crash course' on the artistic form, collaborative methodology and how to transform the language of experience into visual metaphors that were unique and not stereotypical. The goal of this approach was to give voice to those individuals whose voices have been silenced, marginalized and socially isolated—in this case, ciswomen and transwomen who are homeless or marginally housed.

The advisory board and research team travelled to four drop-in centres across Toronto to engage groups of ciswomen/transwomen in the art-making sessions (overall n = 50+). Through painting, costumes, theatre and photography, groups of ciswomen and transwomen who have experienced homelessness created scenes depicting their own visions and stories of inclusion, friendships and safe spaces. The preliminary findings were then followed by subsequent consultations with advisory board members and feedback sessions with ciswomen and transwomen at four drop-in sites. In addition to printing four posters depicting these four stories, a community research report was published to more fully capture the process and outcomes of research (Sakamoto et al. 2007). Dissemination of the research results included public exhibits of photos, distribution of posters and research reports, academic and community presentations and writing of journal articles (Sakamoto et al. 2009), followed by a larger synthesis report, joint exhibit and new website with seven other community-based, arts-informed research projects on homelessness in Toronto, entitled Homelessness: Solutions from Lived Experiences through Arts-Informed Research[3] (Sakamoto et al. 2008). For further description of the methodology, please refer to the project report, *Coming Together: Homeless Women, Housing and Social Support—With a special focus on the experiences of Aboriginal women and transwomen* (Sakamoto et al. 2010).

An 'Indigenized' Approach to Grounded Theory Data Analysis

Building upon the grounded theory methodology employed in the broader research project, the analysis of the Aboriginal women's subset of data employed a methodology that drew upon both grounded theory and Indigenous knowledge practices regarding the gathering

and care of knowledge (research). The challenge of bridging between these two ways of knowing and handling knowledge is not easy, and the limitations of Western approaches to organizing data in being able to generate a meaningful understanding of Indigenous experiences have been increasingly discussed by other Indigenous researchers (Absolon and Willett 2004; Kovach 2009; Lavallée 2009). Moreover, the considerable abuse, harm, loss and exploitation historically endured by Indigenous peoples in the name of scholarly research means that any kind of research method used with Indigenous peoples requires the utmost critical consciousness and attention to issues of power, domination and marginalization. As an Indigenous researcher [the first author of this article, Billie], this issue is particularly personal; I entered the process with a visceral understanding of all that has been stolen, misrepresented and used to create and enforce colonial policies and practices on our peoples (Absolon 2011; Smith 1999). Therefore, the process of engaging in data analysis involved a constant negotiation between the ideas of grounded theory, and the Western knowledge system from which it evolves, and Indigenous ways of conceptualizing and understanding all of existence. The process required a decolonizing lens in order that we all be cognizant of how both the process and the outcome of the research impacted the lives of the women: Did it further reinforce their marginalization and dehumanization or did it help to bring forward their voices, stories and wisdom? Was the analysis ignoring or embodying the values of Indigenous ways of knowing and caring for the stories the women had gifted us with?

The approach to coding and the subsequent themes and stories that emerged and are shared here reflect Smith's (1999) project of reframing, which acknowledges the power of framing not only in how an issue is understood, but whether and how it is responded to:

> The framing of an issue is about making decisions about its parameters, about what is in the foreground, what is in the background, and what shadings or complexities exist within the frame. The project of reframing is related to defining the problem or issue and determining how best to solve that problem. (153)

The use of grounded theory coding processes to stay close to the knowledge provided by each participant, positioned within an

Indigenous worldview that attends to the historical and contemporary contexts of Aboriginal women and to the project of reframing, follows what Cree scholar Margaret Kovach (2009) has referred to as a 'modified grounded theory' in which the researcher must attend to both the 'berry' (each small piece of knowledge) and the 'bush' (the context and relations in which each 'berry' exists). This 'grounding' of analysis in an Indigenous worldview aims to resist the fragmentation of Indigenous experience that may otherwise be caused by a grounded theory approach to data analysis as highlighted by Algonquin/Cree/Metis scholar Lynn Lavallée (2009).

Results: Voices and Vision, Using Lived Experience to Create Change

The Aboriginal women participating in the project (both in the interviews and arts-making sessions) offered many recommendations to improve service provision based on their lived experiences, insight and the wisdom they carry inside of themselves—this wisdom could also then be understood as their *embodied knowledge*. Honouring the embodied knowledge of participants ruptures the discourse of *who* is understood to hold knowledge in the interactions between those accessing and and those providing services addressing the health and well-being of Aboriginal women experiencing homelessness. It also challenges *what kind* of knowledge is understood as valid. Centring the embodied knowledge of Aboriginal women honours their strengths, voices and visions, as well as their struggles, challenges and needs. It disrupts practices, intentional or unintentional, that position Aboriginal women as lacking understanding, insight or expertise of their very own lived experiences.

The recommendations offered by participants ranged from micro to macro practices, such as improving communication between and within agencies, increased outreach services, the development of services for women who are homeless with disabilities and efforts to remove structural barriers to service for women who are actively using drugs and alcohol. Themes within this part of the data included understanding/compassion, communication and transforming services. We explore these themes below, drawing linkages and discussing the implications for those involved in policy-making, programming (design, delivery and evaluation) and frontline services.

Understanding and Compassion

Participants discussed the challenges of navigating systems of service and care and spoke directly to the need for deepened understanding and compassion on the part of staff at receiving agencies or services.

> *We shouldn't be treated like criminals or like we've done something bad and need to be punished. This humiliation is re-victimizing—we've already left abusive situations and now we get treated like this in the shelter . . . . When I arrived at the shelter I was told by one of the intake workers not to make friends with the other women. This goes to show how that worker regards the women staying in the shelter. And at the shelter, compassion is taking a second seat. It feels that the rules are more important to the shelter than each person as an individual.*
>
> – Dorene,[4] Ojibwe-European woman, 40–59 years old, residing in a shelter, following approximately one year of marginal housing

> *Don't blame it on you 'cause I find I get a lot of that 'It's your fault you're homeless', so more open-mindedness and understanding of where that person's coming from.*
>
> – Shelley, Ojibwe woman, 25–39 years old, residing in a shelter for the past five months after having lived on the streets for 1.5 years

These recommendations may seem small or even simple in terms of what is needed to create change. However, in light of the historical and contemporary conditions experienced by Aboriginal women previously discussed in this chapter, it is even more apparent why experiences of uncompassionate or even humiliating care could compound personal and societal experiences of colonization and racism. On the other hand, caring, genuine and accepting care can constitute a major element of accessibility of services.

Improved Communication

Communication between agencies, and between staff within agencies, was a need clearly identified by the women. Increased communication was viewed as an essential piece of respect, and necessary to avoid humiliation or re-victimization:

> *Share information amongst staff better so that we don't have to keep telling our histories of abuse over and over. Women are shuffled around, not helped. Once you've told your story, you shouldn't have to keep reliving it. Direct and respectful communication is a key to building trusting relationships between those seeking and providing services.*
>
> – Dorene

Problematic communication can speak to underlying dynamics, as discussed by a participant in the following passage:

> *So there is a whole lack of understanding by social service workers who try to speak a pretty language under the crisis management ideal as opposed to speaking plain English and saying this is what I want from you. Social services are very much about treating people like children. If you're good I'll feed you and if you're bad you have to go home now—even though you don't have a home. As opposed to 'this is an adult, and I'm asking you to be respectful in my space', 'I have to work here so you need to be respectful'. That's what is not happening in social services. There is an 'us' and a 'them'. And they talk about boundaries. 'Boundaries' is another fake social services word. Boundaries are for people who don't have the nuts to say 'no'.*
>
> – Kim, Metis woman, 40–59 years old, residing in subsidized housing with a history of both homelessness and marginal housing

A focus on increased direct and positive communication could go a long way towards uprooting and transforming unhealthy or harmful power dynamics. Uprooting power dynamics is necessary to transforming the accessibility and experiences of health and social services for those who are homeless, where access and quality of these services is understood as a determinant of health and well-being. For Aboriginal women, open examination and transformation of power dynamics can serve to honour their knowledge and contributions in the process and contribute towards Aboriginal self-determination.

Transforming Services

Participants offered concrete recommendations for transforming services based on their lived experience and embodied knowledge. These recommendations underline the importance of, as one participant stated, "a system in place to meet each woman's specific needs.

They need to realize that we are individuals and we have individual needs". Moreover, the following recommendations would all serve to decrease the marginalization of Aboriginal women (and women generally) experiencing homelessness. They make visible the interlocking nature of oppression where existing marginalization based on race, culture, gender and housing status are further compounded by additional factors.



Figure 3-2. Example of Coming Together project dissemination posters

For example, one participant spoke of the challenges she faced in navigating homelessness services with a disability. She suggested that

> *There should be specific places/facilities for women with disabilities where women can get extra rest [and not be forced out during the day] and get special diet requirements met and have counsellors.*
>
> – Dorene

Ensuring that services for those experiencing homelessness or marginal housing are not only physically accessible but also appropriate and responsive to the specific needs of women with disabilities should be considered a basic act of maintaining human rights. While the context of shelter services in particular tends to be marked by a lack of resources, high workloads and low staffing, a failure to recognize and respond to the needs of women with disabilities could be read as a symptom of a system that ignores the individual needs and context of each woman. Moreover, there is a need to deconstruct policies that require women to leave shelter services during the daytime, since these policies assume the ability to do so—and to do so without risk of harm to oneself or one's health.

Another participant spoke to the challenges and barriers to services faced by women who are actively using substances or alcohol. She advocated for a revision of policies that exclude women who are using from accessing services:

> *These women need agencies even if they are smoking crack. They should be allowed to smoke crack inside agencies if that is what it takes to get them in the door 'cause even if they are stoned, at least they're sitting there* [in an agency] *talking. Giving them a place to cry if they need to and relieve themselves could mean more to them than even buying them a house.*
>
> – Diane, Native/Black woman, 40–59 years old, residing on the street for about five years

While allowing service users to smoke crack inside an agency may situate on the extreme end of a spectrum of options to make services more accessible to women who are using, the suggestion does highlight some important considerations. First, increasing the accessibility of services for women who are using should reflect a compassionate

understanding of the reasons they are engaged in use in the first place. Secondly, it is arguable that women who are using, specifically Aboriginal women, may be at increased risk of harm in terms of violence and sexual assault. As such, policy and practice revision around substance and alcohol use could also increase safety.

Outreach services were a focus for one participant, who emphasized the role of outreach in decreasing isolation and making service utilization more viable for her:

> *They should have more outreach support for loners like me. 'Cause a lot of the time I won't go searching for something. Either I'm too afraid, or nervous, so more outreach for women on the streets, and support.*
>
> – Shelley

While another participant stressed the importance of having options in terms of service providers available to her:

> *Where I go for support depends on how I'm feeling. For example, if I want a male or a female. Different days, different feelings—different people. Sometimes only females* [service providers] *will do. Some days a male* [service provider] *will ask me how I'm doing and I'll say 'fine', meanwhile my life could be falling apart. That's why it's important to have a lot of different people around you who can give you support, so you can pick and choose.*
>
> – Ruth, Aboriginal woman, 40–59 years old, recently residing in rented room in private apartment after having been homeless for approximately three years

One participant shared from her experiences of having both been homeless and of providing 'frontline' services to women experiencing homelessness. She offered several powerful insights into needed transformation in how we deliver or even imagine services directed towards those experiencing homelessness:

> *If you want to do anything to support street people, they have an incredible amount of grief. I have spent more time with my clients allowing them a safe place to grieve than anything else because it's not safe out there. The only thing you can do in social work is give them that space, because they are in a chronic state of loss.*

> *My advice to agencies is to get out of Dodge. Why are we pouring money into shelters? I don't want shelters. I refuse to do any activism around shelters. People are not dogs. I do not need a 20-year-old kid telling me when I can take a shower, when I can wash my hair, what clothes I can wear, when to go to bed, and, and, and, and. This is ludicrous. There's a whole political agenda to keeping people poverty ridden and homeless. We pump more and more money into shelters and we get more and more homeless. Hasn't somebody said 'What the fuck!!!' That has nothing to do with any of this, this is about land! There is enough empty land in this city and enough empty houses to house everybody in it . . . . There are a million creative ways to solve the problem that poor people already do all the time which is squat, break in, jump in, sleep on it, bring a friend into it, climb over the roof of it. Just give people a spot, they'll build a home, have a barrel and be perfectly happy. They don't need you, they don't need me. We have been conned that we're helpless. We're told we're psychologically unhealthy if we're independent.*
>
> – Kim

Kim (not her real name) problematizes both the micro and macro understandings and responses to homelessness and the needs of those who are homeless. These passages highlight how current discourses of homelessness obscure, erase or ignore the agency of those who are homeless, resulting in services that can inadvertently imply to service users that they are helpless and reinforce feelings of grief, isolation and marginalization. In response, then, raising the voices of those who have or currently are experiencing homelessness and ensuring their active and meaningful involvement in policy, program and service development and delivery should transform both individual experiences and societal discourses of homelessness.

Discussion

Looking Towards the Future

The Aboriginal women who participated in the Coming Together project generously shared their voices and vision, clearly demonstrating their agency and wisdom in opposition to the negative stereotypical constructions of homeless Aboriginal women. They offer suggestions on how to move forward in a good way. While commonly housing, income, and service are understood as critical components

of addressing homelessness in Canada, the specific needs, history, strengths, and experiences of Aboriginal women need to be taken into account, considering when Aboriginal peoples are disproportionately represented in homelessness in general. It is not enough just to address universal formula of resolving homelessness, but we need to step further to address particular issues, such as issues of colonialism, violence against Aboriginal women, and many other issues that affect Aboriginal women's lives differently than non-Aboriginal women's lives every day. Figure 3-3 (Sakamoto, Chin and Baskin 2010; Sakamoto et al. 2008) highlights this notion of needing to meaningfully include specific experiences of different identity/social membership groups that go through homelessness differently in order to effectively address homelessness as a whole. Reflecting on the voices and vision of the Aboriginal women participants shared in this chapter, we propose the following implications for those working within systems associated with homelessness.

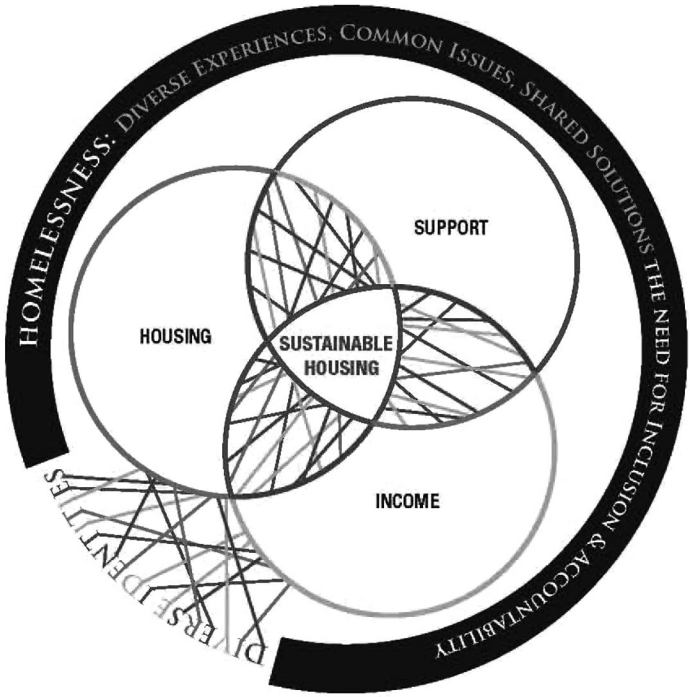


Figure 3-3. Illustrating the themes of 'inclusion and accountability' to address homelessness

Reconstructing Ideas of Help and Helpers

There is a lot to be learned in here for how we think about, undertake, evaluate and plan the role of helping. Helping in the Western sense typically constructs the helper as one side of an equation, the powerful, normative, functional side. However, from an Aboriginal perspective a helper is an honoured role and responsibility. We all carry roles as helpers, but with different gifts to give. Aboriginal women, and particularly those experiencing homelessness, are not typically recognized for their gifts. They are situated among the lowest of the low in terms of marginalization in Canadian society. The racialized, sexualized violence levelled at Aboriginal women is starkly marked by the epidemic of missing and murdered women (e.g., NWAC 2010). We need system and service level responses that disrupt insidious societal stories of Aboriginal women experiencing homelessness as dependent, unworthy or helpless. Systems and services should honour the gifts and roles of these women as helpers, with important wisdom and experience to offer, in transforming their own safety, well-being and health and that of their families and communities. Honouring their voices and visions should occur in the creation, implementation or evaluation of policies, programs and services aimed at meeting their needs (including housing, shelter, health and social service systems). Aboriginal women who have or are currently experiencing homelessness should be well-represented in service organization boards of directors, community advisory panels, policy-making bodies, research teams and frontline service delivery and management.

Decolonizing Systems, Services and Care

Decolonizing the education, practice and research of health and helping professions requires knowledge of Aboriginal histories prior to contact, of the history of colonization and cultural genocide and of the ongoing and intergenerational effects of colonization on both Aboriginal peoples and broader Canadian society today. Ignorance of the colonization and its effects enables the severe marginalization of Aboriginal women, their families, communities and nations to remain invisible and intact. As such, this should constitute mandatory content in the education and training of service providers and policy-makers. This education should also be delivered by Aboriginal peoples themselves.

In the context of policy development or change, decolonization efforts would include the involvement of Aboriginal women with

direct experiences of homelessness, extending well beyond tokenism or one-off consultations, to ensure meaningful input and actual power to effect change. In the context of program development and delivery, decolonization would demand that programs are not simply based in Western perspectives; indeed, Aboriginal approaches to helping would naturally fit with a decolonizing agenda. Reflecting notions of interconnectedness, interdependence and reciprocity, an Aboriginal approach would recognize all parties as sharing responsibility for health and well-being and each person having something to offer. In this way, Aboriginal women accessing services would be recognized as helpers just as much as those who are formally employed to serve them. This approach recognizes that formal service providers have just as much to learn and benefit as much from helping relationships as those accessing services. Interconnectedness and interdependence considers the relationships between all things, and in the context of the health and well-being this reflects an understanding that the health of the collective is impacted by the health of the individual just as the health of the individual is impacted by that of the collective. If systems and providers of health social services moved away from an individualist stance (your health and well-being is *your* problem) to a collectivist stance, then we could operate as a society that understands how the illness and marginalization of some affects the health and well-being of all. Utilizing an Aboriginal approach also firmly recognizes and honours the agency of Aboriginal women in determining their own health and well-being and helps to foster a system in which seeking help does not equate with being helpless.

Notes

1. In this chapter, the terms *ciswomen, women,* and *non-transwomen* may be used interchangeably. For those unfamiliar with the term, "A ciswoman, shorthand for 'cissexual woman' or 'cisgender woman', is [a] non-transsexual woman—a woman whose assigned gender is female, and whose assigned female gender is more or less consistent with her personal sense of self. This distinguishes her from transwomen, shorthand for 'transsexual women'—women who were initially assigned a male gender, but have a female identity. If you identify as a woman but are not a transsexual woman, you're a ciswoman" (Head n.d.).

2. Traditionally, in 'staged' photography the artists take on the role of the director, creating or staging an image (McDonald 1999). They use models, props, costumes or lighting, often creating a sense of theatre that is then photographed. This kind of photography has ties to theatre, dance, sculpture, painting and literature. It is well suited to making stories from experiences because the images that are photographed are always coming out of context. The viewer is therefore invited to make the connections between the 'before' and 'after' sections of the story.
3. For more information about this project, visit www.artsandhomeless.com or www.homelesshub.ca/Topics/Arts-and-Homelessness-492.aspx.
4. All the participants' names shown here are pseudonyms, chosen to protect the anonymity and confidentiality of study participants.

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CHAPTER 4

Homelessness and Health in the Crowded Canadian Arctic: Inuit Experiences

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Introduction

The experience of homelessness for Inuit in the Eastern Arctic is the culturally mediated product of a history of displacement compounded by a serious shortage of affordable housing. Despite prominent photographs to the contrary in the national media (Paperny and Minogue 2009), homelessness in Nunavut is made most visible not by people sleeping in the streets but by extraordinarily high levels of residential crowding. However, key measurements of residential crowding only capture a portion of Inuit experiences of homelessness. In this chapter we explore Inuit experiences with four objectives. First, we present the cultural context and history of policy development relevant to housing in the Eastern Arctic. We then seek to better define what homelessness means, laying out different dimensions of homelessness and matching them to Inuit experiences. Third, we use the results of an innovative community-based survey, designed with local input, to estimate the prevalence of different types of homelessness in Nunavut and how these relate to more conventional measures. Finally, we establish relationships between homelessness and health issues in Nunavut, captured in the same community survey. Overall, we underscore the importance of housing as foundational in addressing a number of health-related problems in the Eastern Arctic. We also suggest that while conventional measures reveal some of the

need for housing in Nunavut, they understate the overall experience of homelessness and miss important connections to health.

Housing in Nunavut: Cultural Context and History of Policy

The following paragraphs provide a glimpse of what the transition to settlement life meant for many Inuit. They are presented as a composite of experiences, relayed to researcher Frank Tester in discussions with elders over years of researching the social history of Nunavut.

> *The dogs were curled about in the snow, a slight north wind stretching across the Barrens. The entrance led down slightly, a tunnel through the walls he built two months earlier. The* kudlik*, or seal oil lamp, a base carved of soapstone and a wick from last summer's cotton grass was off to one side, frozen char and seal on the other, with a warm and familiar bench across the igloo's back, spread with several layers of skins from last fall's caribou hunt. Each family member had their designated spot, including hers, next to the kudlik, burning all day, all night, as long as there was seal oil to be had.*
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> *The bench was a place for games; for children to play with tiny bone and ivory carvings, some passed down from grandfather (*ataatattiq*) to child (*pariaq*). The next day, weather permitting, would be another at the floe edge; another day with dogs, raised from pups and harnessed to the* komatik *(sled) he'd made last winter with driftwood and pieces from the* Qallunaat's *(white person's) packing crates left behind the Hudson's Bay Post, three sleeps down the coast. It had been a tough winter. Bad storms (*uannaq*) had kept him away from the floe edge and the kudlik was burning low. It was a world, sometimes warm, but when not, still glowing with the satisfaction of things—skinning a seal or making new leads for the dog team—well done.*
>
> *It was the winter before the plane came, skimming across what had, only a few weeks before, been a small bay (*ikirasaq*) full of floating ice. It carried the Reverend Father and the* RCMP *[Royal Canadian Mounted Police] Constable who had come to take Peter away to the Qallunaat school. He had to go. No choice in the matter. Neither he nor his wife could stand the thought of Peter, four, maybe five sleeps away, learning—what? To make a decent harness for the dogs? To set a successful fox trap? To find the right snow for building a home?*
>
> *After a few months they followed where he'd gone. Now theirs was a government-supplied plywood home. The door didn't quite fit.*

> *When it opened, the outside came in with a vengeance. The space heater fought the icy draft; a losing battle. The floor was cold, the ceiling sweaty. Money was needed for rent and fuel. The* RCMP *officer who provided family allowances and the social assistance that paid the bills was to be feared—and respected. He was surrounded by all that was no longer needed: his skill with a snow knife, her way of rolling cotton grass wicks, and dogs. What to do with a team that was hard to feed; confused in the presence of Inuit they'd never responded to before, and viewed with suspicion by a rifle-toting Mountie, threatening to shoot if some means was not found to tie them up.*

This scenario captures one of the circumstances that brought Inuit into settlements and the feelings of 'being useless' that often accompanied the move. Commencing in 1949, the federal government introduced a policy of providing Inuit children with an education designed to prepare them for entry into modern Canadian society. Through the 1950s, Inuit parents were increasingly pressured to send their children to federal day schools and church-run residential facilities. Inuit parents often followed their children, fearing what might become of them, and not willing to trust their children to the hands of strangers. Inuit also moved because they could no longer make a living on the land. Following the Second World War, the price of Arctic fox pelts and the trapping economy collapsed (Tester and Kulchyski 1994).

There were other reasons for moves to the settlements. Epidemics of disease, notably, tuberculosis and bouts of measles, whooping cough, diphtheria, chicken pox and influenza, made being in the vicinity of a nursing station useful. By the late 1960s, the migration of Inuit off the land was virtually complete. Inuit went from their homes—tents, igloos, *qamaqs* (sod homes) and a landscape they knew well—to clustered shacks made of scrap building materials, often gleaned from dumps at American-built radar stations. One energetic public health officer, in 1957, after touring the Eastern Arctic aboard the *C. D. Howe*, making its yearly visit with supplies and a party of physicians, nurses, dentists and X-ray technicians to check on 'Eskimo' health, compared what he saw to the worst slums of India, where he had served in the past (Tester 2006).

The northern administration introduced its first housing policy for Inuit in 1959, providing rigid frame, plywood one-room houses of 192 square feet. The rigid frame design (incorporating unnecessarily sloped roofs) was soon replaced by a variety of flat-roofed homes,

affectionately known as matchboxes, a nickname reflecting their shape. The northern administration, fearing the 'dependency relations' that were imagined to develop should housing be given to Inuit, came up with a rent-to-own initiative. The houses cost about $1,500. Inuit were to pay $10 a month toward ownership, $500 being granted as a subsidy. Yet it cost about $50 a month to heat one of these units, and as a result few could keep up with the payments. As rent-to-own homes were converted to welfare units, record keeping became challenging. The units were poorly insulated and vented. They had no sanitary provisions other than a pail or 'honey bucket' lined with a green plastic garbage bag that was left outside when full. The water supply consisted of an indoor plastic tank that could be filled with water or ice to be melted down (Tester and Kulchyski 1994).

In Arviat (Eskimo Point), an epidemic of tuberculosis broke out in 1963 and was traced in large part to the appalling housing conditions (Moore 1964). Thirty-two percent of the community was ultimately evacuated to southern sanatoria for treatment. The cost was equivalent to providing the entire Eastern Arctic with three years' worth of housing. The rent-to-own policy was replaced in 1965 by the Eskimo Rental Housing Program. It provided Inuit with homes of up to three bedrooms with rent geared to income and house size and configuration to need. At the time, it was estimated that 1,600 homes were needed to properly house Inuit. In 1968, the federal government handed responsibility for the administration of social housing over to the Government of the Northwest Territories (GNWT). The GNWT integrated the initiative with a similar one in the Western Arctic and changed the name to the Northern Rental Housing Program.

Between 1968 and the present, housing policies in the Eastern Arctic have been marked by various attempts at encouraging home ownership. These policies have been costly, funnelling resources away from social housing (Hulchanski 1988), and have mostly failed to achieve their goals in the face of unsteady employment opportunities and low wages relative to the costs of housing. According to Statistics Canada 2006 census data, over 75 percent of households in Nunavut were renters. Commencing in 1981, Section 40 of the *National Housing Act* was used to fund public housing in the Northwest Territories. The Central Mortgage and Housing Corporation (CMHC) paid 75 percent of the capital costs of construction and 75 percent of the operating deficits. The capital cost provisions of this agreement were cancelled in 1993, and CMHC support for the maintenance of public housing is

to decline to zero by the year 2037. Between 1992 and 1997, the GNWT spent $160 million on 1,435 social housing units in an attempt to address the growing housing shortage (Bourgeois 1997). Yet, by 1997, shortly before the new territory of Nunavut was carved out of the Northwest Territories, an estimated 4,350 new units were needed to meet the Northwest Territories' social housing needs, including the replacement of old stock (Northwest Territories Housing Corporation 1997). The response of the Northwest Territories' finance minister was to inject even more funding ($40–$50 million) into another home ownership program (Bourgeois 1998).

By 1999, the newly formed government of Nunavut had an estimated list of 1,231 households waiting for social housing. The Nunavut Housing Corporation (NHC) was created in 2000 to create, administer and coordinate housing programs in the territory. The 1,231 Inuit households on the wait list confronting the newly formed corporation were distributed among fewer than 5,600 existing households (5,665 households were enumerated in the 2001 Aboriginal census for Nunavut two years later). Given that all materials must be imported from the south and designs must address Arctic conditions, the costs of Arctic construction are considerable. In 2006, the federal government provided Nunavut with $200 million to build some 725 new units of affordable housing through the Nunavut Housing Trust (OAG 2008), at an average cost of $275,000 per unit. Unexpected labour and material costs added another estimated $75,000 to the cost of each (Windeyer 2010b). No funds were allocated for the operation and maintenance of the units. The $350,000 price tag of these dwellings compared to the $16,069 median income for Inuit aged 15 years and older (Statistics Canada 2006) provides insight into the reasons the severely limited stock of social housing dominates housing options for residents of Nunavut. By September of 2010, it was estimated that the $200 million Trust program set up to address the considerable social housing needs of Nunavummiut was $110 million over budget (Windeyer 2010a).

Dimensions of Homelessness

Prominent definitions of homelessness, such as that offered by the United Nations, emphasize physical shelter from the elements in a unit meant for human habitation and a secure location for one's possessions so they need not be carried from place to place (Hill 1991;

Springer 2000; United Nations 1998). These often become working definitions for surveys of homelessness, focused on where people last slept or what services they've used (Peressini, McDonald and Hulchanski 1995). These definitions may be broadened to incorporate those living in inadequate shelter, usually defined with reference to tenure and physical security, privacy, space, basic services (water supply, sanitation, etc.) and affordability (Springer 2000).

In the Canadian context, being defined by CMHC as in "Core Housing Need" incorporates aspects of affordability, suitability (having enough bedrooms given household composition) and adequacy or state of repair (CMHC 2009a). Households are counted as being in core housing need if they do not meet the minimum thresholds for affordability, suitability and adequacy and are unable to afford local accommodation that meets these thresholds. According to these criteria an estimated 12.7 percent of households across all households in Canada and an estimated 44.7 percent of Inuit households in Nunavut in 20065 (CMHC 2009a) are in core housing need.[1] Those in core housing need and currently spending at least half their income on shelter costs have been identified as at risk of homelessness (Fiedler, Schuurman and Hyndman 2006).

While affordability drives the prevalence of core housing need in most parts of Canada, suitability is clearly the main driver in Nunavut. The measurement of suitability emphasizes privacy, home as a sanctuary and having a room of one's own (Lauster and Tester 2010). 'Home' has also acquired broad meanings as a symbol and stage for making claims to social belonging and inclusion (Hopper 1997; Mallett 2004). In this sense, acquiring a home may be related to the development of family and adult identity (Goldscheider and Goldscheider 1999; Lauster 2006). Together, the ideas of home as sanctuary and home as symbol relate to Goffman's notions of the back stages and front stages required for putting on successful social performances (Goffman 1959). In effect, people are always performing social roles for one another and they need spaces to both prepare their performances and to enact them. In this sense, home is a meaning-making tool. Correspondingly, being homeless means being unable to put on successful social performances, resulting in stigmatization and a sense of meaninglessness. Home as belonging is also tied to a sense of community and country, locating people in a homeland and way of life (Mallett 2004).

As varying definitions serve to indicate, the idea of 'home' used to define 'homelessness' remains highly subjective, often contested, malleable in definition and strongly dependent upon context (Hopper 1997; Kellett and Moore 2003; Mallett 2004). The ambiguity of the concept has driven at least one researcher to suggest replacing homelessness with 'houselessness' as a social problem, privileging more objective measures of shelter as definitional in order to enable cross-cultural comparisons (Springer 2000). Yet both what is seen as a problematic housing circumstance and what is seen as home are necessarily culturally specific. Consequently, we suggest that the best way to account for cultural difference in understandings of homelessness is not to ignore difference but to ask people in varying contexts about the problems they face in feeling at home throughout their daily lives.

In this sense we define homelessness as multidimensional, corresponding to problems in achieving various subjective experiences of feeling at home. From the literature reviewed above, we take the experiences of feeling at home to mean feeling: (1) sheltered from the elements, (2) physically secure, (3) secure in the storage of one's possessions, (4) secure in one's privacy, (5) a sense of belonging and meaning and (6) a connection to one's homeland. We define problems encountered in producing these feelings as problems of homelessness. Below we apply this understanding of dimensions of homelessness to the lived experience of Inuit in Nunavut, taking into account the crucial importance of cultural context, to estimate the prevalence and impact of homelessness.

The Experience of Homelessness in the Eastern Arctic: The Kinngait Harvest Society Survey

Given the sketch of homelessness above, we use the results of a community-developed survey in Kinngait, Nunavut (formerly Cape Dorset) to estimate the prevalence of different forms of homelessness in the Eastern Arctic and to understand their relationships with health. Kinngait is one of 25 communities making up Nunavut, and in 2006 it contained just over 4 percent of the territory's population (1,236 people). It is located in the southwest corner of Baffin Island (Qikiqtani). According to the most recent census, over 90 percent of the community's population is Inuit. Approximately 85 percent of the housing is rented social housing. The official unemployment

rate was high in 2006, at 25.3 percent, and the median annual income for Inuit members of the community, age 15 and older, was $12,672. Median household incomes were higher at $35,200, but still far below the median for the country as a whole ($52,634).

In 2005, researcher Frank Tester worked with community members from Kinngait to create and administer a questionnaire exploring the housing situations and the physical and mental health of residents. Sampling for the survey was stratified by categories of age, sex, family status (couple vs. single) and position on a housing waiting list. Households in the community were numbered and selected randomly until a household with a member meeting stratification criteria was found. That member was selected to be interviewed in the survey and the household was not replaced. As a result, some 91 residents of Kinngait (age 15 and older) were surveyed, reflecting 91 different households in the community. Overall, the sample is somewhat younger and more dominated by women than both the population of Kinngait and Nunavut as a whole, though it also has a slightly higher representation of residents over age 55. Census estimates for age–sex categories allow the sample to be re-weighted to correspond to the population distribution in Nunavut, and these results are reported in the analyses that follow, where indicated. The sample proportion in common-law and marital unions (49%) lies between the proportion reported in the 2006 census for Kinngait (47%) and for Nunavut as a whole (52%). Similarly, the sample proportion drawn from the waiting lists (14.3%) lies between that of the proportion of Inuit (15 years or older) on the waiting list estimated for Kinngait (12.2%), and the proportion estimated for Nunavut as a whole (using 1999 estimates, this would be approximately 15.9%).[2]

Community participation in the design of the survey incorporated local understandings of both the meaning of home and the related problems associated with feeling at home. Given the hunting culture of Inuit and that many Inuit lived on the land until the mid-1960s, we suggest a connection to one's homeland is especially important in the Eastern Arctic. The capacity to return to the land and a more traditional way of living away from settlements—spending summer and even long winter periods out of settlements and in cabins scattered along the coast in areas traditionally occupied—helps many Inuit "feel better" and "at home". Table 4-1 details the survey responses as they relate to these problems. The nature of the survey, based in local experience, helped avoid situations where language

Table 4-1. Homelessness dimensions as measured by equivalent survey item responses

Homelessness Dimension	Equivalent Survey Responses
Lack shelter from elements	"I need a different house because it's too wet here" or "this house is cold or very cold, causing sickness or making us stay at someone else's house"
Lack physical security	"I do not sleep at home because of problems at home, or because I have nowhere to sleep there" or "violence is a problem related to my housing circumstance"
Lack security for possessions	"Someone sold furniture/appliances/equipment from house because of gambling, drug use, drinking, needing $ for food, etc."
Lack privacy	"I never have time alone or privacy"
Lack belonging	"Someone in my house needs to have a house of their own" or "I don't have a bedroom / sleep on the couch, etc."
Lack access to land	"I lack the equipment I need to get out on the land, and it is not okay"

and concepts imported from southern Canada fail to make sense to local residents and broadened the range of topics considered, to include culturally specific concerns. A fuller description of the survey design is available in the report *Iglutaq: The Implications of Homelessness for Inuit* by Tester and the Harvest Society (2006).

Measurement and Prevalence of Experiences of Homelessness

The extreme weather of the Arctic climate means that occupying a dwelling meant for human habitation, including a roof and walls, may not be enough to fully protect one from the elements, especially the cold and wet. Thirty-three percent of the respondents felt a lack of protection from the elements by these measurements, roughly matching the census estimates of 29 percent of occupied units in Kinngait needing major repairs in 2006 (Statistics Canada 2006). This compares to 23 percent of Nunavut's Aboriginal households as a whole needing major repairs in the CMHC estimate (CMHC 2009b).

We interpret physical security to mean having a stable place to stay, especially to sleep, where one can feel safe. Many Inuit reported sleeping away from home simply because they felt like it, reflecting

the cultural flexibility of sleep arrangements for Inuit households and the difficulty of applying measurements of household suitability derived from elsewhere (Lauster and Tester 2010). But others reported sleeping away from home because of problems or lack of space, or they otherwise reported violence as a problem at home. Altogether, some 15 percent of the sample felt a lack of physical security according to these measurements. Given that recent data on the rate of violent crime in Nunavut is over eight times the Canadian average (Statistics Canada 2006), it may not be surprising that nearly one-sixth of the sample feels a lack of physical security in their housing situation.

Rates of breaking and entering are about four times higher in Nunavut than for Canada as a whole (Tester and the Harvest Society 2006), but we have little data on experience with breaking and entering from the survey. Instead, we have data on whether or not a household member has ever sold any "furniture, appliances, or equipment" from the respondent's house because of various immediate needs. Living in a household where household items needed for daily living might be sold at any time to cover costs for any of the items listed (and needing money for food was by far the most commonly reported reasons) constitutes a problem, leaving residents feeling insecure about their tenure. This possibility affected 32 percent of the sample respondents.

Given the widely acknowledged residential crowding in Nunavut, it is unsurprising that many Inuit reported feeling a lack of privacy. The survey asked those reporting that their housing situation was crowded, what problems this made for them. Those responding with "I never have time alone or privacy" as a problem were considered to be lacking in privacy, including 33 percent of the sample.

To measure lacking belonging, we focus on someone in a household being seen as needing a place of their own as a potential indicator of the lack of an opportunity to define oneself and, consequently, to belong to a family or community as both a member and contributing individual. Such individuals do not 'fit' in the household in some way, either because they are seen by other household members to be old enough to have their own place or because they make too much noise, they argue too much with a romantic partner, they are lazy, they disrespect their elders or some other reason. The sense of lack of belonging generated by this bad fit creates a feeling of homelessness, both for the household member who does not seem

to fit, and for other household members who must deal with them, often being denied the respect they feel they should be accorded in the process. In the case of those old enough to have a place of their own, the lack of belonging is double-edged. By being denied a place of their own, they are also denied a place in the world of adults befitting their age. As a separate indicator of those not 'fitting' into a household, we include as lacking belonging those who do not have a clear space of their own in their housing situation, sleeping on the couch, the floor or some other location. In total, some 40 percent of the sample experienced a lack of belonging defined in these ways. This is the most prevalent form of homelessness we record, likely linked to the long waiting lists for public housing units across all Nunavut communities.

Finally, we consider the lack of access to the land as a dimension of homelessness for Inuit. Inuit are a hunting culture and despite attempts at acculturation, Inuit identity and social relations are still tied to hunting and 'life on the land'. Some 25 percent of the sample, mostly older respondents, indicated that they lived on the land before moving into the community. The land also supports a traditional way of life and the historic sources of food important to Inuit culture. Over 5 percent of Inuit reported returning to living on the land for a while since first moving to the settlement, either for better hunting, because they thought the traditional way of living was better or they missed it or because they simply wanted to get away from the community. However, it takes special equipment to get out onto the land. Respondents were asked whether or not they had the equipment needed to get out onto the land. Of the 36 percent of respondents who did not have the equipment, some reported feeling "okay" about not being able to go out. We considered those who did not feel "okay" about not having the equipment to get out on the land as lacking access to the land.

Table 4-2 provides estimates of the prevalence of homelessness by these various measures. An estimate of the percentage of households in core housing need is also included in this table. Data from the survey do not allow an easy calculation of affordability for the sample. But the *Canadian Housing Observer* estimates for core housing needs in Nunavut indicate that this is the least important criteria for the territory (despite being the most important criteria determining housing needs in every province in Canada). The sample estimate of core housing needs is drawn from questions about household

Table 4-2. Estimates of homelessness prevalence by dimension amongst those over age 15

	Sample *n*	Sample %	Est. Nunavut %	Est. Nunavut *n*	*95% CI Low*	*95% CI High*
Lack shelter from elements	30	33%	35%	5,429	*3,768*	*7,477*
Lack physical security	14	15%	17%	2,584	*870*	*3,606*
Lack security for possessions	29	32%	36%	5,638	*3,925*	*7,753*
Lack privacy	30	33%	35%	5,372	*3,752*	*7,371*
Lack belonging	36	40%	42%	6,446	*4,357*	*8,119*
Lack access to land	28	31%	31%	4,807	*3,082*	*6,651*
Core housing need*	40	44%	44.7%	2,600	*	*

*Core housing need refers to % of Inuit households rather than % of individuals. Estimated Nunavut data on core housing needs drawn from the *Canadian Housing Observer.*
Source: "Characteristics of Households in Core Housing Need, Nunavut, 2006" (CMHC, 2009b). No confidence intervals are provided, though estimates are based on approximately 1 in 5 household census sampling.

composition and bedroom numbers, taking a conservative estimate of the number of bedrooms required to meet Canadian National Occupancy Standards given the age and relationship status of household members (suitability), and questions about whether or not respondents need a new dwelling because of repair issues involving their current dwelling (adequacy). Overall, the sample estimate of those in core housing need matches well with the territorial estimates provided by the *Canadian Housing Observer* (CMHC 2009b).

Both estimates (sample and territorial) of core housing need suggest that the size of the at-risk-of-homelessness population, as may be currently considered by policy-makers, is higher than any single dimension of homelessness discussed above. However, considering that the coincidence of dimensions, as in Table 4-3, suggests that overall most Inuit—an astounding 87 percent—are likely to experience some dimension of homelessness, with about 30 percent experiencing three or more dimensions of homelessness. As a result, policy-makers are likely to underestimate the prevalence of homelessness amongst the Inuit. Notably, the dimensions of homelessness measured here tend to be positively correlated with one another, but

Table 4-3. Coincidence of homelessness dimensions (homelessness index alpha = 0.396)

	Sample *n*	Sample %	Est. Nunavut %	Est. Nunavut *n*
Lacking nothing	11	12%	13%	1,956
Lacking 1 item	35	38%	34%	5,317
Lacking 2 items	20	22%	22%	3,440
Lacking 3 items	15	16%	16%	2,540
Lacking 4 items	4	4%	6%	953
Lacking 5 items	5	5%	8%	1,178
Lacking all items	1	1%	1%	126

the correlations are not high (the highest is 0.27). Creating an index of homelessness by combining dimensions provides an overall alpha that's relatively low (0.396) indicating that different dimensions are indeed being tapped by each indicator.

All homelessness dimensions except for 'Lacking shelter' and 'Lacking access to the land' are positively and significantly ($p < 0.05$) correlated with being in core housing need, but again the correlations are relatively low (the highest is 0.27). As in Table 4-4, combining all the dimensions into the single homelessness index yields a higher and statistically significant correlation of 0.38 to core housing needs, but the relationship between experiential measures of homelessness and core housing need measures indicates that much of the experience of homelessness in the Eastern Arctic is currently not being accounted for by CMHC measures. Other seemingly objective crowding measures (also included in Table 4-4) perform similarly or worse, failing to capture the full range of the homelessness problem in Nunavut, as described above. Survey respondents were asked directly about whether or not they subjectively felt they lived in a crowded house. For the 47 percent of respondents who felt they lived in crowded circumstances, over a third (35%) indicated they had no problems with it. A substantial minority (18%) of those experiencing crowding said they even liked having all the people around. Crowding is clearly a primary driver of the high prevalence of homelessness amongst Inuit, but the experience of homelessness is not entirely about crowding, nor is it fully captured by culturally ignorant measures of the phenomenon that fail to take into account Inuit experience (Lauster and Tester 2010).

Table 4-4. Other measures of housing need and crowding from survey (weighted to Nunavut age/sex distribution)

	Mean	Std. Dev.	Min.	Max.	Correlation to Homelessness Index
Core housing need	0.50	0.50	0	1	0.38***
Bedrooms needed (CNOS)	0.60	1.17	−2	4	0.43***
Occupant to bedroom ratio	1.95	0.82	0.5	5	0.32***
Number sharing bedroom*	1.13	1.01	0	4	0.15

*Other than partner.

Homelessness and Health in the Eastern Arctic

A number of studies have linked crowding and aspects of housing situations in the Canadian North to health issues. Most prominently, researchers have linked tuberculosis (Clark, Riben and Nowgesic 2002; Lodge et al. 2006) and respiratory infections in children (Kovesi and Gilbert 2007) to housing circumstances and crowding. A larger literature has also linked psychological distress to crowding (Evans 2003). Here we extend this work by exploring the link between dimensions of homelessness and a more diverse set of health-related outcomes, as reported by respondents.

The survey asked, broadly, about various indicators of the health of Inuit respondents. In particular, the survey identified a set of ailments understood within the community to be health related and asked respondents whether or not they experienced them. The survey also asked about encounters with other key problems. Items are listed in Table 4-5. The separate items within each list were added together to create a health issue index (combining the former items, $\alpha = 0.7018$) and a more general problem index (combining the latter items, $\alpha = 0.4275$). Separate items and combined indices were subjected to a correlation analysis with dimensions of homelessness and the homelessness index, as well as with the indicator for core housing needs. Table 4-6 reveals the significant correlations emerging from this analysis corresponding to each measure of homelessness. In all cases, correlations to health issues and problems are positive.

Notably, every dimension of homelessness is significantly correlated with a set of health conditions and related problems. Moreover, each of the problem sets associated with different dimensions of homelessness is unique to that dimension. The problem index, obtained by

Table 4-5. Items measuring health conditions and related problems

Health Conditions	Related Problems
Do you get cold sores?	Do you have any problems with:
Do you get the flu?	Drinking?
Do you get colds and coughs?	Violence?
Do you have tuberculosis?	Depression?
Do you have cramped muscles or body pain?	Drug use?
Do you have poor sleep?	Problems with school?
Do you have skin problems?	Problems with work?
Do you suffer from stress?	People being angry?
Do you get migraines or headaches?	
Do you have other health conditions?	

combining the items of problems with drinking, violence, depression, drug use, problems with school, problems with work and people being angry, was significantly associated with all dimensions of homelessness. By contrast, the health issue index was not associated with all dimensions of homelessness but seemed at least marginally related to lacking security of possessions, lacking privacy and lacking access to the land. Combining every dimension of homelessness together into a single index produced particularly powerful relationships to the broadest swath of problems and issues raised by respondents. Higher scores on the homelessness index were correlated with experiencing cold sores, flu, poor sleep, drinking, violence, depression, drug use, school problems and problems with people being angry. In this way, the homelessness index proved far more comprehensive than the measure of core housing need derived from the survey as roughly equivalent to CMHC measurements. Again, the core housing needs designation seems to capture some of the issues related to homelessness in Nunavut, but by no means all of them.

The significant positive correlation between the homelessness index and both the health issues index and the problem index (treated as dependent variables) persists after controlling for age, gender, presence of a partner, presence of children and schooling in OLS regression models (not shown here). By contrast, when our measure of core housing needs is introduced in the model, it does not attain significance, but the significant effect of the homelessness

Table 4-6. Links between homelessness measures and health conditions or related problems

	Significantly Positive Correlations
Lack shelter from elements	problem index, headaches, other health issues, *stress, depression, drug use*
Lack physical security	problem index, cold sores, violence*, drug use, *drinking, depression, anger*
Lack security for possessions	problem index, violence, drug use, school problems, *health issue index, cold sores, drinking*
Lack privacy	problem index, poor sleep, depression, *health issue index, school problems*
Lack belonging	problem index, drinking, violence, drug use
Lack access to land	problem index, violence, poor sleep, depression, work problems, anger, *health issue index, drinking*
Homelessness index	health issue index, problem index, cold sores, poor sleep, drinking, violence*, depression, drug use, school problems, anger, *flu*
Core housing need	health issue index, problem index, poor sleep, school problems, *flu*

Note: Italicized health-related problems are marginal ($0.05 < p < 0.10$) in the significance of their correlation.

*Listing violence as a problem related to housing is included as part of the definition of homelessness in this case.

index remains. Including each dimension of homelessness separately in regression models, treating the problem index as the dependent variable, indicates that each retains significance by itself and almost all retain significance in combination with one another. However, when treating the health issue index as the dependent variable, separate dimensions of homelessness do not attain significance. Overall, multivariate regression results support the significance of the bivariate correlations shown here and are available from the first author upon request.

Community Perceptions of Links between Homelessness and Health

Finally, respondents in the survey were also asked directly whether or not they thought any of their health issues related to their housing circumstances. Table 4-6 summarizes the results. Headaches and tuberculosis were experienced by a very small portion of respondents

but were readily linked to housing situations by those respondents. Of more common ailments, poor sleep and stress were most often linked to housing situations, but all health issues were linked to housing situations by at least some respondents. A similar question was asked about overall health, linked more specifically to whether or not respondents felt their health would be better with more space. Over half of respondents (57% weighted to Nunavut distributions) felt that their health would improve with more space.

Table 4-7 summarizes similar results for other problems. Here the wording of the question about links to housing situation was

Table 4-7. Links between health conditions and housing situation, as perceived by respondents (weighted to Nunavut age/sex distribution)

	% Experiencing	Of Those Experiencing, % Linking to Housing
Cold Sores	20.3%	20.0%
Flu	46.9%	33.1%
Tuberculosis	3.6%	48.0%
Cramps/Pains	30.2%	14.0%
Poor Sleep	28.6%	67.1%
Skin Issues	7.4%	21.8%
Stress	35.5%	48.0%
Headaches	2.9%	100.0%
Other Health	8.0%	37.0%

Table 4-8. Links between related problems and the number of people in the house, as perceived by respondents (weighted to Nunavut age/sex distribution)

	% Experiencing	Of those Experiencing, % Linking to Number of People in House
Drinking	6.8%	70.4%
Violence	10.1%	78.8%
Depression	12.4%	49.4%
Drug Use	20.3%	20.5%
School Problems	17.4%	54.2%
Work Problems	8.8%	61.1%
People Being Angry	25.6%	51.6%

closely tied to whether or not fewer people in the house would help the problem. Overall, problems were more consistently linked to housing situation than health issues. Problems with violence were most often thought to be fixable with fewer people in the house (over four-fifths of respondents experiencing problems with violence felt this way). By contrast, only about a fifth of respondents felt drug use problems would be fixed by fewer people.

Conclusions

By all reliable accounts there is a housing crisis in Nunavut. The territory has the highest rate of core housing needs in Canada, well over twice its nearest competitor, the Northwest Territories (CMHC 2009a). Our analyses estimate that a shocking 87 percent of Inuit experience some form of homelessness, dimensions of which are strongly tied to the housing crisis. Dimensions of homelessness are also strongly correlated with a wide range of health problems. The costs associated with building and maintaining enough decent and affordable housing in the Eastern Arctic to ease the housing crisis have often been far outweighed by the costs of dealing with the various health problems associated with homelessness.

At the same time, the ways in which the lack of housing in Nunavut affects people are not quite the same as the way the housing crisis is measured by estimates of core housing need. Those in core housing need are often treated as being at risk of homelessness (Fiedler, Schuurman and Hyndman 2006). In the case of Inuit living in Nunavut, we suggest that most of those classified as being in core housing need are, in fact, experiencing multiple dimensions of homelessness. Strikingly, this is also true for many Nunavut residents who would not be considered in core housing need.

In Nunavut, homelessness is the result of a particular history of displacement, as well as a history of inadequate resources for housing, mapped onto a shifting cultural definition of home. Thinking about homelessness in terms of various dimensions of the meaning of home provides a powerful way to incorporate history and culture into definitions. The result of Nunavut's history and culture is that sizable portions of the population of Nunavut feel they lack shelter, security, a place to store their property, privacy, a sense of belonging and any way to feel connected to their ancestral lands and the way of life that makes them feel Inuit. In a very real sense, these are the

dimensions of homelessness of relevance to the Inuit population of Nunavut. The housing problems of Nunavut are rooted in material circumstance, but these material circumstances, in turn, are culturally interpreted as they are experienced in everyday life.

Each of the dimensions of homelessness we specify and attempt to measure here were correlated with aspects of health and well-being. Each of the dimensions also remained distinct from the other dimensions of homelessness measured. It seems clear that homelessness is a multifaceted experience, at least in the context of the Eastern Arctic.

We provide only rough estimates of the size of the population in Nunavut experiencing homelessness. These estimates come with many qualifications, especially since we attempt to generalize from the experiences recorded in only one of Nunavut's 25 communities. Nevertheless, we argue that the survey analyzed here provides valuable results for the study of homelessness in Nunavut. We suggest that one of the problems encountered in studying relationships between homelessness and health is the lack of attention provided to how culture matters. The experience of home and problems associated with achieving it are culturally mediated, as ultimately are experiences of health. One particularly valuable aspect of the survey analyzed here is that it was constructed with significant input from the community members being studied. As a result, the findings of the survey better reflect local understandings of homelessness and health than would be the case for a survey designed without this input.

This is a direction that needs to be pursued further. Since the NHC was created in 2000, there have been a number of detailed studies of housing in Nunavut territory. These include the 2009–2010 Nunavut Housing Needs Survey and a report on the NHC prepared by the Auditor General of Canada and released in May of 2008. These documents do a credible job of detailing the extent of overcrowding noted in the report used to frame this chapter. The statistical information collected in these studies meets primarily the managerial needs of the NHC. Their findings are important. The recommendations made by the Auditor General of Canada include: improved training for the local housing authorities responsible for total management of social housing at the community level, ensuring that the rating system for determining priorities in the provision of social housing are actually applied, taking steps to ensure that eligibility criteria

are met and updating manuals and procedures and ensuring that proper procedures are followed in maintaining and reporting on the condition of social housing stock. These are all important to making the existing system work better.

But the Inuit experience of home—what it is, how it works, what it means, how its provision might be changed and improved—merits more attention. The research presented in this chapter attempts to moves in this direction. The Nunavut housing situation is characterized by considerable need and inadequate resources. The withdrawal of CMHC maintenance funds for social housing over the next 25 years will place considerable additional financial pressure on the NHC. A report prepared by the Government of Nunavut and Nunavut Tunngavik Incorporated (2004) estimates that it would take the unlikely sum of $1.9 billion invested between 2006 and 2016 to bring housing in Nunavut up to Canadian standards. This is an unlikely investment, suggesting the need for a radically different approach to dealing with overcrowding (homelessness) in Nunavut. If 'home' is about meaning-making and belonging, if self-esteem is tied to what one accomplishes in the creation and management of space, then Inuit need both the pride and responsibility of 'ownership' in a situation where conventional ideas about ownership are unrealistic. These considerations suggests the merit of exploring radically redesigned cooperative or co-housing associations, perhaps defined in relation to extended family units involving otherwise unemployed coop members in construction, management and maintenance of units for which they have a budget and responsibility, with the NHC providing technical, managerial and related assistance. While the details and complexities of such a program are considerable, the current social housing program operating in Nunavut is unsustainable, suggesting that alternatives integrating social, cultural and health—as well as conventionally understood space-related needs—are in order.

Notes

1. Only 12.9% of non-Inuit households in Nunavut experienced core housing need in 2006.
2. Assuming approximately two persons per household on the waiting list.

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CHAPTER 5

Homeless Immigrants' and Refugees' Health over Time

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Introduction

Gaps in health research in Canada have been noted with regard to both persons who have experienced homelessness (Frankish, Hwang and Quantz 2005) and immigrants and refugees (Beiser 2005; Dunn and Dyck 2000). Recently, some investigations have reported research on immigrants and refugees who have been homeless (Chui et al. 2009; Kappel Ramji 2002; Klodawsky et al. 2005, 2007; Paradis et al. 2008). In particular, Chui and colleagues' (2009) Toronto-based research on the health of homeless immigrants is the first peer-reviewed published research on this topic in Canada. One important question investigated in that article is whether the *healthy immigrant effect*, as noted more generally among Canada's newcomer populations, is relevant to homeless immigrants. The healthy immigrant effect is a tendency among newcomers to arrive in Canada (or the United States) healthier than their native-born peers but then for their health status to decline in proportion to the time spent as an immigrant (Ali, McDermott and Gravel 2004; Argeseanu Cunningham, Ruben and Narayan 2008; Beiser 2005; Dey and Lucas 2006; Fennelly 2007; Huh, Prause and Dooley 2008; McDonald and Kennedy 2004; Newbold 2005; Singh and Hiatt 2006). Reasons for the decline remain unclear. Explanations range from adopting lifestyles that are less healthy than those practiced in the country of origin to the adverse

impact of stress related to discrimination, poverty and/or unexpected difficulties in finding suitable employment (Simich et al. 2005; Singh and Hiatt 2006). Some researchers also highlight the need to further explore the ways that the heterogeneity of immigrant backgrounds and characteristics intersects with health status, health service utilization and changes over time (Ali, McDermott and Gravel 2004; Argeseanu Cunningham, Ruben and Narayan 2008; Beiser 2005; Castro 2008; Dunn and Dyck 2000).

Chui and colleagues' analysis confirms that the healthy immigrant effect is also relevant to Toronto's homeless population, with recent immigrants being "physically and mentally healthier and less likely to have chronic conditions and substance use problems than native-born homeless individuals" (2009: 946). They note the significance of length of time since entry to Canada: "the health status of homeless individuals who immigrated more than 10 years ago is not significantly different from that of homeless non-immigrants" (946). That study is significant in that it was based on a large, representative sample of English-speaking homeless immigrants and native-born homeless persons in Toronto. Limitations include its cross-sectional nature and its inability to include refugees and immigrants who were not able to complete the survey in English.

The primary goal of this chapter is to contribute further insights to that of Chui and colleagues (2009) as well as other Canadian health research about immigrants and refugees that have experienced homelessness. Here, we report on an analysis of responses by both foreign-born and Canadian-born participants who were homeless in 2002 or 2003 and who were participants in a longitudinal study in Ottawa, Ontario: the Panel Study on Homelessness in Ottawa. The Panel Study's objective was to examine the diversity of pathways that lead people into and out of homelessness over time by following a mixed group of individuals and adults with children in Ottawa who were homeless at the beginning of the study. Additional goals were to explain factors that distinguished those who successfully exited homelessness from those who remained homeless or experienced multiple episodes of homelessness and to assess the impacts of their pathways on health (Aubry et al. 2003, 2007; Klodawsky et al. 2007). The Panel Study offers a unique opportunity to contribute knowledge about changes over time in homeless immigrants' and refugees' health status and about their use of health services in a mid-sized Canadian city. It is one of only a few Canadian longitudinal studies

having to do with people who have been homeless, and it is the only extant study that offers the opportunity to examine what happens to homeless immigrants and refugees over time.

Methods

Setting and Study Population

Ottawa is Canada's national capital and fourth largest city, with about 1 million people located in the census metropolitan area (which includes Gatineau, Quebec). The City of Ottawa has become an attractive alternative to Toronto, Montreal and Vancouver for many newcomers. Between 1996 and 2001, Ottawa's immigrant population grew at almost twice the rate of its Canadian-born population. The 2009 report of the Community Foundation of Ottawa (CFO) observed that "foreign-born persons accounted for 22.3 percent of Ottawa's population, or 178,545 persons in 2006 compared to 21.8 percent in 2001" (CFO 2009: 3). The report also highlighted a growing gap between rich and poor, the high cost of housing and health deficiencies as areas of concern that required particular attention (CFO 2009).

The Panel Study researchers defined being homeless in a manner consistent with other North American academic literature (Susser, Moore and Link 1993) and the City of Ottawa's municipal government: "a situation in which an individual or family has no housing at all, or is staying in a temporary form of shelter" (Region of Ottawa-Carleton 1999: 2). Based on research indicating that the overwhelming majority of homeless adults in Ottawa used emergency shelters at some point (Farrell, Aubry and Reissing 2002), we decided to recruit adult participants from the emergency shelters. On the other hand, because use of emergency shelters by homeless youth was more variable (Farrell, Aubry and Reissing 2002), we specified that half the sample would be drawn from among those who were using homeless services, such as drop-ins, but were not staying in an emergency shelter.

The Panel Study's interest was in capturing a diversity of experiences of individuals who had been homeless rather than in capturing a representative sample of Ottawa's homeless population overall. As a result, we sought a representative sample from within each of five equal-sized groups of individuals who were homeless at the time of the first set of interviews: adult men, adult women, male youth, female youth and adults accompanied by at least one child under 16. Within each group, the sampling frame was based

on available emergency shelter data. Sampling criteria were established as follows: length of stay, in the case of adult women and men; and citizenship status, in the case of adult women and adults with at least one child under 16. After assessing the available data, we specified that 40 percent of adults with children and 25 percent of adult women for the study would not be Canadian citizens and that cultural interpretation would be offered to reduce the likelihood of language as a barrier to being interviewed. Selective sampling was not required in the case of youth: we were able to interview all male and female youth who were eligible and who accepted an invitation to participate (see Table 5-1).

Four hundred and twelve face-to-face interviews took place between October 2002 and June 2003, and 255 individuals were interviewed again between October 2004 and June 2005. At baseline, 99 respondents were foreign-born, and 58 of them participated in follow-up interviews. The baseline interviews were carried out by 11 trained interviewers with a background in clinical psychology and/or experience in working with homeless people. These interviewers conducted 356 interviews in English, 30 in French and 14 in Somali. The services of cultural interpreters were used for 16 additional interviews (Somali, 4; Arabic, 5; Spanish, 3; Cantonese, 1;

Table 5-1. Overview of panel study subgroups, sampling criteria, number of recruitment sites and baseline and follow-up sample size

Subgroup	Size of Baseline Sample (2002–2003)	Sampling Criteria	Number of Shelters and Drop-in Facilities* Involved in Recruitment	Size of Follow-up Sample (2004–2005)
Adult Men	88	length of stay	4	43
Adult Women	85	length of stay citizenship	14	55
Male Youth	79	population	5	50
Female Youth	81	population	5	49
Adults with Children	83	citizenship	7	58
TOTAL:	412			255

*Youth were recruited at shelters and drop-in facilities in equal numbers.

Lingala, 1; Russian, 1; and Ukrainian, 1). At follow-up, there were 221 interviews in English, 13 in French and 13 in Somali. The services of cultural interpreters were used for eight other interviews (Arabic, 4; Spanish, 2; Somali, 1; and Cantonese, 1). Their countries of origin are summarized in Table 5-2.

Interview Protocol and Content

Managers at the emergency shelters and drop-in centres that we visited and consulted with were very enthusiastic about the study. Their support was vital to the study's success since respondents were recruited with the help of staff at these facilities, who were the first point of contact. Interviewers followed up staff referrals and explained to potential respondents the purpose of the study and its informed consent provisions (as approved by the University of Ottawa Research Ethics Board for the Humanities and Social Sciences). Shelter staff also facilitated the availability of private interview spaces at the shelters. At follow-up, respondents were contacted directly by specially trained 'trackers'. In some cases, these trackers arranged interviews in advance but in many instances, the trackers conducted the interviews themselves as quickly as possible after contact had been made with an interested respondent.

These interviews took place in private spaces in a variety of locations, including community centres, emergency shelters and offices at the Centre for Research on Community Services at the University of Ottawa. The trackers contacted respondents on the basis of information gleaned from a variety of means that had been approved by respondents at baseline, including address and telephone contact information obtained through the City of Ottawa's Ontario Works files or from family and friends (Aubry et al. 2004). Typically, each interview took between 50 and 150 minutes, with an average length of about 75 minutes. At follow-up, 36 follow-up interviews took place over the phone with individuals who no longer lived in Ottawa. These interviews tended to be about 20 minutes longer than the face-to-face interviews. Individuals were paid an honorarium of $10 for the first interview and $20 for the second interview.

The interview instruments consisted of both quantitative and qualitative measures. To assess respondents' self-reported health status, we relied on a widely used instrument called the SF-36. This instrument provided a measure of physical health and mental health relative to the US general population, matched on the basis of

Table 5-2. Country of origin of foreign-born respondents

Country of Origin	Foreign-Born Respondents (*n* = 98)	Immigrants (*n* = 45)	Refugees (*n* = 53)
Somalia	22	6	16
United States	8	8	
Haiti	6	5	1
Unknown/Missing	6	4	2
Rwanda	5		5
Djibouti	4		4
Zaire	3	2	1
Ethiopia	3	1	2
Columbia	3		3
Congo, Dem. Rep. of	3		3
Burundi	2		2
Italy	2	1	1
Kenya	2		2
Lebanon	2	1	1
Palestine	2		2
Philippines	2	1	1
Ukraine	2	2	
Africa (unspecified)	1		1
Angola	1	1	
Armenia	1	1	
Burkina Faso	1		1
China	1	1	
Congo, Republic of	1		1
England	1	1	
Eritrea	1		1
Guatemala	1		1
India	1	1	
Kuwait	1	1	
Poland	1	1	
Saudi Arabia	1		1
Scotland	1	1	
Singapore	1	1	
South Korea	1	1	

Table 5-2. (Continued)

Country of Origin	Foreign-Born Respondents (*n* = 98)	Immigrants (*n* = 45)	Refugees (*n* = 53)
Sudan	1	1	
The Gambia	1		1
Trinidad	1	1	
Vietnam	1	1	
Yemen	1	1	

age and sex (Ware, Kosinski and Gandek 2002). We also asked a series of questions about chronic conditions and injuries that were part of the National Population Health Survey, a longitudinal survey of over 17,000 households across Canada about the current state of health, contact with health-related service providers and health care needs. To this we added questions about other physical health and mental health chronic conditions that were likely relevant to a population that had experienced homelessness. In order to assess the extent and severity of alcohol and drug use problems, we relied on CAGE, a four-item scale identifying the presence of alcohol use problems (Chan, Pristach and Welte 1994; Mayfield, McLeod and Hall 1974) and the Drug Abuse Screening Test (DAST), a 20-item scale identifying the presence of drug use problems (Skinner 1982). Qualitative measures were created and integrated into the interview protocol in order to provide more in-depth information and to provide participants with an opportunity to share their experiences and perceptions.

In the baseline interviews, we asked respondents whether they were Canadian citizens and whether they had been born in Canada. For those born elsewhere, we also asked when they had arrived in Canada and in Ottawa, and why they moved to Canada. During the course of an investigation of the baseline results in which we compared Canadian-born and foreign-born respondents, we realized that an important question had been missed, having to do with whether respondents had arrived as immigrants or as refugees (Klodawsky et al. 2005). To compensate for this limitation, we revisited the interviews and were able to categorize foreign-born respondents as immigrants or refugees on the basis of their qualitative responses to such questions as why they had come to Canada. In other words, we assessed their qualitative responses overall to answer the question, "does the evidence suggest that this individual came to Canada as

an immigrant or a refugee, or is there insufficient evidence to make a decision either way?"

Statistical Analyses

Our analysis of the baseline interviews revealed that the socio-demographic characteristics of refugees and immigrants in the study were distinct from their Canadian-born peers. Whereas the former were more likely to be female and living with children, Canadian-born respondents were more likely to be men on their own. The reasons for being homeless also differed, with the former more likely to be homeless for economic reasons. To address and compensate for these differences, comparisons were made on the basis of matched pairs

The matches were selected using the following criteria: (1) participation in both the baseline and follow-up interview and (2) paired matching based on age (adult or youth), sex (male or female) and family status (with or without at least one child under 16). In matching by pairs, random selection among Canadian-born participants was used within subgroups that were made up of these matching variables.

Results

The results reported here are based on interviews with 90 respondents—45 Canadian and 45 foreign-born—who were matched according to the criteria and approach described above and who completed the follow-up interviews. These matched respondents included: 1 pair of adult men, 11 pairs of adult women, 6 pairs of female youth, 4 pairs of male youth, 12 pairs of women in families and 4 pairs of men in families.

The quantitative, health-related results of the Canadian-born and the foreign-born matched samples are summarized in Table 5-2. A series of repeated measure ANOVAs were conducted to examine for differences between the two groups, for changes across time and for interactions of group and time on health-related variables measured with continuous data. A series of chi-square analyses were conducted on data presenting the percentage of alcohol and drug use among participants of the two groups at the two time points.

Overall, foreign-born respondents reported a significantly higher level of mental health functioning than their Canadian-born peers. At follow-up, both Canadian and foreign-born respondents showed a significant and similar level of improvement in mental

health functioning However, the average score of both groups of respondents on the SF-36 showed them to have poorer mental health functioning when compared with the average score of the normative sample drawn from the US general population.[1]

With regard to physical health, foreign-born participants reported a significantly higher level of physical health functioning than Canadian-born participants across the two time points. There were no changes in level of physical functioning over time with both groups showing similarly stable levels at both time points. In comparison to the US normative group, foreign-born participants demonstrated slightly better physical health than the normative American sample. In contrast, Canadian-born participants reported a similar level of physical functioning to the American sample.

In line with the differences in the level of physical health functioning, Canadian-born participants also reported having significantly more chronic health conditions at baseline and at follow-up than foreign-born participants. No changes in the number of chronic health conditions were evident over time for either of the groups. Over the two data collection points, foreign-born participants had significantly less contact with service providers in the previous 12 months than Canadian-born participants. Although the utilization of health care providers increased for foreign-born participants, the interaction between groups and time was not significant.

A significantly higher proportion of Canadian-born participants reported drug use problems at baseline than foreign-born respondents. A larger proportion of foreign-born participants (26%) reported not having a health card compared to Canadian-born participants (13%) at the baseline interview, although this difference was not statistically significant. On the other hand, a higher proportion of Canadian-born respondents (20%) indicated at baseline, when they were homeless, that they had had an experience of not receiving health care when they needed it, compared to foreign-born participants (15%). Again, these differences were not statistically significant.

The quantitative, health-related results of the immigrants and refugees making up the foreign-born participant group are presented in Table 5-3. A series of repeated measure ANOVAS were also conducted to examine for differences between the two groups, for changes across time and for interactions of group and time on health-related variables measured with continuous data. As well, a series of chi-square analyses were conducted on data presenting the percentage

Table 5-3. Health-related quantitative results for panel study matched Canadian-born and foreign-born respondents, and immigrant and refugee respondents

	Canadian-Born (n = 45)		Foreign-Born (n = 45)	
	Baseline	2-Yr. Follow-up	Baseline	2-Yr. Follow-up
Variables	Mean (SD)		Mean (SD)	
SF-36: Mental Health Component Score[a, b]	35.89 (13.83)	40.65 (13.12)	42.52 (10.65)	45.75 (12.57)
SF-36: Physical Health Component Score[c]	49.51 (9.19)	49.84 (12.69)	54.48 (7.12)	55.96 (7.46)
Number of Chronic Conditions[d]	2.47 (1.98)	2.71 (2.27)	0.89 (1.28)	1.11 (1.52)
Number of Health Care Providers Consulted over Past Year[e]	3.09 (1.80)	3.14 (1.55)	2.0 (1.24)	2.77 (1.60)
	%		%	
Alcohol Use Problems?	20%	11%	7%	7%
Drug Use Problems?	30%[f]	16%	13%[f]	7%

[a] $F^{(Group)}$ (1, 88) = 6.79, $p < 0.02$; [b] $F^{(Time)}$ (1, 88) = 8.06, $p < 0.01$; [c] $F^{(Group)}$ (1, 88) = 9.01, $p < 0.005$; [d] $F^{(Group)}$ (1, 90) = 22.01, $p < 0.001$; [e] $F^{(Group)}$ (1, 87) = 7.41, $p < 0.01$; [f] *Chi-square* (df = 1) = 4.09, $p < 0.05$.

of alcohol and drug use among participants of the two groups at the two time points.

Our analyses found no differences across the two time points between immigrants and refugees in terms of reported levels of physical health functioning or mental health functioning, number of chronic health conditions and number of health care providers seen in the past year. There was a significant increase in the number of health care providers over time for the two groups together. There were no differences between immigrants and refugees in terms of the reported prevalence of alcohol use or drug use problems at baseline or at the two-year follow-up. Changes over time within the group were also non-significant statistically.

We also examined the health related, qualitative results of the interviews with adults in families (12 pairs) and single adult women (11 pairs). The qualitative analysis in this study was conducted with the help of ATLAS.ti, a software package for the analysis of qualitative data (http://www.atlasti.com/). ATLAS.ti is organized around the capacity to assign codes to words or phases in the qualitative data

Table 5-4. Health-related quantitative results for immigrant and refugee respondents

	Immigrants (n = 23)		Refugees (n = 22)	
	Baseline	2-Yr. Follow-up	Baseline	2-Yr. Follow-up
Variables	Mean (SD) or %		Mean (SD) or %	
SF-36: Mental Health Component Score	41.94 (10.87)	45.39 (11.94)	43.12 (10.65)	46.12 (13.45)
SF-36: Physical Health Component Score	52.85 (8.01)	56.69 (8.0)	55.14 (6.18)	55.22 (6.99)
Number of Chronic Conditions	0.95 (1.29)	1.04 (1.69)	0.81 (1.30)	1.18 (1.37)
Number of Health Care Providers Consulted over Past Year[a]	2.43 (1.24)	3.10 (1.73)	1.55 (1.10)	2.45 (1.44)
	%		%	
Alcohol Use Problems?	4%	4%	4.5%	4.5%
Drug Use Problems?	22%	13%	4.5%	0%

[a]F (1, 42) = 5.29, $p < 0.05$.

that are relevant to the research questions under discussion. In this study, 33 sets of questions at baseline and six at follow-up included some qualitative elements (Aubry et al. 2007). We began by examining systematically the respondents' answers to open-ended questions that directly addressed health care to assess the extent of differences and similarities in the responses of those born in Canada and those born elsewhere. Key questions included, "Have problems with your physical health contributed to your being/becoming homeless? If yes, what are they and how have they contributed?" and "Have you ever been told by a health care professional that you had mental health problems? If yes, how were they explained to you?" In the course of this examination, it became clear that a strict interpretation of health-related codes (those having to do with discussions of one's physical and/or mental health) would be overly restrictive in terms of what respondents had to say about health-related matters, when 'health' is interpreted as having to do with well-being. In order to address this shortcoming, each respondent's file was scanned across all open-ended questions for other health-related commentary. The following questions proved to be particularly useful: "What helps you get through the rough times? What are some of the things you

do to cope?"; "What is the best place you ever lived? What did you enjoy about it?"; "Do you have any advice for people who are homeless and looking for regular housing?"; and "What difference has it made for you to be in regular housing?" After this scan, we identified four additional sets of questions/topics where health-related themes were mentioned or implied. Health-related commentary was then organized for each of the respondent subgroups according to the six resulting themes (in addition to an 'other' category): (1) physical health, (2) mental health, (3) sense of control, (4) advice to others, (5) feelings and (6) particularly important services.

Among adults in families, those born in Canada were more likely than the others to report both physical and mental health problems:

> *She has fibromyalgia, asthma and bronchitis* (CDN 214).
>
> *Post-traumatic stress disorder (from childhood experiences) and depression* (CDN 225).
>
> *Being bullied throughout my public school years affected my ability to concentrate on school work and get proper education. As a result, it disturbed me mentally until today* (CDN 530).

No immigrants mentioned physical or mental health difficulties, and the reasons given by refugees for their health-related problems were specifically linked to their experiences of war and conflict:

> *The torture was worse than the war. War is just hearing the Boom Boom. It is not like having someone hold a gun to your head and your neck* (REF 124).
>
> *I have shrapnel in my leg that prevents me from climbing stairs if an emergency occurs* (REF 524).

The experiences of access to health care services were somewhat more similar. All of the adults in families reported difficulties:

> *I didn't get a doctor at Cobourg because they were not taking new patients* (CDN 519).
>
> Why did you not get care? *Transportation; couldn't get to the office; not convenient; single dad* (CDN 530).
>
> Why did you not get care? *Six months ago I tried to see a GP and made the appointment but the doctor had to cancel* (REF 545).

> Why did you not get care? *When living with my husband, needed somebody to talk to and listen to—and nobody was there for me* (IMM 551).

Overall though, the adults in families did not emphasize their health status or access to health services as primary factors that explained their homelessness, although health was sometimes used to explain why they didn't have sufficient income:

> *I had a mechanical back disorder, and if I wouldn't have that I would be working and making more money to avoid homelessness* (CDN 521).
>
> *Due to my physical disability I can't obtain employment and that forced me to be on social assistance. As a result, the money doesn't allow me to rent a private accommodation* (REF 524).

Access to affordable housing (and often, escape from abuse) were the factors that generated the most response. In fact, many of the adults identified moving into the family shelter as a strategic decision:

> *I was a single mother who is working and not making enough money. For a year, 85% of my earnings was going to my landlord. I couldn't continue doing that, and decided to come into the family shelter so I can find an affordable place to live. Before [that] I was living in a tent on Bank Street . . .* (CDN 518).
>
> *I had been in an abusive relationship for 15 years and finally decided to leave, but I couldn't find an affordable place to rent and sought help in this shelter* (CDN 523).
>
> *I was in an abusive relationship for a long time. I couldn't accept that type of abuse any longer, and sought refuge in this shelter* (IMM 527).
>
> *I have been in this shelter for 7 months, waiting to find an affordable place to live* (IMM 509).
>
> *My two sons and I were renting a one-bedroom apartment and paid $818 for rent, while our income was $1162 from Ontario Works. In order to avoid being homeless, I had to take a portion of our food allowance . . . to pay the rent* (REF 524).

For all of the adults in family respondents, the services that were highlighted as being of most benefit were closely tied to access to economic and/or housing resources. When health services were

mentioned, it was typically as part of a broad range of services that together were perceived as helping the individual to become self-sufficient:

> How do they help you? *Welfare (Ontario Works) shelter, Native Women's group—came with me to Ontario Works, helped me get to Ottawa and into the shelter* (CDN 139).
>
> *The shelter when I had no place to stay and the food banks when I had no food* (CDN 537).
>
> How do they help you? *When we have appointments: babysit. Worker gives what I need. If I leave a message . . . he helps right away, he does job well* (IMM 229).
>
> *The shelter for housing; legal aid for immigration; the community health centre for health services* (REF 147).

In contrast to the adults in families, there were clearer distinctions among the single adult women, with Canadian-born women being much more likely than those born elsewhere to focus on health-related problems and services:

> *Self-mutilated. Bipolar disorder. Panic attacks* (CAN 109).
>
> *Alcohol addiction* (CDN 240).
>
> *I can't work—my lower back has bad pain, neck muscle spasms go all the way down my arms* (CDN 112).
>
> *I need some nursing care because of my legs. I don't know if I will need a second amputation . . .* (CDN 149).
>
> *Seeing my family doctor at Centretown Community Health Centre* (CDN 149).
>
> Do you receive help from outreach workers? *ACT Team—bring medication, my dad gives them $150/month, and they bring me $5/day; find out about housing; book doctor app'ts, drive me around, take me for coffee* (CDN 101).

The foreign-born adult women also mentioned physical and mental health problems, but their overall focus was more similar to the adults in families than they were to their single Canadian peers. For example, when asked what advice they would give to others in similar circumstances, the foreign-born women emphasized strategies that would help them exit homelessness, whereas the focus of the Canadian-born women was more on personal healing:

> *When they are in shelters they should get help and education—counselling, help for employment, getting a house—fill up everyday with activities. They have to follow you, push you to go out and look for work, housing . . .* (IMM 144).
>
> *You have to fight for a living and it will make you feel good; you need to work at it and never give up; there's always help* (REF 141).
>
> *Find counselling. Work things out with a counsellor. It's mostly addictions to drugs or alcohol or mental illness why people are homeless, they need to get help* (CDN 137).
>
> *Keep their appointments. Keep your act together. Don't fuck up* (CDN 240).

The foreign-born single women and adults in families also were similar in their responses to questions about the difference it has made to be in regular housing (that they perceived as being of good quality):

> What difference has it made for you to be in regular housing? *Big time difference. I am much better here* (single adult, REF 901).
>
> *I am really happy to be provided with subsidized housing. And for the social assistance that the Government provides me. English courses are free of charge. Legal aid was a turning point to stabilizing my family situation. I know for sure in Ukraine they have no social network like this* (single adult, IMM 222).
>
> What difference has it made for you to be in regular housing? *Peace of mind. My children have become healthy kids again after residing at this address* (adult in family, CDN 517).

Discussion

This study contributes to knowledge about the health of immigrants and refugees in Canada who have been homeless. In the analysis discussed here, the mental and physical health status of foreign-born respondents was higher than that of their matched, Canadian-born peers. But contrary to other research on immigrants' health, there was no evidence of a shrinking gap between the two groups over the two-year study period. Mental health status generally remained lower than that of the US normative sample but it did improve for all of the respondents over time. Immigrants and refugees' physical health status also was better than that of the Canadian-born

respondents and, somewhat surprisingly, remained at a higher level than the US normative general population sample.

It is plausible that improvements in mental health were associated with respondents who were in stable housing at follow-up and who perceived their housing to be of good quality. The adult-in-family respondents (both Canadian and foreign-born) were almost all stably housed at follow-up. Statistical analyses of the full Panel Study sample revealed that improvements in mental health status occurred when respondents perceived their living circumstances as being of good quality (Aubry et al. 2007). In the specific case of refugees, it is also plausible that feelings of safety and security had improved as compared to their situations at the beginning of the study.

With regard to physical health status, the substantially more extensive reporting of chronic physical health conditions among the Canadian-born certainly provides one window on why there is a gap between the physical health status of those born in Canada and those born elsewhere. Although it is unsurprising that immigrants would have many fewer chronic conditions, given the extensive screening of their health status as a condition of entry, the case of refugees is more surprising, since their entry is not governed by the same health-related limitations. However, the superior health of refugees may be a testament to their resilience in surviving extremely difficult life circumstances in their home country and finding a way to escape these circumstances to a new country. Overall, our findings do provide further evidence of the healthy immigrant effect at least in terms of physical health among foreign-born adults who are homeless. Moreover, there was no evidence of a diminishment in physical health functioning among these individuals over the course of the two-year study.

The health service utilization results do suggest a move towards similar rates of use among foreign-born and Canadian-born respondents over time, but this trend raises at least as many questions as answers. Given that foreign-born respondents report better mental and physical health, are they seeking the same kinds of health services as their Canadian-born peers or are they seeking help for settlement-related issues? The higher utilization of religious leaders and similarities in the rates that they and the Canadian-born respondents report in not getting the help they needed suggest that settlement-related issues are of particular concern for those born outside the country.

The respondents' qualitative commentary revealed more similarities than differences among foreign-born and Canadian-born adults with family, but they also revealed clear distinctions between the foreign-born single women and their Canadian peers. It is likely that site-specific factors had a role to play. Among the full Panel Study sample, fully 97 percent of the adult-in-family group was stably housed at follow-up, and, of that group, 78 percent were living in subsidized housing. Given that homeless adults with children were placed on the priority list for subsidized housing in Ottawa, this trend is, at least in part, the unsurprising result of a municipal public policy choice. Among adult women, the probability of access to subsidized housing was considerably lower and depended on additional conditions such as mental health impairment or escape from domestic abuse: 73 percent were stably housed at follow-up, and, of that group, 51 percent were living in subsidized housing. Although respondents would not have been privy to the statistics presented here, the adult-in-family group might well have been aware of others who were successful in accessing subsidized housing, making the choice to move to the shelter a meaningful strategy in the search for affordable housing. The logic of using such a strategy in the case of single women would have been much less straightforward. In the case of foreign-born women, similar to the case of adults with family, it is likely that their poverty and/or domestic abuse were the driving factors in the decision to move to a shelter, whereas for the Canadian-born women, the reasons were more likely to do with interactions between mental and physical health limitations, domestic conflict and abuse and poverty.

Strengths and Limitations

This study has several strengths. One is the Panel Study's site-specific success in re-interviewing 255 participants two years after first meeting them at an emergency shelter or drop-in in Ottawa. The Panel Study's interest in diversity and its systematic approach to capturing that diversity in a statistically rigorous manner is a second positive feature. It permitted the investigation of similarities and differences in the health status and health trajectories of matched samples of Canadian-born and foreign-born respondents living in Ottawa. The benefits of combining close-ended and open-ended questions in the interview contributed further insights into the 'healthy immigrant

effect' for persons who have been homeless, and it identified additional reasons for examining the impacts of settlement-related concerns. The use of cultural interpreters and the ability to incorporate the experiences of both immigrants and those who arrived in Canada as refugees are additional significant features of the study.

Our study also had a number of limitations that need to be taken into account in interpreting the findings. The first was that the study was not representative of the overall homeless population in Ottawa; in addition, the sample did not include single adults and adults in families who were living on the street or temporarily living with friends or family. A further limitation of our sampling strategy was the reliance on shelter staff to find participants in the single adult and adult-in-families subgroups who matched specific characteristics. This process had the potential to introduce some bias toward sampling higher functioning individuals. There were also refusals by some of the individuals invited to participate. Another limitation was the level of attrition in the study, as 38 percent of the original participants were lost at follow-up. There were no differences found between participants and non-participants in the follow-up interview on all of the compared characteristics with the exception of length of residency in Ottawa (Aubry et al. 2007).

All of the information collected in the study was self-report in nature. Self-report information may be prone to inaccuracy because of faulty memory, lack of information or discomfort with self-disclosure. Related to the use of self-report measures in the Panel Study, it is important to note that the SF-36 provides a subjective assessment of physical health functioning and mental health functioning. Other limitations associated with the use of SF-36 include the potential lack of relevancy of some of the items in the measure related to inquiring about physical functioning and social functioning from people who are experiencing homelessness. As well, our use of cultural interpreters may have affected the interpretation and response of participants on some of the items. Despite these limitations, scores on the SF-36 showed the expected differences between immigrants and refugees and Canadian-born participants, with immigrants and refugees reporting better physical health functioning and mental health functioning. As well, the measure proved to be sensitive to capturing improvements in mental health functioning over time for both groups of participants.

Another limitation of our study was the relatively short length of the follow-up period (i.e., two years). It was of sufficient length

to capture the housing instability experienced by a relatively large proportion of our participants. However, a longer period of time may have shown more changes in the health-related characteristics. A further limitation was the fact that no distinctions were made among the foreign-born respondents who were recent arrivals and those who had been in Canada for a longer period of time. This shortcoming may have compromised the ability to examine the healthy immigrant effect over time. A final limitation was the relatively small numbers of respondents that were compared based on matched samples.

Conclusions

Beiser's (2005) review of extant research on the health of immigrants and refugees revealed a complex picture and lent support to his conclusion that "unexpected and paradoxical findings underline the need to take account of heterogeneity in future studies . . ." (539). The results reported here lend support to his conclusions and also raise questions about the impact of site-specific public policy measures on respondents' health status and health services utilization. Although the study results do provide support for the widely observed healthy immigrant effect, the similarities noted between immigrants and refugees raise questions about its causal roots. So too do the observations about similarities between the foreign-born and Canadian-born adults with families. These findings have implications for policy-makers, health administrators and health and social care professionals. This study suggests that the existence of a certain difference (such as country of origin) does not automatically mean a linear relationship with other distinctions (such as reasons for being homeless). In fact, our data suggest that adults with children, whether born in Canada or elsewhere, are more similar than different, whereas this is not the case among unaccompanied adult women. The data also raise further questions about the circumstances under which a healthy immigrant effect occurs and suggests that contextual factors need careful consideration before inferences are drawn on the basis of this tendency. Thus, in the case of Chui and colleagues (2009), the focus on English-speaking immigrants in Toronto homeless shelters needs to be taken into account in drawing inferences from that study. It would also be useful to investigate healthy immigrant effects among persons who have been homeless in locations other than Toronto or Ottawa.

It is clear that further research is required and that its ideal form would be both longitudinal and multi-site. The Housing and Health in Transition study, now underway in Toronto, Vancouver and Ottawa, has the potential to contribute further insights about the health of single adults, both foreign- and Canadian-born, who have been homeless or unstably housed in these three cities.

Note

1. Standardized scores involve converting the raw score to a scaled score based on a normative sample of the 1998 general US population (ages 18–64; n = 6742) where the mean is 50 and the standard deviation is 10.

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PART II

POLICY & PROGRAMMATIC RESPONSES TO HOMELESSNESS & HEALTH

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CHAPTER 6

Housing and HIV/AIDS among People Who Inject Drugs: Public Health Evidence for Effective Policy Response

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Introduction

Injection drug use is a serious public health concern in many countries, including Canada. Recent estimates suggest that between 220,000 and 375,000 Canadians, or approximately 1 to 2 percent of the general population, have ever injected an illegal drug (Mathers et al. 2008). People who inject drugs (injection drug users or IDU) represent a diverse population with a range of health needs and outcomes. In Canada, the majority of IDU are male, and persons of Aboriginal ancestry are heavily overrepresented among IDU (PHAC 2006). Initiation into injection drug use typically occurs at 20 years of age (Ompad et al. 2005); however, a significant proportion of IDU report beginning injecting in their early teens (Miller et al. 2006). Although the pathways into injection drug use are varied, heavy non-injection drug use and homelessness in the months preceding injection onset are common (Roy et al. 2003). Further, several recent studies (Kerr et al. 2009; Ompad et al. 2005) have pointed to the role that childhood maltreatment plays in increasing the risk of initiating injection drug use.

Prior to the discovery of HIV in 1982, very little research involving IDU had been conducted in Canada. However, injection drug use

was prevalent across the country well in advance of the HIV pandemic. Historical documents suggest that by the mid-20th century, 4,000 Canadians were actively injecting drugs: the vast majority of these early users were from poor working-class families living in the cities of Vancouver and Toronto (Carstairs 2002). By 1989, 120 AIDS cases attributable to injection drug use had been reported to the Federal Centre for AIDS, and high rates of HIV-related risk behaviour among IDU began to garner significant public health attention (Smart 1991). In the same year, studies presented at the 5th International AIDS Conference in Montreal provided further evidence that immediate public health action was required to prevent the situation from worsening (Bruneau et al. 1989). An early study undertaken in Montreal suggested that the prevalence of HIV among IDU was approximately 4 percent (Lamothe et al. 1988). In 1997, a massive HIV epidemic, described as one of the most severe in the developed world, was observed among IDU in Vancouver (Strathdee et al. 1997). In more recent years, the proportion of HIV infections attributable to injection drug use has remained relatively constant at just under 20 percent, representing between 390 and 750 new cases of HIV infection annually (PHAC 2009). In addition to a sustained and unacceptably high rate of HIV incidence, IDU face multiple social and structural barriers to accessing appropriate HIV treatment and experience poorer clinical outcomes (Wood et al. 2008).

Homelessness and the Risk Environment

The limited success of conventional public health interventions to reduce HIV-related morbidity and mortality among IDU has led to a new emphasis on ecological approaches that incorporate how factors exogenous to the individual impact exposure to risk and poor health. For example, the 'risk environment' model posits that social, physical and structural factors intersect to produce differential exposures to infectious disease risks and drug-related harms (Rhodes et al. 2005). These environments thus impose constraints on one's ability to mitigate risk behaviour and achieve health. Within this framework, substandard housing and homelessness have been identified as key factors that play direct roles in augmenting vulnerabilities to HIV and perpetuating health inequities among marginalized populations (Galea and Vlahov 2002). Complementary to this body of literature is a large volume of research indicating that secure and stable housing is a robust determinant of health within the general population (Hwang 2001).

Despite evidence to suggest a powerful link between lack of access to housing, HIV infection and overall health, there remains no clear policy approach to addressing housing and HIV/AIDS issues in Canada (Canadian AIDS Society 2009). Although research has shown that housing plays an important and direct role in the prevention of HIV and other health-related harms among IDU (Briggs et al. 2009), policy-makers in Canada have failed to implement housing interventions as central tenets of current HIV/AIDS strategies for this population. In order to more effectively influence the development of evidence-based policy and programs that benefit equivocally housed drug users, scientists, policy-makers and service providers must promote rigorous housing-focused research, articulate why housing and HIV/AIDS issues are closely linked and justify how the provision of supportive housing can improve the health of drug users living with HIV/AIDS (Aidala and Sumartojo 2007).

This review synthesizes evidence, primarily from a Canadian context, examining the relationship between housing and HIV/AIDS among IDU populations, compares housing interventions to reduce HIV risk behaviour and support individuals who are already living with HIV/AIDS and provides recommendations for future research to best inform the development of housing policy. Given the recent call to action by the Canadian AIDS Society to address housing as a critical component of the federal response to HIV/AIDS in Canada (Canadian AIDS Society 2009), this chapter aims to serve as a key tool for public health practitioners and other stakeholders interested in advocating for evidence-based housing interventions to improve the health of people who inject drugs.

Housing and HIV/AIDS among Drug Users

Homeless people in Canada face significant barriers to accessing health and social services and experience a range of adverse health outcomes (Hwang 2001). Notably, homelessness is a strong predictor of premature mortality (Hwang 2000). Homelessness is extremely common among people who inject drugs, particularly those who are HIV positive (Song et al. 2000). An inability to attain safe and stable housing is known to be both a cause and consequence of drug use (Galea and Vlahov 2002). For example, studies of homeless young people have shown that drug use is often a critical factor in deciding to leave home, while many youth initiate illicit drug use only after becoming homeless (Mallett, Rosenthal and Keys 2005). It is clear

that chronic homelessness tends to exacerbate the negative consequences of drug use (and vice versa), which can result in a mutually reinforcing pattern of complex service needs and declining overall health (Neale 2001). Therefore, elucidating how homelessness, drug use and HIV/AIDS intersect to produce and perpetuate health inequities is crucial for informing more effective public health strategies to address the needs of this marginalized population.

Housing environments shape and perpetuate HIV risk among people who inject drugs (Aidala et al. 2005). Many studies have demonstrated that homeless IDU are more likely than housed individuals to participate in sexual and injecting-related HIV risk behaviour, including syringe sharing, shooting gallery attendance and sex work (Coady et al. 2007; Des Jarlais, Braine and Friedmann 2007; Reyes et al. 2005; Salazar et al. 2007). Furthermore, homeless IDU are more likely to report higher intensity drug use patterns than those with stable housing (Lloyd-Smith et al. 2009), while higher levels of sexual risk have been observed among drug-using youth who are equivocally housed (Marshall et al. 2009). Among young drug users, HIV risks tend to accumulate as the severity and frequency of homelessness increases, indicating a dose-response relationship between HIV vulnerability and exposure to street environments (Ennett et al. 1999). Similarly, residential transience and long-term housing instability are important drivers of HIV risk among drug-using adults. Injection risk behaviours are more common among adult IDU who report frequent moves (German, Davey and Latkin 2007). Frequent relocation may also disrupt social networks and diminish one's exposure to positive peer norms, which have been shown to be important mitigating factors of risk behaviour among IDU (Latkin et al. 2003). Finally, unstable housing and homelessness have been identified as key determinants of poor treatment outcomes among HIV-positive IDU (Knowlton et al. 2006).

Given the strong and consistent relationship between inadequate housing environments and HIV risk behaviour, it is not surprising that several studies have identified an independent association between poor housing conditions and increased rates of HIV infection among IDU. One of the earliest studies to demonstrate this link was conducted in Ohio, and although the overall HIV prevalence was low (1.5%), living in a homeless shelter residence was second only to being a man who has sex with men as the strongest correlate of HIV infection (Siegal et al. 1991). A more recent study conducted

in Baltimore also observed a strong relationship between exposure to homelessness and both HIV prevalence at baseline and seroconversion over follow-up (Song et al. 2000). In Canada, a large prospective cohort study of injection drug users in Vancouver (i.e., the Vancouver Injection Drug Users Study) has investigated the relationship between housing status and HIV among IDU for over a decade. HIV infection was more common among IDU reporting recent homelessness or unstable living conditions at baseline, independent of other risk factors including sex work and syringe sharing (Strathdee et al. 1997). A follow-up study indicated a strong association between unstable housing and HIV incidence (Tyndall et al. 2003). This trend has continued: after eleven years of follow-up, housing status has remained a significant predictor of HIV seroconversion (see Figure 6-1).

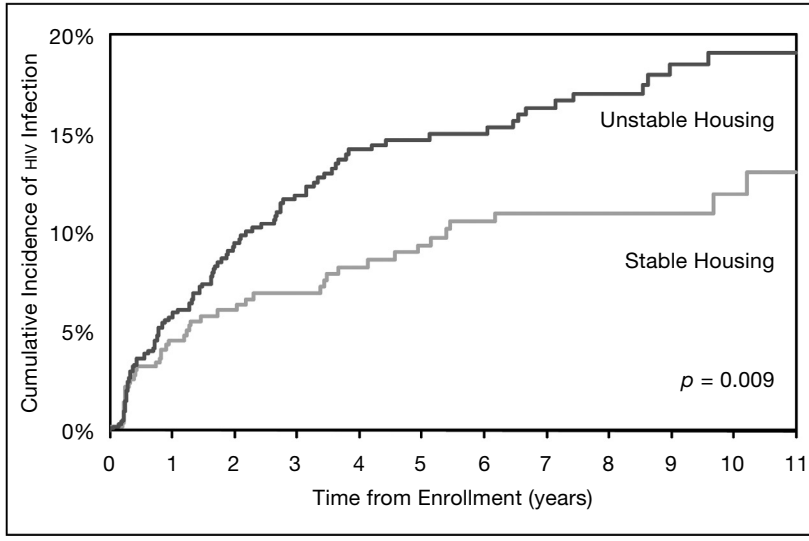


Figure 6-1. Cumulative incidence of HIV infection among Vancouver injection drug users from 1996 to 2007, stratified by housing status at baseline

Note: *Unstable housing* includes living in a shelter/hostel, treatment/recovery house, jail, single-room occupancy hotel or on the street. *Stable housing* was defined as living in an apartment or house.

Source: Urban Health Research Initiative, British Columbia Centre for Excellence in HIV/AIDS (2009).

Homelessness and the Production of HIV Risk

Detailed ethnographic investigations have established the importance of place in the social-structural production of HIV risk among homeless IDU populations. For example, participant-observation studies have shown how homelessness and the extreme social marginalization experienced by many IDU result in survival strategies in which precarious income-generating activities and social relationships of mutual dependence are prioritized over HIV risk reduction practices (Bourgois 1998). Among women, homelessness also exacerbates exposure to everyday violence and subordinated positions in social hierarchies, in which the risk of HIV infection is secondary to immediate physical dangers (Epele 2002).

Ethno-epidemiological studies have also suggested that a multitude of environmental and structural factors may explain the observed relationship between housing instability and HIV vulnerabilities. For example, homeless IDU experience increased exposure to high-risk injecting environments (e.g., shooting galleries, open drug scenes), which have been shown to be settings of heightened HIV vulnerability, particularly for younger IDU (Rhodes et al. 2006). Homeless IDU who inject in public settings are also more likely to skip safer injecting practices due to fears of being intercepted by the police, physically assaulted or robbed (Small et al. 2007). Furthermore, homeless IDU frequently encounter police as a result of participation in illegal income-generating activities and are thus more likely to experience HIV risks associated with incarceration (Wood et al. 2005). At a policy level, features unique to unstable housing environments have also been shown to perpetuate HIV risks among IDU. For example, evening 're-entry fees', a common feature of single-room occupancy hotels, dissuade individuals from accessing HIV prevention and harm reduction services (Wood and Kerr 2006b) and thus may be partially responsible for the high prevalence of HIV observed among persons who live in these environments (Shannon et al. 2006).

Barriers to Housing

IDU experience a multitude of social and structural barriers while attempting to access safe and stable housing. Many IDU are considered by housing providers as 'hard to house' for reasons including lack of stable employment and income, 'unclean' visual appearance, erratic or aggressive behaviour and the presence of co-morbidities

(e.g., mental illness) associated with chronic substance use (Gurstein and Small 2005). Having a criminal history and experiencing incarceration, common among IDU, further complicates one's ability to obtain housing (Mizuno et al. 2009). Furthermore, individuals who are actively drug dependent and continue to use substances are often ineligible for abstinence-contingent housing services or will be discharged upon relapse or positive urine test (Kruas, Serge and Goldberg 2006). For many drug-using youth, the fact that many shelters are abstinence focused and adhere to a 'zero-tolerance approach' severely restricts acceptable housing options (Krüsi et al. 2010).

The ability to obtain stable housing is further complicated by inadequate access to substance abuse treatment, income support and employment opportunities. For example, IDU who are homeless are less likely to enrol in any form of addiction treatment (Wood et al. 2005) and are less likely to attain legal employment (Richardson et al. 2008) compared to those who are stably housed. Furthermore, unstable housing status has been associated with a decreased uptake of methadone maintenance therapy (MMT) among opioid users in Canada (Fischer et al. 2008). Homelessness has also been found to impact the types of addiction treatment most often accessed by people who inject drugs. A large study conducted in Massachusetts demonstrated that homeless IDU were more likely to enter detoxification and residential treatment programs but were half as likely to access MMT over the four-year study period (Lundgren et al. 2003). These short-term programs often do not lead to improved long-term housing outcomes due to a lack of integration between substance abuse treatment and housing services, insufficient or unacceptable housing options and other gaps in the continuum of care (Meschede 2010).

Housing as HIV/AIDS Prevention, Treatment and Care

Housing programs are increasingly well recognized as an integral component of comprehensive HIV prevention strategies (Shubert and Bernstine 2007). In the United States, observational studies and randomized controlled trials have demonstrated that the provision of rental assistance and other housing supports is associated with improved health outcomes and better treatment adherence among persons living with HIV/AIDS (PLWHA) (Wolitski et al. 2010). Among homeless PLWHA, treatment compliance is complicated by competing priorities associated with homelessness (e.g., obtaining shelter, meeting dietary requirements), lack of transportation to HIV-related health

care services and inability to store medications (Henry et al. 2008). The advent of single-pill regimens will likely mitigate many of these concerns, although the provision of housing should continue to be a key priority to improve HIV-related outcomes and overall health among IDU. Even with less than perfect adherence, homeless PLWHA have been shown to benefit from HIV treatment; thus, service providers should not restrict access to highly active antiretroviral therapy (HAART) on the basis of housing status alone (Wolitski, Kidder and Fenton 2007). Finally, given the evidence indicating that housing instability significantly reduces one's ability to engage effectively with HIV treatment and practice risk reduction behaviours, secondary prevention programs for PLWHA at risk for HIV transmission should include housing assistance within a package of comprehensive intervention strategies (Fisher and Smith 2009). HIV-infected persons with unsuppressed viral load (i.e., detectable levels of virus circulating in body fluids) are more likely to transmit HIV during high-risk sexual or injection-related behaviours (Attia et al. 2009). Higher levels of HIV viral load among IDU have also been associated with increased HIV incidence at the community level (Wood et al. 2009). Given that antiretroviral therapy induces viral load suppression among adherent patients (Gulick et al. 1997), the expansion of access to HAART is now thought to be an effective means to control the spread of HIV (Montaner et al. 2006). However, HIV-infected IDU who are homeless are less likely to achieve viral load suppression upon receiving HAART (Knowlton et al. 2006). Therefore, if IDU populations are to receive maximal treatment and preventive benefits of HAART expansion programs, efforts should also be made to address housing instability and other barriers to treatment initiation and compliance. Under this framework, safe and stable housing are viewed not only as a necessary prerequisite to effective HIV/AIDS management and care but also as an evidence-based public health intervention to reduce new HIV infections among drug users.

Evidence-Based Interventions

Several interventions and models of housing assistance programs have been proposed for drug-using individuals who are homeless or are at risk for homelessness. In this section, we provide a brief discussion of several housing interventions and a review of evidence regarding the effectiveness of each program.

Case Management

Case management has been found to facilitate access to stable housing and improve adherence and other treatment outcomes among homeless and marginally housed drug users with HIV infection (Kushel et al. 2006). Furthermore, the provision of case management can prevent individuals undergoing substance abuse treatment from relapsing and becoming unstably housed (Katz et al. 2001). However, evidence suggests that better long-term housing outcomes are achieved with more comprehensive housing support services compared to case management alone (Clark and Rich 2003). For these reasons, case management in the absence of other comprehensive interventions is not recommended as a best practice to achieve sustainable housing among people who use drugs.

Linear Approach Programs

In the United States, linear approach programs (also called the 'continuum of care' model) are common and provide housing once an individual has completed a course of addiction treatment and has achieved abstinence (Milby et al. 2000). These programs have demonstrated efficacy in some settings, and sustained periods of abstinence have been demonstrated among individuals who achieve abstinent-contingent housing (Schumacher et al. 2007). However, many of these programs fail to recognize the chronic nature of substance abuse and thus are unable to provide appropriate support upon relapse. For example, individuals who do return to drug use after obtaining housing may be evicted, thus dramatically increasing the risk for homelessness and return to engagement in HIV risk behaviours.

A second limitation of this type of intervention is that a lack of formal linkages with placement programs and low rental stock may prevent individuals who achieve abstinence from obtaining affordable stable housing. This has been demonstrated recently by a Vancouver study showing that enrolment in addiction treatment failed to predict obtaining stable housing over four years of follow-up (Palepu et al. 2010). Improved integration of addiction treatment services with supportive housing programs for individuals who are able to maintain abstinence and those who continue drug use or experience relapse is therefore recommended.

Housing First

A more recent model is 'Housing First', premised on the notion that housing is a basic human right and should not be requisite to abjuring substance use. Within a Housing First framework, homeless individuals with substance abuse or other co-morbidities (e.g., mental illness) are immediately provided with their own apartments without any prerequisites for treatment or sobriety (Greenwood et al. 2005). Thus, individuals are not required to be in substance abuse treatment in order to obtain or maintain housing. In addition to the provision of housing, these models often include additional support services that participants can access at their discretion, including an 'Assertive Community Treatment' team consisting of health care and social service professionals, for example (Tsemberis, Gulcur and Nakae 2004). The underlying principle of this approach is one of 'consumer choice'; that is, participants are empowered to determine the priority and order of services they receive.

Housing First programs have been shown to result in higher rates of housing stability compared to individuals receiving abstinence-contingent services and do not lead to increases in substance use among participants (Tsemberis, Gulcur and Nakae 2004). Housing First interventions have also been shown to be highly cost effective for chronically homeless persons with severe alcohol dependence (Larimer et al. 2009). These programs have also been strongly endorsed by the Canadian Mortgage and Housing Corporation (CMHC) as the preferred mode of housing homeless individuals with substance abuse or dependence. In a review of housing programs in Canada, CMHC (2006) concluded that the immediate provision of safe, independent and secure housing is one of the key factors in assisting individuals to reduce drug use and the negative health impacts of substance abuse on their lives.

Harm reduction approaches provided in *combination* with permanent, independent housing are an effective means to address the needs of homeless people with substance abuse and are thus a central tenet of the Housing First model (Tsemberis, Gulcur and Nakae 2004). *Harm reduction* refers to policies and practices that aim to reduce the risks and harmful effects associated with substance use without requiring reduced drug consumption or abstinence (Inciardi and Harrison 2000). In Canada, some housing programs have adopted a 'client-centred' harm reduction approach, which focuses on supporting individuals in meeting their housing, substance abuse and

health care needs in a flexible, respectful and dignified way (Evans and Strathdee 2006). The provision of housing is increasingly viewed internationally as an evidence-based harm reduction strategy to reduce risk behaviour and prevent adverse health outcomes among people who inject drugs (Briggs et al. 2009). Evidence also exists to suggest that IDU who achieve stable housing are more likely to cease injection drug use altogether and are less likely to relapse (Shah et al. 2006). These findings provide further support for Housing First models and suggest that the immediate provision of housing should be regarded as an evidence-based pathway to drug use cessation.

Recommendations for Research and Policy

Throughout this chapter we have argued that housing is good for health. This is particularly true for marginalized people who are equivocally housed and use drugs. The benefits of housing in terms of HIV prevention are clear: a large volume of evidence indicates that safe and stable housing is associated with reduced engagement in HIV risk behaviour and improved health outcomes for those living with HIV disease. In order to more effectively inform housing and health policy in Canada, researchers must now do more than simply state that these relationships exist. Novel lines of inquiry should be proposed and examined; for example, evidence that differentiates which modes of housing interventions are most successful at improving the health of homeless people who use drugs would be invaluable for the design and implementation of new housing programs. Examining these 'second generation' questions is only a very recent phenomenon and thus many questions remain unanswered. Although an increasing number of researchers are investigating the effectiveness of the *integration* of housing and addiction treatment services based on Housing First and harm reduction models, case studies of success, particularly in the Canadian context, are urgently needed. One example is the Dr. Peter Centre in Vancouver, which has successfully integrated an assisted-living residential program for HIV-positive IDU with harm reduction approaches, including a supervised injecting room and spaces where residents can consume non-injection drugs such as crack cocaine (Krüsi et al. 2009). The evaluation of innovative models of care for homeless people who use drugs is critical for the creation of evidence-based housing programs across the country.

It must be recognized that additional scientific evidence is on its own insufficient to enact the policy and programmatic changes that would often be required to meaningfully improve the health of homeless IDU. Controversial interventions (even those with a significant scientific evidence base such as needle exchange programs) can be met with moral and ethical arguments that in some cases have impeded their implementation and expansion (Buchanan et al. 2003). Acknowledging moralistic opposition to harm reduction-based approaches and identifying ways to engage communities and policy-makers that hold these views is critical to ensuring that future interventions are based upon the best available scientific evidence.

A second area of future research is the identification of *points of intervention* to most effectively bring homeless IDU in contact with the health and social service systems. Given that IDU are an extremely marginalized population who experience a multitude of barriers to accessing traditional primary and ancillary services (Wood and Kerr 2006a), housing programs should provide multiple points of entry and be highly flexible to diverse health needs and challenges. For example, although many IDU are completely disconnected from services, those who are unstably housed report high rates of emergency room and acute care utilization (Kerr et al. 2005). These points of contact with the primary health care system may be an important opportunity to engage and connect homeless IDU with low threshold housing support programs. The responsibility lies with service providers to identify these opportunities and with researchers to evaluate their potential to improve the health and functioning of people who use drugs.

Finally, given recent Canadian research suggesting that the use of non-injection drugs (e.g., crack and methamphetamine) among marginalized groups may be associated with elevated HIV risk (Bungay et al. 2010; DeBeck et al. 2009), future studies should seek to elucidate the intersection of homelessness and non-injection drug use in the production of HIV-related risks and harms. Importantly, there are few effective treatments for stimulant dependence (Rawson et al. 2006), and few studies have determined whether the provision of housing may improve treatment outcomes among these groups. It is clear, however, that the creation of sustainable supportive housing for non-injection drug users should be a policy and public health priority.

We wish to conclude this chapter by emphasizing that the implementation of housing interventions should proceed in tandem with improved access to and expansion of comprehensive

HIV services. Indeed, it is the *integration* of housing and homelessness prevention programs with addiction treatment, HIV treatment, health services and other HIV prevention interventions where the largest benefits to the individual and to society will likely be observed. It is our hope that this chapter will act as a call to researchers, service providers and advocates to better articulate the need for housing to assume a central role in Canadian public health strategies to improve the health of all citizens, including those who use drugs.

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CHAPTER 7

Supported Housing as a Promising Housing First Approach for People with Severe and Persistent Mental Illness

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Introduction

Since the 1970s, deinstitutionalization has been the main focus of mental health policies in provinces across Canada (Kirby and Keon 2006). A primary reason behind deinstitutionalization was the recognition of the negative consequences associated with long-term treatment in psychiatric institutions (Mechanic and Rochefort 1990). The main objective of deinstitutionalization has been to move people with severe and persistent mental illness from psychiatric institutions into the community by replacing institutional services with community supports. The end goal of this major transformation in psychiatric services is to assist the deinstitutionalized population in assuming normal roles and becoming integrated back into society.

Unfortunately, close to four decades after the onset of deinstitutionalization in Canada, the goal of integrating people with severe and persistent mental illness remains a work in progress. A primary reason has been the slowness in developing much-needed community services to replace institutional ones, including housing. As a consequence, a substantial number of people with severe and persistent mental illness across Canada are socially isolated, live in extreme

poverty and are either homeless or at constant risk of becoming homeless (Kirby and Keon 2006).

Only one Canadian survey has been completed to estimate the prevalence rates of mental illness in the homeless population. In a study conducted in Toronto, Goering, Tolomiczenko, Sheldon, Boydell and Wasylenki (2002) used a structured diagnostic interview among the city's homeless and found an overall lifetime prevalence rate of 67 percent for mental illness and 68 percent for substance abuse or dependence. Six percent of the sample reported having had a psychiatric hospitalization in the past 12 months. The lifetime prevalence of schizophrenia among the sample was 6 percent. A comparison of individuals who were experiencing homelessness the first time and individuals having had multiple episodes found no differences in prevalence rates of mental illness or substance abuse problems or in the percentage having had a psychiatric hospitalization in the past year.

In a review of 29 different studies conducted between 1979 and 2005 on the prevalence of major mental disorders among the homeless population in seven Western countries other than Canada, Fazel, Khosla, Doll and Geddes (2008) reported a pooled prevalence rate across studies for psychotic disorders of 12.7 percent with estimates from individual studies ranging from 2.8 percent to 42.3 percent. They found a similar pooled prevalence rate of 11.4 percent for major depression, with estimates in individual studies ranging from 0 percent to 40.9 percent. Among the disorders examined in the research, alcohol dependence had the highest pooled prevalence rate across studies with over a third of surveyed individuals (37.9%) identified with the problem. In response to the high prevalence rates of homelessness among people with mental illness and substance abuse problems, the development of effective housing and supports has been a preoccupation of mental health systems in Western countries, including in Canada (Nelson 2010).

The objective of this chapter is to review the current status of supported housing, a contemporary approach that is gaining increasing interest and support throughout North America and Europe for addressing homelessness of people with severe and persistent mental illness (Nelson 2010). In the Canadian context, the Mental Health Commission of Canada is in the process of investigating the effectiveness of supported housing through a large multi-site study in which housing and support of different levels of intensity are being

delivered to people with mental illness and a history of homelessness (MHCC 2011). In this chapter, we present a history of the development of housing in response to deinstitutionalization, followed by a description of the supported housing approach. Subsequently, we will review the outcome research on supported housing. Based on this review, we will present limitations of this research. The chapter will conclude with a discussion of future directions for research and implications of the current state of knowledge on policy and program development.

History of Housing for People with Severe and Persistent Mental Illness

In the wake of deinstitutionalization, the development of housing for people with severe and persistent mental illness has involved three distinct approaches: custodial housing, supportive housing and supported housing (Nelson 2010; Trainor et al. 1993). In tracing the policy stages with regard to housing in the province of Ontario, Trainor (2008) described the first type of housing created in response to the initial stage of deinstitutionalization in the 1970s as being custodial in nature. This was followed by the development of supportive housing in the 1980s and 1990s. Over the past 15 years, supported housing has emerged increasingly as the preferred housing approach. Table 7-1 presents a comparative description of the three approaches.

Custodial housing refers to board and care homes—often for-profit, semi-institutional facilities and single-room occupancy hotels (Parkinson, Nelson and Horga 1999). The residents are typically people with disabilities and support is provided by staff on-site (Parkinson, Nelson and Horga 1999). Custodial housing was critiqued for the segregation, social isolation and dependency that it fostered among its residents. As well, the quality of custodial housing was often very poor with residents lacking privacy or control over their living situation (Nelson 2010).

In response to these critiques, supportive housing was developed with the primary objective of helping residents develop life skills through community treatment and rehabilitation (Ridgway and Zipple 1990). Supportive housing was intended to be organized in a residential continuum (e.g., quarterway houses, halfway houses, group homes, etc.) in which the intensity of rehabilitation and the amount of autonomy varied in accordance with an individual's

Table 7-1. Description of different housing approaches implemented after deinstitutionalization

	Custodial Housing	Supportive Housing	Supported Housing
Definition	• Consumers receive shelter, medication and meals, but little or no rehabilitation or support.	• Consumers receive shelter and on-site rehabilitation. As their functioning improves, they move to less restrictive setting.	• Consumers choose, get and keep regular housing in the community. They often receive rent supplement; support is portable and not tied to housing.
Key Characteristics	• Special care homes or foster families • Congregate housing • Staff control • In-house staff provides custodial care	• Group home or clustered apartment with common areas • Shared control over household decisions • In-house staff provides rehabilitation services	• Apartment or other type of independent housing • Consumers are regular tenants and have control over their housing. • Staff are off-site and provide supports that are individualized according to needs.
Strengths	• Less expensive then institutions • Does not require trained staff	• Consumers have more control over housing arrangements • Housing includes an individualized rehabilitation program • Facilitates the development of a social network with other tenants	• Preferred housing for majority of consumers • Residents have choice and control over housing and support • Less expensive than other alternatives • Ongoing support

Table 7-1. (Continued)

	Custodial Housing	Supportive Housing	Supported Housing
Weaknesses	• Lack of privacy • Quality of the housing is often poor • Frequently fosters dependency • Consumers have little control • Can include people with different disabilities • No individualized support provided	• Full continuum of housing often lacking • Transitional housing and services lacking permanency • Interpersonal demands of group living • Discharge to affordable permanent housing with support may not be available	• Some consumers report being socially isolated and lonely • Lacks sufficient resources for consumers to pursue leisure activities and achieve community integration • Intensity of support may be insufficient

functioning level (Nelson 2010; Parkinson, Nelson and Horga 1999). Individuals were supposed to move along the continuum until they were ready to live independently. Although considered better living situations than custodial housing, supportive housing also had its share of detractors, who noted that a full continuum of housing options were rarely created in communities, moving in and out of housing was not in the best interest of consumers and individuals rarely achieved independent living (Blanch, Carling and Ridgway 1988; Nelson 2010; Ridgway and Zipple 1990).

Beginning in the late 1980s and early 1990s, mental health advocates called for the development of supported housing, wherein individuals with severe and persistent mental illness would be provided with the necessary support to live in regular housing as tenants (Blanch, Carling and Ridgway 1988; Carling 1993, 1995; Ridgway and Zipple 1990). The type of support in this approach usually involves Assertive Community Treatment (ACT) or Intensive Case Management (ICM) or some variant of these (Tabol, Drebing and Rosenheck 2010).

Wong and Solomon (2002) identified three factors as contributing to the development of the supported housing approach: (1) the criticism of supportive housing and the residential continuum model, (2) the recognition of homelessness as a significant social problem, particularly for individuals with severe and persistent mental illness

and (3) the development of effective approaches for providing treatment and support in the community, including ACT and ICM. Another important contributor to the ascendancy of supported housing has been the results of research on consumer preferences in relation to housing and support.

In a review of 26 studies of mental health consumers' preferences for housing and support conducted between 1986 and 1992, Tanzman (1993) reported that the most preferred living arrangement was independent living in a house or apartment. In 20 of the 26 surveys, at least 70 percent of the sample expressed this preference. Consumers in the reviewed studies also reported a preference for living alone or with a spouse or romantic partner and not living with other mental health consumers. With regard to staff support, consumers expressed a preference for having outreach staff that are readily available but separated from their housing. A majority of the respondents in the surveys also underlined the importance of income support and rent subsidies for them to be able to afford their preferred housing.

Two other Canadian studies had very similar findings concerning consumer preferences as Tanzman (1993). Nelson, Hall and Forchuk (2003) surveyed 300 individuals with severe and persistent mental illness in Ontario using the same instrument used in the American studies reviewed by Tanzman (1993). Of these respondents, 79 percent reported wanting to live independently in regular housing and only 38 percent actually lived in the housing that they preferred. Similar to the results of the American surveys, a very high proportion of survey respondents (82%) identified greater income support as being required for them to access their preferred housing. Less than one quarter of respondents (23%) wished to live with other mental health consumers. With regard to supports, consumers preferred supports that are external to their living situation and available on an on-call basis.

More recently, Piat and colleagues (2008) evaluated the housing preferences of a stratified random sample of 315 mental health consumers living in housing supervised by health and social service organizations in Montreal. Over three-quarters of the sample (77%) expressed a preference for living in their own apartment, social housing or a supervised apartment. In contrast, less than half of consumers' case managers (49%) chose these options for them and only 35 percent of case managers agreed with their clients' preferences.

Piat and her colleagues (2008) interpreted their results as showing that consumers preferred housing that offered them more independence than the housing in which they were currently living. Case managers also showed preferences in this direction but were generally more conservative in these preferences relative to their clients, wanting more structure and clinical involvement in the housing, such as that offered by supervised apartments. Overall, these findings show unequivocally that consumers prefer supported housing over custodial or supportive housing.

Core Principles, Dimensions and Elements of Supported Housing

Early writings advocating a supported housing approach argued that, compared to custodial housing or supportive housing, it was most conducive to facilitating consumer empowerment, community integration and normalization (Blanch, Carling and Ridgway 1988; Carling 1992, 1993; Ridgway and Zipple 1990). This represented a paradigm shift wherein former psychiatric patients would be supported to assume the normal role of tenant in regular and integrated housing through supported housing. A fundamental assumption of the approach was that people with severe and persistent mental illnesses can succeed in independent housing without first requiring a period of rehabilitation (Rog 2004).

The adoption of supported housing as a response to the chronic homelessness experienced by individuals with severe and persistent mental illness has gained momentum in North American cities because of the very promising findings emerging from research on the Pathways to Housing program in New York City (Greenwood et al. 2005; Stefancic and Tsemberis 2007; Tsemberis 1999; Tsemberis and Eisenberg 2000; Tsemberis, Gulcur and Nakae 2004). Four studies on the Pathways program have been completed in the United States, and their findings show participants remaining stably housed despite having a chronic history of homelessness (Greenwood et al. 2005; Pearson, Montgomery and Locke 2009; Stefancic and Tsemberis 2007; Tsemberis and Eisenberg 2000). A more detailed review of this research is conducted in a later section of the chapter.

Typically, the support includes a rent subsidy and there are no requirements for treatment of their mental illness and/or addiction for consumers to move into or stay in housing. For this reason,

supported housing is often referred to as 'Housing First'. It is important to note that most supported housing described in the literature is Housing First in nature. However, not all housing that is described as Housing First is necessarily supported housing since both custodial housing and supportive housing can adopt Housing First principles and not require their residents or participants to engage in treatment or remain abstinent from alcohol or drug use to qualify for the housing. We will examine the criteria of supported housing in more detail next.

Three reviews defining the core ingredients of supported housing have been conducted (Rog 2004; Tabol, Dreben and Rosenheck 2010; Wong, Filoromo and Tenille 2007). The core ingredients of supported housing identified in each of the reviews are presented in Table 7-2.

In an attempt to operationalize the supported housing approach, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Centre for Mental Health Services, located in the United States, defined eight core dimensions to the approach (as cited in Rog 2004):

1. An individual owns the housing or holds a lease in his or her name as a tenant and the housing is considered permanent.
2. Housing and services are legally and functionally separate.
3. Housing is integrated in the community (i.e., regular in nature).
4. Housing is affordable (i.e., does not exceed 40% of gross income).
5. Participation in services is voluntary and not a condition of getting or keeping housing.
6. Individuals are given choice for both housing and services.
7. Services are community-based and external to the housing (i.e., no live-in or regular in-house staff).
8. Crisis services are available 24 hours per day and seven days per week.

Rog (2004) noted that descriptions of supported housing programs in research literature are frequently missing certain dimensions. As well, alternative housing programs to which supported housing is compared often are presented as having some of these dimensions.

In examining the implementation of supported housing in Philadelphia and based on a review of the literature, Wong, Filoromo

Table 7-2. Criteria of supported housing as defined in different reviews focusing on implementation issues

Criteria Areas	Rog (2004)	Wong et al. (2007)	Tabol et al. (2010)
Use of Regular Housing	• An individual owns the housing or holds a lease in his or her name as a tenant and the housing is considered permanent. • Housing is integrated in the community. • Housing is affordable (i.e., does not exceed 40% of of gross income).	• Typical and normalized housing	• Housing is affordable • 'Normal' tenancy agreement • Privacy over access to the unit • Appearance of residence fits with neighbourhood norms • Integrated with non-consumers • Long-term placement/ potentially permanent housing
Separation of Housing and Services	• Housing and services are legally and functionally separate. • Participation in services is voluntary and not a condition of getting or keeping housing. • Services are community-based and external to the housing (i.e., no live-in or regular in-house staff).	• Promotes the independence and control of consumers with regard to their relationships with support providers	• Housing and services legally/ functionally separate • Absence of requirements as condition of stay • No live-in/ regular in-house staff

Table 7-2. (Continued)

Criteria Areas	Rog (2004)	Wong et al. (2007)	Tabol et al. (2010)
Delivery of Flexible Supports	• Crisis services are available 24 hours per day and 7 days per week.	• Housing located close to community resources • Support delivered to consumers is individualized, flexible and of varying intensity based on needs	• Individualized and flexible support • Crisis services available 24/7 • Resources in close proximity
Facilitation of Choice	• Individuals are given choice for both housing and services.	• Consumer choice for housing • Promotes the independence and control of consumers with regard to their relationships with support providers	• Shared decision-making • Choice in housing options
Immediate Placement			• Immediate placement into normal housing (i.e., no preparatory setting)

and Tenille (2007) descried supported housing as being based on four core principles: (1) housing is a basic right for people with psychiatric disabilities, (2) people with psychiatric disabilities are to live in housing as regular tenants and community members, (3) empowerment is the practice goal for the relationship between consumers and support staff and (4) access to and the delivery of housing and mental health services are functionally separate. According to Wong, Filoromo and Tenille (2007), these principles produce five operational domains integral to supported housing and pertaining to either housing/tenancy or support/services. The first principle is ensuring 'consumer choice' particularly as it relates to the location and type of housing as well as with whom and how consumers will live. The second principle refers to consumers living in 'typical and

normalized housing' that corresponds to neighbourhood norms and is located in an environment (e.g., apartment block, neighbourhood) where there are a majority of non-disabled individuals. The third principle has housing located close to community resources and facilities that can facilitate community participation and integration. The fourth principle promotes the independence and control of consumers with regard to their relationships with support providers. Finally, the fifth principle holds that support delivered to consumers be individualized, flexible and of varying intensity based on needs.

Wong, Filoromo and Tenille (2007) conducted an extensive analysis of data from housing providers and consumers to evaluate the extent that 27 housing programs for people with severe and persistent mental illness in Philadelphia demonstrated these five operational principles. Results showed substantial variations in housing and mental health support characteristics in terms of being in line with these principles. The researchers concluded that this variation reflects the existence of different versions of supported housing with some programs showing high fidelity to these principles while others deviate from them.

In a recent study, Tabol, Drebing and Rosenheck (2010) conducted a comprehensive review of the literature on supported housing programs and examined the degree of clarity of the approach and the degree of fidelity to the model in the descriptions of programs appearing in studies published in the research literature. For this review, key articles on supported housing were investigated to identify the critical elements of the model. A total of 15 elements were identified and clustered into five broader overarching categories—namely, (1) normal housing, (2) flexible supports, (3) separation of housing and services, (4) choice and (5) immediate placement (see Table 7-2). Using the identified elements in their conceptualization of supported housing, Tabol, Drebing and Rosenheck (2010) evaluated the descriptions of 38 different housing programs described in articles published in peer-reviewed journals between 1987 and 2008. In particular, they assessed if the descriptions of the programs in these articles included each of these elements and determined the extent they adhered to them. Of the 38 programs, 25 were characterized in the published articles as supported housing, seven programs as supportive housing and the remaining six programs as unlabelled or other.

Tabol, Drebing and Rosenheck's (2010) analysis found that although programs described as supported housing adhered to more

elements than those defined as supportive housing or other housing, less than half of the supported program adhered to most of the 15 elements. Based on these findings, the researchers concluded that the lack of clarity of the supported housing model along with the lack of fidelity to the critical ingredients of the model in many programs has hindered the broad dissemination, implementation and evaluation of the approach. Related to these issues is the inconsistency in the community mental health sector of the use of the labels *supported housing* versus *supportive housing* to describe programs. As a result, there is confusion in the field among researchers, practitioners, policy-makers and the public about the critical ingredients of these two approaches and how to differentiate them. In the next section of the chapter, we turn our attention to the outcome research on supported housing, focusing on those programs that show adherence to the key core elements of the approach.

As yet, there is no consensus on the criteria that should be used to evaluate the validity of a supported housing approach, nor has a fidelity measure for the approach been developed. Each of the reviews used a different process to establish their criteria. Rog (2004) used the early criteria developed by SAMHSA's Center for Mental Health Services that were based on a set of interviews and surveys with key informants. Wong, Filoromo and Tennille (2007) operationalized the key dimensions of supported housing appearing in the theoretical literature as defined by Carling (1995), Hogan and Carling (1992) and Ridgway and Zipple (1990). Tabol, Drebing and Rosenheck (2010) reviewed the criteria appearing in the extant research literature, including from the two previous reviews (Rog 2004; Wong, Filoromo and Tenille 2007), and developed what they considered an exhaustive list of key criteria of supported housing.

Review of Research on Effectiveness of Supported Housing

Criteria for Selection of Studies

An electronic literature search was conducted of the databases of published research, PSYCINFO and MEDLINE, by entering the keywords "housing first", "supported housing", "homeless", "homeless mentally ill", "assertive community treatment", "intensive case management" and "case management". We also examined recent literature reviews on housing in the area of community mental health (Aubry, Doestaler and Baronet 2004; Coldwell and Bender 2007; Leff et al.

2009; Nelson, Aubry and Lafrance 2007; Nelson 2010; Tabol, Drebing and Rosenheck 2010).

The selection of eligible studies emerging from our literature search was based on the following criteria: (1) the study needed to be published in a refereed journal, (2) the study involved a comparison of at least two groups, of which one of the groups comprised individuals living in supported housing and (3) the study examined effectiveness using at least some quantitative measures.

In order to determine if a study included at least one group in its design in which individuals received supported housing, the description of the housing and support in the paper reporting had to include the presence of four criteria which we considered the minimum critical ingredients of the approach. These criteria were selected from Rog's (2004) critical elements of supported housing: (1) housing and supports are provided separately by different organizations, (2) individuals in the program live in regular housing that is integrated into the community, (3) individuals live in housing that is affordable, defined typically as costing 40 percent or less of their income and (4) support services are delivered separately and externally from the housing (i.e., portable rather than involving live-in support). A total of nine studies were identified.

Description of Selected Studies

Table 7-3 presents descriptive information about the selected studies. All of the studies were conducted in cities in the United States. Of the nine studies, six adopted a true experimental design (i.e., participants were randomly assigned to different treatment conditions) and another three used a quasi-experimental design (i.e., participants of different groups were not randomly assigned but were matched on key variables instead).

In terms of comparison groups, four studies compared supported housing to a continuum model of housing (McHugo et al. 2004; O'Connell, Kasprow and Rosenheck 2009; Tsemberis 1999; Tsemberis et al. 2003), three studies compared supported housing to case management without housing or to standard care in the community (Hurlburt, Hough and Wood 1996; Rosenheck et al. 2003; Stefancic and Tsemberis 2007), one study compared supported housing to supportive housing (i.e., congregate housing with on-site case management) (Dickey et al. 1996) and one study compared supported housing to two types of housing models: (1) supportive housing and (2) multi-site

Table 7-3. Characteristics of selected supported housing studies

Study	Location	Sample	Comparison Group(s)	Experimental Group	Study Type	Follow-up
Hurlburt, Wood & Hough (1996); Hurlburt, Hough & Wood (1996); Wood et al. (1998)	San Diego	C1: 90 C2: 91 E1: 90 E2: 91	No Section 8 certificate with comprehensive (C1) or traditional case management (C2)	Supported housing: Section 8 certificate with either comprehensive case management (E1) or traditional case management (E2)	Experimental	24 months
Dickey et al. (1996); Goldfinger et al. (1999); Seidman et al. (2003)	Boston	C:63 E: 55	Evolving consumer households with congregate living (C)	Supported housing, independent living (E)	Experimental	18 months
Tsemberis (1999); Tsemberis & Eisenberg (2000)	New York	C: 3,811 E: 139	Residential continuum model (C)	Pathways supported housing with ACT (E)	Quasi-experimental	36 months (Tsemberis 1999); 60 months (Tsemberis & Eisenberg 2000)

Table 7-3. (Continued)

Study	Location	Sample	Comparison Group(s)	Experimental Group	Study Type	Follow-up
Gulcur et al. (2003); Tsemberis et al. (2003); Tsemberis, Gulcur & Nakae (2004); Greenwood et al. (2005)	New York	C: 119 E: 87	Residential continuum model (C)	Pathways supported housing with ACT (E)	Experimental	24 months (Gulcur et al. 2003; Tsemberis et al. 2003; Tsemberis et al. 2004) 36 months (Greenwood et al. 2005)
Rosenheck et al. (2003); Cheng et al. (2007); O'Connell, Kasprow & Rosenheck (2008)	San Francisco, San Diego, New Orleans, Cleveland	C1: 90 C2: 188 E: 182	No Section 8 certificate with case management (C1) or standard treatment (C2)	Supported housing: Section 8 certificate with intensive case management (E)	Experimental	36 months (Rosenheck et al. 2003; Cheng et al. 2007); 60 months (O'Connell et al. 2008)
McHugo et al. (2004)	Washington, DC	C: 61 E: 60	ICM with congregate housing or non scattered-site housing (C)	Supported housing with ACT (E)	Experimental	18 months

Table 7-3. (Continued)

Study	Location	Sample	Comparison Group(s)	Experimental Group	Study Type	Follow-up
Stefancic & Tsemberis (2007)	New York, NY	C: 51 E1: 105 E2: 104	Standard care (C)	Supported housing with ACT (Pathways) (E1); Consortium of treatment and housing agencies (E2)	Experimental	20 months (E1, E2, & C); 47 months (E1, E2)
O'Connell, Kasprow & Rosenheck (2009)	15 sites across the United States	C: 183 E: 139	Section 8 voucher with multistage housing and case management (C)	Section 8 voucher with direct placement into independent housing and case management (E)	Quasi-experimental	24 months
Pearson, Montgomery & Locke (2009)	Seattle (DESC); San Diego (REACH); New York (Pathways)	DESC : 25 (C1); REACH 29 (C2); Pathways: 26 (E)	Supportive housing (C1); Multi-site housing with modified ACT (C2)	Supported housing with ACT (E)	Quasi-experimental	12 months

housing with modified ACT support (Pearson, Montgomery and Locke 2009).

Some of the studies were reported in several different articles, sometimes with different sample sizes or overlapping samples. When there were overlapping samples in different reports, it was decided to count them as one study, rather than separate studies, using the article with the largest sample size reported. There was great variability in the supported housing models across the studies in terms of fidelity criteria for supported housing. A full description of the different supported housing programs examined in the literature was often lacking. As well, few studies conducted fidelity assessments to determine how adequately the program components were being implemented. In general, as Tabol, Drebing and Rosenheck (2010) reported, there was great variability in the housing programs described in the different studies in terms of fidelity to the supported housing criteria.

Description of Population in Selected Studies

The samples of participants in the selected studies are characterized by a preponderance of non-white, middle-aged men. Only one study had a majority of white participants (Hulburt, Wood and Hough 1996) and only one study had a majority of women (McHugo et al. 2004).

Most studies targeted a population with severe and persistent mental illness as reflected by the relatively high prevalence of schizophrenia among study participants in seven of the nine studies. The remaining two studies were conducted on military veterans (O'Connell, Kasprow and Rosenheck 2009; Rosenheck et al. 2003), and less than 10 percent of participants from those studies had a diagnosis of schizophrenia. In these studies, the eligibility criteria included having a serious mental disorder (e.g., schizophrenia, psychotic disorder, depression, post-traumatic stress disorder) and/or addiction in addition to being homeless. The samples in eight of the studies show a high prevalence of substance use, indicating the presence of concurrent disorders in a majority of study participants.

A large proportion of participants in the reviewed studies had experienced lengthy periods of homelessness leading up to their participation in the study. Upon admission to the study, they were either living in emergency shelters, on the street, in transitional housing, in jail or in a psychiatric hospital.

Findings on Outcomes

Table 7-4 presents a summary of results of studies examining the effectiveness of supported housing in relation to other housing models or to standard care. In discussing the findings, outcomes will be summarized into the categories of housing outcomes (e.g., length of time housed), service use outcomes (e.g., number of hospital admissions, length of hospitalizations and satisfaction with services), clinical outcomes (e.g., client functioning and symptoms), community adaptation (e.g., quality of life, employment, and community integration) and costs.

Housing. Overall, individuals placed in supported housing had better outcomes in relation to housing compared to individuals placed in residential continuum housing. In particular, supported housing resulted in superior housing outcomes including the achievement of stable housing in five of the nine studies when compared to residential continuum housing models (Tsemberis 1999; Tsemberis et al. 2003), programs providing case management without housing (Hulburt, Hough and Wood 1996; Rosenheck et al. 2003), supportive housing, and standard care (e.g., Rosenheck et al. 2003; Stefancic and Tsemberis 2007).

In one of the studies, tenants in supported housing achieved comparable housing outcomes to tenants in supportive housing and residential continuum housing but reported having fewer housing problems (Pearson, Montgomery and Locke 2009). In two of the studies, supportive housing was found to yield superior housing outcomes to supported housing (Dickey et al. 1996; McHugo et al. 2004). Finally, in the remaining study, housing outcomes were mixed, with tenants in supported housing showing a greater reduction of homelessness over 24 months than tenants in residential continuum housing (O'Connell, Kasprow and Rosenheck 2009). However, tenants in supported housing had more days of homelessness over the course of the study. The non-equivalence of the housing history of the two groups was interpreted as contributing to these differences in findings.

Service use outcomes. In three of the six studies that looked at service use outcomes, tenants in supported housing were found to experience less time in hospital in comparison to tenants in residential continuum housing (Gulcur et al. 2003; O'Connell, Kasprow and

Table 7-4. Summary of outcomes in effectiveness studies on supported housing

Studies	Housing	Service Use Outcomes	Clinical Outcomes	Community Adaptation	Costs
Hurlburt, Hough & Wood (1996); Hurlburt, Wood & Hough (1996); Wood et al. (1998)	(+) shorter amount of time to being housed (+) % independent living at 2 yrs.	(+) greater continued contact with services			
Dickey et al. (1996); Goldfinger et al. (1999); Seidman et al. (2003)	ND % housed at 18 mos. (−) lower % experiencing homelessness, mean # of days homeless	ND hospitalizations ND use of mental health and addiction services	ND neuropsychological functioning over time (−) decreased executive functioning over time		
Tsemberis (1999); Tsemberis & Eisenberg (2000)	(+) % housed at 5 yrs.				
Gulcur et al. (2003); Tsemberis et al. (2003); Tsemberis, Gulcur & Nakae (2004); Greenwood et al. (2005)	(+) time stably housed	(+) less time in hospital (−) substance abuse treatment	NC drug use, alcohol use, psychiatric symptoms	ND self-esteem, ND quality of life	(+) lesser hospitalization/ housing/shelter costs

Table 7-4. (Continued)

Studies	Housing	Service Use Outcomes	Clinical Outcomes	Community Adaptation	Costs
Rosenheck et al. (2003); Cheng et al. (2007); O'Connell, Kasprow & Rosenheck (2008)	(+) days housed at 36 mos., housing satisfaction, retention at 60 mos. (+) fewer days homeless	(+) fewer days institutionalized (+) greater use of mental health services	(+) fewer days of alcohol use (+) fewer days intoxicated, days using drugs, drug index score (+) reduced alcohol index score	(+) greater housing satisfaction, social network, quality family relations (+) fewer housing problems employment, legal involvement and income	(−) lesser societal costs
McHugo et al. (2004)	ND % in stable housing at 18 mos. (−) increased time in stable housing, decreased homelessness ND housing satisfaction ND neighbourhood satisfaction	ND medical or dental care, treatment for alcohol and drug use, psychiatric services	ND decreased psychiatric symptoms over time (−) fewer psychiatric symptoms ND days of alcohol use & days of drug use	ND exposure to community violence ND increased life satisfaction over time (−) greater life satisfaction	
Stefancic & Tsemberis (2007)	(+) % retention of housing at 2 yrs.				(+) lesser program costs vs. emergency shelter costs

Table 7-4. (Continued)

Studies	Housing	Service Use Outcomes	Clinical Outcomes	Community Adaptation	Costs
O'Connell, Kasprow & Rosenheck (2009)	(−) fewer days homeless ND increased days housed in past 90 days (+) decreased days homeless over time	(+) fewer days institutionalized (+) fewer days institutionalized over time (+) greater use of outpatient services	ND decreased psychiatric symptoms and substance abuse over time	ND increased employment, quality of life, income, social network, days of drug use over time ND decreased minor and major crimes over time (−) increased employment over time	(+) lesser health care costs
Pearson, Montgomery & Locke (2009)	ND % housed at 12 mos. (+) fewer housing problems				

Note. (+) outcomes in favour of supported housing, (−) outcomes in favour of comparison group, ND = no difference, NC = no change over the treatment time.

Rosenheck 2009) or those receiving case management or standard care (O'Connell Kasprow and Rosenheck 2008). With regard to participation in substance abuse treatment, individuals in the residential continuum group reported significantly greater participation in substance abuse treatment programs than individuals living in supported housing (Tsemberis, Gulcur and Nakae 2004). In terms of utilization of outpatient services, supported housing tenants showed greater utilization in comparison to tenants living in a residential continuum program (O'Connell, Kasprow and Rosenheck 2009). Finally, two studies found no differences between tenants of supported housing group and those in a residential continuum program with regard to overall health care utilization (Dickey et al. 1996; McHugo et al. 2004).

Clinical outcomes. Of the five studies evaluating clinical outcomes, mixed results were found. Two studies found no differences in changes over time in the severity of psychiatric symptoms or substance use between supported housing and residential continuum housing tenants (O'Connell, Kasprow and Rosenheck 2009; Tsemberis, Gulcur and Nakae 2004). McHugo and colleagues (2004) and O'Connell, Kasprow and Rosenheck (2009) also report no group differences in psychiatric symptoms or substance use between individuals in supported housing and individuals in residential continuum program, but McHugo and colleagues (2004) did find that the residential continuum group had significantly greater improvements in their psychiatric functioning. Pearson, Montgomery and Locke (2009) report that although individuals experienced month-to-month variation in their levels of impairment, there were no significant decreases in psychiatric impairment or substance use over the course of the first year in either of the three housing programs (i.e., supported housing, supportive housing, multi-site housing with modified ACT support).

The Rosenheck set of studies found perhaps the most compelling results. In particular, Cheng, Lin, Kasprow and Rosenheck (2007) found that the group of individuals receiving supported housing had substantially and significantly fewer days of alcohol and drug use, fewer days on which they drank to intoxication and lower scores on a composite drug problem index than the groups receiving either case management or standard care. O'Connell, Kasprow and Rosenheck (2008) also report lower scores on alcohol and drug scales for their supported housing clients, as well as less money spent on substances.

Seidman and his colleagues (2003) looked at different clinical outcomes than the other studies. They assessed the neuropsychological functioning of tenants in supported housing and supportive housing. Overall, neuropsychological functioning improved significantly across both groups from baseline to 18 months. However, the executive functioning of the tenants in supported housing had a significant decline across the study period, while supportive housing tenants had a slight, but non-significant, increase in their executive functioning.

Community adaptation. The studies assessing community adaptation outcomes also yielded mixed results. Specifically, tenants of supported housing were found to either have achieved superior outcomes in this area or showed no difference from consumers receiving services from other programs. Tenants of supported housing perceived their choices to be more numerous than did tenants in a residential continuum program (Tsemberis, Gulcur and Nakae 2004). Supported housing tenants also reported fewer housing problems, larger social networks and greater satisfaction with their family relationships in comparison to consumers receiving case management or standard care (Rosenheck et al. 2003). As well, tenants in the supported housing group reported higher quality of life scores in terms of their overall life, their finances, their health and their social relations in comparison to consumers receiving case management (Rosenheck et al. 2003). There were no differences in the same study between tenants in supported housing and consumers receiving standard care.

On the other hand, there were no differences found between consumers in supported housing and consumers in residential continuum programs with regard to increases in self-esteem (Tsemberis et al. 2003), improvements in family relations (Wood et al. 1998), size of social networks (O'Connell, Kasprow and Rosenheck 2009), increases in satisfaction with neighbourhood, decreases in exposure to community violence (McHugo et al. 2004) or increases in quality of life (O'Connell, Kasprow and Rosenheck 2009; Tsemberis et al. 2003).

In terms of employment, individuals living in residential continuum housing had higher than average scores on an employment index and a greater number of days worked in comparison to individuals in supported housing (O'Connell, Kasprow and Rosenheck 2009); however, both groups reported significant increases in the number of

days worked in the past 30 days and in their total income. With regard to legal involvement, one study found no significant differences among individuals in supported housing, case management only or standard care (Rosenheck et al. 2003). O'Connell, Kasprow and Rosenheck (2009) report that although no differences were found between their groups, both the residential continuum and the supported housing tenants demonstrated decreases in occurrences of minor and major crimes.

Costs. In relation to costs, tenants in supported housing were evaluated as having hospitalization, residential and shelter costs that were lower than tenants in residential continuum programs (Gulcur et al. 2003), program costs that were lower than emergency shelter costs for individuals in standard care (Stefancic and Tsemberis 2007) and health care costs that were lower than for tenants in residential continuum housing (O'Connell, Kasprow and Rosenheck 2009). In contrast to supported housing tenants having lower costs relative to other approaches, one study found the opposite, with services consumed by supported housing tenants costing more than those for consumers receiving case management or standard care (Rosenheck et al. 2003). However, unlike the other studies, which conducted costing on a limited range of health and social services, this latter study used a comprehensive costing to assess societal costs associated with a full range of services consumed by individuals.

Limitations of Research to Date

Based on our review of the extant research literature, an important limitation is the relatively small number of studies that have been conducted on supported housing to date. Our review of the peer-reviewed literature found only nine studies, even though liberal criteria were set for programs being considered supported housing. Of those studies examined in our review, several of them had small samples, limiting the power to detect differences between groups. In fact, three of the nine studies had groups with fewer than 65 participants (Dickey et al. 1996; McHugo et al. 2004; Pearson, Montgomery and Locke 2009). Another limitation to the samples of studies in our review was the overrepresentation of participants who are male, non-white and diagnosed with schizophrenia and substance use problems.

As noted by Tabol, Drebing and Rosenheck (2010) and Wong, Filoromo and Tenille (2007), the definition of supported housing varies in the research literature, with programs described in this way being

implemented in different ways in different locales. Some programs appear to adopt criteria that make them a hybrid of supported and supportive housing. Other programs adopt only some of what are considered critical ingredients of supported housing. We purposely kept in our review only programs that had these critical ingredients. However, the description of housing programs in published studies does not always provide enough information to accurately identify if critical ingredients of supported housing are present or not. Moreover, a majority of the outcome studies we reviewed did not report having undertaken an evaluation of program implementation or an assessment of program fidelity in terms of the criteria of supported housing.

Another limitation of the research in this area is the narrow range of outcomes that have been examined in the majority of studies. In particular, studies have relied heavily on housing, service use and clinical outcomes in examining the effectiveness of supported housing programs. Limiting outcomes to just these areas is inconsistent with the goals of recovery-oriented programs such as supported housing, which are intended to assist individuals with severe mental illness to live successfully in the community in a manner similar to that of non-disabled persons.

As presented in our review, the variety of comparison groups used in the small number of studies, which included standard care, case management without housing and supportive housing, limit the conclusions that can be drawn at this point from the literature. As well, the examined outcomes vary across the studies making it difficult to compare them to each other or draw reliable conclusions about the effectiveness of supported housing in relation to different outcomes. Also related to outcomes, most of the outcomes were measured in the studies through the use of self-report measures.

A further limitation of research conducted in this area is the relatively short follow-up period for many of the studies. Given the complex needs of persons with severe mental illness with a history of homelessness, an examination of outcomes over periods longer than two years seems necessary to capture the full range of positive benefits experienced by participants over time. Early treatment often focuses on engaging participants, building a trusting relationship and stabilizing functioning (Foster, LeFauve, Kresky-Wolff and Rickards 2010). Once progress has been made in these areas, treatment can focused on improving an individual's quality of life in the community.

Finally, the large majority of studies we reviewed were conducted in large cities in the United States. Given the differences in the mental health systems of the United States and other Western countries such as Canada, findings from American studies are not necessarily generalizable. A major difference in the delivery of health care between the United States and Canada is the universal coverage provided in Canada, including in the area of mental health services. Other contextual differences between the United States and Canada that may limit generalizability include the larger size of cities in the United States and the different racial and ethnic origins of urban populations in the two countries.

Future Directions for Research

Based on these limitations, a number of suggestions for future research are indicated. Firstly, there is a clear need for studies with larger and more diverse samples. The use of multi-site research designs can provide the necessary power and diversity to examine effectiveness and cost-effectiveness as well as identifying the types of individuals who benefit from the approach. A large multi-site trial that is currently being conducted in five cities in Canada testing a number of different supported housing approaches adapted to local needs can be expected to address limitations related to sample size and sample makeup as well as knowledge gaps (MHCC 2011). Given the eligibility criteria for participation in this study, which includes having mental health diagnoses of psychotic disorders or non-psychotic disorders, including affective disorders and some anxiety disorders, it is expected that this study will extend our understanding of with whom supported housing can be effective.

In our reviewed studies, there are a minority of individuals placed in supported housing who fail to achieve housing stability and return to homelessness. In a critique of the Housing First approach including supported housing, Kertesz, Crouch, Milby, Cusimano and Schumacher (2009) question the effectiveness of the approach for people with active and severe addictions. The researchers note that the approach has been tested on individuals with severe mental illness whose addictions are at a low to moderate level. Consequently, they conclude that the current state of the evidence on supported housing is not strong enough for it to be applied as a singular strategy for people with active and severe addictions. Instead, they recommend the continued need for residential treatment programs

such as therapeutic communities that adopt a residential continuum approach to promote recovery for this subpopulation.

Secondly, there is a need for studies on supported housing to use fidelity scales and report in a clear manner how programs being examined meet the criteria of supported housing. The work of Tabol, Drebing and Rosenheck (2010) that outlines 15 criteria characterizing supported housing can be very helpful in guiding fidelity assessments. It would probably be helpful if the criteria for supportive housing could also be defined in a similarly distinct and detailed manner.

Thirdly, future research needs to examine how supported housing can be combined with vocational services, peer support and integrated concurrent disorders treatment. To date, research shows that the most prevalent outcome produced by supported housing is the achievement of housing stability. Outcomes in other areas such as participation in work or school, community integration and reduction in alcohol or drug use have not been achieved, at least not consistently, across studies. A likely reason for this inconsistency in outcomes in these areas is that they have not been targeted in a systematic manner in many of the investigated supported housing programs.

Further rigorous studies comparing the outcomes of supported and supportive housing are also needed. The research to date indicates that supportive housing produces positive outcomes including housing stability (Nelson 2010; Nelson, Aubry and Lafrance 2007). In fact, the two studies from our review in which supported housing had inferior housing outcomes involved comparisons to supportive housing (Dickey et al. 1996; McHugo et al. 2004). In a 16-year follow-up of participants in the study by Dickey and colleagues (1996), Schutt (2011) reports that tenants of supportive housing experienced a higher level of housing retention than tenants of supported housing.

To date, as reported in our review, only a small number of studies have evaluated the costs of supported housing with only one study using a comprehensive costing method, which produced mixed findings. Future research is required to examine the cost–benefit and cost-effectiveness of supported housing using a comprehensive costing methodology.

It is recommended that future studies follow participants for greater lengths of time. In addition to determining if the housing stability achieved by participants is enduring, longer study periods will

also determine if outcomes in areas other than housing are achieved as a result of individuals receiving long-term support.

Finally, most of the studies on supported housing have relied on self-report measures to evaluate outcomes. The combination of self-report measures and observational measures can strengthen the conclusions that can be drawn from studies on the effectiveness of supported housing, particularly as it relates to severity of mental health symptoms, functioning and substance use.

Implications for Policy and Program Development

Our review of the small number of studies focusing on supported housing suggests that it is effective for what it targets—namely, the exiting from homelessness and the achievement of housing stability. The combination of these findings favouring supported housing with the values promoted by the approach and the fact that it is the type of housing preferred by a vast majority of consumers make it an attractive intervention for mental health policy development in Canada. In addition, the nature of the approach, which relies on private market housing, lends itself to being implemented in communities in a rapid manner As well, it does not require the major capital outlay associated with building residential facilities. This is particularly important in the Canadian context, where there has been a paucity of investments over the last two decades by provincial governments and the federal government in the creation of affordable housing including social housing (Hulchanski 2002).

Although communities throughout North America are implementing supported housing as a Housing First strategy to address chronic homelessness, custodial housing continues to be very prevalent in mental health systems, particularly in Canada (Trainor 2008); however, there are examples of communities in Canada shifting housing from custodial housing to supported housing (Nelson 2010). This shift is an important policy direction for systems to take up in order to finally integrate people with severe and persistent mental illness fully into the community. Of course, in order for supported housing to be in sufficient supply to meet the demand, the development of an affordable housing stock is needed, something that is sorely lacking and which has contributed to the growing homeless population in cities across Canada (Hulchanski 2002).

Overall, our review of research on supported housing found relatively little evidence of supported housing achieving superior

outcomes than other housing approaches in terms of reducing psychiatric symptoms or substance use or improving community adaptation. These findings are not surprising given that the support provided in most of the programs studied through ACT or ICM is generic in nature. As suggested in the section on future research directions, it would seem important that supported housing evolve so that more targeted support be integrated in the approach that is intended to address substance use, vocational needs, leisure needs and social support needs. The development and evaluation of the effectiveness of treatments and supports addressing these need areas are an important part of the multi-city trial of supported housing currently being conducted in Canada (MHCC 2011).

As discussed, supported housing originated from the mental health field in response to the deinstitutionalization of people with severe and persistent mental illness. In the context of high levels of homelessness throughout Canada, supported housing is now being applied increasingly as a response for people who are experiencing chronic homelessness, most of whom have a severe mental illness and substance use problem. Although they use a high proportion of shelter beds, the latter group makes up only a small minority of the homeless population (Kuhn and Culhane 1998; Aubry et al. 2013). Given the success of supported housing at achieving housing stability, it makes sense that variants of it could be developed in response to homelessness of other groups in Canada such as youth, families, and individuals with less severe mental health problems. In particular, the intensity and length of support provided could be shaped in response to the needs of these different homeless groups.

Conclusion

Supported housing has been heralded as representing a transformative change of the mental health system and with how we assist people with severe and persistent mental illness to become fully integrated into the community (Nelson 2010). The approach alters the view of individuals from being patients or clients to being seen as tenants and neighbours with the same housing rights and responsibilities as other citizens. Based on our review of the research on the effectiveness of the approach, we conclude that supported housing is a promising approach to ending homelessness for individuals with

severe and persistent mental health problems who have experienced chronic homelessness.

Specifically, the research evidence to date is indicative of supported housing being effective in assisting a majority of this population to achieve housing stability. Although all of the studies on supported housing to date involve relatively small samples and have been conducted in the United States, the large multi-site demonstration research project being conducted in five cities by the Mental Health Commission of Canada will provide a rigorous evaluation of its effectiveness in the Canadian context. We also believe that supported housing has the potential to serve as a platform on which housing and support can be evolved to help other subgroups within the homeless population who require assistance to exit homelessness and achieve stable housing.

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CHAPTER 8

Homelessness and Oral Health

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Introduction

In Canada, dentistry is generally funded as an employment-based benefit or as an out-of-pocket expense rather than via the public health care system. Consequently, socioeconomic status heavily influences access to dental treatment. In this system, persons experiencing poverty and homelessness face significant barriers to oral health care. The links between poverty and poor oral health are well documented, as is the importance of good oral health to overall health and well-being. However, less is known about how to reduce the barriers to oral health care faced by persons experiencing poverty and homelessness.

Dentists often seek to meet the needs of homeless persons and other low-income populations through charitable donations of their services. However, there are strong opinions that charity offers little more than a 'band-aid solution' to a complicated set of social problems (Crall 2006; De Palma and Nordenram 2005; Frankish, Hwang and Quantz 2005; Hwang 2001, 2002; Moore, Gerdtz and Manias 2007; Mouradian 2006). The British Dental Association (2003), for example, states that charitable dentistry by unpaid volunteers "is clearly no substitute for a coherent and properly-funded dental access strategy for homeless people", and adds "that homeless people, just as much as any other section of the community, are entitled to adequate and

accessible dental care as a right, and should not be forced to rely on charity" (37).

The issue of access to dental care is gaining more prominence as a health policy issue in Canada. Social and professional pressure has mounted on governments for renewed investments in dental care, and some provincial and municipal governments have responded (Quiñonez et al. 2010). However, policy-makers and service providers lack a definite strategy to respond to the numerous groups and challenges associated with oral health and oral health care inequalities (Quiñonez, Figueiredo and Locker 2009a). Meanwhile, governments and local health authorities continue to reduce health care spending and to encourage shifts of public health care into the private realm (Quiñonez, Figueiredo and Locker 2009a). Therefore, it appears that dental care reform is not a priority at present (Birch and Anderson 2005) and that dentistry is likely to remain outside the Canadian national health care system for the foreseeable future. In this context, the oral health needs of homeless persons are often ignored and excluded in service plans or policies that address access to dental care, and similarly in those that address homelessness and health in general.

Improvements to oral health policies and practices for homeless populations are most likely to occur through the inclusion of oral health within national, provincial and local strategies to reduce poverty and homelessness. Provincial poverty reduction plans with measurable goals and timelines have been developed as a proactive response to regressive 'welfare reform', which has dismantled the public safety net significantly over the last few decades. In some cases, the strategies have recommended increased public dental benefits. For example, the Ontario Poverty Reduction Strategy contains a Low-Income Dental Program that includes building community capacity to deliver prevention and treatment services for low-income Ontarians (Province of Ontario 2008). New Brunswick's poverty reduction plan includes a plan to provide dental care to children in low-income families and the extension of dental benefits for individuals leaving welfare for work for three years as part of an overall goal of a comprehensive system of supplementary health care for low-income people (Government of New Brunswick 2010).

Homeless action plans have become a standard response to homelessness. Again, the inclusion of dental care in these strategies is a possible approach to ensure that oral health is not excluded from

health care for the homeless. The report of the Mayor's Homelessness Action Task Force from Toronto (Golden et al. 1999) notes that many people who are homeless cannot access dental care and that we must first ensure that all homeless persons get dental benefits and then expand the number of accessible clinics where people can walk in and receive basic dental care along with other health and social services (Golden et al. 1999). Victoria's Mayor's Task Force on Breaking the Cycle of Mental Illness, Addiction and Homelessness (City of Victoria 2007) led to the creation of the Greater Victoria Coalition to End Homelessness. Calgary developed a 10-Year Plan to End Homelessness (Calgary Committee to End Homelessness 2008) and Ottawa also has a Community Action Plan on Homelessness—and there are similar examples of more local poverty responses in other Canadian urban areas.

Meanwhile, communities are seeing the immediate needs and, on a local basis, are responding in unique ways. There are now numerous examples of treatment alternatives helping homeless persons and persons living in extreme poverty get the dental care they need (Leake 2005, 2006; Main, Leake and Burman 2006). The literature on community dental clinics in Canada and the United States shows that they can play a unique and valuable role as a source of dental care for groups with traditional access barriers (Byck, Cooksey and Russinof 2005; Geller, Taylor and Scott 2004; Gooch, Griffin and Malvitz 2006). Indeed, they have been deemed by some as a 'mandatory' health service due to the shortcomings of the existing dental care delivery system and the overwhelming unmet dental health needs of the underserved (Byck, Cooksey and Russinof 2005).

Community dental clinics in many parts of Canada are expanding dental care for underserved populations, including homeless populations. Inner-city community health centres (CHCS), in particular, provide an avenue to address the health care needs of vulnerable and marginalized populations, yet most of them do not have dental clinics. To advance discussion in this area, we will describe the oral health care needs of homeless populations, the barriers they face to accessing these services and the growing role that community dental clinics play in improving access to care.

Oral Health and Homelessness

Studies of homelessness and oral health (Table 8-1) are few and usually limited to small sample sizes (Blackmore et al. 1995; Chi and Milgrom 2008; Collins and Freeman 2007; Conte et al. 2006; Daly, Newton and Batchelor 2009; De Palma and Nordenram 2005; De Palma et al. 2005; De Palma 2007; Gibson et al. 2008; Jago, Sterberg and Westerman 1984; Kahabuka and Mbawalla 2006; Kaste and Bolden 1995; Lee, Gaetz and Goettler 1994; Luo and McGrath 2006; Pizem et al. 1994; Waplington, Morris and Bradnock 2000). Overall, they show that homelessness has a direct association with poor oral health (Bolden and Kaste 1995; Clarke et al. 1996; Conte et al. 2006; De Palma and Nordenram 2005; De Palma et al. 2005; De Palma 2007; Dogan et al. 2006; Gaetz and Lee 1995; Gelberg, Lin and Rosenberg 1988; Gibson et al. 2003; Han, Wells and Taylor 2003; Jago, Sterberg and Westerman 1984; Kaste and Bolden 1995; Lee, Gaetz and Goettler 1994; Luo and McGrath 2006; Pizem et al. 1994). Homeless persons have poor oral health, such as missing and decayed teeth, oral pain, gum disease and related conditions in need of urgent attention (Allukian 1995; City of Toronto 2000; Clarke et al. 1996; Collins and Freeman 2007; Hwang 2001, 2002; King and Gibson 2003). For example, 91 percent of clients of a dental program associated with homeless shelters in Boston had a very high need for preventive and restorative dentistry due to caries (Kaste and Bolden 1995). They reported difficulty accessing dental care and caring for their teeth due to a lack of oral hygiene products and adequate restroom facilities. Similar observations were made in Brisbane, Australia, where homeless individuals had thick calculus deposits on their teeth and seemed to accept tooth loss without complaint or obvious concern, although they did state that dentists were reluctant to treat them (Jago, Sterberg and Westerman 1984).

Research published as early as the 1990s shows that Canada's homeless populations have fared no better. In Montreal, in 1994, Pizem and colleagues (1994) reported that 61 percent of the homeless population needed dental treatment. In Toronto, 50.6 percent of the homeless youth (14 to 25 years old) reported toothache and 74.1 percent expressed willingness to visit a dentist, but among those one-third did not know where to go (Lee et al. 1994). Also in North York, Ontario, 29.4 percent of the homeless youth needed dental restorative treatment and 72.7 percent had moderate to severe gingivitis (Clarke et al. 1996).

Table 8-1. Select published studies of the oral health status of homeless people

Author	Location	Sample Size	Age Range in Years	Finding
Jago, Sterberg & Westerman 1984	Brisbane, Australia	162	15–85	34.6% needed urgent treatment for one or more of the following conditions: toothache, oral infection, endodontic problems, large carious lesions, fractured teeth.
Gelberg, Lin & Rosenberg 1988	Los Angeles, USA	529	18–78	56% observed to have at least one grossly decayed tooth and 27% reported a toothache during the previous month.
Lee, Gaetz & Goettler 1994	Toronto, Canada	174	14–25	40.8% had not been to the dentist in the previous two years.
Kaste & Bolden 1995	Boston, USA	73	19–64	91.4% had untreated caries and 88.6% were missing some teeth.
Blackmore et al. 1995	Leeds, UK	101	18–75	59% of the dentulous men had 12 or more missing teeth, and 69% need some dental intervention.
Clarke et al. 1996	North York, Canada	155	14–20	59% had not been to the dentist in the previous year, and 18% had toothache in the previous four weeks.
Waplingon, Morris & Bradnock 2000	Birmingham, UK	70	19–94	54% had caries involving the pulp.
Gibson et al. 2003	US national survey	1,152	24–79	68.1% reported need for dental care.

Table 8-1. (Continued)

Author	Location	Sample Size	Age Range in Years	Finding
De Palma et al. 2005	Stockholm, Sweden	147	20–79	Almost 100% had calculus and considerable plaque accumulation.
Luo & McGrath 2006	Hong Kong, China	147	21–75	53% considered their oral health poor or very poor, and 52% had dental pain in the previous year.
Conte et al. 2006	Newark, USA	46	40.4 (mean age)	66.7% reported oral facial pain during the previous year.
Collins & Freeman 2007	North and West Belfast, Ireland	317	16–91	75% had bleeding gums and calculus.
Chi & Milgrom 2008	Seattle, USA	45	14–28	29% self-rated their oral health as "very bad" or "bad" and 38.5% reported a toothache.
Daly, Newton & Batchelor 2009	London, UK	201	25–54	71% required treatment for dental decay, recurrent decay, and root caries.
Robbins et al. 2010	San Francisco, USA	340	42.8 (mean age)	64% of homeless injection drug users (IDUS) reported need for dental care.
Daly et al. 2010	London, UK	102	19–77	76% required treatment for dental decay, root caries, recurrent decayed teeth and 80% required oral hygiene and periodontal treatment.

A recent report from Toronto found similarly high distributions of oral pain and poor self-rated oral health (Khandor and Mason 2007). The report also notes that many of those interviewed were without teeth or dentures because social assistance in Ontario would only pay to have their teeth extracted (Khandor and Mason 2007). Moreover, nearly half (43%) of respondents stated that they could not afford dental care and had not been to a dentist in the past three years due to poverty (Khandor and Mason 2007). Homeless persons in Vancouver and Victoria also made little use of dental services compared to other health services, especially emergency departments of local hospitals (SPARC-BC 2008; Victoria Cool Aid Society 2007). Homeless persons in Victoria identified dental problems as a barrier to finding work (Victoria Cool Aid Society 2007), and they feel that public dental benefits from welfare programs do not cover extensive treatment needs (Klein et al. 2008).

Many factors contribute to poor oral health of homeless people:

- a chaotic lifestyle and more pressing 'survival needs' prevent routines of eating and personal hygiene;
- acceptance of poor dental health and appearance;
- limited access to washing facilities, toothbrush and toothpaste;
- poverty;
- lack of awareness of diet and oral hygiene issues;
- mental health problems and substance misuse (British Dental Association 2003: 13).

People with dental pain or who have no teeth often eat only soft foods, such as the day-old pastries and coffee offered by drop-in day-programs and other social service agencies (Gelberg, Lin and Rosenberg 1988). Frequent consumption of refined carbohydrates and other sugary foods, especially when oral hygiene is poor, quickly leads to rampant caries (Bolden and Kaste 1995; Gaetz and Lee 1995; Han, Wells and Taylor 2003). Undoubtedly, many people who are homeless are acutely aware of the consequences of poor oral hygiene. As one homeless youth in Gaetz and Lee's (1995) study reported: "*I left home two weeks ago and I haven't been able to brush my teeth since. I hate that feeling—my teeth all furry. It's kind of embarrassing*" (34).

Tobacco, alcohol and illicit drug use are widespread among homeless people and can have a devastating impact on oral health, with problems such as 'meth mouth' from inhaling crystal meth

(Gelberg, Lin and Rosenberg 1988; Conte et al. 2006; Blackmore et al. 1995; Chi and Milgrom 2008). Other studies (Robbins et al. 2010), however, questioned the supposed impacts of 'meth mouth' with the view that the oral diseases might be related more to poverty, homelessness and poor hygiene than to crystal meth. Dental problems are common among injection drug users who are homeless in San Francisco, where 64 percent of participants in a recent study reported a need for oral health care in the past six months (Robbins et al. 2010). Methadone has also been associated with increased incidence of caries, whilst untreated oral disease adds to the complications of HIV and hepatitis C. Frequent substance use can suppress dental pain and therefore mask awareness of dental problems, which explains why the self-assessed need for dental care is usually low in this population (Daly, Newton and Batchelor 2009). Mental health challenges can also lead to a chaotic lifestyle, low priority for oral health care and cravings for sugar and tobacco. Furthermore, dry mouth is a side effect of many medications used to treat mental health challenges. Finally, homeless individuals are at greater risks of trauma generally, and teeth can be knocked out as a consequence of such experiences (Gaetz and Lee 1995; King and Gibson 2003).

Barriers to Access

It is difficult to access primary health care, including oral health care, if you are homeless (Hwang, Tolomiczenko, Kouyoumdjian and Garner 2005). Access to dentistry is complicated by the private service model that demands direct out-of-pocket payments for service. Consequently, minor problems are often ignored because of treatment costs and, when untreated, lead to pain, infection, swelling and even more costly care (Bolden and Kaste 1995; Gibson et al. 2003; King and Gibson 2003). People in dire poverty may use over-the-counter analgesics for quite severe toothache rather than seek the services of a dentist (Bedos et al. 2003; Bedos et al. 2005), and some people have even been driven to extract painful teeth with household pliers and use other domestic remedies (Cohen et al. 2009; Bedos et al. 2003).

Hospital emergency departments are used all too frequently by people who are unable to pay for a visit to a dentist (Cohen et al. 2009). Yet emergency departments are not usually prepared or suitably equipped to tackle dental emergencies involving endodontics and are even less prepared for routine restorative dental care and

prosthodontics (Daiski 2007; Hwang 2001; Schanzer et al. 2007). Indeed, the level of dental care in emergency rooms rarely involves much more than symptomatic advice or prescriptions for antibiotics and painkillers.

Financial Barriers

Dentistry is not covered by Canada's system of national health benefits and is available as a tax-based benefit only to Aboriginal peoples, recipients of social assistance, some children, the armed forces and Royal Canadian Mounted Police, veterans of the armed forces and some elderly populations in the Yukon (Health Canada 2011). Approximately 4 percent of Canadians use public dental benefits when paying for dental treatment (Leake 2006), and dental benefits available to homeless people are typically provided through provincial social assistance. Poverty and poor oral health are very closely linked, in part because low incomes limit access to dental care in North America (Lawrence and Leake 2001; Locker 2000; MacEntee, Harrison and Wyatt 2001; Quiñonez et al. 2009b).

Public dental benefits in North America have been criticized as overly restrictive, burdened by red tape and based on payment fees significantly below the fees received by dentists in private practice (Gaetz and Lee 1995; Han, Wells and Taylor 2003). Improving public dental benefits might reduce the financial barriers to accessing dental care by encouraging more dentists to participate in the service (Altieri et al. 2002; Birch and Anderson 2005; Dharamsi and MacEntee 2002; Kalebjian and Murphy-Tong 2001; Patrick et al. 2006; U.S. General Accounting Office 2000). However, people experiencing poverty and homelessness confront many barriers to accessing treatment in general dental practices. Improved public dental benefits might help, but other types of barriers to accessing dental care would likely remain.

Patient-Related Barriers

Homeless persons have continual difficulties obtaining food, shelter, safety and money. Consequently, dentistry is rarely a priority until a problem surfaces in or around the mouth. Competing priorities are often interpreted as general apathy or a lack of motivation rather than a sign of adaptation to unpleasantness and chaos (Daiski 2007; De Palma and Nordenram 2005; Gelberg, Lin and Rosenberg 1988). Yet this adaptation is usually a source of social embarrassment sufficient to inhibit the search for care.

A high level of dental anxiety has been reported within homeless populations, for reasons that are not altogether clear but probably relate to personal trauma and mental health issues (Clarke et al. 1996; Kaste and Bolden 1995; King and Gibson 2003; Lee, Gaetz and Goettler 1994; Luo and McGrath 2006; Pizem et al. 1994; Collins and Freeman 2007). Just as a chaotic lifestyle predisposes the individual to poor oral health, it is also makes it all but impossible for them to access care. Keeping appointments is a challenge without a daily routine, a watch, an alarm clock or a daily planner—even more so when confounded by substance use or mental health problems.

There is a wide gulf of distrust between people living in poverty and the system of dental care around them, as well as a perception among homeless people that dentists will not accept them as patients (Bedos et al. 2003; British Dental Association 2003; Greenberg, Kumar and Stevenson 2008). This can include being very critical of dentists, whom they see as rich, unsympathetic, at the opposite end of the social scale and motivated professionally by money (Daiski 2007; Frankish, Hwang and Quantz 2005; Han, Wells and Taylor 2003). Consequently, when they encounter dental problems, they prefer community dental clinics rather than private dental practices (Bedos et al. 2003).

Private Practice Dentistry

While 81 percent of Canadian dentists surveyed report supporting government spending on dental benefits, most (70%) report that less than 10 percent of their patients are publicly insureds (Quiñonez, Figueiredo and Locker 2009a; Quiñonez et al. 2010). Similarly, many people on low incomes in Canada feel that their access to dental care is likely to improve only when their relationship with dentists improves (Quiñonez et al., 2009b). Dental care providers often hold misconceptions and negative stereotypes about people receiving social assistance (Bedos et al. 2005; Quiñonez et al. 2010). In defence of this position, dentists cite financial risks, low reimbursement rates, excessive and complicated paperwork, broken appointments, unpredictably disruptive behaviour and a general disregard for oral health as reasons for refusing to accept patients with public dental benefits (Greenberg, Kumar and Stevenson 2008; Levesque et al. 2009; Patrick et al. 2006).

The reluctance among dentists to accept homeless patients is not just stereotyping, then, but includes a pragmatic awareness of the

challenges involved in providing appropriate care to a population facing multiple psychological, social and biological barriers. Patients with mental health or substance use problems can be unpredictable and socially disruptive (Muirhead et al. 2009) and, consequently, tend to be shunned by dentists (Allukian 1995; Clarke et al. 1996; De Palma and Nordenram 2005; Falvo 2009; Lee, Gaetz and Goettler 1994; McCormack and MacIntosh 2001; Pizem et al. 1994).

Community Dental Clinics

Concern regarding the extent of untreated dental pain and oral infection has led to a growing interest in the potential of community dental clinics (British Dental Association 2003; Leake 2005; Melanson 2008; Wallace 2008). With limited funds available from governments, these clinics are often dependent on the charity of dental volunteers. Typically, they have developed locally, independently of similar experiences elsewhere (Wallace 2008). Some of them operate with charitable donations of time and professional skill to provide emergency care for a few hours each month. Others pay full-time staff members to provide a comprehensive range of dental treatments in well-equipped clinics. However, the financial risks increase as the services expand, because of the relatively low income generated from the low professional fees they must charge to meet the needs of low-income patients (Quiñonez et al. 2010).

Community dental clinics in Canada have emerged with little documentation or scrutiny, other than the observations that they are either run as a charity or on a not-for-profit basis, and in community drop-in centres and health care centres (Wallace 2009). Many dentists also provide charitable dentistry in private practice as well as in teaching clinics for dental personnel attached to colleges and universities in larger cities.

Charitable Volunteer-Operated Dental Clinics

The dental services provided by charitable clinics vary greatly around the country, but they usually limit their activities to relief of pain and gross infection by extracting teeth. The Calgary Urban Project Society, for example, offers free emergency dentistry with volunteer staff and supplies donated by local supply companies. In Toronto, the Shout Clinic and Evergreen Health Centre for Street Youth were established and serviced by volunteer dentists to provide

dentistry for minimal professional fees. The Ottawa Mission Dental Clinic is also an active volunteer-based clinic providing a range of preventive and restorative treatments. Likewise, in British Columbia, the population in Vancouver's Downtown Eastside can get relief of pain and infection without charge by the East Side Walk-In Dental Clinic. The Kelowna Gospel Mission opened a free dental clinic with funds from the national Homelessness Strategy, while dental volunteers in Prince George operate a community dental clinic several evenings a month without charge, to relieve dental pain for low-income residents. The most compelling concern about the limited services provided by most charitable clinics is that they might become the basic and legitimate standard of care for low-income and vulnerable populations, which some believe is an unacceptable breach of human rights and tiering of an important health service (Dharamsi and MacEntee 2002; McNally 2003).

Non-profit Dental Clinics

Community dental clinics resemble community health centres (CHCS) and are often part of integrated health settings focused on providing primary health care that is accessible, affordable, comprehensive and well-integrated. There is very little information available on how these clinics operate, other than that they usually have full-time hours and employ dentists and other dental professionals to provide a full range of emergency and comprehensive treatments including prevention. These clinics can have relatively large operating expenses, which require secure funding. Some operate in part with government funding to supplement pro bono treatment. However, most of them rely on reduced fees paid by patients. Therefore, these are social enterprises operating as non-profit businesses with significant financial risks. Examples of non-profit dental clinics are Edmonton's Boyle McCauley Community Health Centre; Winnipeg's Mount Carmel Clinic; Toronto's Queen West Community Health Centre and Regent Park Community Health Centre; Vancouver's REACH Community Health Centre, Mid-Main Community Health Centre and Strathcona Community Dental Clinic; and Victoria's Cool Aid Community Health Centre. While most operate within integrated health settings such as a CHC, some are integrated within other settings. For example, the Strathcona Clinic operates within an inner-city school, while the Portland Clinic is administered as part of Vancouver's Downtown Eastside housing projects and supervised drug consumption service.

Teaching Clinics

In cities with teaching clinics for students of dentistry, dental hygiene, denturism or dental assisting, there is opportunity for oral care from students at a reduced fee. All of the dental schools in Canada offer students opportunities for community service learning (Brothwell 2008; Brondani et al. 2008). Consequently, teaching clinics are an integral part of the oral health care system in Canada as in most other industrial countries.

The Centre Local de Services Communautaires (CLSC) des Faubourges Clinic operated by L'Universite de Montreal provides preventive and restorative dental care to young homeless persons in Montreal and is integrated with other health and social services for homeless youth in the city (Allison, Allington and Stern 2004; Wallace 2008). The University of Manitoba operates the Centre for Community Oral Health (CCOH), which provides dental care for inner-city poor. The University of British Columbia operates on- and off-campus teaching clinics for dental and dental hygiene students, while the general practice residency program rotates young dentists through various community clinics in the province. Although they offer care at reduced fees, teaching clinics rarely operate without professional fees, and frequently these can exceed the financial resources of people in extreme poverty.

Future Research

While existing research confirms that homelessness is directly associated with poor oral health and a lack of access to oral health care, future research should inform responses to address these inequities. One recent exploratory study of the oral health of the homeless population in Toronto (Figueiredo, Hwang and Quiñonez 2013) recommends future research that includes mixed method study designs with adequately large sample sizes in order to explore all subgroups of the homeless population and, most importantly, to investigate the potential for alternative models of service provision for this population. Currently, though, there remains a dearth of evidence to inform responses to best meet the complex needs of these populations and no evaluations of alternative care models in Canada.

Conclusions

Non-profit dental clinics serving homeless communities have the capacity to:

- *Reduce the financial barriers to accessing dental care for patients who have low incomes and are uninsured or without public dental benefits:* Community dental clinics address the financial barriers to accessing dental care by reducing the fees for individuals who lack dental coverage and the ability to pay private practice dental fees. For individuals with public dental benefits, the clinics are able to subsidize additional care at lower rates by billing public benefit plans. Still, while fees are reduced and pro bono services provided when possible, even at these reduced fees the costs can be prohibitive, notably for significant procedures such as root canals or dentures.
- *Provide dental care within integrated care settings to reduce barriers to care within the general social and health needs of this population:* In addition to addressing the financial barriers experienced by most patients of community clinics, there are additional barriers that community clinics must address to effectively meet the diverse needs of specific vulnerable groups. Community dental clinics are often integrated within community health centres, providing a medical and dental home for persons who are homeless and facilitating the delivery of complex oral health care that can often be associated with other medical co-morbidities.
- *Provide a full range of dental diagnostic and restorative services similar to the distribution of services available from private dental practices:* Volunteer-charitable clinics are demonstrating the value in providing emergency, relief-of-pain dental treatment (notably extractions) for free. Meanwhile, the other model of community dental clinics is demonstrating the ability to provide a full range of diagnostic and restorative services; the distribution of services provided are similar to the distribution of services in private practices.
- *Accommodate a high frequency of missed appointments and emergency needs:* Private practice dentistry is challenged to accommodate the high numbers of missed appointments that can be expected when treating individuals in crisis and facing

significant challenges to self-sufficiency. The clinics similarly report a high rate of missed appointments; however, there is also high demand for unscheduled emergency treatments. These challenges actually complement each other, and the clinics can keep their clinicians very busy despite the broken appointments.

- *Sustain a pool of dental professionals employed in community-based dentistry and paid competitive salaries:* It appears that recruitment and retention of dental staff may be challenging but not an absolute barrier. If community treatment alternatives are to expand, it would be beneficial if the curriculum for dental professionals could support the development of dental graduates with the interest and skills to work in these settings.

Charitable dentistry by unpaid volunteers cannot adequately address the enormity and complexity of unmet dental needs experienced by those who are experiencing dire poverty. These 'band-aid' responses, while valuable and laudable, risk becoming an accepted standard of care for low-income populations. The financial sustainability of community-based clinics depends on relatively small but regular financial subsidies from government combined with some fees recovered from patients with public dental benefits. The recommendation to support and expand community dental clinics is vital, yet limited. While clinics can play a critical role in a response to the oral health needs of people experiencing homelessness, the safety net they provide has limited capacity to overcome the overwhelming barriers to accessing dental care (Slott 2005). Ultimately, the social determinants of oral health of homeless persons must provide the framework to locate the various components of a comprehensive response.

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CHAPTER 9

Close to the Street: Nursing Practice with People Marginalized by Homelessness and Substance Use

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Introduction

Nurses are often an initial and ongoing point of contact for persons marginalized by homelessness and substance use in health care settings. As such, nurses are uniquely positioned to facilitate access to health care for people who have poor health and face multiple barriers to care. In particular, persons marginalized by homelessness and substance use often encounter stigma and discrimination when accessing health care. Professional standards for ethical nursing practice include promoting health and well-being, preserving dignity and promoting justice and health equity (Canadian Nurses Association 2008). The promotion of justice means that nurses do not discriminate in the provision of care on any basis and refrain from judging and stigmatizing behaviours. However, specific concerns related to exclusionary 'othering', in which others are differentiated on the basis of class, race, gender or some other aspect, contribute to negative processes of engagement and are prevalent in health care (Canales 2000; MacCallum 2002; Peternelj-Taylor 2004; Varcoe 2004). Further, nurses have a specific professional commitment to the promotion of equity in health and health services.

This chapter discusses findings from an ethnographic study exploring access to health care for people marginalized by homelessness and substance use within nurse–patient interactions and

the environment in which these interactions took place. A key finding was that forging a chain of trust in a climate of distrust fosters access to health care. This chain of trust is triple-linked, consisting of interlocking interpersonal, organizational and systemic linkages. Health care access is negatively impacted when these links are weak or broken. Strategies for enhancing access to health care for people marginalized by homelessness and substance use through enhancement of ethical nursing practice are also discussed.

Stigmatization, Discrimination and Health Care Encounters

People impacted by homelessness and substance use often encounter stigma and discrimination when accessing health care services (Butters and Erickson 2003; Crockett and Gifford 2004; Gelberg et al. 2004; Lloyd 2010; McLaughlin et al. 2006; Stajduhar et al. 2004; Trevana, Simpson and Nutbeam 2003; Wen, Hudak and Hwang 2007). Negative attitudes of health care providers have been implicated in the development of stigmatizing experiences and discriminatory practices associated with class, substance use, disease conditions or other factors such as race or ethnicity.

Stigma is the outcome of social processes that result in social devaluing and spoiled identity in which individuals are marked on the basis of negative attributes (Goffman 1963). Stigmatization results in either *enacted stigma,* where individuals are actively discriminated against, or *perceived or felt stigma,* where stigmatized individuals internalize negative beliefs (Goffman 1963). Stigma is highly contingent on an individual's social location and "entirely dependent on social, political and economic power" with power imbalances between those who are the subject of stigma and those who stigmatize (Link and Phelan 2001). Stuber, Meyer and Link (2008) argue that stigmatization and discrimination share common features, "including exposure to negative attitudes, structural and interpersonal experiences of discrimination or unfair treatment and violence perpetrated against persons who belong to disadvantaged social groups" (351). Further, people may be subject to intersecting stigmas associated with age, sex, gender, sexual orientation, race, ethnicity socioeconomic status or disease (Benoit and Shumka 2009; Wailoo 2006). For example, the stigma associated with homelessness may combine with other stigmatizing conditions, such as mental illness, HIV/AIDS, hepatitis C and substance use, and contribute to discrimination (Harter et al. 2005; Takahashi 1997; Wolitski et al. 2009).

Researchers have reported that homeless persons often encounter negative experiences or judgments when accessing health care (Ensign and Planke 2002; Gelberg et al. 2004; Stajduhar et al. 2004). For example, Wen, Hudak and Hwang (2007) found that homeless persons either implicitly or explicitly connected unwelcomeness with feelings of discrimination. The stigma associated with drug use has contributed to negative experiences in health care settings for this population (Butters and Erickson 2003; Crockett and Gifford 2004; Lloyd 2010). Stigma and discrimination decrease the likelihood that individuals will access health care in the future and may contribute to further marginalization and feelings of low self-worth and may also manifest in physical and mental health concerns (Bird, Bogart and Delahanty 2004; Browne et al. 2002; Dinos et al. 2004; Krieger 1999; Wen, Hudak and Hwang 2007; Zickmund et al. 2003).

In contrast, several studies have found that registered nurses providing primary care outreach and provision of care in community health centres are perceived more positively by marginalized populations (Hilton et al. 2001; Politzer et al. 2004). For example, a Vancouver evaluation of the street nurse program was found to foster the development of relationships and enhance access to heath care. However, there is limited understanding of ethical nursing practice and strategies within nurse–patient interactions that might provide insight into reducing barriers and fostering access to health care services for those marginalized by homelessness and substance use.

Methodology and Methods

An ethnographic approach that drew on critical and feminist perspectives was used to examine access to health care and ethical nursing practice in interactions between nurses and persons experiencing homelessness and/or substance use and the environment in which these interactions occur. The specific research objectives were to: (1) describe the nature of interactions and the development of relationships between nurses and marginalized populations, (2) explicate the underlying factors (social, political, economic and historical) supporting and limiting the enactment of professional standards and practice by nurses within these relationships, (3) explore the impact on access to health care and (4) identify the insights of clients and nurses that would contribute to the development of more equitable

access to health care services. A detailed description of the methodology is provided elsewhere (Pauly 2008b).

Data collection methods included qualitative interviews with 26 primary participants (13 registered nurses, four people accessing health care, nine non-nursing health care staff) and 203 hours of participant observation at two community health care centres (CHCS) and one emergency department (ED). Interviews and participant observation were conducted over a period of 10 months. All interviews and field notes were audio recorded and transcribed verbatim. Both the CHCS and the ED were located in western Canada and were identified as serving an inner-city population in areas associated with poverty, homelessness and substance use. Data collection and analysis occurred concurrently. Inductive methods of data analysis as described by Lincoln and Guba (1985) were used. Immersion in the transcripts and field notes through multiple readings contributed to the identification of activities, events and conversations that provided insight into nurse–patient interactions within the social context that facilitated or inhibited access to health care. Consistent with feminist approaches, nurse participants were actively consulted at various points to clarify and extend the analysis. Criteria for reliability and validity in feminist research including dependability, adequacy, reflexivity and catalytic validity were employed to ensure rigour in the study (Hall and Stevens 1991; Lather 1991).

Ethical approval for the study was granted by each site as well as the University of Victoria. Initial information sessions were conducted in both CHCS to inform staff about the study. Written consent was obtained from all primary participants for interviews and observations. Throughout the study, staff members in each setting were informed about the study when observations were conducted. Verbal consent was obtained from individuals who were observed during nursing care delivery.

Findings

All participants emphasized that people marginalized by homelessness and substance use were often distrustful of mainstream health care services and expressed an avoidance or reluctance to access health care, particularly in hospitals. One participant echoed the feelings of many: "*I'm not going to go, I don't go to hospital unless I absolutely, desperately have to go, unless I am on my deathbed*." Client participants

relayed a range reasons for avoiding hospital care, including fears of being overlooked, prejudged and treated like garbage by a system that focuses on addressing acute concerns and getting people through quickly (Pauly 2005). Distrust was exacerbated by a 'culture of fixing' in the emergency department and embedded in personal experiences of past trauma and being on the street, where "trust is a lousy survival tactic" (Pauly 2008b). In this climate of distrust, re-establishing trust with people experiencing homelessness and substance use was central to the work nurses did to facilitate access to health care services. Rebuilding trust occurred on three interrelated levels: interpersonal, organizational and systemic.

Interpersonal Linkages

Building trusting relationships over time. In this study, nurses felt that each client interaction was an opportunity to build trust that could facilitate access to health and ancillary services. A nurse describes:

> *It is a process over time. Yeah. It doesn't . . . it certainly doesn't happen on the first visit. It certainly takes a while, and sometimes the first visit is . . . just meeting their immediate needs but letting them know that the door is open . . . Really . . . the basis of providing access to care is that relationship and that sense of trust.*

Multiple interactions build interpersonal trust over time and are necessary to facilitate access to health care services. Some key features of building interpersonal trust were preserving respect, not brushing concerns off and sensitivity to life circumstances.

Preserving respect. Client participants' fears of being "overlooked", "prejudged" and "treated like garbage" highlight the lack of respect they often experience in health care relationships. All participants noted the importance of respect in health care encounters and relationships and a desire to be treated "like a real person". One client participant remarked, "*I just want a doctor that respects me and treats me like a person*." This client participant continued:

> *You know, [the street nurse] has seen me when I've been so stoned I could hardly walk or talk or anything, gibbled, or you know, doing the chicken or whatever they call it, flailing away. And he doesn't degrade me for it. Like you know [the street nurse] accepts the fact that I'm a*

> *junkie and I'm going to be a junkie the rest of my life. But I'm still a good person inside. I mean I have compassion for people. I try and help people out. You know he understands I have compassion for people.*

Nurses and health professional participants endeavoured to see their clients as persons with unique value and worth, not as 'addicts', 'junkies' or 'the homeless'. Some nurses described their clients as 'survivors' and admired them for how they coped with daunting life experiences and the daily challenges of homelessness, poverty and life on the street.

As suggested by the quote above, a key to respecting clients was the ability to move beyond judgments and stereotypes. One nurse describes how it was easy to fall into the trap of thinking of her clients in stereotypical ways:

> *I think what I do is that I'm able to split my thoughts and how I react to these guys. When I'm on [the street] Christmas shopping and when I'm having my glass of wine in a wine bar, I do think of my clients as scumbags, addicts, who broke into my car. Get an f'in life, go to work . . . I do think of it that way. And when I come here and I'm actually physically caring for them . . . and I'm actually wiping the purulent discharge from the horrible festering cellulitis all over their body and they're telling me how hungry they are because they've only had this whatever it is. I can chit chat with them and really feel for them. So again, it's overcoming all these prejudices, right? Also, you know . . . it's the environment that's along with it . . . you live the middle-class life, it's so totally removed. . . . Actually physically doing it without having this colonial attitude that I'm doing good for these poor little souls and helping them.*

This nurse describes how one has to navigate judgments about personal responsibility that are part of societal norms while not taking up an attitude of servitude and charity and striving to find genuine compassion.

In light of past experiences and the hypervigilance necessary for survival on the streets, nurses were aware that clients were both hypervigiliant and attuned to negative judgments when accessing health care. One nurse describes, "*You know I think they are so sensitive about everything because they've been so bruised and so damaged and everything is seen as a reprimand, a spank, put in the corner. They're not*

able to decipher that out." In response, nurses described being hypervigilant and super sensitive to non-verbal and verbal behaviour that might communicate negative judgments. One nurse noted:

> *You always have to be checking yourself doing a mental check, saying oh, because now I'm more aware of it than I was. So that's why yesterday I thought, I'm getting my back up, I need to take a deep breath because I'm not going to be able to help this guy if I'm feeling defensive. It's just a question of breathing through it and recognizing what it is that's triggering me.*

This excerpt demonstrates the challenges of being self-aware and recognizing when one is being triggered by a client's behaviour and monitoring potentially negative responses that could reduce access to care.

While health care interactions are a precious opportunity to show respect, nurses described the challenge of maintaining respect in the face of disrespect. For example, one nurse observed:

> *It means you have to constantly find respect for people that constantly step on you and don't do what it is you're there to help them do. . . . And you secretly lose respect for someone that yells at you from the door. You can't help it . . . when somebody says, Fuck off! Well okay, I will fuck off. You know. And it's very hard not to develop that attitude and just take yourself out of it.*

'Taking yourself out of it' could mean withdrawal from the person or situation or refusing to take it personally. One social worker indicated it would have been easy to say something harsh to someone who was being verbally abusive but recommended a more respectful approach:

> *But it was that kind of behaviour [respect] that would throw people off more than. And [I] got to let you know this isn't okay but the last thing I'm going to do is do this dance with you. I'm going to take every opportunity I can to model something different. You're deserving of respect, I'm deserving of respect. So, let's work on that.*

When respecting a client became difficult, often due to violent behaviour, nurses and other health professionals emphasized the importance of preserving and respecting a client's right to receive health

care services without judgment. Several participants expressed the belief that the CHC was the last stop for health care and that it would be ethically wrong to limit care even in the face of challenging behaviours. In preserving a client right to access health care, nurses had to navigate two tensions: (1) management of health care resources and (2) perceived threats to personal safety and security (Pauly 2008b).

Not brushing people off. Nurses listened and acknowledged clients concerns and sought to never 'brush clients off'. Nurses strived to view all presenting concerns as serious and worthy of time and attention. For example:

> *A man came into the exam room and told the nurse he thought he had glass in his scalp from a broken bottle. As he pulled and picked at his hair, the nurse put on disposable rubber gloves and explained she would have a look and patiently began parting his hair and examining his scalp. After a few minutes, she said, "I can't see anything." The interaction ended abruptly as he jumped up and said, "Well okay, I must have gotten it all out." Later, the nurse explained that he has come in many times before with the same complaint and that he often picks his scalp until it bleeds. She suspected it was a side effect of cocaine use. As I had watched the interaction, I had assumed from the nurse's behaviour, that she had taken seriously his request to see if there was any broken glass in his scalp.*

Nurses were attentive to the presenting concerns regardless of their perceived validity. Such an approach can become a tangible way of showing respect to clients who are frequently 'brushed off' not just in health care services but every day.

In their interactions with nurses, clients frequently expressed anger and frustration at their life situations, such as conflicts with family and friends, housing difficulties and money problems. Nurses listened patiently to these concerns and, once clients had expressed their frustrations and the client was ready to move on, nurses would often calmly ask about the reason for their visit and what assistance they needed. One client describes the powerful impact this has:

> *I've been in rages sometimes and gone and see the . . . nurse and totally calmed down because I got everything off my chest in five minutes, right. From a totally raging animal to nice mellow guy again in*

> *five minutes. I talk to the [nurse], I tell him you haven't got the golden pill but you've got the golden ear. . . . You know just getting things off my chest. And if I didn't see [the nurse] there, I probably would have gone downtown and got in a fight and took my rage out on somebody else right rather than talking to the [nurse]. A lot of times it's just the listening part means the whole world of difference from freakin' out and going totally ballistic. You know when you're right on the edge, maybe haven't made money for a day or so and somebody's in jail and you're trying to get her out of jail. And you're right on the edge, you know, you're full of rage. You can talk to the [street nurse] for five minutes or the other girl and you know you get it all off your chest.*

After a few minutes of expressing their frustration, clients were frequently observed to experience a shift in demeanor from anger or frustration to calm. Not brushing these concerns off did not imply agreement or necessarily require additional action by the nurse. Rather, listening conveyed respect and helped build relationships that were essential to facilitating access to and provision of nursing care. Some nurses expressed a view that listening to clients about whatever was on their mind helped them to get to know them better, what their worries and concerns were.

Sensitivity to life circumstances. Sensitivity to life circumstances helped to contextualize individual behaviours and choices and foster respect for clients. One nurse noted that clients often felt embarrassed and apologized for the odour of their feet when they take their socks off for an exam. Rather than judging them as a "rude stinky street person", she observed that being on the street makes it difficult for people to shower every day and they don't always have access to clean socks. Thus, rather than judging them for their appearance and cleanliness, the nurse situated these encounters within the context of life on the street, specifically lack of access to showers and resources to promote personal hygiene. Another nurse noted:

> *Trying to put yourself in their shoes and understanding the issues that they're talking about and sometimes it's the hardest thing because it's hard for them to communicate their reality and it's hard for you to understand them because the living situations are so different. . . . One patient told me the [medication she is on] and I told her it's important to drink lots of water to minimize side effects. And I asked*

> *her how many glasses of water she drinks and she says, "Well, I just drink coffee in the pharmacy where I pick up my methadone then maybe I buy a coffee in McDonald's. But I don't drink water in my A hotel. It's undrinkable. It's disgusting." So to get to the bottom of these details is crucial for people's treatment. You need time and you have to then think of solutions that . . . you would not otherwise think in any other situation.*

Recognizing that clients' decisions are shaped by the context in which they live and recognizing that the life circumstances of their clients was different than their own provided an avenue to avoid judging behaviours and fostered provision of care that was situated and relevant to the life circumstances of the client. As illustrated above, telling someone to drink water when they do not have access to water is ineffective and would not promote proper medication administration. It is necessary to constantly think in terms of 'what would this be like if I didn't have housing and access to taken for granted privileges such as water, showers, privacy and so on?'

Individuals' ability to care for their health is profoundly shaped by their individual living situations, social position and access to resources. Some nurses were quick to caution that you may never know a client's whole story or could only understand to degrees the effect of poverty, addiction and violence on clients' behaviours and choices. Rather than expecting individuals to share their life story, nurses assumed there was also more to individual client situations than they might ever know, need to know or understand.

Organizational Linkages in Building a Chain of Trust

Organizational linkages are vitally important in building a chain of trust. Key organizational linkages in creating a climate of trust that fostered access to health care were harm reduction, outreach and inter-agency trust. The absence of these conditions inhibited access to health care for those marginalized by homelessness and substance use.

Harm reduction: meeting people where they are. Nurses working in CHCS recognized harm reduction as an organizational philosophy, a set of strategies and a practical approach to working with homeless and substance using populations. They described harm reduction as integral to ethical nursing practice, the development of relationships

with clients and the consequent increased access to health services. Harm reduction created a relational space in which relationships between health professionals and clients could develop without judgments related to substance use. The context of health care delivery shifted from a 'culture of fixing' substance use to accepting that people 'fix'. Some of the nurses and other participants in the study described harm reduction as taking the pressure off trying to fix people and instead putting the focus on keeping them safe. A philosophy of harm reduction shifted moral values to (1) focus on reducing harm associated with substance use and living conditions, (2) emphasize the moral worth of clients and (3) enhance the decision-making capacity of clients (Pauly 2008b). For CHC nurses, harm reduction meant being ready for change but not expecting it and not giving up. One nurse noted, "*Ethical practice is when the person can keep coming back without judgments, without recriminations*". Another nurse stated, "*We don't fire people and we don't give up on them*". Nurses consistently tried to minimize harm not only from substance use but also the other harms associated with homelessness and street-involvement that might impact health and well-being. Reducing harm became a moral imperative for guiding ethical nursing practice.

Outreach: meeting people on their turf. Outreach from the CHC provided an important organizational linkage to help rebuild the chain of trust. Nurses and health professional participants described the importance of meeting clients 'on their turf'. One outreach nurse noted:

> *Outreach is a golden opportunity to be able to intervene and change the situation. Although you've had many no gos, no shows, whatever, you can't ever assume that you're going to be able to turn that around. That's what we wait for, that golden opportunity and it happens. It happens and you have to be there. You have to actually be there where they are to make it happen and that's why our model of being in shelters being like we set it up in the [downtown hotel], being at the shelter. We run the clinic there. You know, we need to do much more of that.*

Outreach helped to provide care to clients reluctant to access health services or unable to access health services due to competing survival needs.

Outreach provided nurses with an opportunity to get to know and build trust with clients outside of clinical settings and allowed them to become an initial point of contact for health information, education, counselling, assessment and referral. 'Curbside consults' were common as outreach nurses moved agency to agency. Although nurses were primarily employed by CHCs, clients considered them to be 'street nurses' because of their outreach role. Nurse outreach to homeless and drop-in shelters was considered an important component of services at one of the CHCs. One nurse noted:

> *When you've been [there] consistently, clients recognize that. They go, 'Oh, I've seen you around before.' And they'll talk to you. Frontline workers who've been there for a long time . . . you've become a consistent presence for them too, so they'll start advocating and pull people in to come and see you. So I'll go up to [one shelter] and often there's a frontline worker [who will] say, 'We told them you'd keep coming around and you're okay.' So they'll see you. So that's really important, the consistency.*

Those CHC nurses who did outreach consistently were able to build trust with both drop-in staff and clients. They were directly linked to the CHC and could facilitate the development of trust with the CHC, thereby facilitating access that fostered earlier intervention and treatment for people who often avoid and delay health care.

Inter-provider trust. Trusting relationships between nurses and other team members in their health settings facilitated access to a broader range of health services. Nurses who had established relationships with health professionals in their setting helped to extend the chain of trust for clients and achieve access to a broader range of services. For example, an outreach nurse noted:

> *Often what I'll do is if I think someone really would benefit from counselling, then well, I'm coming in and I'm talking with you. I say, 'Yeah that's fine but I think you're at a point where you would really benefit from someone that has expertise that I don't have.' And then I'll go and see if [the counsellor] is free and then I'll bring them down and say, 'Let me introduce you to the [counsellor]. If you feel this is someone that you could talk to, that you feel comfortable with, then this will be great.' So sometimes, just initiating contact and bringing them down.*

> *Then they put a face to the [counsellor]. . . . If you know, he doesn't have anybody, he'll sit down with them for five minutes and go, 'Well, what's going on? We'll make an appointment. . . .' Then people tend to follow him through then with that [i.e., the appointment]. . . . I'm always advocating for the other practitioners too. 'Oh, you've got an appointment coming up with Dr. So and So.' 'Well I don't really like doctors.' 'Yeah, I don't either, but you know [laughs] this is a good one. I think you'll like this one.'*

By establishing trusting relationships with other professionals in her organization, this nurse was able to facilitate access to a wider range of health services for her client. Nurses stressed that working with like-minded colleagues was particularly important to the development of inter-provider trust. Where team approaches were valued and the role of nurses was understood and respected, health care teams facilitated client transitions between health care providers. In the absence of trust and respect for other roles, access was inhibited.

Working in physical proximity as part of an interdisciplinary team provided multiple opportunities for hallway consults and referrals. In the presence of trust, this fostered a shared care approach, which improved the ability of team members to address multiple and complex client health needs. One client noted:

> *I can get in quickly when I need to. I can see the nurse and she consults the doctor so I don't need an appointment with the doctor. This is the whole package. I can get my drugs here even have my blood drawn (But not have X-rays). Much better than going to emergency where you have to wait five hours.*

Clients highly valued coming to one location and having access to an integrated team of health care providers. Health centre managers were integral to fostering the development of teams that are supportive and able to work together. For example, in one centre, the manager played a central role in establishing the values of the centre, reminding the team of their mandate and keeping everyone on track, especially in difficult situations. An additional benefit of shared care approaches is that nurses were not left to deal with challenging clients alone. Nurses cautioned against hiring nurses and making them solely responsible for caring for homeless and street-involved populations, as this would potentially lead to burnout.

Systemic Trust: Disrupting Negative Judgments and Missing Linkages

To rebuild trust in the health care system, CHC nurses disrupted negative chains of judgment and worked to build inter-agency trust. However, there were often fundamental links missing that limited nurses' ability to facilitate access to health and social services.

Disrupting negative chains of judgment. Negative chains of judgment—that is, negative labels passed from one provider to another—led to adverse experiences and limited access to health services. For example, one nurse explains:

> *You're seeing how other staff, treat certain clients, so you can see that domino effect. . . . I mean, when I worked emerg, it was amazing that the ambulance guys would come in and go, oh yeah, so and so again; blah, blah, blah and then that is passed on to the triage nurse and then passed on to the nurses you're giving report to. . . . And you're passing that on to the doctor and so that judgment is all the way down and it was something that it took me a long time to realize. . . . Then all of a sudden you're at the bedside and someone shows up, like a family member or a friend, and they're giving you a different take on what the parmedics picked up. And all of sudden it's like, oh, I feel bad because we had that judgment happening and so we've been treating that person a certain way and there's actually something else much more complicated going on and we're compromising care because of that. . . . And you see that often with overdoses and things like that. Oh, you're bringing in another overdose. You know. How to break that chain. So that's something that you have to be aware of.*

This example highlights how judgments are played out in health care systems. Societal beliefs that individuals are at fault of their poor health are at the root of these judgments and have the tendency to blame individuals for their current situations. Participating nurses attempted to break negative chains of judgments by facilitating access to health care in emergency departments and hospitals. One nurse described calling the ED to facilitate the admission of a client living with HIV:

> *His hemoglobin just dropped in his boots and he just showed up one day, like, so white he was yellow, short of breath, just standing there but did not want to go to the hospital because he was always mistreated.*

> *I was the one who ended up calling the emerg doc, and right away, he's well, how come I'm talking to the nurse not to the doctor [i.e., referring physician]. I said, well right now I've got a man with a hemoglobin of 30. He needs to come in and I'm giving you a heads up. And I said, now he's going to swear, you're all fuckin' assholes and idiots and he hates doctors, but that's just who he is and we love him [laughs]. And so the emergency room doctor actually laughed. The patient stayed there for a couple of days, got some transfusion and came out and said, they treated me really well. They even fed me.*

This client returned several times and was willing to do so because of his initial positive experience. The referring nurse indicated that her goal was to help the physician focus on how sick the client was and shift away from viewing the client as only a 'homeless person' or 'drug user'.

Inter-agency trust. Trust between nurses, health care providers and agencies is integral to enhancing access to health and social services. Access becomes compromised when there is little or no trust between agencies. One nurse manager noted:

> *I think the agencies themselves need to trust each other and to know about each other. Extremely challenging [here]. There's so much history. . . . Everybody has some kind of historical view of where they're working and who their next door neighbours are and what they doing and how they're doing it. . . . Everybody thinks that they're . . . doing the right thing and everyone else is doing it wrong. And, if only the other person over here could understand that this is the way it should be done, we could save the population, which of course isn't true. Because, if we could save this population, if someone has the answer . . . we'd know that because all of the people would be all better, cured and going off and that is not happening. . . . Nobody seems to want to see that and to really look and see that maybe there is more than one [route to take]. . . . Maybe sharing what I'm doing, instead of holding onto it tightly, would be a good thing.*

When there is a lack of trust between providers and agencies, providers may refuse to refer individuals to those agencies because of fears that their clients will be mistreated. In such situations, agencies became distrustful of each other and services were more likely to be

fragmented and marginalized. When linkages of trust between agencies were developed, there was an increased capacity to foster access to needed services for clients. Inter-agency meetings and collaboration on projects provided opportunities to develop relationships, but such opportunities were rare and often not formalized due to limited time and resources.

Missing and absent linkages. There were frequently missing linkages, barriers or gaps that prevented clients from accessing needed services. Of particular concern, there were missing linkages with detoxification programs, hospitals, prisons and housing. Clients were repeatedly unable to gain timely access to detoxification services simply because such services were not accessible. One nurse explained:

> *Ready for detox and you fill out the forms and you fax it and tell [them to wait]. You want to do the best for people who have decided that now's the time and want to detox, [the best] would be to take them there, put them in a cab right now. While they're ready.*

Wait times averaged four to six weeks, and if the client was admitted after two weeks, they were required to fill out the form again. After being told this, one client replied, "*I can't wait a month, I don't know if I can wait a week*." He turned around and walked out and the nurse did not fill out the form. Nurse and health professional participants grew weary of filling out these forms, which led to the false impression that there was a decreased demand for these services.

There was a lack of linkages with hospitals, prisons, community resources and housing. A specific concern was clients being 'dumped into the community'—that is, discharged to the shelters or community directly from hospitals or prisons without any discharge planning around housing and community supports. As one social worker said, "*Discharge to a shelter is not a discharge plan*." Nurses pointed out that being discharged to the shelter is very different than being discharged to home where one can rest and convalesce in a safe place. In a shelter, clients may not be able to access their rooms during the day to rest.

Central to the problem of 'dumping' is the lack of affordable housing in the community. Attempts to link individuals to housing were often unsuccessful due to high costs of rent and low vacancy rates in the cities where the research was conducted. In particular,

there was lack of access to housing that tolerated drug and alcohol use. In one city, low-cost supportive housing had policies that restricted access even to individuals currently on methadone. Thus, individuals frequently returned to the shelters even after going through detox and rehabilitation only to re-enter the cycle of homelessness and drug use. Further access to affordable housing was impacted by welfare reform and shelter rates that prevented those on social assistance in finding affordable housing.

Discussion

Access to health care services for persons who are marginalized due to homelessness and substance use is facilitated by the rebuilding of trust at three interrelated levels: interpersonal, organizational and systemic. Trust in health care is often taken for granted but is at issue when there is uncertainty about another's behaviour and how one might be treated (Smith 2005). Lack of trust can negatively impact access to health care. Trust is most often understood at the interpersonal level and reflects a moral concern for the other (Smith 2005). Rebuilding interpersonal trust between nurses and clients is the first link in building a chain of trust that can facilitate access to the health and social services needed to address complex health and social care challenges. Organizational policies supporting harm reduction and outreach enabled nurses to meet people 'where they were at' and 'on their own turf' and contributed to development of trust. Inter-provider trust fostered access to broader range of health and social services within CHCs. Disrupting negative chains of judgment and building inter-agency trust fostered access but highlighted gaps and missing systemic linkages. These findings suggest that health care providers rebuild trust not only interpersonally but organizationally and systemically to enhance access to health care.

The importance of respect for persons regardless of their behaviours is underscored and strategies for conveying respect highlighted. The importance of being treated as a person and not being brushed off are similar to the findings of Wen, Hudak and Hwang's (2007) discussion of welcomeness and unwelcomeness in health care encounters for homeless persons. These findings extend this discussion by providing insight into strategies nurses use to facilitate welcoming encounters. Guirguis-Younger, McNeil and Runnels (2009) found that past experiences, having a client-centred approach and engaging in

inter-professional knowledge exchange were important strategies in caring for homeless populations. This study provides further insight into the professional knowledge that nurses use in enhancing access and delivery of care as well as the importance of inter-provider and inter-agency trust to delivery of services.

While respectful behaviours foster trust and access, they also ensure that health issues are not overlooked because the person is a 'frequent flyer' or seen as less deserving (Corley and Goren 1998; Malone 1996). Of particular interest is the importance of health care providers being able to see patients in an appropriate life context in order to overcome judgments and plan care appropriately. This suggests that knowledge of the life circumstances of clients is important and that potential insights from fields of study such as cultural safety may be important areas for exploration (Anderson et al. 2003; Browne et al., 2009). Cultural safety is, in part, a means of engaging nurses in reflexive praxis and the development of situated knowledge that promotes awareness of stereotypical discourses that impact the provision of health care to various groups.

Registered nurses have dual professional and ethical commitments to respect the dignity of all persons through provision of care on the basis of need regardless of race, ethnicity, gender or other conditions and to promote social justice through the development of equitable health care policies (Canadian Nurses Association 2008). Harm reduction is consistent with professional and ethical nursing standards of practice (Lightfoot et al. 2009; Pauly et al. 2007). Although harm reduction is a partial approach to tackling health inequities among those marginalized by homelessness, nurses can embrace and advocate for harm reduction as part of their commitment to social justice and reducing inequities (Pauly 2008a).

Although not solely responsible for creating the conditions in which trust is fostered at organizational and systemic levels, nurses, through their actions, can disrupt prevailing negative judgments and promote inter-provider and inter-agency trust to facilitate access to health care. Further, nurses can seek and use opportunities to raise issues related to inter-agency collaboration, lack of discharge planning and missing linkages to managers and other leaders. Nurses have unique knowledge of missing linkages and the way in which lack of access to services and housing negatively impact health. Through engagement and participation in team, organizational and community activities nurses can bring such issues to the fore and

inform solutions. Advocating for primary health care, harm reduction and housing are consistent with promotion of social justice and equity for those marginalized by homelessness and substance use.

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CHAPTER 10

Dignity in Design: The Siting and Design of Community and Shelter-Based Health Facilities for Homeless Persons

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Introduction

Community and shelter-based health services have emerged as one of the main strategies for improving the health of homeless persons in Canada. One of the earliest shelter-based health services, the Seaton House Annex Harm Reduction program in Toronto, has been in operation since 1997, and community and shelter-based health services have since followed in cities across Canada. These services are intended to reduce the impact of barriers preventing homeless persons from accessing services in hospitals and community clinics, such as geographic isolation, lack of identification cards and family physicians, feelings of unwelcomeness and long wait times (Hwang 2001; Podymow et al. 2006b; Podymow, Turnbull and Coyle 2006a; Wen, Hudak and Hwang 2007). Community and shelter-based health services have also been demonstrated to improve treatment compliance and health outcomes while reducing hospital stays and emergency room visits (Podymow et al. 2006b; Podymow, Turnbull and Coyle 2006a; Schwarz et al. 2008; Stergiopoulos et al. 2008) and play an increasingly prominent role in health services delivery in many Canadian cities. As a consequence, health services are now located in many settings not traditionally associated with health care

delivery. This raises many questions for health and social services providers. For example, what are the perceived benefits of community and shelter-based health services delivery? How are community and shelter-based settings adapted in order to accommodate health services delivery? And what factors influence the design of community and shelter-based health facilities?

Although researchers have increasingly turned their attention toward the relationship between urban planning, design and health and human services delivery to homeless persons (Takahashi and Dear 1997; Graham, Walsh, and Sandalack 2008), these questions remain unanswered. A growing body of research has examined the impact of community opposition to health and human services facilities for homeless persons (see, e.g., Dear and Wolch 1987; Takahashi and Dear 1997; Strike, Myers and Millson 2004); factors affecting the siting of emergency shelters and facilities serving homeless clients, such as AIDS service organizations and needle exchange programs (see, e.g., Chiotti and Joseph 1995; Takahashi 1997; Takahashi and Dear 1997; Brinegar 2003; Datta 2005); and, lastly, the characteristics of optimum emergency shelter design (see, e.g., Davis 2004; Shier, Walsh and Graham 2007; Graham, Walsh and Sandalack 2008). Yet relatively little attention has been paid to how the social, political and built environment impact the siting *and* design of community and shelter-based health facilities, despite the steady growth in the number of these facilities over the past decade.

This chapter examines the interplay of the siting and design of community and shelter-based health facilities across Canada. It looks at the perceived benefits of community and shelter-based health facilities, including increased access to health services and responsiveness to the day-to-day challenges in shelters. It explores the siting of these facilities within the context of categories of urban space (see, e.g., Duncan 1978; Snow and Anderson 1993; Snow and Mulcahy 2001) to shed light on the factors that contain these facilities, as well as how agencies resist containment. It then considers the characteristics of community and shelter-based health facility design, drawing on previous research on emergency shelter design (see, e.g., Davis 2004; Shier, Walsh and Graham 2007; Graham, Walsh and Sandalack 2008). Lastly, this chapter discusses the implications of these findings for those involved in the development of these facilities. It is hoped that this chapter will help to improve the design of community and shelter-based health facilities and, as a result, health services delivery.

Methods

The authors collected data between April 2007 and July 2008 as part of a study on health and end-of-life care services delivery to homeless persons. Homeless persons receive health services in a range of settings, including hospitals, community health clinics, emergency shelters and harm reduction facilities. The availability of these services is often affected by the local social, cultural and political context, which might or might not support the delivery of health services to this population. This study focused on identifying the characteristics that improved health services delivery to homeless persons, including the design of community and shelter-based health facilities. A section of the questionnaire included the questions about the impact of facility location and building design on health services delivery and clinical practice.

The authors collected data in Halifax, Hamilton, Ottawa, Thunder Bay, Toronto and Winnipeg. Existing relationships with health and social services providers in Ottawa and Toronto helped to facilitate participant recruitment in those cities. Research assistants developed an annotated directory of organizations providing health and social services to homeless persons in Halifax, Hamilton, Thunder Bay and Winnipeg that helped the authors identify key informants in those cities. Potential participants were sent letters outlining the study and inviting them to participate. Fifty-four individuals agreed to participate in this study, including physicians, nurses, social workers, mental health professionals and program directors. All participants worked either full- or part-time in community or shelter-based settings. Semi-structured interviews were conducted with participants at their place of employment or off-site, if they preferred to be interviewed elsewhere. One section of the interview guide concentrated on facility design. Participants were invited to discuss the development of their organizations, how their facilities help or do not help them work effectively with homeless persons and how their facilities may be modified to improve health services delivery. These questions were structured so as to address the questions raised in the chapter introduction. Interviews ranged in length between forty-five minutes and two hours. Informed consent was obtained at the time of the interview.

Interviews were audio recorded and transcribed verbatim. Data were coded using NVivo qualitative data analysis software (version 8)

to identify preliminary themes. Analysis focused on the siting and design of community and shelter-based health facilities, as well as their impact on health services delivery to homeless persons. A coding tree was developed based on these preliminary themes and used to recode data. Hard copies of the coding summaries were reviewed by the authors and used to make further refinements to the coding tree in order to better explicate themes. Once the final categories were established, the authors recoded a section of the data to verify theoretical validity.

The authors identified the perceived benefits of community and shelter-based health services delivery to homeless persons. They then identified two general categories: (1) the siting of community and shelter-based health facilities and (2) the design of community and shelter-based health facilities. Each of these categories includes several sub-categories that identify characteristics that might optimize the design of health facilities and contextualize the challenges that health and social services providers encounter in planning and developing them.

Findings

Perceived Benefits of Community and Shelter-Based Health Facilities

Community and shelter-based health services delivery was perceived as an important strategy for improving access to health services for homeless persons. Participants described how community and shelter-based services reduced geographical barriers to health services for homeless persons, as well as responded to the day-to-day challenges encountered by homeless service organizations. In addition, participants indicated that community and shelter-based health services facilitated the development of interdisciplinary strategies to meet the health and social care needs of homeless persons.

Strategy to overcome geographical barriers to health services. Participants described how community and shelter-based health services allowed them to overcome many of the geographical barriers that prevent homeless persons from accessing health services. One of the main barriers that many participants identified was the inaccessibility of hospitals and clinics. Many participants observed that hospitals in their communities were located in residential or isolated

areas. They noted that many homeless persons were unable to access services because they had reduced mobility or were not healthy enough to walk to hospitals or clinics and could not afford to take public transit. One emergency shelter director recalled:

> *I remember several years ago in our old place, watching an elderly gentleman that had taken his socks off. I saw his bare feet. He was suffering from diabetes and his feet looked like black clubs. I said, "You need to go to the hospital and get those looked at." He just refused. And one level in my naïveté I thought, what happened if I had feet like that? Would I walk to the hospital?*

These neighbourhoods also lacked services used by homeless persons to meet daily survival needs, such as soup kitchens and emergency shelters. Participants observed that community and shelter-based health services, on the other hand, had the potential to minimize these barriers because these services were already a part of the daily patterns of homeless persons. These services were thus perceived as a strategy to overcome geographical barriers by, as one nurse stated, "*Meeting clients where they are, wherever they are comfortable.*"

Responding to day-to-day challenges in shelter settings. Integrating health services into emergency shelters was not only identified as an optimum strategy for addressing the complex health and social care needs of homeless persons but also as a necessity due to the health challenges of the homeless population. Participants reported that emergency shelter clients had complex health needs—or, as one nurse practitioner observed, were the "*sickest of the sick*"—that shelter staff lacked the training to address. This contributed to adverse outcomes, including client deaths. An agency director recalled:

> Agency Director: *They'd come here at night and we'd find, we'd find a dead body at least once a month, in the beds here. They'd be people that would be sick, and the other thing they'd do is that they'd either take a whole bunch of pills some nights, so some of them would just overdose and say 'I'm out of here'. Some of them would just drink, and drink, and drink. Some of them would mix the two, and I'm sure their deaths were accidental. But people who were sick would just not go to the hospital then.*
>
> Interviewer: *How did you deal with that at the time?*

> Agency Director: *It was really hard on staff. The cleaners got so they wouldn't want to go upstairs. I mean really, it was really difficult. . . . We were doing this work and nobody was trained. I don't even think we did a good grieving piece after. Some young cleaner finding two bodies in a month and saying to him, "Are you okay?"*

One factor that exacerbated this situation was poor discharge planning—or, to be more specific, the practice at some hospitals of discharging homeless patients directly to shelters or the street. Many participants reported that this commonly happened, despite the fact that many emergency shelters lacked the capacity to care for these clients. Another agency director recalled:

> *We recently had a death here at the shelter of a gentleman who came to us mentally ill. He was really a mess. He was discharged [from hospital] to us at 11 p.m. on a Friday evening and he was not well at all. My staff had big concerns with him, but they kept him here. He was exhibiting signs of his mental illness and he was dead by 1 a.m. the next morning. He went and committed suicide over here.*

Participants identified cases such as these as one of the driving forces behind the development of shelter-based health services.

Furthermore, several participants reported that community and shelter-based health services responded to clients' desire to receive health services in shelter settings. An agency director recalled, "*[The client] came and asked if he could die here. He knew he had* AIDS. *He knew he was going to be dying, and he did not want to go into the hospital*." Previous research has, likewise, suggested that emergency shelters are a preferred site of usual care for homeless persons and result in higher levels of satisfaction with care received (O'Toole et al. 1999). However, participants of this study went further and reported that shelters were often a preferred site for receiving palliative care because clients considered dying in the shelter to be dying at home. As a consequence, many participants felt that it was important to develop these services in order to accommodate these wishes.

Harmonizing health and social services delivery. Integrating health services into community and shelter-based settings harmonized health and social services delivery, allowing both health and social services providers to benefit from greater access to potential clients.

Many participants reported that they were able to gain access to new clients and provide them with services responsive to their needs, while maintaining continuity with health or social services received in other settings. For example, participants referred clients directly to services delivered on-site—or by nearby community agencies—and had clients referred to them by these services. One of the added benefits of this, according to participants, is that they were able to better respond to changes in the health status of clients. For example, a program manager observed:

> *Often with our Managed Alcohol people, they will do very poorly. If we can't care for them in that setting, we will move them to the hospice and then often stabilize them. I'd say 50 percent of them stabilize enough to come back.*

Participants observed of this continuity helped them to develop interdisciplinary strategies to address client needs and implement these strategies across settings.

Siting Health Facilities for Homeless Persons

The siting of community and shelter-based health facilities is impacted by the interplay of community values, health systems, infrastructure and the distribution of homeless persons. This interplay is most evident in the factors that contribute to the siting of community and shelter-based health facilities in prime and marginal spaces—that is, areas that have use value to the majority of community members and areas that have little or no use value to the majority of community members, respectively (Duncan 1978; Snow and Anderson 1993). It is useful, then, as a point of departure, to identify the strategies that contribute to the successful siting of community and shelter-based health facilities in each these categories of urban space, as well as the challenges encountered.

Siting facilities in marginal spaces. Marginal spaces have little or no use or economic value to the majority of community members and, as a consequence, are largely abandoned to homeless persons and other marginalized populations (Duncan 1978; Snow and Anderson 1993; Snow and Mulcahy 2001). Many of the common characteristics of marginal spaces, such as high concentrations of homeless service organizations, single-room occupancy hotels and abandoned

buildings (Snow and Anderson 1993; Snow and Mulcahy 2001), were apparent in neighbourhoods with community and shelter-based health facilities. In fact, the majority of community and shelter-based health facilities surveyed in this study were concentrated in marginal spaces—or, to be more specific, in impoverished inner-city neighbourhoods or near industrial areas. But what accounts for the concentration of these facilities in these spaces?

In many cases, participants reported that these were the only spaces available to them for facilities due to community opposition to their facilities in other neighbourhoods. One participant, for example, remarked that when his organization attempted to move to a downtown area, local business owners persuaded the city to deny their re-zoning application. Another participant noted that the only site that the city agreed to zone for the facility was in a poor neighbourhood, adjacent to a highway on-ramp. Participants, however, noted that these locations were not without their benefits. They reported that the siting of community and shelter-based health facilities in marginal spaces often improved their capacity to deliver health services to homeless persons—whom they reported were largely concentrated in these areas—while minimizing community opposition. One of the key benefits of siting community and shelter-based facilities in marginal spaces, according to participants, is that they are most likely to be frequented by homeless persons. Participants believed that this increased their visibility and, hence, their accessibility to clients and potential clients. For example, many participants reported that they were better able to provide services to clients on the street, as well as advertise their services to potential clients, due to their location. A nurse recalled:

> *We walk our catchment area with harm reduction kits. We hand out kits, socks, whatever, but we're also there to advertise the nursing clinics. We'll walk by most, if not all, of the shelters at some point in our outreach, plus we'll do alleys and places we know people are—parks in the summer—so in that way we're able to advertise our clinic and what we do and it's all within walking distance.*

Other participants reported that their close proximity to single-room occupancy hotels and low-cost housing helped them provide services to clients at risk of homeless and, in several cases, provide them with health services that helped them maintain housing. Another nurse noted:

> *We've had palliative people in [the social housing complex] right beside us, which is this big high rise. Those are people who are going to come to us, but are still able to remain in their own home.* CCAC *[Community Care Access Centre] alerts us of those people, or the community agencies will.*

Another key benefit, according to participants, is that siting community and shelter-based health facilities in marginal spaces results in reduced community opposition. Participants reported little opposition to their facilities and, in some cases, noted that their cities seemed most receptive to siting their facilities in these areas. This echoes previous research suggesting that these neighbourhoods are least opposed to homeless service organizations, but, while this research—and, indeed, several participants—warns that this might result in service-dependent ghettos (Wolch and Dear 1993), the majority of participants emphasized the benefits of increased access to clients and lower rent and property costs. Several participants suggested that low rent and property costs played a crucial role in allowing them to expand and diversify their services in order to increase their responsiveness to the needs of their target population. An agency director of a recently relocated inner-city shelter recalled:

> *When we bought this building, we bought it with the idea that it could do a lot of programs that weren't being done. As we developed the first floor, our architect drew up the floor plans and he had a large space that was supposed to be used for storage for our clothing bank. But, as our construction guys were building it, I said just leave that space alone because someday I am going to have a health centre there.*

Siting facilities in prime space. A small number of community and shelter-based facilities in cities surveyed in this study were located in prime space—that is, areas with use or exchange value to most community members, including spaces used for residential, economic and navigational purposes (Duncan 1978; Snow and Anderson 1993). These organizations typically had long histories—in some cases, reaching back more than one hundred years—and remained in their locations even as the surrounding areas gentrified, while others were affiliated with hospitals or community health clinics. Participants reported community opposition to these facilities was most likely due to negative attitudes toward homeless persons among people living

in these neighbourhoods, which is a well-documented dynamic of community opposition to homeless services facilities (Takahashi and Dear 1997; Takahashi 1997). However, they also identified strategies that minimized the impact of community opposition. One of the key strategies involved shifting the terms of the debate by emphasizing that the organizations provided health services, not emergency housing. A nurse at a community-based health facility recalled:

> Nurse: *[Community members] were afraid that this was going to be a shelter and there would be lots of homeless people roaming the neighbourhood, possibly breaking into their houses. That was what their greatest concern was and, note, today we haven't had a single complaint in fifteen months.*
>
> Interviewer: *What were some strategies that were used to overcome that perception?*
>
> Nurse: *We held a community meeting where about 300 people showed up. The Executive Director of [Community Ministry Organization] spoke. The program manager of [the proposed facility] spoke about the program. I spoke about the program and the alderman of the neighbourhood spoke in favour of the program. He got it and explained to his constituents that it's not a shelter, it's a residential facility.*

Another strategy was to site health services in existing facilities—or, to be more specific, to integrate health services into emergency shelters. Participants reported that doing so allowed their organizations to expand and diversify their services, while avoiding applications for re-zoning and community opposition.

Designing Community and Shelter-Based Health Facilities

Participants reported that the design of community and shelter-based health facilities has a significant impact on the delivery of health services to homeless persons. Participants identified design features of the community and shelter-based health facilities that improved the delivery of services to their target populations, as well as shortcomings that prevented some clients from accessing services.

Using building design to promote client confidentiality. Participants reported that buildings ought to promote client confidentiality by blending in with the surrounding neighbourhoods. Many of the

buildings visited by the authors were consistent with the architectural style of their neighbourhoods, because existing buildings had been renovated to accommodate health and social services delivery, while newer buildings had been designed to blend in with their surroundings. Participants believed that this consistency with neighbourhood design helped to promote client confidentiality by making it less obvious to passersby that clients entering and exiting the building were homeless. Participants reported additional design features that helped clients remain anonymous—something that, according to participants, is particularly important when providing services to stigmatized populations, such as persons living with HIV/AIDS, sex workers and injection drug users. For example, many buildings did not post signs on their property identifying their organization. One social worker remarked:

> *If you notice outside of the building, there are no signs that say HIV and AIDS. Some people feel comfortable coming here and we're kind of out of the area of the HIV circle. Most of it is on [street name]. Well we're a little outside of it so people do feel comfortable coming here.*

Nondescript entrances helped clients to retain anonymity. A harm reduction specialist noted that having separate entrances at a community clinic allowed clients to access harm reduction services while remaining anonymous to clients receiving other services. The use of one-way glass also ensured that these clients could not be seen by passersby.

Improving accessibility for clients. Participants reported that physical disabilities might decrease the ability of homeless persons to access their facilities, if appropriate actions were not taken improve accessibility. Many buildings included ramps, automatic doors, elevators and wide doorways. Participants reported that these mobility aids helped them work with clients. A nurse explained how these mobility aids improved client care:

> *They have a wheelchair right in the shower—everything now is so user-friendly and easy. Before, how were we to get a person down the stairs to shower them? That's what we were faced with. You took them into the bathroom and pretty much hosed them down in the bathroom and sponged bathed them. It has only been in the last few years that we*

> *have had an elevator. You used to have to go down a very steep flight to the bathroom, so it wasn't about [the client's] problems. . . . We needed a place that is full serviced, that provides all the level of care of all the other agencies.*

Several of the facilities the authors toured were less accessible, and participants reported challenges providing care to clients. Participants drew attention to the fact that they had difficulty providing services to clients in wheelchairs and, in some cases, could not provide them with services. The challenges of an intake coordinator and outreach worker illustrate the challenges faced:

> Intake coordinator: *There are certain things I have to think about in this house. Because three of the rooms at the back of the house have four steep steps to get to them, those ones can only be used by people who are mobile enough to get up the stairs to the elevator. I have to look at mobility.*
>
> Outreach worker: *We just don't have the resources to be as inclusive as we'd like. As you notice there's no ramp out front but we do have actually several clients that are confined to wheelchairs. There are so many different types of sex workers.*

Using safety precautions and security systems to ensure staff safety. Another important consideration is staff safety, which many participants identified as a chief concern. These participants reported that, due to the high incidence of mental illness and addiction among clients, they believed that safety precautions needed to be taken. Many of the facilities had complex security systems, including security cameras and safety buttons, and sightlines allowing staff to monitor the facilities. Several participants indicated that this minimized the likelihood of disruptions, as well as the impact of these events. Several facilities, however, lacked safety precautions, and participants in these settings reported concerns about personal safety. For example, a physician explained:

> *There's a safety concern amongst physicians on an individual level, which I think can be a pretty intimidating environment to step into. You're dealing with a pretty rough clientele and you're in a setting that is fairly variable. The offices we work in aren't set up with individual safety in mind. When you work in isolation many of the times, we can't*

> *just have someone in the room when we're dealing with sensitive issues. The office that I work in is at the end of a hallway behind two closed doors and I've asked over and over again for a safety button to be put in there to call for help.*

Participants who perceived themselves as being at risk due to the absence of safety precautions and security reported higher levels of stress—in some cases, implying a link to staff burnout.

Improving the design of clinical spaces. Participants reported that, because of the wide range of functions carried out in their settings, clinical spaces needed to provide sufficient space and flexibility to serve multiple purposes. Many of these spaces were originally intended only for treatment and rehabilitation but also needed to address unanticipated health and social care needs. A nursing station at a shelter-based facility, for example, had originally been intended to serve mainly clinical functions, such as intake, charting and dispensing medication, but in practice served a variety of other functions, including preparing meals, organizing social activities and, often, monitoring the movement of clients in and out of the shelter. When the facility was later redesigned, the nursing station was expanded in order to better accommodate this wide range of functions. Other clinical spaces, including exam rooms and offices, often had to be flexible in order to meet client needs and address emergency situations. Participants reported that the space and flexibility to move equipment, including beds and medical equipment, in and out of rooms improved the efficiency and efficacy of clinical spaces.

Using private rooms to help clients feel 'at home'. Multiple participants reported that the design of their facilities helped clients feel 'at home'. Many of these facilities not only had a home-like atmosphere—that is, they were located in formerly residential buildings—but also provided clients with private or semi-private rooms. Participants indicated that providing clients, many of whom had lived on the streets and in shelters for decades, with private and semi-private rooms helped them feel 'at home', leading to greater satisfaction with care. Participants explained that clients were often pleasantly surprised to find out that they would have a private room and, in some cases, expressed that they wished they had arrived there sooner. A nurse remarked:

> *Some of them would think that our hospice is like heaven—I mean, it's just beautiful. They're amazed that they have a private room and they're amazed they have a TV. They're amazed they've got a beautiful dresser to put their things in and that there's endless juice and there's endless coffee, you know.*

Furthermore, multiple participants observed that, because palliative clients considered their facilities to be their home, they wanted them to be their place of death. A program manager observed:

> *What we have really noticed is that some of our long-term residents—who have been with our organization for the last 10 or 15 years—don't necessarily want to go. We have been trying to do our very best in maintaining a place of dignity for them during their last days, but it is not easy.*

Participants, therefore, suggested that private rooms and a welcoming environment allowed clients to construct home spaces.

Using common areas to create a social atmosphere. Participants reported that common areas, such as television rooms and lounges, improved the atmosphere in residential care settings by allowing staff to host social activities, as well as facilitating relationship-building among clients and staff. Many of the facilities that provided complex long-term care had multiple common areas. Common areas allowed participants to host a range of social activities, including teas, movie nights and games, as well as provide a venue for unstructured interaction between clients. One clinical manager explained how this helped to create a caring atmosphere among clients:

> *I watched them play bingo the other day and I thought this is so much more than bingo. Bingo is one thing, but the fact that they're all together in the room, that they're respectful of the caller, that they're quietly playing bingo, that it's something to test their mind, right, their ability to connect. One of the guys in the room he's mentally ill, he has dementia and he has HIV, and they set him up and he has a card and he has a dabber and he has a snack and he can't dab the numbers but he's there with them. And so she'll bring out a prize and maybe they'll be two prizes and one of them is like a chocolate bar and she'll say to*

> *the group, "Can [client name] have the chocolate bar?" And they'll all say, "Yeah that's okay." Like he didn't win it but he can have it, so then they give the chocolate bar to him.*

But also, multiple participants described how creating a caring atmosphere improved the self-efficacy of clients. They reported several ways in which clients became increasingly engaged in the day-to-day operations in their setting by volunteering, helping each other and taking a leadership role in social programming. One program coordinator observed:

> *I think that the atmosphere now is a very uplifting, very positive atmosphere. It is a very family-like atmosphere. It has come a long way over the last seven years. We have a resident mayor. So, they elect their own mayor. They have resident meetings. If they have any issues, they will go the mayor. The mayor will come to us. As I mentioned with Social Initiative the volunteering is very important part of the program. They have certain residents that make breakfast every day with staff supervision. Make lunch, make dinner, do all of the laundry, clean the sheets, and disinfect the mattresses. They really have taken a sense of ownership of their own program.*

Aligning design with organizational values. Participants explained that the design of health care facilities should be congruent with the values of their organizations. This included mandates to provide homeless persons with the same quality of care as the housed population received but in a way that is congruent with organizational values and the experiences of homeless persons. One health administrator observed:

> *We just painted our office. It's freshly painted and we put new rugs down. For the first five years that we were here, we just had primer on the walls. We've never had paint before. It's a big symbolic thing, to get paint but, you know, that is how our clients live. It's very hand to mouth and it hasn't done us any harm. I do think that there's a certain way that a program that works with the clinically homeless needs to be. We can't have big fancy offices. It is just incongruent with the work that we're doing.*

Summary and Implications

Community and shelter-based health services are an important strategy for improving the health of homeless persons in Canada and, as the recent growth in the number of these services suggests, they play an increasingly vital role in health services delivery to this population. In this chapter, the authors have explored the context of community and shelter-based health services delivery, drawing attention to the fact that it developed out of necessity to address the dire situation in many emergency shelters and offered an opportunity to overcome barriers that homeless persons face to accessing traditional services. Previous research echoes these claims and points also to the demonstrated cultural competence that community and shelter-based health services have in providing care to homeless persons (Podymow et al. 2006b; Podymow, Turnbull and Coyle 2006a; Guirguis-Younger, McNeil and Runnels 2009).

This chapter also examines the impact of community opposition to the siting of facilities serving homeless clients and, as a result, can be situated within the growing literature on this topic (Wolch and Dear 1993; Takahashi 1997; Brinegar 2003; Strike, Myers and Millson 2004; DeVerteuil 2006). Previous research has charted the evolution of the 'Not In My Backyard' (NIMBY) syndrome and discrimination against homeless persons on the basis that they are dangerous, undeserving of services and hurt property values (Takahashi 1997; Takahashi and Dear 1997). This body of research has drawn attention to strategies that communities have used to limit the development and expansion of health and human services facilities, such as the use of zoning by-laws, echoing statements made by study participants (Smith 1998; Brinegar 2003; Ranasinge and Valverde 2006). But, as is the case when the need is so great, these facilities are built and this chapter has outlined some of the considerations of the siting of these facilities. Of note, although facilities are often pushed into marginal spaces, they might benefit from closer proximity to potential clients. Also, siting health facilities in shelters might allow organizations to circumvent community opposition.

Lastly, this chapter explored the characteristics that might improve the design of community and shelter-based health facilities. Several of these characteristics have been previous described in the literature on emergency shelter design (Davis 2004; Shier, Walsh and Graham 2007; Graham, Walsh and Sandalack 2008). This research

identified several characteristics of optimum shelter design that were also described in this chapter, including using building design to promote client confidentiality and improving accessibility for clients (Shier, Walsh and Graham 2007; Graham, Walsh and Sandalack 2008). This chapter, however, is the first to describe these characteristics within the context of health facilities for homeless persons and consequently identified previously overlooked characteristics. These include the characteristics that improve clinical services and increase client satisfaction and self-efficacy, such as flexible clinical spaces, private rooms and social spaces. Together, these findings have several key implications for decision-makers and future research.

First, this chapter documents some of the factors that have contributed to the evolution of shelter and community-based health services in Canada. It situates their emergence within the context of the health needs of the client population, as well as the Canadian social and political environment. This is an important factor that helps us better understand *why* these facilities emerged and the problems that they were intended to address.

Second, these findings have the potential to inform the development of community and shelter-based health facilities. They identify characteristics that planners, designers and decision-makers might want to consider in order to optimize the design of these facilities. For example, what impact would health services have on the operations of the shelter? What changes need to be made to the building to accommodate health services? Is community opposition to the proposed facility expected and, if so, what can be done to minimize its impact? Is the proposed facility accessible to potential clients? Does the building promote client confidentiality? And does the facility account for the personal and social needs of potential clients?

Lastly, this research opens up the possibility for future research on the design of facilities intended for use by homeless and marginalized populations. There are many questions regarding the impact of health facility design on the health of homeless and marginalized populations that go unanswered. For example, how do private rooms affect the health of homeless clients? What characteristics do clients feel are most important about these facilities? What changes do they feel would improve them? It is hoped that this chapter represents a step in this direction and will pave the way for future improvements in the design of community and shelter-based health facilities.

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PART III

NEW APPROACHES: INNOVATIONS TO ADDRESS HOMELESSNESS & HEALTH

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CHAPTER 11

An Examination of the Delivery of Psychiatric Services within a Shelter-Based Management of Alcohol Program for Homeless Adults

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Introduction

Approximately one in five Canadians will have a dual disorder (mental illness and substance use disorder, commonly termed 'concurrent disorder' in Canada) in their lifetime (CAMH 2001). Yet there is a paucity of research on the delivery of, or measurement of the impact of, efficacious concurrent treatment (Drake et al. 1998; Mercier and Beaucage 1997; RachBeisel, Scott and Dixon 1999). Rates of concurrent disorders among the homeless population in Ottawa are estimated at 60 to 70 percent of the population (Farrell 2003;

Farrell et al. 2000), in comparison to incidence estimates of 18 percent in the housed population (CAMH 2001). Persons with concurrent disorders are one of the fastest growing groups of the homeless population as the rates of substance use and the detection of mental illness are increasing (Barreira et al. 2000; Mayes and Handley 2005; Nuttbrock et al. 1998; Rosenblum et al. 2002). This population represents an extensive cost to the health care system due to their frequent need for acute health care and their demonstrated difficulty accessing and remaining attached to existing models of service delivery (Burnam et al. 1995; Tsemberis, Gulcur and Nakae 2004).

Treatment programs for homeless persons with substance abuse problems have been found to be effective for those whose goal is abstaining from substance use (Hwang et al. 2005). However, it remains a challenge to work with persons who wish to address but not stop their substance use. Harm reduction is the focus of treatment used most often for those who do not wish to stop substance use (Baer, Peterson and Wells 2004). *Harm reduction* is an umbrella term for the variety of practices used to reduce the negative consequences of substance use and promote improved quality of life while incorporating a spectrum of strategies from safer use to managed use to abstinence (Harm Reduction Coalition 2003). Marlatt and Witkiewitz (2010) note that the primary goal of harm reduction is to minimize the harmful effects of behaviours related to substance use. These may include health risks, psychosocial risks or criminal involvement. As noted by Pauly and colleagues (2007), the adoption of a harm reduction philosophy has been primarily within street outreach, inner-city health care centres, needle exchange programs and, more recently, supervised injection sites. This chapter focuses on harm reduction within an emergency shelter, particularly on persons who have a concurrent disorder of alcohol dependence and mental illness.

Harm reduction programs with a housing focus such as Housing First have been implemented to assist homeless individuals with psychiatric illness and substance abuse problems to attain a residence (Gulcur et al. 2003; Tsemberis, Gulcur and Nakae 2004; Tsemberis et al. 2003). Some housing programs had aids to sustain housing, such as substance abuse and/or mental health treatments (Bebout 1999; Blankertz and Cnaan 1994). Other harm reduction programs that have been developed and implemented for homeless individuals have been mental health and substance abuse treatments (Tsemberis et al. 2003).

Despite literature on the key principles of harm reduction being pragmatism, humanistic values, focus on harms, balancing costs and benefits and hierarchy of goals (Riley et al. 1999), which should be agreed-upon principles within universal health care, harm reduction has been a controversial issue. Harm reduction has been described by its critics as promoting continued substance use (Buchanan et al. 2003). Advocates of harm reduction, by contrast, support it as a model for reducing the detrimental effects of substance abuse rather than promoting abstinence from substances (Davis et al. 2006; Pauly et al. 2007). Harm reduction strategies have been most prominent in initiatives for injection drug users (Wood et al. 2004), although the need for harm reduction strategies for persons with alcohol abuse has been recognized (Health Canada 2001). Interestingly, although there has been some initial opposition to harm reduction practices for alcohol use (Svoboda 2009), this has not been considered as controversial as harm reduction practices and programs for injection drug use (MacPhee 2006/2007; Wood et al. 2003), despite several studies showing evaluation results for safe injection sites including social and health-related improvements and no detrimental effects for users or the community. Although the reasons are not clearly known, a possible explanation for the decreased level of controversy for harm reduction for alcohol is that alcohol use is not illegal, unlike injection drug use. Similar evaluations of the effects of harm reduction for alcohol use programs are less common and none to date have focused on the partnership of harm reduction and psychiatric services to address concurrent disorders (Hass 2001; Podymow et al. 2006).

Harm reduction for alcohol (or managed alcohol) programs for homeless persons exist within a few emergency shelters in Canadian cities. As noted by Svoboda (2009), a coroner's inquest into the death of three homeless men in Toronto who had uncontrolled heavy alcohol use and mental illness in 1996 led to jury recommendations for a 24-hour-in-shelter harm reduction program to be provided within an emergency shelter. Known as The Annex, and located within Toronto's largest homeless shelter (Seaton House), this managed alcohol program has been found to reduce emergency room and detoxification unit visits, as well as police interactions (Svobodoa 2010). What has not been investigated within the Canadian harm reduction literature is the impact on client characteristics of offering concurrent psychiatric treatment for concurrent disorders within a management of alcohol model program. This is the focus of the

present chapter, which examines the Ottawa Inner City Health (OICH) Managed Alcohol Program (MAP), in which individuals who are homeless with substance dependence reside within a shelter in a closed harm reduction program and receive concurrent psychiatric services.

Ottawa Inner City Health—Management of Alcohol Program (MAP)

Ottawa Inner City was developed in 2001 as a unique model of providing health care to persons who are homeless with complex health needs (Podymow et al. 2006). One of the component programs of Ottawa Inner City Health is the Management of Alcohol Program (MAP), which is a 25-bed residential harm-reduction program located on a separated unit within an emergency shelter. The program is designed for persons who are homeless and have a long history of alcohol use and limited success with other attempts to control their drinking, plus frequent or prolonged experiences of homelessness, and who are identified as a frequent disruption in the community (as defined by frequent contact with police or disruption to local merchants or residents due to public intoxication). Clients reside in a designated floor of the emergency shelter that is staffed by client care workers and has a medical staff of physicians and nurses available for 24-hour care. Clients are served a regulated amount of wine during the day (one standard serving per hour, 13.6 grams of alcohol) in an attempt to both regulate their alcohol consumption (70% of clients reported daily or weekly binge drinking before admission to MAP) and as a harm reduction approach to decrease their consumption of non-beverage alcohol (e.g., mouthwash, aftershave, hair spray) (Hass 2001). Both substituting a less dangerous ingested substance and monitoring the intake of the substance contribute to minimizing personal harm and adverse social effects from substance use (Hass 2001). The first small sample outcome study of MAP ('before and after' design of 17 participants) found a significant decrease in the number of emergency room visits and encounters with police for clients after admission to the program (Podymow et al. 2006). However, the initial study did not account for whether MAP clients had been diagnosed with mental illness.

Shortly after the inception of MAP, program staff recognized that many of the clients had symptoms of concurrent psychiatric illnesses

(mainly psychotic and depressive disorders). At that point, psychiatric services (offered by an Advance Practice Nurse, Psychiatry, of the Psychiatric Outreach Team of the Royal Ottawa Health Care Group) were introduced into the program. The Psychiatric Outreach Team is a multidisciplinary team developed to provide specialized mental health services directly to individuals with serious mental illness and/or concurrent disorders who are homeless. The advance practice nurse (APN) role was designed to deliver psychiatric services (under the medical directives of the team psychiatrist) to provide assessment, pharmacological treatment and education to clients and staff about mental illness and concurrent disorders. This was the first known on-site delivery of psychiatric services within a residential management of alcohol program. This unique model of introducing psychiatric services to a management of alcohol program, therefore, requires further investigation and evaluation. Health Canada (2001) identified the need to understand best practices in concurrent disorders for vulnerable, underserved populations such as persons who were homeless, yet noted that this evaluation research was not available in Canada.

The purpose of the present study was to examine the effects of delivering psychiatric services within a shelter-based management of alcohol program for homeless adults. Given this new area for investigation, outcomes for investigation were selected in consultation with an advisory committee that consisted of program staff, client representatives and community service providers. The effects of delivering concurrent psychiatric services in a MAP was examined by investigating the effects of program participation on changes over time in psychiatric symptoms, mental status, global functioning, aggression, quality of life and consumption of alcohol and alcohol substitutes for participants in the MAP.

Directional hypotheses were assumed for each of the clinical outcomes over time. Specifically, it was hypothesized that: (1) Clients receiving psychiatric services during their residence in the MAP will have a decrease in the severity of their psychiatric symptoms (as measured by the Brief Psychiatric Rating Scale [BPRS]); (2) Clients receiving psychiatric services during their residence in the MAP will have an increase in their cognitive functioning (as measured by the Mini Mental State Examination [MMSE]); (3) Clients receiving psychiatric services during their residence in the MAP will have an increase in their mental health–related functioning (as measured by the Global

Assessment of Functioning [GAF]); (4) Clients receiving psychiatric services during their residence in the MAP will have a decrease in the frequency of their aggressive behaviour (as measured by the Cohen-Mansfield Agitation Inventory [CMAI]); (5) Clients receiving psychiatric services during their residence in the MAP will have an increase in both their subjective quality of life (client ratings of domains) and providers' perception of their quality of life (as rated by the Wisconsin Quality of Life Index, client and provider forms [W-QLI]); (6) Clients receiving psychiatric services during their residence in the MAP will have a decrease in their consumption of alcohol and alcohol substitutes.

Methods

Participants

All clients of the Ottawa Inner City Health's MAP were considered for the project. All participants in this study were already admitted to MAP when approached for their consent to participate in this study. For the duration of the study, all participants resided within the MAP in a specialized unit of a homeless shelter. As noted above, inclusion criteria for the study were based on acceptance to the MAP, in the absence of exclusion criteria, which included a diagnosis of dementia, acquired brain injury or previous head injury—due to the cognitive demands of the measure completion. Only two people were excluded based on these criteria. Four additional people did not consent to participate due to the range of information collected.

Procedure

The project protocol was developed in collaboration with Ottawa Inner City Health staff and approved by the Royal Ottawa Health Care Group Research Ethics Board. Informed consent for participation was obtained by MAP staff approaching all clients upon admission with a prepared script describing the project. If interested, participants met with project staff to complete a consent form and discuss the project (to accommodate a range of literacy levels in clients) and then review a written consent form. Participants were informed that participation in the project had no effect on receiving full MAP services.

Data collection occurred at admission and at six months following admission to MAP. MAP clients are admitted individually as this

is not a structured group treatment program. Therefore, given the variation in intake date for each client, a follow-up calendar method was used to determine the required timing for each phase of data collection. All measures were completed within three to five days of the required interval and were always collected before noon to ensure consistency in clients' alcohol consumption at each interval.

All data were collected by trained staff at admission and follow-up. In addition, an independent reviewer, who is a psychiatrist working with persons who are homeless and have concurrent disorder, saw each participant at both time intervals. The independent review consisted of a psychiatric interview, completion of a mental status exam and rating of global functioning (see Measures section). The independent reviewer conducted the evaluation session using the same procedure mentioned above within the premises of MAP.

Measures

Brief Psychiatric Rating Scale-Expanded. The Brief Psychiatric Rating Scale-Expanded (BPRS-E) was used (by trained raters) as a measure of psychiatric symptoms (Rhoades and Overall 1988). The BPRS-E provides a seven-point Likert-scale rating of the severity of symptoms related to 14 diagnostic categories and 10 clusters of behavioural patterns. The BPRS is the most commonly used measure of psychiatric symptoms in evaluation research of persons involved in community-based treatment programs and has been demonstrated to have sufficient sensitivity to detect symptom change within brief intervals in a treatment program. Past research has demonstrated estimates of inter-rater reliability ranging from $r = 0.53$ to 0.98 (Gabbard et al. 1987; Tarrell and Schultz 1988; Ventura et al. 1993).

Mini mental state examination. The mini mental state examination (MMSE) was used by the independent raters as an objective and short assessment of an individual's cognitive state. It is mostly used as a determinant of cognitive dysfunction at any time, as well as measuring changes in treatment effects (Folstein, Folstein and McHugh 1975; Psychological Assessment Resources 2005). There are two parts to the MMSE: (1) assessment of attention, orientation and memory performed orally and (2) assessment of labelling, following orders, composing a sentence and duplicating a polygon. The MMSE has also demonstrated strong inter-rater reliability ($r = 0.83$) as well test–retest reliability ($r = 0.98$) (Folstein, Folstein and McHugh 1975). In essence,

adequate reliability and validity has been confirmed with the MMSE among multiple populations with mental health concerns.

Global assessment of functioning. From the rating scale provided in the DSM-IV-TR, a global assessment of functioning (GAF) score was provided by the independent rater at each time interval. The GAF score is a scale from 0 to 100 that rates an individual's overall psychological, social and occupational functioning and is used to track clinical progress of individuals in global terms (APA 2000). The GAF scale is divided into 10 ranges of functioning and each range has two components: symptom severity and functioning. A single score is derived for functioning in the current time period (a period of five days was used for the current project).

Cohen-Mansfield Agitation Inventory. The Cohen-Mansfield Agitation Inventory (CMAI) was used as a measure of aggressive behaviour and is completed by trained staff raters (Cohen-Mansfield, Marx and Rosenthal 1989). Decreases in aggressive behaviour (both physical and verbal) and related agitation symptoms are often related to improved mental health of clients (Koss et al. 1997). The CMAI provides a rating of the severity and frequency of physical aggressive, physical non-aggressive, verbal aggressive and verbal non-aggressive behaviours. The measure is completed by staff who observed the client over the past week. Estimates of inter-rater reliability range from $r = 0.88$ to 0.92 (Cohen-Mansfield, Marx and Rosenthal 1989; Koss et al. 1997).

Wisconsin Quality of Life Index, client. The Wisconsin Quality of Life Index (client form) was used as a measure of subjective and other ratings of quality of life (Becker, Diamond and Sainfort 1993). The client form was used (completed in interview format with trained staff raters) to provide ratings of subjective quality of life and satisfaction with physical and psychological health and social relations (Maspero 1998; Sainfort, Becker and Diamond 1996). The measure has been previously used in Canadian studies of quality of life for persons with serious and persistent mental illness (Diaz, Mercier and Caron 2000; Diaz et al. 1999; Diaz and Mercier 1996). The test–retest coefficient of this instrument was noted to be 0.82 and high criterion related validity coefficients were observed between the QLI-MH and the Quality of Life Index (0.91), client ratings (0.68) and provider ratings (0.80) (Becker, Diamond and Sainfort 1993).

Advanced practice nurse practitioner service inventory. This measure was created for the current study to record the frequency and type of activity provided in each contact by the Advance Practice Nurse (Psychiatry) with participants. The inventory included a record of dates and foci for initial and all subsequent intervention.

Consumption record. The consumption record was created for the study and consists of a daily log of alcohol consumption for each client of the managed alcohol program, including both the type of alcohol consumed (i.e., beverage or non-beverage alcohol) and the location of consumption (i.e., inside or outside of the program). This record is already a part of the daily OICHP daily record keeping protocol.

Results

Demographic Characteristics

The final sample consisted of 80 participants in Time 1 and 63 in Time 2 over a six-month period. Demographic characteristics of the full sample are shown in Table 11-1. There were no significant differences found in demographic characteristics between those who did and did not complete both testing times. The reasons for non-completion were participant leaving the program by his/her own intention (n = 12), being discharged from the program (n = 3) for medical or behavioural issues or no longer wishing to participate in the study (n = 2). Those participants who completed both time intervals were included in the analysis of clinical outcome measures.

As shown in Table 11-1, the sample was mostly male (88%) with a mean age of 49.73 years (range: 30–70 years). Three quarters of clients (75%) had not completed formal education beyond secondary school, almost all (97%) had past involvement with the legal system and 40 percent had current involvement. The details of legal system involvement were not available. The range of medical conditions reported in the past two years and currently is shown in Table 11-1. However, less than a quarter (24%) reported having been hospitalized or in an emergency department in the past 12 or 24 months. The most common mental health diagnosis among the sample was depression (71%) and 88 percent reported substance use other than alcohol (predominantly marijuana, crack and cocaine).

Most participants had independent functioning in the areas of personal care, ambulation and communication. However, most (88%)

required partial assistance (dispensing support) for daily medication adherence.

Advanced Practice Nurse Practitioner Service Inventory

Review of the advance practice nurse practitioner service inventory suggests that the most frequently completed clinical activities of the APN were assessment (initial, 100%; monitoring, 95%), medication prescription and monitoring (80%), staff education (75%) and client education (65%). Assessment activities involved psychodiagnostic interviewing and symptom monitoring. Medication interventions were prescription and monitoring of medication effects and side effects. Staff education consisted of formal teaching and informal case discussion about concurrent disorders, the effects of mental illness on behaviour and information on medication interventions. Client education covered the same topics as staff education but was delivered in informal one-to-one sessions delivered in a manner corresponding to the client's cognitive abilities. As shown in the frequency distribution of activities, all clients were seen initially by the advance practice nurse and most remained in follow-up services. The number of interventions provided in the six-month time frame was $M = 13$ (range = 1–35).

Clinical Outcomes

Comparison analyses of clinical outcome measures were conducted using parametric and non-parametric tests. Total scores were used for symptom rating scales (BPRS-E, CMAI, MMSE and GAF) and domain scores were used for the quality of life measure, selected on the basis of clinical relevance.

As shown in Table 11-2, to determine significant change in clinical outcomes over time, a paired-samples t-test was conducted for the CMAI, BPRS and MMSE total scores and the GAF score. Results indicated that there was a significant change in the severity of psychiatric illness symptoms (as measured by the BPRS), and in the frequency of aggression observed (as measured by the CMAI) between Time 1 and Time 2. There was also a significant improvement reported in the assessed mental status of participants between Time 1 and Time 2, but not in ratings of their global assessment of functioning.

Quality of life, as rated from the client and staff perspectives, was assessed for changes over time using non-parametric statistics. Statistically significant differences were found for the provider

Table 11-1. Demographic characteristics of study sample

	Frequency	Mean (Standard Deviation)
Sex		
Male	88.4	
Female	11.6	
Age		49.73 (7.85)
Level of Education		
Primary	26.6	
Secondary	48.3	
University	13.4	
Other Post-secondary	11.7	
Legal System Involvement		
Past	97.1	
Current	40.2	
Mental Health Diagnoses (primary, excluding substance abuse)		
Depression	71.2	
Bipolar disorder	10.1	
Schizophrenia	9.2	
Anxiety disorder	6.1	
Personality disorder	4.5	
Use of Other Substances	88.2	
Use of Emergency Room		
Past 12 months	23.8	
Past 24 months	22.6	
Primary Medical Condition (at time of admission to MAP)		
Hepititis C	18.4	
HIV/AIDS	7.8	
Broken bones/fractures	9.2	
Seizure disorder	5.3	
Skin disorders	5.3	
Arthritis	4.9	
Asthma	3.9	
Anemia	2.6	
Level of Functioning, Personal Care		
Independent	70.1	
Partial assistance	27.3	
Complete assistance	2.6	

Table 11-1. (Continued)

	Frequency	Mean (Standard Deviation)
Level of Functioning, Medication		
Independent	7.9	
Partial assistance	88.2	
Complete assistance	3.9	
Level of Functioning, Ambulation		
Independent	82.9	
Partial assistance	14.5	
Complete assistance	2.6	
Level of Functioning, Communication		
Independent	96.0	
Partial assistance	1.3	
Complete assistance	2.7	

ratings of: (1) psychological health: $\chi 2 = 14.8$, $p < 0.01$; (2) physical health: $\chi 2 = 6.97$, $p < 0.05$; (3) quality of relations with family: $\chi 2 = 60.1$, $p < 0.001$ and (4) quality of life (overall): $\chi 2 = 39.5$, $p < 0.001$. Client ratings of perceived quality of life were significant for change over time for physical health: $\chi 2 = 23.3$, $p < 0.001$.

Related to substance use, review of the consumption record at Time 2 stated that there was no longer recorded ingestion of non-alcohol substances by participants. This is a clinically significant change in substance use patterns, but statistically significant change cannot be calculated because reliable estimates of ingestion could not be provided at Time 1 (admission to program), since they were solely based on participant recall. Alcohol consumption at Time 1 was not reliable because it was also based on participant recall. However, the amount of alcohol consumption remained constant between admission and Time 2 as it was regulated within the MAP protocol, and although it is decreased for some MAP clients, it was not for this sample.

Discussion

The purpose of this study was to examine the effects of delivering psychiatric services within a shelter-based management of alcohol program for homeless adults. The effects of delivering concurrent psychiatric services was examined by investigating changes for MAP

Table 11-2. Changes in clinical outcomes

	Time 1	Time 2	Significance Test
Psychiatric Symptoms (BPRS)	51.29 (17.4)	48.71 (16.3)	$t = 5.31$*
Mental Status (MMSE)	22.8 (4.6)	25.1 (3.2)	$t = 2.20$*
Global Assessment of Functioning (GAF)	36.95 (9.3)	37.29 (7.0)	NS
Aggression (CMAI)	65.71 (16.9)	55.1 (21.1)	$t = 3.11$*

*$p < 0.05$.

participants in their psychiatric symptoms, mental status, global functioning, aggression, quality of life and consumption of alcohol and alcohol substitutes. The hypotheses of the study were that clients of the MAP who were receiving concurrent psychiatric services would have a decrease in the severity of their psychiatric symptoms, an improvement in mental status, an increase in their mental health-related functioning and a decrease in the frequency of their aggressive behaviour. It was also hypothesized that clients would have an increase in both their own subjective quality of life (client ratings of domains) and in providers' perception of their quality of life, as well as a decrease in consumption of alcohol and alcohol substitutes.

Results of the study demonstrated mixed support for the hypotheses. There was statistically significant improvement in severity of psychiatric symptoms, mental status and frequency of aggressive behaviour, but not in a global rating of mental health–related functioning.

The lack of significant change in global functioning may be due to many of the elements of a GAF rating not being changed within participation in the MAP. The global assessment of functioning (GAF) provides a composite score based on psychological, social and occupational functioning, in addition to symptom severity (APA 2000). Since social and occupational functioning are outside the purview of the MAP, a composite score of functioning may not be sufficiently sensitive to detect change for MAP clients. Psychiatric interventions in the MAP focused on symptom identification, medication treatment and education. These interventions were expected to decrease symptoms, improve mental status (by reduction of interfering symptoms) and

decrease behavioural disturbance, but not necessarily change global functioning in some clients. The regulation of alcohol consumption is also expected to have contributed to improved mental status and decreased behavioural disturbance.

Findings of improved psychiatric symptomatology in this study are consistent with other studies that found a decrease in psychiatric symptoms for homeless individuals with a dual diagnosis (concurrent disorder) as a result of receiving treatment interventions to help them attain sobriety and build work-related and social skills (Drake, Yoveitch and Bebout 1997). Additionally, in another study that compared a Housing First and continuum of care group, it was found that psychiatric symptom improvement was associated with perceived choice and mediated by beliefs of empowerment that was associated with the Housing First model of service (Tsemberis et al. 2003; Tsemeris, Gulcur and Nakae 2004). As noted above, the differences in these approaches, with a focus on building additional skills or improved empowerment, may account for some differences in overall clinical functioning from those observed in the current study, in which clients reside in the shelter and are in earlier stages of engaging in vocational or other types of skill building.

Changes to ratings of quality of life had mixed results. Service providers rated more positive changes in participants' lives with increases in psychological health, physical health, quality of relations with family and overall quality of life. Conversely, participants rated significant improvement in only their physical health. This may be explained by participants being able to first detect (and report) changes in their physical health, due to changes from the time of admission, when they may have been using non-alcohol substances, to the management of alcohol approach with pre-selected administration of alcohol and other health care needs addressed by MAP medical staff. Participants' ratings of psychological health, quality of relations with family and overall quality of life did improve over the time interval, but the change was not statistically significant. This may mean that although change had (or was starting to) occur, it was insufficient during the measured time interval to the perception of participants. This may explain the non-significant finding in client and provider ratings in other areas of quality of life such as occupational, social and domestic areas, as these areas may not have changed while in a shelter-based program. Drake, Yovetich and Bebout (1997) found increased ratings of quality of life in the

areas of social contact and social relations for homeless clients with a dual diagnosis in an integrated treatment approach (psychiatric and substance use treatment) as compared to a standard treatment group. The focus of that approach, however, had more emphasis on quality of life and assessed participants over a longer time interval. This suggests that with the program being studied, ratings of change in domains of quality of life should be assessed over a longer time interval, such as following residential placement upon successful completion of the MAP. It may also suggest that domains of quality of life should become a focus of intervention or skill building within the program once participants' initial symptoms are stabilized.

The incomplete findings related to a decrease in the consumption of alcohol and alcohol substitutes was due to the lack of reliable information at the time of admission to the program, although the reported decrease and ceasing of use of alcohol substitutes represented clinically significant change. Elongation of the length of the follow-up intervals would have allowed for improved examination of consumption patterns within the program.

There are limitations in this study of the areas of participants' lives measured and the methods used. As noted, not all aspects of quality of life or functioning were addressed within the MAP. As for study methodology, the duration between time intervals of investigation in this study is a limitation of the study. Some variables under investigation may not have had sufficient time or been sufficiently a focus of service to have undergone significant change during the course of this study. With the finding that 85 percent of services delivered focused on pharmacological treatment, change measured in psychiatric symptoms, aggressive behaviour and mental status may have been detected because of the high number of participants receiving pharmacological and behavioural interventions targeted to these issues. Since all persons in the MAP were considered for this study, there is the limitation of having no control group against which to compare the clinical outcomes attained by this group. Insufficient detection of change may also be due to the shortened time intervals between ratings, the lack of focus on the domain during intervention or the heightened acuity of initial symptoms, such that the time frame was not sufficient to detect clinically observable change.

Client attrition from the final sample also limits sample size and the scope of the investigation. For this sample, clinical outcomes were measured for all clients receiving psychiatric services, but due

to sample size constraints, the relationship between service intensity and clinical outcomes was not assessed. In a larger sample it would be of value to investigate difference between clients receiving different levels of service intensity and focus. This study also examined clinical outcomes only while clients resided in a shelter-based program. A longer longitudinal measure of their outcomes achieved, or maintained, upon program discharge and transition into housing would be valuable.

Findings of this study indicate that the introduction of psychiatric services, focused on assessment, pharmacological intervention and education and education to staff and clients can be an important addition to a management of alcohol program, delivered in a concurrent model of service delivery. The extent to which the influence of the characteristics of these clients (their mental health diagnoses, levels of aggressive behaviour, mental status) on the outcomes are not known, but this study suggests that a concurrent model of service delivery (of psychiatric and harm reduction services) for underserved homeless clients, such as these who would not otherwise access traditional models of treatment, should be considered for effective service delivery. The model of management of alcohol within a shelter for homeless persons should also continue to be replicated as a responsive and appropriate service model for persons with substance dependence. It is within this model that concurrent psychiatric services are also well applied to deliver concurrent disorder services for this underserved population. This model of concurrent service delivery should also be replicated for other shelter-based populations to address their mental health issues, substance use and quality of life. The philosophies of many service agencies may present challenges to the further development of concurrent service delivery (since many require abstinence from substances); a broader understanding of need for introducing harm reduction principles while delivering psychiatric services is required. In addition, the use of the concurrent service delivery model that offers harm reduction for other substances should be considered to provide innovative service delivery for the growing rates of concurrent disorder in the homeless population.

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CHAPTER 12

Collaborative Approaches to Community-Based Mental Health Care for Homeless People: Toronto's Inner City Health Associates

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Introduction

Several recent reports have reviewed the health consequences and costs of homelessness in Canada (CIHI 2007; Patterson et al. 2008). Homeless persons in Western countries have high rates of mental health challenges and addiction and approximately one-third have a severe mental illness (CIHI 2007). A recent systematic review and meta-analysis of mental disorders among homeless persons in Western countries reported pooled prevalence rates of 12.7 percent for psychotic disorders, 11.4 percent for major depression, 37.9 percent for alcohol dependence and 24.4 percent for drug dependence (Fazel et al. 2008). Furthermore 4 percent to 7 percent of homeless persons experience global cognitive deficits, and many more experience focal deficits in verbal or visual memory, attention, executive function and speed of cognitive processing (Burra, Stergiopoulos and Rourke 2009). These rates are much higher than mean prevalence rates reported for these conditions in the general population.

Not surprisingly, the risk of homelessness among individuals with serious mental illness is 10 to 20 times higher than the general population, and 4 percent to 36 percent of psychiatric hospital patients experience homelessness before or after their hospital stay (Susser et al. 1997; Kuno et al. 2000). Homeless persons with mental illness and addictions are at increased risk of experiencing chronic

homelessness and utilize more health and social services than others experiencing homelessness (Aubry, Klodawsky and Hay 2003; CIHI 2007). Furthermore, many chronically homeless persons with mental illness have multiple and complex physical health needs including infectious diseases, chronic medical conditions and physical disabilities (Hwang 2001). In addition to mental and physical illness, homeless persons experience high stress levels and low self-esteem and report poor coping skills and suicidal behaviours (CIHI 2007). Mortality among homeless persons is much higher than the general population, and many unexpected deaths among homeless people in Canada are related to mental disorders and suicides (Hwang 2000; Hwang et al. 2009).

Toronto is home to Canada's largest homeless population, with over 5,000 people experiencing homelessness on any given night (City of Toronto 2009). More than three-quarters (79%) of those live in shelters, 8 percent live on the street, 6 percent in correctional facilities, 4 percent in health care or treatment facilities and another 3 percent in transition shelters for women who have experienced domestic violence. Over the course of the year, approximately 28,000 unique individuals use homeless shelters in Toronto (City of Toronto 2009). Similar to those in other jurisdictions, homeless persons in Toronto have complex health needs. A 1998 study reported that 67 percent of a representative sample of shelter users in Toronto have a lifetime diagnosis of a mental illness (Mental Health Policy Research Group 1997; CIHI 2007). The more recent 2007 *Street Health Report* (Khandor and Mason 2007) identified that 35 percent of Toronto homeless respondents had been previously diagnosed with a mental illness, with the most common diagnoses reported being depression (17%), anxiety (11%), bipolar affective disorder (8%), schizophrenia (5%) and post-traumatic stress disorder (5%). Approximately 25 percent of respondents reported a concurrent mental health and substance use disorder.

Despite Canada's universal health care system, few homeless persons in Toronto are connected to a regular health care provider. Furthermore, it is estimated that 75 percent of those diagnosed with a mental illness have not had a psychiatric outpatient contact in the previous year (CIHI 2007). Even those accessing health services have a high rate of unmet needs, as they often receive services that do not match the level of care they require (Stergiopoulos et al. 2010a). A study at Ontario's largest shelter for homeless men revealed that

38 percent of the clients required intensive case management or assertive community treatment and 9 percent required 24-hour supervision in a residential care facility. Despite the presence of primary care services on site, half the men did not have their service needs met (Stergiopoulos et al. 2010a).

Finally, unlike major US urban centres, Toronto has not developed a coordinated approach to homeless health service provision. Local services for homeless persons include a range of supportive and alternative housing, emergency shelters, drop-ins, street outreach teams, housing help and eviction prevention services, meal programs and a nurse led health bus, funded by both government and non-profit organizations. More recently, the City of Toronto launched a Streets to Homes program, which focuses on moving homeless individuals living outdoors into housing (City of Toronto, Shelter, Support and Housing Administration 2009). In addition to these homeless specific services, there is a resource-rich health service network accessible to both homeless and housed individuals, including nurse and physician primary care providers, community health centres, in-patient and outpatient specialty care, case management, assertive community treatment, early intervention for psychosis programs, court support services and mobile crisis intervention teams, amongst others.

Despite the large range of services and supports, homeless persons with mental illness and addictions face major barriers to accessing services that can meet their needs. Access to comprehensive care is limited, discharge planning from hospitals is poor and coordination and collaboration among service providers and service sectors, including housing, income support and health programs, is lacking (Goering et al. 2004). Physician care specifically remains challenging to access because medical and hospital care require a valid provincial health card, which many homeless persons do not possess. Furthermore, physicians are remunerated on a fee for service model, which fails to adequately compensate for much of the indirect and complex care involved in addressing the health needs of this population.

To effectively address these barriers and support the complex health needs of homeless people with mental health and addiction problems, comprehensive interventions that address their needs and preferences must be designed and implemented (Stefancic and Tsemberis 2007). This chapter describes the efforts of Toronto's Inner

City Health Associates (ICHA) to address some of these challenges through targeted placement of physicians in frontline homeless service settings and through the development of innovative collaborative models of service delivery in partnership with frontline health and social service providers. It also discusses the lessons learned in the efforts to build community capacity and to promote hospital and community integration and the integration of health and social service delivery. These lessons may be instructive for other jurisdictions facing similar barriers to accessing comprehensive care for homeless people with mental health and addictions problems and can support efforts to improve care for this vulnerable population.

Toronto's Inner City Health Associates (ICHA)

St. Michael's Hospital, Toronto's urban teaching hospital, has a long history of working and planning collaboratively with local community partners to improve care for the poor and the underserved. Following persistent advocacy efforts by a small group of St. Michael's physicians and administrators, the Ontario Ministry of Health and Long Term Care negotiated an alternate payment plan to facilitate recruitment of family physicians, psychiatrists and other specialists into frontline homeless service settings, many of which are located within blocks of the hospital. To our knowledge, this was the first such alternate payment plan in Canada. The funding addressed physician compensation, a barrier to recruitment in the past, but provided no administrative or other health provider infrastructure. This limitation necessitated building extensive inter-agency and inter-sectoral partnerships and collaborations to coordinate medical care with frontline homeless social services and other health supports through innovative, collaborative models of service delivery.

In recent years, there has been increased interest in community participation in the design of health services, in an effort to improve the quality of health care (Institute of Medicine 2004). Using the principles of community-based participatory research, the efforts of health planners and policy-makers have increasingly focused on including local stakeholders, patients and their families in the redesign of local systems of care for the purpose of system improvement. Keyser and colleagues (2010) have recently outlined the steps taken for mobilizing a region to redesign its local system of care. Action steps in their efforts have included forging partnerships with local

funders and policy-makers; involving all relevant system players in the collaborative change process; prioritizing community goals for system change; understanding barriers and issues faced by local providers and program staff who work in the system; learning from national and local programs; identifying potential policy levels and, finally, developing a blueprint for community action and sustainability (Keyser et al. 2010). In a similar fashion, given its intent to act on behalf of the community it serves, ICHA organized internally and aimed to set the stage for planned local system change through three broad approaches: (1) developing partnerships with local stakeholders, (2) collaborative planning and program development and (3) collaborative organizational program structures. Planning had a clear focus on addressing access to health care for homeless people and frontline social service providers and recognized the diversity of needs and perspectives of local stakeholders. It relied on frequent communication, commitment to optimal use of expertise and resources and regular review and evaluation. The framework for change was clearly set by community-driven needs assessment efforts and was informed by an extensive review of the literature.

Previous local studies have documented multiple unmet health needs among homeless persons, with less than one-third of homeless persons with mental illness in Toronto receiving treatment (Mental Health Policy Research Group 1997; Stergiopoulos et al. 2010a). Furthermore, an assessment of the health, mental health and addiction treatment needs of people using emergency shelters in Toronto highlighted the lack of coordination and collaboration among health and social service providers, leading to fragmentation, duplication and gaps in services (Goering et al. 2004).

Drawing on the findings and recommendations of these needs assessments, ICHA identified two key domains upon which to focus initial change efforts: (1) community engagement and (2) care coordination/service integration. ICHA program planning began with extensive consultations with the City of Toronto's Shelter, Support and Housing Administration Division, the Toronto Drop-In Network and several local health and social services planning groups to ensure homeless health care needs were addressed across geographical areas and service- and population-specific sectors. ICHA embarked on further extensive local needs assessments, including individual and focus group interviews of program planners, service providers and people with lived experience of homelessness, to identify perceived

strengths, weaknesses and opportunities in each geographic area within the city, service priorities and needs of clients and service providers and directions for effective and inclusive planning and communication, including the principles upon which to base partnership development, planning and collaboration.

Different models of frontline health care provision were developed, depending on client needs and resources available at each service site. Models ranging from integrative and consultative collaborative care models (Stergiopoulos, Rouleau and Yoder 2007; Tam 2010) to intensive case management and assertive community treatment team models (Stergiopoulos et al. 2010a) were developed to facilitate access to the different levels of care that homeless clients with complex health needs require. Given that ICHA only has access to physician funding and that health services for homeless persons remain un-integrated and poorly coordinated, these models depended on successful partnerships and collaboration with a range of other health and social services providers, including shelter and drop-in counsellors, homecare nurses and community mental health case managers.

ICHA currently numbers 65 physicians, including 32 psychiatrists, 29 family physicians and 4 other specialists, and provides medical and psychiatric care to more than 40 frontline homeless service agencies, including men, women, family and youth shelters, drop-ins, street outreach teams and select supportive housing agencies serving homeless persons with complex health needs. The group served more than 1,700 people in 2010, providing approximately 5,700 hours of primary care and 8,700 hours of psychiatric care. ICHA physicians provide direct and indirect care, advise frontline staff on service and case management plans, and teach on selected topics in efforts to build community capacity. They also advocate to different service sectors to help coordinate care and ultimately connect homeless people to mainstream services and supports. ICHA physicians are recruited to provide recovery-oriented care from a harm reduction framework, focusing on the determinants of community health. They prioritize housing, income and social support in their treatment plan. In addition to direct and indirect care to homeless people with complex health needs and development of community capacity, ICHA has identified student and resident education as a priority. A number of elective, selective, career-track and research opportunities for medical and other health discipline students, residents and fellows have

been made available. Most ICHA physicians are affiliated with the University of Toronto and have primary appointments at one of the affiliated teaching hospitals, spending only a small portion of their clinical time in homeless service settings. They also advocate, within their mainstream service settings, for services that are respectful and responsive to the needs of clients who experience homelessness or housing instability.

This approach is unlike other attempts to organize care for homeless persons, in advocating for better use or coordination of existing services and supports though integrated planning and collaboration, rather than creating a parallel system of homeless health care. ICHA services aim to create a gateway to mainstream services and supports by engaging and providing a healing relationship to patients who may have experienced stigma and discrimination in past health encounters and by developing the capacity of both mainstream health and frontline homeless social service providers to address the complex needs of homeless persons comprehensively, developing and using best practice models.

Bringing Services Together through Partnerships and Collaborations

ICHA program development addresses needs for preventive care, management of acute illness and comprehensive management of chronic complex health needs. The following sections describe some of the programs developed through partnerships and collaborations over the past seven years.

Shelter and Drop-in Based Collaborative Mental Health Care Teams

Collaborative mental health care is an important component of health care reform in many countries (Craven and Bland 2006). This term refers to models of practice in which patients, their caregivers and health providers from a variety of primary care and mental health settings work together to provide timely and better-coordinated services for individuals with mental health problems. Given the complex physical, mental health and social service needs of homeless persons, collaborative mental health care is an intuitively appealing service model. Since 2005, both consultative and integrative models of collaborative mental health care have been developed in the largest men, women and youth shelters and drop-ins in Toronto. These

enable rapid evaluation and treatment of patients with a wide range of mental health problems, improve the ability of shelter and drop-in staff to manage them, improve the education of shelter staff and trainees on the needs of homeless persons and reduce reliance on emergency department visits and hospitalizations for unmet mental health needs.

Fusion of Care, developed at Seaton House, one of Canada's largest shelters for homeless men, is an integrated collaborative care model with on-site medical support and a flexible referral process. In this model, shelter staff and ICHA physicians work as a single team. The impetus for adopting this model of service delivery was the communication breakdown and lack of coordination in care delivery experienced when case management or medical care of clients was brokered to external agencies (Stergiopoulos, Rouleau and Yoder 2007). The Fusion of Care Team provides medical care and in-house case management to the clients of the 240-bed Hostel Program, one of Seaton House's seven programs, and has the capacity to serve 40 clients at any one time. The team consists of a client service worker, a counsellor, a nurse and a team leader/counsellor, all Seaton House full-time staff, as well as a family physician and a psychiatrist. The two ICHA physicians offer concurrent clinics at the shelter for a half day every week, working collaboratively through both direct and indirect consultations.

The target population is chronically homeless persons whose health needs exceed the hostel's resources and who are unable to access community-based services. Once a client is identified by hostel staff as a candidate for the program, the client meets with a counsellor for one hour to set goals and complete a comprehensive psychosocial assessment. The client subsequently meets with the team nurse for a comprehensive health assessment. Once the main health issues are identified, the client is referred, depending on the complexity and acuity of health needs, to either a family physician or a psychiatrist. A comprehensive care plan is developed during weekly multidisciplinary team rounds for each client. The client service worker facilitates adherence to the plan by escorting clients to appointments off site and provides team members feedback and information about the client's function, hygiene and behaviour. Medications are dispensed daily to clients by the team's nurse. Although a rigorous evaluation is under way, preliminary program evaluation results are promising. A chart review of 73 clients referred

over a 12-month period revealed that six months after intake into the program 35.3 percent had improved clinically and 48.5 percent were housed. Factors associated with positive outcomes included the number of visits with a psychiatrist and treatment adherence (Stergiopoulos et al. 2008).

Consultative rather than integrative collaborative care models have been developed in other settings not resourced to support integrated teams. For example, at Agincourt Community Services, a community centre serving homeless and under-housed people at the city's east end, a psychiatrist provides consultation services to the agency's housing and outreach programs, working closely with drop-in staff. Agency case managers frequently attend appointments to ensure care is seamless and coordinated. In addition to supporting frontline staff and clients, the psychiatrist, in collaboration with Toronto Social Services, completes disability assessments to facilitate access to income support for eligible homeless persons (Tam 2010).

Multidisciplinary Outreach Team (MDOT)

An inter-agency, multidisciplinary street outreach team—the first such team in Canada—was designed in 2007 to enable rapid evaluation and treatment of street homeless clients with a wide range of disorders, to improve the ability of street outreach staff to manage these disorders and to contribute towards ending street homelessness related to illness and disability by streamlining access to housing, entitlements and health care. The development of the clinical street outreach team was an initiative undertaken by the City of Toronto's Streets to Homes program (City of Toronto 2009) to complement the network of city-funded programs providing street outreach.

MDOT consists of two part-time psychiatrists, one full-time nurse case manager, one full-time housing case manager, one full-time street outreach case manager and one part-time concurrent disorders specialist. This team composition was thought to include the content expertise and organizational resources required to address the needs of this population. Additional program partners include a community health centre that offers comprehensive primary care services and the provincially funded Ontario Disability Support Program that provides priority access to adjudication for income supports. MDOT follows a Housing First philosophy, developed to meet the housing and treatment needs of the chronically homeless population (Shern et al. 2000; Tsemberis, Gulcur and Nakae 2004). Housing First views

housing as a human right and involves providing homeless persons with immediate access to subsidized housing and case management supports. No preconditions, such as bringing substance abuse under control or being stabilized on medications, are imposed. Housing First supports access to housing concurrently with addressing immediate needs in other areas.

Unlike the Pathways Housing First model, MDOT does not provide long-term assertive community treatment, but rather offers transitional intensive case management until clients are housed and referred to appropriate long-term health services. This approach reserves the team expertise and resources for the engagement, housing and community connection of street homeless persons, transferring care to other agencies once these goals are achieved. This approach facilitates ongoing access to this highly specialized team for the street dwelling population. The team accepts referrals for clients whose needs exceed other street outreach teams' expertise and resources and who have unmet needs in one or more of the following areas: severe mental illness including severe substance abuse, developmental challenge or other acute medical needs.

Outreach and client engagement focus on frequent contact with clients to identify and address immediate needs and a client-centred approach to service provision. Client assessment and case management are integrated and multidisciplinary. Each client is assigned to a primary case manager at intake but accesses team resources and expertise according to identified needs. The team of providers from different home agencies and professional backgrounds shares an integrated clinical record. Communication and collaboration between team members is fostered through regular team meetings. Clients are directed to one of the two partner hospitals for their acute care needs. Discharge planning is facilitated and coordinated by a close working relationship with hospital discharge planners of the partner hospitals. The team provides ongoing support to clients after housing placement until other community partners are able to engage them successfully into the appropriate level of long-term treatment, often many months after the original intake to the program.

Coordinated Access to Care for the Homeless (CATCH)

In the absence of appropriate community-based health services, many homeless persons rely on hospital emergency department visits or in-patient hospitalizations for health care (Salit et al. 1998; McNiel and

Binder 2005; D'Amore et al. 2001), which are not designed to address their needs comprehensively. When admitted to hospital, homeless persons have longer hospital stays with higher costs (Salit et al. 1998; Hwang et al. 2011). Unsurprisingly, the 2007 CIHI report on *Mental Health and Homelessness* confirmed that mental illness and addictions were the most common reasons for homeless clients visiting emergency rooms or necessitating in-patient care in Canada (CIHI 2007).

Leveraging additional funding to address both local health priorities to decrease emergency room wait times and lengths of stay in hospital, as well as community-identified needs for better discharge planning and integration of hospital and community care, ICHA led the development of a coordinated access to care for the homeless program (CATCH). The program offers a centralized referral process for community-based health services for homeless persons presenting to hospital who are not able to access other services. CATCH aims to improve access to medical care, psychiatric care, peer support and case management and facilitate appropriate discharge planning of homeless persons with complex health needs. An additional program goal is to relieve pressure from emergency departments and in-patient units by coordinating hospital-based care with community-based homeless clinical and social services. The program, in addition to streamlining access to primary and psychiatric care, offers access to nursing, personal, peer support and transitional case management in partnership with other agencies, including a large community mental health agency, a homeless shelter and a consumer-driven community centre. It also leverages partnerships to offer facilitated access to disability income support to hospitalized homeless persons and a discharge planning checklist as a guide to hospital-based discharge planners.

The program improves service coordination and hospital community integration and provides assertive outreach, transitional case management and linkage to the apporpriate level of needed support. Program participants are supported in navigating the complex system of services and supports already available to them and are linked to additional needed services as soon as it is feasible. CATCH clinicians provide transitional supports over a period of four to six months in most cases. The project team includes four full-time staff: an ICHA administrative coordinator/agency liaison, who processes referrals to the team members, and three transitional case managers, who provide outreach to three emergency department and in-patient units in

downtown Toronto and the team physicians. The program enjoys the support of peer support workers, who accompany clients to appointments as needed.

Barriers and Facilitators

ICHA strategies for creating local system change have included nurturing community partnerships, building community capacity, influencing the health care system and linking sectors and resources. Over time, several factors contributed to the growth of the association and collaborative program development, including physician funding on a competitive hourly remuneration rate, institutional support from the University of Toronto and St. Michael's Hospital, which facilitated physician recruitment and educational and research activities, and a shared vision with the City of Toronto's Support and Housing Administrative Division, the Toronto Drop-In Network and Toronto Social Services for enhanced access to comprehensive health services.

Despite program growth, several barriers to program development emerged over the years, including a diverse and poorly resourced group of frontline homeless service providers; long standing tensions between health and community-based social services; lack of central planning for the various service components that homeless persons require access to; different privacy legislations binding health information custodians and social services providers; and cultural differences in some frontline homeless service settings, who offer institutional rather than recovery-oriented care by frontline staff with very limited mental health training or supervision.

Despite these barriers, ICHA has been very successful in meeting its operational goals and priorities. Several strategies were successfully utilized for that purpose. To overcome resistance by social service providers, relationship building with frontline homeless service providers, their managers and service planners was an early ICHA priority. Extensive consultations and joint planning and program development, both within individual agencies and local homeless planning committees ensured buy-in for hosting clinics in key frontline agencies, as well as operational support for clinics by frontline agency staff. Partnerships were nurtured based on shared values, with the belief that each partner makes a unique and valuable contribution, resulting in power sharing and mutual benefit. Furthermore, ICHA leadership engaged municipal and provincial

levels of government and local health networks to ensure planning meets and facilitates government identified priorities and contributes to overall system effectiveness. Helping align client centred care, frontline homeless agency needs and government priorities was very helpful in fostering partnerships and collaborations for innovative programming that spanned different sectors that do not traditionally work together. The ability to translate research findings into clinical programs was a critical aspect of developing effective relationships with these key stakeholders, informing system priorities and capitalizing on funding opportunities.

To address different privacy requirements in the frontline settings served, careful planning and rollout of a web-based electronic medical record (EMR) system, which provides role-based access to clinical notes, was undertaken. Finally, to address cultural differences in some settings, and further build community capacity, ICHA members strove to develop training seminars and workshops on a range of behavioural health topics and to provide a toolkit of knowledge and skills for frontline service providers who may have limited mental health training and supervision.

In addition to these barriers, inter-professional team building, not only at the different clinic sites, but within the ICHA leadership team, was a significant early challenge. Team members, in light of their different training and experiences, held very diverse views of system priorities and strategies for system change or for meeting homeless clients' complex health and support needs. Learning to appreciate and embrace those differences, and creating organizational structures that allow for problem solving and transparent decision-making, have been instrumental for fostering healthy teams and programs, as has the commitment to high quality, evidence-informed care.

Lessons Learned and Future Directions

Designing effective programs and minimizing barriers to access for homeless persons with mental illness continue to be major challenges for health service systems, which are plagued by limited resources and a high degree of fragmentation. ICHA has attempted to address some of these challenges through collaborative planning and program development, partnerships with stakeholders from various sectors and collaborative organizational program structures, with

little new investment. Unlike traditional health care approaches, this effort to bring local system change has required collaboration by all key stakeholders, responsiveness to community identified priorities and focused efforts on frontline social service agency staff empowerment and capacity building. It has fostered relationships that involve mutual respect, equity and inclusiveness, recognizing the community as a resource and aiming for shared leadership and power in health program development. Lessons learned through these efforts are generalizable in many urban settings facing similar challenges.

There are several advantages to the approach described above for planned system change. First, partnerships and collaborations can lead to improved access to a continuum of health, housing and income supports. Second, integrating primary and specialist mental health care in the frontline homeless settings addresses several system barriers: it avoids long waiting lists for mental health services; it improves coordination of primary care and mental health services and integration of medical care with social work and other frontline social services; it builds on the strengths of the partners, relieving pressures from other parts of the health care system; and it promotes academic–medical linkages and community development.

Our efforts to date have highlighted the need for widespread system change and the important role that communities and researchers can play in this effort through joint exploration of system barriers and working collaboratively to identify the evidence base for guiding the systems change process. In addition to drawing attention to homeless health as a priority for reform in a system that values health equity, future directions in planning an appropriate and effective mix of treatment and support services for homeless persons with mental illness should consider several complimentary approaches. First, standardized and detailed needs assessments of social, clinical and rehabilitative problems should be conducted to identify the need for mental health services (Acosta and Toro 2000; Salize et al. 2001; Stergiopoulos et al. 2010b). Second, evidence-based practices should be integrated into housing and support services, such as Housing First approaches and Assertive Community Treatment (Shern et al. 2000; Tsembersis, Gulcur and Nakae 2004; Goldwell and Bender 2007). Last, but not least, systems-level coordination should be pursued to promote hospital–community integration, the integration of mental health with addictions treatment and the integration of mental health

services with the rest of the health care system (Rosenheck, Resnick and Morrissey 2003; Durbin et al. 2006).

Greater collaboration between agencies and sectors will be instrumental to better meet the goal of providing client-centred care to homeless persons with complex support needs. Finally, alternative funding models for medical care, to address the limitations of fee for service models for this population, should be considered across jurisdictions.

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CHAPTER 13

The Development and Operational Context of an Emergency Shelter–Based Hospice in Ottawa, Ontario: A Qualitative Study

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Introduction

In Canada and internationally, there is growing recognition that homelessness is a significant public health challenge (Hwang 2001), with homeless persons experiencing high levels of morbidity and mortality (Cheung and Hwang 2004; Hwang 2000; Garibaldi, Conde-Martel and O'Toole 2005). Over the past two decades, research has demonstrated that homeless persons experience high incidences of chronic and infectious diseases, such as HIV/AIDS (Culhane et al. 2001; Robertson et al. 2004), hepatitis C (Nyamathi, Dixon and Robbins 2002; Roy et al. 2001), respiratory diseases (Snyder and Eisner 2004) and diabetes (Hwang and Bugeja 2000). In addition to these challenges, homeless persons frequently have co-morbid mental health or substance use challenges (Fisher and Breakey 1991; Grinman et al. 2010) that increase the complexity of care and, in many cases, serve as a barrier to medical care (Gelberg et al. 1997; Hwang 2001).

As the number of homeless older adults increases (Hahn et al. 2006; Stergiopoulos and Herrmann 2003), there will be a growing need to adapt services to the needs of this population and, in particular, to provide palliative care (i.e., end-of-life care oriented toward

managing pain and symptoms, rather than curative treatment). This is especially true given the cumulative burden of disease experienced by this population (Cohen 1999). However, in spite of the growing need for palliative care services among this population, the palliative care system has been slow to develop strategies to ensure that homeless persons are able to access needed care at end of life (Cagle 2009; McNeil, Guirguis-Younger and Dilley 2012a).

Previous research has noted that the palliative care system has largely been developed in accordance with a series of assumptions (i.e., that prospective clients are housed, supported by caregivers and, in many cases, have the financial resources to pay for supplementary care) that do not reflect the circumstances of homeless populations (Cagle 2009; McNeil, Guirguis-Younger and Dilley 2012a; McNeil et al. 2012b). Furthermore, while homeless populations have high levels of alcohol and/or illicit drug use, palliative care services typically operate under abstinence-only policies that constrain access to care (McNeil and Guirguis-Younger 2012). Accordingly, homeless persons are typically unable to access much needed care at the end of life, often dying alone and unsupported (Hwang 2001).

In Ottawa, a coalition of community leaders began working toward developing palliative care services for homeless persons in the early 2000s. This effort culminated in the opening of the Ottawa Mission Hospice in 2002, Canada's first emergency shelter–based hospice. The Ottawa Mission Hospice is a 16-bed palliative care program integrated into an emergency shelter in downtown Ottawa and is operated in conjunction with Ottawa Inner City Health, a homeless health care organization that coordinates health care services delivery to homeless persons in multiple shelter-based locations. The Ottawa Mission Hospice provides palliative and supportive care to homeless individuals and, in recognition of high levels of substance use among this population, operates under a harm reduction policy that permits managed alcohol use and off-site illicit drug use. An evaluation of the impact of this facility has shown that it reduces overall costs to the health care system by minimizing hospital stays and admission, while increasing overall satisfaction with care among homeless persons (Podymow, Turnbull and Coyle 2006).

This initiative represents a significant innovation in the care of homeless persons who are dying, in that it is a unique palliative care model that aims to provide care in a community context that is familiar

with and accustomed to serving this population. Furthermore, given that it has been demonstrated to produce positive outcomes, there is a need to document its development so as to inform the continued evolution of palliative care services for those who are socially marginalized in Canada. This chapter provides an account of the development of end-of-life care services for persons who are homeless in Ottawa, and in particular the Ottawa Mission Hospice, based on qualitative interviews with those involved in its development and ongoing operation. Specifically, it explores the factors that led to the development of this service, as well as the current structures that support its ongoing operation.

Methods

We undertook qualitative interviews with health and social services professionals over a five-month period (April to August 2007) as part of a case study of palliative care services delivery to homeless populations in Ottawa, focusing on the Ottawa Mission Hospice. We used a qualitative case study design to facilitate the study of the development of the Ottawa Mission Hospice and the individual, social and structural factors that shape palliative care services delivery in that setting (Yin 2003).

We relied upon a purposive sample of health and social services professionals involved in palliative care services delivery to homeless persons in Ottawa, all of whom worked directly for or in collaboration with the Ottawa Mission Hospice. We drew upon the expertise of an advisory committee made up of local and regional experts (e.g., senior health and social services administrators) to identify potential participants. In addition, the lead author (Manal Guirguis-Younger) had previously undertaken research on the palliative care needs of homeless persons in Ottawa (Guirguis-Younger, Runnels, Aubry and Turnbull 2006) and thus drew upon existing contacts with health and social services providers. Thirty individuals were sent a letter or email that outlined the study and study procedures and invited them to participate in an interview. Twenty-one individuals agreed to participate and represented a wide range of professional backgrounds, including health and social services administrators, physicians, nurses, social workers and personal support workers. Approximately half of our participants were employed by the Ottawa Mission Hospice or Ottawa Inner City Health, while

the remaining participants worked collaboratively with this organization to provide palliative care to homeless persons.

An interview topic guide was used to facilitate interviews with participants. This interview topic guide was designed to encourage conversation regarding the individual, social and structural dimensions of palliative care services delivery to homeless populations. Given our interest in exploring palliative care services delivery at the Ottawa Mission Hospice, this interview guide included sections focusing on a range of topics related to palliative care services delivery in this setting, including but not limited to: (1) how the Ottawa Mission Hospice was developed, (2) how it was situated within the larger landscape of health care services for homeless persons in Ottawa, and (3) how organizations collaborated with the Ottawa Mission Hospice. Interviews ranged in duration from 45 to 120 minutes, were audio recorded and later transcribed verbatim by research assistants. One of us (Ryan McNeil) reviewed the transcripts while listening to the accompanying audio recordings to ensure the quality of the transcription and make any necessary changes.

Our analysis focused on factors that shaped the development and delivery of palliative care services to homeless individuals at the Ottawa Mission Hospice. We imported the interview transcripts into NVivo qualitative data analysis software (version 8) to facilitate coding. We drew upon constant comparative analysis methods to code the data, whereby we identified emerging categories and expanded them by constantly comparing the data (Strauss and Corbin 1990; Glaser and Strauss 1967). We developed a coding tree inductively, and revisions to this coding tree were made on a continuous basis as the data were coded. Once the final thematic categories were established, the lead author recoded sections of the data to check the credibility of these categories and ensure reliability.

This study was approved by the institutional research ethics boards at Saint Paul University and the University of British Columbia. We obtained informed consent prior to interviews, and participants were given a duplicate copy of the informed consent protocol for their records.

Results

Pioneering Work: Identifying and Responding to Unmet Palliative Care Needs

The Ottawa Mission led efforts to develop palliative care services for homeless populations in recognition that homelessness is a significant barrier to accessing mainstream palliative care services. The Ottawa Mission and partnering organizations acknowledged the complexity of the issues surrounding palliative care in the context of homelessness and identified the need to develop an alternative service delivery model responsive to the needs of this population. Two critical factors shaped the initial planning of palliative care services for homeless persons in Ottawa. First, key stakeholders identified factors contributing to a gap in palliative care services for homeless populations. Second, those involved in developing the Ottawa Mission Hospice shared a philosophy of providing compassionate palliation responsive to the unique needs of homeless persons.

Incompatibility of Homelessness and Mainstream Palliative Care Services

The palliative care system has been developed in accordance with a series of assumptions regarding the social and structural context of service delivery (Lewis et al. 2011). Participant accounts indicated that many of these assumptions did not reflect the needs and circumstances of homeless populations. Specifically, participants noted that, while the palliative care system assumed that its clients were older adults with housing and caregiver support, these assumptions did not reflect the experiences of homeless persons. In this context, participants emphasized that homeless persons had vastly different experiences and needs due to intersecting individual characteristics (e.g., high levels of substance use and mental illness) and structural factors (e.g., homelessness, poverty, food insufficiency, etc.). For example:

> *[There was] an appreciation in the community that there was a group of people that were chronically homeless, with complicated health problems, and not a really good understanding of whether the chronic homelessness was a cause or an effect of the physical health. . . . But, basically, the community deciding that, on some level, it doesn't really*

> *matter. You have to address the problem and that's really where Inner City Health came from . . . to look at the chronically homeless and see if we could find better health care.*
>
> – Administrator, Emergency Shelter

In the local context, key stakeholders identified the need to develop an innovative approach to providing palliative care services to homeless persons and, given the promise that emergency shelter–based health services have shown elsewhere, identified an emergency shelter–based hospice as a potential model. Participants reported that this model of care was identified as having the potential to minimize barriers to palliative care services for homeless populations, such as stigmatization of homeless persons and substance-use or behavioural policies. In addition, those involved in the development of this service perceived a shelter-based service delivery model as having other benefits, notably that staff have demonstrated cultural competence in providing care to this population. For example, one participant noted:

> *[Homeless persons] deserve a way to die that represents the way they lived. They are uncomfortable in the traditional hospital care, where their friends are not allowed in. They are uncomfortable being told what [the] parameters of their dying are. They really need their own model. We are ready to house that model and see if it works.*
>
> – Executive Director, Emergency Shelter

Ensure Basic Rights around Death and Dying

Mainstream palliative care services are a part of a long tradition that aims to meet the health and social needs of dying individuals and their families (Chochinov 2002). In this context, considerable attention has been paid to how to best develop respectful services that allow individuals to die with dignity (Sepulveda et al. 2002). Given that these are the cornerstone philosophies of palliative care, they were identified by local stakeholders as guiding principles to inform the development of palliative care services for homeless individuals. Participants articulated that, in addition to pain and symptom management, promoting dignity and respect was a critical component to providing shelter-based palliative care services and countering the widespread discrimination experienced by this population in other palliative care settings. Participants emphasized that it was

important to foster an environment in which clients could receive social, emotional and spiritual support and that promoted social inclusion and self-worth:

> *They have been faceless and nameless for long periods of their lives. One thing, which has been very important, is to give people a place to be acknowledged.*
>
> – Mental Health Worker

> *The biggest thing is supporting them . . . praying for them, and then they don't die alone.*
>
> – Outreach Worker

Respecting the Unique Social and Personal Needs of Persons Who Are Homeless

Participants indicated that identifying the unique needs and life circumstances of homeless populations was critical to the development of the Ottawa Mission Hospice. Those involved in planning this health care service consulted with community stakeholders and homeless persons to identify unique challenges that shape palliative care services delivery to this population. This ongoing dialogue focused on how to ensure that this model was responsive to the needs of this population. In this context, it was critical that services account for issues typically associated with palliative care (e.g., pain and symptom management), while also accounting for challenges associated with providing care to homeless persons (e.g., substance use, mental illness, etc.). For example, participants emphasized that there was a need to take a different approach to substance use than the abstinence-only approaches common in health care settings. For example:

> *At the end of the day, we are all part of one community. . . . The more you marginalize people, the less safe the community is for everybody. . . . Where we have some common ground is there. . . . For example, injection drug users. . . . It's not like they think that the wild and crazy behaviour and injection drug use is a good thing. They don't. . . . I think, we have the opportunity, if we can get past that [i.e., injection drug use], there is some common ground.*
>
> – Administrator, Emergency Shelter

One of the anticipated challenges posed by providing palliative care to people who use drugs was managing pain and symptoms associated with terminal illness. For example, participants indicated that administering the recommended dosages of pain medication (e.g., narcotics, opioids, etc.) were insufficient in managing pain among those with histories of drug dependence. In this context, participants indicated that they identified a need to tailor their strategies to the individual needs of clients and, in some cases, exceed recommended dosage levels. Participant accounts indicated that this was a delicate balancing act, whereby they had to weigh the client's needs against the potential risks:

> *We weren't one hundred percent sure of the volume of dying homeless and some of the complexities of managing [their health needs], like people who are addicted to narcotics and you have to control their pain. How much [pain medication] do you give? What is pain? What is addiction?*
>
> – Physician

In addition to these challenges, participants indicated that homeless persons may exercise individual agency and thereby choose to forgo treatment. Participants acknowledged that there were many reasons why individuals may make this decision, including concerns regarding potential adverse side effects (e.g., pain, nausea, etc.) and fears that they would be sedated. For example:

> *If somebody [i.e., a client] looks at me and says, "Don't try to give me any of those wacko-pills or make me into a zombie," that is the end of it. Fair enough, you don't want medication. That is the answer. End of story.*
>
> – Mental Health Nurse

Some participants indicated that, while they acknowledged the importance of promoting agency among clients, it was often difficult for them to understand choices that had potentially negative health consequences:

> *He's an adult and he makes choices for himself. We support him in whatever those choices are. The choice about whether or not he goes into housing is not mine and it's not yours.*
>
> – Administrator, Health Services

Recognizing the Non-linear Trajectory of End of Life among Homeless Persons

Participant accounts emphasized that homeless persons had end-of-life trajectories far different than those of individuals receiving care in mainstream palliative care settings, who are typically in their final hours or days of life. On the contrary, participants indicated that palliative care for the homeless potentially prolonged life because of treating previously unmanaged health conditions (e.g., HIV, hepatitis C, etc.). As one participant noted,

> *We have a guy, he was supposed to die five years ago. He hasn't. He had bipolar [disorder] that had never been treated. He went on medications for his hepatitis C and HIV. He looks like the walking dead, but he's still here.*
>
> – Mental Health Nurse

In this regard, participants indicated that palliative care in the context of homelessness was akin to long-term or continuing care in that it often (although not always) lasted longer than palliative care provided in mainstream settings. Participants identified this as a potential benefit because it allowed them to build trust and rapport with clients and thus improve the overall quality of care. This was especially important given that homeless persons often lacked the support of family and friends. Whereas participants noted that it was important to attempt to reunite clients with family, they also needed to provide care and support in the absence of this. For example:

> *Talking with them, spending time with them, playing cards with them. Bringing them down to the big TV room, taking them out for a walk. Making them happy. They feel safe.*
>
> – Care Worker

Maintaining Compassionate Palliation in the Context of Homelessness

Addressing the complex social care needs. Participants reported that, in addition to palliative care needs, homeless persons have complex social care requirements. Participants noted that, because homeless persons have difficulty meeting everyday survival needs (i.e., obtaining food and shelter), palliative care services need to address these needs and, moreover, foster a safe environment. For example:

> *He told me, before he came here, that at times he had nothing to eat. . . . That was hard, but then I said to him, "Now you are here and now we are going to take care of you and try to let you have as less pain possible. You will have food and you will have clothing. You will have what you need."*
>
> – Client Care Worker

In addition, participants noted that, due to the absence of caregiver support, homeless persons were in need of social support:

> *As a nurse, you're spending all the time in the evening helping the client go through whatever emotional things they need to go through. Or, they might come back drunk or they maybe in pain and you have got to deal with pain management.*
>
> – Nurse

Commitment to minimizing suffering at the end of life from a harm reduction perspective. Participants emphasized that it was important to integrate harm reduction strategies into palliative care so that clients would not face barriers to necessary care as a result of continued substance use. In this regard, harm reduction programming was identified as a form of palliation insofar as it minimized the potential suffering associated with withdrawal. As one participant noted,

> *I could have a patient who is dying, who requires end-of-life care who still wishes to drink. They can drink, but what we do is we decide with the patient how much he can have in a day and we will dispense it as medication.*
>
> – Nurse

Although abstinence should not be the goal, participants identified that it was important to provide support to those who wished to discontinue drug or alcohol use. Accordingly, it was felt that palliative care should also include detoxification programs:

> *We have a protocol here for detox. If we have to detox them, if they're in withdrawal, then we have a protocol to help them with their alcohol withdrawal. We also have a protocol for drug withdrawal.*
>
> – Nurse

Building a System of Services

Three major themes emerged in regards to the development of palliative care services at the Ottawa Mission Hospice: (1) consultations with clients and community stakeholders, (2) partnership building with Ottawa Inner City Health and researcher and educators and (3) defining the operational principles of palliative care services.

Consulting with clients. The Ottawa Mission Hospice emerged out of a dialogue between the organization and a group of emergency shelter clients. These consultations were critical in ensuring that homeless persons had a voice in the development of palliative care services, which had the potential of increasing the ability of these services to meet their needs. Specifically, following the death of a longtime shelter resident, the Ottawa Mission's executive leadership consulted with a group of peers who provided support to that individual. These consultations aimed to identify the parameters of services focused on the unique needs and wishes of people who are homeless.

> *[The client's friends] sat with him until he died. It was a moment that they hadn't experienced—that dignity that they were allowed to have with somebody who was on the streets. . . . After that, I met with those five people and I said, "Do we need a place like this for people to die?" They said, "Yes."*
>
> – Emergency Shelter Director

This consultation provided a foundation for launching culturally competent services. In addition to this early dialogue, the conversation around the nature and implementation of these services continued with the clients, specifically around the structure and governance of service.

> *I said, "What would the rules be?" Because I knew they wouldn't be regular rules. We chatted back and forth and decided [that] we needed respect and dignity for the person. [Friends and visitors] couldn't come in high. They couldn't bring alcohol or drugs to the person. They were part of the caregiving team. They wanted to be able to talk to the doctor.*
>
> – Emergency Shelter Director

The involvement of clients in their own care took place in many levels. The ongoing nature of this dialogue is an important feature

in the ultimate success of building services that work and extending these services into multiple areas of the death and dying experience.

Consultation with community stakeholders. Following initial consultations with emergency shelter clients, the Ottawa Mission brought the issue of palliative care for homeless persons to the larger community of service providers, with the goal of increasing awareness of the need for an alternative palliative care services delivery model. The Ottawa Mission identified that it was advantageous to involve the local hospitals and academic institutions in order to build support within the community and encourage the development of a shelter-based hospice.

> *I started becoming part of every advisory group I could find that was talking about palliative care. . . . I sat in on, I cannot tell you how many meetings—medical meetings. I kept giving the message: these people deserve dignity.*
>
> – Emergency Shelter Director

One of the most difficult issues to reconcile among organizations was incorporating harm reduction strategies as part of palliative care. This became an important point of consideration in terms of finding a way to work together. Discussions took place to ensure that no one organization has to compromise its ideology or philosophy of care, while at the same time ensuring that services met the needs of those who used alcohol or drugs at the end of life.

> *[Some agencies] do not allow alcohol, but they weren't doing palliative care. They were doing convalescent care. [Other agencies] had managed alcohol programs. That was the whole idea. If you prescribed alcohol, they didn't have to drink Listerine. It's a range of harm reduction. We are always struggling, trying to find a middle ground. There's a set of rules now that we each can work by and understand where everybody is.*
>
> – Emergency Shelter Director

Partnership with Ottawa Inner City Health. Whereas the Ottawa Mission had extensive experience providing emergency shelter services, it lacked experience providing health care services, and thus sought out opportunities to formally partner with a health care organization. In this context, the Ottawa Mission developed a

symbiotic relationship with Ottawa Inner City Health, an organization with a mandate to provide care to homeless persons in the Ottawa region. The Ottawa Mission would provide the infrastructure, resources and staffing, including the program administrators, while Ottawa Inner City Health would provide health care services in coordination with its partnering agencies (i.e., a network of shelter-based health services, local hospitals and other community agencies). An important benefit of this approach is that it situated the shelter-based hospice within the larger context of health care services available to homeless persons in Ottawa. For example:

> *There was sort of an understanding that we needed to integrate across the [health and social care] system. Other partners were gradually brought on board. [Ottawa Inner City Health] was a pilot project. The focus was primarily on a set of deliverables: palliative care, short stay convalescent care and alcohol addiction. Those were picked by the community as being the three priorities.*
>
> – Administrator, Health Services

The Ottawa Mission and Ottawa Inner City Health would share in the decision-making on matters relating to the shelter-based hospice. In this regard, while there was a need to maintain some continuity between the hospice and emergency shelter in general, there was a recognition that a different set of rules were needed for the hospice due to its unique demands.

> *We had to really be very respectful around what [the Mission's] constraints were. There are some people who would say, "Well, they're dying. Anything they want to do is fine." Well, that would be what a health care provider would say but that's not what you say if you're running a shelter that has two hundred other people. You basically have to say, "Yes, this person's going to get a lot more leeway than anybody else because of the situation that they're in but, if they're disrupting the operations of the Mission, if they're threatening or injuring the staff and other clients, these are the conditions under which we can and can't take care of them."*
>
> – Administrator, Health Services

Because the Ottawa Mission was well-established within the community, it was able to generate financial support for the hospice through

donors that was critical in establishing this service. As a registered non-profit and heath care organization, Ottawa Inner City Health was able to secure funding for health care services from a variety of sources, including the local health authority and the provincial government.

> *Every organization that's part of Inner City Health has, in fact, not just given what they originally said that they would give, but everybody has given more. Ottawa Inner City Health process, to some extent, was just bringing people together around the table to figure out who can offer what.*
>
> – Administrator, Health Services

> *It was a partnership between the Mission and the Ottawa Inner City Health. It grew out of that initial meeting where the Mission, all the other shoulders were together, we knew that we needed palliative care services as a group. We agreed to bring in the health piece of it and the Mission was kind enough to bring the infrastructure side of it. They fundraised, they developed a beautiful wing, and provided excellent facilities for us, and we provide the health care.*
>
> – Physician

Community–academic partnerships. Partnering with universities provided the opportunity for research and program evaluations, which lent credibility to the work undertaken by the Ottawa Mission Hospice. In this regard, Ottawa Inner City Health first emerged as a pilot research program operated in conjunction with the University of Ottawa, with the expectation that all of its programs be evaluated, including the hospice. A pilot study was undertaken to look at the efficacy of programs across the Ottawa Inner City Health system, which included an evaluation of the Ottawa Mission Hospice. The evaluation indicated that the Ottawa Mission Hospice was successful in decreasing health care costs, while increasing the quality of and satisfaction with care. This positive evaluation helped to validate the benefits of this service delivery model. As one participant noted:

> *There is a great deal of scientific evidence that supports what we're doing . . . . [There was] an independent evaluation, which produced very promising results. You've spent a very small amount of money and in fact you're showing good results.*
>
> – Administrator, Health Services

Continuity of care in palliative care services. The partnership with Ottawa Inner City Health was critical to facilitating continuity of care across services providing care to homeless persons in Ottawa. This continuity was important due to the complex co-morbidities experienced by most hospice clients. In particular, because medical personnel typically worked in multiple locations across the Ottawa Inner City Health system and regularly met to discuss patient care, they were knowledgeable of the overall needs of their clients. For example:

> *We have rounds here at the office every week and there are patient reviews. Anybody who we have that's new, we get the whole history and the story and hear about things on an ongoing basis.*
>
> – Administrator, Health Services

Given the special needs created by homelessness, one of the operational principles of effective service provision became a flexible delivery of what is necessary at various points of service contact. That is, individuals did not need to be physically at the hospice or imminently dying to receive palliative care.

> *We do palliative care in other places [i.e., partnering agencies] besides the [Ottawa Mission Hospice]. Not everybody that is palliative is necessarily at the [Ottawa Mission Hospice]. People can go where they want to be and receive services, as long as we can do it safely.*
>
> – Administrator, Health Services

Discussion

Clearly identifying the factors contributing to service gaps in palliative care for those who are homeless and marginalized was a crucial step toward a more equitable service delivery model. Consistent with other studies (Cagle 2009; Lewis et al. 2011; McNeil, Guirguis-Younger and Dilley 2012a), our data suggest that the mainstream palliative care system is not suitable to address the needs of homeless persons due to its structure and parameters of service delivery (e.g., abstinence-only approaches). Our participants associated homelessness with many social barriers that constrained access to equitable health care, including but not limited to stigma, poverty, substance use and complex co-morbidities. Homeless service organizations and

allied health organizations were uniquely positioned to identify the nature and dynamics of these barriers and to propose an alternative service delivery model. Accordingly, the Ottawa Mission Hospice may be understood to be the product of the desire of these organizations to help homeless persons die with dignity and access to best care.

In this context, two factors informed the development of the Ottawa Mission. First, key stakeholders acknowledged that palliative care services would best respond to the needs of homeless individuals if they were integrated into services already accessed by this population (i.e., an emergency shelter). Second, there was recognition that palliative care services needed to incorporate a wider range of social care services to address the complex needs of this population, especially given the non-linear nature of their end-of-life trajectories. Specifically, the Ottawa Mission Hospice identified a need to combine compassionate palliation and harm reduction strategies (i.e., providing managed alcohol consumption services, providing harm reduction paraphernalia and allowing off-site illicit drug use) and situate this service within a larger network of homeless health care services. Participants believed that this was necessary to facilitate access to services and ensure continuity of care, echoing the findings of other studies emphasizing the important role that public health services should play in palliative care services delivery to underserved populations (McNeil et al. 2012b; McNeil, Guirguis-Younger, Dilley 2012a).

Importantly, the Ottawa Mission Hospice demonstrates how community leaders and the affected community (i.e., homeless persons) can work together to develop and implement innovative solutions to community challenges. Whereas service providers, researchers and administrators spearheaded the development phase, early consultations with homeless persons were critical in informing the development of this initiative. Involving potential clients in defining the parameters of palliative care service delivery helped to ensure that the resulting service delivery model was client centred. Equally important was the consultation and brainstorming that took place with community organizations involved in the delivery of health and social services to homeless persons, given that palliative care may be initiated outside of the Ottawa Mission Hospice. Those concerned with developing palliative care services responsive to the needs of homeless populations in their community would benefit from similarly involving diverse partners and homeless persons in the planning of these services.

An important element in maintaining the momentum of this initiative was building partnerships, and in particular formally partnering with Ottawa Inner City Health. Ottawa Inner City Health played a critical role in mediating relationships across a range of health and social care services that enhanced continuity of care. Many of Ottawa Inner City Health's partnering organizations developed formal and informal service agreements with one another with respect to the provision of palliative care. Furthermore, Ottawa Inner City Health continued to serve as the backbone of service integration in that it coordinated the delivery of health care services across this system. While a complete description of the operational context of Ottawa Inner City Health is beyond the scope of this chapter, it should be noted that a great deal of organization development was necessary to ensure the continued success of this service and that partnering organizations, including the Ottawa Mission, informed its development.

The partnership with educational institutions and with mainstream services (e.g., hospitals) provided some infrastructure at the inception of the corporation and allowed the use of existing resources and procedures. The involvement of researchers allowed the rigorous evaluation of palliative care services, notably their impact on clinical outcomes and cost effectiveness (Podymow, Turnbull and Coyle 2006). A partnership that comprises academic NGOs, community-based NGOs and clients would be a formidable voice in eliminating health inequities and generating information for evidence-based public health practice (Robinson et al. 2007). Documenting the various stages of this process can serve as a guide for other communities looking for some direction on how to develop palliative care services for homeless or underserved groups.

The lessons learned in the development of the Ottawa Mission Hospice are instructive to all those who may wish to develop innovative service delivery models to meet the needs of homeless persons in their community. Accordingly, the processes outlined in this chapter, while focused on palliative care services delivery in a particular case, are likely transferable to other settings. Although communities and their challenges vary widely in accordance with the unique social, political and economic factors within those communities, our findings demonstrate that, if there is agreement around fundamental service goals, then it is possible to develop innovative services responsive to the needs of homeless populations.

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Ex # 5 m/d/y 8/26/2024 Pg 1 of 4
Exam of Dr. Aaron Orkin 1428
Heegsma et al v City of Hamilton
Nimigan Mihailovich Reporting Inc.

Rethinking involuntary admission for individuals presenting to Canadian emergency departments with life-threatening substance use disorders

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INTRODUCTION

Substance use disorders carry a substantial disease burden and premature mortality,[1] and have become a leading and growing cause for hospital service use across Canada.[2,3]

People with severe substance use disorders experience high rates of serious comorbidities, and often use hospital emergency departments (ED) as the first and only point of medical care.[3] With medical complexity compounded by stigma, and poorly resourced community care, this population is challenging to engage in treatment, and more likely than the general population to leave hospital against medical advice or without adequate intervention, facing a high risk of imminent and serious harm.[4]

Although increasingly involuntary detention of individuals with severe substance use disorders is being advocated for by families and community providers as a means of engaging this population in potentially life-saving treatment, scholars and practitioners have recently argued against the use of involuntary measures for this population, citing inconsistent evidence of effectiveness and better outcomes associated with voluntary treatment.[5,6]

Given the unique role of emergency clinicians in hospital settings, and the opportunity to initiate evidence-based treatments in hospital, this commentary explores the legal, ethical, and clinical grounds for and against involuntary admission and calls for further research, reflection, and dialogue on this important issue.

LEGAL BASIS IN CANADA

In Canada, involuntary admissions to hospitals are regulated provincially. Two involuntary admission criteria are consistent across all jurisdictions: (1) that an individual presents with a "mental disorder" and (2) that without involuntary admission, presentation of the "mental disorder" itself results in likely "harm."

Most Canadian jurisdictions are aligned and endorse a definition of "mental disorder" derived from the Uniform Law Conference of Canada's *Uniform Mental Health Act* (1987), which neither explicitly includes nor excludes substance use disorders. However, substance use disorders are designated as mental disorders in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.),[7] and Canadian mental health tribunals have consistently determined substance use disorders to be mental disorders.[8]

Criteria for "harm" in provincial mental health legislations vary significantly across Canada and range from likely bodily harm to substantial mental or physical

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deterioration. Although available case law is scarce, provincial mental health tribunals have found that harms associated with substance use disorders can satisfy both the "serious physical impairment" and "serious bodily harm" criteria.[9,10] Such precedent-setting decisions support the legal opinion that substance use disorders can satisfy both the "mental disorder" and "harm" criteria in all provinces and that involuntarily admissions for this population are possible under current provincial legislations.

Are legal provisions for involuntary admission then under-utilized in this population? Lack of awareness and publicly available legal precedents for the application of such legislation might contribute to possible under-utilization. Is the possible under-utilization of involuntary measures in people with severe substance use disorders, or the exclusion of people with substance use disorders from everyday interpretations of involuntary admission criteria, a manifestation of therapeutic nihilism, or worse, stigma, which further compounds this population's marginalization? These questions merit further exploration and dialogue between service users, providers, families, and policy-makers.

As a caveat, we are *not* suggesting that involuntary admission should be considered as a general or appropriate way to initiate treatment for people with substance use disorder, but rather that people with severe substance use disorder should not be excluded on the basis of legal grounds from accessing the protections to health that might follow from involuntary admissions when their circumstances would otherwise mandate it.

ETHICAL BASIS

Under a bioethics lens, support for involuntary admission in mental health is clear under certain circumstances.[8] From this perspective, involuntary admission can be ethically justified if the imperatives of medical care, beneficence, nonmaleficence, or justice, are significantly challenged by an individual's presentation and risks.[11] Substance use disorders are characterized by compulsory use of substances and impaired capacity to reflect on and overcome cravings and urges, undermining affected individuals' autonomy and placing them at risk of serious and imminent harm.[5] In this sense, there is no cogent bioethical reason why the involuntary admission of people at imminent risk of harm for reasons related to substance use disorders ought to be considered categorically different to any other cause of involuntary mental health admission, although the goals of treatment may vary.

From a broad human rights perspective, both the *Canadian Charter of Rights and Freedoms*[12] and the *United Nations Convention on the Rights of Persons with Disabilities*[13] argue that every individual, regardless of mental disability, is to be considered equal before the law. Within this human rights context, ethical dilemmas arise when one is confronted with competing rights, such as autonomy, or the right for self-determination,[5,6] v. the right to life and health.[14]

That said, autonomy need not be antithetical to the use of involuntary admission.[11] A pragmatic approach would view autonomy as a multidimensional construct in which clinicians aim to support individuals with substance use disorder in their first steps toward regaining autonomy, by engaging in life-saving treatment of their substance use disorder and related comorbidities.[11]

CLINICAL CONSIDERATIONS

With both legal and ethical grounds allowing for the involuntary admission of people with severe substance use disorders at imminent risk of harm, what are key clinical considerations and barriers? First, although voluntary treatment, shown to be effective, may not be an option for some individuals with severe substance use disorders, research on the effectiveness of involuntary treatment of this population is scant and inconclusive.[6] Is the immediate, short-term protection from harm enough to justify involuntary admission when the long-term outcomes are unclear? In some cases, it may be, if brief hospitalization allows for treatment of life-threatening comorbidities and engagement with community supports.

Second, with little guidance to clinically determine the risk threshold for involuntary admission for this population, it would be difficult to enact consistently in practice. Furthermore, the goals of concurrent medical, psychiatric stabilization and engagement in substance use disorder treatment require expertise and resources not readily available in either hospital or community settings in Canada, given the underfunding of such services and system fragmentation. Is there an opportunity for the development of practice guidelines and decision-making aids to support front line emergency clinicians, psychiatrists, and medical specialists in their work with this population?

Last, but not least, concerns have been raised that the possibility of involuntary admission might deter people with substance use disorders from appropriate help-seeking, further marginalizing this population.[5,6] Consultation with people with severe substance use disorders in recovery, their families, and community organizations would be needed to further explore and mitigate against these concerns.

IMPLICATIONS

There is an urgent need to improve access to community based medical care, behavioral supports, voluntary residential treatment, and harm reduction services for people with substance use disorders across Canada. Among Canadian emergency physicians and their community counterparts, a variety of mechanisms would enable high-quality care for this population. These may include medical education, adequately resourced practice settings, research, and community advocacy. Such mechanisms necessitate a pressing call to action on numerous fronts.

First, knowledge and practice gaps in the care of people with substance use disorders will persist without adequate investments in research. Researchers should continue developing novel treatment approaches, as well as the evidence base on predicting risks of harm from substance use disorders, and the proximal and distal outcomes, including the potential benefits of involuntary admissions for the small group of individuals with severe, life-threatening substance use disorders.

On the clinical front, physicians can intervene to offer life-saving treatment without invoking mental health legislation, keeping in mind that premature discharge against medical advice may compromise outcomes and the ability to connect this population to much needed supports. Decisions about involuntary admission under provincial legislative provisions should never be taken lightly or applied liberally. Involuntary admission to the appropriate medical or psychiatric service may be considered, however, on a case by case basis, for select individuals whose escalating patterns of use, lack of or decreasing engagement with community supports, and complex comorbidities result in imminent and significant risk of harm. In the absence of clear guidelines or thresholds for admission, deciding on risks and potential benefits of an involuntary admission requires extensive collaboration with an individual's support network, and colleagues in Addictions and Psychiatry.

Advocacy and administrative action across hospital and community providers will be essential to secure adequately resourced practice settings, targeted education/capacity building, and permissive policies to support clinical care decisions about hospital admissions and practice-based research initiatives.

Finally, from a policy perspective, a clearer stance on the potential use of provincial legislative provisions in the context of substance use is required by relevant policy-makers, as is increased public reporting of adverse substance use outcomes to better inform research and practice.

Ultimately, the intent of such efforts is to improve care and outcomes for people with substance use disorders, and address knowledge, practice, and advocacy gaps for a highly marginalized population.

Box 1. Case example.

Consider this

Joseph drinks mouthwash and hard liquor daily and has a history of generalized anxiety disorder. He presents to the emergency department daily in relation to his harmful use of alcohol, including following severe intoxication, falls, and complex withdrawal. Despite intensive community supports, behaviors putting him at imminent risk of death continue to escalate, including falling asleep outside while intoxicated in sub-zero temperatures. He frequently leaves hospital against medical advice while medically unstable or in severe withdrawal. His community supports alert you to escalating high-risk behaviors, increasing isolation, poor physical health, and disconnection from services.

Is there a role for involuntary admission to stabilize medically, treat underlying anxiety, and re-engage with community supports?

Keywords: Bioethics, emergency medicine, involuntary admission, substance use disorder

Competing interests: None declared.

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LAW, ETHICS AND MEDICINE

Pressure and coercion in the care for the addicted: ethical perspectives

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The use of coercive measures in the care for the addicted has changed over the past 20 years. Laws that have adopted the "dangerousness" criterion in order to secure patients' rights to non-intervention are increasingly subjected to critique as many authors plead for wider dangerousness criteria. One of the most salient moral issues at stake is whether addicts who are at risk of causing danger to themselves should be involuntarily admitted and/or treated. In this article, it is argued that the dilemma between coercion on the one hand and abandonment on the other cannot be analysed without differentiated perspectives on the key notions that are used in these debates. The ambiguity these notions carry within care practice indicates that the conflict between the prevention of danger and respect for autonomy is not as sharp as the legal systems seem to imply. Some coercive measures need not be interpreted as an infringement of autonomy—rather, they should be interpreted as a way to provide good care.

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Over the last two decades, many countries have adopted new laws that regulate the use of coercive measures in psychiatric care.[1 2] These laws have been guided by the principle of autonomy. Patients are considered autonomous unless there is sufficient proof to the contrary. This also implies that patients who refuse admission or treatment cannot be coerced. In the USA, like in many European countries, the right to non-intervention is considered absolute unless harm has been caused, as a result of the disorder, or there is a high enough risk or harm.[3 4] The new autonomy based laws reflect the philosophy of J S Mill.[5 6] Individuals have sovereignty over themselves unless others are harmed. Yet important questions have arisen regarding the so called "dangerousness" criterion of the new laws.[7 8] How wide should this criterion be interpreted? Is the term "dangerousness" appropriate at all? Or are other notions better equipped to render account of involuntary interventions? Narrow, libertarian interpretations of notions such as autonomy, coercion, and danger are again under discussion. It is increasingly argued that if we do not want to abandon those who need but refuse care, more frequent use of coercive measures in the care for the addicted is indicated.[9]

However, the problem is that adoption of a wider dangerousness criterion in the new, autonomy based laws is difficult to put into practice. More frequent use of coercion raises a number of ethical, medical, and political questions. There seems to be a "catch 22" situation in the sense that neglect of languishing, chronic addicts who are reluctant to receive care is hard to accept whereas at the same time, the beneficial effects of more frequent use of coercion are difficult to predict.[10] The aim of this article is to provide directions for a way out of this dilemma through a critical, philosophical analysis of the notions that are central in the debate on the use of coercion in the care for the addicted. Philosophical reflection, based on the practice of the care for the addicted, reveals that the central notions of the juridical realm are not as clear cut as is sometimes implied by the laws. A differentiated perspective is imperative because it reveals that, within their practical context, the notions carry different, often ambiguous meanings that are morally relevant. We hope to be able to indicate that this philosophical analysis is relevant for most European and American countries as many Western societies are struggling with this dilemma in similar ways. At the same time, differences are acknowledged and it must be admitted that a certain degree of generalisation is inescapable. The focus on literature and recent jurisprudence from the Netherlands is only provided as a concrete example.

1. ETHICAL ISSUES

The ethical problems in the care for the addicted are complex. Understanding this ethical complexity requires a philosophical analysis of prevailing ambiguities in the way the problem of addiction is understood. Two different philosophical anthropologies underlie the ethical debates about addiction. Both raise the question to what extent the addicted should be regarded as autonomous moral agents and both, though partly incompatible, seem to be relevant. The troublesome concept of autonomy in the care for the addicted indicates the need for differentiated perspectives on autonomy. After having analysed the issue of autonomy, it will be argued in two consecutive sections that the concepts of coercion and of danger are also not as unequivocal as is implied in the law and some of the literature. The different meanings that the notions of coercion and danger carry should be accounted for.

1.1. Different anthropologies

Addiction is generally conceived of as a disease with concomitant psychosocial aspects.[12–15]

Addicted people are called patients, in need of medical treatment instead of punishment. They cannot be considered fully accountable for their addiction. At the same time, moral aspects are intrinsically connected with the problem of addiction. Addicts are not only considered victims of their disease, they are also regarded as autonomous agents. They have somehow chosen for a particular lifestyle.[12] Unwanted psychomedical interventions seem to violate the individual integrity of the addict. Only when others are put in danger by the behaviour of the addict is society entitled to intervention. When the danger is taken away, the addict who refuses treatment should be left alone.

In other words, the ambiguity in the care for the addicted comes forth out of the interconnectedness of two, partly incompatible, anthropologies. Within one anthropology, the addict is regarded as a patient, in need of help. Drug use is primarily seen as an individual problem. The goal of medical treatment is abstinence. If this goal is frustrated and the addict relapses again and again, palliation of the symptoms that are caused by drug use should be aimed at.[16] This anthropology can be called a *medical* anthropology. It acknowledges that illness is something that can happen to you and that illness, especially psychiatric illness, can result in a partial reduction of competence. Within the other anthropology, the addict is regarded as a client and an autonomous moral agent. Addiction is a self inflicted condition; a vice. It is not regarded as an individual problem but rather as a societal problem, and society has to protect its citizens. Addicts choose to use a certain drug, realising that drug use involves certain risks. If criminal behaviour follows, the addict must be held accountable because he knew that risks were involved. Therefore, if others are being harmed by an addict, the addict deserves punishment. Neither abstinence nor palliation is the aim of treatment but the prevention of harm to others. This anthropology can be called a *legal* anthropology. Elements of both anthropologies coincide in the care for the addicted, because addiction is regarded as both an illness and as a vice.[12] In countries like the USA, the Netherlands, Sweden, and Germany, where the notion of beneficence has been pushed into the background and where courts decide the permissibility of coerced admission, the legal anthropology is dominant. In countries such as the UK and France, where elements of the older laws survived and where physicians decide about the permissibility of coerced admission, the medical anthropology is dominant.[1 17 18]

The interconnection of these two different anthropologies in the care for the addicted raises the question of the competence of the addict. Typically, within the medical anthropology, the disease can be considered as an excuse for the patient's behaviour. Medical treatment is needed because it serves to restore autonomy. Within the legal anthropology, the client's chosen lifestyle makes him responsible and accountable for his acts. In other words, the old distinction between an ethic of autonomy and an ethic of paternalism presents itself. Recently, however, more differentiated perspectives on autonomy in the care for the addicted have been proposed in which elements of the old, beneficence based laws coincide with elements of the new, autonomy based laws.[11 19]

1.2. Varieties of autonomy

Juridical discourse and laws necessarily simplify: a person is competent, partially incompetent, or incompetent. Whereas the beneficence based laws stressed that psychiatric disorders render patients incompetent, the new laws presuppose competency unless there is sufficient proof of the contrary. For instance the autonomy based laws in the Netherlands, Germany, and Austria hold that patients who refuse outright or fail to give their consent (as is the case for many addicted patients) cannot be voluntarily admitted. Rather, they have to meet the dangerousness criteria of the laws.[20] Competency is closely associated with a right to non-intervention. If harm is done to others, people need to account for their acts. Thus, competent addicts who refuse care should be left alone, unless the threat they pose to themselves or others is sufficiently grave to allow for coercive intervention. The concept of autonomy that has been adopted in the new laws reflects the philosophical writings of J S Mill.[5 6] As long as no others are harmed, the individual has sovereignty over himself. Not surprisingly, the notion of autonomy has received little attention in the debates on care for the addicted. After all, from a juridical point of view, the harm that comes forth out of the disorder is decisive for intervention, not the question of whether the subject is autonomous or not.[21]

Therefore, the concept of autonomy is conceived of as a negative right in the sense that it sets limits for others; it articulates what others are *not* allowed to do.[22] This conception, important as it is within law, has limited relevance for care practice. It is based on mistrust between patient and caregiver because it only articulates the limits of care and says nothing about what proper care is or should be. In other words, it fails to appreciate practically relevant moral meanings. Alternatively, in a more positive sense, autonomy can be conceived of as a capacity to form and shape one's life together with others. This concept of autonomy stresses not only the cognitive capacities patients need in order to make respectable decisions, it also stresses the importance of patients' emotions and values. It not only focuses on the question of whether a patient's decisions are autonomous or not, it focuses on the decision making *process*, taken as a dialogue between caregiver and patient. Within this process, the patient is stimulated to make decisions that fit with his personality as it has evolved in the past and through relations with others. Then, the ability to understand the caregiver's information and to articulate good—or at least acceptable—reasons for one's decision is only a minimum requirement. More important is that there is sufficient openness in the conversation in order to allow the patient to address the values and issues that are important to him.[23 24]

An example of an alternative, practically relevant conception of autonomy can be found in the writings of Dworkin who distinguishes between first order and second order desires. First order desires relate to impulsive, short term preferences. Autonomy is considered critical self reflection. It is a capacity of the second order because it signifies the capacity to critically reflect on first order desires and preferences. Acting upon short term desires would be considered autonomous only if there had been sufficient critical reflection.[25] A two layered concept of autonomy can also be found in the writings of Harry Frankfurt. According to Frankfurt, it is not so much through rational reflection that a person can take distance from his first order desires but rather it is the will. People are autonomous if they are able to want a desire to be the one that moves them effectively to act.[26] To be autonomous, it does not suffice to only want a desire (Frankfurt speaks of ''wanton''). What is needed is the ability to want a desire to be one's will (Frankfurt speaks of ''volition''). Typically, within this theory, addicts are not fully autonomous. At a second order level, they may hate their addiction and want to overcome their first order desires but in the vast majority of cases, the first order desires are decisive.

It has been argued that people suffering from recurrent mental disorders typically feel that they have two different selves.[27] One ''self'' is inclined to act upon short term desires; the other ''self'' is guided by longer term preferences and

goals. After having given in to their addiction, many addicted people suffer because they have (again) harmed themselves or their loved ones. In other words, their addiction can diminish their autonomy because the capacity to critically reflect on short term preferences is limited. Increasing the patient's autonomy can then be regarded as a goal of care in the sense that the caregiver, in dialogue with the patient, tries to help the patient reflect on his addiction and articulate his second order desires. Fostering the patient's autonomy can imply a persuasive or even manipulative approach, trying to bring the longer term values and goals of a patient to the surface. Criticising the cognitively oriented concept of Dworkin, Agich has linked autonomy to identity.[28] Respecting a patient's autonomy is not only concerned with conflict situations in which difficult decisions have to be made. The libertarian presumption of a rational and sovereign individual is an abstraction from reality. In care practice, it is more important to enable a patient to identify with the concrete situation.[24 29] This means that actual autonomy is attributed a dynamic character, and is not something that is present or absent—rather, it has to be developed through interaction with ever changing circumstances. Within the caregiver-patient relationship, autonomy is a challenge. It is not only the patient who decides after having received and understood the caregiver's information. Rather, the patient decides together with the caregiver. The patient is stimulated to regain his identity and to make decisions that fit his identity. If the development of an identity is an interpersonal process, then autonomy too is intrinsically linked with others: actual autonomy is a social notion that presupposes a community.

In the context of the care for the addicted, this dynamic, differentiated, and positive concept of autonomy seems to carry more practical relevance than the negative concept adopted in the law. Firstly, the distinction between short term desires and long term goals is recognisable to most of us but it is of special importance for the addicted. Secondly, it acknowledges that patients have a life history behind them that has developed in and through interpersonal relationships, and that patients also hope for a (better) future. Thirdly, it provides room for solidarity in the sense that it acknowledges our common interdependency. Acknowledging this opens the way for compassion to those who rely on care from others. Finally, it provides room for persuasion when a caregiver feels that his patient is at risk of relapse. In the patient-caregiver relationship, some forms of pressure are justifiable without necessarily violating the patient's right to self determination. A crucial question then is what kinds of pressure are justifiable. As will be indicated below, the distinction between pressure and coercion is not as clear cut as is sometimes implied in the literature.

1.3. Varieties of coercion

The law typically assumes a restricted definition of coercion—that is, involuntary commitment or treatment. The concept of coercion is ambiguous. A narrow concept of coercion has been suggested by Frankfurt.[30 31] In his view, coercion implies the absence of a possibility to choose. The victim is psychologically compelled to do what he does. The autonomy of the person is violated because he is driven by desires he does not want to be driven by. Wertheimer acknowledges that coercion is linked to a feeling of constraint but questions at the same time that this would imply the absence of autonomy.[32] Even if there is only one possible decision, Wertheimer leaves open the possibility that one can still experience this decision as one's own. Coercion need not extinguish the cognitive and volitional capacities of the person coerced. Contrary to Frankfurt, Wertheimer does not define coercion in relation to the absence of choice. Instead, central to Wertheimer is that coercion implies that the coercing person does not have a right to make the coercive proposal. In Wertheimer's view, coercion is a moral notion. Problematic in this view is that individuals can disagree over what constitutes a right or an obligation.[31] In the context of this contribution, Wertheimer's moralised view on coercion is of limited practical relevance. It would be paradoxical to speak of proper use of coercion in the care for the addicted acknowledging at the same time that the coercing person does not have a right to make the coercive proposal. Questions can be raised against Frankfurt's narrow conception of coercion as well. In the context of the care for the addicted, coercion also denotes less extreme violations of patients' choices. It is hard to conceive of cases of involuntary admissions and involuntary treatment in which any rational consideration of the addict is absent (Wertheimer is right to acknowledge this). There is always a choice—for instance, the choice between resistance and cooperation. In the care for the addicted, coercion need not always exclude any kind of deliberation of the victim. Thus, the point where pressure becomes coercion is not so easy to determine.

Useful standards for the use of coercion have been developed that acknowledge the principle of subsidiarity.[21 33] Experience suggests that much can be done to prevent the kinds of danger that would allow for involuntary admission.[34 35] And if use of coercion is a prima facie moral evil, it is morally imperative that preventive measures are taken in an early stage of the care process.[36] Outpatient interventions are necessary because they support the patient in coming to grips with the situation. Many addicts will not spontaneously ask for care. When the caregiver is notified by the patient's loved ones, interference may prevent further deterioration. Caregivers, together with the addict's family, may be successful in persuading the patient to enter an inpatient or outpatient treatment programme. If caregivers foresee that the addicted patient's condition is at risk of deteriorating, pressure can be used in order to convince a patient to have himself treated. Even though from a libertarian perspective, pressure can be rejected as it manipulates the patient's autonomous preferences, from a communitarian perspective it can be defended as a form of good care.[24] What is more, if we adopt a positive and dynamic conception of autonomy, pressure intends to stimulate autonomy and enable the patient to articulate the longer term goals of his life. In short, pressure and autonomy can under certain circumstances go hand in hand.

Apart from persuasion and manipulation, pressure can also take the form of a coercive offer or a coercive threat. In the former case, the patient will be rewarded if he meets certain criteria. For instance, if a patient enters a treatment programme, he will receive more respect from his children. In the latter case, the patient will experience negative consequences if he does not meet certain criteria. For instance, he will be at risk of becoming homeless if he does not enter a treatment programme. It is not difficult to see that the more radical the impact of the consequences is on the life of the patient, the harder it becomes for the patient to resist the pressure. Coercive offers or threats can thus take the form of coercion, even if one adopts Frankfurt's narrow conception. Offers and threats can appeal ''to desires or motives which are beyond the victim's ability to control''.[30] Although Wertheimer limits his concept of coercion to threats (offers are called inducements), we claim that, depending on the impact of what is offered, offers can be coercive.

The use of coercive offers and coercive threats by caregivers is not ethically unproblematic and it requires a moral justification. In fact, research that was conducted in the US showed that addicts experienced various kinds of pressure outside of institutions as more coercive than legal coercive measures such as involuntary admission.[37] A majority of the subjects of the study expressed that the main reasons for

entering treatment were non-coercive. Instead, treatment entry was associated with positive recognition from loved ones and a positive motivation to improve oneself.

For many, pressure will not convince them to accept treatment. Their situation continues to deteriorate. Some will already have lost a social network and might even have become homeless. According to many new laws, the patient is to be left alone unless the risk of danger would be grave enough to allow for involuntary admission.[1 3 18] The alternative of compulsory outpatient treatment would seem hard to justify within the new laws as the dangerousness criteria for compulsory treatment are more restrictive than the criteria for involuntary admission. Yet, empirical data indicate that compulsory outpatient treatment is positively evaluated because it is less restrictive than involuntary admission and it may provide a way out of the vicious circle many addicts find themselves in.[38 39]

The options of persuasion, use of informal pressure, and the possibility of outpatient commitment are to be taken into consideration before legal coercive measures such as involuntary admission or treatment can be justified.

Yet, when legally sanctioned coercive measures are carried out, there seems to be a shift of paradigm. As described above, debates on coercive measures centre on the notion of danger. The autonomy of the patient becomes irrelevant. It is no longer the patient himself who is in the middle, it is the harm that he is likely to cause that needs to be prevented or taken away. But what kinds of danger and risks of harm would allow for legal intervention that sanctions involuntary admission or even involuntary treatment?

1.4. Varieties of danger

Self evidently, not all kinds of danger inflicted by addicts can lead to legally sanctioned coercive measures. The following discusses the requirements the Dutch law states but there is evidence that the differences with other countries that have accepted the dangerousness criterion are marginal.[1 4 18]

Firstly, the recent laws and/or jurisprudence hold that the danger needs to come forth out of the mental disorder. And indeed, because addiction clinics are authorised to execute the law for involuntary psychiatric admissions, addiction is conceived of as a mental disorder. Precisely because of the ambiguity in our understanding of addiction (see above), it is not always easy to determine to what extent the danger actually comes forth out of the addiction or whether other factors may have been decisive. Secondly, the danger need not already have taken place even though the risk must be high. But how high should the risk be to allow for involuntary admissions? A certain degree of arbitrariness is difficult to avoid. Anticipating a court order, psychiatrists can be extremely reserved issuing medical accounts. Thirdly, jurisprudence has articulated the objects of the danger that would be conditional for an involuntary admission. Distinctions have been made between danger to oneself, danger to others, and danger to public security and public goods.[40] In many cases, the admission itself is the means that takes away the danger.[41] As the patient is to be discharged when the danger has been taken away, strictly speaking, this could be the case very shortly after admission. This also means that, according to the law, the involuntarily admitted addict may refuse treatment at all times. Involuntary treatment is unjustifiable unless there is risk of *extreme* danger for oneself or for others that is a result of the mental disorder. Recently, voices were raised in the Dutch Parliament pleading to erase the adjective ''extreme'' in order to allow for coerced treatment in the context of a coerced admission.[42] But currently, involuntary treatment is only allowed in cases where danger is caused or likely to be caused after admission—that is, inside the clinic. Surprisingly, in the case of addiction the involuntary admission coincides with the start of treatment, as the detoxification automatically starts with the admission.

The criteria for danger caused to oneself are more restrictive than the criteria for danger caused to others. In most countries the dangerousness criterion is currently being widened, especially regarding danger caused to oneself. Chronic addicts who end up on the streets and are reluctant to accept care would cause sufficient danger for themselves in order to allow for coerced admission and/or treatment. But what exactly does it mean to widen the dangerousness criterion in order to allow for involuntary admissions of people who cause danger to themselves? Should it not be interpreted as a return to the beneficence criterion of the older laws?[40]

2. DANGER OR BENEFICENCE

Everyday care—inpatient or outpatient—is provided in the context of interpersonal relationships. Referring to the philosophy of Lévinas, it is the Other—the addict or his loved ones—that sets the norm for the caregiver.[43] In a patient-caregiver relationship, the patient's wellbeing has priority over societal benefit. In other words, for the caregiver the principle of beneficence must carry more weight than the criterion of danger.

For ethics to be practically relevant, care practice should be its starting point. Following a juridical discourse (legitimate as this discourse is) will leave important moral meanings unarticulated.[44] If there is a way out of the ''catch 22'' dilemma as described above, then the crucial notions of the new laws need to be reinterpreted in the context of the caregiver-patient relationship. Therefore, from an ethical point of view, it is problematic that the dominance of juridical discourse has turned the good of the patient into a taboo subject, even though it should be acknowledged that the juridical discourse resulted from the legitimate desire to give a voice to patients and protect them from maleficent interventions. It seems as if the notion of beneficence has become so much associated with the paternalism of earlier laws that it has become forgotten within the debates on the use of coercion in care for the addicted.[45] If there is not a sufficient risk of danger, the addict should be left alone. In other words, autonomy is considered as antithetical to beneficence. And it is precisely this antithetical relationship that makes it impossible to escape from and transcend the ''catch 22'' dilemma.

In fact, care practice itself gives clues for the limited relevance of the autonomy based laws. After all, strictly applying the law in everyday practice would lead to situations that are difficult to morally justify. Coerced treatment with an involuntarily admitted patient is hardly ever an option because, in the vast majority of cases, it is the involuntary admission itself that takes away the danger. Then, involuntary admission is not much more than a temporary measure unlikely to help the so called ''revolving door'' patients. Outpatient involuntary treatment has to be considered impossible because the criteria for coerced treatment are stricter than the criteria for coerced admission. If coerced treatment is administered, it should be stopped immediately once the severe danger has been taken away or prevented. So again, we face temporary measures that in the longer term will not be effective. Current appeals to widen the dangerousness criteria of the new laws can be understood and explained in this light. In fact, everyday care practice reveals that involuntary admissions and involuntary treatment are not as strictly separated as the law seems to imply. A stay in a drug free environment can be a good start to enter a treatment programme, as well as in the context of an involuntary admission. As the moral issues at stake in everyday practice seem to be far more complex and differentiated than juridical

discourse implies, it is striking that the current ethical debates on conditions that would allow for more frequent use of coercion in the care for the addicted have by far and large adopted a juridical language. The scope of the notions is under discussion, but the notions themselves are not scrutinised.

In order to transcend the apparent dichotomy between beneficence and autonomy it is imperative to introduce alternative, more differentiated concepts than is currently the case. Then, it becomes apparent that everyday care for the addicted is always interpersonal and that beneficence—that is, taking up one's responsibility in the face of the other—is the guiding criterion within this relationship. In the first place, it is the wellbeing of the other that is at stake, and this wellbeing is intrinsically related with his autonomy. If autonomy is conceived of as a dynamic challenge, to be developed and fostered through interpersonal relations, then autonomy need not be antithetical to the use of pressure or even coercion. The patient, including his history, his hopes for the future, his emotions, and his values, remains the guide. Sometimes, this implies that pressure or coercion is not indicated as it may severely damage the patient-caregiver relationship. But sometimes this implies that the current preferences of the patient are overruled in favour of other, longer term goals and values. In this sense, the autonomy of the patient is safeguarded, not by upholding his right to non-intervention but, contrarily, by intervention.

Within a narrow concept of coercion—for instance, the admission of a patient to an institution against his autonomous will—the will of the patient is put aside. Currently in the Netherlands there is a public debate, not only on the scope of the dangerousness criterion but also on the possibility to increase the number of options when coercion becomes justifiable. In a proposal for amendment of the BOPZ law, an observational court order was proposed that would allow for an involuntary admission of three to five weeks to assess the psychiatric condition in people with mental illness (such as substance related disorders).[11]

Furthermore, in the context of a socialisation of mental health care, members of parliament have pleaded for the possibility of a conditional legal court order.[42] If there is a sufficient risk of danger but the danger can be averted outside institutions, the judge can issue a conditional legal court order that makes it possible for the patient to remain at home if (and only if) certain conditions are met. In most cases, these conditions will involve the use of medication but in the care for the addicted, a concomitant condition can involve abstinence from alcohol or drug use. If the patient does not meet the conditions he will be admitted to a clinic even if he refuses at the time of admittance. These conditions must have been negotiated with the patient and the physician. As is the case with court orders, the conditions have to relate proportionately to the (risk of) danger. Not all kinds of conditions can be enforced. Contrary to the narrow concept of coercion in the law, the will of the patient is not completely eliminated. Even in such extreme situations, where the threat of danger is high enough to justify coercion, there remains the possibility of a choice even though the advantages of accepting the conditional court order stand for the vast majority of patients in no proportion to the disadvantages of an involuntary admission. Apart from the advantage that the will of the patient is not eliminated, other advantages are that the patient can stay in his own environment and keep contact with his loved ones. More than in institutions, he will be able to keep some control of his daily activities. In other words, his autonomy, regarded as a capacity for identification, is respected and can be fostered during the time of the conditional court order. Necessarily, this option implies a widening of the dangerousness criterion as the current Dutch law explicitly requires that coercive measures cannot be justified if the danger can principally be averted in the outpatient situation. For many caregivers however, it will first and foremost imply a good possibility to provide empathic care taking the autonomy of the patient into account.

A second option that has been included in the law from the beginning but has only recently been given attention is concerned with court orders at the request of the patient. This coercive measure has been designed specifically for the addicted. Those who are willing to be admitted and treated in institutions can, together with their physician, request the court to issue an order for half a year to one year that regulates continuing admission when the patient wants to be dismissed and/or continuing treatment if the patient wants to stop treatment. Moreover, and similar to the conditional court order, it is possible that the patient and his physician request the court to issue an order, saying that the patient can be involuntarily admitted when he stops his outpatient treatment or when he starts using drugs again. Contrary to the conditional court order, it is the patient himself who requests coercive measures under well circumscribed conditions. For the court to meet the request, danger must be present but it need not necessarily come forth from the mental disorder. From a juridical point of view, these orders are difficult to regulate because good reasons can be given to be reluctant about enforcing private agreements that limit personal freedom.[46] From an ethical perspective however, it can be argued that this option does not harm the patient's autonomy, at least if we adopt alternative conceptions of autonomy that were analysed above. The patient allows his longer term goals and values to prevail over his short term desires, and in doing so, he hopes that his capacity to identify himself with the situation is fostered. Again, even in extreme situations when danger lurks, the patient's self determination does not necessarily have to be neglected. Chronically addicted patients particularly, who tend to be reluctant to professional care and for whom use of legal coercion is contraindicated, may profit from less restrictive options than strictly coerced admission or treatment. For the patient-caregiver relationship, beneficence and trust are not necessarily harmed if the patient himself has requested to be involuntarily treated if well circumscribed conditions are met.

3. CONCLUSION

The moral dilemmas regarding use of coercion in the care for the addicted cannot only be understood within a juridical realm but need also input from well trained caregivers themselves. It will then appear that, in order to be of practical relevance to caregivers, notions that are central in the juridical realm need to be reinterpreted. In this contribution, differentiated perspectives have been sketched out on the notions of autonomy, coercion, and danger. Whereas the notion of beneficence seems to have been abandoned in the new, autonomy based laws on involuntary admission, for the caregivers themselves this notion may be more adequate than the notion of danger. In the face of a severely addicted patient in need of care, caregivers may not have the experience to realise when danger has to be averted. Rather, they want to provide beneficial care. If autonomy is regarded as a positive capacity to identify oneself with the situation, pressure and even some coercive measures are not necessarily antithetical to respect for autonomy. Strict coercion—that is, admitting or treating a patient against his will—can be indicated. Research mentioned above has revealed that the efficacy of coercive measures is not less, and sometimes even higher, than the efficacy of voluntary measures and thus, coercion can be beneficial on the longer term. Yet, less restrictive alternatives that have not been given sufficient

attention thus far can sometimes be applied. Recently, a debate began on alternative coercive measures that do not completely overrule or neglect the will of a patient. Further discussion on measures such as a conditional court order, allowing the patient to be treated in the outpatient situation, and a court order at the request of the patient, seems imperative because these measures reveal that, even in extreme situations, there is still a possibility of choice and the will of the patient need not be fully put aside.

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Heegsma et al *-and-* **CITY of HAMILTON**

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Court File No.COA-25-CV-0166

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APPEAL BOOK - VOLUME 8

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